	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Practice Plus Group Health and Rehabilitation Services Limited**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 24 August 2020 I commenced an investigation into the death of Dominic Robert Noble, aged 32. The investigation concluded at the end of the Inquest on 30 June 2022. The conclusion of the Inquest was a narrative conclusion based upon the cause of death of 1a Hanging. The narrative conclusion was that Mr Noble died as a result of suicide and made findings in relation to his management and the healthcare provided to him whilst he was on remand in prison.
4	**CIRCUMSTANCES OF THE DEATH** Mr Noble was remanded to HMP Leeds on 8 June 2020 on terrorist charges. In the 10 weeks he was in prison he was seen on multiple occasions by the nursing staff. A decision was made on 14 July 2020 that he should be assessed by a psychiatrist but he remained on the waiting list without an appointment date at the time of his death on Saturday 15 August 2020.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) Evidence was taken at the inquest that: (i) HMP Leeds has only 3 days per week of a psychiatrist's time available (ii) HMP Leeds has some 5000 prisoners arriving each year (iii) A large proportion of the prisoners arriving have mental health issues (iv) The mental health team is mainly a nurse-led service (v) The division of labour between mental health nurses and psychiatrists is that a doctor is responsible for the diagnosis of mental illness, prescribing medication such as anti-psychotic drugs and seeing prisoners/patients with severe or complex conditions. Mental health nurses make initial assessments and provide ongoing care. (vi) Concern was expressed about the adequacy of the psychiatric doctor provision to provide psychiatric treatment for a large population which includes men with significant mental health issues. (vii) Mr Noble was deemed to require assessment by a psychiatrist on 14 July 2020 as a non-urgent case but at the time of his death on 15 August 2020 no appointment had been given.

	(viii) A mental health nurse working on behalf of PPG on 10 July 2020 identified the "possibility of emerging psychotic features" and noted the sentiment that engaging in treatment as soon as possible militated in favour of a better outcome. Where such a suspicion was raised it would have been advantageous to obtain a second opinion from a psychiatrist swiftly (particularly after his mother contacted the prison to report his paranoid and bizarre conversation regarding a gun, a secret room in the prison and some unknown person trying to kill him.) (2) It is acknowledged that evidence was given at the inquest that: (i) PPG could draw additional psychiatric input from elsewhere in the PPG group, but there was no evidence to indicate when, if ever, this was last done. (ii) Waiting times for an appointment with a psychiatrist in the community could be 5 months or more and thus the principle of equivalence of care was achieved. (3) Concern was expressed in the course of the inquest that the meagre provision of psychiatric consultant availability might deter mental health nurses from making referrals. This concern was not accepted on behalf of PPG. Despite this the concern remains that a self-fulfilling prophecy has inadvertently been created in which referrals are not made because there is no resource to respond to any which may be made (4) The concerns raised mirrored issues raised in an inquest which concluded on 1 June 2022 relating to the death of Mohammed Irfaan Afzal in HM Prison Leeds on 4 August 2019. In a narrative conclusion the jury concluded that despite an urgent referral to a psychiatrist on 15 July 2019, no appointment had been provided before his death on 4 August 2019, "it is possible that the delays in providing treatment contributed more than minimally to Mr Afzal's death". (5) In view of these concerns PPG are asked to review the availability of psychiatrists at HMP Leeds to determine whether it is sufficient to meet the needs of a cohort of mentally unwell prisoners.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 September 2022. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons • [redacted], mother of the deceased I have also sent it to: • NHS England • The Rt Hon Dominic Raab MP, Secretary of State for Justice • The Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care • *The Independent* newspaper FAO [redacted] who may find it useful or of interest.

	I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	 **Kevin McLoughlin** **Senior Coroner, West Yorkshire (East)** **1 July 2022**