REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] (Head of Healthcare at HMP Hewell), Practice Plus Group, c/o HMP Hewell, Hewell Lane, Redditch, Worcs B97 6QS.**
1	**CORONER** I am David Donald William Reid, Senior Coroner, for the coroner area of Worcestershire.
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 28.7.21 an investigation was commenced into the death of Gary McDonald, a prisoner at HMP Hewell, who died at the prison on 21.7.22, being 49 years of age. This investigation concluded at the end of the inquest on 16.9.22. The medical cause of death was: 1a hanging. The conclusion of the inquest was as follows: *"Gary McDonald died as the result of suicide."*
4	**CIRCUMSTANCES OF THE DEATH** At the time of his death Mr. McDonald had spent nearly 4 months on remand at HMP Hewell awaiting trial. On 21.7.21 he was found deceased in his cell at HMP Hewell having apparently suspended himself [redacted] Although his medical history included a diagnosis of depression (dating from 2011) and two recorded episodes of overdoses (in 2012 and 2020), he had never given staff at the prison any reason to believe that he might have been struggling with his mental health throughout his time there.
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) During his initial healthcare screening appointment on the evening he arrived at HMP Hewell (25.3.21) and his secondary healthcare screening appointment the following day, Mr. McDonald denied any mental health issues, and denied any current thoughts of suicide or self-harm. His community GP records were

	requested and were received by the prison on 30.3.21; these showed a previous history of depression, and two previous drug overdoses, the most recent of which had been only 7 months earlier; 2) Despite this history, no appointment was made with Mr. McDonald by the healthcare or mental healthcare teams to follow this up with him, and discuss his mental health in more depth; 3) In his evidence to the inquest, the current Head of Healthcare at the prison conceded that it might have been appropriate for someone to have visited Mr. McDonald, raised with him what the GP summary had shown, and asked him if he would like any help, but that he would only have expected any such follow-up if there had been any current concerns about his mental health. He further confirmed that there would have been no automatic follow-up about this, even if staff believed that Mr. McDonald may have deliberately misled them about his mental health history during his healthcare screening appointments; 4) In subsequent correspondence to my office, the Head of Healthcare has suggested that it might be appropriate to delay a prisoner's secondary healthcare screening appointment until his GP records have been obtained and scrutinised, so that concerns about any history set out in those records can be raised with the prisoner. That proposal is due to be raised at the prison's next Local Quality Assurance Meeting; 5) I am concerned that there is currently no system in place at HMP Hewell to follow up with a prisoner any discrepancy between the mental health history which he has disclosed on arrival at the prison, and that revealed in his community GP records. Experience suggests that a prisoner with a recorded history of mental health issues, particularly one which includes a recent episode of attempted suicide or self-harm through overdose, may be at his most vulnerable during his first days and weeks at a prison, and having been reluctant to disclose such issues for any number of reasons (e.g. fear, embarrassment), may be reassured to be told that healthcare staff at the prison are aware of that history and can provide confidential support. In my view, without routine follow-up in such cases, there remains a significant risk that a prisoner's recent significant history of suicide or self-harm may be overlooked in those important early days and weeks in prison, and that such prisoners will therefore be at an increased risk of further episodes of attempted suicide during that period.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action by conducting an investigation into the deficiencies outlined above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th November 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:

	1) [redacted] Chief Executive Officer, Practice Plus Group, Hawker House, 5-6 Napier Court, Napier Road, Reading, Berkshire, RG1 8BW; 2) [redacted] solicitors, 180 North Gower Street, London NW1 2NB, who represent Mr. McDonald's family; 3) Government Legal Department, who represent HM Prison Service; 4) The Prison and Probation Ombudsman. 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	**Signed** **----------** **D. D. W. Reid** **20th September 2022** **H.M. Senior Coroner for Worcestershire**