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. **The Governor, HMP Hewell, Hewell Lane, Redditch, Worcestershire B97 6QS.**
1	**CORONER** I am David Donald William Reid, HM 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 31.3.21 an investigation was commenced into the death of Andrew Paul SHIRLEY, a prisoner at HMP Hewell who died in his cell at the prison on 23.3.21 having deliberately suspended himself by a ligature. He was 25 years of age at the time of his death. This investigation concluded at the end of the inquest on 20.1.23. The medical cause of death was: 1a external neck compression (hanging). The conclusion of the inquest was as follows: "Andrew Shirley died as the result of deliberately suspending himself by a ligature. It is not possible to determine what his intention was at the time he did this. See questionnaire. Questionnaire: 1. Did healthcare and mental healthcare staff at HMP Hewell: (a) take sufficient steps to identify and record Andrew's risk of suicide and/or self-harm? NO (b) put in place sufficient measures to try to reduce that risk of suicide and/or self-harm, whether (for example) by locating Andrew on the Targeted Care Pathway, opening an ACCT document, recording concerns on the Initial Segregation Health Screen document, formulating a mental health care plan, or otherwise ? NO (c) share sufficient information about Andrew's risk of suicide and/or self harm with prison staff, so as to enable prison staff to make appropriate decisions themselves about reducing that risk? NO 2. If any of your answers to Questions 1(a)-(c) above is NO (a) did that failure/those failures probably cause or contribute to Andrew's death on 23 March 2021? YES

	3. (a) on 20.3.21 should the Duty Governor, after reading the Initial Segregation Health Screen document before making the decision that Andrew should remain on the Segregation Unit, have made any more enquiries about the answers given on that document? YES If YES to Question 3(a): (b) would those enquiries probably have led to further information being provided about an increased risk of Andrew committing an act of suicide or self-harm? YES If YES to Question 3(b): (c) should the Duty Governor have taken any action to try to reduce that risk (e.g. by opening an ACCT document)? YES 4. If YES to Question 3(c): (a) Did the failure to take such action probably cause or contribute to Andrew's death? CANNOT SAY (b) If NO or CANNOT SAY to Question 4(a), did that failure possibly cause or contribute to Andrew's death on 23 March 2021? YES Neglect 5. Was Andrew's death contributed to by neglect? YES
4	**CIRCUMSTANCES OF THE DEATH** In answering the questions "when, where, how and in what circumstances did Andrew come by his death?", the jury found as follows: *"On 23.3.21 Mr. Andrew Shirley was found unresponsive in cell 14 of the Segregation Unit at HMP Hewell suspended by a ligature. Advanced life saving measures were undertaken but he was pronounced dead at the scene at 1944hrs."* To clarify, at the time of these events Andrew was a diagnosed paranoid schizophrenic who had been receiving a monthly depot injection of anti-psychotic medication. He also had a documented history of self-harm and suicide attempts. Andrew had been in police custody from 25.2.21 until 1.3.21, during which time he had undergone a formal Mental Health Act assessment at the Caludon Centre, Coventry because of concerns about his mental health. Those conducting that assessment concluded that he did not require treatment in a psychiatric hospital, whether as a detained or voluntary inpatient. Following a court hearing on 1.3.21, Andrew was remanded into custody to await trial, and was taken to HMP Hewell. At the prison, Andrew's mental health history was noted and he was allocated a mental health care coordinator. During the three weeks that Andrew was at the prison, his care-coordinator failed to carry out any in-depth mental health assessment of him, failed even to begin to formulate a mental health care plan for him, and failed properly to assess and manage his risk of suicide and/or self-harm. The overall failings of the healthcare and mental healthcare teams at the prison are reflected in the answers of the jury to Questions 1, 2 and 5 in the Jury Questionnaire [above]. Throughout his time at the prison, Andrew said on several occasions that he felt that his medication was not working.

	On 20.3.21 Andrew was placed in the Segregation Unit at the prison, following an incident in which he spat at two prison officers. In order to assist the Duty Governor in deciding whether Andrew could be held safely on the Segregation Unit, a nurse completed an Initial Segregation Health Screen document, in which she recorded that Andrew was currently on anti-psychotic medication. In addition, during the course of her assessment of Andrew, he told her that he was hearing voices which were telling him to kill himself, and that he wanted a radio so that he could drown those voices out. That information was not relayed to the Duty Governor, but the Duty Governor accepted in his evidence that, in light of the information that Andrew was on anti-psychotic medication, he should have spoken to, and sought further information from the nurse. In their answers to Questions 3 and 4 in the Jury Questionnaire, the jury found that, had the Duty Governor sought this further information, he would probably have taken action to reduce Andrew's risk of suicide and/or self-harm (e.g. by opening an ACCT document), and his failure to do so possibly caused or contributed to Andrew's death on 23.3.21. Two further Initial Segregation Health Screen documents were completed on 22.3.21, by a paramedic and mental health nurse respectively. In the first of those, the paramedic concerned concluded that there were no "healthcare reasons" not to segregate Andrew at that time. That conclusion was based on two wrong answers in the algorithm contained within that document. The paramedic conceded that she had neither seen Andrew, nor looked at his medical records before completing this document. The mental health nurse who completed the second Initial Segregation Health Screen document also conceded that he had not seen Andrew beforehand, and accepted in evidence that he might have reached a different conclusion if he had read entries contained within Andrew's medical notes. Andrew was found collapsed and unresponsive in his cell on the following evening of 23.3.21, suspended by a ligature. He was confirmed deceased at the scene later that that day.
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) I heard evidence that v.6 of the ACCT document had been in place at prisons throughout England and Wales since June 2021, and that training relevant thereto consists of: (I) ACCT v.6 training; and (II) SASH (suicide and self-harm) model 3 training. However, I also heard that, as at 20.1.23 (over 18 months after the introduction of the latest ACCT document), 280 out of 400 members of staff at the prison (70%) were yet to have completed that training. It is of considerable concern that such a high percentage of staff at the prison may not be in a position to recognize the risk which a prisoner presents of suicide and/or self-harm, and therefore to take appropriate steps to reduce that risk; (2) I also heard evidence that, despite the introduction of a new initial Segregation Health screen algorithm document for prisoners in the Segregation Unit, Duty Governors at the prison had not yet received any training about the steps they should take in order to complete that document appropriately.
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 and failures outlined above, and ensuring that appropriate training is provided to all relevant staff.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24.3.23. 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: Bimberg Peirce solicitors, who represent Andrew's family; [redacted] Chief Executive of HM Prison and Probation Service; [redacted] HM Chief Inspector of Prisons; [redacted] chair of the Independent Advisory Panel on Deaths in Custody; Practice Plus Group; Midlands Partnership NHS Foundation Trust; 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** **27th January 2023** **H.M. Senior Coroner for Worcestershire**