REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], Director General Operations His Majesty's Prison and Probation Service (HMPPS) **2.** [redacted], Chief Executive of NHS England **3.** [redacted], Governor at HMP Guys Marsh, Shaftesbury, Dorset
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 13th August 2020 an investigation was commenced into the death of Jason Anthony Williams, born on the 7th January 1981. The investigation concluded at the end of the Inquest on the 30th January 2023. The Medical Cause of Death was: 1a Synthetic cannabinoid intoxication The jury reached a narrative conclusion that "Jason deliberately took drugs but did not intend the consequences to be fatal i.e he had no intention to end his life"
4	**CIRCUMSTANCES OF THE DEATH** As recorded by the jury in Section 3 on the Record of Inquest: At 15.15 hours on the 31st July 2020 Jason Anthony Williams was found unresponsive in his cell, cell 42, Gwent wing, HMP Guys Marsh, Shaftesbury, by prison officers carrying out accommodation fabric check. His death was confirmed a short time later by attending paramedics. Prior to his death he had used psychoactive substances. On 30th July 2020 prison staff on the wing opened a welfare log following suspicion that Jason was under the influence of illicit substances, however the process set out in the Illicit Substances Welfare Document was not fully followed. It cannot be established that this had any causative or contributory bearing on Jason's death the following day.

	On 31st July 2020 Jason's cell door was unlocked by prison staff at 14.14 hours however a welfare check was not conducted upon unlock. It cannot be established that this had any causative or contributory bearing on Jason's death. i JASON'S HISTORY OF MISUSE OF DRUGS Jason's history of misuse of drugs probably caused or contributed more than minimally to his death. Jason had a habitual drug habit that was documented on assessment on entering HMP Guys Marsh and throughout his custodial sentence. ii JASON'S VULNERABILITY We are satisfied that Jason's vulnerability possibly contributed to his death more than minimally. Jason's drug dependency in Prison contributed to his vulnerability due to his apparent willingness to take illicit substances. iii THE DRUG PREVENTION STRATEGIES IN THE PRISON IN JULY 2020 The restrictions imposed in July 2020 due to Covid, impacted the execution of the drug prevention strategy. This possibly contributed more than minimally to Jason's death. iv. THE MEASURES TAKEN BY THE PRISON FOLLOWING THE SUSPECTED THROWOVER ON 25TH JULY 2020 v THE STEPS TAKEN BY THE PRISON, AND/OR ISMS TO SAFEGUARD JASON FOLLOWING THE SUSPECTED THROWOVER ON 25TH JULY 2020 AND ONCE HE WAS FOUND TO BE UNDER THE INFLUENCE OF PS ON 30TH JULY 2020 No specific instruction was given to staff relating to Jason following the suspected throwover of illicit items and the increase of psychoactive substance incidents around this time. Nor were there any additional briefings to prison officers or notices distributed to prisoners. This possibly contributed more than minimally to Jason's death. This could be constituted as a safeguarding failure towards Jason from the steps taken by the Prison.
5	**<u>CORONER'S CONCERNS</u>** 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 the Inquest evidence was heard that: i. There was a differing opinion between professionals including those from the healthcare, Integrated Substance Misuse Service (ISMS) and prison staff as to whether Jason was vulnerable.

		Evidence was given that there is no national guidance either from HMPPS or the NHS on how to care for vulnerable prisoners in custody. It was confirmed that there is reference in certain documents such as PSI 64/2011 to vulnerability but no specific dedicated guidance on vulnerability. There is no definition of vulnerability, what to look out for regarding vulnerability, who may be deemed to be vulnerable or how to care for a vulnerable prisoner. Those serving sentences relating to sexual offending are often referred to as vulnerable prisoners, but there are other reasons for vulnerability and there is no targeted guidance to assist those working within the prison estate to care for these individuals. For example, evidence was given that at HMP Guys Marsh they are in the process of creating guidance for caring for those at risk of self-neglect as there is no national guidance on this issue.
	ii.	Evidence was heard that the keyworker programme is a national programme for application in all prisons. Keyworker sessions are an essential part of a prisoner's journey through their sentence and prison life. Evidence was given that there has been limited success nationally since it's roll out which was believed to be in 2016/2017 and one of the reasons for this is resourcing. Evidence was given that at HMP Guys Marsh they struggle to deliver the keyworker programme and that it has not been delivered at the desired level for a long time. I have concerns therefore that the current system in place is not fit for purpose.
	iii.	There is national guidance in PSI 23/2014, which relates to the Prison NOMIS system, around the recording case notes on the system. At paragraph 4.9 it states: *All staff who have contact with an offender and who have access to Prison-NOMIS must update case notes on a regular basis.* In the NOMIS case notes for Jason there did not appear to be regular entries from Prison staff. For example, between the entry on the 19th March 2020 and 7th June 2020 there was no record by prison staff who had contact with Jason on the wing. Whilst it is noted this was when the Covid 19 pandemic began, this was a time when there should have been increased monitoring and recording due to the fact activities were suspended and there was less general contact with prisoners from others outside the wing. Information was provided that Prison staff have access to PSI 23/2014, they are provided with the Prison Officers' Guide produced by HMPPS and they are provided with training on record keeping at the Prison Officer Entry Level Training (POELT) training. There is no refresher training at HMP Guys Marsh on record keeping, or the importance of it other than to cover

	information sharing. Evidence was given as to the importance of triangulation of communication and care between the prison, healthcare and ISMS staff. Healthcare and ISMS have access to the NOMIS records as well as the prion staff and this is therefore the key record for information sharing about a prisoner, their risks and vulnerabilities. iv. Governor notices can be sent to prison staff and prisoners to advise them of any matters, including when there are warnings to be given to prisoners. In the past at HMP Guys Marsh, Governor notices have been sent out when there has been a spike in psychoactive substance incidents. There was no Governor notice sent out between the 25th July 2020, when there was a suspected throw over of illicit items into the prison, and the 3rd August 2020. Over this period of 9 days there were 106 recorded psychoactive substance attacks which was described in evidence as an incredibly high number. Evidence was given that these notices are issued at the discretion of the Governor. 2. I have concerns with regard to the following: i. There is a lack of specific and dedicated national guidance to prison and healthcare staff on how to define and care for vulnerable prisoners. I would request that consideration is given to producing national guidance on this, to also include guidance on addressing self-neglect. ii. The current keyworker programme is not working as planned at HMP Guys Marsh and there was reference to this also being reflected nationally. I would request that consideration is given to a review being undertaken of the keyworker programme within the whole prison estate, and also specifically at HMP Guys Marsh. iii. The quantity and quality of record keeping by prison staff at HMP Guys Marsh on NOMIS. I request that consideration is given to providing refresher training to prison staff on record keeping to cover the importance of records and their contents, and the required regularity of recording. iv. A Governor notice was not issued in the time leading up to Jason's death to prisoners or staff around the concerns regarding access to, and the impact of using, psychoactive substances. I request that consideration is given to a review being undertaken by HMP Guys Marsh as to when such notices should be issued, particularly in relation to increased risks to prisoners around drug use.
6	**ACTION SHOULD BE TAKEN**

	In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 30th March 2023. 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) GT Stewart Solicitors on behalf of Jason's family (2) Government Legal Department on behalf of the Ministry of Justice (3) Hill Dickinson LLP on behalf of Practice Plus Group (4) EDP I am also under a duty to send the Chief Coroner a copy of your response. I have also provided copies to the following who I believe this report will be of interest to: (1) Hill Dickinson LLP on behalf of Oxleas NHS Foundation Trust (2) Hill Dickinson LLP on behalf of Change Life Grow 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	**Dated** **2nd February 2023**	**Signed**  **Rachael C Griffin**