Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Ministry of Justice (Coroners)**
1	**CORONER** I am Kate AINGE, Assistant Coroner for the coroner area of Liverpool and Wirral
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 05 May 2021 I commenced an investigation into the death of Stuart Michael ROBINSON aged 20. The investigation concluded at the end of the inquest on 15 May 2023. The conclusion of the inquest was that: Stuart Michael Robinson arrived at HMP Altcourse on 3rd March 2021 after receiving a 26 week sentence for breach of license. He was due to be released on 1st June 2021. He arrived with a history of attempted suicide and self-harm. On the 8th April, a ACCT book was opened following the interception of a letter detailing Mr Robinson's intention of suicide. Subsequently he was put under a regime of 5 observations an hour and 2 meaningful conversations per day. On the 9th April he underwent a mental health assessment and the first ACCT case review reduced the number of hourly observations to 3, with the number of meaningful conversations remaining at 2 per day. A care plan was put in place as part of this first case review. On the 14th April at a second case review, the observations were removed entirely, however the meaningful conversations remained at 2 per day. On the evening of 18th April Mr Robinson self-harmed, leading to hourly observations being reinstated. This led to the 3rd case review being brought forward to the 19th April. Hourly checks were once again removed and Mr Robinson continued to have 2 meaningful conversations. On 23rd April Mr Robinson self-harmed again, leading to the fourth case review being brought forward. On this same date Mr Robinson's podmate was released from prison and Mr Robinson was therefore alone in his cell. Mr Robinson was last seen at 7 pm on the 24th April. In the early hours of 25th April between approximately 12 am and 1 am, Mr Robinson applied a ligature ultimately resulting in his death by suicide. His body was discovered at 5am and a code blue was called. Medical staff attended the scene but it was clear that Mr Robinson was incapable of resuscitation. Mr Robinson was declared dead at 5:16 am.
4	**CIRCUMSTANCES OF THE DEATH**
5	**CORONER'S CONCERNS**

	During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) This inquest highlighted the significant numbers of prisoners who enter the prison system with known or undiagnosed mental health issues. Whilst ACCT 6 requires multidisciplinary attendance at review meetings, this case highlighted the need for specific attendance of an RMN or other mental health expert at any review, (Mr Robinson had repeatedly self harmed prior to committing suicide but had presented without concern at each review which had been carried out without any input from the mental health team). The prison in question now operates a local policy to ensure someone from the mental health team attends all ACCT reviews irrespective of other disciplines attending. This has enabled the prison to identify issues which may not be picked up by other professionals involved, to enable support to be put in place by way of separate care plans which has had a notable impact upon SASH in the prison.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by July 11, 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 [redacted] **BLM LAW** I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 16/05/2023**

	Kate AINGE Assistant Coroner for Liverpool and Wirral