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. MINISTER OF STATE FOR PRISONS AND PROBATION**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent & Medway
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 13th June 2022 I commenced an investigation into the death of Liam Ryan Wayne Bentley. The investigation concluded at the end of the inquest on 29th June 2023. The conclusion of the inquest was Liam Bentley took his own life ([redacted]) but his intention in doing so was unclear. The failure to provide adequate physiological support through SOS and/or a psychologist possibly contributed to the death. Other issues which were deemed to be relevant to the circumstances of the death but could not possibly contribute to the death were as follows. 1. Failure to open an ACCT on or after 16th April. 2. Failure to instigate a care plan 3. Inadequate response to missed medication from 16th April onwards. 4. The Management of the self seclusion plan was inadequate, and failures to implement agreed actions from CSIP and SIM meetings. 5. Ineffective communication between the prison and the health care provider. 6. Staff shortages and gaps in training.
4	**CIRCUMSTANCES OF THE DEATH** Liam Bentley was transferred to HMP Swaleside on 25th March 2022. He was a serving prisoner with a sentence expiry in 2024. He had ADHD and ASD for which he was medicated with mirtazapine administered by healthcare and at the time of his death atomoxetine, held in possession. He had 19 previous ACCTs for self harm and an attempt at suspension whilst serving his sentence at other establishments. Following his transfer he informed prison staff that he was in fear of other prisoners and wanted a move to another wing. He caused a superficial cut to his hand and said that he wanted to kill himself before anyone else did. An ACCT was not opened, the evidence being that officers after further speaking to him did not regard this as a self harm issue, the focus being to engineer a wing move. He was moved to a different wing but continued to express concerns about prisoners on the new wing. A self seclusion document was opened, a local policy closely aligned to the ACCT process aimed at reintegrating the prisoner to the regime was started but was not managed in accordance with the policy with assessments and reviews being done weeks after they should have been and no management plan were not put in place. Required daily interactions were sometimes done, sometimes not, referrals to psychology and SOS were either not made having been identified as necessary through the self seclusion, CSIP and SIM processes or made and not actioned

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 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. – (1) There was evidence from prison staff from which it was concluded by the jury that the safety of deceased was compromised as a result in staff shortages (2) The current complement of Band 2 Operational Support Group staff is 71% this is predicted to further reduce to 54%, the current complement of Band 3 Prison Officers is 68% this is predicted to further reduce to 46%.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **29th August 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 Family of Liam Bentley, HMPPS, HMP Swaleside. I have also sent it to HMPPO and Oxleas NHS Foundation Trust 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	**3rd July 2023** **Patricia Harding** **Senior Coroner Mid Kent & Medway**