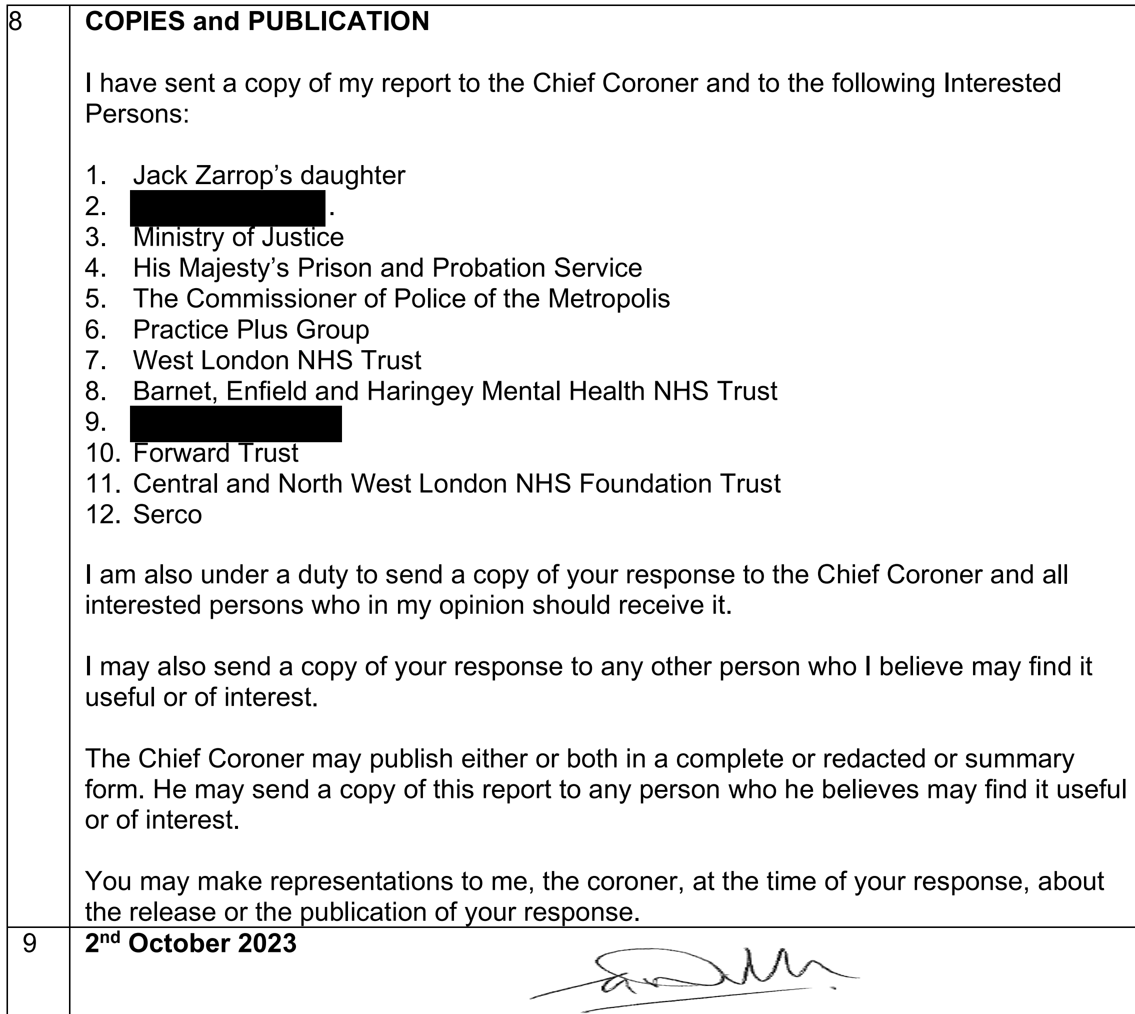
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Home Office** **2. National Police Chiefs' Council** **3. NHS England**
1	**CORONER** I am Dr Anton van Dellen, HM Assistant Coroner, for the coroner area of West London
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** An investigation was commenced into the death of Jack Peter Zarrop, aged 23. The investigation concluded on 29 September 2023. The conclusion of the jury in the inquest was: *Suicide.* *We, the jury, find the:* *1. Failure to remove the bedsheet and close the hatch allowing Jack to create a ligature point* *2. Failure to refer to Liaison and Diversion services in Central and North-West London and the failure to open an ACCT whilst in prison custody, either of which would have triggered a more thorough risk assessment* *3. The difficulties accessing relevant and important information relevant to J. Zarrop's history, both medical and custodial* *were the main contributing factors to the death of J. Zarrop.* The medical cause of death was 1a Aspyhxia 1b Hanging
4	**CIRCUMSTANCES OF THE DEATH** Jack had a history of difficulties with his mental health and a history of alcohol abuse. He had made multiple previous suicide attempts, including a very serious previous suicide attempt of hanging. He had previously been arrested in December 2020 and assessed by Liaison & Diversion services whilst in Police custody. After he was remanded in custody, he was placed on an ACCT twice in prison. After his release from prison on 14th February 2021, he was referred to the community Mental Health Crisis service by his GP and also had another very recent suicide attempt in the form of an overdose of anti-depressants about a week before he was again arrested on 17th March 2021. In Police custody, he was seen by a Custodial Nurse Practitioner (CNP) who had very limited training in Mental Health and the recognition of the risk of suicide. The CNP was working alone and not alongside a doctor. The CNP assessed Jack's risk as low. The CNP also did not refer him to Liaison & Diversion services, which the jury found that probably contributed to Jack's death. A Forensic Medical Examiner in Police custody subsequently assessed Jack's risk as high. Jack was again remanded in custody. Despite Jack's

	significant risk history as well as other significant risk factors, such as being young, withdrawing from alcohol and early days in custody, no ACCT was opened by prison or healthcare staff, who were overly reassured by Jack's presentation. An agency healthcare member of staff had no training in the ACCT process. The jury found that the failure to open an ACCT by prison and healthcare staff probably contributed to Jack's death and that, on the balance of probability, the risk of suicide was not adequately identified for Jack. These findings by the jury were based on the over-emphasis by prison and healthcare staff on Jack's presentation against clear and evidenced previous suicide and self-harm risks and attempts, which were available to relevant police, prison and healthcare staff. The Court heard evidence that 65% of primary care healthcare staff in prison are agency staff. The Home Office circular from 2003 relating to the use of Custodial Nurse Practitioners refers working alongside doctors and being specifically trained for their role. However, the Circular makes no mention of assessing the risk of suicide or self-harm in its Annex which lists competencies.
5	**CORONER'S CONCERNS** During 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. The use of Custodial Nurse Practitioners (CNPs) in Police custody instead of doctors. The 2003 Home Office circular appeared to envisage nurses working alongside doctors, when this is not how they are deployed. CNPs are also seeing high risk and complex patients without adequate training in mental health. The deployment in Police custody of CNPs places detained persons at risk of death in the future. The 2003 Home Office circular also does not recognise the risk of suicide and self-harm as being a core competency. 2. The training of agency staff in the ACCT process and recognising the appropriate threshold to open an ACCT. The training of agency staff in ACCT does not appear to be part of the commissioning process by NHS England and individual providers do not appear to provide training to agency staff in the ACCT process. This places residents in prison at risk of death, given the high level of usage of agency healthcare staff in prison.
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 27th November 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. Jack Zarrop's daughter 2. [redacted]. 3. Ministry of Justice 4. His Majesty's Prison and Probation Service 5. The Commissioner of Police of the Metropolis 6. Practice Plus Group 7. West London NHS Trust 8. Barnet, Enfield and Haringey Mental Health NHS Trust 9. [redacted] 10. Forward Trust 11. Central and North West London NHS Foundation Trust 12. Serco 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 other 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.
9	**2nd October 2023**