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 Director General CEO, HM Prison and Probation Service**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 02 June 2020 an investigation was commenced into the death of Thomas Victor HUNTLEY (aged 54) who had died in HMP Winchester. The investigation concluded at the end of the inquest on 05 April 2023. The inquest, which was held with a jury, ended with a narrative conclusion. The medical cause of death was 1(a) hanging. The jury concluded, amongst other matters, that: (a) Relevant information about Mr Huntley, namely information from the recall notification and previous 'Assessment, Care in Custody and Teamwork' (ACCT) documents, was not recorded on NOMIS. (b) The risk level recorded in the ACCT document opened on the 23/05/2020 did not reflect a higher level of risk indicated by witness evidence and neither did it align with the guidance on risk levels contained within that document. This caused or contributed to Mr Huntley's death. (c) There was a failure to record triggers for self-harm behaviour in the ACCT document. There was a failure to record all relevant risks within the 'Caremap' section of the ACCT document. These factors contributed to the death of Mr Huntley. (d) The level of observations under the ACCT document opened on the 23/05/2020 were not adequate based on the level of risk Mr Huntley posed to himself. This caused or contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Huntley was recalled to prison on the 23/05/2020. Whilst in the community Mr Huntley had been under the care of Steps to Wellbeing for PTSD and anxiety. He had disclosed daily suicidal thoughts to them with no intent to act upon these thoughts. The recall notification of the 22/5/20 stated that Mr Huntley reported low mood and claimed to want to take his own life but was not brave enough to do so. This information from the recall notice was not recorded in the record keeping system which could be accessed by all prison security staff (NOMIS).

Mr Huntley denied thoughts of suicide or self-harm when asked by the police on the 23/02/2020. During the reception process at HMP Winchester he denied thoughts of suicide or self-harm.

On the 25/05/2020 Mr Huntley called for help [redacted]. He later disclosed that this had been a planned act with the intent to end his own life. He had taken steps to avoid being discovered and had only called for help when he awoke [redacted].
Mr Huntley was subsequently taken to hospital and discharged later the same morning. Having left hospital he collapsed and was admitted to the Healthcare wing of the prison for observations.

An ACCT document was opened. This is a way of monitoring persons in custody who are at risk of harm. During previous periods of imprisonment in 2010 and 2016 ACCT documents had been opened for Mr Huntley. These documents were not contained within in core records as should have been the case and still cannot be located. Their existence, and the circumstances of the 2016 ACCT, were recorded on NOMIS.

Mr Huntley was initially placed on 30-minute observations when the 2023 ACCT was opened, this was reduced to hourly observations after the first case review on the 25/05/2020 and then to 3 random observations overnight after the second case review on the 27/05/2020. These changes were made following assessment meetings involving Mr Huntley, prison staff and staff from the NHS Trust providing physical and mental health interventions within the prison.

Mr Huntley denied further thoughts of self-harm or suicide during these meetings.
On the 28/05/2020 Mr Huntley was moved from his original cell in the healthcare wing to cell 13. Cell 13 was located in the area of the healthcare unit primarily used for patients with mental health difficulties. Apart from cells 6 and 13 all of the cells in this area were designed to have reduced ligature points. However in 2019 telephone points had been installed in each of these cells which protruded from the wall. The decision to move Mr Huntley was made at a Multi-disciplinary meeting at which no-one who had met Mr Huntley to assess his mental health was present.

On the evening of the 28/05/20 the night duty prison officer completed their rounds at approximately 20.30 and noted that Mr Huntley was sat on the floor of his cell in a partial blind spot. Between 21.00 and 21.30 the nurse on duty knocked on Mr Huntley's cell door and received a verbal response.

At about 23.30 the prison officer attended to complete the first observations required under the ACCT document for Mr Huntley. They saw that Mr Huntley was in the same position as some 3 hours earlier and Mr Huntley did not respond to him. The officer entered the cell with other prison officers at about 23.35 and found Mr Huntley sat motionless [redacted].

The prison officers cut the ligature and commenced CPR. An emergency call was put out and further prison officers and both on-duty nurses attended. Those present provided CPR to Mr Huntley until the arrival of paramedics. Sadly despite the efforts of staff and the attending medics Mr Huntley could not be revived and his life was declared extinct.

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)

ACCT documents

In evidence at the inquest ACCT assessors and case managers accepted that they had not complied with various mandatory actions required under PSI 64/2011: Managing Prisoner Safety in Custody. They were not able to identify in evidence the risk factors it was mandatory to consider for persons at risk of suicide or self-harm. They had not recorded triggers in the relevant section of the ACCT nor recorded all risk factors in the Caremap section. One ACCT case manager stated that they did not know whether it was necessary to record a trigger if action had been taken to mitigate it. They also stated they categorised risk based on 'remaining' risk after action had been taken despite having not recorded the trigger.

This leads me to have 2 concerns:

The first regards the provision and quality of ACCT training and refresher training given this evidence was given some 2 years after the death of Mr Huntley and well after the disruptions brought about by the Covid-19 pandemic.

I also heard evidence that despite an ACCT being a 'whole prison' document (which can and should be opened by any member of staff) training was not mandatory for non-security staff.

In 2019 there was no joint training for prison and heathcare staff on the use of ACCT documents. I am informed by CNWL that under ACCT v6 (which has been in force since July 2021) joint training is provided for and this is reassuring. However I understand that the frequency of this training is determined in relation to operational capacity at individual establishment level. This is of concern given the evidence from witnesses at this inquest some 20 months after this version came into force.

The second relates to the quality and effectiveness of ACCT audits. We heard evidence that ACCT documents are reviewed annually. The case manager mentioned above advised that he had not received any adverse feedback about the quality of his ACCT documents and no issues with them had been identified. Given the inadequate nature of the ACCT document opened on Mr Huntley and apparent lack of understanding about completing the documents the quality of the audits is brought into question.

Information sharing.

In evidence it was clear that the ACCT document was the only written document used for sharing information between the healthcare staff employed by the NHS trust and the prison security staff. Healthcare staff record and share their information within SystemOne which the prison security staff do not have access to. Prison security staff record information within NOMIS which healthcare staff do not have access to.

Evidence from witnesses revealed that these information systems are not necessarily fully reviewed for relevant information prior to attending ACCT meetings.

In addition a decision relating to Mr Huntley's care (i.e. the move to a different cell) was taken by healthcare staff at their own meeting when they did not have the benefit of information available to prison staff.

[redacted] of HMP Winchester informed me that a Safety Intervention Meeting was now

	carried out weekly, chaired by a Senior Governor and attended by representatives of the prison, physical and mental health care providers and the probation service. This meeting covers each person subject to an ACCT and any relevant information is share via the ACCT case manager, NOMIS and the multi disciplinary team. [redacted] could not assist me with whether this was a HMP Winchester initiative or had a wide application across the prison estate. My concern is therefore that the current procedures and policies for sharing information are incomplete or not fully complied with. This renders the information on which separate teams make decisions about a prisoner incomplete and increases the risk that important factors are not considered. <u>Cells</u> At HMP Winchester within the area, considered and referred to by most healthcare and prison staff, as the 'mental health' cells there are 2 cells which are not equipped in a way to reduce the amount of available ligature points. It was clear from the evidence of the healthcare staff at the MDT meeting on the 28/05/2020 that they did not consider the contents of the cell when deciding to move Mr Huntley to the 'mental health cells' simply due to the fact he was on an ACCT. I heard evidence that the policy of CNWL has now changed and that a cell move risk assessment must now be carried out and that there is now a revised ligature audit process. HMP Winchester informed me that there is now an annual ligature audit carried out in conjunction with the new healthcare provider at that establishment. In addition I was informed that all telephone points in the 'mental health cells' at HMP Winchester have now been removed and placed outside the cells. These are welcome developments. However at inquest those representing the HMPPS could not inform me whether all telephone points within cells designed for use by those at risk of self harm across the prison estate had been removed. Nor was any evidence available as to what consideration had been given to reducing the risk of the telephone points by design of the points themselves or the manner of their installation. Those representing were invited to provide this information after the hearing but have not done so. I am concerned that telephone points which provide a ligature point may remain within cells which prison and health care staff consider to be suitable for use by those at risk of self harm. The final area of concern is the lack of certified Safer Cells at HMP Winchester. The inquest heard evidence that these had either never existed at HMP Winchester or had not done so for many years. The evidence from prison governors was that, generally speaking within the prison estate, they were not used or proved too hard to maintain to the certified standard. However certified Safer Cells are still referred to in PSI 64/2011 as a means of managing risk from ligatures. It was heard in evidence that HMP Winchester experience high levels of self-harm and suicide and yet it did not appear that consideration had been given recently to introducing these. Those representing the HMPSS at the were invited to provide information about the status and use of safer certified cells across the prison estate. No such information has been forthcoming.
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 09, 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 **Central & North West London NHS Trust,** **Family members of Mr Huntley, and** **Prisons and Probation Ombudsman.** I have also sent it to **The Governing Governor HMP Winchester** 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: 14/05/2023**  **Robert SIMPSON** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**