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.** The Rt Hon Edward Argar MP, Minister of State for Prisons, Parole and Probation **2.** [redacted], Director General Chief Executive of His Majesty's Prison and Probation Service (HMPPS) **3.** [redacted], Chief Executive of NHS England
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 11th May 2021 an investigation was commenced into the death of Samuel Lewis Jones, born on the 24th November 1998. The investigation concluded at the end of the Inquest on the 28th November 2023. The Medical Cause of Death was: 1a Ligature Suspension The conclusion of the Inquest heard before a jury was a narrative conclusion that "Sam suspended himself by a ligature, there is insufficient evidence that has been presented to the jury to show that Sam had or had not intended to take his own life."
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on the 30th April 2021 after he suspended himself by a ligature in his cell at HMP Portland, Portland, Dorset.
5	**CORONER'S CONCERNS** 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. Sam's mother died by an act of self-harm on the 12th April 2014. Sam was greatly affected by his mother's death which was known by the prison and healthcare staff at HMP Portland, however the date of her death was not identified in the prison or healthcare records and was not known to those caring for Sam.

   Had both prison and healthcare staff been aware of the date they would have spoken to Sam around this time to provide support to him.

   Prisons nationally use a records system called NOMIS and healthcare providers in prisons nationally use a records system called SystmOne. There is no mechanism in NOMIS or SystmOne to highlight key or trigger dates that may have an impact upon a prisoner.

   Following the evidence at this Inquest, local processes have been immediately put into place at HMP Portland to ensure that prisoners will be asked about any significant or trigger dates at the initial and second healthcare screen when they arrive at the prison. This information will be recorded on SystmOne manually in the risk information box and a task will be scheduled close to the key date. Prison staff do not have access to SystmOne. This is a local process and not a national one and this issue is likely to arise at all prisons in England and Wales.

   There is no national guidance or policy on this and no specific question on the SystmOne records, or location in the NOMIS records, to enquire into, or highlight, significant dates for the prisoner.

   ii. When meeting with a prisoner, prison staff have access to the NOMIS records, however, most of the prison staff who gave evidence at the Inquest stated that they would not read the full records and just look at the last 2 or 3 contacts. Due to the current reduction in staffing levels at HMP Portland as a result of difficulties in recruitment, which is affecting staffing within prisons nationally, staff gave evidence that they do not have the time to consider the NOMIS records in full for routine checks or welfare checks under the keyworker scheme. Evidence was also given by a Supervising Officer at the prison that when ACCT reviews are conducted this could be the first time they meet the prisoner and they do not have time to go through all the records due to current staffing pressures.

   There is no ability to search the NOMIS records by a key word search as there is on SystmOne, so key information about a

prisoner may be buried within the case notes section on NOMIS which can be very lengthy. To find out this information staff would have to go through all the records which as stated above is not practically possible due to current staffing levels. As a result information can be missed.

Although there is an alerts page on NOMIS this only allows certain standard entries and there is no free text box to allow bespoke entry of information. This results in key information about a prisoner being overlooked. Some witnesses gave evidence that they were not aware of Sam's history contained in the NOMIS records and had they been, they would have acted differently.

There is a new version of NOMIS which although being used in the Prison Service at the moment, is still under development which could address these issues.

iii. In prison, prisoners are prescribed medication to take either under supervision or in their own possession. This means that a prisoner can self-medicate in their cell. Prescriptions of medications can be given to cover a supply for up to 28 days. Prior to a determination as to whether it would be safe for a prisoner to have medication in their possession, a risk assessment is undertaken both around the type of medication and the prisoner's individual risks.

Sam was prescribed [redacted] and was permitted to take this in possession for a period of 7 days. He last collected this on 26th January 2021, over 3 months before his death. Following his death, he was found to have [redacted] in his blood and [redacted] was found in his cell. It may have been that he was illicitly obtaining [redacted], however it may also be that he had left over medication from that he had been prescribed previously.

When a prisoner stops taking medication, healthcare teams have little option other than asking if a person has any leftover medication and are dependent on the prisoner handing any excess medication back. Healthcare teams do not have the power to search a cell although can pass information on to the prison staff if they have any concerns regarding the stockpiling or access to medication in the cell.

There is a local operating policy in place within the healthcare department at HMP Portland to cover medication. Following the evidence heard during the Inquest, this has already been amended to ensure steps are taken to try to ensure that a prisoner does not have any medication in their cell which they should not have. There is, however, no national guidance to assist both healthcare and Prison Service staff deal with this issue and it is for individual prisons to set up their own processes.

	2. I have concerns with regard to the following: i. The lack of flagging of, and access to, key dates which may have an impact on prisoners' safety. ii. The lack of national Prison Service or NHS guidance on how to manage key dates where risks to the safety of the prisoner may be increased, such as a bereavement or traumatic incident or any other key dates. iii. The accessibility of information recorded on NOMIS and the potential to miss key information which could impact on risk assessments. iv. The lack of national guidance around the operation of in possession medication in prisons either by HMPPS or NHS England to ensure prisoners do not stockpile or retain medication when they have stopped using it.
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 January 2024. 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) Sam's family (2) The Ministry of Justice/HMP Portland (3) Practice Plus Group (4) Oxleas NHS Foundation Trust (5) Change Grow Live I am also under a duty to send the Chief Coroner a copy of your response. I have also forwarded the report to the following who may find the report of interest: [redacted], Director General of the Department of Health and Social Care

	[redacted], Chief Executive Officer, Public Health England 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** **5th December 2023**	**Signed**  **Rachael C Griffin**