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 NHS England**
1	**CORONER** I am Kate AINGE, Assistant Coroner for the coroner area of Cheshire
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 16 September 2019 I commenced an investigation into the death of John Joseph SINGLETON aged 42. The investigation concluded at the end of the inquest on 16 November 2023. The conclusion of the inquest was that: Suicide
4	**CIRCUMSTANCES OF THE DEATH** John Joseph Singleton [redacted] with a history of depression following significant family bereavements and epilepsy secondary to a head injury. Compliance with medications for these conditions had previously been sporadic. John had a history of previous incarcerations when he arrived at HMP Risley in May 2019 to serve a 10 month sentence for attempted burglary. In August 2019 John began acting bizarrely, had fixed thoughts of persecution and paranoia but did not disclose any thought of self-harm or suicide ideation. Periods of intermittent self-isolation followed these paranoid thoughts. An Assessment, Care in Custody and Teamwork document was initiated on Saturday 31st August 2019 to identify the issues, offer support and put monitoring in place, but John's mental health continued to deteriorate. On 1st September 2019 during the prison transition period from night to day state, John was on his own in his locked cell [redacted] with the intention of ending his life. At 7:56am access to the cell was gained and John was found hanging [redacted] The ligature was cut to release John and appropriate emergency response made. Upon arrival paramedics took over emergency care, obtained a cardiac output and transferred John to Warrington Hospital where he later died on the 10th September 2019 at 17:25. Aspects of the systems relating to medicines non-compliance and mental health referrals at HMP Risley were lacking but did not cause or contribute to John's 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) During the inquest it came to light that John was prescribed medications for depression and epilepsy whilst incarcerated. His compliance with medications was found to be sporadic and as a result he failed to collect a number of prescriptions to enable continuity of his medication. Some of the reasons around this were anxiety in attending to collect his medications and also periods of self-isolation. Whilst Healthcare at the prison were aware of some of the periods of non-compliance and in fact a GP referral and action was taken to enable John to have weekly in-possession medication to support his compliance, other periods were not flagged or identified and it became clear that monitoring those prisoners who are not medication compliant, particularly if receiving weekly or monthly medication was challenging due to the SystmOne electronic patient system not being able to flag a warning for non-compliant prisoners for early identification and referral. John subsequently suffered a decline in his mental health and whilst the lack of medication compliance was not deemed to cause or contribute to his death, the importance of consistent medication for medical conditions and early identification of prisoners who do not comply was an issue which was raised and explored within the inquest. The action taken by the prison after John's suicide was to put a cross check system in place by which pharmacy technicians cross reference the medication by way of a weekly stock check to identify the prisoners who have not collected medications or had the same dispensed, so that referrals can be made to the Healthcare team and or GP to task. Such a system is less than ideal as it is both resource heavy, carries real risks of not being accurate and in the Coroners view, for prisoners in possession of medication, there is likely to be a much longer period before non-compliance is identified which carries real risks of fatalities. The inquest touched upon the SystmOne electronic record used across the Prison estates by Healthcare. From the evidence it appears that the system has a facility to flag concerns and tasks to action and in fact, certain flags are generated automatically to alert healthcare staff to live issues around a prisoner, however, something as simple and the system generating a warning flag to identify when medication is not dispensed or collected was neither possible nor available on the current operating system. An automated flag alert via the system upon the failure to dispense or collect medication by a prisoner would be a far more efficient and effective way in which prisoners failing to comply with medications could be identified and actioned quickly and in which future deaths could be prevented.
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 January 11, 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 **Bridgewater Community Healthcare** **Greater Manchester Mental Health Trust** **HMP Risley**

	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: 16/11/2023**  **Kate AINGE** **Assistant Coroner for** **Cheshire**