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 Secretary of State for Health and Social Care **2.** The Minister of State for Prisons, Parole and Probation **3.** [REDACTED], Director General of His Majesty's Prison and Probation Service (HMPPS) **4.** [REDACTED], Chief Executive Officer for NHS England **5.** [REDACTED], Governor at HMP Guys Marsh **6.** [REDACTED], Chief Executive Officer of Unilink Software Ltd, provider of email a Prisoner
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 10th March 2022, an investigation was commenced into the death of Frazer Charlie Williams, born on the 30th October 1993. The investigation concluded at the end of the Inquest, before a jury, on the 17th May 2024. The medical cause of death was: Ia Ligature suspension The conclusion of the Inquest was "Frazer Charlie Williams died by suicide in circumstances where there was inadequate assessment and monitoring of his risks of self-harm and suicide prior to his death".
4	**CIRCUMSTANCES OF THE DEATH** Frazer was found deceased on the 7th March 2022, in his cell at HMP Guys Marsh, Shaftesbury, Dorset, suspended by a ligature [REDACTED] I have attached to this report the Record of Inquest.

5	**CORONER'S CONCERNS**

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. On the 4th June 2021 Frazer, was placed at HMP Lewes where he remained until his release on the 4th October 2021 having served a sentence of imprisonment. On the 7th October 2021, he was remanded into custody and placed at HMP Winchester. He was sentenced to a term of imprisonment on the 10th November 2021 and was due to be released on the 25th March 2022.

   ii. During his placement at HMP Lewes, Frazer presented with a deterioration in his mental health and remained subject to an ACCT due to an incident of self harm, and was also under the care of the healthcare team until the point of his release on the 4th October.

   iii. Following his arrival at HMP Winchester, which has a residential healthcare unit, referrals were made to the mental health team. Frazer was assessed by a psychiatrist on the 20th December 2021 who felt that he was suffering with enduring psychotic illness and required further review.

   iv. On the 14th January 2022 Frazer was transferred to HMP Guys Marsh. HMP Guys Marsh does not have a healthcare unit or a 24 hour in prison healthcare provision. The healthcare team operating hours are 7.30am to 6pm daily.

   v. An email was sent from the healthcare team at HMP Winchester to the healthcare team at HMP Guys Marsh with Frazer's name and that he was a person of interest. No other handover took place between the healthcare teams or the prison staff teams.

   vi. Following Frazer's transfer, the Head of Healthcare at HMP Guys Marsh raised an inappropriate transfer investigation as the clinical opinion was that he should not have been transferred to HMP Guys Marsh. Prior to Frazer's transfer, there had not been a discussion with the healthcare teams at HMP Winchester and Guys Marsh by the prison service to consider suitability of Frazer's transfer in view of the fact he was in the process of being assessed, and a confirmed diagnosis being made, relating to his mental health.

   vii. The Associate Medical Director for Practice Plus Group (PPG) who provided the healthcare at HMP Lewes and HMP Guys Marsh when Frazer was at those establishments, confirmed that there is no national directory that explains what healthcare facilities are

available at each prison and PPG have created one internally for the prisons they provide healthcare at. It was explained that this would assist when making decisions around suitability of location within the prison estate for prisoners, given their needs. Further if there was a national directory across all prisons this would greatly assist as PPG are only 1 of the 10 different healthcare providers across 114 prisons. He gave an example that he would not know how many disability access beds or cells there are at the prisons where PPG do not provide the healthcare. He also explained that there is no national specification in relation to healthcare units.

viii. Frazer was a person with complex needs. His mental health deteriorated at HMP Guys Marsh. He would spend most of the time in his cell, he generally did not engage with staff or ACCT reviews, and there were records that he missed and secreted medication. He held delusionary beliefs that if his toilet was flushed or he watched television, his family would come to harm. His cell was in an extremely poor state, littered with rubbish, an unflushed toilet and a bucket which was used for him to urinate and defecate in. This bucket was found to be full in his cell at the time of his death. It was acknowledged by the staff at the time he was self neglecting and he was referred to the Safety Intervention Meeting (SIM) process on the 9th February 2022. The Head of Healthcare gave evidence that there was not an adequate plan between the prison and healthcare teams to manage Frazer's self neglect.

ix. There is no national guidance on how to manage self neglect in prison. HMPPS are currently finalising a Social Care Learning Brief on Managing Self Neglect which is expected to be issued later this year, however there is no NHS guidance on this issue or joint guidance between HMPPS and NHS as to how to manage self neglect in a prison setting.

x. Frazer's mental health deteriorated to such an extent that following an assessment on the 9th February 2022, he was deemed to require transfer to hospital under Section 47 of the Mental Health Act 1983. The second doctor assessment was carried out the following day, 10th February 2022, and an application was sent to Ravenswood House Hospital, a secure unit within Southern Health NHS Foundation Trust on the 15th February 2022. Frazer was visited by the community psychiatrist on the 25th February 2022 when it was confirmed he required transfer to hospital for full assessment and treatment. The warrant was obtained from the Ministry of Justice for the transfer on the 1st March 2022. A bed was offered to HMP Guys Marsh by the hospital on the 1st March 2022 for admission on the 3rd March 2022, however, the prison could not facilitate an escort that day. The hospital could not facilitate safe admission on Friday 4th March 2022 or over the weekend, and the transfer was arranged for Monday 7th March 2022. Frazer was told on the 3rd March

2022 he would be transferred to hospital, however the evidence indicated he was not told when. At approximately 03.15am on the 7th March 2022 Frazer was found deceased in his cell, suspended by a ligature.

xi. The ligature was made from a ripped bedsheet attached to the top corner of the cell door. The bedsheet was the same colour as the door and had not been seen prior to his death, and was therefore camouflaged. I refer to the attached photograph of the cell door which shows the ligature in place. The colour of the cell doors in each prison is directed by the Governor of the prison and not by national directive, however the same bedsheets are issued nationally across the prison estate. The similarity in colour could be a national issue and apply to other prisons.

xii. An ACCT was opened in relation to Frazer on the 15th January 2022 and remained open until his death. Between 15th January and 7th March 2022 there were 11 case reviews. The ACCT records were incomplete and inadequate. The last case review took place on 1st March 2022. The next case review was scheduled for 3rd March 2022, however this did not take place and there was no further case review prior to Frazer's death. The evidence did not reveal why this had not taken place. As the ACCT is a paper based system, a missed case review is not automatically flagged in any way.

xiii. Since Frazer's death there has been the implementation of the ACCT assurance process nationally which requires the ACCT paperwork to be reviewed on 3 occasions as quality assurance or audit. Firstly, between 25 and 72 hours of the ACCT being opened, secondly at day 7 of the ACCT being opened and finally at the post closure review. If a person is subject to an ACCT for a lengthy period of time, there is a gap between day 7 and the post closure review where no quality assurance is required to be undertaken.

xiv. Frazer's key worker at HMP Guys Marsh gave evidence that in an ideal world prison officers would sit down with a prisoner for 45 minutes once a week to undertake key work as per national guidance. He explained that the 2 key work sessions he had with Frazer lasted no more than 5 minutes and were conducted on the landing outside his cell whilst other people would be walking around the wing. This was due to the fact the officer had to run the wing at the same time and he therefore explained the keywork sessions were not effective. He confirmed that the keywork sessions he undertakes now with prisoners now would probably be no more than 15 minutes. He further confirmed he was not invited to any of Frazer's 11 ACCT case reviews and to date he has never been invited to any ACCT reviews for any prisoner at HMP Guys Marsh, even as a prisoner's keyworker.

xv. There is inequity in the system in that if a person is deemed

detainable under the Mental Health Act 1983 in the community, they will be admitted to hospital straight away. If there is no bed available in a psychiatric unit they will be placed in an acute hospital where there is monitoring and access to medical care 24 hours a day. If a person is in need of hospital care and treatment under Section 47 of the Mental Health Act 1983, there are delays in the transfer to a hospital setting. When a prisoner suffers a physical health problem they can be transferred to hospital for care by ambulance or escort. With a mental health care problem, the appropriate paperwork needs to be completed, a hospital bed found and arrangements made for transfer before a person is admitted to hospital. During this time a prisoner may be placed, as Frazer was, in a prison without a healthcare unit and without 24 hour healthcare monitoring and care. The current legal timeframe for this is within 28 days. In relation to Frazer, his transfer would have been completed 26 days after he was first assessed Several witness said this was one of the quickest transfers they had experienced.

xvi. When a code blue or code red is called at HMP Guys Marsh, evidence was given that the control room do not automatically call an ambulance and before doing so, ask questions such as is the patient conscious and breathing. Annex A of Prison Service Instruction (PSI) 03/2013 requires an ambulance to be called automatically as a mandatory contingency response upon a code blue or red being called, and the directs staff to await updates from the scene. This PSI is not currently being followed at HMP Guys Marsh.

xvii. Frazer did not have any contact with his family whilst at HMP Guys Marsh and when his mother was told of his death, she thought it was a mistake as she thought he was still at HMP Winchester. She had been writing to Frazer at HMP Winchester through the email a prisoner service. There was no evidence her correspondence had reached Frazer. Email a prisoner is based on the person in the community who wants to contact the prisoner, entering the prisoner’s location in the prison estate, rather than their unique prison number. If the location is wrong or the prisoner has been moved, the prisoner will not receive the contact.

xviii. Frazer told prison staff during his induction at HMP Guys Marsh and the ACCT assessment that he was in contact with his family and he used his parents for support. Familial contact can be a key protective factor in the management of a person’s mental health. In the personal information section of Frazer’s NOMIS records, he was recorded as having no next of kin. There is no record the contact details of his next of kin were discussed with him. This evidences missed opportunities to involve Frazer’s family in his care and management prior to his death.

xix. Evidence was given that at the time if there was no next of kin

recorded for a prisoner at HMP Guys Marsh a monthly report would reveal this and prisoners would be spoken to about this. There is no record Frazer was spoken to about this and it did not appear from the prison there was a clear process as to how next of kin is detailed or checked.

2. I have concerns with regard to the following:

    i. There is inequity within the system of the treatment of a person with mental illness in the prison setting compared to an individual in the community, due to the fact that in the community a person would be placed in a hospital setting on the day they were deemed to require hospital admission, however in prison there are delays in transferring a prisoner in the same situation to hospital.

    ii. There is a lack of NHS guidance, and joint guidance with HMPPS, on the identification, management, and treatment of someone with self neglect in the prison setting.

    iii. There is a lack of a national directory detailing the facilities and provision of healthcare at individual prisons across England and Wales, and associated guidance on the transfer of individuals between prison establishments when they are under the care of the healthcare teams and are not placed on medical hold. There is a lack of guidance on consultation with prison doctors where a prisoner is receiving medical care, whether that be for physical or mental health, when there is consideration by the prison to transfer the prisoner who is not placed on medical hold. Further there is a lack of consultation with the healthcare team at the proposed receiving prison to ensure they can provide the appropriate care for the person.

    iv. There is a lack of national guidance for healthcare teams working in prisons around the handover of healthcare of a prisoner to the receiving prison when they are transferred to another prison.

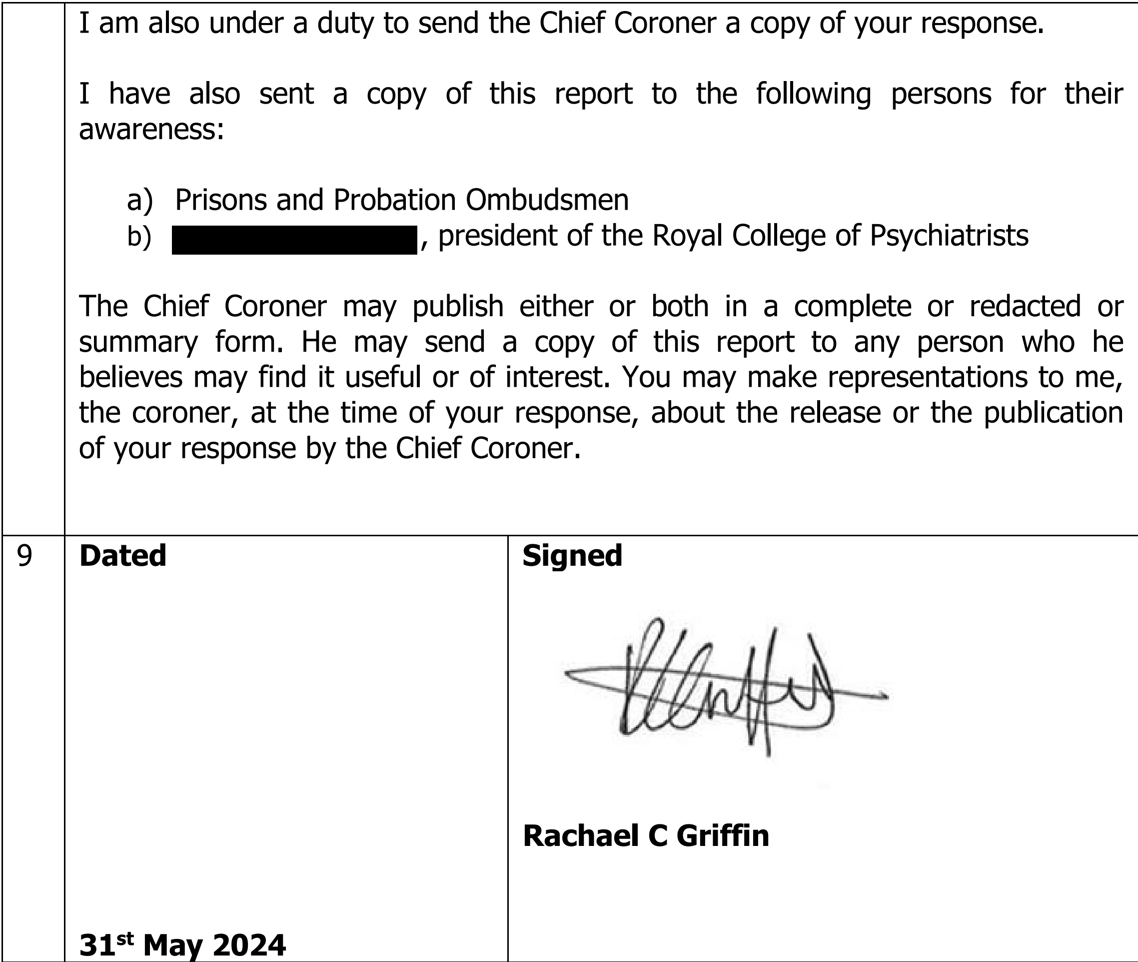
    v. There is a lack of national specification in respect of prison healthcare units.

    vi. There is lack of national guidance for both senior management and operational prison staff in relation to the handover of a prisoner in advance of their transfer, not specific to, but especially those with complex needs, when transferring between prisons.

    vii. The lack of ACCT quality assurance, or audit, between day 7 of the ACCT and the post closure review.

    viii. There is lack of automatic flagging of a missed ACCT review at HMP Guys Marsh and this could also be a national problem.

	ix. Relevant individuals, such as key workers are not being invited to attend ACCT reviews at HMP Guys Marsh in line with ACCT 6 guidance. x. The keyworker scheme is not being delivered in line with national guidance at HMP Guys Marsh. xi. The colour of the cell doors and bedsheets at HMP Guys Marsh, and possibly at other prisons nationally, being very similar can camouflage ligatures. xii. PSI 03/2013 is not being followed at HMP Guys Marsh as there is no immediate call to the ambulance service when a code blue or red is raised. xiii. There is a lack of process regarding the recording of a prisoner's next of kin and involvement of them at HMP Guys Marsh. xiv. The email a prisoner system is dependant on the person wanting to contact the prisoner knowing their location, so if the prisoner is transferred to another prison and the person contacting them is not aware, contact which can be a protective factor particularly in a prisoner's mental health care, will not be facilitated.
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, 26th July 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) Leigh Day on behalf of Frazer's Family (2) Government Legal Department on behalf of the Ministry of Justice and HMP Guys Marsh (3) Hill Dickinson LLP on behalf of Practice Plus Group and Oxleas NHS Foundation Trust (4) DAC Beachcroft LLP on behalf of Southern Health NHS Foundation Trust (5) EDP (6) CGL (Change Grow Live)



	I am also under a duty to send the Chief Coroner a copy of your response. I have also sent a copy of this report to the following persons for their awareness: a) Prisons and Probation Ombudsmen b) , president of the Royal College of Psychiatrists 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** **31st May 2024**	**Signed** **Rachael C Griffin**