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: -** **The Rt Hon Alex Chalk KC MP, Secretary of State for Justice 102 Petty France London SW1H 9AJ United Kingdom**
1	**CORONER** I am Peter Nieto, senior coroner for the coroner area of Derby and Derbyshire.
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 14 November 2016 I commenced an investigation into the death of Yasmin Louise ADAMS aged 25. The investigation concluded at the end of the inquest on 19 April 2024. The inquest was an Article 2 inquest. **The jury made the following findings: -** Although not found to be contributory to Yasmin's death the jury recorded the following omissions: - During Yasmin's second prison term the majority of prison staff were not aware of her mental health and learning disability diagnoses but should have been informed of these by prison healthcare. There should have been consideration for Yasmin's care to be managed as an enhanced or complex case under the ACCT arrangements. The duty governor should have considered whether to terminate cellular confinement having been updated about Yasmin on 12 November 2016. Healthcare should have been informed of and attended all post self-harm incidents. There should have been documented consideration for involvement of Yasmin's family in the ACCT process. All prison staff should have been provided with basic mental health awareness training. Basic first aid training to prison staff should have included instruction in CPR. Assessment of risk for prisoners who self-harmed should have included a clear documented environmental risk assessment of cells.

	There should have been clarity as to the availability of safer anti-tear clothing at the prison. **The jury returned the following conclusion: -** Misadventure. Contributed to by: - Prison mental health care were not always invited to Yasmin's ACCT reviews during Yasmin's second prison term, did not attend any ACCT reviews, and only contributed to two reviews out of sixty-four by telephone consultation. This omission possibly contributed because healthcare could have provided a fuller picture of Yasmin's current mental health state, which may have informed the decision-making process. On 11 November 2016, Yasmin was placed on cellular confinement in a cell with a fixed shower rail despite it being known that fixed shower rails were generally a ligature risk of self-harming and suicidal prisoners, particularly in the context of the bathroom areas being out of sight during prison staff observation checks, [redacted] This omission probably contributed [redacted]. There should not have been a gap of 29 minutes in observations between 15:10 and 15:39 on 12 November. This omission possibly contributed because it provided Yasmin a greater opportunity to ligature, and not be discovered and not receive medical attention sooner.
4	**CIRCUMSTANCES OF THE DEATH** Yasmin had learning difficulties and behavioural problems from a young age. As an adult she was diagnosed with emotionally unstable personality disorder. After the death of her grandmother in April 2015, her mental health declined, which resulted in multiple episodes of self-harm, in which she became known to police and the mental health team. Yasmin's first prison sentence at HMP Foston Hall commenced on 7 April 2016 after being found with a bladed article in a public place. Yasmin was placed on an ACCT after initial assessment. During her second screening, she was found to have superficial self-harm scratches and expressing a wish to die. During her 1st prison sentence, she continued to struggle with her mental health. Yasmin's second prison sentence at HMP Foston Hall commenced on 29 August 2016 due to carrying a bladed article in a public place. On the initial screening, she was placed on an ACCT and referred to primary mental health care during her prison sentence. Self-harm incidents were frequent due to Yasmin hearing voices telling her to self-harm and telling her to kill herself. Yasmin self-harmed frequently [redacted] in her cell. Yasmin was referred to a psychiatrist for an initial assessment, which resulted in a gatekeeping assessment for a secure mental health placement. However, she did not meet the criteria. Yasmin remained on observations during her second prison sentence, which averaged at 4 times per hour. She was subjected to multiple sanctions under the adjudication scheme for noncompliance. Yasmin was placed on cellular confinement on 11 November 2016 after an adjudication for refusing to return to her cell. Yasmin ligatured twice within a short period of time on the morning of 12 November 2016. She appeared unsettled after the removal of her television and table from her cell. Yasmin was repeatedly pressing the call bell in her cell. Later in the day, she was found suspended and unconscious [redacted]. Yasmin was cut down and prison staff commenced CPR until paramedics arrived. Yasmin was transported to hospital where she

	passed away the next day on 13 November 2016.
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: - 1. Immediately prior to Yasmin's death there had been a gap of twenty-nine minutes in her ACCT observations and at the time she was subject to four checks per hour. The relevant guidance for ACCT observation checks understandably states that the checks should not take place at set time to lessen the chances of a prisoner being able to predict when observations will occur, but the guidance does not advise avoiding overly long gaps between observation (e.g. twenty-nine minutes as in Yasmin's case). 2. The inquest heard that HMP Foston Hall no longer has fixed shower rails in prisoner's cell bathroom areas. It could not be confirmed to the court that other prisons across the prion estate do not have fixed shower rails in prisoner's cell bathroom areas, or other shower areas where prisoners may be out of view of staff. Although potential ligature points are multiple within prisons, and cannot totally be eliminated, fixed shower rails present particular and clear risk of use as ligature points. 3. There was lack of clarity concerning what training and awareness prison staff receive on personality disorder. Yasmin was diagnosed with emotionally unstable personality disorder which could make her behaviour impulsive, and unpredictable. She had also been diagnosed with learning disability in the community which was relevant to her understanding and communication with her. I have been provided with the training course slides for Introduction to Mental Health Awareness, produced by HMPPS Learning and Development in conjunction with the National Psychology Service. I am informed that this course is delivered to prison officer staff generally. There is nothing on the slides to indicate that the course covers personality disorder or learning disability. 4. Yasmin was subject to cellular confinement on a residential prison wing. 'Normal' or 'standard' cells may not be best for cellular confinement, particularly for a prisoner placed on an ACCT and therefore deemed at risk and vulnerable, due to cell environment and ligature points and less ability to check and observe by prison staff. It is unclear whether appropriate cells are now used for placement of prisoners subject to ACCTS who are also subject to cellular confinement, across the prison estate.
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 August 15, 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:- [redacted] (mother of the Yasmin), via her solicitors. Practice Plus Group. Midlands Partnership University NHS Foundation Trust. Birmingham and Solihull Mental Health NHS Foundation Trust. 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: 20 June 2024**  **Peter Nieto** **Senior coroner** **Derby and Derbyshire**