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 Governor, HMP Nottingham**
1	**CORONER** I am Miss Laurinda Bower, HM Area Coroner for the coroner area of Nottingham City and Nottinghamshire
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 30 September 2022, I opened an investigation touching the death of Kevin John McDonnell, aged 47 years. The inquest into his death concluded before a Jury on 22 July 2024. The conclusion of the inquest was that Kevin had died by suicide. The Jury further recorded a narrative conclusion capturing a series of failings in his prison and health care, which probably more than minimally contributed to his death from suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 29 September 2022, Kevin was discovered deceased in his cell, having died as a result of ligature asphyxiation. He had a long history of mental ill health, paranoia and self-harm behaviours. He was placed on an ACCT plan and had identified 29 September 2022 as a trigger date when he might be more susceptible to self-harm and suicide on account of this being the anniversary of a relative's death. There was a failure by prison staff to perform a planned ACCT review on 28 September 2022 and on 29 September 2022. Staff on the wing were unaware of the trigger date identified in the ACCT because this risk pertinent information was not passed on in handover and the ACCT booklet had been taken off of the wing for quality assurance (so was not accessible to staff). Landing staff were unaware that Kevin was on an ACCT so did not perform any ACCT checks on the morning of his death. Kevin had appeared agitated overnight and had not slept at all. This information was not shared with day staff. There was a failure to provide Kevin with the necessary support for his mental health in terms of therapy, medication review and psychiatric assessment. Following the death, the ACCT observation and conversation history sheet for 29 September 2022 (which had been blank from the day shift at the time of death) was amended by staff, under the supervision of a senior officer, to record all interactions with Kevin that morning, even though none of those interactions were in fact ACCT checks. This tampering with evidence misled the Prison and Probation Ombudsman's investigation, and only fully came to light during the inquest.

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. Prison staff were unfamiliar with the need for ACCT observations and conversations to be meaningful and have purpose. Witnesses repeatedly described these checks as simply "proof of life" checks. One witness gave the example of an ACCT observation being completed simply by hearing a noise from within the cell or observing the prisoner collecting his lunch from two landings above. Such cursory observations of prisoners at risk of suicide and self-harm is inconsistent with the aims and objectives of the ACCT PSI (64/22011). 2. Prison staff have not read and understood the July 2021 annex to PSI 64/2011. There was a failure to share risk pertinent information about Kevin to all staff caring for him that day. 3. Failure to secure and retain documentary evidence following a death in custody. If post-death investigations are misled by inaccurate documentation that has been amended post-death, then the ability to learn from deaths in custody will be hampered. The preservation of accurate documentary evidence must be of paramount concern when a person dies in custody.
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 Wednesday 02 October 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 Interested Persons I have also shared a copy with the PPO. 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: 07 August 2024**  **Miss Laurinda Bower** **HM Area Coroner** **Nottingham City and Nottinghamshire**