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 The Governor, HMP Ranby**
1	**CORONER** I am Michael WALL, Assistant 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** Mark Stephen Beresford aged 39 died by hypoxic brain injury due to hanging on 7 July 2023. On 19 July 2023 I commenced an investigation into the death. An inquest was opened and later resumed before a jury on 7 October 2023, concluding on 15 October 2023.
4	**CIRCUMSTANCES OF DEATH** Mark Stephen Beresford died on the 7 July 2023 at Bassetlaw District General Hospital from hypoxic brain damage due to hanging. Mark was remanded at HMP Nottingham on 24 February 2023. He was later sentenced and was due for release on 25 August 2024. He transferred to HMP Ranby on 11 April 2023. Between 12:53 and 13:26 on 3 July 2023, while locked in his cell, Mark applied a ligature to his neck [redacted]. He was discovered unresponsive at 13:26. He was successfully resuscitated but remained in critical condition. He died following withdrawal of treatment 3 days later. Between 6 March 2023 and 29 April 2023, there were 15 risk related incidents, including 13 acts of self-harm nearly all involving the application of a ligature. After a period of apparent stability, there were further risk related incidents on 2 and 3 July 2023. He was subject to Assessment Care in Custody and Teamwork (ACCT) procedures at various points during his detention, with observations ranging from constant supervision to 1 at least every 3 hours. Mark attributed his actions to anxiety that he and his family would be under threat from a former cell mate upon his release on 25 August 2023. There was little evidence that Mark and his family were in fact under any significant threat. On several occasions he also expressed anxiety due to his belief that prisoners and staff were talking about him. There was no evidence to support this belief. Upon transfer to HMP Ranby Mark had disclosed to a member of the mental health team that he struggles with paranoia and hearing voices. The jury found that at the time of his death, Mark was suffering significant mental ill health. The jury returned a short form conclusion of misadventure within a narrative conclusion.

They found the following failings contributed to Mark's death:

i) The decision by healthcare staff to discharge Mark from under the care of the Mental Health team and not refer him to the psychiatric MDT on 20 April 2023 was unreasonable in all the circumstances at that time. (Admitted by the Healthcare Trust)

ii) A failure by healthcare staff at HMP Ranby to adequately assess the nature and extent of Mark's mental health problems between 11 April 2023 and 3 July 2023. (Admitted by the Healthcare Trust)

iii) When Mark's ACCT was reopened on 2 July 2023, the decision by prison staff to set the observation levels at no more than 1 every 2 hours was unreasonable in all the circumstances.

iv) Following a second self-harm incident on the 2 July 2023, there was an unreasonable failure to increase the level of observations.

v) The assessment of Mark's risk and the decision by healthcare and prison staff to close the ACCT at approximately 9:50am on the 3 July 2023 was unreasonable in all the circumstances. (Admitted by the Healthcare Trust)

vi) When the ACCT was reopened again at around 12pm that day, the assessment of his risk by prison staff and the decision to leave the observation levels at no more than 1 every 2 hours was unreasonable in all the circumstances.

vii) A failure by prison staff to complete an immediate action plan within the required 1 hour or at all. (Admitted by prison authorities)

viii) A failure by prison staff to respond to the cell bell that Mark activated at approximately 12:53 on 3 July 2023 in a prompt manner, which went unheeded for approximately 33 minutes until Mark was discovered unresponsive at 13:26. (Admitted by prison authorities)

ix) A failure by prison management to ensure there were sufficient staff on duty on House Block 3 to respond to cell bells over the lunch period. (Admitted by prison authorities)

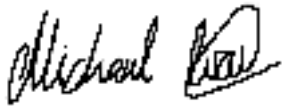
5 CORONER'S CONCERNS

During the inquest I heard evidence of 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.

I heard evidence that the prison authorities have already taken important steps, which I am satisfied address many of the concerns arising from Mark's death. I am concerned however, that despite very strong evidence to the contrary, they maintained the risk assessments conducted on 2 and 3 July were reasonable in all the circumstances.

The supervising officer involved in the decision to close Mark's ACCT on the morning of 3 July 2023, gave evidence that there was ***no*** likelihood Mark would commit further ACCTs of self-harm. While the inexperienced officer who later reopened the ACCT set Mark's observations at one no more than two hours apart, relying in part on the fact that that is what they had been set at when the ACCT had been reopened the previous day. However, there had since been two significant risk incidents and the officer did not consult a supervising officer as required by PSI 64/2011. It is difficult to understand the prison's

	position that these assessments were reasonable in all the circumstances. Furthermore, on two occasions, the Head of Operations gave evidence that was incorrect and liable to mislead the jury and/or the coroner. He gave evidence confirming the requirement for a person raising a concern under the ACCT process to consult with a supervising officer in respect of observation levels. He then added: "*I firmly believe that the supervising officers who gave evidence earlier this week, whether they recall it or not, would naturally have had that conversation, out of being inquisitive, that would be my own personal view point but in terms of the prison stance, that's what the policy says.*" When it was pointed out to him that that was not supported by either of the witnesses involved – who were both very clear that there had been no consultation - he apologised and suggested he had misunderstood. I am troubled by the fact that the Head of Operations, instead of reflecting on the significance of that evidence in terms of learning lessons from Mark's death, suggested to the jury that these witnesses must have been mistaken. The second occasion concerned the issue of cell bell cover on the day of the event that caused Mark's death. Mark was housed on HB3 North. The Head of Operations gave evidence that it is normal for both HB3 North and HB3 South to have a single officer detailed to deal with cell bells over the lunch period. The officer on duty on 3 July was however very clear in his evidence that he was detailed to cover HB3S only. Every other prison witness asked about this agreed that there should be an officer covering each side of HB3 over lunch. Curious and concerned as to how a member of the prison's leadership team could have made such an error, I later recalled and asked the Head of Operations for an explanation. He could provide none. Although, he did later apologise for his difficulty answering other questions asked of him, explaining that he does not usually work in safer custody. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. That, notwithstanding steps since taken to improve work around ACCT processes and risk assessments, there remains an issue with understanding and assessing risk, which extends up to the leadership team at HMP Ranby. 2. That there was a failure by the prison authorities to act with due reflection and candour during the inquest which, if unaddressed, will impede their ability to fully learn the lessons from deaths 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 20 December 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: **Family - [redacted] and [redacted]** **Nottinghamshire Healthcare (NHS) Foundation Trust** 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. 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: 25/10/2024**
	 **Michael WALL** **Assistant Coroner for** **Nottingham City and Nottinghamshire**