	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Midlands Partnership NHS Foundation Trust, St. George's Hospital, Corporation Street, Stafford ST16 3SR.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16 January 2023 I commenced an investigation and opened an inquest into the death of Oliver Peter DAVIES. The investigation concluded at the end of the inquest on 11 October 2024 The conclusion of the inquest was as follows: *Oliver Davies died as a result of suicide.* *[Questionnaire]:* 1. *(a) During Oliver's time at HMP Hewell, were sufficient steps taken to ensure a proper and timely review by a GP of Oliver's mental health needs, and whether mental health medication should be re-prescribed to him?* *NO* *(b) If your answer to 1(a) above is YES or CANNOT SAY, go to Question 2;* *(c) If your answer to 1(a) above is NO, did that failure probably cause or contribute to Oliver's death on 31 December 2022?* *YES* *(d) If your answer to 1(c) above is NO or CANNOT SAY, did that failure possibly cause or contribute to Oliver's death on 31 December 2022?* *YES/NO/CANNOT SAY* *(e) If your answer to 1(d) above is NO or CANNOT SAY, please include the following words at the end of Section 3 of the Record of Inquest: 'It is admitted that the fact that Oliver was not seen by a GP in the prison before his death represents a failing in the healthcare system provided there. It cannot be concluded that this failing possibly caused or contributed to Oliver's death on 31 December 2022.* 2. *(a) Was information relevant to Oliver's recent and current mental state shared sufficiently between prison staff, healthcare staff and mental healthcare staff at HMP Hewell, such that Oliver's ongoing risk of self-harm of suicide could be properly assessed?* *NO* *(b) If your answer to 2(a) above is YES or CANNOT SAY, go to Question 3;*

(c) If your answer to 2(a) above is NO, did that failure probably cause or contribute to Oliver's death on 31 December 2022?
YES
(d) If your answer to 2(c) above is NO or CANNOT SAY, did that failure possibly cause or contribute to Oliver's death on 31 December 2022?
YES/NO/CANNOT SAY

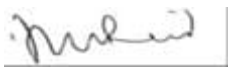
3. (a) Did the mental health assessment on 6.12.22 consider sufficiently all information relevant to Oliver's ongoing risk of self-harm or suicide?
YES
(b) If your answer to 3(a) above is YES or CANNOT SAY, go to Question 4;
(c) If your answer to 3(a) above is NO, did that failure probably cause or contribute to Oliver's death on 31 December 2022?
YES/NO/CANNOT SAY
(d) If your answer to 3(c) above is NO or CANNOT SAY, did that failure possibly cause or contribute to Oliver's death on 31 December 2022?
YES/NO/CANNOT SAY

4. (a) Did the ACCT case review of 30.12.22 consider sufficiently all information relevant to Oliver's ongoing risk of self-harm or suicide?
NO
(b) If your answer to 4(a) above is YES or CANNOT SAY, go to Question 5;
(c) If your answer to 4(a) above is NO, did that failure probably cause or contribute to Oliver's death on 31 December 2022?
NO
(d) If your answer to 4(c) above is NO or CANNOT SAY, did that failure possibly cause or contribute to Oliver's death on 31 December 2022?
YES

5. (a) Was Oliver kept sufficiently informed of progress regarding his applications for a doctor to review his mental health needs and to consider whether mental health medication should be re-prescribed to him?
NO
(b) If your answer to 5(a) above is YES or CANNOT SAY, go to Question 6;
(c) If your answer to 5(a) above is NO, did that failure probably cause or contribute to Oliver's death on 31 December 2022?
YES
(d) If your answer to 5(c) above is NO or CANNOT SAY, did that failure possibly cause or contribute to Oliver's death on 31 December 2022?
YES/NO/CANNOT SAY

6. (a) Was Oliver kept sufficiently informed of his allocation to, and forthcoming appointments with, a mental health care-coordinator?
NO
(b) If your answer to 6(a) above is YES or CANNOT SAY, go to Question 7;
(c) If your answer to 6(a) above is NO, did that failure probably cause or contribute to Oliver's death on 31 December 2022?
YES
(d) If your answer to 6(c) above is NO or CANNOT SAY, did that failure possibly cause or contribute to Oliver's death on 31 December 2022?
YES/NO/CANNOT SAY

	7. Was Oliver's death contributed to by neglect? *YES*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Oliver come by his death?", the jury recorded as follows: *"Oliver Davies committed suicide in his cell at HMP Hewell by hanging. He died on the 31.12.22."*
5	**<u>CORONER'S CONCERNS</u>** 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) Oliver had been at HMP Hewell since 20.10.22. He was a man with long-standing mental health issues, for whom this was a first experience of custody. After a steady deterioration in his mental state, a mental health referral on 17.11.22 led to a belated mental health examination conducted by a registered learning disability nurse on 6.12.22. In the week leading up to the nurse's assessment: (a) A prison officer had made an urgent TAG mental health referral on 30.11.22, citing concerns that Oliver was experiencing active thoughts of self-harm or suicide, and that he (the officer) had "mild concerns" about intentional self-harm, and there were "definite indicators" of unintentional self-harm; and (b) Oliver himself had submitted a healthcare application form asking to see a doctor, saying that he was "extremely depressed", his anxiety was "really high" and he was "not coping at all, please help"; These important events were not highlighted on Oliver's SystmOne medical record, and so the nurse conducting the assessment 6.12.22 was not aware of either of these important recent events, and did not take them into account when assessing Oliver; 2) Oliver was allocated a care coordinator on 6.12.12 following the nurse's assessment. An appointment was fixed for Oliver to meet the care coordinator for the first time on 14.12.22. Due to workload pressures, the care coordinator was unable to fulfil that appointment before he went on leave from 16-28.12.22. Shortly before he went on leave, the care coordinator conducted a "RAG rating" exercise to determine whether he should prioritise seeing Oliver, and determined that Oliver's case merited the lowest priority RAG rating (green). When conducting that RAG rating exercise, the care coordinator did not take into account: (a) The prison officer's urgent TAG mental health referral of 30.11.22 (above); and (b) A further TAG mental health referral made by a prison paramedic which cited "mild concerns" about both deliberate and unintentional self-harm on Oliver's part, the details of which had been entered onto Oliver's SystmOne medical record. In addition, the care coordinator did not raise in the mental health team's daily forum.the fact that he was unlikely to have time to see Oliver before he went on leave. Had the care coordinator taken into account the referrals at (a)-(b) above, and raised at the daily forum his difficulty in being able to see Oliver, it may well have been that Oliver's case would have merited a more urgent response from the care coordinator or someone else in his stead.

	Having heard evidence at the inquest from your Trust's Clinical Director, [redacted], I was not satisfied that the Trust has fully recognized the above shortcomings, and taken action to ensure that they are not repeated for other mental health patients in custody at HMP Hewell.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of The Midlands Partnership NHS Foundation Trust, which is responsible for mental health care within HMP Hewell, 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 **6 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 Parties at the inquest: (a) [redacted], Oliver's mother; (b) HM Prison and Probation Service; (c) Practice Plus Group; (d) West Mercia Police; (e) GEOAmey. I am also under a duty to send the Chief Coroner a copy of your response. 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	**11 October 2024**  **David REID** **HM Senior Coroner for Worcestershire**