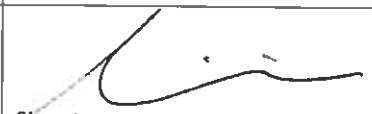
M. E. Voisin
His Majesty's Senior Coroner
Area of Avon

4th December 2024

REF: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **HMP Eastwood Park** **Healthcare – Practice Plus Group** **Mental Healthcare – Avon and Wiltshire Mental Health Partnership Trust** **Ministry of Justice**
1	**CORONER** I am M. E. Voisin HM Senior Coroner for Avon
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 19th July 2022 I commenced an investigation into the death of Kayleigh Ann MELHUISH. The investigation concluded at the end of the inquest on 17th October 2024. The conclusion of the inquest was Suspension by a ligature contributed to by neglect
4	CIRCUMSTANCES OF THE DEATH Kay arrived at HMP Eastwood Park on 15th June 2022. It was her first time in prison and she had a history of autism, attention deficit and hyperactivity disorder (ADHD), and a personality disorder. She arrived with a suicide and self-harm warning form having been completed as she had tried to [redacted] Staff started a suicide and self-harm monitoring process referred to as an ACCT. Initially Kay was placed on the prison induction wing, subsequently she was moved to Residential Unit 3. During her time at the prison she continued to self-harm, she banged her head, she punched herself, she made scratches and cuts to herself, she made ligatures and was found with them on two occasions. She found it difficult to cope with the noisy environment and prison regime. On 21st June a neurodiversity specialist met her and created a communications support plan for her. This set out the difficulties she had with noise, smells, food, and physical contact, it suggested ways for people to understand and interact with her. On 4th July Kay cut her arms in the morning, a nurse cleaned her wounds and Kay handed to her a ligature that she had made.

	At around 6.30pm Kay could not be found and after a search she was located hiding under a table in the association room. She refused to go back to her cell. She was restrained and carried back to her cell by officers. At 7.26pm 3 officers went into her cell and found her hanging, she was cut down and cardio-pulmonary resuscitation is commenced. Paramedics arrive and she is then taken to Southmead Hospital. Kay died on 7th July 2022. During her numerous ACCT case reviews her care plan with support action was never completed. After the control and restraint constant observations were not considered. There was little understanding by the prison staff of Kay's neurodiversity.
5	**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. To HMP Eastwood Park and The Ministry of Justice - training issues in relation to the following areas for new and existing staff: a. Neurodiversity, I am told 75% of women in prison have mental health or neurodiverse issues, this training is not mandatory; b. ACCT, there was little understanding of the requirement to complete or review the care plan and support actions at every ACCT review not just the planned reviews; c. Little or no understanding of when constant supervision can be used and how is it used; 2. Healthcare (AWP and PPG): training issues arose in relation to, when attending ACCT reviews that they check the care plan with support actions part of the document is reviewed and if necessary updated; it was suggested that consideration could be made to making changes to the system-one database to check this step has been taken. 3. To HMP Eastwood: the ligature point in Residential Unit 3 where the privacy screen meets the wall.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 28th January 2025. 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 **a Kayleigh's family** b **HMP Eastwood Park** **c Healthcare – Practice Plus Group** **d Mental Healthcare – Avon and Wiltshire Mental Health Partnership Trust** **e Ministry of Justice** 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	 Signature M. E. Voisin HM Senior Coroner for Avon