REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Ministry of Justice
1	CORONER I am Alison Mutch , senior coroner, for the coroner area of Manchester South
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 17th January 2024 I commenced an investigation into the death of Nathan Harry SHEPHERD. The investigation concluded at the end of the inquest on 20th December2024. **The conclusion of the inquest was suicide and the medical cause of death was 1a) Hypoxic brain injury 1b) Hanging.**
4	CIRCUMSTANCES OF THE DEATH Nathan Harry Shepherd had a history of mental health issues and drug use. Whilst in custody in 2023 he was subject to an ACCT following him taking an excess amount of medication in his cell. His calls were recorded from June 2023 and indicated he was using drugs and that his mental health fluctuated. On 8th January 2024 he was released from custody to approved premises at Ascot House. He was allocated a single room at Ascot House, he did not indicate any immediate thoughts of suicide or self-harm to staff. The full extent of his mental health history and ACCT history was not known to the staff at Ascot House. This was due to poor information sharing by probation service staff, this probably did not contribute to his death. On 11th January 2024 he sent a series of messages to other residents which demonstrated he was deteriorating. Staff were unaware of those messages. Ascot House overnight was staffed by one member of probation and an agency worker. Both were required to be first aid trained. On 11th January a text message was sent by Nathan Shepherd to the landline in the office at Ascot House. It caused the phone to ring and the message said the door was blocked and he was hanging. It was acted on by the member of staff going straight to Nathan Shepherd's room. An attempt to gain entry was unsuccessful because he had barricaded himself into the room. The barricading of entry to the room was made possible because the furniture was moveable. Attempts were made to force entry. After approximately 12 and a

	half minutes, entry was gained, and Nathan Shepherd was found suspended from a ligature. Entry would have been gained immediately had he not been able to barricade himself into his room. The staff cut the ligature on entry releasing the compression and began CPR. Paramedic assistance arrived approximately within 10 minutes after the staff gained entry. CPR continued along with attempts to intubate him. Intubation was unsuccessful until the arrival of a critical care paramedic. Successful intubation was followed by a return of spontaneous circulation at 06:38. He was transported to Stepping Hill Hospital where a CT scan 08:35 showed extensive loss of grey-white matter differentiation indicating an anoxic brain injury. He was moved to the critical care unit. On 15th January a further scan showed that the position had deteriorated further and he had a hypoxic brain injury that was not compatible with life. He died at Stepping Hill Hospital on 16th January 2024.
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 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. The inquest heard evidence that the Probation Service had no policy to cover incidents of residents barricading themselves into rooms at Approved Premises. This meant that staff did not have training on how to deal with a situation. The inquest was told that the Probation Service were now developing such a policy but it had not been signed off or rolled out to staff. 2. A copy of the draft policy was available to the inquest but it was unclear what if any discussion there had been with Police Forces and how it would link in with Police policies such as the GMP Right Care Policy. 3. The evidence before the inquest was that Mr Shepherd was able to barricade himself with relative ease due to the mobility of the furniture in his room. The Approved Premises had no clear policy regarding furniture which meant that furniture could be used to create a barricade with relative ease. 4. The [redacted] was a ligature point. Such ligature points remained in the Approved premises. It was unclear if changes could be made to reduce the risk they presented. 5. Agency staff were used under a national contract. The evidence before the inquest was that at the time of Mr Shepherd's death there was no policy for ensuring they could deliver CPR / First Aid. It was part of the

	national contract that they should be so trained but there were no checks to ensure that this part of the contract was being followed. The evidence at the inquest was that the agency worker in place on the night did not appear able to deliver CPR. 6. Evidence from Probation and Prison staff showed a lack of understanding of how the prison system could update the probation system and where that information could be found. This meant that key information was not shared effectively creating a risk that probation staff in the community would not have a full picture of risk. 7. The inquest heard evidence that the information shared with the Approved Premises staff by other probation staff was not accurate and did not give a full picture of risk. This was in part due to the fact that it appeared key documents were being regularly completed by probation staff who were not the allocated probation officer and so were unfamiliar with the history.
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 19th March 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 mother of Mr Shepherd on behalf of the family. I have also sent it to GMP, Prisons & Probation Ombudsman (PPO), HMP Berwyn & Probation Services who may find it useful or of interest. 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. They may send a copy of this report to any person who they believe 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	**Alison Mutch** **HM Senior Coroner**  **22/01/2025**