	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) The Minister of State for Prisons, Probation and Reducing Offending, Ministry of Justice, 102 Petty France, London SW1H 9AJ**
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 18 October 2024 I commenced an investigation and opened an inquest into the death of Emmett Peter MORRISON aged 40. The investigation concluded at the end of the inquest on 06 February 2026. The conclusion of the inquest was that: "Emmett Morrison died as a result of suspending himself by a ligature [redacted] It is not possible to determine what his intention was at the time he did this. See Questionnaire: QUESTIONNAIRE When you provide your answers, circle where appropriate. 1. (a) Did the admitted failure to consider and include on the ACCT Care Plan support actions to try to mitigate Emmett's risk of suicide and/or self-harm possibly cause or contribute to his death on 16 October 2024? YES 2. Following the ACCT review on 8 October 2024, should a further ACCT review have been arranged sooner than 14 October 2024? YES 3. If your answer to Question 2 above is YES, did that failure possibly cause or contribute to Emmett's death on 16 October 2024? YES"
4	**CIRCUMSTANCES OF THE DEATH** On 13.10.24 Mr. Morrison, who was a serving prisoner since May 2023 at HMP Long Lartin, was found suspended by a ligature in his cell. He was resuscitated and taken to Worcestershire Royal Hospital where on 16.10.24 he died from his injuries.
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) Continued influx of drugs into HMP Long Lartin

Throughout Emmett's time at HMP Long Lartin, and at the time of his death, the influx of illicit drugs into the prison was a major problem. HMP Long Lartin is a high security prison, a large proportion of whose inmates are serving lengthy sentences. The demand for, supply and distribution of drugs within the prison is therefore capable of causing significant disruption to its security and stability, as well as posing significant risk to the wellbeing of prisoners and staff working there.

Staff at the prison are doing all they can to try to reduce the demand for these drugs, and to assist those dependent on them, but their job is being made considerably harder by the continued and steady flow of illicit substances into the prison.

I have been told in evidence that HMP Long Lartin has been identified as one of the two prisons in the country with the biggest issues in this regard.

I have also heard evidence that measures put in place since Emmett's death have reduced the number of drone drops of drugs into the prison, and that funding is now in place to install grilles on windows at the prison to prevent prisoners reaching out to retrieve drugs from those drones, although that work is yet to be carried out.

Those involved in the supply of drugs within the prison are often part of highly sophisticated organised crime groups, and unless proper measures are put in place at the prison, its regime and the welfare of its staff and prisoners will continue to be placed at risk as the influx of drugs continues.

Class A drugs, which continue to be used within the prison, present a clear and obvious risk to the lives of those who use them.

Novel Psychoactive Substances, like Spice, the make-up of which can change from batch to batch and makes detection problematic, and whose effects can be both unpredictable and life-threatening, as was apparent in EM's case, also remain prevalent throughout the prison.

2) Failures in ACCT process

Emmett was a prisoner with a considerable history of substance misuse and self-harm while in custody.

Of the eight ACCT reviews which were conducted after Emmett's ACCT document was re-opened on 10.9.24, not one resulted in any support actions being entered onto the ACCT care plan.

The ACCT care plan is a key part of the ACCT process, which requires those taking part in ACCT case reviews to set in train actions designed to reduce the prisoner's risk of suicide or self-harm. As the guidance then in force made plain, it is a mandatory part of the ACCT process.

The reasons given by staff who took part in these ACCT reviews for not having done this included:
(i) being sure that they had talked about it, but had not noted anything down;
(ii) thinking that, if EM didn't attend an ACCT review, they couldn't put any actions in place because that could only be done with his agreement; and

	(iii) they were so weighed down by the number of ACCT reviews which they had to carry out and the rest of their workload, that they simply had no time to complete this part of the review. Most worryingly, two of those witnesses who cited a heavy workload and pressures of work for Care Plans not being completed, made clear that not only this was commonplace at the time of these events but also that it is still an issue. Despite hearing evidence that measures have been put in place to train officers conducting ACCT reviews, and to conduct Quality Assurance checks on open ACCT documents, I was left with the clear impression that ACCT Care Plans are still being overlooked. I also note that as long ago as 2021 this court heard an inquest into the death of a prisoner at the same prison in 2018, following which I wrote a Prevention of Future Deaths report to the then Governing Governor of the prison, indicating my concern that ACCT Case Reviews for that prisoner had, on several occasions, failed to review or add actions to the ACCT Care Plan. It is therefore a concern that, 6 years on from that prisoner's death, the same issue arose in Emmett's case. As long as that remains the case, the lives of those vulnerable prisoners whom the ACCT process is designed to protect will continue to be put at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the nominated individual responsible for the care home, 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 **3 April 2026**. 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: [redacted] **(Emmett's mother)** **(solicitor, Government Legal Department)** [redacted] **(solicitor, Hill Dickinson LLP, representing Practice Plus Group)** [redacted] **(solicitor, Browne Jacobson LLP, representing Midlands Partnership NHS Foundation Trust)** I am also under a duty to send the Chief Coroner a copy of your response 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	**6 February 2026** [redacted] **David REID** **HM Senior Coroner for Worcestershire**