REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. HMPS** **2. The Governor of HMP Manchester**
1	**CORONER** I am Caroline Sarah Sumeray, Assistant Coroner, for the Coroner Area of Manchester City.
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 1st January 2011 I commenced an investigation into the death of Michael James Meyler, aged 28. The investigation concluded at the end of the inquest on 29th October 2013. The conclusion of the inquest was Misadventure (by a majority of 10:1). The medical cause of death was found to be: 1a Pneumonia 1b Hypoxic Brain Injury 1c Compression of the Neck
4	**CIRCUMSTANCES OF THE DEATH** 1) Michael James Meyler was born on 21st March 1982 and was 28 years of age at the time of his death. 2) Mr Meyler had been in a long term relationship with his partner, [redacted] for some 14 years, and they had two children together. In the latter half of 2010 difficulties arose within their relationship and Mr Meyler moved out of the family home. Both Mr Meyler and [redacted] had formed relationships with other partners. Part of the reason for the difficulties in Mr Meyler's long-term relationship was that he had made another woman pregnant in the late summer of 2010.

3) Mr Meyler struggled emotionally with the breakdown of his relationship and loss of contact with his children. On 18th October 2010, he attended hospital in Liverpool, having harmed himself by making cuts to his forearms. He was referred to the local mental health team and was seen then next day. He presented at hospital again on 21st October 2010, apparently after an overdose of diazepam tablets, although it is not certain whether he actually took the medication.

4) He was discharged to his sister's home in Liverpool, but when mental health services attempted to contact him the next day, he was not there. The next day, his family reported him missing to the police. They believed he had returned to Manchester to attempt contact with his children and former partner.

5) On 29th October 2010, he was arrested in Manchester for offences of burglary and taking a vehicle without consent. He was granted bail. He appeared in Manchester Magistrates Court on 19th November 2010 and pleaded guilty to those charges. He was sentenced to 8 months imprisonment and was transferred to HM Prison Manchester. This was Mr Meyler's first time in prison.

6) The Prisoner Escort Record that accompanied him contained the information that he had recently tried to harm himself and a suicide/self-harm warning form had been completed in order to make prison staff aware. Additionally, a copy of his pre-sentence probation report which mentioned this had been faxed to the prison, but apparently was not received.

7) As part of the prison reception process, Mr Meyler was seen by a nurse and he disclosed his recent emotional difficulties and self-harm attempt. He stated that he now felt fine. The nurse recorded that there were no concerns regarding his mental health and he was not referred to the mental health team for further assessment. (The nurse concerned subsequently conceded in evidence that this was an error on her part.) Mr Meyler was accommodated in a cell on the induction wing of the prison. He also had a routine health screening three days later, on 22nd November 2010, where no concerns were recorded regarding his mental health.

8) On 25th November 2010 his probation officer contacted the prison to advise a post-sentence review of Mr Meyler's mental health, given the disclosures he had made prior to his court appearance. He was spoken to by a senior prison officer, who recorded no concerns in relation to self-harm.

9) On 1st December 2010, Mr Meyler moved from the induction wing to B wing of the prison. As part of his induction, he telephoned his ex-partner to inform her of the move. During the call, she confirmed the end of their relationship and requested that he not contact her. He mentioned self-harm and she said to him "Go and do it then." He was visibly upset by this. Prison officers were concerned for his welfare and an Assessment, Care in Custody and Teamwork (ACCT) plan was opened that afternoon. It was agreed that Mr Meyler would share a cell with a mature and experienced prisoner, that he would have four good quality interactions with staff during the day and be checked on four occasions at night.

10) It is apparent that there was a pattern of somewhat turbulent phone calls between Mr Meyler and his former partner. All phone conversations at the prison are recorded, but except for some high-security prisoners, only a sample are listened to at the time they are made. The recordings of Mr Meyler's conversations have been listened to and show that he spoke about suicide by hanging on 24th and 25th November 2010. He also telephoned his former partner on several further occasions in December but she indicated she did not want contact with him. He wanted contact with his children and to arrange for his older daughter to visit him, but this was not facilitated and he expressed sadness and frustration.

11) At the time of Mr Meyler's arrest, he was already on bail for an alleged assault upon his former partner. One of his bail conditions was that he should not contact her. This is noted on his Police National Computer entry that forms part of his prison file. It does not appear that regard was had to this.

12) Mr Meyler's first ACCT review was held on 8th December 2010. It was decided to keep the ACCT open for a further week. He was noted in the daily observations to generally be coping well. On 13th December 2010, he moved to share a cell with someone he had been friendly with outside prison, who was also his co-defendant on the matters for which he had been imprisoned.

13) A second review was held on 15th December 2010. It was noted that Mr Meyler was not at current risk of self-harm and that he would like the ACCT to be closed. However, it was felt that it would be wise to keep the ACCT open over the Christmas period as this was likely to bring stresses around having contact with his children. The level of observation remained the same and the next review was scheduled for 29th December 2010.

14) Records of the continuing observations show that Mr Meyler had some periods of being low in mood or at times agitated over the next fortnight but that these would then resolve.

15) Beginning on 18th December 2010, he started to have telephone contact with the partner with whom he had more recently formed a relationship and who was expecting his child. He expressed the wish to settle down with her on his release but she was guarded about agreeing to this and he became anxious about the security of the relationship. He was also apparently concerned about the progress of the case in relation to the alleged assault of his former partner and whether his sentence might be extended.

16) On the night of 27th December 2010, Mr Meyler spent some time in the toilet area of the cell and then emerged, having made shallow cuts to his forearm with a razor blade. His cellmate helped him to clean the cuts and intended to inform prison staff. Mr Meyler asked him not to do so as he wanted the ACCT to be closed. His cellmate reluctantly agreed to this.

17) On the morning of the next day, Mr Meyler appeared subdued in manner and remained in bed. At around 1.15 pm, his cellmate recalls that he went into the toilet area. It was not unusual for him to withdraw there for several minutes if he was feeling emotional. Approximately 15 minutes later, his cellmate called to him but received no response. Shortly afterwards, he became concerned and opened the toilet door. Mr Meyler was hanging by the neck from the window bars by a ligature made from a torn bed sheet which was wound around his neck, as opposed to being tied around it.

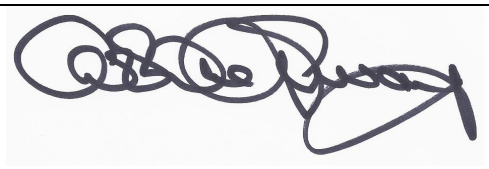
18) His cellmate immediately summoned help. Prison staff cut Mr Meyler down and CPR was commenced. An ambulance arrived and paramedics continued advanced life support, achieving some return of spontaneous circulation. He was transferred to North Manchester General Hospital.

19) He was admitted to the Intensive Care Unit. He was breathing with the assistance of a ventilator, was sedated and was in a stable condition. It was not known how long he had been without oxygen and it was difficult to predict an outcome at this point.

20) Over the next 24 hours, Mr Meyler showed signs indicating that he had sustained a hypoxic brain injury. When sedation was withdrawn on 30th

	December 2010, he did not recover consciousness. His condition continued to deteriorate and on 1st January 2011, with the agreement of his family, he was treated to keep him comfortable only and he died that afternoon.
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. I am concerned that if a Risk of Self-Harm / Suicide document enters the prison after the prisoner has undergone first Reception Screening, that the information in this document is not adequately circulated to all those who would need to know about it within the prison system. Whilst I am now told that the information is made the subject of an Intelligence or Information Report, which is disseminated (after being "sanitised") to the Head of Healthcare, the Deputy Head of Healthcare and the Head of Safer Custody, it unclear to me why it is not sent as a priority to Healthcare in the first instance as the information contained within it must be passed on without delay. 2. Furthermore, I am concerned that the information in the Risk of Self-Harm / Suicide document is not brought to the attention to the Senior Officers on Wings which the prisoner may move to at a later stage during their incarceration. I believe that a copy of the Risk of Self-Harm / Suicide document is contained in the prisoner's physical (buff) folder, which goes with them from Wing to Wing, however there needs to be a safeguard to ensure that this information is read and considered at each stage of the prisoner's term of imprisonment. 3. I am concerned that if an ACCT document is opened for any reason that if there should be a Risk of Self-Harm / Suicide document in existence for the prisoner, that it MUST be attached to the ACCT document. In this case the ACCT document was opened principally as an "instrument of support" where it was believed that the prisoner's primary issues involved contact with his family and his children in particular. It was not known by those who opened the ACCT document and who conducted the various ACCT reviews that he had a history of self-harm which involved both taking an overdose and cutting his wrists on several occasions in the immediate months before he was committed to prison as a consequence of his distress over a long-term relationship breaking down. Furthermore, in the light of the information contained in the Risk of Self-Harm /

	Suicide document which came to their attention after the death of the deceased, all the Prison Officers involved indicated that they would have referred the deceased on for a Mental Health Inreach Assessment had they known of the details of his previous history. All the Prison Officers concerned felt that they had not been able to make "informed decisions" regarding the welfare of the prisoner concerned as they were not in possession of all the facts at the relevant times. 4. I am concerned that there is no way of logging that the Senior Wing Officer has read any entries of relevance on CNOMIS when a prisoner moves to their wing, and believe that a method of signing CNOMIS to say that they've done so would improve practices within the Prison. 5. I am concerned that Healthcare are simply scanning important documents like a Risk of Self-Harm / Suicide document into their system so that they have "a contemporaneous note" rather than actually reading the content. There should be a way of ensuring that these documents are not just scanned to be read in the event that the prisoner has an appointment with someone from Healthcare at a later stage, but that they MUST be read and disseminated in order that they actually make a difference.
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 27th January 2014. 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] HMPS and the PPO Investigator. 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	 **H.M. Assistant Coroner – Manchester City area** **2nd December 2013**