	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **Re: Inquest touching the death of Adrian Johnson dod 13th May 2010, Case number: 01259/2010, concluded 6th December 2013.**
	THIS REPORT IS BEING SENT TO: **1. Mr Michael Spurr, Chief Executive Officer, National Offender Management Service** **2. [redacted] Head of Public Health, Armed Forces Health and Offender Health NHS England** **3. [redacted] Head of Health Care, HMP Belmarsh**
1	**CORONER** I am Andrew Harris, senior coroner for the jurisdiction of London Inner 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** By a majority, the jury found that Mr Adrian Johnson died by an act of accidental hanging between 12.50 and 13.55 on 13th May 2010 in the Segregation Unit of HMP Belmarsh.
4	**CIRCUMSTANCES OF THE DEATH** 1. Circumstances related to initial screenings in the First Night Centre: The jury concluded that Mr Johnson died in part from serious failures within the prison system. His initial screenings within the First Night Centre failed to highlight the urgent need for a mental health assessment and did not ensure his medication needs would be met and failed to take appropriate heed of Adrian Johnson's exceptional dependency on nicotine, the single trigger recorded on the already open ACCT. 2. Circumstances related to ACCT Reviews: The jury found that the ACCT Review on the morning of 13th May 2010 was inadequately conducted, in the absence of clinical records, with no appropriate psychologist present as per HMP Belmarsh Suicide Prevention Policy and the omission of the solicitor's letter from the family, received into Health Care Unit on the 12th May 2010. The reduction in the level of observations and relocation into a non-gated cell prior to securing the overdue mental health assessment amounted to neglect. On the balance of probabilities the ACTT Review failed to maintain adequate protection for a highly vulnerable inmate with a history of recent impulsive self harm (Two out of ten jurors objected to the use of the term impulsive in the absence of any mental health assessment being conducted).

5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern in each of these areas:

1. Circumstances related to initial screenings in the First Night Centre:

a) The nurse conducting the primary reception screen said that she could not ask questions about smoking or withdrawal as she was not toxicology trained.

b) The doctor to whom Mr Johnson was referred in the First Night Centre by the nurse, said that she did not routinely assess smoking habits and that she expects the matter to be covered by nurses. She does not get involved in tobacco issues.

c) The nurse who conducted the secondary screen recorded the number of cigarettes that she said he smoked, but did not ask any questions about withdrawal.

d) The mental health nurse who later saw Mr Johnson, on referral by the doctor said that smoking was not his area; he assumed it was assessed in reception.

e) There was no health care worker who assessed whether he had problems with withdrawal from tobacco. According to the exert witness, Dr [redacted] who was a GP with substantial experience working in prisons, for this patient, withdrawal and agitation due to lack of tobacco was obviously an issue. He said that nicotine withdrawal was very important in this case, increasing the patient's vulnerability and anxiety and thus his risk.

f) Dr [redacted] said that this prisoner had made it very clear that, although a majority of prisoners can manage their tobacco withdrawal, he could not, so that vigilance should have been higher and greater steps taken to support this, which becomes highly relevant when we see him moving to health care, which is a smoke free environment. He said that he would have treated him with a patch or lozenges to reduce anxiety, or he might use Diazepam. There was a prescription of Diazepam, but it was not in the dose being given in the previous prison and police station on transfer, it was not administered when the prescriber intended and was not prescribed for tobacco withdrawal.

g) Dr [redacted] who was Chair of the RCGP Secure Environments Group, advised that tobacco use should be screened for as part of the reception screen in the first 24 hours, including a question as to whether tobacco withdrawal might be a problem. He was sufficiently concerned that without such a question in routine use in prisons, there was a potential risk to future lives and recommended that I should make a prevention of deaths report, to those named.

2. Circumstances related to ACCT Reviews

a) The ACCT review on 11/05/2010 chaired by Officer A, was held without input from health care, despite the main trigger for his self suspension days earlier being anxiety related to tobacco withdrawal.

b) The court heard that a governor did not know that the prisoner was on an open ACCT when he was informed of his initial transfer to the segregation unit

c) There was a lack of consistency in case management, with no handover from case manager Officer A (who was not informed or invited to the subsequent reviews) to the case manager of the ACCT review on 12/05 or to the ACCT review with a third case manager, chaired by the governor on 13/05. This appeared not be in compliance with PSO guidance.

d) The attendees for enhanced care team review on 13/05 were not selected by the governor, who was in the chair, who left the invitations to the Segregation Unit. A psychologist was not invited, contrary to local guidance. Health care was invited at the last minute with no notice to prepare.

e) The health care member attended with very little knowledge of the case. He did not know that there was an alcohol abuse history and did not discuss his personality disorder, possible prior diagnosis of schizophrenia or potential withdrawal problems. He did not know of the Diazepam prescribing prior to admission or at Belmarsh. It was not clear that the review team had been informed of an admission by the prisoner that the recent ligature was a serious attempt on his life. A LISA form was completed at reception, giving details of Diazepam dependency, alcohol abuse, past history of schizophrenia, previous in patient psychiatric care and current antidepressants but this information was not available to the Review teams

f) The listed Caremap areas for consideration were not all considered. Action to link the person to people who can provide support did not include his family (after the two minute reception call). Actions to encourage alternatives to self injury, to reduce emotional pain caused by practical problems, action to reduce vulnerability because of mental health problems and action to reduce vulnerability because of drug and alcohol problems were either not or inadequately considered. The governor agreed that he had not conducted a comprehensive careplan.

g) Many of those actions required mental health assessment, which was not conducted before he died, which the expert said should have been done in 48hrs of admission, and not doing it was a really serious failure. The last ACCT review did not consider whether or when it would be done.

h) The last Review agreed the reduction of observations to hourly, without any information from mental health assessment. The governor had not seen the entry in the prison records that Mr Johnson was at high risk of impulsive behaviour causing accidental suicide. Had he known that, he would have asked for the results of the mental health assessment prior to downgrading his observations

i) The expert was critical of the decision to keep him in Segregation Unit, in the light of his vulnerability and health problems. It was not clear that all other options had been fully explored: this was not an item considered at the last ACCT Review.

	The **MATTERS OF CONCERN** are as follows. – (1) Expert opinion has been given that the failure to routinely screen for and enquire into tobacco withdrawal as part of prison reception screening creates risks to the lives of a small number of vulnerable prisoners. Withdrawal problems may be interpreted by staff as behaviour designed to gain benefits, unless an appropriate health care assessment is conducted. Health care staff at HMP Belmarsh do not appear to be trained to conduct such screening, nor manage withdrawal, nor is it clear whose responsibility it would be. (2) To questioning about steps that HMP had taken to reduce future risks, a governor reported a significant improvement in the conduct of ACCT reviews and pleasing spot checks. However she could not confirm whether there had been any individual learning by those involved. It was not clear that there would be any better consistency of case management in prisoners who move to the Segregation Unit, nor in the way in which members were asked to attend, nor the adequacy of caremap planning. The discipline staff appeared to blame the health care staff for the incomplete health care information at reviews, but there was no indication that they accepted that the case manger and chair had responsibilities to secure the information if it was not volunteered. It remained unclear how decisions on reduction of observations would in future be fully informed in exceptional cases where vulnerable prisoners are in the Segregation Unit. Improvements in the processes and conduct of ACCT reviews may not have fully addressed the areas of concern, which create significant risks for vulnerable prisoners
6	**ACTION SHOULD BE TAKEN** (1) NOMS and NHS England are asked to consider the expert opinion on the risks associated with tobacco withdrawal and consider whether any national initiative is required to include screening in the reception process, or issue appropriate guidance. HMP Belmarsh health care is asked to be mindful of the identified risks and advice of these bodies. (2) HMP Belmarsh is asked to review the areas of concern that were raised in this inquest, in relation to the adequacy of the ACTT Review process and either take appropriate action or report on the steps taken already to address these areas.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th February 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: Ms [redacted] next of kin Ms [redacted] Treasury Solicitors for Prison Service Mr [redacted] Radcliffes Le Brasseur for Dr H Kucper Ms [redacted] Mills & Reeve for Virgin Care Ltd Ms [redacted] Royal College of Nursing for Nurse [redacted] and to Dr [redacted] 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. 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. If you would like further information about the case, please contact my officer, [redacted]
9	**[DATE]** 20th December 2013 **[SIGNED BY CORONER]**