ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Michael Spurr – Chief Executive Officer, NOMS** **2. Paul Sly – Chief Executive Officer, Dorset Healthcare University NHS Foundation Trust**
1	**CORONER** I am Sheriff Stanhope Payne, senior coroner, for the coroner area of Dorset.
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 12th January 2012 I commenced an investigation into the death of JORDAN ANTHONY BUCKTON, aged 20. The investigation concluded at the end of the inquest on 1st August 2013. The conclusion of the inquest was that the medical cause of death was Ia) Hanging and that he killed himself.
4	**CIRCUMSTANCES OF THE DEATH** At 0640 hours on 28th January 2012 Mr Buckton was found hanging by a ligature from the ceiling light fitting in his single cell at HMYOI Portland.
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) **Information Sharing** Mr Buckton had previously hung himself in his cell at Exeter Prison on 14th February 2011 but was saved by prison staff and hospital treatment. He had also committed 3

acts of self-harm within that prison.

At the Inquest none of the wing staff at Portland were aware of his history of such acts nor had they read the C-NOMIS Record of the Potential Identified Risks form.

Evidence was given by medical witnesses that a history of previous self-harm is one of the most significant indicators of a future risk of suicide. This is also recorded in PSO 2700 and in the Self-harm Guidance issued by NOMS.

The jury reported that there was a failure to share verbal and written information within the prison in a suitable manner that all the staff members were informed so as to be able to carry out informed actions.

(2) **Follow Up After Issue of Anti-Depressant Medication**

On the 6th December 2011 one of the attending GP's [redacted] prescribed Fluoxetine to Mr Buckton on the recommendation of Healthcare Assistant Board who stated that she had discussed such prescription with the Mental Health Team and felt that Mr Buckton was depressed. [redacted] did not see Mr Buckton nor did she see him after that date to check the effectiveness of the medication. The jury found there was a failure by Healthcare staff to follow up Mr Buckton's appointment with the GP and a failure to complete a PHQ9 Assessment.

If there had been a follow up appointment with Mr Buckton at the end of January 2012 it may be that raised risk of suicide would have been spotted and treated.

The expert witness [redacted] was critical of this failure. He gave evidence that a follow up appointment is recommended in the Quality and Outcomes Framework Guidance to GP's but is also a requirement of the National Institute of Clinical Excellence Guideline 90 which recommends "For people stated on anti-depressants who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly thereafter for example at intervals of 2-4 weeks in the first 3 months and then at longer intervals if the response is good. Early cessation of treatment is associated with a greater risk of relapse".

(3) **The failure to continue the "Emotional Wellbeing" Course in January 2012**

Mr Buckton had 4 sessions with HCA Board on this course which she regarded as successful in improving his outlook on life. However she was injured on the 1st January 2012 and off work but no other mental health staff were available to continue the course. Only 2 full time members of staff were in place to carry out the work of 5 full time mental health practitioners with 1 or occasionally 2 locum nurses employed to make up the deficiency.

Whilst the jury did not regard the failure to continue the course as causative or contributory to Mr Buckton's death they clearly felt it was important to record that the failure to continue possibly had a detrimental affect upon Mr Buckton's wellbeing. He had been diagnosed with a personality disorder. Evidence was given that the only effective treatment for such a disorder is by talking therapy and management strategies. Greater regard should have been given to the cessation of this course and the effect upon all prisoners involved.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 9th October 2013. 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 Messrs Irwin Mitchell acting for Mr Buckton's father and Messrs. Weightmans acting for Dorset Healthcare University NHS Foundation Trust. 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	**14th August 2013** **Sheriff Stanhope Payne** **Senior Coroner for Dorset**