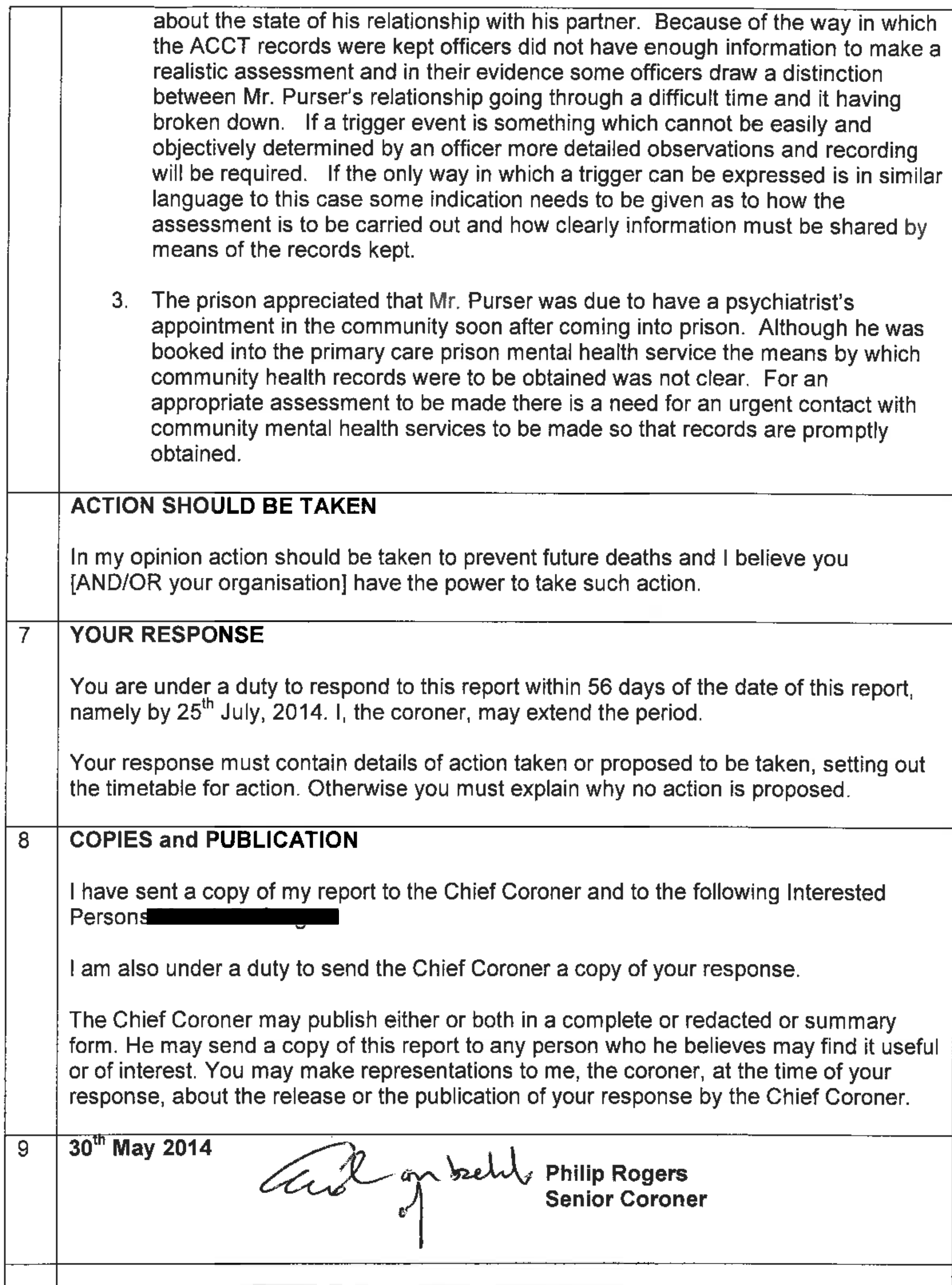
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: MINISTRY OF JUSTICE** 1. **The Chief Executive, NOMS,** 2. **The Governor, H.M. Prison Swansea** 3. [redacted]
1	**CORONER** I am PHILIP ROGERS Senior Coroner, for the coroner area of Swansea and Neath Port Talbot
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 21st June 2012 I commenced an investigation into the death of Matthew Thomas Purser aged 29. The investigation concluded at the end of the inquest on 24th of February 2014. The conclusion of the inquest was a Narrative conclusion. The cause of death as given by the Pathologist was: 1a) Hanging A summary of the Narrative conclusion of the Jury is that the deceased took his own life by hanging himself on 13th June 2012 at H.M. Prison Swansea. The deceased intended to take his own life due to contributory factors of severe depression and relationship breakdown. ACCT reviews should have taken place after incidents at noon and 4 pm on 13th June 2012 and the sharing of information between prison staff by way of recording significant interactions in the ongoing record of the ACCT plan were inadequate. However, these matters were not considered to have more than minimally contributed to the deceased's death.
4	**CIRCUMSTANCES OF THE DEATH** Matthew Purser hanged himself in his cell at Swansea Prison about 7.25 pm on 13th June 2012. He had been on remand from 9th June 2012 and was in the drug recovery wing because of his substance misuse. He was receiving medication for alcohol withdrawal and had been placed on an ACCT (self harm monitoring document) from the time of his initial assessment by a Nurse on arrival at the Prison. At this initial assessment Mr. Purser referred to recent bereavement, attempted self harm about three weeks before and very high alcohol intake. He stated he was hearing voices and that he had an appointment later that month in the community with a psychiatrist. He was given anti withdrawal medication and a referral was made by the Nurse to the in-reach mental health team ie. the Local Health Board ran secondary mental health service working in the prison. Under the ACCT observations were set at two hourly in the day, with three meaningful

	conversations to be conducted. On the following day a second health screen was carried out involving seeing the prison GP and a mental health nurse on two occasions. Mr. Purser was booked into the "lighthouse clinic" (primary care prison mental health service). On the same day the deceased underwent his ACCT assessment and first ACCT review. The triggers for further review were recorded as "loss of contact with partner/breakdown in relationship". During the assessment interview for the ACCT the deceased had shown himself to be very dependent on being able to speak to his partner and the prison tried to facilitate this contact with one of the officers ringing the partner on that day to give her information about visiting and after which the deceased was said to be much improved in mood. Mr. Purser continued to have telephone contact with his partner on 11th and 12th June but on 13th June in a telephone call to her shortly before midday he was seen by officers to become visibly upset and was noticed punching the metal hood over the telephone. An officer who witnessed this took the Mr. Purser to an interview room to calm him down. An entry was made at midday on the ACCT that Mr. Purser had stated his girlfriend had had a miscarriage and wanted to leave him. The officer said that he would see Mr. Purser after the lunch break and at 2.30 pm he took him to a staffroom and rang the partner on behalf of Mr. Purser, saying that Mr. Purser was sorry to put pressure on her and that Mr. Purser would not telephone her again for 24 hours as the calls were upsetting them both. After this Mr. Purser seemed more settled. No entry was made in the ACCT concerning the interaction of the officer and Mr. Purser after lunch. Despite the agreement which the officer had reached between Mr. Purser and his partner Mr. Purser telephoned her again at about 3.50 pm. The same officers saw Mr. Pursher on the telephone and when challenged he said he was calling his mother but one of the officers asked control to check the number called and was told it was the partner. An ACCT entry was made at 4 pm stating that Mr. Purser was a manipulative individual, willing to say anything to get his own way, but the officer who had made the agreement with the partner did not challenge him about his behaviour and decided to leave speaking to him until the next day. After 6 pm there were two further telephone calls between Mr. Purser and his partner in which they argued and he threatened to hang himself. These were not observed by officers. At about 6.35 pm Mr. Purser asked to go back into his cell to use the toilet. The officer who allowed this had no concerns about his demeanour although his cell mate said he was very upset. At about 7.25 pm the same officer noticed the observation hatch covered and on investigating found Mr. Purser hanging. This was about twenty five minutes after he was last observed.
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. The Doctor who saw Mr. Purser for the second health screen on the day after admission had not received ACCT training as required by PS1 64/2011 and HMP Swansea Suicide Prevention Policy 2010 and was not aware of the requirement for him to be trained in the procedures although he was aware of the procedures. 2. The trigger event endorsed on the documentation requiring review of Mr. Purser under the ACCT was given as "loss of contact with partner/breakdown in relationship". Mr. Purser's apparent dependence on maintaining contact with his partner was correctly identified by the prison but the way in which the wording of the trigger was expressed left much to the subjective assessment of the officers



	about the state of his relationship with his partner. Because of the way in which the ACCT records were kept officers did not have enough information to make a realistic assessment and in their evidence some officers draw a distinction between Mr. Purser's relationship going through a difficult time and it having broken down. If a trigger event is something which cannot be easily and objectively determined by an officer more detailed observations and recording will be required. If the only way in which a trigger can be expressed is in similar language to this case some indication needs to be given as to how the assessment is to be carried out and how clearly information must be shared by means of the records kept. 3. The prison appreciated that Mr. Purser was due to have a psychiatrist's appointment in the community soon after coming into prison. Although he was booked into the primary care prison mental health service the means by which community health records were to be obtained was not clear. For an appropriate assessment to be made there is a need for an urgent contact with community mental health services to be made so that records are promptly obtained.
	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 25th July, 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] 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	**30th May 2014** **Philip Rogers** **Senior Coroner**