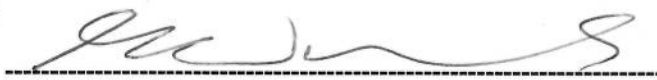
ANNEX A

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. Governor HMP Hewell** **2. Worcestershire Health and Care Trust** **3.**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of 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.
3	**INVESTIGATION and INQUEST** On 14th August 2014 I commenced an investigation into the death of Liam SMITH then aged 32 years. The investigation concluded at the end of the inquest on … The conclusion of the inquest was narrative (attached) the medical cause of death being combined methadone, mirtazipine, olanzapine and zopiclone toxicity .
4	**CIRCUMSTANCES OF THE DEATH** Mr Smith was admitted into HMP Hewell on 7th August 2014. He was a known high risk drug users who took a cocktail of his prescribed medication and other illicitly obtained medication in his cell and died as a result.
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) Evidence suggested that Mr Smith was at risk of inadvertant self harm and that therefore in accordance with PSI64/2011 ACCT procedures should have been opened in respect of him. Witnesses confirmed their understanding of that mandetory requirement but indicated that they would use their clinical judgement in deciding whether or not to open an ACCT. It is of concern that staff may therefore may therefore not be following mandetory PSI instructions and that prisoners are not receiving appropriate protection by way of the ACCT process. (2) Evidence was given that certain medical information which arrived at the prison with Mr Smith was not disemminated to those in reception or those who had later dealings

	with him which meant that they were unaware of the potential risk of suicide or self harm. It was suggested by some witnesses that documentation "goes astray" and is only found much later. (3) Healthcare Staff indicated that they do not always read relevant sections of the System 1 notes and that the "summary page" of System 1 does not always "pull through" relevant important information with a result that staff may be unaware of that information. (4) Evidence suggested only limited interaction between members of Healthcare Staff and prisoners who were deemed as "high risk drug users" with a concern that warning signs are missed
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action; specifically to review the processes and procedures to deal with the matters outlined above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13th November 2015 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	**Signed**  ---------- **G U Williams** **18th day of September 2015** **H M Senior Coroner**