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 **RE: RICHARD SCOTT GREEN Deceased** **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Justice** **2. Chief Executive of National Offender Management Service**
1	**CORONER** I am David Llewelyn Roberts, Senior Coroner for the coroner area of Cumbria.
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 May 2014 an investigation was commenced into the death of Richard Scott Green, aged 23 years. The investigation concluded at the end of the inquest on 23rd October 2015. The conclusion of the inquest was 1 (a) Death by Hanging Open Conclusion
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found hanged in his cell at Haverigg Prison on 9th May 2014. He had made a ligature from a torn bed sheet and had used the narrow gap at the top of the door leading to his en-suite shower room as a ligature point. The Jury found that bullying and debt had contributed to his death. Whilst satisfied he had placed the noose about his neck, the Jury were not satisfied so as to be sure that he intended to kill himself. Evidence also showed he had, apparently unjustly, been refused a family day visit on 27th May. He had a well documented history of self-harm and apparent suicide attempts.
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. – I was clear that serious incidents of self-harm/suicide attempts from 2007 and 2013 were recorded on his SystmOne records. These do not appear to have been recognised or acted upon by various medical professionals in the prison system.

	This meant that a nurse at screening had not read the records, neither had a GP or a mental health nurse who later carried out an assessment. The result was that throughout his prison term at Haverigg no one was aware of the history and the risk he presented. As a result, there were missed opportunities which might have made a difference. Evidence showed that a) there appeared to be no reliable tool to help assess depression in a prisoner (community tools being unsatisfactory). b) Although entries were there to be seen on System One, none of the clinicians saw them. Pressure of work and the time needed to check were reasons cited, together with lack of resources. It seems SystmOne was not easy to use, some staff being unaware they could "search" and an absence of a way to clearly flag important historical information to ensure it was at the clinicians' finger tips.
6	**ACTION SHOULD BE TAKEN** Minister of Justice and Head of Prison Service. Action to be taken to consider the development of: 1) A tool or process to help clinical staff better assess and predict those prison inmates who are at greatest risk of deliberate self-harm or suicide. 2) Improvements to the SystmOne clinical records to make them more fit for purpose so that important entries relating to deliberate self-harm or suicide are easily accessible and staff have requisite training so they can use the system efficiently and to best advantage.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th December 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: Prison Governor – Haverigg [redacted] Denby & Co Solicitors The Government Legal Department Cumbria Partnership NHS Foundation Trust Greater Manchester NHS Trust [redacted] I have also sent it to [redacted] Prison and Probation Ombudsman 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	**2nd November 2015 [*SIGNED BY CORONER*]**