## **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. The National Offender Management Service (NOMS)
- 2. The Governor, HMP Nottingham
- Nottinghamshire Healthcare NHS Trust (as responsible for healthcare at HMP Nottingham
- 4. NHS England, as commissioners of healthcare at HMP Nottingham.

#### 1 CORONER

I am Miss Stephanie Haskey, Assistant Coroner, for the Coroner area of Nottinghamshire

### 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

Shalane Blackwood died at HMP Nottingham on 5<sup>th</sup> August 2015. An investigation was begun, an Inquest opened and heard from 25<sup>th</sup> April 2015 to 3<sup>rd</sup> May 2015 before a Jury. The Jury concluded that the duodenal ulcer should have been diagnosed and treated and that systematic failures amounting to neglect by prison and healthcare staff significantly contributed to his death.

# 4 CIRCUMSTANCES OF THE DEATH

Mr Blackwood died as a result of a bleed from a duodenal ulcer. His case was complex and his presentation challenging due in part to his being unable to communicate effectively. At the time of his death he was on a "four person unlock" in the Segregation Unit and had been referred for specialist mental health opinion. There was evidence that he had bled, for a reason unknown at the time, on 4<sup>th</sup> August but that no GP or hospital referral was made following the blood being 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:

- That there is no proper provision for the care and supervision of prisoners who
  present with complex physical and/or mental health needs. It is understood that
  such a provision could be provided by means of an inpatient unit within the
  prison, such as for example is the case at HMP Liverpool.
- 2. That at present, if a prisoner is assessed as needing a four person unlock, and is within the Segregation Unit, there are insufficient prison staff to provide him with a proper regime and to unlock him after lunchtime, for example to allow

- 3. That the use of New Psychoactive Substances (NPS) remains rife within the prison, and presentations such as Mr Blackwood's are not diminishing, and that the Substance Misuse Team requires further staff to be effective in future.
- 4. That the documentary tool for decision making between prison staff and healthcare staff, as to whether a prisoner is fit to remain in Segregation and should do so, is unclear in design or in use.
- That healthcare staff are insufficiently alert to the issue that physical symptoms which require urgent medical attention may be occluded by mental health issues.

#### 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisations, as appropriate to the issues above, have the power to take such action.

# 7 YOUR RESPONSE

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:

1. Mr Blackwood's Family

I have also sent it to:

1. The Prison and Probation Ombudsman and the Care Quality Commission

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.

9 **[DATE]** 

[SIGNED BY CORONER]