	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Ian West. Governor, HMP Gartree.** **[redacted] Acting Chief Executive.** **East Midlands Ambulance Service NHS Trust.**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire South
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 15 May 2015 I commenced an investigation into the death of Ahmedreza Fathi. The Inquest concluded on 12th April 2016.The Juries conclusion was, Suicide on May 13th 2015, Gallow Field Road, Market Harborough, Leicestershire. The circumstances that the deceased came by his death were a combination of plastic bag asphyxia and multi drug toxicity, which we believe to be a deliberate act of suicide. From the evidence presented we are of the opinion that the main two contributing factors to Mr Fathi's actions are; the constant physical pain he was experiencing, and the lack of trust (he developed after acute episodes of anxiety and paranoia) for his support network. With the evidence presented, we have heard that there was a fragmented incohesive approach to the care and support Mr Fathi received which lacked a strategic lead. On the night of 12th May 2015 there were clear changes in Mr Fathi's usual pattern of behaviour that should have been managed more appropriately. It is evident that there was a breakdown in effective communication which led to partial information being provided and inadequate decisions being made. Questions to Jury. Q1) Do you agree the cause of death to be 1a. Combination of plastic bag asphyxia and multi drug toxicity? A) Yes. Q2) Following his admission to Leicester Royal Infirmary on 26th March 2015, was Mr Fathi appropriately risk assessed with access to all relevant information, after his return to HMP Gartree ? A) No. Q3) Did the care plan approach used by the healthcare teams include sufficient detail to ensure all aspects of his safe-keeping were available to and understood by all relevant staff with direct contact with Mr Fathi ? A) No. Q4) Did the prison, primary and secondary healthcare services work together and share appropriate information, and review this regularly, to keep Mr Fathi as safe as can reasonably be expected within a secure prison environment? A) No. Q5) On the evening of 12 May 2015, were the changed observation levels appropriate at all times? A) No. Q6) If your answer to question 5 is "no", do you think that different, more appropriate, observations may have resulted in an alternative outcome on this night? A) Yes. Cause of death 1a Combination of plastic bag asphyxia and multi drug toxicity

4	**CIRCUMSTANCES OF THE DEATH** Mr Fathi was a serving prisoner on a life sentence at HMP Gartree. He was on an ACCT document for many months and under the ongoing care of the physical and mental health teams, as well as receiving physical health care outside the prison. He had made several attempts to harm himself in the past, including 4 significant episodes during 2015 when he required emergency treatment out of hospital and had threatened to take his own life on many occasions. On 12th May he made a comment to a fellow in-mate that he intended to take his own life that night, and his observation levels were increased, but not to an appropriate level according to the jury's findings of fact. He was discovered in his cell during the night, his head and chest inside a large plastic bag in a collapsed state and resuscitation efforts were unsuccessful. Toxicology revealed high levels of drugs, both prescribed and non-prescribed, that he should not have had in his possession.
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. On previous occasions following deaths in prison locally in Leicester, the Coroner and the PPO have raised concerns regarding delays in requesting 999 emergency assistance. On the night of 12 May 2015 there was a delay in summonsing an ambulance, in breach of PSI 03/13 and the prisons own internal policy. The then serving Head of Safety advised the Court that she "dealt with this problem a lot". There appeared to be a perception from gatehouse staff that calls had to be delayed until further information could be obtained from those officers at the scene. EMAS advised the court that 3 protocols already exist between other stakeholders and discussions to consider a prison/emergency response protocol would be welcomed and could be accommodated. I therefore encourage both the prison and EMAS to arrange a meeting to take this matter forward.
	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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30/06/2016. 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] (Cousin) [redacted] (PPO) Dr P Miller. Chief Executive, Leicestershire Partnership NHS Trust. [redacted] Government Legal Dept) Mr J. Adler (Chief Executive University Hospitals Leicester) [redacted] (Thompsons Solicitors) Ms. Angela Hillery, Chief Executive Northamptonshire Healthcare 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	**[DATE]** 5 May 2016 **[SIGNED BY CORONER]**

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Ian West. Governor HMP Gartree.** **Dr P Miller. Chief Executive, Leicestershire Partnership NHS Trust.** **Ms. Angela Hillery, Chief Executive Northamptonshire Healthcare NHS Foundation Trust.**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire South
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 15 May 2015 I commenced an investigation into the death of Ahmedreza Fathi. The Inquest concluded on the 12th April 2016.The Juries conclusion was, Suicide on May 13th 2015, Gallow Field Road, Market Harborough, Leicestershire. The circumstances that the deceased came by his death were a combination of plastic bag asphyxia and multi drug toxicity, which we believe to be a deliberate act of suicide. From the evidence presented we are of the opinion that the main two contributing factors to Mr Fathi's actions are; the constant physical pain he was experiencing, and the lack of trust (he developed after acute episodes of anxiety and paranoia) for his support network. With the evidence presented, we have heard that there was a fragmented incohesive approach to the care and support Mr Fathi received which lacked a strategic lead. On the night of 12th May 2015 there were clear changes in Mr Fathi's usual pattern of behaviour that should have been managed more appropriately. It is evident that there was a breakdown in effective communication which led to partial information being provided and inadequate decisions being made. Questions to Jury. Q1) Do you agree the cause of death to be 1a. Combination of plastic bag asphyxia and multi drug toxicity? A) Yes. Q2) Following his admission to Leicester Royal Infirmary on 26th March 2015, was Mr Fathi appropriately risk assessed with access to all relevant information, after his return to HMP Gartree ? A) No. Q3) Did the care plan approach used by the healthcare teams include sufficient detail to ensure all aspects of his safe-keeping were available to and understood by all relevant staff with direct contact with Mr Fathi ? A) No. Q4) Did the prison, primary and secondary healthcare services work together and share appropriate information, and review this regularly, to keep Mr Fathi as safe as can reasonably be expected within a secure prison environment? A) No. Q5) On the evening of 12 May 2015, were the changed observation levels appropriate at all times? A) No. Q6) If your answer to question 5 is "no", do you think that different, more appropriate, observations may have resulted in an alternative outcome on this night? A) Yes. Cause of death 1a Combination of plastic bag asphyxia and multi drug toxicity

4	**CIRCUMSTANCES OF THE DEATH** Mr Fathi was a serving prisoner on a life sentence at HMP Gartree. He was on an ACCT document for many months and under the ongoing care of the physical and mental health teams, as well as receiving physical health care outside the prison. He had made several attempts to harm himself in the past, including 4 significant episodes during 2015 when he required emergency treatment out of hospital and had threatened to take his own life on many occasions. On 12th May he made a comment to a fellow in-mate that he intended to take his own life that night, and his observation levels were increased, but not to an appropriate level according to the jury's findings of fact. He was discovered in his cell during the night, his head and chest inside a large plastic bag in a collapsed state and resuscitation efforts were unsuccessful. Toxicology revealed high levels of drugs, both prescribed and non-prescribed, that he should not have in his possession.
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. Healthcare complex case planning was not robust or effective, and was not reviewed or updated in response to subsequent events. Multi-disciplinary team meetings, if they took place, were not formalised and there was no ready access to all relevant information relating to risk assessment and case management through either System1 (the medical record storage and case management system) held by healthcare, or the ACCT document held by the prison. 2. The enhanced case management system referred to in PSI 64/11 was under-utilised for a prisoner of this complexity and further consideration should be given to its role in situations of this nature. 3. Mr Fathi was taken to hospital with (on the balance of probabilities) an earlier overdose, some weeks before he lost his life. Neither the prison services nor healthcare considered the significance of this event, raised any hospital enquiries or completed an accident/near-miss incident report procedure and applied learning outcomes. This was a missed opportunity to consider Mr Fathi's intentions, his ability to access drugs in appropriately and to take appropriate safeguarding actions. Consideration should be given to adopting a system that ensures investigating such events on each occasion to ensure lessons can be learnt.
	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.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30/06/2016.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. (Cousin) (PPO) (Government Legal Dept) Mr J. Adler (Chief Executive UHL) Thompsons Solicitors) Acting Chief Executive. (EMAS) 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]** 5 May 2016 **[SIGNED BY CORONER]**