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:** **The National Offender Management Service** **Safer Custody** **Equality, Rights and Decency Group** National Offender Management Service 4th Floor, 70 Petty France London, SW1H 9EX
1	**CORONER** I am André J A Rebello, Senior Coroner, for the area of Liverpool and Wirral
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 4th September 2014 I commenced an investigation into the death of **Roy Patrick HOEY**, Aged **20**. The investigation concluded at the end of the inquest on 4th October 2016. The conclusion of the inquest was Ia Compression of the Neck Ib Hanging Roy Patrick Hoey committed suicide
4	**CIRCUMSTANCES OF THE DEATH** The jury found after seven days of inquest hearing:- Roy Patrick Hoey died at 05.22 hours on 04/09/14 at Altcourse, Brookfield Drive, Fazackerley, Liverpool in Meeling Brown Wing, cell 14. He died by compression of the neck from hanging by using a curtain as a ligature. We are sure that he put himself in the position in which he was found with the intention of ending his life.
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. – During the course of this investigation inquest a considerable amount of time was taken up with the detailed questioning of witnesses around the meaning of local and national safer custody guidance. The court was taken to **Noms PSI 64/2011** and the apparent discrepancy between chapter 1 and chapter 5 was highlighted.

Chapter 1 Page 10 -This related to the entire document **"Management of prisoners at risk of self harm to self, others and from others (Safer Custody)**
All staff who receive information, including from concerned family members, or observe changes in a prisoner's behaviour which indicates a change in the risk they pose to themselves, to others and/or from others must communicate their concerns immediately to the Residential, Daily or Night Operational Manager, and/or consider opening an ACCT Plan and make a record in an appropriate source e.g. observation book, NOMIS, Security Information Report, ACCT Plan.

The court ruled that this general catch-all chapter covers everything covered by the policy, self-harm, violence and bullying of others and protection from others – so that is why there are alternative solutions.

Chapter 5 Page 26 - This chapter only related to the operation of the ACCT Process **– Assessment, Care in Custody and Teamwork**
Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form.

HMP Altcourse – safer custody Document
"All prisoners suspected of being at risk of suicide or self-harm are placed onto an ACCT Plan – All Mandatory actions in PSI 64/2011 must be followed."

Admissions Policy at HMP Altcourse
"All prisoners will be assessed for risk of suicide or self-harm during reception process. Upon arrival into admissions a prisoner's documentation, PER or other documents received from courts, such as suicide warning forms will be checked for risks of suicide or self-harm Prisoners will be asked about this."

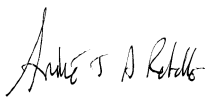
And then

"Admission staff must raise an ACCT Plan when a prisoner is identified at risk of suicide or self harm"

I ruled

I direct you that there is no internal conflict in PSI 64/2011 chapter 1 and chapter 5 are referring to different things - And in any event the Altcourse policy properly embraces national guidance in full.

The mandatory actions in the policy are italicised and I read again – "*Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form."*
This does not mean that every contact from family members or external agencies or observed behaviour requires an ACCT to be opened. ***There needs to***

	be investigation, assessment and evaluation of the issue – which may indicate a risk of suicide /self harm – and thereafter it is mandatory to open an ACCT. The reason I make this ruling is not only that it common sense and the plain English meaning of the paragraph - but also we have heard expert and experienced evidence from a MOJ/ NOMs trained ACCT trainer that that is the cascaded training down from NOMS – to each Prison and that is what is trained to ACCT assessors and to all those who have basic ACCT training. So in each scenario that has been raised was there assessment and evaluation of the presenting issue which may indicate a risk of suicide and self-harm? **I am reporting this matter to NOMS as there was confusion for the witnesses when different parts of the guidance were put to them and this may lead to confusion as to what is required to apply the best practices of safer custody within prisons. It may be that clarification of the updated policy will improve safer custody, notwithstanding what the court was advised about the national training. Clarification would have certainly reduced the length of time for the inquest hearing considerably.**
6	**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 30th December 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 HMP Altcourse and Mr Hoey's Family. 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **Dated: 13th October 2016**