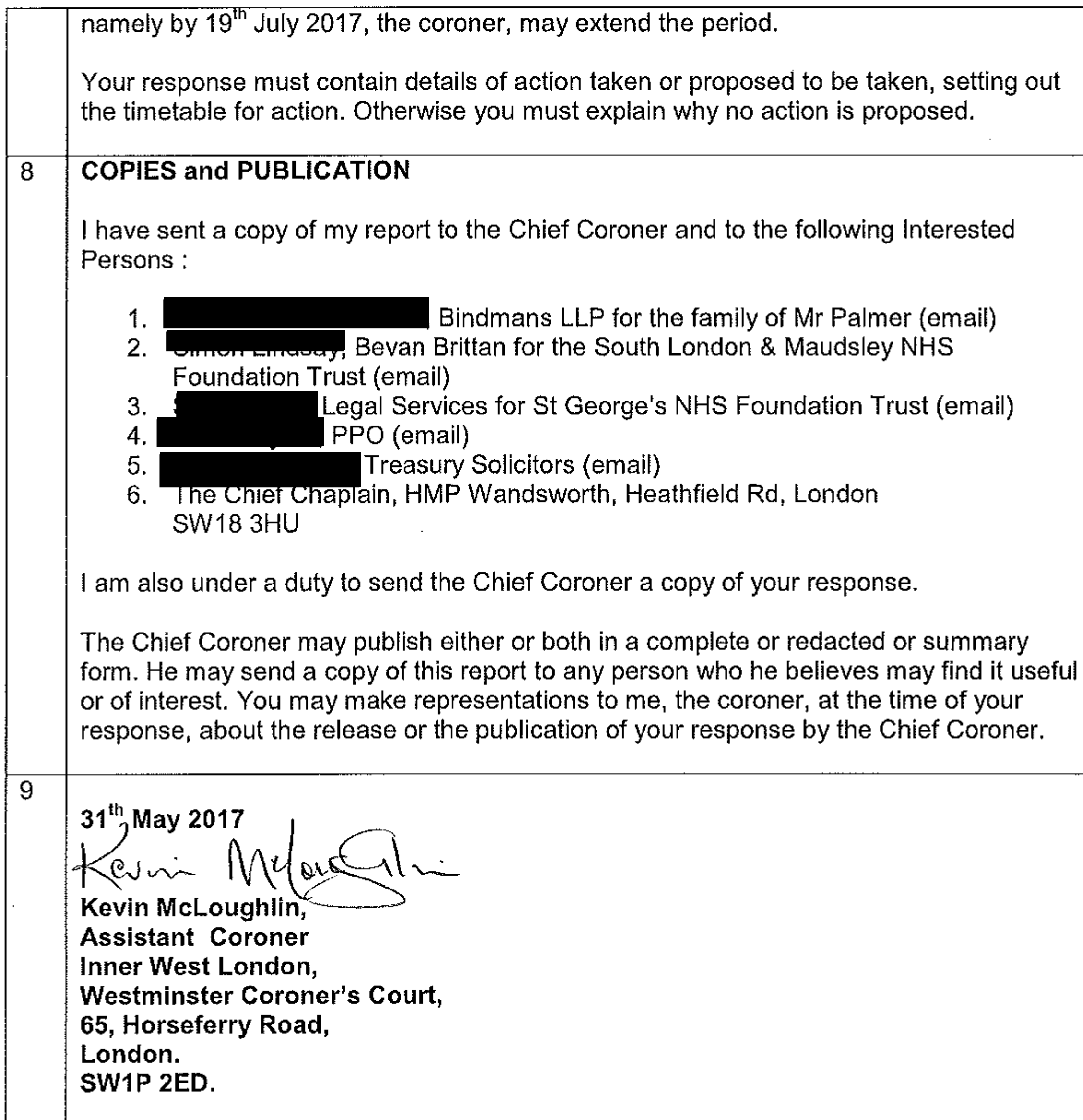
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO** (1) The Rt Hon Amber Rudd The Secretary of State for the Home Department Home Office 2 Marsham Street London SW1P 4DF (2) [redacted] Governor of HMP Wandsworth Heathfield Rd London SW18 3HU
1	**CORONER** I am Kevin McLoughlin, an Assistant Coroner in the Inner West London Coronial Area.
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** On 30 November 2015 an investigation was commenced into the death of Jonathan David Palmer ('Mr Palmer'). On 18 May 2017 I concluded the investigation at the end of an 8 day Inquest, sitting with a jury. The Jury returned a Narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** On 3 June 2015 Mr Palmer was brought to HMP Wandsworth on remand prior to a trial which was listed to commence on 23 November 2015. On19 November 2015 at approximately 1400 hours Mr Palmer's lifeless body was discovered suspended from a ligature in his cell. He was declared dead at 14.58 hours, after resuscitation efforts were abandoned. The Inquest found the cause of death to be 1a Hanging. In the period between June and November 2015 Mr Palmer had exhibited bizarre and violent behaviour. The prison and medical staff attributed his behaviour to the effects of an illicit drug, Spice. Mr Palmer's family (including his two brothers who were also held on remand and shared a cell with him for part of the time) were convinced that he was experiencing a developing psychotic illness in addition to his pre-existing psychiatric conditions. The Narrative conclusion returned by the jury did not make a finding on the balance of probability as to whether his behaviour prior to his death should be ascribed to the misuse of illicit drugs, an emerging psychotic illness or a combination of the two. Mr Palmer's community GP records were not obtained and hence those responsible for his assessment and treatment in the prison from June 2015 onwards, had little information available as regards his previous medical history. Relevant aspects would have included his suicidal ideation in earlier years and the diagnosis of a major depressive illness, approximately four months before he was remanded in prison.

	Mr Palmer's family gave evidence that they endeavoured to make the prison aware of their concerns about his mental health in numerous telephone calls to safer custody, RAPt and the prison chaplains, as well as posting documents to the prison governor, but the records available from chaplains and others did not enable the Inquest to determine the date, nature and value of all of the information alleged to have been sent to the prison. Evidence taken at the Inquest indicated that Mr Palmer admitted at various times to having smoked Spice. The Jury did not, however, find any causal link between any illicit drug usage and the death. One prisoner asserted in the course of his evidence that contraband material is smuggled into the prison by corrupt individuals, but the investigation of this matter was outside the scope of the Inquest.
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. There is no effective system by which the family of a prisoner can input information they deem relevant to a prisoner's health needs and be assured this will be disseminated to relevant teams within the prison, with appropriate records being maintained in order to be able to demonstrate this has been done. Families can be a source of valuable medical information, particularly, where GP records have not been obtained and the individual himself may not be a reliable source. It would be beneficial to have a clear, publicised conduit for a family to provide relevant medical information to a specified department. The Inquest was informed that a single point of contact has now been established, but it remains unclear whether comprehensive records of all contacts will be maintained, or whether this will result in the timely dissemination of information to those with a role in the prisoner's welfare, such as healthcare staff, RAPt or the chaplains. As the Personal Officer scheme appears to have been abandoned at HMP Wandsworth there is no alternative individual for a concerned family to approach. 2. The steps taken to control the inflow of contraband material into the prison (such as the illicit drug known as Spice), appear ineffective. Insidious substances such as Spice can mimic the symptoms of psychotic illness and jeopardise life when unpredictable reactions occur to those using it. Spice is also likely to adversely affect discipline within the prison, create the potential for intra prisoner bullying (arising from drug debts) and stretch already depleted healthcare resources. In order to combat this menace, steps should be taken to identify the entry points in order that they can be more effectively controlled and those involved, deterred.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Secretary of state for the Home Department and /or the Governor of HMP Wandsworth 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 19th July 2017, 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 : 1. Bindmans LLP for the family of Mr Palmer (email) 2. Bevan Brittan for the South London & Maudsley NHS Foundation Trust (email) 3. Legal Services for St George's NHS Foundation Trust (email) 4. PPO (email) 5. Treasury Solicitors (email) 6. The Chief Chaplain, HMP Wandsworth, Heathfield Rd, London SW18 3HU 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	**31th May 2017** **Kevin McLoughlin,** **Assistant Coroner** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**