	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. THE MINISTRY OF JUSTICE (MoJ) 2. HM PRISON AND PROBATION SERVICE (HMPPS) 3. HM COURTS & TRIBUNALS SERVICE (HMCTS) 4. CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST (CNWL)
1	**CORONER** I am **HH SIR PETER THORNTON QC**, Assistant Coroner for the coroner area of the City of London.
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 11 January 2016 a coroner's investigation was commenced into the death of **SARAH LYNNE REED** who died in HMP Holloway on that date, aged 32 years. The investigation concluded at the close of the inquest on 19 July 2017. The inquest, which was held with a jury, ended with a narrative conclusion. The medical cause of death was given as ligature compression of the neck. The jury concluded that Sarah Reed took her own life at a time when the balance of her mind was disturbed to which a failure in management of her medication contributed. The jury was not sure that Sarah intended to take her own life. The jury also concluded that the failure to finish the fitness to plead assessment process in a sufficiently timely manner contributed to her death. The jury also concluded, amongst other things, that there was - (a) failure by the mental health staff at HMP Holloway to act in a timely manner on the recommendation of a community health team psychiatrist that anti-psychotic medication be considered, despite specifically requesting his input; (b) failure in the management of her medication, including failing to provide an anti-psychotic medication as a safer alternative to Quetiapine (which had to be stopped for good medical reasons), particularly pending transfer to hospital, and a lack of a contingency plan to manage her psychosis or the recurrence of it, with the result that Sarah was not receiving adequate treatment for her deteriorating mental health state, leaving her in a distressed state; (c) inappropriate reduction of the frequency of observations at Assessment Care in Custody and Teamwork (ACCT) Review No.4 on 5 January 2016, six days before her death, with the decision being made by a review team that was not multi-disciplinary; (d) failure by some of those attending ACCT Reviews to read and review the whole ACCT document before making a decision; (e) unacceptable delay before holding a Care Programme Approach (CPA) meeting for long-term planning and inappropriate quality of the meeting when held; and (f) an unacceptable number of cancelled visits including a solicitor's visit, which contributed significantly to Sarah's isolation.

4	**CIRCUMSTANCES OF THE DEATH** The deceased took her own life on 11 January 2016 in a single occupancy cell in C1, the mental health assessment unit, of HMP Holloway, North London. She strangled herself with a tight ligature made from bed linen. She had been remanded in custody by the Inner London Crown Court on 14 October 2015 solely for the purpose of obtaining one or more reports on her fitness to plead and stand trial on a charge of alleged serious assault upon a nurse at a psychiatric hospital. She had previously been on bail, but while on bail she had failed to attend two appointments in the community with psychiatrists for the purpose of their assessment of her fitness to plead. According to the Case Log, the Judge at the Crown Court expressed the view on 14 October 2015 that 'I can't see any way these reports will be prepared whilst the defendant remains on bail.' At the hearing on 14 October 2015 the Judge therefore ordered the Court to obtain these reports and remanded Sarah in custody. She was taken to HMP Holloway. By the time of Sarah's death on 11 January 2016, three months later, one report had been obtained. It was dated 11 January 2016. A second report was due on 15 January 2016. No date had been fixed by the Crown Court for a hearing to determine the issue of her fitness to plead. There was agreed evidence that Sarah's mental condition deteriorated in HMP Holloway for the last three weeks of her life, particularly from 5 January 2016 when she was moved to the mental health assessment unit (C1). She had been on observation watch under an ACCT procedure (the second procedure since reception), which had been opened on 28 December 2015 and was still open at the time of her death. On reception, it was noted that Sarah had been assessed as previously suffering variously from Emotionally Unstable Personality Disorder (EUPD), schizophrenia, psychosis, bipolar affective disorder, alcohol and substance abuse, and bulimia nervosa. She had been admitted to HMP Holloway and other prisons since 2005 and had been 'sectioned' on a number of occasions. The deterioration of her mental health and appearances before criminal courts dated in the main from the period after the death in September 2003 of her six month old daughter from spinal muscular atrophy.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – **A. Fitness to Plead Reports** (1) The deceased had been remanded in custody for the sole purpose of the Court obtaining two reports by psychiatrists on her fitness to plead and stand trial. Yet by the time of her death, three months later, this objective had not been achieved and no date for a hearing of the issue had been fixed. It is clear from the evidence that Sarah was uncertain what was happening and when she would be going to court. (2) On 7 January 2016, four days before her death, doctors at HMP Holloway had decided that Sarah should be referred to a secure hospital for assessment and treatment. They concluded that she suffered from EUPD and psychosis and

was in effect unmanageable in prison, having refused medication and failed to comply with requests for blood and ECG tests. Had the Court obtained the psychiatric reports on fitness to plead earlier, the Court may well have imposed a hospital order (with or without a restriction order) under section 5(2)(a) of the Criminal Procedure (Insanity) Act 1964. The two necessary requirements would have been easily satisfied: the reports were to find her unfit to plead and she had admitted the act charged, namely striking a mental health nurse over the head with a metal bar in June 2014.

(3) By the time of her death the deceased had been given no target date for the hearing of the issue of her fitness to plead. Her diary entries suggest that the hearing was important to her and in the forefront of her mind. An earlier date of 14 December 2015 had been vacated and not replaced. Her mental state and behaviour in prison deteriorated markedly from late December 2015 to 11 January 2016.

(4) It was not clear on the evidence who took responsibility for obtaining the reports. The Court had ordered them, but the formal request for the first report, dated 27 October 2015, was (a) directed to HMP Holloway, but (b) sent by email from the Court to an administrative officer employed not by the prison but by the Central and North West London NHS Trust (CNWL) who worked from HMP Holloway. One month later, on 27 November 2015, a psychiatrist employed by CNWL in HMP Holloway wrote back to the Court, apologising for the delay and indicating that the request be directed not to CNWL but to the South London and Maudsley NHS Trust. As a result, by about six weeks after the Court's order, no psychiatrist had yet agreed to prepare a report.

(5) The jury found that the evidence that key members of Sarah's mental health team in HMP Holloway were unaware that the sole purpose of her remand in custody was for the preparation of fitness to plead reports was 'incomprehensible'.

(6) The jury concluded that the failure to conclude the fitness to plead assessment process in a sufficiently timely manner contributed to Sarah's death.

B. ACCT Reviews and Observations

(7) The jury concluded that the decision to reduce the frequency of observations on Sarah Reed at ACCT Review No.4 on 5 January 2016, six days before Sarah's death, was inappropriate given the clear evidence of the deterioration of her mental state.

(8) The jury also found that the above decision was not multi-disciplinary, which it should have been (as the senior Governor conceded in evidence).

(9) The jury also found that not all members of the ACCT Review team fully reviewed the ACCT document before making a decision.

(10) The jury also found the system of some members of the multi-disciplinary team recording observations which were not accessible to all other members of the team to be 'detrimental'. For example, many helpful observations about Sarah's behaviour were recorded in the prison medical notes on SystemOne by doctors and nurses, but they were not accessible to prison officers.

(11) In addition the Coroner observes that HMP Holloway maintained a practice of recording observations on prisoners which deviated from the national instruction. According to the national policy *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* (PSI 64/2011) observations should be recorded 'immediately or as soon as practicable thereafter'. According to the local policy at HMP Holloway, as implemented in this case, any observations at any time need be recorded only at four hour intervals in summary form.

C. CPA Meeting

(12) The jury concluded that the delay in holding a Care Programme Approach (CPA) meeting was unacceptable. The evidence showed that a CPA Meeting for

	assessing a prisoner's long-term care should have been held within four weeks from reception. In this case it was held after nine weeks. (13) The jury also found that the quality of the meeting was not appropriate. It lasted five minutes and only the nurse care coordinator and community psychiatrist were present with the prisoner. **D. Visits** (14) The jury concluded that the number of cancelled visits was unacceptable, particularly for a prisoner such as Sarah with Emotionally Unstable Personality Disorder where engagement is a principal means of treatment. (15) The senior Governor at the time of Sarah's death found records that in the relevant period 19 visits were scheduled, of which eight were cancelled (one visitor did not attend, three were cancelled because of Sarah's behaviour and four were cancelled with no reason given), three were completed and eight were listed as 'scheduled' (which probably meant completed but was not clear). The last cancelled visit was by a solicitor; she was simply told that Sarah was 'unwell'. (16) The Governor conceded that the records for cancellations were insufficient and all cancellations should have been sanctioned at the level of Duty Governor (which they were not) and not by staff of lesser seniority. (17) The Coroner also observes that with a little thought and effort arrangements could be made for a visit for Sarah even when her mental state had affected her behaviour. For example, on one occasion on 2 January 2016 (and apparently on one occasion only), Sarah's mother was allowed to see Sarah in the adjudication room on the Segregation Unit (where Sarah was then housed). It is clear from the evidence that this visit was helpful to Sarah and that more completed visits would have assisted her. The jury so found. (18) The Coroner also observes that the information provided to visitors including close family was often short on detail and lacked helpful information. **E. Notification of Prisoner's Release** (19) There was evidence from Sarah's care coordinator in the community, a social worker with the START Team, that she was never informed by HMP Holloway of the release of any prisoner whom she had previously supported in the community, despite the care coordinator having close links with the prison, for example visiting prisoners she had supported and sometimes taking part in CPA meetings. The care coordinator said that this would be 'incredibly helpful'.
6	**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. **A. Fitness to Plead Reports** MoJ; HMCTS; HMPPS; CNWL You may wish to consider whether the procedures for obtaining and providing psychiatric reports on the issue of fitness to plead, when ordered by the court, are sufficiently timely, sufficiently robust and sufficiently well-managed. In particular HMCTS may wish to consider whether the courts have sufficient control over the process under present procedures so as produce reports sufficiently promptly and whether timetabling including the setting of court dates could be more efficiently and effectively scheduled. I am aware, from a helpful letter in reply to me as Coroner from the Senior Presiding Judge (SPJ), dated 21 April 2017, that this specific issue is not covered by either the Criminal Procedure Rules or the Criminal Practice

Directions issued by the Lord Chief Justice. The SPJ has also informed me, as has HMCTS, that the office of the SPJ and HMCTS will be reissuing guidance on the provision of psychiatric reports for sentencing purposes, although fitness to plead is a separate issue from sentencing and is not included in the current guidance.

B. ACCT Reviews and Observations
MoJ; HMPPS; CNWL

Despite much past consideration of the ACCT process and a number of reports from coroners about it, the Ministry of Justice and HMPPS in particular may wish to consider afresh whether action should be taken to improve the ACCT process and the process of review.

In particular consideration could be given to the following:
(i) whether a single sheet of ongoing risk and assessment, noting especially negative highlights, should be introduced for easy access and reading by those attending a review;
(ii) whether all those attending a review should be required to read the ACCT document in full; and
(iii) whether those attending a review should always be multi-disciplinary (as required) and whether those attending should be more consistently the same personnel.

Consideration should also be given to access to the recording of observations, particularly of adverse behaviour of the prisoner, for all staff who have the care of prisoners. In this case medical staff had made extensive records (not of a medically confidential nature) to which prison officers did not have access, thus rendering their information about the prisoner incomplete.

The Ministry of Justice may also wish to consider whether it is acceptable that a prison should be permitted to develop a local policy, in this case on recording observations, which is at variance with a national policy. This is not the first time that a local policy may have been in conflict with a national policy. In the decision of the High Court in *R (Maxine Hamilton-Jackson) v HM Assistant Coroner for Mid Kent and Medway* [2016] EWHC 1796 (Admin), the local policy on when to open an ACCT document differed from the national policy, partly because it was based on an out-of-date national policy.

In this context the Coroner notes that the Government Legal Department have indicated in a helpful letter to the Coroner dated 25 July 2017 that Safer Custody Learning Bulletins, which highlight the need to record ACCT observations 'as soon as possible after they are made', will be issued to all prisons on 27 July 2017. The Coroner welcomes this and notes that this approach accords with the national policy and not the local policy which was in force at HMP Holloway at the time of Sarah's death (and which had previously been criticised by the Prisons and Probation Ombudsman).

C. CPA Meeting
MoJ; HMPPS; CNWL

Consideration should be given to ensuring that the purpose of CPA Meetings is properly satisfied both as to their nature and quality. According to the evidence they are intended for long-term planning of the prisoner's care. In this case the meeting was held after nine weeks, not within four (as required); it lasted five minutes; and only two persons in addition to the prisoner were present. It is not sufficient for the care coordinator to say, as in this case: 'I was not able to get

	the right people together on an earlier date.' **D. Visits** MoJ; HMPPS A remand prisoner is entitled to a visit every day subject to the requirements of good order and security. The evidence also emphasised the importance of visits for a prisoner with Sarah's mental disorders so as to encourage engagement and to avoid isolation and feelings of isolation. Consideration should therefore be given to the procedure for cancelling visits, - (i) whether visits should be cancelled only at Duty Governor level and not by less senior staff; (ii) whether there should be better recording of visits including cancelled visits and the reason for cancellation; (iii) whether better and clearer explanation could be given to a visitor (family, friends and lawyers) when a visit is cancelled and preferably in advance of the meeting; and (iv) whether special visiting arrangements could be made more often for prisoners, particularly remand prisoners, who have exhibited problem behaviour. **E. Notification of Prisoner's Release** MoJ; HMPPS; CNWL Consideration should be given to informing external agencies, in this case such as the START Team, of the impending or actual release of a prisoner. (On the facts of this case Sarah was not released or due to be released. But there was evidence that other prisoners had been released without the prison informing relevant agencies who were known to the prison and would be expected to provide care and support to the vulnerable in the community.)
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **22 September 2017**. 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: the mother of Sarah Reed and SLAM. I have also sent it to HM Inspector of Prisons, the Prisons and Probation Ombudsman and NHS England Liaison and Diversion Services, 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	**28 JULY 2017** **HH SIR PETER THORNTON QC**