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:** Michael Spurr Chief Executive and Chief Executive Officer HM Prison and Probation Service Clive House 70 Petty France London SW1H 9EX
1	**CORONER** I am André Joseph Anthony Rebello, Senior Coroner, for the area of Liverpool & 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 1st November 2016 I commenced an investigation into the death of **Edwin Lewis O'DONNELL**, Aged **26**. The investigation concluded at the end of the inquest on 3rd July 2017 and subsequent days to the 13th July 2017. The cause of death was found as: Ia Asphyxia Ib Compression of the Neck Ic Hanging by a Ligature The Jury **concluded**: - Edwin Lewis O'Donnell died from an **Accidental Death contributed to by neglect**. Mr O'Donnell was in a dependent position because of incarceration. Edwin Lewis O'Donnell's death was contributed by neglect relating to the following issues. A) The events of the early morning of the 23rd October 2016 when Ned said he would kill himself, we the jury agree there should have been an Assessment Care in Custody and Teamwork (ACCT) review. This was a failure. B) On the early morning of the 23rd October 2016 the nurse completed a ledger for the day staff to bring his entry to the attention of the Mental Health Team. There is no evidence that this was acted upon. We the jury agree there should have been a Mental Health assessment. This was a gross failure. C) Following the evidence the senior officer on duty was told Ned said he would be dead by 8.00 p.m. The supervising officer should have called an ACCT review. This was gross failure.

4	**CIRCUMSTANCES OF THE DEATH** Mr Edwin Lewis O'Donnell has died from an accidental death. We, the jury find that it is more likely than not, that Mr O'Donnell put himself in the position in which he was found but did not intend to end his life. He put himself in this position for a reason which inadvertently proved fatal. Ned was known to numerous authorities throughout his life. It was documented that Ned had a history of self-harm and was on a waiting list to engage with counselling services whilst in prison. He was transferred to another prison and there was a failure to provide that prison with relevant information. On arrival, there was an inadequate handover of previous medical history and insufficient available information to nursing staff, resulting in a lack of continuity of care. Ned was not always consistent with his engaging of healthcare and mental health services within the institution. The first Assessment Care in Custody and Teamwork (ACCT) document was opened when Ned began a fire in his cell, (23 September 2016). It is documented as an act of self-harm. Ned stated he began a fire to be moved to the segregation unit, with no intention of self-harm. The ACCT was closed. The condition of the cells Ned resided in whilst in segregation were recognised by prison staff as being not fit for purpose. Ned had a history of drug use and we the jury find it more likely than not that Mr O'Donnell was using synthetic cannabinoids during the days leading to his death. We the jury conclude this contributed to his behaviour and presentation but did not contribute to the fatal event. On the 21st October 2016, the second ACCT was opened after Ned deliberately cut his ear with a razor. The evidence states this incident of self-harm was a way of drawing attention to his concerns about his health issues. On the 22nd October 2016, following a multidisciplinary team meeting (first case review) the ACCT remained open. Hourly observations were agreed upon. In the early hours of the 23rd October 2016, Ned told prison staff that he was going to kill himself, before someone else does. The prison officer informally increased Ned's observations but this was not documented and there was a failure to effectively communicate with other staff that observations had been increased. Ned was seen by healthcare. Healthcare referred him for an emergency mental health review. This referral was not acted upon. During the day Ned engaged in extremely disruptive behaviour and protests along with several other prisoners. There were allegations of bullying which we the jury conclude did not contribute to his death. Ned told a cleaner that he would be dead by 20.00 pm. The cleaner told a senior officer on duty at the time of this information. The senior officer on duly failed to escalate this information despite informally increasing observations on Ned. Nothing was communicated to the following prison staff. During the 23rd October 2016, we the jury agree Mr O'Donnell's state of mind was not appropriately documented or communicated between prison staff. When utilising the ACCT document, there were several failings: - The evidence highlighted that there was an inconsistency and lack of understanding with regards to the threshold of opening and reviewing an ACCT. There were a number of missed opportunities to increase interactions/observations, or call for an ACCT review. The documentation was inappropriately completed, with interactions being documented at regular intervals (e.g. hourly) and the level of initial level of risk not being identified. The legibility of handwriting and signatures was unsatisfactory. During a prison officer's first interaction with Ned at 18.00 pm, whilst completing a required ACCT interaction, Ned did not engage verbally. At 18.45 pm, Ned was unresponsive and out of view to the prison officer. The prison officer escalated this as he was concerned. Oscar (the orderly officer) was called, senior officers and other prison staff entered Ned's cell. Ned was unresponsive and hanging by a ligature from his tap. Cardio pulmonary resuscitation was attempted and unsuccessful Ned was pronounced deceased at 19.15 pm.

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 the inquest into the death of Edwin Lewis (Ned) O'Donnell it was apparent that a nurse carrying out the first health reception screening was not given access to the PER (Prisoner Escort Report) which had accompanied the prisoner from another prison establishment.

a) The PER form had content which was pertinent to mental wellbeing which was inconsistent with the information provided by Ned.
b) Though the previous prison indicated that they had sent a print from the digital IMR System One the nurse conducting the first health reception screening had no recollection or notes to indicate whether this was available at the time of the screening.
c) There is expected to be a second health screening of inmates some 24 to 48 hours later – which enables information from the community to be received and fuller informed access to the digital IMR System One. In this case the second screening was not until the 27th March 2016. Whereas the first screening was on the 9th March 2016.
d) An offender supervisor (Probation) working in the prison has been ACCT trained but did not know that there was a low threshold for opening an ACCT

The Court considers that in other cases important information in assessing risk could be missed if action is not taken to remedy these matters by making it a requirement that prison discipline staff record on C-Nomis all documentation received with a prisoner in particular

- PER forms
- SASH forms
- Printed summaries from System One
- Prescriptions

C-Nomis should also be noted that these have been handed to (or copies have been handed to healthcare in reception.

It could also be a mandated requirement that the digital IMR System One be updated (possibly when the digital IMR System Two is rolled out if that is imminent) with forced fields to ensure that nurses carrying out the first health reception screening record the documentation provided by the Prison staff which accompanied the prisoner.

The Court has heard evidence of the new training developed for the ACCT protocol and that this is being rolled out in a prioritised manner within HMP Liverpool. The Court considers it important that the Probation service takes responsibility to ensure that (offender managers and supervisors) probation staff working within prisons all receive basic ACCT training. Probation staff often have to break unwelcome news and this must require a risk assessment of the effects of that news on inmates.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action with if necessary cooperation from other parts of government.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 8th September 2017 at 16.00. 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 Ned O'Donnell's family, HMP Liverpool, Lancashire Care NHS Foundation Trust. I have also sent it to the Prison and Probation Ombudsman PPOFIIAdmin@ppo.gsi.gov.uk , HM Prison Inspectorate hmiprisons.enquiries@hmiprisons.gsi.gov.uk 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **Dated: 13 July 2017**