REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Governing Governor HMP Wymott (concerns 1 and 2)** **2. Head of Healthcare HMP Wymott (concern 2)**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Lancashire
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** In March 2014 an investigation was opened into the death of John Martin Chapman aged 43. The investigation concluded at the end of the inquest on 10th January 2018. The conclusion of the inquest was that the deceased died as a result of accidental hanging.
4	**CIRCUMSTANCES OF THE DEATH** On 23rd January 2014 the deceased was transferred to HMP Wymott. Within the Person Escort Record and CNomis there were alerts in respect of two previous occasions when the deceased had self-harmed or threatened self-harm and been placed on an ACCT. This information was not passed on to the reception nurse and as a result the nurse did not interrogate the deceased on these matters and give consideration, for instance, to a referral to mental health or to taking such other action as may have been appropriate in the light of the information and the deceased's response thereto. On 21st March 2014, the deceased, who up to that point had shown no signs of low mood or distress, was found hanging in his cell.
5	**<u>CORONER'S CONCERNS</u>** 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. <u>TO THE GOVERNOR HMP WYMOTT</u>** Although evidence was heard to the effect that currently at reception at HMP Wymott the CNomis entries relating to a newly arrived prisoner are scrutinised by prison reception staff to ascertain whether there are any self-harm or welfare alerts, it did not appear that a direction exists to pass relevant information to the nurse carrying out the reception medical screen. **2. <u>TO THE GOVERNOR AND HEAD OF HEALTHCARE</u>** There does not appear to be a mechanism at reception whereby information relevant to the self-harm or well-being of a prisoner is routinely shared by prison staff with medical staff carrying out a reception medical screen including alerts on the CNomis system. As

	a result, there appears to be a danger that significant alerts concerning a prisoner might not come to the attention of the reception nurse to enable the nurse to take appropriate action and make relevant entries within the medical records. Those in authority, giving evidence on behalf of the prison and healthcare on the subject of reception practice, saw merit in there being a formal procedure agreed between prison discipline staff on the one hand and healthcare staff on the other, for the sharing of information relevant to a prisoner's well-being, and for this to be accomplished promptly.
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 10th March 2018. 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 legal representatives of the family and other properly interested persons. 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	**Dated 11th January 2018 SIGNED** **Assistant Coroner**