REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Ministry of Justice, London 2. NHS England, Skipton House, 80 London Road, London SE1 6LH
1	**CORONER** I am Ms L Hashmi, HM Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 16th August 2017 I commenced an investigation into the death of Mr Bradley Fraser Brown. The investigation was concluded by way of inquest (sitting with a jury) on the 31st October 2018. The jury reached a narrative conclusion, which included that the deceased had taken his own life by way of self suspension, on the balance of probabilities.
4	**CIRCUMSTANCES OF DEATH** At the time of his death Mr Brown was a serving prisoner. He had been transferred to the prison (where he subsequently died) late on the afternoon of Friday 11th August 2017. Upon arrival, it was too late for Healthcare to conduct its initial assessment. A brief mental health assessment was carried out but the Nurse did not have access to Mr Brown's full records. The IMR was not transferred with Mr Brown as Healthcare at the transferring prison had not been made aware of the plan to move him. Whilst Mr Brown had a past history of paranoia and drug misuse, the Mental Health Nurse's assessment did not give rise to any cause for concern. Mr Brown declined referral to the mental health team. For clarity, he was not subject to an ACCT. He was placed in a single occupancy cell on the induction wing. Mr Brown did not attend his first healthcare screening assessment appointments on the 12th/13th August. Over the course of the weekend, he participated in periods of association etc. and did not raise any concerns. He appeared settled but quiet. On the night of the 13th August 2017, an Operational Support Grade Officer (OSG) was allocated to patrol to induction wing as part of her duties. The first roll count was completed without issue. The OSG had no cause to visit Mr Brown's cell during the course of her shift. There had been problems with the OSG's 'pegging' on the wing during the night. In the early hours of the 14th August, Prison Officers discovered the OSG asleep on duty. This was escalated to the duty manager who reprimanded her. He did not report the incident to the duty Governor and did not record the incident. At around 06:30-06:45 on the morning of the 14th August the OSG carried out the morning roll count. When she checked Mr Brown's cell she noted that the observation panel had been obscured by a piece of material. She could not see Mr Brown and she did not try to vocalise with him because she heard what she believed to be a noise coming from within. She did not report/escalate the matter. At around 07:30 the oncoming Prison Officer noted that the observation panel was blocked and attempted to speak with/see Mr Brown. When he looked down the side of the cell door he could only see the front of him. Suspecting something untoward had happened, he called a colleague over. When they entered the cell, they found Mr Brown suspended by ligature from the light fitting. Mr Brown was cut down, CPR commenced and a 'code blue' called.

	Despite best efforts, Mr Brown could not be resuscitated and the fact of his death was confirmed by attending Paramedics later the same day.
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. Late transfer of Prisoners between Prisons -** on Fridays/at a weekend puts Prisoners at increased risk of death as adequate mental health/risk assessments cannot be conducted. There are no mental health nurses available to assess/monitor prisoners over the weekend, thus making late transfers unsafe. The same concern applies, in principle, to public/bank holidays. There are different levels of healthcare at the weekends as compared to weekdays. This gives cause for concern given the inherent susceptibilities with which prisoners frequently present. Transfer itself creates vulnerability that requires additional support, intervention and care and is of particular concern where the transferring prisoner is being held in isolation within the Care and Separation Unit (CSU or 'Seg' as it is colloquially known). By virtue of the very different prison regime at the weekends (increased lock up periods/isolation in cells, fewer staff on duty, reduced activities) timely risk assessment is critical in the prevention of self-harm leading to death. Late transfer also risks inadequate assessment where the clinician concerned cannot access the prisoner's full healthcare record, thus substantially reducing the amount of key information available to them. Where the transferring prisoner has not been seen by Healthcare, other clinicians such as mental health nurses cannot access the healthcare record database. There is no national guidance in relation to late transfers/'cut-off' points etc. **2. Commissioning of Mental Health/Healthcare Services:** As commissioners for healthcare services within prisons, the above concerns are also being brought to the attention of NHS England, for action. These issues are not unique to the Prison involved in Mr Brown's case.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 25th January 2019. 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 namely:- - Mr Brown's family - HMP via the Government Legal Service ('GLS')

	- Greater Manchester Mental Health ('GMMH') 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 from. 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	Date: 30th November 2018 Signed: