	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **i. NHS England** **ii. Birmingham and Solihull Mental Health Foundation Trust ('BSMHT')** **iii. Birmingham Community Healthcare NHS Trust ('BCHT')** **iv. G4S** **v. The Ministry of Justice ('MOJ')**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 09/03/2018 I commenced an investigation into the death of John Anthony Delahaye. The investigation concluded at the end of an inquest on 14th December 2018. The conclusion of the inquest was that on a balance of probabilities Mr. John Delahaye deliberately took an overdose of insulin with the intention of ending his life. At the time of his death Mr. Delahaye was a remand prisoner at HMP Birmingham and it was further determined by the jury that: i. It was not appropriate that Mr. Delahaye was discharged by the mental health team (after taking an overdose of insulin on the 31st December 2017) on the 2nd January 2018 and not reviewed again and this possibly caused or contributed to his death. ii. There should have been involvement of mental health and/or physical healthcare in the ACCT process, the absence of which possibly caused or contributed to his death. iii. It was not appropriate for Mr. Delahaye to have insulin in his possession and this probably caused or contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Delahaye was found dead in his cell, M301, at HMP Birmingham on the 5th March 2018. As a result of post mortem examination and toxicology it was identified that his death was a result of an insulin overdose. Mr. Delahaye was a type 1 diabetic and had been given an insulin pen to keep in his possession in his cell. Mr. Delahaye had previously been admitted to City Hospital, Birmingham on the 31st December 2017 as a result of an insulin overdose. He returned to HMP Birmingham on the 1st January 2018. On the 2nd January 2018 Mr. Delahaye was reviewed by a mental health nurse who found no evidence of an acute mental illness and discharged Mr. Delahaye. At that time he stated he did not remember what had happened at the time of the overdose. On the 2nd January 2018 a primary healthcare nurse opened an Assesment, Care in Custody and Teamwork book (an 'ACCT'), as a consequence of the initial ACCT assessment and review on the 3rd January 2018 he was referred back to the mental health team for an mental health assessment but no assessment was carried out. He remained on the ACCT book until the 17th January 2018. At no time did the mental health team have any involvement in the ACCT process, the team was invited to attend by the custodial first line manager but declined. Following his return after the overdose Mr. Delahaye had initially not been allowed to have his medication in his possession but on the 29th January 2018 a GP assessed Mr. Delahaye and determined that he was suitable to have his self-administering insulin pen in his possession. He was last issued a pen on the 3rd March and it was found empty in his cell on the 5th March 2018 indicating he had taken an overdose of between 230 and 270 units.
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 confusion surrounding the meaning of the following question from NHS England's national clinical template for *in possession* Risk Assessments in the Secure Estate: "Have you had problems in the last 6 months with not taking, or not remembering to take your medicines as prescribed?" The Risk Assessment had not been used in the assessment for Mr. Delahaye's *in possession* modification on the 29th January 2018 when it ought to have been. However, during the course of considering what the outcome would have been if the risk assessment had been undertaken, more than one clinician interpreted the question as pertaining only to consideration of incidents where medication had not been taken. It was the Coroner's view that the question is also asking about incidents where medication may have been taken but not "as prescribed" thus encompassing an overdose (accidental or deliberate). The question is not clear and this creates a risk that the score generated may be incorrect and *in possession* medication may be authorised where it ought not to be, putting lives at risk. 2. During the inquest it emerged that the mental health nurse who assessed Mr. Delahaye on the 2nd January 2018 and the GP who assessed him for *in possession* medication on the 29th January 2018, had not identified from his notes all relevant past medical conditions. It emerged that whilst the System One records (a case management system used across the prison estate) has the facility to provide a summary of significant past and current medical conditions, it is not reliable at HMP Birmingham because conditions are not consistently given the correct 'read code'. Evidence from the NHS England clinical reviewer, [redacted], was that this problem is not unique to HMP Birmingham and is found in other prison healthcare teams and requires a change of culture and practice to bring the system for read coding into line with that in the community. The absence of a reliable source for quickly identifying relevant past and current medical conditions puts lives at risk from misinformed decision making. 3. No member of the healthcare team was present at any of Mr. Delahaye's ACCT reviews. It was identified during the inquest that a member of either the mental health team, primary care or the drug/alcohol service ought to have been present at the first review at least. It was the evidence of a first line manager who had involvement in the ACCT that a member of the custodial team had contacted healthcare and asked them to attend but this was not documented and the healthcare team maintained they were unaware of the date of the first review. Whilst the ACCT book provides a checklist of actions to be undertaken at various times it does not include making healthcare aware of the first review. As this is a national Ministry of Justice form, HMP Birmingham can't change it but a failure to inform healthcare of an ACCT review could result in useful knowledge or expertise not being available to the ACCT team and could put lives at risk. 4. On the morning of the 5th March 2018 Mr. Delahaye's cell had been unlocked at approximately 07:50. It is likely that he was already dead at this time (and had been so for some hours) but he was not found because the prison custody officer who unlocked his cell did not look into the cell or seek any kind of acknowledgement from Mr. Delahaye. It was acknowledged by the relevant PCO and by the Safer Custody Manager that unlock ought to have involved a welfare check. The Safer Custody Manager's evidence is that the need for a welfare check on unlock has been emphasised to senior managers and leads through a bilateral document covered at formal briefings. However, it was not clear how this is then communicated down to the individual custody officers and how they are being audited to make sure they are conducting a welfare check on unlock. The absence of a welfare check creates a risk that a prisoner in need of life saving assistance at the time of unlock is not identified.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe: i. NHS England have the power to take such action with respect to matters 1 and 2 above; ii. BSMHT and BCHT have the power to take such action with respect to matter 2 above; iii. The MOJ have the power to take such action with respect to matter 3 above; and iv. G4S and the MOJ have the power to take such action with respect to matter 4 above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 February 2019. I, the coroner, may extend the period. You are asked to respond to the matters relevant to your organisation as identified in section 6 above but you are not prohibited from responding on other matters if appropriate. Your response must contain details of action taken or proposed to be taken (in respect of the matters relevant to your organisation), 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 Mr. Delahaye's family. I have also sent a copy of the report to the Prison and Probation Ombudsman 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	18/12/2018 Signature  Emma Brown Area Coroner **Birmingham and Solihull**