	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Michael Spurr, HM Prison and Probation Service, 102 Petty France, London, SW1H 9AJ** **2. Mr Jim Easton, Chief Executive Officer, Healthcare, Care UK, Hawker House, 5-6 Napier Court, Napier Road, Reading, Berks, RG1 8BW**
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
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** At Oxford Coroner's Court on 26, 27 and 28 February 2019 I conducted the inquest into the death of John Wright at HMP Bullingdon. The Jury returned a Narrative Conclusion as follows: *'John Wright was found at 23.45 on 14 December 2017 in cell 114 unresponsive with an electrical cord as a ligature around his neck. The cord was suspended over the head of the bed and brackets on the left-hand wall of the cell. John Wright's life was pronounced extinct at 00.58 on 15 December by the South Central Ambulance Service. Cause of Death, declared by the Pathologist to be 'Compression of the neck consistent with suspension'.* *Based on the evidence presented we, the Jury, believe that it was Mr Wright's intention to end his life that evening by deliberately placing a ligature around his neck.* *We, the Jury, believe that the opportunity for Mr Wright to end his life was afforded by the decision to downgrade the level of observation from constant watch pre-arrival at HMP Bullingdon to twice hourly in the Healthcare wing for the first night.* *The decision to downgrade the level of observation taken by the Duty Governor, The Senior Prison Officer and the Healthcare representative was taken based on how Mr Wright presented during screening without due consideration to the information provided in the PER and accompanying SASH form.* *This decision taken was further compounded by inconsistencies and inadequacies in the systems and processes for sharing important and pertinent information at the appropriate time and to relevant parties. Being in possession of all the information available would have assisted the staff in their decision making around the level of observation required.'*

	HMP Bullingdon/Ministry of Justice were legally represented at inquest. In addition to family, other 'Interested Persons' included the main health care provider, Care UK, and also Midland Partnership NHS Trust to whom the secondary mental health provision is sub-contracted. Evidence was collated prior to inquest and a copy of the inquest file was provided to the Government Legal Service. For this reason, I am not providing you with a full copy of the inquest file, but I anticipate it would be helpful for you to have a copy of witness statements that were obtained from [redacted] (Prison Governor) and [redacted] (Head of Healthcare at HMP Bullingdon). The statements contain evidence concerning various recommendations made by the PPO/Clinical Review and Care UK's internal investigation. I am also sending this letter to Care UK because, largely speaking, the issues which I raise apply to both organisations.
4	**CIRCUMSTANCES OF THE DEATH** John Wright was 32 years old when he died at about midnight on Thursday 14/Friday 15 December 2017 at Bullingdon Prison in cell 114 in the healthcare department. He was found partially suspended with an electrical cable from a bed. The cause of death was Hanging. He had only been in prison for about 8 hours having arrived from court in Reading earlier. He had been in police custody since Tuesday 12 December having been charged with murdering a young woman. He was due to return to court on Friday 15 December. He had expressed suicidal thoughts and had been on constant watch at the police station and at court and when being transported from the court to HMP Bullingdon. It was his first time in prison. For further circumstances relating to Mr Wright's death I refer you to the Jury's Narrative Conclusion above.
5	**CORONER'S CONCERNS** **During the course of the Inquest the evidence revealed matters giving rise to concerns. 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 make this report to you.** It is reassuring however to see that significant measures have been put in place following this incident and an action plan has been formulated to comply with recommendations. For this reason, I am restricting my Regulation 28/Prevention of Future Death Report to relatively narrow issues which I do not believe are adequately addressed elsewhere. The **MATTERS OF CONCERN** are in relation to the following: 1. The first concern which I raise applies to both the prison and healthcare and relates to the receipt of information by the prison and/or healthcare about a heightened risk of self-harm/suicide for a prisoner who has yet to arrive at prison. I heard evidence that it is not uncommon for outside agencies to pass on concerns, and, for example, copies of relevant mental health assessments, in anticipation of the prisoner arriving at the prison in a state of heightened risk requiring help and assessment. I also heard evidence that the software system operated by healthcare (System One) does not enable healthcare staff to make entries prior to the prisoner being received at reception and a prison officer opening a record on the computer

and allocating a prisoner number. This being the case, I understand that the practice has been to email or print a hard copy of the document and take it to reception. In this case, a mental health nurse who was part of the secondary mental health team received a report about heightened risk and telephoned the nurse in reception to pass on details. The secondary mental health nurse said in evidence she would normally take a hard copy of the mental health assessment that she received and place it in a tray in reception. There was an alternative of emailing, but this was not considered the best way to bring it to the attention of the relevant healthcare staff in reception.

Of course, information about an incoming prisoner, who is assessed at high risk of suicide, is precisely the sort of important information which should not be allowed to fall through any gaps. It is high priority. An outside person or agency has considered it necessary to bring the matter to the attention of the prison or health care.

I understand that Care UK have set up a generic email address for healthcare staff in reception which may assist. Clearly, this still relies on healthcare staff checking to see if any such emails have been received. I appreciate that it is very busy in reception in the late afternoon/early evening.

I will also be copying this report to Midland Partnership NHS Foundation Trust to request their response in relation to this matter.

There is a related concern about the availability and sharing of such information or documentation amongst prison or health care staff in reception. From the evidence I heard at inquest, it appeared to me that the system for ensuring the staff in reception have access to all available information is in need of improvement. The senior prison officer in this case did not have all relevant information and she said that, if she had, there may have potentially been a different decision (I understand her to mean that Mr Wright may have remained on constant cell watch). I understand the Governor has created a position of 'Head of Early Days' and a system is in place to improve the process of documentation so that it follows the prisoner.

2. The second matter I wish to raise, also to the prison and healthcare, is in relation to the level of observations. I heard evidence that this is often a joint responsibility held by the prison and healthcare. In this case, Mr Wright had been on constant watch, but a decision was taken during the reception process to step down to twice hourly observations. Given that staff may not have access to all available information in those first few hours, and the fact that there will not have been an opportunity for a prisoner to be observed over a significant period of time, and the fact that a more detailed assessment will not have taken place yet, there should in my view be some guidance to staff when reducing observations from constant watch.

   I note that the Prison and Probation Ombudsman stated at the beginning of her report that ..... '*Mr Wright had been under constant watch by police and court staff because he said he wanted to take his life at the earliest opportunity. Although prison staff started suicide and self-harm prevention procedures when Mr Wright arrived at Bullingdon, they reduced the level of observations from constant to twice an hour. In my view, this decision was misjudged and taken far too quickly, without a proper assessment of Mr Wright's risk.*'

	I appreciate there is a great deal of responsibility on prison and healthcare staff when making assessments. Much depends on how they assess the prisoner in front of them. It may be appropriate to reduce a newly arrived prisoner from constant cell watch to less frequent observations on occasions. The concern which I raise relates to such decisions being made in reception and I enquire if there should be some guidance available to assist staff in their decision-making process? For example, should such a decision be postponed until a further assessment has been carried out the following day? I realise that this issue is not straightforward and there are significant resource implications in keeping a prisoner under constant watch.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. I may extend the period on request. 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 confirm that a copy of this report and your response will be sent to Mr Wright's family. 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	**Signed** **Date** 21st March 2019 **Mr D.M. Salter** **HM Senior Coroner for Oxfordshire**