Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Dr Jo Farrar, Chief Executive of HM Prison and Probation Service

1 CORONER

I am James Healy-Pratt, HM Assistant Coroner for the area of East Sussex.

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 8 May 2017 I commenced an investigation into the death of Ryan Stephen TRIMMER, aged 29. The investigation concluded at the end of the inquest on 20 May 2019. The conclusion of the jury at the inquest was:

Cause of death:

I a. Hypoxic ischaemic brain injury
I b. Hanging
II. Emotionally Unstable Personality Disorder

Narrative Inquest conclusion of:

Ryan deliberately chose to attach a ligature to himself but did not intend that the outcome be fatal. The following matters caused or contributed to Ryan's death; lack of phone calls, relationship, HMP Lewes prison staff resourcing on the healthcare wing, the complex nature of EUPD, inadequate ACCT reviews.

4 CIRCUMSTANCES OF THE DEATH (JURY FINDINGS)

Ryan Trimmer was remanded to HMP Lewes on 4 March 2017. He had a history of self harm and suicide attempts. An ACCT was opened by reception staff. Ryan was found with a ligature around his neck on 4 March, 6 March and 20 April and he self harmed on 30 March.

Ryan was found hanging in his cell on 22 April and he died in hospital on 26 April 2017.

Ryan was on an ACCT throughout this entire period.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows:

The ACCT process was ineffective. They jury made a factual finding of inadequate ACCT reviews. The Court heard evidence of the ACCT Pilot Scheme underway in certain other prisons. HMP Lewes should be considered as a priority facility for future extension of the ACCT Pilot Scheme.

Prison staff are often first responders to medical emergencies of prisoners, but not all have received first aid training. One frontline prison staff member gave evidence that he had not received training in

16 years of working for HMPS and felt he needed refresher training.

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, namely by **16 August 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.

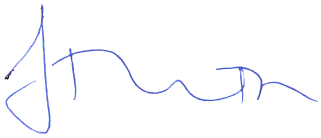
8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons
Family of Ryan Trimmer
HMP Lewes
Sussex Partnership NHS Foundation Trust

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



James HEALY-PRATT
Assistant Coroner for
East Sussex
Dated: 21 June 2019