	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Phil Copple, Director General, H M Prison and Probation Service 102 Petit 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** **3. Mr Neil Carr, Chief Executive, Midlands Partnership NHS Foundation Trust, St George's Hospital, Corporation Street, Stafford ST16 3SR**
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 Coroners Court between 29 April and 7 May 2019 I conducted the inquest into the death of Daniel Davey at HMP Bullingdon. The Jury returned a Narrative Conclusion as follows: *Mr Davey died on 12 January 2018 at 12:31am at the John Radcliffe Hospital after taking approximately 63 tablets of propranolol at around 8pm in cell E114 at HMP Bullingdon Prison.* *The Jury concludes that Mr Davey deliberately took an overdose of his propranolol with the intention to commit suicide.* *HMP Bullingdon failed to adequately train prison staff in ACCT management, assessment and review processes. It also failed to implement national policy regarding the inclusion of healthcare in the ACCT process and also failed to perform a search of Mr Davey's cell upon opening ACCT 2.* *Healthcare providers failed to adequately and regularly risk assess 'in possession' medication. Healthcare failed to adequately share risk relevant information given by Mr Davey on 29 December 2017. Mr Davey's request to reduce his medication was based on misleading information relating to a move to Grendon and wasn't challenged or adequately assessed by any healthcare professional.* *Following the reduction of medication on 4 January and the incident of self-harm on 7 January, there was no follow up or intervention from the secondary healthcare team and a system wide failure to recognise a pattern of behaviour and escalating "cries for help".*

	The Jury concludes that there was a failure to act on the sum of information that was reasonably available to both prison and healthcare personnel in order to keep Mr Davey safe. HMP Bullingdon/Prison and Probation Service were legally represented at inquest as was Care UK (CUK) and Midlands Partnership Trust (MPT). Mr Davey's father, [redacted] was also legally represented. A copy of the inquest file was available to Interested Persons prior to inquest. For this reason, I am not providing you with a full copy of the file, but I anticipate that it would be helpful for you to have a copy of the witness statement for [redacted] (Prison Governor) and [redacted] (Head of Healthcare, Care UK). The statements contain evidence concerning recommendations made by the PPO and Care UK's internal investigation. It will be seen that this Regulation 28 Report is being sent to HMPPS, CUK and MPT because the issues which I raise apply to all organisations albeit to varying degrees.
4	**CIRCUMSTANCES OF THE DEATH** Daniel Davey was 21 Years old when he was pronounced deceased just after midnight on 12 January 2018 at the John Radcliffe Hospital, Oxford. The cause of death following a post mortem examination was 'Aspiration of gastric contents and propranolol intoxication'. He initially became unwell at about 10pm in his cell prior to suffering seizures and a cardiac arrest at the prison and being taken to hospital by ambulance. Mr Davey said to prison staff at the prison that he had taken an overdose of his prescribed medication, propranolol. He had been in Bullingdon Prison since 1 December 2017 (just over a month) having been sentenced to 10 years for sexual offences. It was his first time in prison. He had a history of mental health problems including suicidal thoughts. It will be seen that further circumstances relating to Mr Davey's death are outlined in the Jury's Narrative Conclusion including reference to failures in his care.
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.** During the course of the inquest I heard evidence from members of prison and healthcare staff. It was apparent that improvements were introduced after the death of Mr Davey and the system operates differently now. I also heard evidence specifically about improvements from Governor Blakeman and Ms Lutton. This helpfully provided a level of reassurance. However, I remain concerned about a number of issues.

The **MATTERS OF CONCERN** are in relation to the following:

1. **Healthcare attendance at ACCT reviews** – This concern relates to both the prison and healthcare. It was clear from evidence from prison and healthcare staff that it was not routine for healthcare to attend ACCT reviews. This is a significant concern and it is not in accordance with local and national policy. I understand that there were occasions when prison staff requested healthcare attendance, but no one was available. The system of providing advance notification to healthcare about the date of ACCT reviews was not comprehensive. It resulted in ACCT reviews, as in this case, taking place without key information being available to the assessor/reviewer. For example, information about suicidal ideation/attempts and other information disclosed to healthcare and also information about 'in possession medication'. Encouragingly, the evidence from prison and healthcare staff was that ACCT reviews no longer take place without healthcare attendance and/or input (perhaps over the telephone). It would be helpful if there could be a further level of reassurance provided about, firstly, communications between prison and healthcare staff in the conduct of ACCT reviews and, secondly, a process of auditing ACCT reviews in order to pick up cases where there is no healthcare input.

2. **Reviews of 'in possession' medication risk assessments** – The second concern also relates to prison and healthcare. In particular, it relates to a prisoner placed on an ACCT. I heard evidence that, initially, a template is used at the reception healthcare screen to determine if medication should be held in possession or not. I was told that, now, this is subsequently reviewed by the prescriber and, on opening an ACCT, there is an automatic review of the risk assessment in accordance with CUK's new policy.

   In the case of Mr Davey, there was an initial risk assessment at reception and he was deemed suitable for in possession medication, but this was not reviewed when he was subsequently placed on the 2 ACCT documents in December and January or when he disclosed to a mental health nurse on 29 December that he had a plan to kill himself. I understand that new systems are in place (with healthcare) but it would be reassuring if there is a system of audit to ensure compliance, namely, that the in possession risk assessments are reviewed. I appreciate a review might not necessarily result in medication being taken away. I also appreciate this is a difficult area in view of patient confidentiality and, of course, the danger that a prisoners physical or mental health could be put at risk if medication is taken away.

   A related concern is the fact that prison officers did not appear to have in mind the risks associated with in possession medication. It appeared to be disregarded because it was information that was not available to them and it was therefore deemed a matter for healthcare. I am concerned that there is a danger in leaving the issue of in possession medication solely to healthcare. There could be a time delay of several hours or even longer between a prisoner having a mental health crisis and healthcare

	involvement/reassessment. It appears there needs to be joint liaison between the ACCT case manager and healthcare and a plan to intervene and remove medicine if necessary. This leads to a final related concern. There is the question of cell searches for stockpiled medication and the collection of properly held in possession medication when there is a change of risk such as an ACCT document being opened. I did not hear much evidence about practice or policies relating to searching and potentially removing medication. This is clearly a task that rests with prison staff and it would be helpful to have further information about this.
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 Davey'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** **16/05/2019** **Mr D.M. Salter** **HM Senior Coroner for Oxfordshire**