REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Head of Safer Custody & Public Protection Group, National Offender Management Service, Ministry of Justice;** **2. Olivia Pinkney, Chief Constable, Hampshire Constabulary;** **3. Andy Milner, Chief Executive, GEOAmey;** **4. [redacted], Governor, HMP Winchester;** **5. Claire Murdoch, Chief Executive of Central & North West London NHS Foundation Trust;**
1	**CORONER** I am Karen Harrold, Assistant Coroner for the coroner area of Central Hampshire.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5 http://www.legislation.gov.uk/uksi/2013/1629/made
3	**INVESTIGATION and INQUEST** On 20 September 2017 the Senior Coroner, Grahame Short, commenced an investigation into the death of Mr Michael Shaun Folley aged 25 years old. The investigation concluded at the end of the inquest on 21 March 2019. The following findings of fact were found by the jury: • Michael Folley was detained in HMP Winchester having been remanded into custody by Portsmouth Magistrates Court on 15 September 2017. • He was found at 11:03 on 16 September 2017 having barricaded the cell door using mirrors and furniture. This delayed entry to the cell and he was found suspended from a ligature made of torn bed sheets placed around his neck and knotted several times around a window bar in cell D4-27. • Prison officers, healthcare and paramedic staff tried to resuscitate him. • He was transferred to the Royal Hampshire County Hospital in Winchester the same day and despite intensive care treatment he was pronounced dead at 16:43 on 18 September 2017. The conclusion of the jury was that Mr Folley deliberately chose to suspend himself by a ligature and, on balance, he intended the outcome be fatal. The medical cause of death was recorded as: 1a) Hypoxic-ischaemic encephalopathy

	1b) Ligature suspension.
4	**CIRCUMSTANCES OF THE DEATH** Michael Folley had a haphazard and complicated lifestyle, living in a variety of locations across the South. He also had a history of being detained by the police and receiving support from community as well as hospital mental health services. This included the fact he registered at the Guildhall walk healthcare centre in Portsmouth on 6 April 2017. At that stage he was homeless having moved to Portsmouth following his release from Winchester prison. He reported having a history of mental health problems and being diagnosed with conduct disorder in 2009 as well as severe anxiety and depression. He had not been on any medication whilst in prison. Mr Folley also self-reported that he had drug induced psychosis following his use of cocaine but he had declined any help from the drug and alcohol misuse teams. He was seen by [redacted] on 10 April 2017 and blood tests were arranged. He attended for that appointment on 21 April 2017 and subsequently the results were unremarkable. Mr Folley attended A&E on 8 July 2017 with multiple injuries to the right hand and left knee as a result of apparently punching a pane of glass. Whilst in hospital he was assessed by the mental health liaison team as he had reported to emergency department staff that he was feeling suicidal, paranoid and was having auditory hallucinations. Mr Folley disclosed to them that he felt he needed sectioning, however following discussion it appeared he simply felt like spending some time in the psychiatric ward would also help address his housing needs. He had been released from prison the day before, 7 July 2017. He was then seen by ambulance crew on 11 July 2017 following a collapse in a shop due to him taking the drug "Spice" and alleging he had been assaulted. He was treated at the scene and not conveyed to hospital. Mr Folley was then removed from a train on 16 August 2017 by the British transport police. They had attended at Southampton Central railway station following a cause for concern into the welfare of Mr Folley who had locked himself in a toilet on the train. Mr Folley was shouting and screaming and entry had to be forced in order to get him out of the cubicle. Mr Folley was taken to Southampton General Hospital and subsequently readmitted to the orchards at St James's Hospital in Portsmouth. Mr Folley self-discharged himself the same day and the diagnosis given during his admission was emotionally unstable personality disorder. The Crisis Resolution Home Treatment Team were unable to contact Mr Folley as part of their inpatient discharge procedures and he was therefore discharged from their caseload. On 17 August 2017 he walked into Havant police station with stolen goods saying that he wanted to be arrested. He was charged and subsequently received a 28 day sentence of imprisonment at Winchester prison on 22 August. He told a resettlement officer that he intended to kill himself by taking an overdose. As a result, he was placed on an ACCT to give extra support and referral to the prison mental health team. He was released from prison on 1 September and the same day was again detained by police in Canterbury due to concerns about his mental health and was transferred on 6 September to a mental health unit in Portsmouth where he remained until discharge on 12 September with a diagnosis of cocaine induced psychosis. A three-day follow-up was to be arranged by the crisis resolution home treatment service. The following day, Mr Folley presented himself at Slough police station and told an officer he wanted to cut people with knives. As a result, he was detained but later released and then travelled to Tesco's in Cosham where he told security staff that he intended to steal. The police were called and a referral was made back to St James's in Portsmouth on Thursday 14 September but as a result of causing damage at the hospital, he was arrested by police and taken to Portsmouth police station. In view of his stated mental health issues Mr Folley was placed on 60 minute observations. During a subsequent interview with an appropriate adult present, Mr Folley

	admitted to smashing windows using furniture stating that he did this as he wanted to be arrested and wanted to go to prison as he did not want to be around people. Mr Folley was charged with criminal damage at 21:11 and after caution replied "guilty". A Person Escort Record was started at 21:30 hours on 14 September and scanned into the custody record at 09:21 hours on 15 September 2017. He was remanded to appear before the next available court and the reasons given for the remand in custody was that Mr Folley had warning markers for failing to appear; 34 previous occasions when he had failed to appear at court; and an indication of self-harm or harming someone else. Mr Folley remained calm and compliant throughout his detention and there was no necessity to alter his observation levels or care plan. Due to his mental health problems, he was however treated as a vulnerable adult. He was also referred to the Hampshire Liaison and Diversion Service (HLDS) for them to research his mental health problems and visit him in the cell which he had requested. However, due to the nature of his arrest and the circumstances leading up to the incident, the HLDS practitioner declined to see him as he had just been assessed at The Orchards. This decision was documented by HLDS in the screening report which was uploaded into the custody record at 17:47 hours on 14 September 2017. The full HLDS report was also uploaded into the custody record at 08:08 the following day, 15 September. Mr Folley was taken to Portsmouth Magistrates Court on the morning of Friday 15 September 2017 and was remanded in custody to Winchester prison arriving in the evening. During the reception process, Mr Folley indicated he did not want to be in a cell in the main part of the prison and requested segregation in D wing. Initially, that was not possible but a space was found for him and he seemed content with that. Mr Folley was further assessed by a prison officer and nurse but neither deemed that an ACCT was required. Checks were carried out during the first night in prison and the following morning on Saturday 16 September there was a period of general association for all prisoners with D wing having association during the second session. Mr Folley did not come out of his cell and his cell mate, [redacted], requested to go back to his cell when he could not gain entry. When officers attended they realised the observation panel in the cell door was completely covered with paper and the door had been barricaded. Further officers were called to remove the anti barricade plate which would normally allow the cell door to open outwards but this proved difficult as the door caught on overhanging bricks in the doorway. The officers used a lump hammer to dislodge mirrors used the wedge the door shut from the inside and push back furniture near the door. When entry was gained, the officers discovered Mr Folley hanging at the rear of the cell. The officers removed the ligature made from bed sheets, put him on the bed at first and then onto the floor. Resuscitation procedures were carried out for some time including the arrival of a doctor and nurse from prison healthcare services and the use of an automated CPR machine. Paramedics attended and Mr Folley was taken to the Royal Hampshire County Hospital intensive care unit where he was placed in an induced coma. Subsequently, the hospital carried out a series of tests that showed there was no sign of brain stem activity and after discussion with his family it was agreed to withdraw organ support and Mr Folley died in hospital at 16:43 on Monday, 18 September 2017.
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. Police: Person Escort Record (PER)

At my request, Hampshire police assisted the jury in understanding the purpose and procedures involved in both the custody process and the process by which information about a person's risk of self-harm is transferred and used as they move between police custody, court and prison. [redacted] greatly assisted the court by drawing on his extensive expertise as a former custody sergeant and now an accredited trainer on all aspects of the custody process. After a short opportunity to familiarise himself with the statements provided by key police personnel as well as the documentation including the police copy of the PER he confirmed:

a) The current PER form uses carbonated paper and is a pilot system adopted by only two police forces in the UK. It has been in use for 2.5 to 3 years and a national working group has suggested moving towards an electronic system but this has not been implemented.

b) Mr Folley was assessed as NCTS (no current thoughts of self-harm or suicide) and thus placed on the lowest observation rate of 60 minutes. However, access to previous data held on police (both internal and external) and other agency systems was not available to officers completing the PER and thus they could rely on current observations only. Despite this, it was essential to consider the risk of self-harm or suicide demonstrated and recorded over the previous months (July – September) not simply since detention on this occasion.

c) Detention Officer PER training may not have been completed if a DO had many years of experience in the police force which would give what he referred to as "grandfather rights".

d) A custody officer can delegate the preparation of the PER but the custody officer should specify the risks to the detention officer and either personally speak to him or telephone. It was not known if that occurred in this case.

e) The responsibility for the completion and quality of the PER rests with the releasing Custody Sergeant. When checking the detention log in the custody record in this case, there was no specific entry. This may not necessarily mean it was not checked by the custody sergeant but if it was then that action should be recorded.

f) It is the custody sergeant's responsibility to ensure the safe transportation of a PER and associated documents by placing them in an envelope or other secure means that all documentation is safely handed over to the court custody officers.

g) The detention officer in this case would not have access to local police Information Systems in Kent or Thames Valley nor the incident on the railway line at Cosham and possibly Southampton as this may have involved British transport police.

h) The suicide/self harm warning alert (SASH) at page 9 of the PER was meant to be completed if there was a risk of self-harm or suicide since arrest or within the last month. In other words, it was felt the relevant period to be considered was not just the current period of detention but also anything relevant within a month before arrest. In this case the SASH form was never completed.

i) A heavy responsibility is placed on a custody sergeant takeaway detainees freedom and to keep a person in custody until they can be brought before a criminal court. In this case, the reasons given included that it was in Mr Folley's own interest in the sense of his own protection given his indication that if he was not remanded in custody, he would harm himself or someone else. That in itself, could be a reason to start the SASH form.

There are a number of issues that need to be addressed:

i. **Ensuring key information is included in the PER and ensuring procedures are adequately followed;**

See 1c) to 1f) and 1h) to 1i) above

ii. **Linking intelligence held on other systems;**

See 1b) and 1g) above.

iii. **Progressing the pilot to reform the PER nationally**

See 1a) above. This is the second prison death inquest I have handled where this issue was raised (Hargrave April 2017). A reply from [redacted] in June 2017 confirmed that the ownership and management of both the PER form and the pilot rests with NOMS who confirmed that they are currently working towards a digital version of the PER as a long term solution. Whilst I accept this may be complex as it involves a range of partners and IT difficulties, no progress seems to have been made to adopt an interim solution and pilot this in Hampshire and some other forces despite a further two years since my last PFD.

2. GeoAmey – Person Escort Record

During the inquest I heard from [redacted] a mental health practitioner employed by Solent NHS Trust who confirmed that when Mr Folley was remanded in custody by the magistrates at approximately 4 PM the same day she telephoned the Geo Amy staff to discuss the associated risks contained within the two HDLS reports. She was explicit that the written reports would need to be placed in the PER and raised with the booking in team at the prison. This was because she was concerned regarding the potentially escalating risk if Mr Folley's needs were perceived by him as not being met and she wanted that information to be passed to the prison staff. She specifically asked the staff to send the two court reports with the PER and her recollection was that she was assured this would happen.

I also heard from [redacted], the Head of Compliance for GEOAmey who confirmed that although officers receive initial training including the completion and handling of PER and SASH forms, the overwhelming perception created was that the police are primarily responsible for the PER and that the court custody officers merely as a courier to transport any paperwork they are given to the prison. I am concerned that the impression created was that GEOAmey staff do not actively engage in and contribute to the contents of the PER to highlight any information relevant to risk assessment irrespective of what source it comes from.

In addition, there was apparently no log of [redacted] call to the court cells. The electronic PER had been checked and nothing was logged. There is no reason to believe [redacted]s call was not made and it is of concern that there was no apparent system for logging such a call let alone action in the contents of her request.

I was also left with a concern that GEOAmey staff would only complete a SASH form if the current risk was identified during Mr Folley's detention at Portsmouth magistrates' court and not if anything came to the attention of the court detention officer to indicate there was a risk of self-harm or suicide within the last month before arrest. For example, this may become apparent from a prisoner in conversation with a court detention officer that may not have been known or recorded by the police.

This evidence raises concerns regarding systems for logging potentially relevant telephone calls; active engagement in the PER system by all GEOAmey staff; and potentially the need for improved PER and SASH training.

2. Training including speed of progress of delivering SASH/PER/ACCT training to police, court custody staff, prison officers, healthcare staff including agency clinical staff.

During the inquest, it became apparent that despite extensive questioning of police/custody staff, GEOAmey staff, prison officers and healthcare professionals, it would not be possible to establish with any degree of certainty exactly what information was available during the induction process once Mr Folley arrived at prison.

I heard from prison officers and a senior nurse involved in the reception process but there was no clarity regarding exactly what information was available to them namely, the PER itself, the HDLS reports or information that had clearly been faxed to the prison by court staff such as the warrants setting out the grounds for the remand.

The nurse confirmed that at the time of Mr Folley's reception checks he did not see the PER or HLDS reports but told me that he now does. In addition, he could not recall any specific training and the system for receipt of important medical information sounded haphazard as hardcopy documents were simply left on a desk.

During the inquest, I asked that organisations respond as soon as possible to any emerging issues particularly those likely to result in a PFD rather than waiting for this document to be released. In April 2019, I received a letter from [redacted] Patel, Clinical Director at Central and North West London NHS Trust. The Trust was commissioned to provide primary care, substance misuse and mental health services at Winchester Prison. He informed me that all new starters , permanent and agency and bank staff will receive ACCT and SASH training and that mandatory update training will also be provided. Furthermore, they have introduced management systems to carry out monitoring checks and ensure there is good staff supervision to ensure that all staff receive this training.

It is unclear exactly what progress has been made by other agencies in respect of ACCT/SASH training as well as training in reception screening.

3. **Aspects of cell safety such as mirror, furniture etc. that can be used to wedge or barricade doors. Doors with gaps to facilitate wedging and windows with accessible bars that can be used to tie a ligature. Bed sheets used to make ligatures.**

I heard evidence that prisoners are issued with plastic mirrors that are frequently used as wedges in cell doors. This means officers are vigilant to ensure prisoners only have one mirror each and if there are more in a cell than necessary they will be removed. It was suggested that a thicker mirror could be issued or a mirror/reflective panel could be inserted into the wall. This was an ongoing process of replacement in the prison.

Window design was also being considered and I was informed a trial had begun prison to roll out a new type of window but that this could take up to 2 years to complete.

it was suggested that beds and furniture could be bolted to the floor. As far as a privacy screen was concerned it would be sensible to replace with screens at three-quarter height so that it least heads or any possible ligatures could be seen. Likewise removing all sheets with double edges and replacing observation panels with metal hatches rather than glass would also assist in prisoner safety.

I also heard that steps had been taken to fit anti-ligature strips in some but not all

	cell doors. All of these suggestions seemed eminently sensible yet the pace of these changes does need to be considered. 4. **Efficiency of the systems used to regularly check that cell doors will open when barricaded from the inside** I heard evidence that every effort was made to gain quick access into Mr Folley self once it became apparent that he had barricaded the door. This was significantly hindered by painting the screws on the anti-barricade plate but significantly, by the fact that even when the plate was removed the door would not open outwards towards this landing due to a brick hanging down in the door frame. Whilst it has to be accepted that Winchester prison is not a modern prison nevertheless this should have been picked up during regular maintenance checks. I was shown some records this tended to imply that either checks had not been carried out on a regular basis or the checks themselves were not adequate. Either way this is of concern. 5. **Efficiency of radios available to prison officers and other staff i.e. the two second delay in connecting and the knock-on effect to timely relaying of information to emergency services.** There was conflicting evidence during inquest about the effectiveness of when the Code Blue call was made and whether this resulted in any delay in the information being passed to the ambulance service. On balance of probabilities, the problem seemed to come from the fact that the custody manager did give the correct callsign but because there is a two second delay when pressing the radio button this may not have been picked up immediately in the control room. This is of significant concern both in respect of the safety prison officers but also the need to obtain medical help for prisoners and suggests the need to update the radio system
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: 1. [redacted], Head of Compliance, GEOAmey; 2. [redacted], Head of Safer Custody, HMP Winchester; 3. [redacted] of Healthcare, HMP Winchester. I have also sent it to: 1. [redacted], Clinical Director for Offender Care; Central & North West London

	NHS FoundationTrust; 2. [redacted], Hampshire Constabulary. who may find it useful or of interest. I have not sent this report to Mr Folley's father given his previous poor state of health but a check will be made with the manager where he resides to check on his progress and a copy will be provided if appropriate. 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	**Date: 21 June 2017** _____ Karen Harrold Assistant Coroner Central Hampshire