M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

19th November 2019 REF: 10521

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Phil Copple** **Director General – Prisons** **HM Prison and Probation Service** **102 Petty France** **Westminster** **SW1H 9EX**
1	**CORONER** I am M E Voisin Senior Coroner for the **Area of Avon**
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/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 09/05/2018 I commenced an investigation into the death of Shaun William Dewey. The investigation concluded at the end of the inquest 18th November 2019. The inquest was held with a jury who found that ... "Shaun William Dewey died on the morning of the 13th April 2018 in his cell on 'A' Wing at HMP Bristol from compression of the neck, having suspended himself from a ligature tied to the bed frame. Shaun's own anxiety, depression and separation from his family, was exacerbated by uncoordinated supervision and erratic medication use. These were all contributory factors to his state of mind and ultimately his death. Although there were prison, health-care and mental health care systems in place to safeguard Shaun, they were insufficiently applied to prevent his death." The conclusion of the jury was recorded as: "Suicide - with narrative. Although Shaun's presentation did not necessarily signify his intent, there were instances during his remand when the systems in place failed to identify issues and act upon them, for instance a previous significant act of self-harm, which was not highlighted or picked up on, during transfer from HMP Hewell. On occasions when signs were identified, there was failure to act sufficiently and there was a tendency to close actions, before issues were fully resolved.

	In the last weeks of Shaun's life the Jury believes there were sufficient signs to warrant the opening of another ACCT."
4	**CIRCUMSTANCES OF THE DEATH** The deceased who was a remand prisoner was found hanging in his cell at HMP Bristol.
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. – During the inquest I was made aware of 2 reports the first was The Prisons and Probation Ombudsman – "Learning from PPO Investigations, Risk Factors in self-inflicted deaths in prison" published in April 2014 which was a review of deaths investigated between 2007 and 2013 and stated: • On page 12 of the report paragraph 3.1 "... remand prisoners ... made up 43% of the deaths ... but are only 13% of the total prison population" • on page 21 of the report paragraph 5.5 "...it is surprising remand is not specifically highlighted in the current context section of the list of risk factors of PSI 64/2011" Next I was referred to a Ministry of Justice document published 31st January 2019 "Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2018 Assaults and Self-harm to September 2018" this report on page 9 states "Prisoners who were in custody serving indeterminate sentences .... or were on remand (2.91 per 1,000 prisoners) had a higher rate of self-inflicted deaths than all determinate sentences .." My concern is therefore whether the risk of remand prisoners being at higher risk of self-harm or suicide should be: • considered by those designing the training for staff; • a factor generally highlighted to those caring for prisoners including prison staff and healthcare teams that is both the mental and physical health teams. • a risk highlighted on the ACCT document or • reflected in any re-draft of PSI 64/2011 national guidance – "Management of prisoners at risk of harm to self, to others and from others (safer custody)"

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 **17th January 2020** . 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 • HMP Bristol • Bristol Community Health • Avon & Wiltshire Mental Health NHS Trust • [redacted] 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.
	19/11/2019 Signature_____ M E Voisin Senior Coroner **Area of Avon**