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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. THE GOVERNOR OF HMP LINDHOLME
2. HM INSPECTOR OF PRISONS
3. THE NATIONAL OFFENDER MANAGEMENT SERVICE
4. THE INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY
5. PRISON OFFICERS ASSOCIATION
6. THE CHIEF CORONER</td></tr>
<tr><td>1</td><td>CORONER

I am Georgina Gibbs, Assistant Coroner, for the coroner area of South Yorkshire East.</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

1. On 18th October 2019 I commenced an investigation into the death of Daniel AKAM, aged 43 years.
2. The investigation concluded at the end of the inquest on 4th December 2019.
3. The jury determined that the medical cause of death was 1a Hanging.
4. The jury returned a combined conclusion of Suicide and a Narrative Conclusion in the following terms: "namely that the lack of an adequate third ACCT Case Review was considered to have possibly contributed to Daniel Akam's death."</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

1. Daniel Akam had some history of depression and self-harm when</td></tr>
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	in the community. Whilst in prison, he had a history of low mood and anxiety. 2. From 4th October 2018, Daniel Akam expressed that he was receiving threats from other inmates, and was suffering acute anxiety as a result. An ACCT was opened, and he was subsequently moved to a different wing on 8th October 2018. 3. Three days prior to his death on 10th October 2018, he made superficial cuts to his wrists and forehead, at which point he was put onto twice hourly ACCT observations. This frequency was to continue until further amendment, save a further stipulation was added following a third and final ACCT review the day before his death, on 12th October 2018, that no observation should be more than 35 minutes after the preceding observation. 4. However, this third ACCT review only lasted for between 5-7 minutes, no member of health care was present, and the assessment wrongly concluded that Daniel Akam posed a risk of harm to others rather than to himself. This was contrary to all his prison records, with which staff conducting the review had not sufficiently familiarised themselves. Furthermore, his worsened mental state was not sufficiently conveyed to health care post review *[The jury concluded that the inadequacy of this third and final ACCT review possibly contributed to death].* 5. Daniel Akam was last seen alive on an ACCT observation at approximately 8:45am on 13th October 2018. 6. The next ACCT observation due at approximately 9:15/9:20a.m. was not performed *[Although it was left as possibly contributory, the jury did not find that this factor possibly contributed to death].* 7. Daniel Akam was found unresponsive on the floor of his prison cell with a rope ligature around his neck at 9:45a.m; and declared deceased at 10:30a.m. 8. He was no longer attached to the ligature upon his discovery, and it was not possible, then or subsequently, to identify the ligature point in the cell; nor how he was able to have a rope in his cell at a time when he was vulnerable to self-harm.
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. – Failure to carry out ACCT observations recorded in the ACCT log (1) CCTV evidence in the inquest established that 18 observations on Mr Akam were not carried out. (2) The same 18 missed observations were recorded in the ACCT document as having been carried out, when they had not been.

	(3) Five different prison officers purportedly signed various of these entries. (4) Whilst the above missed observations occurred 24 hours prior to Daniel Akam's death and were not contributory, the purpose of ACCT observations is to reduce the risk of suicide and self-harm in a vulnerable prisoner. If necessary observations are missed, the risk of suicide and self-harm amongst vulnerable prisoners will likely increase. (5) The fact that the five separate officers did not carry out observations, when they recorded that they did, indicates that the problem is systemic. <u>ACCT training for prison officers</u> (6) In addition, the evidence revealed that the prison officers did not appear to know what their own obligations and responsibilities were in relation to the ACCT procedure and processes. The general evidential picture was that of inadequate ACCT training for officers, who universally indicated that it would be helpful to have refresher training. (7) Unless adequate and repeated ACCT training is provided for all officers, particularly for those junior and more inexperienced officers, the lives of vulnerable prisoners will not be safeguarded in accordance with the purpose of the ACCT procedure.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 3rd February 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:

	1. Care UK. 2. [redacted] 3. [redacted] I have also sent it to: 1. HM Inspector of Prisons. 2. The National Offender Management Service. 3. The Independent Advisory Panel on Deaths in Custody. 4. Prison Officers Association. 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	**10th December 2019** **GEORGINA GIBBS** **ASSISTANT CORONER (SOUTH YORKSHIRE EAST)**