REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Mr Phil Copple, Director General of H M Prison Service (HMPS) 102 Petty France, London SW1H 9EX • [redacted] Medical Director of Greater Manchester Mental Health NHS Trust (GMMH) Trust HQ, Prestwich Hospital, Bury New Road, Manchester M25 3BL Copied for interest to • Chief Coroner • The Family of the deceased • The PPO • Inquest Org
1	**CORONER** I am Mr Nigel Meadows – H M Senior Coroner for the Manchester City Area
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	**INQUEST** I concluded the inquest into the death of Tomasz Nowasad on the 12th December 2019 and the jury recorded that died from· 1a Hanging The Jury came to the Conclusion : **Suicide Contributed to by Neglect**
4	**CIRCUMSTANCES OF THE DEATH** The deceased was born on 16 March 1989 and was found dead in his cell A34 on A wing at HMP Manchester on 2 February 2017 at about 7 20 pm as a result of him hanging by a ligature attached to the window about 27 hours after arriving on the wing at about 4 20 PM on 1 February having been transferred from the healthcare centre (HCC) This was an ordinary wing location and in a "non-safer" cell with a number of potential ligature points His death was reported to the police and to the Coroner and an investigation into his death immediately commenced The PPO also commenced an investigation and appointed an investigator and the NHS appointed a clinical reviewer It appears that the clinical review report was completed on 10 April 2017 and the initial PPO report was published on 14 July 2017 The clinical reviewer was a registered nurse and health visitor and is a registrant panellist with the NMC The clinical reviewer says that "for the last eight years I have inspected health services which will care in places of detention including prisons, with a focus on primary care

services, mental health services and substance misuse services I have previously completed 6 clinical reviews for NHS England and the PPO "

The clinical reviewer was not a registered mental health nurse, a GP or a Psychiatrist and does not appear to have any experience of working in healthcare services as a practitioner in a category A high security prison

The Clinical Review Report

The terms of Reference are identified at Paragraph 1 01 and 1 04 identifies what are described as Key questions and at 1.04 says "the review will; examine the provision of clinical care and treatment, including both risk assessment and risk management , identify any care or service delivery failings along with the factors that contributed to these problems , identify any route cause(s) that inform the identification of learning opportunities ,make timely clear and sustainable recommendation prison healthcare provider and service , provide explanations and insight for the relatives of the deceased"

The copy of the system 1 records provided to the court amounted to 81 pages and that was within the jury bundle during the inquest The jury also had a complete copy of the ACCT and other relevant documentary evidence

The Review report is a total of 51 pages and has a chronology as appendix 2 of the review report It appears at face value to be a copy of the original System 1 records comprising paginated between 28and 51

However, the entry related to 16 January appears on pages 45 and 46 is headed "scanned from Mersey care NHS notes of "Dr C" The 23rd January note is similarly referred to and included on page 48 The last interview on 30 January is once again similarly referred to and appears starting on page 49 These entries replicate word for word [redacted] typed notes of the interviews that were obtained during the inquest but had not been seen by the court before but there is no indication whatsoever as to how these entries came to be added to the system one records or when and why the typed notes on Mersey Care NHS notepaper were not simply scanned in It would seem on the face of it that the contents have been removed from that those notes and scanned in separately

It is apparent that the reviewer was unaware or even understood the correct position and when, if at all, the healthcare staff could have had access to the full notes and considered them

The reviewer needed to be absolutely clear as to when they were actually uploaded onto the system and how they appear on the system 1 records which may be different from how they appear in appendix 2 of the reviewers report In addition exactly when they were there were uploaded, how and by whom? Why do they seem to appear in the format in appendix 2?

The reviewer had to look at both a physical healthcare and mental health care It is also said that the deceased was "admitted" to hospital under section 2 of the MHA between 20/1/16 and 25/1/16 and again between the6/4/16 and the 6/6/16

The first of those dates is correct but the second is incorrect The correct date for the next admission is between 5/4/16 and 2/5/16 He was then "detained" under section 3 of the MHA between 3/5/16 and 2/6/16 The statutory criteria for those admissions are different All of these are compulsory admissions and not voluntary GMMH were the responsible NHS Trust for the community admissions and they are also the responsible health provider for their physical and mental health when a prisoner is in custody at HMP Manchester.

The conclusions of the clinical review

The reviewers' conclusions are recorded in section 7 of the report In particular paragraphs are relevant

7 02
Having reviewed the physical and mental health clinical care extended to Mr Nowosad, I consider that the majority of care received was of a reasonable standard and was largely equivalent to and perhaps in some instances, particularly in relation to some aspects of the mental health care, better than that which he would have received in the wider community

7 06

In relation to the timing of his transfer from the healthcare unit to the main prison, Mr Nowosad had indicated on several occasions while he was on the healthcare unit, that he felt safer there and that he was frightened about how he would feel if he was moved back to a prison wing. The final decision to move him appears to have been made at least partly on the basis of him asking for this move, yet none of the records describe this request There did not appear to be any particular pressure to free up spaces on the healthcare unit at that time

7 07

Steps were taken to make Mr Nowosad's transition from the unit into the main prison as safe as possible including an ACCT review and a risk assessment before he was moved He remained on an ACCT with checks made at intervals during the day and the night and he was to have a 72 hour period of assessment on A wing However in the light of his consistently expressed fears regarding how he might feel on a main wing, it appears more might have been done to better identify the source of his specific fears and whether his mental state was as stable as it appeared In the light of his expressed fears, it might have been prudent to keep him on the unit until he indicated that the fears had receded However, I acknowledge, that even had his move to the main prison been postponed a little longer, sadly he may still have decided to end his own life, albeit at a later point

A summary of the main or significant evidence admitted and heard at the inquest and the jury's conclusion

The deceased had an established diagnosis of schizophrenia which required three compulsory detentions Mental Health Act (MHA) from January 2016 and then was alleged to have committed a serious assault shortly after his last discharge in June 2016 and in the context of him being abstinent of consumption of his prescribed medication. He was remanded in custody and arrived at Manchester prison on the 26th September 2016 GMMH was the detaining authority in the community and also provides physical and mental healthcare in the prison

During an initial health screening process conducted by a Mental health Nurse he disclosed his diagnosis of schizophrenia and that he was being prescribed Olanzapine (an anti-psychotic drug) It was recognised straight away that English was not his first language and that he would require the use of the language Line (LL) interpretation service Whilst he may have been able to speak a little English the extent of his real understanding and comprehension was a different matter and was never established during the course of his time in prison Thereafter there was intermittent use of the language LL interpretation service in contacts with healthcare staff and at subsequent ACCT reviews A repeated feature was that although he was asked regularly about self-harm or suicidal thoughts there was a lack of

understanding between some of the health care staff that prisoners will frequently deny have such thoughts or ideating but nonetheless still have those experiences and that they may not deliberately disclose this or otherwise disguise it

He saw a locum Consultant Psychiatrist on 28th September and then a mental health nurse on 29th September and then saw the same locum Consultant Psychiatrist on 13 October and although the deceased had stopped taking his prescribed medication as from 5 October but which had been initiated on 28 September The locum Psychiatrist told the court he was entirely satisfied that the deceased did suffer from schizophrenia and had exhibited genuine symptoms

It is not possible to compel a patient prisoner take medication in a prison but this can be undertaken in a mental health hospital The Court had instructed an independent Consultant Forensic Psychiatrist (Dr M) to provide expert evidence and he told the court that a symptomatic schizophrenic who refuses to take medication that was previously considered to be therapeutically beneficial was bound to deteriorate and relapse Consideration should have been given for transfer out of prison to a hospital where he can be more easily and successfully treated This would have been appropriate in the period of some months when he was abstaining from taking his medication On the 10th November he reported a Paranoid episode but an appointment to see a Psychiatrist was not progressed due to staffing levels In Dr M's opinion this was an indication of his deteriorating mental health and a sign of relapse

Another locum Psychiatrist saw him on 30th December but this Dr had only been working at the prison for approximately three weeks and had no training on the use of the LL interpretation service and was not expecting to use it when she saw him. This was despite the deceased telling her that he needed an interpreter. She tried to explain to him that he would become unwell again if he did not take his medication

9th January 2017 he presented to a mental health nurse who did use the LL telephone interpretation service He was acutely unwell voicing paranoid thoughts and auditory hallucinations and was unable to communicate in English and the nurse considered this to be another indication that his mental state had deteriorated In particular she recorded that the deceased heard voices telling him to hang himself Furthermore, that he feared if he was sent back to the wing someone would kill him. In addition it was recorded that he had made no previous serious attempt on his life

Quite appropriately an ACCT was opened to try and ensure his immediate safety He was transferred the HCC and placed in a safer cell The prison has 19 cells in the HCC , 9 of which are "Safer" cells and of those 5 have CCTV monitoring The rest of the prison has only 2 "Safer" cells and no CCTV monitored cells On the 10 January he saw the same psychiatrist who he saw on 30 December She accepted that he was psychotic the day before and he was prescribed with olanzapine which he agreed to take She did use the LL service on this occasion He voiced delusional thoughts but it was noted he disclosed to the RMN he saw the day before a presentation that would be consistent with "Thought Insertion" In addition his thoughts and voices he heard were worse in the evening

He then saw a Consultant Forensic Psychiatrist (Dr C) on the 16th, 23rd and 30th of January At the first interview Dr C recorded in the System 1 records that the deceased still had some residual delusional beliefs His subsequently prepared typed note revealed that the deceased had revealed a previous attempt to hang himself but some time before

Dr C usually works at Ashworth High Secure mental health Hospital and was employed by a different NHS Trust with whom GMMH had an arrangement for him to work at the prison usually one day a week He had done so since 2013 and his practice was to make some

brief hand written notes during his interviews and then subsequently dictate a more detailed note which was passed to his secretary to be typed up and uploaded to the HMPS System 1 medical records The original typed notes were produced to the court and Dr C's first interview record was not uploaded until 1 February and his other two not until 8 February, two days after the deceased died Consequently, they were not available to be read and considered by other healthcare staff He accepted that it was his duty appropriate clinical records as soon as possible and they should have been put on the system sooner I required him to produce his original manuscript records but he could only find those for the 16th and 23rd January but not the 30th Those notes did not accord with his typed notes and he told the court he used those and his recollections to formulate the typed note and the record was not made and recorded on System 1 at the time but only very brief notes

During his interview with the deceased on 16th January he disclosed for the first time that he had previously tried to hang himself Dr C accepted that this was inconsistent with his denial that he had any thoughts or plans of deliberate self-harm now or ever

When Dr C saw the deceased on 23rd January he could not explain why he thought a couple of weeks earlier that his brother wish to cut off his ears and take his eyes out whereas now he denied that was ever the case Dr C felt that the deceased was now responding well to his medication and that he could remain on the HCC days before being transferred back to normal location and follow-up by the MHIT. His dosage had also been increased to the maximum

The deceased had been subject to ACCT reviews on the 9th (raised risk of self-harm or suicide) and 13th of January when the risk of suicide or self-harm was recorded as being low He was further reviewed on 15th January when LL service was used and Nurse R (the HCC Deputy manager) was present and once again his risk was assessed as being low It was recorded that he was scared to return to the wing as there are people talking about him and he does not know what they are saying This was followed by another review on 21st January when once again the risk was assessed as being low The third ACCT review took place on the 22nd January and the level of risk was still assessed as being low although it was reported by him that he had no current thoughts of self-harm or suicide but still has delusional thoughts about his family The fifth review took place on the morning of the 30th January and was attended by Nurse R, the deputy manager of the HCC This took place in the morning before Dr C saw in the afternoon Nurse R recorded that the deceased disclosed no current thoughts of self-harm or suicide but the consensus of the meeting was that if he returned to the wing he would develop suicidal thoughts Deceased reported that he still felt that people were trying to hurt him The level of risk was still assessed as being low but on no occasion was there any recorded explanation as to how and why this assessment of risk had been arrived at or what factors had been taken into account

He was seen again by Dr C on the afternoon of the 30th January and Dr C considered it was appropriate for him to be discharged from the HCC to what he understood to be the own protection or vulnerable prisoners wing. However, the deceased had told him that whilst he disclosed no current thoughts of self-harm or suicide if he was moved back to a normal location he may hurt someone else or himself. In addition he felt safe on the HCC Dr C recorded in his typed note uploaded to the System 1 records after the death that "now he was better and had taken his medication that we would be unable to keep him longer term on the HCC wing as this was for the most vulnerable patients with severe illnesses who cannot be managed in another place" Furthermore "Tomasz agreed to discuss with the officers making himself a vulnerable prisoner for his own protection" This was putting the onus and responsibility of this on a schizophrenic patient whose first language was not English

Dr C accepted just because he did not report thoughts of self-harm and suicide does not mean that he was not having those thoughts or that he may still be suffering from paranoid delusions but no objectively or subjectively disclosing them. However, Dr C additionally told that the court that he understood there was a process for transfer but did not know that this involved a 72 hour period of assessment and that there was no guarantee that he would actually be transferred and that he was going to be placed in practical terms on an ordinary wing location He thought that he would be treated as a vulnerable prisoner in the meantime but still would have to be placed in an ordinary cell with a number of ligature points Dr C maintained that SO B/r was present at this interview but the officer denied this and was no record of who was present, if anyone whether they be nursing staff

When the expert witness Dr M gave evidence he told the court that the VP or Own Protection unit was not an appropriate placement in any event for a schizophrenic patient that although was improving still was suffering some symptoms In addition he would have to understand exactly where he was going to and the nature of the regime and the other prisoners he may be associating with

On the 31st January a Case review prior to discharge from the HCC was undertaken Nurse R attended once again. A member of healthcare staff who spoke Polish acted as an interpreter although he was not recognised officially as being one He told the court that he simply told the deceased that he was being transferred to A wing which he understood had been explained to him before Nurse R told the court that at this time the process and procedure for transferring prisoners was changing or had changed

She also told the court that she had not seen the typed records of his interviews with Dr C but there was very significant and important clinical information contained within them Had she been present at any interview when clinically significant information was obtained particularly relating to risk she would have made a record on System 1 and there was none to reflect any attendance by her at interviews conducted by Dr C His risk of self-harm or suicide was still assessed as being low on 1 February but had she seen and been aware of the true position and the content of Dr C's clinical records in full she would have stopped the discharge from the HCC and regarded the risk of self-harm or suicide as being high

No one from the receiving wing attended this case review although it was understood that SO B from A wing had been invited It does not appear that this officer had been interviewed and asked whether or not this was correct and, if so, why he had not attended or sent another member of staff from the wing SO O'C was the supervising officer in charge of A wing on 1 February but had not been on duty the previous day He told the court that had he been involved the previous day he would have arrange to attend himself or send a member of staff PO C was the movements officer for the wing who received a phone call indicating that the deceased was being transferred She could not remember who made the call Upon his arrival at about 4 20 PM she noted that he was on for daily observations four at night but did not read the act or the ACCT file or the recent case reviews Neither did SO O'C The deceased was placed in a cell on his own because he had a high risk CSRA He had a handful of contacts with the wing staff that day and on 2 February he was last seen by PO C at about 5 pm and she had an interaction with him but made no record of this in the observation log

At about 7 20 pm two prison officers went to his cell to get a spare mattress from it and discovered him hanging by a torn bed sheet attached or secured to the window. There were no safer cells on the wing He was cut down from the ligature and that was removed The alarm was raised and other prison officers and then healthcare staff arrived Extensive efforts were made to resuscitate the deceased which continued when paramedics arrived and continued thereafter Unfortunately this proved unsuccessful and he was pronounced officially dead about 8·15 pm.

	The Court appointed expert witness Dr M told the court that consideration for him to be transferred out of prison to a hospital should have been given when he was refusing medication and it was very likely that this would have been almost certainly accepted Dr C had made the decision to discharge the deceased from the HCC on a complete misunderstanding of the correct position with regards to the transfer process and the belief that the deceased was not going to an ordinary wing location when he had indicated he felt safe on the HCC and was then located in an ordinary cell. Dr M described this as a perfect storm of misunderstanding Whilst it was not possible to predict with certainty that the deceased would have killed himself exactly when it was predictable that transferring him off the HCC in the circumstances and to what was an ordinary wing location would inevitably increase the risk of self-harm or suicide It was also not clear that the deceased understood the nature of the wing he was going to or regime and this was reinforced because of Dr C's misunderstanding The jury returned a conclusion of Suicide contributed to by Neglect In the context of a prison death this is a high threshold reach Their determinations of how the deceased came by his death were critical of several aspects of his care management and were recorded in some detail
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 The below specific issues of concern could have wider application throughout the whole prison estate rather than simply being regarded as local to Manchester prison 5 1 The context of this case has to be seen in the light of the fact that in 2019 two self-inflicted deaths happened at HMP Manchester There were four in 2018 and my records indicate that there have been 29 from the beginning of 2006 up to date In view of the evidential issues highlighted above it is suggested that there has been a repeated theme in the majority of these cases that there was an over reliance and emphasis on the assertions made by a prisoner that they "had no thoughts of self-harm or suicide" This is often simply recorded in ACCT reviews by ticking boxes on the review document. Whilst it is appropriate for this issue to be addressed whenever a prison is on an ACCT either by healthcare staff or at ACCT reviews because in many cases prisoners still go on to harm themselves or commit suicide It should not be regarded as definitive This was recognised and recorded in the latest PPO Investigation Report relating to a death that occurred on 5 April 2019 This was specifically referred to in paragraph 26 of the report which said *"In previous investigation into self-inflicted deaths at Manchester, we identified weaknesses in the risk assessment of prisoners at risk of suicide and self-harm We found in particular that staff placed too much emphasis on prisoner's presentation and did not give sufficient consideration to their risk factors"* 5 2 PSI-64/2011 recognises that there are a number of potential triggers to self-harming behaviour or suicide All staff should be alert to the increased risk of self-harm or

suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary However, it is suggested that the list of factors is not exhaustive and everything neds to be considered in light of the overall picture This will usually involve discipline staff and health care staff It is suggested that thereafter, particularly if the prisoner is moved to the HCC, considering all the risk factors and the changing position taking into account the previous recorded history of the prisoner from both a health care and general prison service records. This is especially so when ACCTs are being reviewed and a prisoner is being discharged from the ACCT or moved out of the limited number of safer cells available in the prison There has to be consideration of the overall or 'big picture' with regards to the risks that the prisoner poses

5 3 It is suggested that whenever an assessment of risk of self-harm or suicide is undertaken there is a written record made of the factors or issues involved in this or what weight or consideration was given to them and how the risk assessment was arrived at It is suggested that it would be appropriate for GMMH and HMPS to ensure that this is introduced

5 4 It appears that there was no consistent use of the language line interpretation service by HMPS or GMMH staff, and it is suggested that wherever an identified need for the use of this service is recognised it should be used on all healthcare interviews as well as at ACCT reviews While some prisoners may speak some, little or virtually no English, it is essential that every effort is made to ensure that they can understand, so far as it possible, the issues being raised and discussed with them.

5 5 It is suggested that there was an absence of timely, full and accurate clinical record keeping by members of GMMH healthcare staff (whether they be healthcare assistants, nurses or doctors) This is a professional requirement under GMC Good Practice and the NMC code of conduct It is suggested that steps are taken to ensure this is completed in all cases and appropriate audits undertaken to check on this.

5 6 It is suggested that whenever there is a healthcare interaction with a patient prisoner and more than one healthcare member of staff is present, their identities should be recorded and all clinically relevant information is included within the System One records and checked between those present as being full and complete

5 7 It is suggested that whenever there is a healthcare interview and a member of prison discipline staff is present, records should be kept by GMMH and HMPS of who was there, but also HMPS staff should record separately within their records evidence and information relevant to the risk of self-harm or suicide

5 8 It is suggested that whenever there is a decision made to move a prisoner who is subject to an ACCT from the HCC to another location in the prison, prison staff of the receiving wing should ensure that they attend any final case reviews prior to discharge so that they are familiar with the relevant history and risks that the patient prisoner presents, make appropriate documentary records and ensure that relevant information is handed over to colleagues

5 9 It is suggested that receiving HMPS staff should ensure that they read and consider the ACCT file with particular emphasis on the assessment of risk of self-harm and suicide and how it has been managed to date and whether or not that needs to be reviewed on arrival Any concerns should be escalated

5 10 It is suggested that GMMH and HMPS staff should ensure as is far as is reasonably possible that the patient prisoner has a real understanding and comprehension of the

	reasons for transfer and a regime to which they are going, particularly if they have been moved from the HCC when they occupied a safer cell but were going to an ordinary cell with a number of ligature points The staff themselves have to have a clear understanding of the reasons for transfer and what the new wing regime or locations means for the prisoner and whether or not it is appropriate Records should be kept of the reasoning and justification 5 11 It is suggested that there should be an auditable process of ensuring that all appropriate information is handed over between different shifts of GMMH and HMPS staff so that there is a continuity and consistency of available information 5 12 It is suggested that GMMH staff should ensure that when they have any clinical interactions with patient prisoners they familiarise themselves with all the developing relevant medical history including recent events and record what they have reviewed or considered 5 13 It is suggested that since that the overwhelming majority of prisoners who kill themselves do so by ligatures particular care should be taken when prisoner who is on an ACCT is moved from a safer cell to an ordinary cell and their ACCT should be carefully reviewed and the number , type and frequency of observations Prisoner can quickly get used to the regularity of observations and undertake self-harming or suicidal behaviour when they think they will not be seen or have contact from HMPS or GMMH staff 5.14 It is suggested that HMPS should consider increasing the number of Safer cells throughout the whole of the prison and also having more CCTV monitored cells. 5 15 It is suggested that it is not appropriate for GMMH clinical or Nursing Staff to put the onus or responsibility on a prisoner to interact with HMPS staff to try and understand why they may be moving from one location to another without both being present and the language line service used to try and ensure no miscommunication and that appropriate written guidance should be given to all staff 5 16 It is suggested that it is not appropriate to indicate to a patient prisoner that they are not so ill or vulnerable as others in considering a move out of the HCC because that may influence their cooperation and disclosure of their symptoms and presentation It is suggested that guidance is issued to GMMH staff about this
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 the 2nd March 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 Interested Persons I have also sent it to organisations who may find it useful or of interest 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:** **NAME OF CORONER:** **Dated : 20th December 2019** **Mr Nigel Meadows** HM Senior Coroner for Manchester City Area **Signed:**