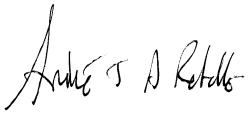
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Secretary of State for Justice** 102 Petty France London SW1H 9AJ
1	**CORONER** I am André Joseph Anthony Rebello, Senior Coroner, for the area of Liverpool and Wirral.
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** On 29th January 2015 I commenced an investigation into the death of **Lee Stewart RUSHTON**, Aged **24**. The investigation concluded at the end of the inquest on 9th-13th May and 16th -19th May 2016. The cause of death was: 1a Hanging The Jury concluded: Lee Rushton died from an Accidental death contributed to by neglect. Mr Rushton was in a dependant position due to mental illness and incarceration. There was a failure to provide and procure basic medical attention. Lee not being discussed at the Single point referral was a gross Failure. The failure to provide medical attention to meet his needs could have saved or prolonged his life. Findings which more than minimally, trivially or negligibly contributed to his death • Failure for single point Assessment • The lack of consistent and sufficient mental health assessment • Assumption of others • Vulnerable prisoner in a single cell • Failure to take action based on observation in ACCT • The lack of understanding or sufficient explanation for Lee about P.P.U. • Inability to send a message.

4	**CIRCUMSTANCES OF THE DEATH** Lee Stewart Rushton died at 14.12 pm on the 28th January 2015 in Cell 13 on the third level of I wing at HMP Liverpool. This was his first time in prison having arrived on the evening of the 22nd January 2015. He was found hanging from a ligature fashioned from a blanket. The Jury found, "We find it is more likely than not the case Lee Stewart Rushton put himself in the position in which he was found but that he did not intend to end his life. Due to not receiving adequate mental health care and a number of missed opportunities we are unable to determine whether Lee acted with intent and of his own free will. A real and imminent risk of self-harm or suicide was recognised on his reception into the prison by the opening of an ACCT. however the risk was not managed adequately and effectively during Lee's time under their care. The ways in which we deem this risk to be inadequate and ineffective managed are; • Failure for Lee to be discussed at the single point assessment meeting despite being referred on 2 separate occasions. • Failure to recognise Lee's level of vulnerability during first case review as a part of the ACCT process. • Failure to fully explain the P.P.U. system to Lee properly which removed a major protective factor. • Ineffective use of cell share assessment leading to a vulnerable adult being left alone at a higher risk of self-harm/suicide. • Distinct lack of communication which resulted in Lee's mental health care not being addressed. • The procedures under the ACCT system were not followed or managed appropriately. • Missed opportunities to increase observations on multiple occasions. • Multidisciplinary approach to the ACCT failed. Ambiguity over who is responsible for actions within the ACCT. • Distinct lack of ownership of issues arising from the ACCT. • Numerous flash points when an ACCT review could have been called but were missed. • Incorrect completion of forms where actions were noted as complete but were not, i.e. Care map. • Failure to record actions on ACCT.

	• Significant observations and issues recalled on testimony not logged within the ACCT. Mr Rushton's drug dependency presentation was recognised initially, however the management was inadequate. • Missed methadone treatments. • Difference between medical opinions resulting in different withdrawal treatments on different occasions. • Lack of recording for medical decisions made. As a result of lack of continuity of treatment for drug dependency added stress or anxiety that more likely than not contributed to his intentions concerning self-harm or not. There was not an adequate or effective assessment of Mr Rushton's mental health in addition to drug dependency presentation. The effect of drug dependency on Lee's mental health was not addressed sufficiently. On 23rd January 2015 injuries sustained by Lee Rushton on H Wing were not appropriately investigated. • No evidence available in regards to investigation of the situation. • On the balance of probability it is more likely than not the incident added to Lee's vulnerability given his mental state. • Expressed feelings of fear documented in C.NOMIS
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. **When a prisoner is on an ACCT (Assessment, Care in Custody and Teamwork) and a CSRA (Cell Sharing Risk Assessment) indicates an inmate should be in a cell alone for the protection of others. What consideration should be given to the ACCT Care plan with regard to a mandatory ACCT review? Should this already be covered in policy or guidance consideration should be given to reminders being issued and or if necessary mandatory training across the prison estate in the light of the jury's findings.**
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 **15th July 2016**. 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 [redacted] Rushton (Lee's parents) HMP Liverpool MerseyCare NHS Foundation Trust Lancashire Care NHS Foundation Trust I have also sent it to [redacted], NOMS 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **Dated: 19th January 2016**