REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Governor [redacted], HMP Belmarsh** **2. [redacted], Director General for Prisons, HM Prison Service**
1	**CORONER** I am Henrietta Hill QC, assistant coroner for the coroner area of Inner South London.
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** Jason O'Rourke died on 2nd April 2019 at HMP Belmarsh, aged 34 years. An investigation into his death was commenced. The investigation concluded at the end of the inquest on 21st January 2021. The jury found that the medical cause of Mr O'Rourke's death was hanging. Their conclusion was that he died by suicide, to which a series of factors possibly contributed, as explained further under section 4 below.
4	**CIRCUMSTANCES OF THE DEATH** Jason O'Rourke died in his single occupancy cell on House Block 3 in HMP Belmarsh at some point between 7.28 pm on the 1st April 2019 and when he was found at 9.33 am on 2nd April 2019, hanging from the window bars in his cell using a ligature made from a bedsheet. He had clearly been dead for some time. No one had entered Mr O'Rourke's cell overnight. The roll checks scheduled to take place at 9.00 pm on the night of 1st April 2019 and 6.00 am on the morning of 2nd April 2019 had not been carried out, although it cannot be said that had those checks been done, the outcome would have been any different. Prior to his death Mr O'Rourke had chosen to self-isolate in his cell. The jury found that Mr O'Rourke's suicide was possibly contributed to be the following factors: (i) The serious failure to take further steps with respect to Mr O'Rourke's mental health after the Primary Care Mental Health Nurse's attempt to triage him on 8th March 2019; (ii) The fact that healthcare staff did not provide sufficient information about Mr O'Rourke's mental health to prison staff during the month that he was resident on House Block 3; (iii) The fact that prison staff on the wing did not have sufficient understanding of Mr O'Rourke's mental health history and his history of self-harm from (a) information received from healthcare; (b) the information on the Cell Sharing Risk Assessment and (c) information on the OASYS record; and (iv) The fact that the Safety Intervention Meetings in March 2019 were an inadequate way of addressing the issue of self-isolation and risk in relation to Mr O'Rourke.

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 could 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) The 'immediate needs' form completed for prisoners on arrival at HMP Belmarsh does not facilitate a clear assessment of any risk of self-harm or suicide and the actions to be taken if such a risk is identified. The form poses a question: "*Is there any specific concerns re self-harm or suicide?*" and then gives the guidance "*If yes, amend care plan*". However, this guidance is only effective for those prisoners who already have a care plan, meaning those who are already on an open Assessment, Care in Custody and Teamwork ('ACCT') plan. The action to be taken for those prisoners where specific concerns regarding self-harm or suicide are identified, but who do not already have a care plan, is unclear from the form. It is also unclear how the above question interacts with further questions below it which address any past ACCTs/F2052SHs, the level of support available to the prisoner and the answer the prisoner gives to the question "*Do you feel suicidal now?*" Accordingly, this form does not sufficiently highlight prisoners who are in fact suicidal, or where there are concerns about their risk of self-harm or suicidal, to those on the wing. (2) The nightly roll checks at HMP Belmarsh are due to be carried out by a single member of Operational Support Grade (OSG) staff at 9.00 pm and 6.00 am. Their stated purpose is to check for escape or death among the prisoners. On handing over to the morning staff, the OSG signs paperwork indicating that the roll checks have been completed. There is no robust system by which the prison management audit this process. This means that the prison management can be under the impression that the checks have been carried out, when they have not been, as occurred here.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 7th April 2021. 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) The family of Jason O'Rourke (2) The member of OSG staff on duty on the night of 1st/2nd April 2019 (3) Oxleas NHS Foundation Trust. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**10th February 2021** Henrietta Hill QC