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:** **1. The Governor, HMP Long Lartin, South Littleton, Evesham, Worcestershire.**
1	**CORONER** I am David Donald William Reid, Senior Coroner, for the coroner area of Worcestershire
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 20.2.19 an investigation was commenced into the death of Geoffrey Harrison HUTTON, a prisoner at HMP Long Lartin, who died at the prison on 8.2.19, being 39 years of age. This investigation concluded at the end of the inquest on 27.5.21. The medical cause of death was: 1a Hanging by ligature. The conclusion of the inquest was as follows: *"Geoffrey Hutton died as the result of suicide.* *(a) HMP Belmarsh's failure to respond to HMP Long Lartin's email of 21.12.18, asking for a copy of their social care plan for Mr. Hutton, possibly caused or contributed to Mr. Hutton's death;* *(b) The Safer Custody team at HMP Long Lartin's failure to follow up that request with HMP Belmarsh possibly caused or contributed to Mr. Hutton's death;* *(c) HMP Long Lartin's failure to carry out a social care assessment or make a social care referral to the local authority probably caused or contributed to Mr. Hutton's death;* *(d) HMP Long Lartin's failure to complete the Caremap action in Mr. Hutton's final ACCT document, which required a referral to social care by the Safer Custody team, probably caused or contributed to Mr. Hutton's death;* *(e) HMP Long Lartin's failure to provide adequate support to Mr. Hutton in relation to his hearing and communication needs, and make reasonable adjustments accordingly, probably caused or contributed to Mr. Hutton's death."*
4	**CIRCUMSTANCES OF THE DEATH** Mr. Hutton hanged himself in his cell at HMP Long Lartin on 8.2.19, having made a ligature from the drawstring of a laundry bag. He had a significant hearing impairment, with cochlear implants in both ears; when those implants were not working he was profoundly deaf. He also had recognized longstanding mental health and substance

	misuse issues, in respect of which he was having regular contact with the Inclusion team in prison. At the time of his death, he was the subject of an ACCT document which had been open for some 2 weeks – his second ACCT since his arrival at HMP Long Lartin on 19.12.18. Mr. Hutton frequently expressed feelings of isolation and concern over his inability to have contact with his family and partner because of his hearing difficulties, and on several occasions self-harmed or threatened to self-harm because of the frustration he felt about this. At the time of his death, no social care referral had been made and therefore no social care plan was in place which identified and sought to meet his needs which resulted from his hearing issues.
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. – (1) **No social care referral** had been made for Mr. Hutton, despite the need for one having been identified soon after his arrival at HMP Long Lartin. This was because no effective system for making such referrals to the relevant Local Authority appeared to be in place at the prison at the time of these events. The Safer Custody team were responsible for making such referrals, but members of that team suggested in evidence that they had insufficient time to deal with such issues. The Safer Custody lead at the time of these events gave evidence as follows: (a) a social care referral, on the correct form as per the prison's Adult Safeguarding Policy, was never made; (b) such a referral should have been made within days of Mr. Hutton's arrival at the prison; (c) he was unable to explain why the system had broken down, but agreed that officers within his team had then, **and continue to have** insufficient time to devote to Equality & Disability issues; (d) there is still no training in place to ensure that officers are able to identify the need for a social care referral, and know how to make such a referral. (2) **There appears to be no effective system for allocating ACCT Case Managers** at HMP Long Lartin. The officer (Officer A) who, when she opened the final ACCT document for Mr. Hutton, appointed herself as Case Manager for this ACCT, did so knowing that she would have no contact with him over the following two weeks. Officer A gave evidence that: (a) this was common practice at the prison; (b) officers were discouraged from not naming a Case Manager when they opened an ACCT, even if (as here) it was opened at night; (c) she was hoping that another officer might "take it over" from her. As she predicted, she herself did indeed have no further contact with Mr. Hutton. Furthermore, this problem was not passed on or identified, and no other officer took over the Case Manager role. Therefore there was no effective oversight of an ACCT involving a potentially very vulnerable individual. **Of particular concern** is that another officer appears to have filled in Officer A's details in the "name" and "signature" boxes at the foot of the ACCT Caremap, and dated them 7.2.19 (the day before Mr. Hutton's death), thereby giving the impression that Officer A had reviewed and satisfied herself that the actions identified in the Caremap had been dealt with. In fact, the most important action on the Caremap, which required a social care referral, had not been completed.

	This lack of effective oversight was not confined to Mr. Hutton's final ACCT document. For his first ACCT document at HMP Long Lartin, only a month earlier, the named Case Manager had no involvement with it until the fourth ACCT Case Review, and made no entries on the Caremap (which was signed off by a different officer). I heard evidence from a member of the current Senior Management Team at the prison that: (a) there is currently no formal training for the allocation of, or fulfilment of the duties of the ACCT Case Manager role; (b) this will be reviewed, and training will be organised. **The lack of an effective ACCT Case Manager, who is able to provide proper oversight of an ACCT, is an issue which was raised by me in a previous Report to Prevent Future Deaths which followed the death of another prisoner at HMP Long Lartin (David KIRSCH – report dated 30.10.19)** (3) **Not all prison staff who carry out ACCT observations on vulnerable prisoners at night have received ACCT training.** This issue became apparent when the Operational Support Grade member of staff (OSG) who found Mr. Hutton on the morning of his death gave evidence to the inquest. Not only had he not received any training about the ACCT procedure at the time of these events, that remains the case now. I heard evidence from a member of the current Senior Management Team at the prison that OSGs are currently required to carry out ACCT observations at night, but that ACCT training for them is not mandatory and some have therefore not received such training. It is of concern that those carrying out potentially critical observations on very vulnerable prisoners may not be aware of what the ACCT procedure involves, or what it may require of them if they have any concerns about a prisoner.
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 by conducting an investigation into the deficiencies and failures outlined above, and by conducting a review of the social care referral process and the ACCT process within your prison.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30.7.21. 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: Hodge Jones & Allen solicitors, who represent Mr. Hutton's family; Hill Dickinson LLT, who represent Practice Plus Group and the Midlands Partnership NHS Foundation Trust; Government Legal Department, who represent HM Prison Service; The Prison and Probation Ombudsman.

	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	**Signed**  **D. D. W. Reid** **4th June 2021** **H.M. Senior Coroner for Worcestershire**