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 Hewell, Hewell Lane, Redditch, Worcestershire;** **2. The Head of Healthcare at HMP Hewell, c/o Practice Plus Group.**
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 11.7.19 an investigation was commenced into the death of Colin BLACKBURN, a prisoner at HMP Hewell, who died at the prison on 6.7.19, being 53 years of age. This investigation concluded at the end of the inquest on 16.9.21. The medical cause of death was: 1a ligature suspension. The conclusion of the inquest was as follows: *"Colin Blackburn died as a result of deliberately suspending himself by a ligature. It is not possible to determine what his intention was at the time he did this.* *A failure adequately to assess Colin Blackburn's risk of suicide and/or self-harm at the case review of 4.7.19 probably caused or contributed to Mr. Blackburn's death.* *A failure to take sufficient action to meet the risk of suicide and/or self-harm which Mr. Blackburn presented at the case review of 4.7.19 probably caused or contributed to Mr. Blackburn's death."*
4	**CIRCUMSTANCES OF THE DEATH** At the time of his death Mr. Blackburn had spent 15 days on remand at HMP Hewell awaiting trial in respect of an offence of serious violence. An ACCT document had been opened on the day he arrived at the prison, as he had expressed thoughts of taking his own life; this remained open until his death. In those 15 days, there were 3 separate incidents in which Mr. Blackburn was found with a ligature around his neck. He spent some 8 days in the Inpatients Unit, initially on constant watch, after the first of those incidents. His death on 6.7.19 therefore represented the fourth occasion on which he had self-ligatured.
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) The Record of Inquest has recorded 14 separate failings in respect of Mr. Blackburn's ACCT document and his risk of suicide/self-harm, all of which were accepted by H.M. Prison Service:
   (a) that no Initial ACCT Case Review was held within 24 hours of the Concern & Keep Safe form being completed on 21.6.19;
   (b) that no entries were made on the Care Map until 26.6.19;
   (c) that no triggers or warning signs have been entered on the ACCT's inside cover;
   (d) that no ACCT Case Manager was assigned until 26.6.19;
   (e) that no ACCT Case Manager had any effective involvement after Mr. Blackburn was transferred from the Inpatients unit to Houseblock 6 on 2.7.19;
   (f) that ACCT Case Reviews were often not multi-disciplinary, with healthcare and mental healthcare sometimes not being invited to attend;
   (g) that the Care Map was not reviewed at some ACCT Case Reviews;
   (h) that those conducting ACCT Case Reviews did not familiarize themselves sufficiently with the ACCT document beforehand;
   (i) that on several occasions, over several hours, the level of observations required under the ACCT document were not carried out;
   (j) that the first ligature incident on 2.7.19 was not documented on Mr. Blackburn's NOMIS record;
   (k) that no ACCT Case Review took place after the first ligature incident on 2.7.19;
   (l) that there was no ACCT Case Review immediately before Mr. Blackburn's transfer from the Inpatients unit to Houseblock 6 on the evening of 2.7.19, given particularly that Mr. Blackburn had been expecting a transfer to Houseblock 5;
   (m) that the second ligature incident on 2.7.19 was not documented on Mr. Blackburn's NOMIS record; and
   (n) that the ACCT Case Review arranged for 3.7.19 did not in fact take place until 4.7.19.

   I heard evidence that:

   - These issues arose because prison staff had so many demands on their time, mainly due to number of prisoners they had to deal with;
   - Since then, the population of the prison has reduced, and more new staff have been taken on;
   - New systems have been put in place regarding the management of ACCT document, the training for which was suspended during the Covid-19 pandemic; and
   - A new version of the ACCT document was implemented in July this year, training for which has been provided to roughly a third of prison and healthcare staff at the prison.

   I am not satisfied that sufficient action has yet been taken to ensure that all members of prison staff understand their obligations in respect of prisoners who are subject to the ACCT process. This is because:
   (i) there is no evidence yet that the changes described above have led to a change in how prison staff deal with ACCT documents; and
   (ii) I heard evidence during the inquest from a number of senior officers who, even now, found it difficult to comprehend that their involvement with Mr. Blackburn and his ACCT document fell short of an acceptable standard.

	2) On 4.7.19, a prison officer, who had concerns about a significant deterioration in Mr. Blackburn's mental state, submitted a paper TAG referral to the Mental Health team at the prison via the internal post. There was a delay in that referral reaching the Mental Team, with the result that it was not opened until after Mr. Blackburn's death. Had it been opened sooner, the court was told that an urgent mental health assessment would have been carried out. I heard evidence from the Head of Healthcare at the prison that urgent TAG referrals can currently be made by email, phone or on paper via internal post. If made late on a Friday or over a weekend, there was no guarantee that the mental health team would pick up the referral until after the weekend; instead, the referral should be made to a member of the healthcare team on duty that weekend, who would then phone Practice Plus Group's regional on-call manager. I received no assurance that prison staff wanting to make an urgent TAG referral over a weekend knew that this was the process to follow, and heard that there is currently no divert service in place, so that if a member of staff tries to make an urgent referral by phone or email over the weekend, they are redirected to the correct pathway. The paper referral system, which relies upon the internal post at the prison, is still in place although, I am told, it can be stopped. In my view, there remains uncertainty amongst staff at the prison about the right way to make an urgent TAG referral to the mental health team, particularly at weekends. There is a risk therefore that a prisoner whose mental health deteriorates significantly during a weekend may not be properly assessed in time for action to be taken to address any risk of suicide or self-harm which he may present.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12.11.21. 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: Hill Dickinson LLP, who represent Practice Plus Group; Capsticks LLP, who represent 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** **17th September 2021** **H.M. Senior Coroner for Worcestershire**