Mid Kent and Medway Coroners
Cantium House
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Kent
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[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Lee Ryan THRUMBLE (died 18 April 2018)

	THIS REPORT IS BEING SENT TO: The Rt Hon Sajid Javid MP Secretary of State for Health and Social Security 39 Victoria Street London SW1H 0EU
1.	**CORONER** I am Scott Matthewson, Assistant Coroner for the coroner area of Mid Kent & Medway.
2.	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3.	**INVESTIGATION and INQUEST** On 1 May 2018 the Area Coroner for Mid Kent & Medway commenced an investigation into the death of Lee Ryan Thrumble who died, aged 26, on 18 April 2018 at the Medway Maritime Hospital, Windmill Road, Gillingham, Kent ME7 5NY.

	The investigation concluded on 26 August 2021 at the end of an inquest, conducted by me sitting with a jury. The jury concluded that Lee, who was a prisoner at HMP Rochester at the time, had died as a result of *"Suicide to which failures to meet Lee's mental health needs contributed and to which failures to respond adequately to Lee's deteriorating behaviour in March and April 2018 contributed."* The medical cause of death was: Ia. Hypoxic Brain Injury and Pneumonia Ib. Cardiac Arrest (resuscitated) Ic. Partial Suspension II.
4.	CIRCUMSTANCES OF THE DEATH Lee was a serving prisoner at HMP Rochester when he suspended himself by the neck whilst in a cell in the Segregation Unit at HMP Rochester on 17 April 2018. Lee had been recalled to prison on the 2nd January 2018. Whilst at HMP Elmley he was put on an Assessment, Care in Custody and Teamwork ("ACCT") plan. He was referred to mental health services on 17 January 2018. His mood stabilised with treatment and support from the mental health team. However, the fact that Lee was under the care of the prison mental health team at HMP Elmley was not recorded on relevant systems and so, when Lee was transferred to HMP Rochester, he was not provided with any mental health support. In addition, a previous referral for 1-1 psychology treatment was not communicated effectively to the receiving prison. On arrival at HMP Rochester Lee did not receive a health screening within 24 hours of arrival. When the health screening was carried out, sufficient time was not allocated which led to health issues being recorded inaccurately. The jury found that: *"There was also a lack of training at this prison which led to a failure to record and review information effectively. Lee did not receive a meaningful clinical interaction after the initial health screening and prior to being found partially suspended on the 17/04/18. This is a failure within the system. Lee's mental health needs were not met appropriately at this prison and this more than trivially contributed to his death on the balance of probabilities. There was a deterioration in Lee's presentation in March/April 2018 for example refusing to work, distancing himself from others and appearing quieter. Adequate steps were not taken to support his deterioration and this contributed to Lee's death."*

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: Evidence was given by a Prison Service Governor and HMP Rochester, the Head of Healthcare at HMP Rochester and (by letter) Prison-NOMIS Application Support And Change Manager that: (1) Critical information relating to prisoners contained on his Prison National Offender Management Information System ("NOMIS"). (2) Prison Service staff and clinical staff working with prisoners are permitted to (and need) access NOMIS in order to keep prisoners safe. (3) Use of NOMIS is restricted to those who have been trained to use it (via a short online course known as the 'Getting Started' module). Once the online training has been completed the person is issued with a certificate. That certificate is then provided to the MOJ Business Application Support Team / Justice Digital & Technology. That department then issues the person a NOMIS username and password. The turnaround time is usually two days. (4) Whilst all prison staff were trained in the use of this system and were able to access it, only some clinical staff are able to access NOMIS. (5) The reason that all Prison Service Staff were able to access NOMIS was because training in the use of NOMIS is a compulsory part of their training. (6) The reason that only some clinical staff could access NOMIS was because it is voluntary (although encouraged and supported by the MOJ). (7) If NOMIS training was a compulsory part of training for all clinicians working with prisoners: a. It is likely that most (if not all) nurses would be able to access NOMIS within a relatively short period of time.

	b. Prisoners would, as a result, be safer. c. The Business Application Support Team / Justice Digital & Technology at the MOJ would welcome and support such training (see attached letter from [redacted] from that team dated 3 September 2021). I am concerned that: (a) Lee died partly because of a lack of training which prevented staff from accessing and reviewing information. (b) NOMIS contains important information that can be of use to clinical staff when looking after prisoners. (c) Not all nurses can access NOMIS because it is not a compulsory part of their training. (d) The NOMIS training is already available, can be completed online and access to NOMIS can be gained within two days. (e) If the current situation continues there is a risk that prisoners may die as a result. This situation should be reviewed and consideration given to whether NOMIS training should be made compulsory for clinicians working within prisons in England and Wales.
6.	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 4 November 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 following: • HHJ Thomas Teague QC, the Chief Coroner of England & Wales • Mr Thrumble's family • HMP Elmley • HMP Rochester • Oxleas NHS Foundation Trust • Integrated Care 24 I am 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.	Signature:  Scott Matthewson, Assistant Coroner, Mid Kent & Medway 10 September 2021