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.** Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care **2.** Victoria Atkins MP, Minister for Prisons and Probation **3.** [redacted], Chief Executive Officer of Her Majesty's Prison and Probation Service **4.** [redacted], Chief Executive Officer of NHS England **5.** [redacted], Chief Executive Officer of NHS Digital
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 26th March 2018, an investigation was commenced into the death of Anthony John Clacher, born on the 19th May 1981. The investigation concluded at the end of the Inquest on the 19th October 2021. The Medical Cause of Death was: [redacted] The conclusion of the Inquest recorded by the jury was a narrative conclusion that Anthony [redacted], but he was not capable of forming an intention that the outcome be fatal due to his mental health state, lack of general observations and use of illicit substances.
4	**CIRCUMSTANCES OF THE DEATH** On the 21st March 2018 Anthony, a serving prisoner at HMP Guys Marsh, was found [redacted] in his cell, C43 on the Dorset Unit at the prison.
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. During the inquest evidence was heard that:

   i. At the time of Anthony's death, the use of psychoactive substances was a problem at HMP Guys Marsh as it was, and continues to be, across the prison estate. Psychoactive substances were said to be the most dangerous drug in prison. They can have both physical and mental impact upon the user and in themselves can cause death as well as an increase in suicidal ideation.

   ii. Approximately 2 hours 25 minutes before Anthony was found [redacted] in his cell, he was found under the influence of psychoactive substances. He was attended upon by healthcare professionals and prison staff and placed in his cell. At the time there was no policy in place regarding welfare checks to be undertaken upon somebody found under the influence of psychoactive substances and the prison staff would rely upon guidance provided by the healthcare staff.

   iii. Observations afford the opportunity of monitoring the prisoners for physical and mental health deterioration and an opportunity to observe preparatory acts for self-harm. There are known risks associated with a person being found under the influence of psychoactive substances and they include the risk of vomiting and choking, seizures, heart attack or a significant deterioration in their mental health.

   iv. There is no national guidance of how to monitor a person in prison once they have been found under the evidence of psychoactive substances.

   v. Following this, and other deaths associated with psychoactive substance use at HMP Guys Marsh, they have developed a local policy of prison officers undertaking welfare checks when a person is found under the influence of Psychoactive substances. In these circumstances a welfare checks log is started, and that person will initially remain under 15 minute observations. If there is no concern after an hour the observations will be reduced to hourly for a 24 hour period. Evidence was given that this has undoubtedly save lives at HMP Guys Marsh.

   vi. In addition, HMP Guys Marsh have developed another local initiative called the Persistent Psychoactive Substances Intervention Plan (PPSIP). This initiative is used where a prisoner is using psychoactive substances persistently and therefore requires further support and monitoring due to an increased risk of harm. Evidence was given that this initiative has undoubtedly reduced deaths at HMP Guys Marsh.

vii. The third initiative HMP Guys Marsh has adopted under local procedures is the Custodial Officer Intermediate Life Support (COILS) initiative. This is a joint initiative between the healthcare and prison staff where the healthcare teams have trained the prison staff in life saving and supportive care. The staff are trained on certain medical processes including the ability to take vital observations, use certain medical equipment, for example a suction machine, and have access to an emergency kit bag to provide more than basic life support to prisoners. The benefits of this system are that the prison staff themselves can provide more advanced care in the absence of healthcare professionals. In addition, when healthcare professionals are in attendance, the healthcare professional can take the lead in advising and making decisions regarding care, whilst the support is provided by prison officers. It was described as similar to when a lead paramedic is on scene supported by paramedics and emergency care assistants. Evidence was again given that this has undoubtedly saved lives at HMP Guys Marsh.

viii. Evidence was given that the role out of these initiatives across all prisons in England and Wales would prevent future deaths. Those at HMP Guys Marsh and Practice Plus Group are happy to share their procedures and documents to assist in the rolling out of these processes at other establishments.

ix. Evidence was further given that at HMP Guys Marsh the healthcare provision is not available 24 hours per day, 7 days a week. At the time of Anthony's death, the healthcare provision was Monday to Friday, 7.30am to 6.00pm. Following Anthony's death healthcare is now available every day of the week but is not available between 6pm and 7.30am. If a medical event were to occur at the prison during these hours, the prison staff would be dependant on waiting for paramedic support.

x. Whilst there has been the benefit of increased awareness and ability to deal with an emergency event due to the roll out of the COILS initiative, evidence was given by the Head of Healthcare at HMP Guys Marsh that medical events happen more frequently when healthcare is not on site during the evening hours. HMP Guys Marsh are discussing extending the healthcare hours until 10.00pm but this would still leave a lack of healthcare provision at HMP Guys Marsh between 10.00pm and 7.30am.

xi. Practice Plus Group use SystmOne as a medical records system for those at HMP Guys Marsh as do all prison in the prison estate. Evidence was given by the Head of Healthcare that this system was designed for use in GP practice and not for use in prisons. Prisoners' medical records are often quite voluminous, and evidence was given that it is not possible to read the entirety of the records and therefore key words are searched to draw out the relevant information. Evidence was given that every entry is very important, and it is important not to miss vital information

especially in those high-risk individuals with complex needs. Evidence was given that whilst certain information can be very clear with SystmOne, complex information about emotional difficulties that prisoners may suffer for example is not the easiest to locate and can be missed.

xii. Evidence was given that it would be of benefit if SystmOne could be adapted so that key information could be flagged, marked or easily identifiable in order that vital information is not missed which could be central to the treatment of a prisoner and particularly their mental health.

xiii. Evidence was given at the Inquest that PSI 64/2011 or the ACCT version 6 guidance does not give direction about the attendance of healthcare at ACCT reviews and most importantly at ACCT reviews where it is proposed to close the ACCT.

xiv. Evidence was given throughout the Inquest that the input of the healthcare team is very important to the ACCT process and it was suggested that to provide direction that healthcare professionals are required to attend at all ACCT reviews especially those where it is to be closed is vital and this should be reflected in national guidance.

xv. Information was provided that the PSI 64/2011 is currently under review and that this could be addressed within new PSI and in a safety bulletin or update following the release of ACCT version 6 in July 2021.

xvi. Evidence was also given that during the Covid-19 pandemic prisoner movements have been reduced which has meant that rather than prisoners arriving at HMP Guys Marsh on a several days a week there has tended to be the arrival of large cohorts of prisoners once a week. One example was given that 17 prisoners could arrive at the prison on the same day. Evidence was given that this has caused significant pressures to be placed upon the prison and healthcare staff to progress the prisoners through the reception area.

xvii. As part of the reception process, prisoners undergo a healthcare screening. Evidence was given that it is simply not possible to review all the medical records of the prisoners arriving in these circumstances and this could therefore result in vital information being missed. It is unknown at this time whether the movement of prisoners in this way will continue beyond the Covid-19 pandemic. The Head of Healthcare at HMP Guys Marsh confirmed that as you cannot access a prisoner's records until they arrive, there is a risk of future deaths given the fact that they simply do not have the capacity to review the all healthcare records at the point of reception.

2. I have concerns with regard to the following:

   i. There could be future deaths across the prison estate nationally due to a lack of observations and welfare checks upon prisoners who are found under the influence of Spice and I request consideration be given to the rolling out of the local processes adopted at HMP Guys Marsh, nationally. This includes the roll out of their Welfare Checks Policy, the Persistent Psychoactive Substances Intervention Plan (PPSIP) and the Custodial Officer Intermediate Life Support initiative (COILS).

   ii. I have concerns that future deaths could occur due to the lack of 24 hour healthcare across the prison estate. I would therefore request consideration be given to the provision of healthcare to all prisons 24 hours a day, 7 days a week.

   iii. I have concerns that future deaths could occur due to the lack of attendance of healthcare staff at ACCT reviews, especially where the ACCT is closed. I request that consideration is given to providing guidance nationally by way of a safety bulletin or an update to the ACCT version 6 guidance and in the new PSI to be released in the future on the policy on management of prisoners at risk of harm to self, to others and from others, ensuring the attendance of healthcare staff at all ACCT reviews.

   iv. I am concerned that vital information contained within a prisoner's medical health records stored on SystmOne, could be missed due to fact the software is more adapted to GP practice than prison healthcare. This could result in a future death and I request consideration is given to adapting SystmOne for better use in prisons to ensure information, especially where there are complex care needs, is easily assessable and highlighted to avoid crucial information regarding a patient's care and safety being missed.

   v. I have concerns with the movement of prisoners around the prison estate in large cohorts as it could result in information regarding a prisoner's health not being identified which could result in a lack of healthcare provision to the prisoner which could result in a future death. I therefore request that consideration be given to the review of the processes when large cohorts are received at prisons and the resources available to prison and healthcare staff prior to the arrival of the prisoner and during the progression of the prisoners through the reception process.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 17th December 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) Irwin Mitchell Solicitors on behalf of Anthony's family (2) Hill Dickinson LLP, of behalf of Practice Plus Group, EDP, Midlands Partnership NHS Foundation Trust. (3) Government Legal Department, One Kemble Street, London, WC2B 4TS on behalf of the Ministry of Justice (4) Radcliffes Le Brasseur LLP on behalf of Central and North West London NHS Foundation Trust 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	**Dated** **22nd October 2021**	**Signed** **Rachael C Griffin**