Record of Inquest

Following an investigation commenced on the 07 March 2016
And an inquest opened on the 11 March 2016
And an inquest hearing at Milton Keynes Coroners Court on the 15th – 26th April 2024, heard before Dr Sean CUMMINGS in the said coroner's area and the undermentioned jurors: [redacted]

The following is the record of the inquest (including the statutory determination and where required, findings)

1 Name of Deceased (if known)
Robert Michael FENLON

2 Medical cause of death:

I a **Hypoxic Brain Injury**
I b **Hanging**
I c

II

3 How, when and where and for investigations where section 5 (2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death.

SEE ATTACHED PAGES

4 Conclusion of the Jury as to the death

UNLAWFUL KILLING CONTRIBUTED TO BY NEGLECT

5 Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death

(a) Date and place of birth: **05 September 1980** **Northampton**	
(b) Name and Surname of deceased: **Robert Michael FENLON**	
(c) Sex: **Male**	(d) Maiden surname of woman who has married:
(e) Date and place of death: **05 March 2016** **Milton Keynes Hospital ITU, Standing Way, Eaglestone, Milton Keynes**	
(f) Occupation and usual address: -, **HMP Woodhill, Wisewood Road, Tattenhoe Street, Milton Keynes**	

Signature of Dr Séan Cummings, HM Assistant Coroner for Milton Keynes

26 April 2024.

Signature of Jurors (if present)

[redacted]

Robert Michael Fenlon was remanded to HMP Woodhill by Northampton Magistrates Court on a charge of burglary. It was his 6th time in HMP Woodhill. He was known to suffer with drug & alcohol dependency and to have had mental health problems. He had on one occasion been admitted compulsorily to a psychiatric hospital and had also previously made an unsuccessful attempt to hang himself.

He asked early on in his stay for a referral to Mental Health services in the prison but the request was declined. This was an unsatisfactory response considering he stated he often has bizarre thoughts about other people. In Nov 2015 it was noted his mental health was declining & this was a missed opportunity to refer to mental health. On the 26th February 2016 he passed a note under his cell door which indicated his despair & was contemplating suicide. An ACCT document was opened. There was no adequate system in place to allocate case managers by the leadership team. The first case review was not multi-disciplinary and did not consider all the relevant risk information.

The risk assessment level was unsuitable considering the guidelines stated in the ACCT. The CAREMAP was general, did not set time-bound actions and did not properly allocate responsibilities. It did not identify all relevant issues. 2 major actions were omitted. The actions on the caremap were woefully inadequate. There was a failure to refer Robert to the mental health team. (2)

The first case review on 27th feb was not multi disciplinary, and did not consider all relevant risk information. The assessment of risk was unsuitable.

- There was another failure to refer Robert to the mental health team.

On the 2nd March 2016 there was a failure to at the ACCT case review to follow ACCT procedures. It was not multi disciplinary, no consideration of all relevant risk information. No consideration of the CAREMAP, no updating of CAREMAP, no review of relevant issues.

Losing his job He was not given a satisfactory update on the paintbrush incident and his sacking

The risk assessment level was inadequate.

"On the 3rd March 2016 Robert was found at unlock with a noose around his neck which he had secured to the bars of his cell window. He was shocked & distressed on discovery. The noose was cut from his neck. Unauthorised medicines were found in his room along with loose razor blades. We are not satisfied that a full and proper ACCT review took place when the record dated & We are not satisfied that Healthcare were present. There was a failure to follow ACCT procedures, no CAREMAP updated all relevant risk information was not considered no review of relevant issues. Roberts risk of suicide was not correctly identified or assessed. There was a serious failure in not putting Robert on constant supervision.

There was a failure to put in place other protective measures.

There was a failure to make an urgent mental health referral.

Snr Healthcare decisions were lacking & inappropriate & care given. There was inadequate oversight of the Senior Healthcare Assistant.

Given the information available, the next case review date was inappropriate.

There was a serious lack of communication to pass across all relevant details about Robert which resulted in missed opportunities for intervention by staff.

The circumstances in which he was found was not reported correctly + indicates that the incident was not taken as seriously as it should have been.

A code blue should have been called.

On the 4th March 2016 Robert was found with a noose on his cell. The ligature was tied to the window. There was a failure to report this correctly and surmise this was not taken seriously enough. A mental health referral was told to Robert before this incident which was told to Robert ? Robert was told a mental health referral was being made. This did not happen

A required ACCT review was not held on the 4th March. The 'chat' was not an effective ACCT review as required.

There was a failure to follow ACCT procedures. It was not multi-disciplinary, no consideration of all relevant risk information no review of relevant issues, no consideration of the CAREMAP.

Roberts risk of suicide was not correctly identified/assessed. There was a failure to put Robert on constant supervision. There was a failure to put in place other protective measures.

There was a failure to ~~put in place other protective measures~~. make an urgent mental health referral.

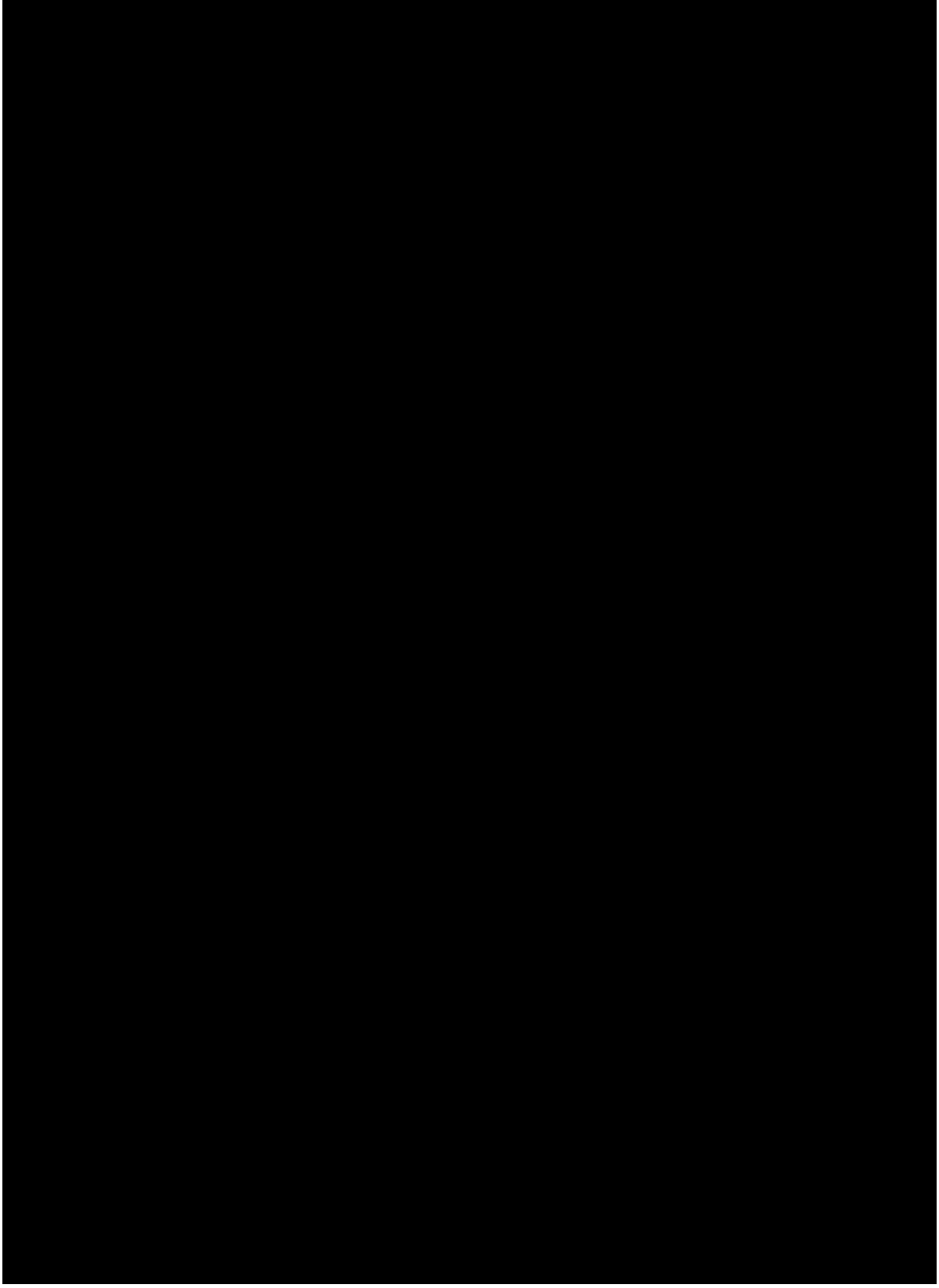
Neither the events on the 3rd or the 4th March resulted in any further measures to preserve Roberts safety.

Roberts mental health clearly deteriorated ~~noted~~ overnight on the 4th -> 5th March and opportunities to intervene were missed
He should have been on constant watch.
Lack of reading the ~~ACCT~~ ongoing records, & lack of suitable handovers & communication resulted in missed opportunities to preserve Roberts safety..

inadequate training, lack of communication inadequate risk assessment + failure to follow related processes.

There was not adequate staffing, oversight of Snr Healthcare assistant + serious failure by the prison to implement previous recommendations.

At 10·45 on the 5th March 2016 a code blue was called as Robert was found hanging & transferred to MK University Hospital



Questions for the jury

Unlawful killing re: the SO who held the ACCT case review on 3 March 2016

1. Was Robert Fenlon unlawfully killed? Yes/No

When answering this question, please refer to the section in the Notes above entitled "Notes for the jury: question 1 (unlawful killing)". That section contains important directions which you must follow when answering this question.

Note that, as with other questions, you should only give an answer to Question 1 if all of you agree upon the answer.

Unlawful killing re: the SO who recorded an ACCT case review on 4 March 2016

2. Was Robert Fenlon unlawfully killed? Yes/No

When answering this question, please refer to the section in the Notes above entitled "Notes for the jury: question 2 (unlawful killing)". That section contains important directions which you must follow when answering this question.

Note that, as with other questions, you should only give an answer to Question 2 if all of you agree upon the answer.

Neglect

3. Was Robert Fenlon's death contributed to by neglect? Yes/No

When answering this question, please refer to the section in the Notes above entitled "Notes for the jury: question 3 (neglect)". That section contains important directions which you must follow when answering this question.

Note that, as with other questions, you should only give an answer to Question 3 if all of you agree upon the answer.

Other questions

4. Was there a failure at the first ACCT case review on 27 February 2016 to follow ACCT procedures, e.g. not multi-disciplinary, no consideration of all relevant risk information, no review of relevant issues, no consideration of the CAREMAP, etc? Yes/No

If you would like to give an explanation for your answer, please do so in the box below.

5. Was there a failure at the ACCT case review on 2 March 2016 to follow ACCT procedures, e.g. not multi-disciplinary, no consideration of all relevant risk information, no review of relevant issues, no consideration of the CAREMAP, etc? Yes/No

If you would like to give an explanation for your answer, please do so in the box below.

6. **On 3 March 2016:**

   a. Was there an ACCT review conducted in Robert's cell shortly after 8.10am? Yes/No

   b. Was there a failure to follow ACCT procedures, e.g. not multi-disciplinary, no consideration of all relevant risk information, no review of relevant issues, no consideration of the CAREMAP, etc? Yes/No

   c. Was Robert's risk of suicide correctly identified/assessed? Yes/No

   d. Was there a failure to put Robert on constant supervision? Yes/No

e. Was there a failure to put in place other protective measure, e.g. removing items from the cell? (Yes)/No

f. Was there a failure to make an urgent mental health referral? (Yes)/No

If you would like to give an explanation for your answer, please do so in the box below.

7. **On 4 March 2016:**

a. Was a required ACCT review held on 4 March after Robert tied a ligature to his window bars? Yes/(No)

b. If yes, was this an effective ACCT review, as required by the policy? ~~Yes/No~~

c. Was there a failure to follow ACCT procedures, e.g. not multi-disciplinary, no consideration of all relevant risk information, no review of relevant issues, no consideration of the CAREMAP etc? (Yes)/No

d. Was Robert's risk of suicide correctly identified/assessed? Yes/(No)

e. Was there a failure to put Robert on constant supervision? (Yes)/No

f. Was there a failure to put in place other protective measure, e.g. removing items from the cell? (Yes)/No

g. Was there a failure to make an urgent mental health referral? (Yes)/No

If you would like to give an explanation for your answer, please do so in the box below.

8. Was the system in general for allocating ACCT case managers adequate? Yes/(No)

If you would like to give an explanation for your answer, please do so in the box below. There was no ~~suitable system in place~~ evedance that a suitable system was in place.

9. Were staff adequately trained in ACCT, risk assessment, and related processes? Yes/(No)

If you would like to give an explanation for your answer, please do so in the box below.

10. Was there adequate staffing? Yes/(No)

If you would like to give an explanation for your answer, please do so in the box below. The evedunce sugests that resource alicaton was wholse enadogate.

11. Was there adequate oversight of the Senior Healthcare Assistant? Yes/(No)

If you would like to give an explanation for your answer, please do so in the box below. She was no

12. Was there a failure by the prison to implement previous recommendations? (Yes)/No

If you would like to give an explanation for your answer, please do so in the box below. There were 43 recomendations in place and none implemented befre Robens death.

Final matters

Before you retire to consider your findings, I must give you these further legal directions.

First, you may not express any opinion on any matter other than giving answers to the four questions and providing details for registration.

Secondly, your conclusion must not be framed in such a way as to appear to determine any question of criminal liability on the part of a named person or civil liability. This does not affect your answers to the questions above, including questions 1, 2 and 3, and your inclusion of your answers to the questions in Box 3 and 4 in accordance with these directions (if applicable).

I must also repeat the warning I gave you before. You decide this case solely on the evidence which you have seen and heard in this court. Do not do your own research or look anything up on the internet. This is most important.

You must reach if you can a unanimous conclusion, one with which you all agree. When you have completed the Record of Inquest, I shall check to make sure there are no errors or inconsistencies. Then you will be called back to court and asked to read it out.

If you want further directions, on the law or the evidence, send a note. The court