IN THE SURREY CORONER'S COURT IN THE MATTER OF:

The Inquests Touching the Death of Amy FRIAR A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

The Rt Hon Chris Grayling MP – Lord Chancellor.

1 | CORONER

Richard Travers HM Coroner for Surrey

2 | CORONER'S LEGAL POWERS

I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

3 INVESTIGATION and INQUEST

The inquest into **Amy Friar**'s death was opened on the 5th April 2011 and was resumed on 13th January 2014 with a jury. It was concluded on 24th January 2014.

The jury found that the cause of death was:

1a - Hanging.

They concluded with a short narrative and returned the following verdict:

Amy Friar took her own life.

4 | CIRCUMSTANCES OF THE DEATH

At or about 13.40 hours on the 30th March 2011 Ms Friar was found in her cell at HMP Downview. She was partially suspended by a ligature which had been attached to some heating pipes. Assistance was summoned and CPR commenced. Paramedics attended the scene as did the HEMS doctor but expert opinion evidence concluded that Ms Friar was already dead by the time she was found.

5 | CORONER'S CONCERNS

During the course of the inquest the evidence revealed a matter that gave rise to a concern that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken.

RT3858 1

The MATTER OF CONCERN is as follows. –

The prison officer who sounded the alarm had recently arrived at HMP Downview from a different prison. That prison used different emergency codes to those which were used at HM Downview. As a consequence, initially the wrong code was called and there was confusion over the nature of the incident. In this particular incident that confusion did not impact upon or contribute to Ms Friar's death.

However, the lack of a universal emergency code across the prison estate has the potential to cause confusion and which, in different circumstances, may cause a delay in assistance being received and thereby lead to circumstances that create a risk of other deaths occurring in the future.

Evidence was heard that in January 2013 a new PSI (PSI 03/2013) established two different sets of emergency codes, one colour and one numeric. Code Blue being for the more serious breathing/collapse incidents and Code Red being for less serious blood/burns injuries. The equivalent numeric codes were One for breathing/collapse and Two for blood/burns.

In my opinion retaining two different codes does not remove the potential for confusion where prison staff move between prisons, as referred to above.

Further, I heard evidence that at HMP Downview the numeric codes are used and that a card has been developed which is of a size to fit at the rear of the prison officers identity card, meaning that it is with the prison officer at all times whilst they are at work. That card sets out in clear terms what the emergency codes are and the situations to which they apply. In addition posters have been put up in a large number of areas around the prison detailing the same information. Consideration might be given to extending this example of best practice across the whole prison estate.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the Secretary of State for Justice has the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must

RT3858 2

	explain why no action is proposed.
8	COPIES I have sent a copy of this report to the Secretary of State for Justice, the Interested Persons in the Inquest, the Chief Coroner and the CSEW.
9	Signed: Ríchard Travers DATED this 3 rd day of February 2014

RT3858 3