

Thomas Ralph Osborne Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGULATION 26 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Mr. Andrew Selous MP
	Minister For Prisons Ministry Of Justice 102 Petty France London SW1H 9AJ
1	CORONER
	I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 13/12/2013 I commenced an investigation into the death of Stephen Philip Owen Farrar, 25. The investigation concluded at the end of the inquest on 01 August 2014. The conclusion of the inquest jury was: Accident; Found with ligature around neck tied to a window in his cell at Woodhill Prison on 12th December (2013) 7.05 pm, CPR administered and pronounced dead at 7.55 pm. Ligature Around Neck
4	CIRCUMSTANCES OF THE DEATH When he was admitted to HMP Woodhill the deceased had a previous history of self harm & suicide attempts (last attempt 4 years ago) but was regarded as "OK now". No concerns raised with 1st, or 2nd night interviews. He was moved to House Unit 2A cell 3-02 on 05/10/13, no known conflicts/problems with any other prisoner and no other concerns raised. It was noted that the deceased was unusually quiet during a computer based learning programme on 12/12/13, and he was unwilling to discuss what the problem was. At 1905 PO (medication) discovered the deceased hanging using a strip of prison bed sheet which he had tied to the outside window cage and secured by closing the window. PO
	& cut the ligature. Death certified by the prison doctor.
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. –
	[BRIEF SUMMARY OF MATTERS OF CONCERN] (1) That when Mr Farrar was first admitted to Woodhill Prison there was formal risk assessment completed as to the risk of self harm or suicide despite the fact that he was under the age of 30, was returning to prison, had a history of previous self harm, and had mental health problems in the past including depression. Almost any risk assessment tool would have identified him as high risk. (2) I was told that there is no formal risk assessment tool available in any of our prisons.

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you Minister for Prisons 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 31 October 2014. 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 and Interested Persons and Interested Persons and Probation Ombudsman. I have also sent it to hiv inspector of Prisons and the National Offender Management Service who may find it useful or of interest.
	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 coloner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 29 August 2014 Signature
	Senior Coroner for Milton Keynes