REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Birmingham and Solihull Mental Health trust** **2. Director of Birmingham Prison**
1	**CORONER** I am Louise Hunt, Senior Coroner, for the coroner area of Birmingham and Solihull
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 15 January 2014 I commenced an investigation into the death of Yohannes Kidane. The investigation concluded at the end of the inquest on 3 September 2014. The conclusion of the inquest was the deceased died from 1a. Asphyxia due to 1b. Low level suspension/compression of the neck and the jury recorded a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Kidane was remanded into custody on 10/12/13 at Birmingham Prison. On 11/12/13 he tried to electrocute himself with a kettle cable and was placed on an ACCT. He was assessed on 12/12/13 and admitted to ward 2 of the healthcare department. On 18/12/13 he smashed his TV and made superficial cuts to his arms and abdomen. On the evening of 19/12/13 he lay on the floor between the window and the bed. He could not be seen from the cell hatch. At 22.53 he was found with a noose around his neck attached via his back to his ankle. This mechanism had been used to self-asphyxiate. CPR was provided but he was declared dead in his cell at 23.20 by paramedics.
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)The healthcare department has 2 wards with 15 patients on each ward. The evidence presented at the inquest confirmed that at night the healthcare wards are staffed by 1 nurse per ward and 1 prison officer who is shared between both wards. Evidence confirmed there were a number of prisoners on ward 2 who required ACCT observation plus other prisoners requiring attention. At the time only 1 nurse was present as the Prison officer was on the other ward. I am concerned the wards have insufficient staff at night to provide for all the healthcare and other needs of prisoners. (2) I am concerned that the ability to undertake effective ACCT observations is compromised by the lack of sufficient staff. (3) When I asked how staff took breaks at night I was told staff did not take breaks during the night. I am concerned about the impact this would have on the care and wellbeing of prisoners and on the staff. Staff must need to take comfort breaks throughout the night which would add an additional burden on the already stretched staffing levels.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 29 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 Mr Kidane's family, I have also sent it to the Prison and Probations Ombudsman's office 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**3 September 2014**