

Coroner for Buckinghamshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Governing Governor Springhill Prison
1	CORONER
	I am Richard Alexander Hulett, Senior Coroner for Buckinghamshire
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 03/01/2014 I commenced an investigation into the death of Peter Harry Mackie, 42 . The investigation concluded at the end of the Inquest heard from 24 th November to 1 st December 2014. The Conclusion was that "He took his own life, whilst the balance of his mind was disturbed. Between 14:51 and 15:08 on Saturday 28th December 2013, the deceased hanged himself in the chapel at HMP Springhill."
4	CIRCUMSTANCES OF THE DEATH At about 1545 hours on Saturday 28th December 2013 Police received a call from staff at the prison to say that a male was hanging (deceased) in the chapel. An air ambulance had been called and he had been declared life extinct at 1536 hours by MCKIE - He was currently at Springhill Prison serving a life sentence for possession of an imitation firearm and robbery in 2001. He had been there for about 4 months after being at different category prisons. After lunch on the 28th December Mr Mackie went and spoke to another inmate outside his hut. Mr MACKIE asked him to go to the chapel and the other inmate thought he looked upset. They walked over to the centre and asked prison staff to let them in to the main building where the chapel was located. At the same time another inmate came over and went into the chapel with them. The first inmate recalls that Mr MACKIE stated that he was upset, he mentioned that it was the anniversary of his mother's death (1 year) and he had never been told about the funeral therefore he never went. He also mentioned that he owed money but this has not been confirmed. They remained within the chapel for about an hour and the second inmate was looking through the Bible and reading out verses to try and help Mr MACKIE. The first inmate thought that after that hour Mr MACKIE was a lot better. He also mentioned that he thought Mr MACKIE was dressed very smartly as if he was in his best clothes. They all left and the first inmate recalls Mr MACKIE asking him to return to the chapel in about half an hour's time. He thought that Mr MACKIE was ok and had other things to do so forgot to go back. At around 1500 hours a third inmate returned to the prison after having leave over the Christmas period. From reception he went straight to the chapel as he spends a lot of time there due to his religious beliefs. He went straight through the unlocked door, up the stairs and then saw a male hanging. Initially he thought it was a prank as he had never seen anything like it befo
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) Despite improvements during 2014 concerns remain as to the overall numbers of first aiders available on the Springhill site at any time including at night. A first aider on the Grendon site is unlikely to be able to respond in time due necessary security moving from a closed estate to an open prison. This applies in respect of those trained to "First aid at work (FAW) and Emergency First aid at work (EFAW). Operational needs may deplete numbers with FAW and/or EFAW by transferring them to the closed part of the overall site.
- (2)There are usually two contracted healthcare staff available during daytimes but they work together and are therefore either on one site or the other. There are inevitable security delays in moving between the two prisons and the possibility of splitting this cover was raised in the evidence.
- (3)It appears that there is not currently any guidance to staff as to when CPR should be commenced. This applies to CPR trained staff. For those without such training there is a lack of clarity as to what if any action they should undertake.

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 30 January 2015 . 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 Trwin Mitchell Solicitors, representing cousin of the deceased)
	(sister of the deceased) (TSOL) (Care UK)
	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 5 December 2014
	Signature Senior Coroner for Buckinghamshire