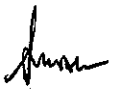
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon Chris Grayling MP** **Secretary of State for Justice** **102 Petty France** **London SW1H** **Michael Spurr** **Chief Executive** **NOMS** **4th Floor** **70 Petty France** **London** **Nigel Newcomen CBE** **Prisons & Probation Ombudsman** **P O Box 70769** **London** **SE1P 4XY**
1	**CORONER** I am André Rebello, Senior Coroner, for the area of Liverpool
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 7th January 2013 I commenced an investigation into the death of **Connor Steven Paul SMITH**, Aged **20**. The investigation concluded at the end of the inquest on 16th December 2014. The conclusion of the inquest was Ia Hanging Connor Steven Paul Smith died of an inadvertent consequence of a deliberate act, where the intentions were unclear, in the early hours of 2nd January 2013. From all the evidence heard, Mr Smith gave no indication of presenting a risk of immediate suicide. All of those who gave evidence who knew Mr Smith, both professionally and personally, were shocked to learn of his death.
4	**CIRCUMSTANCES OF THE DEATH** Connor Smith was a 20yr old male who had been in custody at HMP Altcourse since November 2012. On 29.12.12 there was an altercation in the prison with another inmate. The inmate was allegedly assaulted by four males including Connor. As a result Connor was moved to another cell where he was the sole occupant. The assault has now been denied by the victim. On 01.01.2013 Connor was seen alive and well by prison custody office [redacted] who had several conversations with him. She said he did not appear down in the dumps or depressed. A head count at 20:30hrs accounted for Connor. The next morning at approx 05:18, PCO [redacted] conducted cell checks. CCTV has shown PCO [redacted] look through the cell hatch and discover Connor hanging from a bed sheet. Other officers attend as well as paramedics and resuscitation is carried out unsuccessfully. There were no provisions in place that required Connor to be checked on more than any other prisoner. Within his prison records, there are two entries to suggest previous self harm. The first in 2005/6

	when he tried to cut his wrists, the second was in 2012 with an attempted overdose.
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. – On the 28th January 2013 the PPO investigator interviewed a PCO with regard to a review hearing under rule 49 – colloquially known as a rule 45 board. The Officer was asked about the record of the meeting in which his name had appeared as an attendee. Given the frequency of such meetings the officer could not remember the meeting on the 1st January 2013 but was interviewed about it creating a 15 page transcript. On examination of other witnesses, other documentary evidence and a video of the meeting made it clear that the PCO was not present at the review hearing – his name had been entered on the Segregation Rule 45/Rule 49 Authority for continued segregation before the meeting but he had not been there. This is an area of concern highlighting the quality of the investigation by the PPO where by such an error could in another case prevent lessons from being learnt. (Documentation is provided to the PPO alone to assist with response to avoid publication of this report being redacted)
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 10th February 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. I have sent a copy of my report to the Harris Review which has expressed an interest HMP Altcourse The family of Mr. Smith 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **Dated: 17th December 2014**