

## **HM CORONER**

Central Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	<ol> <li>Director of Public Sector Prisons, NOMS</li> <li>Governor HMP North Sea Camp</li> <li>Governor HMP Lincoln</li> <li>The Director, NHS England</li> <li>The Director, Nottinghamshire Healthcare NHS Trust</li> </ol>
1.	5. The Director, Nottinghamshire Healthcare NHS Trust
	I am Stuart P G Fisher, Senior Coroner, for the coroner area of Central Lincolnshire, Lindum House, 10 Queen Street, Spilsby, Lincolnshire, PE23 5JE.
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 13 March 2013 I commenced an investigation into the death of John Derek Stabler, aged 55 years. The investigation concluded at the end of the inquest on 17 October 2014 The Jury returned a conclusion that 'He killed himself' The medical cause of death being:
	1a. Hanging
	CIRCUMSTANCES OF THE DEATH
	At 0100 hours on 4 March 2013 the deceased was found hanging in cell D1.5 in HMP Lincoln. He was taken to Lincoln County Hospital where he died on 6 March 2013.
	He was serving an indeterminate sentence, was an inmate at HMP North Sea Camp where he had a history of mental health problems. He was transferred to HMP Lincoln on 1 March 2013 and was found hanging (though not deceased) in a cell on the Segregation Wing on 4 March 2013. He was taken to Lincoln County Hospital where he died on 6 March 2013.
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. –
	(I) That there is a need for the Prisoner Escort Record to be reviewed and redesigned

	(II) The requirements for System 1 (Medical Records) to be made available in Reception at HMP North Sea Camp and in The Care and Reception Unit at HMP Lincoln
6.	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action.
	(1) Director Public Sector Prisons, NOMS
	(2) Governor HMP North Sea Camp
	(3) Governor HMP Lincoln
	(4) The Director, NHS England
	(5) The Director, Nottinghamshire Healthcare NHS Trust
7.	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 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 and to the following :
	(1) Deighton Pierce Glynn (2) Treasury Solicitors
	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.
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	SPG FISHER
	Senior Coroner for Central Lincolnshire Area