In the matter of Stuart Megginson BAUMBER (Deceased)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **National Offender Management Service, Clive House, 70 Petty France, London SW1H 9EX** **Sodexo Justice Services, One Southampton Row, London WC1B 5HA**
1	**CORONER** I am David Heming, Senior Coroner for the coroner area of Peterborough.
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 18/11/2013 I commenced an investigation into the death of Stuart Baumber. The investigation concluded at the end of an inquest with a jury on the 30th January 2015. The jury found the medical cause of death was :- 1a. Hanging The determinations and conclusion of the jury was suicide where they found clear evidence of a deliberate act by the deceased with intent to take his life by hanging at his cell at HMP Peterborough between 22:30 on 14 November 2013 and 04:10 on 15 November 2013. The jury also found for the purpose of this report the following :- 1. Between 29 October 2013 and 14 November 2013 there were one or more occasions when a concern and keep safe form (the first step in the ACCT process) should have been opened. 2. A lack of understanding of and adequate training in the ACCT process, especially relating to the requirement of when an ACCT book must be opened as stated in PSI 64/2011 contributed to the ACCT process not being initiated.
4	**CIRCUMSTANCES OF THE DEATH** The deceased encountered marital problems. On the 20th and 27th October 2013 he was subject to detentions in a place of safety under s.136 Mental Health Act. On the 28th October 2013, he poured petrol around his rented property and a fire was started. He was extricated from the premises by fire brigade officers . The deceased was a first time offender, charged with arson (reckless), and was remanded in custody following a magistrate's courts appearance. At no stage was the deceased subject to the ACCT process despite the 136 detentions and the nature of the offence and the fact he was a first time offender.

33 Thorpe Road, Peterborough, PE3 6AB
Tel 01733 452275 | Fax 0870 238 4085

	The solicitor for the deceased telephoned the prison on one occasion to express concern about him but no record could be produced of this or action taken. A bail application at the Crown Court was unsuccessful on the 13th November 2013. At approximately 04:10 on the 15th November 2013, an officer gained entry to his cell and on opening the door the body of deceased fell to the floor. A laundry bag had been used as a part ligature and there was also a shoelace ligature around his neck.
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. – **NOMS/SODEXO -** **ANTI-LIGATURE STRIPS ON CELL DOORS** 1. The deceased was a design engineer and his sketches found after death in his cell set out diagrammatically how he deduced that the gap between the cell door and frame would allow a ligature to be threaded through and that a wedge could be created with paper pamphlets to prevent slippage of the ligature. 2. The risk of cell doors being used for ligature points is well known. In HMP Dovegate alone some years ago, there were 3 suicides close in time where the upper hinge was used as a ligature point. 3. However, whilst the current specification for cell door design now incorporates an anti-ligature strip, there is no retrofit programme in operation and thus, there are significant numbers of cell doors that do not meet the current standard. 4. The need to eradicate ligature points in cells has been the subject of recommendations in PPO reports in Northern Ireland (JOHN MARTIN GERARD KENNEWAY published 10.12 2009 at recommendation 10 and COLIN MARTIN BELL published 9.1.2009 at recommendation 9) and many Australian Coronial decisions and observations of Coroners in England and Wales in the old Rule 43 and the new Regulation 28 reports. 5. Further, this was the subject of detailed commentary in the paper produced by the Jill Dando Institute of Crime Science (University College London) where it was recognised as being of paramount importance that there be removal of as many ligature points as possible in cells and that remedial action would need to be taken as quickly as possible before a new method spreads within and between establishments. 6. Evidence was given that the cost of a national retrofit programme for all doors being adapted with an anti-ligature strip to meet the new design would be a significant proportion of the current budget. However, given the particular vulnerability of prisoners on induction and remand wings, a retrofit of those cells doors on such wings not meeting the requirement would provide some protection and would be a measured response to those prisoners who are known to be at heightened risk. **NOMS/SODEXO –** **THE ACCT PROCESS** 7. PSI 64/2011 and the Quick Time Learning Bulletin (issue 12 august 2012) which clarified opening an ACCT was the subject of much scrutiny. There seems to be no national pro forma document to guide staff through the process and document the decision making. By contrast, the Act 2 Care risk assessment in the Scottish prison system does provide a structured approach. A pro forma regime would have the

	advantage of providing an audit trail and can be reviewed for training purposes if shortcomings emerge. 8. There appears to be on occasions an over reliance on assessment of current risk as emphasised in the QTLB of 2012 by considering demeanour and presentation at the reception stage. The PPO bulletin of March 2015 highlights deficiencies in this approach. There are known risk factors for suicide and self-harm and active identification of relevant risk factors from documentation and information (e.g. SASH forms and PERs and medical records and an FME report) should be fully considered and balanced against apparent mood so that the there is a comprehensive risk assessment.. A pro forma document could record what factors and documentation have been considered and the reasons for the decision. 9. It is known that a prisoners risk of self-harm and/or suicide may increase in certain circumstances. This applied to the deceased in this inquest. HMP Gartree have identified measures to identify potential triggers and there has been developed a database on trigger dates but only for those who are or have been subject to an ACCT. This could be refined to deal with re assessment of risk for many prisoners if key factors exist. (See Equality and Human Rights Commission paper in 2015 on Preventing Deaths in detention of adults with Mental Health Conditions). Again, the PPO bulletin of March 2015 highlighted increased vulnerability where a restraining order was made and this could be input into a database to prompt a review of risk. The deceased was served with papers concerning harassment whilst on remand that may have emphasised that his marriage was over and therefore increased vulnerability particularly when bail was subsequently refused and victim impact statements were referred to in court. 10. The PPO report recommended that an ACCT should be opened whenever a prisoner has recently self - harmed or expressed suicidal intent. **NOMS** – **HEALTHCARE SCREENING.** 11. The healthcare screening which is a question and answer discussion based on specifically designed questions is prescriptive. It makes no mention of s.136 detentions which would be a clear indicator of enhanced risk and the deceased had two such detentions. **SODEXO** - **ITEMS USED TO FACILITATE SUICIDE** 12. Some prisoners at HMP Peterborough are allowed to carry their cell door key which is placed on shoelaces tied together and placed around the neck of the prisoner which clearly creates a self-made ligature for those who may be at risk. 13. In addition, the deceased referred to experimentation by suffocation in his diary by putting a plastic bag over his head and some cells are known to have plastic removable bin liners which can be used as a means to take life.
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 **19 May 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 [redacted] [redacted] (Bhatt Murphy) [redacted] (Bhatt Murphy) Cambridgeshire and Peterborough NHS Foundation Trust (Kennedys) Serco (DLA Piper) 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 24th March 2015 Signature: David Heming (signed electronically) …….. Mr David Heming, Senior Coroner for Peterborough