John Sleightholme
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Ms Kate Davies OBE** Head Of Public Health, Armed Forces Health & Offender Health, NHS England, Birch House, Southwell Road West Rainworth Nottinghamshire NG21 0HJ
1	**CORONER** I am John Sleightholme, Assistant Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27/05/2014 I commenced an investigation into the death of Samuel William Gale, 18 . The investigation concluded at the end of the inquest on 15 October 2015. The conclusion of the inquest was Open conclusion. The cause of death 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** Samuel Gale was received into custody at HMP Doncaster on 3rd May 2014. He was 18 years of age, a first time inmate who faced serious charges of rape. Furthermore, it was recognised by prior custody officers and healthcare nurses that he was very distressed at being barred from attending his father's funeral by his mother and siblings who blamed him for his father's suicide in February 2014. He had self-harmed and made an attempt at suicide recently and at times felt suicidal. He was immediately placed on an ACCT and half hourly observations were directed. On 16th May the ACCT was closed and he was found hanging the following day.
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) Samuel was seen by a nurse on admission for a health screening followed by a triage by a mental health nurse. Following Samuel's death the Nottinghamshire NHS Trust, who were responsible for healthcare at the prison, reviewed their note assessment procedures. (2) The importance of an objective risk assessment has been recognised by the Trust which now uses a mandatory risk assessment from on System One. It is

	understood that NHS England is in the process of procuring a new version of System One, and is invited to consider whether this procurement exercise provided an opportunity for formalising the risk assessment process throughout the prison estate nationally.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Ms Kate Davies OBE 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 14 December 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] HMP & YOI Doncaster, Mills and Reeve Solicitors, Lupton Fawcett Solicitors and Irwin Mitchell 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.
9	Dated 23 October 2015 Signature_____ Assistant Coroner for South Yorkshire (East District)

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