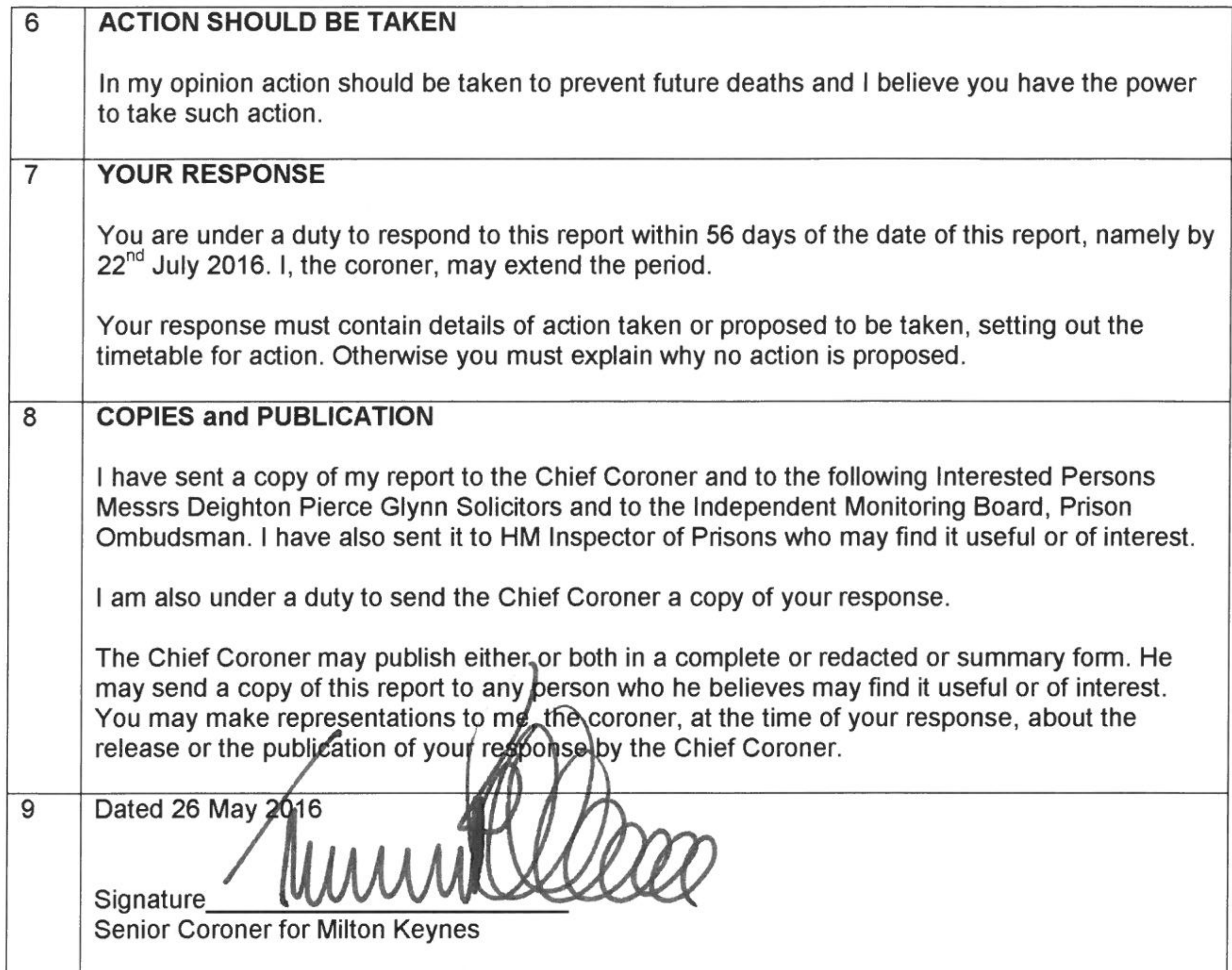
Thomas Ralph Osborne
Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Govenor, HMP Woodhill and to Mr. Andrew Selous MP Minister for Prisons**
1	**CORONER** I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes
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 20/07/2015 I commenced an investigation into the death of Ian Keith Brown, 44 . The investigation concluded at the end of the inquest on 26 April 2016. The conclusion of the inquest was set out in the Jury's narrative conclusion set out in their answers to the questionnaire.
4	**CIRCUMSTANCES OF THE DEATH** Mr Brown suffered from mental illness and had been on remand at HMP Woodhill since the 10th January 2015 and occupied Cell 301 in House Block 3B.At 12:10 hours on Sunday the 19th July 2015 he was locked in his cell (he was the only occupant), he pressed his bell. PO Gary Lindop responded and Mr Brown said he wanted to speak to Senior Officer Miss Jones. He was told that she was on her lunch break and could probably come and see him after her break. At 13:10 hours 19/07/2015 PO Phil Arthur started his rounds to check the cells. Mr Brown's cell was the first one. The PO looked through the hatch and saw that Mr Brown was slumped forward in his chair facing the window. There was a belt ligature tied around his neck which was connected to the window. PO Arthur called a "code blue" (prisoner not breathing) through his radio for help. He then entered the cell and cut the ligature with his fish knife and proceeded to do CPR until Healthcare arrived. An ambulance was called and Paramedics confirmed death at 14:00 hours. A short note written to his sister was found in his cell.
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)During the course of the evidence I was referred to the most recent report from the HM Inspector of Prisons that highlighted "Recommendations made by the Prisons and Probation Ombudsman following previous deaths in custody, such as the need to improve the quality of ACCT case management documentation for prisoners at risk of suicide or self harm, had not been implemented with sufficient rigour. (2) Deaths at the prison from suicide and self harm continue to rise. (3) The recommendation from the Inspectors is that there should be a "prison-wide strategy and action plan to reduce the number of self inflicted deaths and incidents of self harm should be developed urgently. This should be based on detailed data and trend analysis and include implementation of Prison and Probation Ombudsman recommendations. It should also include

	improvements in the quality of ACCT case management documentation, and the lessons learned from internal investigations into life-threatening incidents." I have concerns that the recommendations will not be implemented and that past recommendations have been ignored. (4) That despite my previous PFD reports the number of suicides at HMP Woodhill continue to rise.



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<tr><td>6</td><td>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.</td></tr>
<tr><td>7</td><td>YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd July 2016. 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.</td></tr>
<tr><td>8</td><td>COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Messrs Deighton Pierce Glynn Solicitors and to the Independent Monitoring Board, Prison Ombudsman. I have also sent it to HM Inspector of Prisons who may find it useful or of interest.

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.</td></tr>
<tr><td>9</td><td>Dated 26 May 2016

Signature______________________
Senior Coroner for Milton Keynes</td></tr>
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