REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Mr P. Novis. Governor, HMP Leicester CORONER I am Lydia Brown, (assistant) Coroner, for the area of Leicester City and Leicestershire 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. INVESTIGATION and INQUEST On 17 September 2015 I commenced an investigation into the death of Michael Williams. The inquest concluded on $7^{\rm th}$ July 2016. The jury made the following findings -The jury concluded the death was suicide. On 15th September 2015 between 21.45 and 22.45 Mr Williams died by hanging in his cell at 116 Welford Road. Although low traces of Mamba were found in his bloodstream, the influence of it on Mr Williams capacity to take his own life cannot be determined. At the time of his death Mr Williams was on 4 observations per hour. Mr Williams was last seen at 21.30 and was heard after this time. During these last two hours Mr Williams, on more than one occasion blocked the observation panel and inundation point of his cell door and wrote 2 suicide notes, 1 of which was ingested, and a note on the cell wall. Access to the cell was at 22.45 an inappropriate delay. The prison officers found Mr Williams hanging from the window bars by a ligature around his neck made from a torn bedsheet. Mr Williams was pronounced dead on 16th September 2015 at the Leicester Royal Infirmary. Cause of Death 1a Hanging CIRCUMSTANCES OF THE DEATH Mr Williams took his own life by use of a ligature, while in a single occupancy locked cell. At the time he was on an ACCT document, and had threatened to take his life earlier that day; had presented as tearful and anxious; had disengaged with prison officers; had covered his observation panel with both layers of paper and a bed sheet and the required 4 observations per hour had not been adhered to. CORONER'S CONCERNS

Mr Williams should have been observed 4x every hour during the evening of 15th September 2015. Several of these checks were missed, and after he blocked the

observation panel, he could only be heard, not seen.

- a) Observations (where they were carried out) were documented at precise 15 minute intervals, commencing on the hour, and were therefore predictable. This is not best practice and should be discouraged.
- b) There was no explanation for the missed observations.
- c) Mr Williams was unobserved for approximately 1 hour before the cell door was opened, and he was found deceased. The jury found this was an inappropriate delay and I agree with them. Clear guidance and training should be provided, and regularly repeated, to assist the Prison Officers in managing such situations in a timely way.

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 Monday 5th September 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.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

(Parents)

Chief Executive University Hospitals of Leicester NHS Trust. Chief Executive, Leicestershire Partnership NHS Trust.

Thompsons Solicitors.

Government Legal Department.

Prison and Probation Ombudsman.

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 [DATE]

11th July 2016

[SIGNED BY CORONER]