

## for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
***	THIS REPORT IS BEING SENT TO: Chief Coroner and Properly Interested Persons
1	CORONER
	I am Tom Osbome HM 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 29/12/2015 I commenced an investigation into the death of Simon John Turvey, 27. The investigation concluded at the end of the inquest on 24 November 2016. The Narrative conclusion of the inquest Jury was Suicide Simon John Turvey was detained in HMP Woodhill. He was found hanging in his locked cell at 05.45am on 29/12/2015. He was declared dead by paramedics at 06.12am. He deliberately suspended himself by the neck in his cell using a towel which caused his death. The relevant processes in place at the time leading to Simon's death, were followed by the staff and this did not highlight any requirement for enhanced monitoring due to suicide risk. On the 28th December 2015 there were no indicators that Simon was at risk of suicide. The prison and healthcare authorities did not appear to be aware of a suicide risk for Simon. But due to a failure of the Personal Officer scheme, and the family not pro-actively made aware of how to share concerns, risk factors may have been missed.
4	CIRCUMSTANCES OF THE DEATH  The deceased was last seen alive when checked at 2046 28/12/15. Found hanging in cell at 0544 29/12/15 by a towel ligature secured to top rail of bunk. 3 notes left in cell. Not on an ACCT, no previous indications of suicidal ideation.
5	CORONER'S CONCERNS
	During the course of the inquest the evidence revealed matters giving rise to concern; it became apparent that the family of Mr Turvey was not aware of the arrangements for the family to notify the prison if they had concerns as to his welfare. If they had known of the telephone line to report concerns they would have used it.  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
	Concerns
is ye in a die a no commonwealer	That the details of the cause for concern line should be given to all visitor and family members so that they can easily report their concerns to the prison.

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 07 February 2016. I, the coroner, may extend the period.
e e e e e e e e e e e e e e e e e e e	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 the Governor of Woodhill Prison. I have also sent it to to the Prison and Probation Ombudsman, and to NOMS 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 REAL PROPERTY AND	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 13 December 2016  Signature
	Tom Osborne
	HM Senior Coroner for Milton Keynes