



André J A Rebello
Senior Coroner for Liverpool and Wirral Coroner Area

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Michael Spurr, CB Chief Executive NOMS 4th Floor 70 Petty France London Sw1h 9ex</p>
1	<p>CORONER I am André J A Rebello OBE, Senior Coroner for Liverpool and Wirral Coroner Area</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 08/02/2013 I commenced an investigation into the death of Luke Myers, 24 . The investigation concluded at the end of the inquest on 17 July 2015. The conclusion of the inquest was that: At 06.45 on 4/2/13 Luke Myers was found in his cell I-4-13, hanging from a bunk-bed by a ligature fashioned from a leather belt, which Luke had tied to the top rail of the bunk-bed, and had fastened the buckle end around his neck. Luke was in a single occupancy cell and should not have had the leather belt in his possession. Luke was troubled by the length of his sentence, and also a pending adjudication relating to a server incident, and these are more than likely a relevant factor in Luke putting himself in a potentially fatal position, but it is unclear as to his intentions. At the time of Luke's death he was on an open ACCT document and was observed at regular intervals throughout the day and night. Luke was last seen alive at 05.10 on 04/02/13. When Luke was found he was cut down from the bunk-beds and efforts were made to resuscitate him. These efforts were unsuccessful. Luke was pronounced dead at 07.05 on 04/02/13. At 06.45 on 4/2/13 Luke Myers was found in his cell I-4-13, hanging from a bunk-bed by a ligature fashioned from a leather belt, which Luke had tied to the top rail of the bunk-bed, and had fastened the buckle end around his neck. Luke was in a single occupancy cell and should not have had the leather belt in his possession. Luke was troubled by the length of his sentence, and also a pending adjudication relating to a server incident, and these are more than likely a relevant factor in Luke putting himself in a potentially fatal position, but it is unclear as to his intentions. At the time of Luke's death he was on an open ACCT document and was observed at regular intervals throughout the day and night. Luke was last seen alive at 05.10 on 04/02/13. When Luke was found he was cut down from the bunk-beds and efforts were made to resuscitate him. These efforts were unsuccessful. Luke was pronounced dead at 07.05 on 04/02/13.</p> <p>The cause of death found was 1a Hanging</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Luke Myers was on an open ACCT process commenced on the 30/01/13. A previous ACCT was closed with a post closure interview on 22/01/15. His mother had died when he was 3 years old and he had ended up within the care system. He self-injured as a distraction. He suffered from a depressive illness and his history involved severe and multiple adversities at the more severe end of clinical practice. He was concerned about the length of his sentence as he did not want history to repeat itself with his own children growing up without a father as he had to without a mother. The prison had calculated his conditional release date as at 27/08/2021 and further that his parole eligibility date was 27/08/2018. The Court asked that the MOJ check for the correct dates and it was only during the inquest that it was confirmed that the conditional release date should have been 25/02/2017 and the parole process did not apply at all. Luke was also concerned about whether adjudication with regard to an altercation with an officer at a food servery could have resulted in added days. The adjudication was due for hearing on the day of Luke's death 04/02/2013.</p>

5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>[BRIEF SUMMARY OF MATTERS OF CONCERN]</p> <p>(1) HMP Liverpool miscalculated Luke Myer's extended sentence of 12 years from November 2012 by erroneously applying Section 226A CJA 2003 and with regard to parole section 246A CJA 2003. The sentence was under section 227 CJA 2003 – Are there any other prisoners sentenced at that transitional time who believe they have a longer sentence than the law prescribed? Luke Myers tried to clarify his length of sentence during his life and it was only clarified during his inquest. The jury found this was a likely factor in his death.</p> <p>(2) During the course of the inquest evidence was heard from two members of Prison discipline staff that they had last been trained in first aid respectively 10 and 6 years ago. In other circumstances this could have had an effect on the outcome. At night officers can be lone working on a wing and presumably you would agree that it would be desirable for any such officer to be first aid trained. First aid training in low hazardous work place environments is usually certified for three years before refresher requalification is needed. Your consideration and plan for first aid training in prisons would be very welcome.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you Michael Spurr, CB, CEO, NOMS have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 September 2015. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ul style="list-style-type: none"> a) Mr Myer's family b) Lancashire Care NHS Foundation Trust c) Merseycare NHS Foundation Trust d) HMP Liverpool. <p>I have also sent it to the</p> <ul style="list-style-type: none"> a) Ministerial Board for Deaths in Custody b) Prison and Probation Ombudsman <p>who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 20 July 2015</p> <p>Signature <u><i>Andrew D Roberts</i></u></p> <p>Senior Coroner for Liverpool and Wirral Coroner Area</p>



Ministry of
JUSTICE

National Offender
Management Service

Andrea Ball
Equality, Rights and Decency Group
National Offender Management Service
4th Floor, 70 Petty France,
London SW1H 9EX
t: 0300 049 7051
e: andrea.ball2@noms.gsi.gov.uk

Mr A Rebello OBE
Senior Coroner
H M Coroner's Court
Gerard Majella Courthouse
Boundary Street
Liverpool
L5 2QD

14 September 2015

Dear Mr Rebello

Thank you for your Regulation 28 report dated 20 July 2015 addressed to Michael Spurr, Chief Executive of the National Offender Management Service (NOMS) concerning the recent inquest into the death of Luke Myers on 4 February 2013. Your letter has been passed to the Equality, Rights and Decency Group in NOMS as we have responsibility for policy on suicide prevention and self harm management and for sharing learning from deaths in custody. I have consulted with the Governor of HMP Liverpool in formulating this response.

Your letter raises two concerns:

Staff at HMP Liverpool miscalculated Luke Myer's extended sentence and may have done so in other cases

I can confirm that staff in the Offender Management Unit at HMP Liverpool have reviewed the sentence calculations for the current population and found no other prisoners to have a miscalculated sentence.

First Aid Training

Individual establishments carry out a risk assessment to determine how many, and which, staff should be trained in 'First Aid at work'. HMP Liverpool has 24 hour healthcare cover, and this is sufficient to meet the identified needs. All nursing staff are qualified nurses and hold an 'Intermediate life support' qualification as part of their training. In addition, first aid training is being provided to all Custodial Managers who carry out orderly officer duties, ensuring that there will be an additional trained member of staff on duty at all times, and Operational Support Grade staff will also be trained.

I hope this provides you with assurance that the matters of concern that you have identified have been fully addressed.

Yours sincerely

Andrea Ball