ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. HM Prison Service of 102 Petty France, London SW1 9EX, (FAO The CEO Ms Jo Farrar)**
1	**CORONER** I am Samantha Marsh, Area Coroner, for the coroner area of Hampshire
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.
3	**INVESTIGATION and INQUEST** On 30th October 2018 I commenced an investigation into the death of Trevor Albert Oakley, who was 74 years old. The investigation concluded at the end of the inquest on 23rd October 2019. The conclusion of the inquest was that Mr Oakley's death was due to suicide, with a medical cause of death as: 1a. Ligature suspension.
4	**CIRCUMSTANCES OF THE DEATH** At 06:26 hours on the Twenty-second of October 2018 Trevor Albert Oakley was found hanging from the window bars in his cell. He had suspended himself from a ligature made of a bedsheet. He was hidden behind a non-prison issue 'privacy curtain'. He was pronounced deceased at 06:50am by attending paramedics. Mr Oakley was due to start his Trail at Salisbury Crown Court that morning (the 22nd October 2018) for serious sexual offences. Mr Oakley was remanded to HMP Winchester on the 14th February 2018. Prior to his remand he had taken an intentional overdose of insulin and prescription mediation on the 28th January 2018; being the day that officers from Hampshire Police had attended to arrest him on suspicion of committing the sexual offences for which he was ultimately due to stand trial. He was hospitalised for 8 days and on discharge from hospital was admitted to a psychiatric ward. On discharge from the psychiatric ward he was arrested and on appearing before Basingstoke Magistrates Court on the 14th February 2018 he was remanded into custody. Mr Oakley had three ACCTS opened whilst he was in prison; the last of which was opened on the 8th August 2018 and closed the following day, namely the 9th August2019. This related to issues of alleged bullying of Mr Oakley by his cellmate. Between August and the date of his death there was no involvement of mental health. On the 22nd October 2018 Mr Oakley was due to start his trial. I head evidence that he would have been aware of this date, most likely via his legal representative, and the trial would have been the first time he would have faced his family since they had made serious allegations against him for sexual assault (of his daughters and grandchildren). I heard evidence from witnesses within the Health Service at the Prison that Mr Oakley had a pattern of being unwell on the occasions when he was due to attend Court, and so

	the start of his trial is likely to have been a stressful time for him.
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 could 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) I was told that the Courts will supply the Prison with a list of prisoners who are required for trial the following day, ("**the List**"). The List is circulated within the prison by the OMU (Offender Management Unit) and the overnight staff should receive the List to enable them to know which particular prisoners need to be unlocked for Court attendances the following day. I was told that the Night Orderly Officer will brief the night shift officers on the wings as to what is due to be happening over the course of the night shift, but it was the evidence of more than one Prison Officer on duty that there was no notification of the prisoners due in Court the next morning. The stance adopted within the prison appeared to be that the information was available if a Prison Officer wanted to go and look for it within the system. (2) I am concerned that within the Prison it is not immediately apparent to the night staff who is due in Court the following morning an from this, it flows, that any increased risk of self-harm by such prisoner(s) is not identified.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 the 21st January 2020. 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 who may find it useful or of interest. (i) HM Inspectorate of Prisons at HM Inspectorate of Prisons, 3rd floor 10 South Colonnade, Canary Wharf, London E14 4PU; and (ii) Independent Advisory Panel on Deaths in Custody of 9th Floor, 102 Petty France, London SW1H 9AJ (iii) [redacted] Governor of HMP Winchester (iv) The next of kin 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	**26th November 2019**