# Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

**REGULATION 28 REPORT TO PREVENT DEATHS**

**THIS REPORT IS BEING SENT TO: The Rt Hon Robert Buckland QC**
**Lord Chancellor Ministry of Justice**

**1 CORONER**

I am Tom OSBORNE, Senior Coroner for the area of 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.

**3 INVESTIGATION and INQUEST**

On 30/04/2019 I commenced an investigation into the death of Mark Samuel CULVERHOUSE aged 29. The investigation concluded at the end of the inquest on 21 May 2021. The conclusion of the inquest was:

I a Hypoxic brain injury and pneumonia

I b Cardiac arrest (resuscitated)

I c Ligature compression of the neck

The jury concluded by a majority of 9-2 that he had died from suicide they also concluded that he had been unlawfully detained and this had contributed to his death and that the decision to take him to segregation on the 23rd April 2019 had contributed to his death

**4 CIRCUMSTANCES OF THE DEATH as found by the jury**

On 17th April 2019, Mr Mark Samuel Culverhouse was involved in an incident where police negotiators in attendance found Mark to be presenting as a person in crisis; he had a noose around his neck and was actively self-harming.
After several hours, Mark is taken to Northampton Criminal Justice Centre where he was booked and assessed by a doctor. It was here where the first serious concerns regarding his mental health were raised.
Mark is seen by two doctors who seem him fit to be detained and fit to be questioned.
On the morning of 18th April, Mark was transferred to Northampton Magistrates Court. On arrival Mark's behaviour was presenting as erratic and he was head banging. A mental health assessment was requested as several staff were concerned about his behaviour. Whilst being seen by the mental health team he self-harms by head butting the wall and collapses. As a result he was sent to Northampton General Hospital.
At both locations, Mark indicated if he was to return to prison he would take his own life.
Whilst in hospital, the probation service recalls Mark's license due to the addition charges from 17th April. A police officer attends hospital to serve the recall and Mark is taken to HMP Woodhill once discharged.
Mark is still presenting as a person in crisis when he leaves the hospital. On arrival at HMP Woodhill, Mark is placed on an ACCT under constant observation. Mark is seen by a doctor and later that evening his observations are reduced to 3 times an hour by the duty governor.
On 19th April, Mark smashes his TV and observation panel and is taken to the segregation unit.
Not long after going into segregation, Mark was found unresponsive. He is taken to Milton Keynes Hospital where he refuses to receive treatment from both medical and mental health teams. He is returned to prison and placed on constant observations to keep him safe.
On 20th April, a mental health nurse referred Mark for a mental health assessment which was

carried out on the morning of 23rd April. It was considered Mark had no unmet mental health needs and that he was not suffering from a mental illness.
A review of his ACCT reduced the level of his observations.
Mark was accepted onto the mental health case load.
At 11am on 23rd April the Offender Management Team calculated that Mark is potentially due for immediate release. This was not communicated to Mark. Validation checks later confirm Mark should be released but he was never made aware of this.
At 1355 Mark had an altercation with another prisoner, he is restrained and taken to the segregation unit for a second time. It is clear he was presenting as a person in crisis again.
The primary care nurse was unable to sign the segregation algorithm due to Mark's presentation and requested input from the mental health team.
Mark was observed twice in his cell, the first he was seen with movement in his leg and the second time he was heard singing; in both events he was under a sheet, his body obscured from view and thus was insufficiently observed.
A mental health nurse arrives and sees no movement. She asks for the door to be open.
At 1449 prison staff enter his cell and Mark is discovered with a ligature around his neck. He is resuscitated and taken to Milton Keynes University Hospital where he dies on 24th April 2019 at 1439.

**5 CORONER'S CONCERNS**

The MATTERS OF CONCERNS are as follows:

During the course of the inquest into the death of Mark Culverhouse it became apparent, and indeed was accepted that his detention at HMP Woodhill from the 18th of April 2019 until the 23rd of April 2019 was unlawful. He had been recalled under the terms of his license having been released from Peterborough prison on the 12th of April 2019. The calculation of his release date was not conducted by the offender management unit at the prison until the 23rd of April 2019, after the extended Easter bank holiday. I was told that there was no process in place whereby a prisoner's release is calculated until such time as they come back into custody. The prison and probation ombudsman brought this matter to the attention of the prison service recommending that the release date calculation should take place within one working day of the prisoner arriving in prison. I cannot see how that can be acceptable particularly where, in Mr Culverhouse's case, it would have made no difference because of the bank holiday. I consider that there was a clear link between his unlawful detention and his eventual death on the 24th of April 2019 and, in order to prevent similar deaths in the future, I believe an urgent review is required and the system changed to ensure that the calculation of the release date is made prior to the decision to recall being taken. This will avoid the possibility of anyone being unlawfully imprisoned in this country under similar circumstances.

**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 19 July 2021. 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

Family
HMP Woodhill
Government Legal
GeoAmey
CNWL
Northamptonshire Police

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.

**9**

**Tom OSBORNE**
**Senior Coroner for**
**Milton Keynes**
**Dated: 02 June 2021**