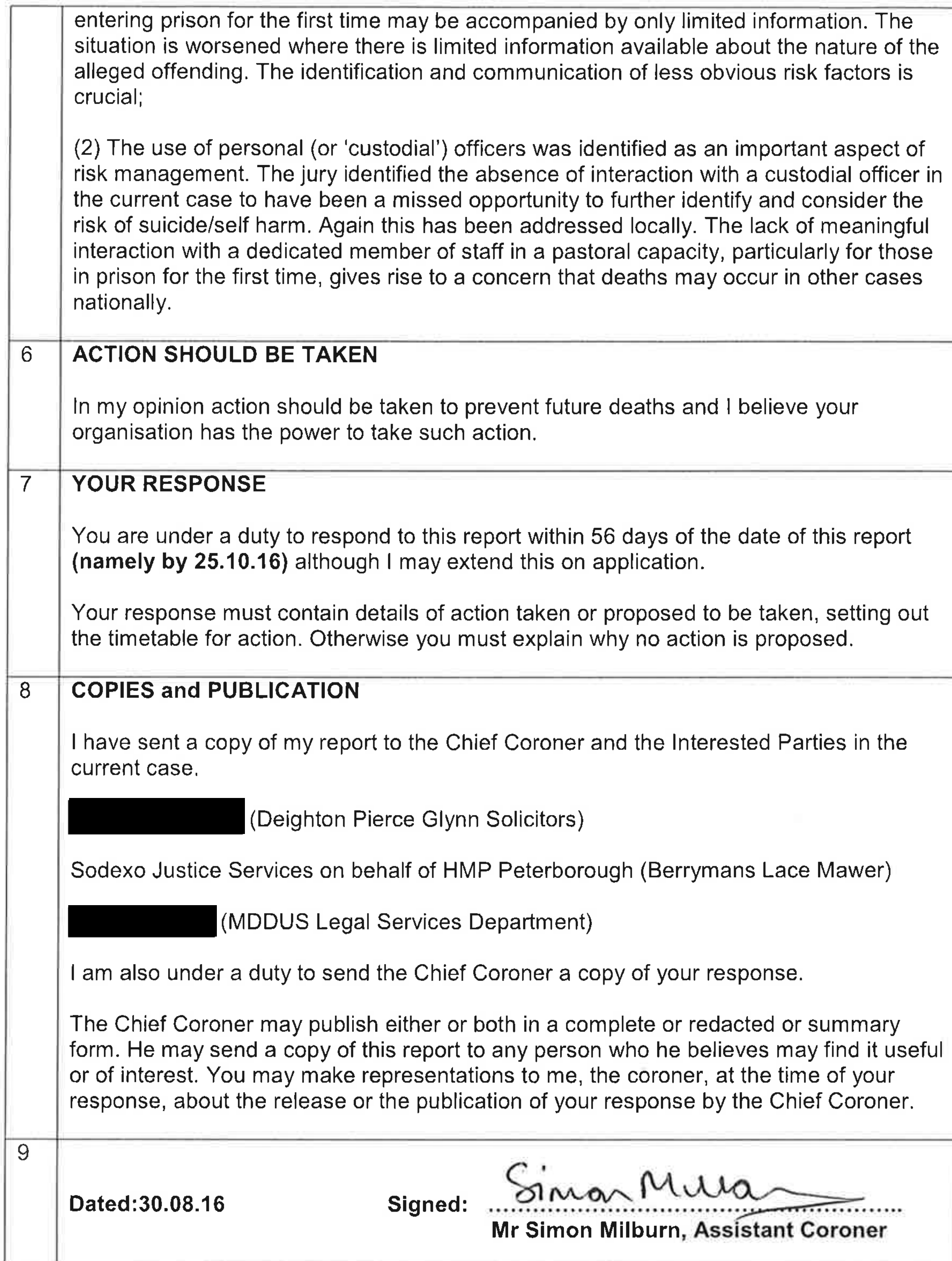
Simon Milburn
Assistant Coroner for Cambridgeshire & Peterborough

Senior Coroner's Office
(Cambridgeshire & Peterborough)
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **National Offender Management Service, Clive House, 70 Petty France, London SW1H 9EX**
1	**CORONER** I am SIMON MILBURN, Assistant Coroner, for the coroner area of Cambridgeshire & Peterborough.
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** In February 2014 I commenced an investigation into the death of Peter Lawrence. The investigation concluded at the end of the inquest on 08.07.16. The conclusion of the inquest was that Mr Lawrence suffered a self inflicted stab wound to the heart. The conclusion of the jury was that Mr Lawrence was a determination of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lawrence was remanded into custody at HMP Peterborough on 06.12.14 charged with serious sexual offences. On 02.02.15 he was found slumped in a toilet cubicle in a prison workshop having stabbed himself with a chisel. He was treated and taken to hospital where death was confirmed.
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 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. – (1) The inquest heard a great deal of evidence relating to the process for identifying, managing and recording risk at the first point of contact between new prisoners and prison/healthcare staff. Mr Lawrence had not been in prison before and there was very little background information available to enable staff to identify less obvious risk factors, particularly in relation to the nature of the alleged offences. It was accepted in evidence that it was of particular importance at the initial screening to identify risk by other means and to record any observations in a comprehensive manner for future reference. HMP Peterborough has put in place a number of measures in recognition of the concern that suicide/self harm risk is identified at the earliest stage, even if no ACCT document is opened. The concern that risk factors may be missed or inadequately recorded has been addressed locally but there may be scope to expand awareness that individuals



entering prison for the first time may be accompanied by only limited information. The situation is worsened where there is limited information available about the nature of the alleged offending. The identification and communication of less obvious risk factors is crucial;

(2) The use of personal (or 'custodial') officers was identified as an important aspect of risk management. The jury identified the absence of interaction with a custodial officer in the current case to have been a missed opportunity to further identify and consider the risk of suicide/self harm. Again this has been addressed locally. The lack of meaningful interaction with a dedicated member of staff in a pastoral capacity, particularly for those in prison for the first time, gives rise to a concern that deaths may occur in other cases nationally.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 25.10.16)** although I may extend this on application.

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 the Interested Parties in the current case.

[redacted] (Deighton Pierce Glynn Solicitors)

Sodexo Justice Services on behalf of HMP Peterborough (Berrymans Lace Mawer)

[redacted] (MDDUS Legal Services Department)

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.

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Dated:30.08.16 **Signed:** Simon Milburn ....

Mr Simon Milburn, Assistant Coroner