	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:**
1	**CORONER** I am Laurinda Bower, HM Area Coroner for **Nottingham City and Nottinghamshire**
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 17 December 2018, I commenced an investigation into the death of NIGEL JOHN SAUNDERS. The investigation concluded at the end of an inquest heard by the Coroner, sitting with a Jury, between 3 and 13 May 2022. The conclusion of the Jury was that Mr Saunders died an Accidental Death as a result of: 1a. Global Hypoxic Brain Injury 1b. Asphyxia by hanging 1c II
4	**CIRCUMSTANCES OF DEATH** Nigel John Saunders was detained at HMP Lowdham Grange, Nottingham, where he was discovered suspended by ligature and unresponsive at 16.00 hours on 17th November 2018 [redacted]. He was transported by ambulance to Queens Medical Centre, Nottingham, arriving at 17.17 hours on 17 November 2018. He was treated in the Adult Intensive Care Unit where he was pronounced deceased at 03.59 hours on 18 November 2018 as a result of global hypoxic brain injury sustained during the period of suspension by ligature. The jury found that Mr Saunders' death was accidental. The jury further returned a Narrative Conclusion, captured by way of questionnaire, determining that there were failings by the Prison Service in relation to Mr Saunders' admittance to the Segregation Unit, his care pursuant to the Assessment, Care in Custody and Teamwork plan (ACCT Plan), and in searching Mr Saunders before he entered the shower area.
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 Prison failed to comply with its obligations pursuant to National Prison policy to retain and preserve evidence likely to assist all agencies to learn from deaths in custody. (2) The local system in place for the retention and preservation of material likely to be relevant to the circumstances of death is not as robust as it ought to be.

	This is not the first time serious disclosure irregularities have undermined the veracity of an Article 2 inquest involving this prison in my coroner Area. I consider this to be a local issue of significant importance. If the investigations following a death are repeatedly hindered in their full and frank examination of the facts due to missed opportunities by the prison to have retained and preserved evidence, then lessons cannot be learned, and the risk of further deaths shall persist. The Chief Coroner highlights this specific area of risk at paragraph 42 of the revised Guidance Note 5.

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 action in relation to the above matters. (1) Governing Governor at HMP Lowdham Grange, c/o SERCO
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 September 2022. 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** In addition to the organisations identified in section 6 above, I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Family Nottinghamshire Healthcare NHS Foundation Trust I shall also share a copy of this report and your response with the Governing Governors at the other local HMP establishments as the issues raised in this inquest have applicability across the local HMP estate. I am under a duty to send the Chief Coroner a copy of the responses received from the organisations listed in section 6 above. 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	DATE Signature_____ Laurinda Bower, HM Area Coroner, **Nottingham City and Nottinghamshire**