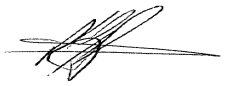
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 19 SEPTEMBER 2023 IS BEING SENT TO:** [redacted] **Governor Exeter Prison** *****by email only*****
1	**CORONER** I am Philip SPINNEY, HM Senior Coroner, for the coroner area of Exeter and Greater Devon.
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 15 July 2020 an investigation was commenced into the death of Stewart Stanley. The investigation concluded at the end of the inquest held on 17 -27 July 2023. The conclusion of the inquest was Suicide in addition the Jury answered a series of questions raised by me. In summary, the Jury concluded that Mr Stanley's death was probably caused or contributed to by a failure to follow the processes resulting in the staff best qualified to appreciate Stewart's risk to himself being excluded from the decision to remove him from constant watch. In the addition the Jury concluded that the multi-disciplinary processes in place were adequate however they were not fully complied with in this case.
4	**CIRCUMSTANCES OF THE DEATH** On 23 June 2020 Mr Stanley was remanded in custody to HMP Exeter. On the night of 9 to 10 July, Mr Stanley's cellmate found him [redacted] seemingly trying to hang himself. He alerted prison staff, who started Prison Service suicide and self-harm prevention procedures (known as ACCT). The staff placed Mr Stanley under constant supervision and moved him to a special cell that allowed an officer to observe him continuously. On 11 July, after a case review it was decided that constant supervision should end and directed that Mr Stanley should now be observed at least once every half an hour during the evening. At around 1.20am on 12 July, the night patrol officer, found

	Mr Stanley hanging. She called for staff assistance and, when it arrived, they opened the cell, removed the ligature and began chest compressions. Paramedics arrived and took Mr Stanley to hospital, where he died on 14 July.
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 evidence revealed that there was an inconsistent approach taken by staff when conducting and recording observations on prisoners subject to the Prison Service suicide and self-harm prevention procedures (known as ACCT). (2) The evidence also revealed that some Officers had a different interpretation of the requirements of set out in PSI 64/2011 in respect of the timing of observations. (3) The evidence also revealed that precise times of such observations were not routinely being recorded accurately. (4) During the evidence it became apparent that a prison officer worked 23 hours out of 24, he was asked if this was normal and he replied, "yes, to make the regime work."
6	**ACTION SHOULD BE TAKEN** **(1) Consideration should be given to reviewing the process of conducting and recording ACCT observations to ensure accuracy and compliance with relevant policy and guidance.** (2) **Consideration should be given to reviewing staffing levels, retention, and recruitment to ensure the efficient and safe running of the prison.** In my opinion action should be taken to prevent future deaths and I believe you and 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 16th November 2023. 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 solicitors for the family of the deceased Government Legal Practice Plus Group Devon Partnership Trust [redacted] The Chief Coroner 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	**SIGNED:**  Mr Philip C Spinney HM Senior Coroner Exeter and Greater Devon