Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Minister for Prisons and Probation, Ministry of Justice, Petty France, London**
1	**CORONER** I am Miss Laurinda Bower, HM Area Coroner, for the coroner area of 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.
3	**INVESTIGATION and INQUEST** Wyndham Richard Thomas died on 6 November 2018, at the Queens Medical Centre, Nottingham. He was a serving prisoner. A coronial inquest into his death was opened on 29 November 2018. An inquest before a jury was resumed on 22 May 2022 but the jury were discharged due to a serious irregularity. The inquest was re-listed before the next available court and resumed before a jury on 30 January 2023, concluding on 10 February 2023.
4	**CIRCUMSTANCES OF DEATH** The following represents the findings of fact returned by the jury: Wyndham Richard Thomas was a prisoner transferred to HMP Nottingham on 29th of October 2018. He had been at HMP Nottingham previously (July – October 2018). Wyndham was serving a life sentence, with a minimum tariff of 10 years which commenced on 9th of April 1998. He ligated and was found unconscious in his cell at 18:04 on 4th of November 2018. He had moved prisons a great deal – 13 prisons in the previous 3 years and had transferred from HMP Norwich. This had made it difficult for his family (based in South Wales) to maintain contact. He had been managed on ACCTs many times – 25 ACCTs between 2016 and 2018. Wyndham had also been prescribed medication for anxiety and depression. He began self-harming in 2016 and first ligated on 3rd of October 2016, because of a lack of tobacco. On arrival at HMP Nottingham on 29th of October 2018 he went onto F Wing. During the safer custody interview several triggers were added to his ACCT plan. These were: - That he managed his self-harm [redacted] - That he had a parole decision coming up on the 31st of October which was a cause of stress for Wyndham (parole was refused on the 31st of October) - That he had taken [redacted] (and so was referred to the substance misuse team) - News about his daughter's [redacted] which coincided with the anniversary of his sister's [redacted]. - That he had issues with going onto B wing because of drugs related issues.

	Wyndham remained on F Wing until 2nd of November and when an officer tried to relocate him from F to B wing Wyndham struck him. At this point (1.30 pm) he was forcibly removed and placed in the segregation unit. An ACCT case review followed at 15:10 during which his healthcare safety segregation paperwork was signed. The Governor's Defensible Decision to Segregate a prisoner on an open ACCT was completed. Wyndham did not receive an assessment of his mental health within 24 hours of segregation. There were no certified safer cells to house Wyndham in, even if they had referred to his history of ligation. No care map was produced, and Wyndham was tasked by the Governor chairing the meeting with writing his goals over the weekend. Wyndham's level of risk was increased from 'low' to 'raised' but his observation was reduced to every 2 hours. There were no measures put in place to reduce his risk of self-harm as there had been no meaningful risk assessment carried out. An officer collected Wyndham's last [redacted] from his cell on F wing at 17:30. Wyndham had been asking for access to [redacted] and had been refused by the Governor in the afternoon. On Saturday 3rd of November, from early in the morning, Wyndham was pressing the cell bell regularly to request more [redacted]. He made a number of demands, one of which was a listener. This was refused and Wyndham rejected the Samaritans phone that was offered. It was a source of ongoing frustration between prison officers and Wyndham. He was 'up and down', becoming verbally aggressive in response to repeated refusals. At 15:30 the Governor carried out his daily review of Wyndham's continuing segregation. Wyndham moved cells in the afternoon. At approximately 18:30 Wyndham showed his escalating frustration by banging his head against the cell window and door. Self-harm, using [redacted] was inflicted on Wyndham's left forearm on the site of an earlier wound and the ACCT book was updated at 19:00. Healthcare was called but Wyndham refused treatment and a dressing was passed under the door. As staff were relying on Wyndham's presentation and were unaware of any risk relevant information, no further action was taken and there was no review of Wyndham's ACCT following this self-harm incident. Had the records been consulted at this point the risks would have been apparent. Wyndham was seen the following morning – on Sunday 4th – by a healthcare nurse and around 9:30am the Governor's daily review was carried out, at which point [redacted] were again refused. Wyndham made repeated use of the cell bell in the morning to request [redacted]. Wyndham was continuing to request vapes and being refused. A radio was provided around 17:00 as a distraction. He was still verbally abusive when his cell bell was answered at 17:45. An officer checked on Wyndham at 17:54 and observed Wyndham for 17 seconds before walking away. Wyndham was standing between the sink and the cell door, almost out of view. He was standing up and breathing although there was no verbal interaction. The officer returned at 18:04, realised that something was amiss and radioed for assistance. He could see the top of Wyndham's head below the observation panel against the door and a ligature running down the side of the observation panel. 3 officers entered the cell at 18:06 and cut the ligature, [redacted]. An officer and nurse commenced CPR and a second nurse arrived with the emergency bag at 18:07. A code blue was called but it is not conclusive at what time precisely. Wyndham was transferred to the Intensive Care Unit at QMC, at approximately 18:45. On the 6th of November 16:40 Wyndham was pronounced dead.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1. There is a lack of local and national system of in-cell ligature point risk assessments, and no ligature point maps available to staff.

	The Prison Staff caring for Wyndham were not aware of the location of known ligature points within the cell. This meant that suspicion was not drawn when Wyndham was seen positioned in an area which had access to a ligature point. 2. There is no mandatory requirement for a HMP Prison to have access to a Safer Cell (one with reduced ligature points). HMP Nottingham does not have designated Safer Cells, including on the Care and Support Unit, where prisoners posing a high risk of harm by ligation may be sent for their own safety. The above matters represent missed opportunities to seek to reduce the risk of self-harm and death by ligature asphyxiation, which is one of the most prevalent mechanisms of self-harm and self-inflicted death across the prison estate. While the above measures will not eliminate risk entirely, any reduction in opportunity to ligate may save lives.
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 15 February 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 Chief Coroner and to the following: • The Interested Persons who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 21 December 2023** **Miss Laurinda Bower** **HM Area Coroner** **Nottingham City and Nottinghamshire**