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. Sodexo (via their General Counsel)** **2. His Majesty's Prison and Probation Service, The Rt Hon Edward Argar MP**
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** Kane Christopher Boyce died by ligature asphyxiation on 3 October 2021, at HMP Lowdham Grange, Nottinghamshire, where he was detained as a serving prisoner. A coronial inquest into his death was opened on 23 November 2021. An inquest was resumed before a jury on 6 November 2023, concluding on 22 November 2023.
4	**CIRCUMSTANCES OF DEATH** The following represents the findings of fact returned by the jury: Kane Christopher Boyce (aged 41) was discovered inside his locked cell at 0150 on 3rd October 2021 with a ligature around his neck. Emergency first aid was provided by wing officers and healthcare prior to the arrival of paramedics. Kane could not be resuscitated, and he was declared deceased at 0223 on 3rd October 2021. His death occurred sometime between the hours of 0013 and 0150 on 3rd October 2021, a period of time he was not subject to observations. Kane was under the influence of alcohol at the time of his death. Kane obtained the alcohol from an unknown source during the day of 2nd October 2021, which was consumed throughout the evening in celebrations of this recent birthday. The level of alcohol found in his body has caused significant impact on Kane's judgement and mood. Kane was prescribed an anti-depressant, which was not present in his toxicology report, which indicates that Kane had not taken his prescribed medication for at least five days prior to his death. Both of these factors combined contributed to this death. The jury returned a narrative conclusion determining that - Kane's death was not intentional He was intoxicated with alcohol which contributed to his death Three separate members of staff suspected Kane to be acting under the influence of alcohol when they spoke to him at 23.14 hours, 23.29 hours and 00.08 hours, respectively. Those staff all failed to adequately share information about Kane's intoxication with colleagues.

	They further failed to open an 'under the influence log' contrary to the local prison policy. This failing contributed to the circumstances of his death because the opening of a log would have necessitated a medical review with regular monitoring of his condition by healthcare over the following hours. Instead of following the policy on the night of his death, staff isolated the electricity supply to the sockets inside his cell in order to prevent him from playing loud music. The decision to isolate his cell from the electricity supply was not an authorised and approved prison action, and it was not supported by training or guidance for staff. Staff failed to consider Kane's level of risk of harm or his wellbeing when isolating the electricity supply. Staff actively ignored Kane's cell bell for long periods of time. The action of ignoring cell bells was not an authorised and approved prison action, and staff were not supported to do so with training and guidance. Again, staff failed to consider how this might affect his level of risk of harm or his wellbeing. The above failings more than minimally contributed to his death.
5	**CORONER'S CONCERNS** During the course of the inquest I heard evidence of 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) The following matters of concern are directed to **Sodexo** for response - It is important to note that at the time of Kane's death, the prison was managed by Serco Ltd under a contract awarded by HMPPS. Since Kane's death, the contract for managing the prison has been awarded to Sodexo. Sodexo were invited to submit learning evidence to the court, if such existed, but instead said they would respond to any prevention of future death report I felt was necessary. A number of the prison staff involved in Kane's care in October 2021 continue to work at the prison and were unaware of local policy in relation to the matters below as of present times. Having received no formal evidence of any changes made at HMP Lowdham Grange, and staff having failed to report any evidence of changes, I highlight the following concerns - **1. Ignoring Cell Bells** I heard evidence that staff were engaging in the deliberate ignoring of prisoner cell bells. I have seen no local policy which either prohibits such activity, or, if such activity is permitted, supports staff to make risk-based considerations about how and when to ignore cell bells. I observe that deliberately ignoring cell bells appears to be a wholly dangerous practice as the cell bell is the only method of communication between prisoner and staff during periods of lock up, including night state. The practice appears to be all the more dangerous when one considers some staff suspected Kane to be in a state of heightened emotion and acting under the influence of alcohol. **2. Isolating power to cells** As above, I have seen no policy which supports the isolation of power to cells including who has the power to make such a decision, how long the power should be isolated for, and whether staff are required to consider any risk factors when determining whether to isolate power to the cell. **3. Failure to follow the local Under the Influence Policy** Three members of staff suspected Kane was under the influence of something in the hours before his death, yet none opened an under the influence log or sought any medical advice

about how frequently to check on him, what signs of deterioration to look out for, and when to seek further assistance.

4. Lack of understanding of Prison Service Instruction 64/2011, and possible discord between local policy and the PSI

A number of prison officers believed Kane's birthday was incapable of amounting to a "*key date or anniversary*" for the purposes of PSI 64/2011. It seems to me to be common sense that a birthday, being the anniversary of one's birth, *could* amount to a potential trigger date for heightened emotions which considering a prisoner's risk of self harm and suicide. That is not to say it would be so for each and every prisoner, but perhaps something to be cognisant of when dealing with an emotional and intoxicated prisoner. I have seen no evidence that this is covered in Sodexo's training for staff on the ACCT process, if indeed any series of training exists.

A number of prison officers gave evidence that an ACCT was not necessary because Kane had not said to anyone that he was going to harm himself (either fatally or otherwise). Serco's Safer Prison Operating Policy (August 2022) is confusing on this point and seems to suggest at paragraph 3.4 that staff should only open an ACCT when a statement of self-harm has been verbalised. This is not consistent with the PSI. Sodexo have not offered for scrutiny any local policy, guidance or training material on the threshold for opening an ACCT, but even if such exists, it appears some staff continue to labour under the misapprehension that a prisoner must say they are thinking of harming themselves before an ACCT can be opened.

5. A failure to implement learning from the investigations that follow deaths in custody

Many of the staff giving evidence explained that they had not read the PPO report, nor were they aware of the issues identified by the PPO prior to giving evidence at the inquest. I have seen no evidence of the systems in place at HMP Lowdham Grange to seek to learn from deaths in custody at the earliest opportunity.

The following matters of concern are addressed to **The Minister for Prisons and Probation, HMPPS –**

6. Poor Quality Early Learning Review process, November 2021

While it is recognised that the ELR process is designed to capture information at a very early stage of the investigation, it is nevertheless an important tool in seeking to identify safety issues that should be addressed swiftly in order to prevent future deaths.

The central issue in this case was obvious from the outset, as recorded in various intelligence reports submitted by staff on the night of the death, namely, a number of members of staff suspected Kane to be under the influence of alcohol yet failed to take the necessary steps to seek to safeguard against harm.

On page 4 of the ELR it is concluded that "*all procedures were followed*" and there were no local or national recommendations for learning lessons. It is difficult to rationalise this conclusion against the evidence available even at the earliest stages of the investigation. The author was clearly aware that staff had considered Kane to be under the influence of alcohol (see page 1) and should have been aware that no Under the Influence Log existed. The author simply notes that "*the policy has been reviewed*". There is no explanation as to why the policy wasn't followed. Was the policy unclear in its requirements? Was there an absence of staff training on the policy? Of great concern to me is the fact that staff giving evidence at the inquest still seemed to fail to grasp the significance of intoxication as a risk factor for self-harm.

My concerns extend beyond the quality of the report, but also to the accuracy of the same.

The report is written in such a way as to create the impression that the author interviewed key members of staff. Comments are attributed to staff at particular points in time, yet all

	prison staff witnesses denied ever having been interviewed as part of the ELR process. It is unclear exactly what methodology the author has used during the investigation. I am concerned that the quality of the investigation has led to missed opportunities to have identified these issues at the outset. **7. A Lack of Candour – both organisationally and individually** I would be very interested to understand how the duty of candour applies to the prison service and those individuals within the employ of the service (whether employed directly or through a private provider, as in this case). There is a statutory duty of candour applicable to healthcare organisations and professionals, as well as a more recent agreement by the College of Policing for members to adhere to a Code of Candour. In practise, candour creates a culture of being open and honest with all stakeholders by accepting when things go wrong, taking remedial steps as soon as practicable, and thus reducing the risk of events repeating themselves. In the context of a death, candour from the outset is essential in order to support the bereaved family. The position adopted by Serco in this inquest, as it has in other inquests, could be said to represent the very opposite of candour. Having heard evidence supplied on Oath by their own staff members that there were multiple failures to open an under the influence log (evidence which was not contested) the organisation nevertheless required the Jury to return a finding on this issue, and each and every issue, instead of a factual finding being presented to the jury as agreed by all Interested Persons. The inquest is not an adversarial process, there is no burden of proof. The Interested Persons are under a duty to assist the investigative process in an open and honest manner by identifying those issues that genuinely require determination by the jury, and those on which there is agreement. Sadly, in my extensive experience of conducting Article 2 inquests locally, this is not an isolated example of the uncomfortable position adopted by the prison service in failing to put forward sensible and reasonable factual admissions of shortcomings. I am concerned by the apparent absence of a culture of candour supporting those staff who work within the prison service. Many of the staff members giving evidence explained that the inquest was the first time it had been suggested to them that they had not adhered to policy. In the intervening period of over two years between Kane's death and the inquest, no-one at the prison had asked key staff to reflect on the care they provided to Kane that night and consider areas of learning. Again, this is not a position unique to this inquest, and is of great concern in the context of a rising number of self-inflicted prisoner deaths at HMP Lowdham Grange since Kane's tragic death in 2021. I would be grateful if your response could address what steps have been, or are being taken, to ensure that candour is applied throughout the death in custody process.
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 13 March 2024. 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 • INQUEST Charity 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: 17 January 2024** **Miss Laurinda Bower** **HM Area Coroner** **Nottingham City and Nottinghamshire**