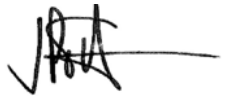
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Rt Hon Edward Argar MP Minister of State for Prisons, Parole and Probation [redacted] 2. [redacted] – Chief Executive (Interim) North Staffordshire Combined Healthcare NHS Trust [redacted] 3. [redacted] – Chief Executive Midlands Partnership NHS Foundation Trust (if appropriate) [redacted]
1	**CORONER** I am Mr John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 22nd September 2022, I commenced an investigation into the death of Martin Samuel WILLIS, aged 55 years. The investigation concluded at the end of the inquest with a jury on the 13th to 17th day of November 2023. The conclusion of the inquest was Mr Willis died from hanging and the narrative conclusion was that: "Mr Martin Willis took his own life, in part because the risk of him doing so was not reported, communicated and the precautions in place were insufficient to prevent him doing so whilst the balance of his mind was disturbed".
4	**CIRCUMSTANCES OF THE DEATH** Mr Willis was a serving prisoner at HMP Stoke Heath when at 8:37 am on the 15th September 2022 he was found hanging in his cell. He was on the suicide and self-harm prevention scheme (ACCT).
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 ACCT procedure was not properly implemented, complied with or supervised. A scheduled observation at 8 am did not take place and a false entry was entered at 7:30 am and later deleted. The last correct entry was at 7 am with earlier omissions. 2. The prison service has taken action to address the issues relating to the ACCT procedure and will be kept under review.

	3. Overriding issues remain as to whether or not the late Mr Willis was on the correct levels of observation up to constant watch and whether he should have been transferred out on psychiatric grounds for treatment at another prison establishment with a hospital wing. 4. Whilst the prison service and the mental health providers have reviewed the circumstances of Mr Willis's death, I am concerned that there should be a collective and not individual response to ensure that all lessons can be learned. I therefore recommend that there be an inter-agency review between the prison service and mental health services as to the mental health care provided to the late Mr Willis including the evidence at the inquest and the jury's findings. In so doing, I do not purport to suggest what the outcome of the review should be.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation/s have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days (plus 14 for the forthcoming Christmas and New Year period) of the date of this report, namely by 27th February 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 Interested Persons: Leigh Day Solicitors Shropshire Community Health NHS Trust Browne Jacobson Clyde & Co LLP Prisons and Probation Ombudsman's Office Government Legal 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.
9	 Mr John Penhale Ellery Senior Coroner Shropshire, Telford & Wrekin 19th December 2023