

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 of State for Prisons, Parole and Probation
1	CORONER
	I am Tom OSBORNE, Senior Coroner for the coroner area of Milton Keynes
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 17 June 2022 I commenced an investigation into the death of Scott William James Rider aged 45. The investigation concluded at the end of the inquest on 20 March 2024. The conclusion at the end of the inquest was that Scott Rider died as the result of:
	Suicide
4	CIRCUMSTANCES OF THE DEATH as determined by the jury.
	Scott Rider was a prisoner at HMP Woodhill, serving a sentence of Imprisonment for Public Protection. This was a sentence of indeterminate length. The minimum tariff was 23 months. Scott had been in prison for 17 and a half years at his time of death. Scott was transferred to HMP Woodhill on 30th June 2021 and after leaving the induction unit he was moved to House Unit 4A. He had been self- isolating for over 200 days.
	He was supported by members of staff to the best of their capacity under the circumstances, but did not always engage.
	There was no outward indication prior to Scott's death that he had an increased risk of suicide at that time. Scott's aim was to be transferred to another prison in the North.
	At the time of Scott's death, there were inadequate staffing levels and the continuing length of his sentence was uncertain.
	On the 13th June 2022, Scott was found hanging in his cell with a ligature around his neck.
5	CORONER'S CONCERNS
	During 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)



	One of the findings of the Prisons and Probation Ombudsman was that Mr Rider was one of many IPP prisoners struggling to progress in his sentence and had limited hope for release. The Governor of the prison in her evidence to me, spoke about indeterminate sentences and said "In my personal view they are indefensible". She went on to say "We find that some of the most challenging behaviours are from this group of men who feel trapped." The governor also commented that if I were to submit a Regulation 28 report to the Minister for Prisons; "most Prison Governors would welcome that intervention." On the 9th September 2005 Mr Rider received an Imprisonment for Public Protection (IPP) sentence with a tariff of 23 months; at the time of his death he had served seventeen and half years and had given up all hope of release. On any consideration of the circumstances of Mr Rider's death one has to conclude that his treatment was inhumane and indefensible and that if action is not taken to review all prisoners sentenced to IPP then there is a risk of further deaths occurring.
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 May 23, 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
	– sister of Scott Rider. The Governor of HMP Woodhill. The Head of Healthcare at HMP Woodhill.
	I have also sent it to:
	The Prison and Probation Ombudsman HM Inspector of Prisons Executive Director of Inquest
	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 and all interested persons who in my opinion should receive it.
	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: 12/04/2024
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Tom OSBORNE Senior Coroner for Milton Keynes