## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. [redacted], HMP Lowdham Grange, Nottingham** |
| 1 | **CORONER**<br><br>I am Miss Laurinda Bower, Area Coroner, for the coroner area of Nottingham City and Nottinghamshire |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 7 March 2023, I commenced an investigation into the death of Anthony Binfield. The inquest has not yet completed. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Anthony Binfield died as a result of ligature asphyxiation inside his cell on H wing, Houseblock 2, at HMP Lowdham Grange, Nottinghamshire, at 22.19 hours on Monday 6 March 2023.<br><br>At 21.23 hours, while undertaking an NPS log check, a prison officer found that Anthony had covered his cell observation panel from the inside. Contrary to the expected policy and guidance in place at the time, the officer left the cell after gaining no response to knocking and returned to the office to collect the inundation unit key. He returned to Anthony's cell and attempted to remove the inundation unit from the door but was unable to do so. He returned to the office again and arranged for a member of the security team to assist him with removing the inundation unit. Eventually, after 11 minutes, the obstruction was moved by officers via the inundation hole, whereupon they discovered Anthony was hanging from a ligature. He could not be resuscitated.<br><br>There was an 11-minute delay between prison staff learning Anthony was *unresponsive* to knocking and banging, and subsequently entering his cell. This delay is unacceptable and contrary to local policy and guidance. It will be for the jury to determine whether this delay probably more than minimally contributed to his death. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>**(1) Prison staff failing to manage the covering of cell observation panels in a** |

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| | **safe way that is compliant with the policy and guidance issued by the prison over many years.**<br><br>I am taking the exceptional step of writing to you formally before the conclusion of the inquest as I am so concerned by the evidence called to date regarding the custom and practice of officers when discovering obscured cell observation panels at night.<br><br>There is a dangerous culture of staff assuming the prisoner has obscured the observation panel for privacy purposes or as a form of protest against the regime. This neglects the obvious and very real risk that the prisoner is seeking to harm themselves, without detection. The HMPPS Safety Nudge, issued in February 2018, made clear that cell observation panels are a vital tool in keeping prisoners safe and must be kept clear at all times in order to preserve life.<br><br>The custom and practice of seeking to visualise the prisoner via the inundation unit hole (and other means, such as the side of the door) has developed over time and is now an embedded culture accepted by many officers as a response to this occurrence. This practice leads to delay in entering the cell, risks lives and is contrary to policy.<br><br>This is not a new issue for the prison and hence my concern that the prison has failed to tackle this issue over many years. In August 2020, a prisoner died at HMP Lowdham Grange as a result of drug use. When officers conducted a welfare check they found his cell observation panel to be obscured. Contrary to policy and guidance, Prison staff delayed entering the cell while they fetched the inundation unit key to attempt to observe inside the cell. The Prison and Probation Ombudsman made a recommendation to the Prison Director that they should ensure that observation panels are kept clear, and that staff actively challenge prisoners who cover them. In response, the Prison Director issued a notice to staff in January 2021 reminding staff of the need to treat any prisoner as *unresponsive* if they fail to acknowledge the officer, and to call a code blue. A similar notice was issued in April 2021, reminding staff of the need to perform a dynamic risk assessment and enter the cell in a quick and safe manner when there is no response to asking the prisoner to remove the offending item. The notice was re-issued in November 2021, and after the inquest in approximately April 2023.<br><br>Despite these multiple notices, a number of witnesses who remain members of staff at the prison (now under HMPPS employ) reported being unaware of the expected procedure when faced with an obscured cell observation panel until attending Anthony's inquest in December 2024. It is clear that the issuing of staff notices has not addressed the problem of prisoners covering their cell hatches, nor the unsafe custom and practice of staff leaving the cell and thereby delaying safe entry. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion urgent action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 February 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I am delaying the publication of this report until the conclusion of the inquest so as not to prejudice the jury who are currently empanelled.<br><br>I shall send a copy of my report to the Chief Coroner and to the Interested Persons. |

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| | I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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 | **17 December 2024** **Miss Laurinda Bower, HM Area Coroner** |