IN THE LIVERPOOLCORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Damion Anthony Andre Martin
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: [redacted] **Chief Executive** **Offender safety, Rights and Responsibilities Group** **NOMS** **Clive House** **Post Point4.11** **4th Floor** **70 Petty France** **London** **SW1H 9EX**
1	**CORONER** Martin Fleming Assistant Coroner for Liverpool
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 13/12/2011 Mr Andre Rebello, HM Coroner for Liverpool, opened the inquest into the death of Damion Anthony Andre Martin, who at the date his death was 36 years old. The inquest was resumed and concluded on 23/10/2013 before a jury. The jury found the cause of death to be: 1a – Hanging

	The jury concluded by finding that Damion Anthony Andre Martin took his own life.
4	**CIRCUMSTANCES OF THE DEATH** Liverpool Magistrates remanded Damion Anthony Andre Martin in custody to HMP Liverpool on 6/12/11 for alleged offences of Common Assault and Witness intimidation against his partner [redacted]. Upon transfer to the prison, Mr Martin undertook initial reception and medical examination and cell share risk assessment, where it was identified that he was a first time prisoner, before being placed in cell 5, landing 4 on G wing with cell mate [redacted]. Mr Martin's cell was visited several times during the role check at approximately 5.15am 11/12/11 by a prison officer. A prison officer did not further visit Mr Martin's cell during the subsequent roll check at 6.15am. Subsequently at 8.25am Mr Martin was found hanging in the w.c. area of cell 5 from a ligature made from bedding attached to the air vent above the window. Although he was cut down attempts to resuscitate him were unsuccessful and he was found to have died.
5	**<u>CORONER'S CONCERNS</u>** During the inquest the following concerns were highlighted by the evidence: - • During the initial prison reception and risk assessment, the domestic nature of Mr Martin's alleged charges of Common Assault and Witness Intimidation against his girl friend were not identified, notwithstanding it was considered to be a known suicidal risk factor. • The first prison officer to respond to Mr Martin did not commence CPR sine he felt out of date with his first aid. This raised concerns that there is no refresher training or a cycle of refresher training in basic life support. • The observation window to the w.c. area of cell 5 had a restricted view which did not extend to the area of the w.c. Mr Martin was found hanging. • Notwithstanding documentation to the contrary, a prison officer upon his roll check at approximately 5.15am did not visit Mr Martin's cell.

	I would ask that you give consideration to these above concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Mr John Illingworth, Governor to HMP Liverpool has the power take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** • Chief Coroner • Lord Chancellor • Coroners Society of England and Wales • [redacted] – Senior Investigator PPO • [redacted] • [redacted] • [redacted] • [redacted] • [redacted] • [redacted] • [redacted] • [redacted] • [redacted] Chief Executive NOMS • [redacted] Chief Inspector of Prisons • NHS (Merseyside)
9	**Signed: Mr Martin Fleming** Martin Fleming **DATED this 30th October 2013**