REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Governor of HMP Bullingdon** **It is envisaged that the Governor will liaise with the Head of Healthcare.**
1	**CORONER** I am Mr D M Salter, Senior Coroner, for the coroner area of Oxfordshire.
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** In April 2013 I commenced an Investigation and then opened an Inquest on 2 May 2013 into the death of Marcin Jacek STOGA, aged 27, who died on 24 April 2013 at HMP Bullingdon. I concluded the case at Inquest on 30 June 2014 at Oxford Coroner's Court. As it was a death in custody, it was a jury Inquest. A copy of the Record of Inquest completed by the jury is attached. It will be seen that the jury gave a narrative verdict which confirmed that Mr Stoga committed suicide but went on to say that in the jury's view there were missed opportunities to support the prisoner which were of a systemic nature. Members of staff from the prison and Healthcare gave oral evidence as did Deputy Governor [redacted] I anticipate that you will have received a report about the Inquest.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances are of course known to you but, briefly, Marcin Stoga had been at Bullingdon Prison since November 2012 on remand. The main charge against him was the attempted rape of a prostitute and, if convicted, he could expect a lengthy prison sentence. It was his first time in a UK prison. He spoke little English. He had been to court on 23 April which is the day before his death. It is believed he was due to return to court at the end of April. He was found hanging in his cell on the afternoon of 24 April. I have not provided you with a copy of the Inquest file because the file was disclosed to the prison/ Treasury Solicitors prior to Inquest.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to concerns. 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 make this report to you. The **MATTERS OF CONCERN** are as follows: (1) Prior to Mr Stoga's arrival at HMP Bullingdon, there was a Prisoner Escort Record which referred to the fact that Mr Stoga had taken an overdose in 2012. It appears that

	this form and this information was not available to the Prison Officers or the Healthcare Nurse who initially assessed Mr Stoga upon his arrival. One would have thought that the form or at least the information on the form should routinely be available to those responsible for carrying out initial assessments of this nature. (2) A second concern, which is to some degree related to the first, is the fact that prisoners (particularly those with mental health difficulties or who are otherwise at a medium/high risk of self-harm) are not routinely assessed on return from court hearings. Mr Stoga attended court on 7 December 2012 and again on 11 February 2013 and 23 April 2013, the day before his death. There were no such assessments. On this last occasion it is believed that Mr Stoga was charged with assaulting his partner. I understand from evidence and information at Inquest that there has been a review (and that this issue also formed part of the PPO Recommendations) and that persons returning from court will be seen by the Duty Reception Nurse to ascertain any change in circumstances. What is not clear is if this is anything other than a cursory assessment. It appears that a more thorough assessment is likely to be required for those prisoners who have a history of mental health issues and are believed to be at a medium/high risk of self-harm or suicide. It appears there may be a need for some written guidance for staff or perhaps a protocol. I appreciate that the two concerns I have outlined are partly within the responsibility of prison staff and partly that of Healthcare staff. Consequently, I anticipate it will be necessary for you to liaise with the Head of Healthcare. It seems to me however that overall responsibility for the safety of prisoners rests with the Governor and HM Prison Service.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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. I may extend the period on request. 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 Interested Persons. 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	[redacted] **MONDAY 21 JULY 2014**