	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Governor, [redacted] HMP Stoke Heath, Stoke Heath, Market Drayton, Shropshire TF9 2JL 2. The Minister of Justice, Clive House, 70 Petty France, London, SW1H 9EX
1	**CORONER** I am John 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 5th June 2015 I commenced an investigation into the death of Derrick Edward ROSE-FOWLER. The investigation concluded at the end of the inquest with a jury on the 15th April 2016. The conclusion of the jury was that 'The death was an intended act but with unintended consequences'.
4	**CIRCUMSTANCES OF THE DEATH** At 10.03am on 5th June 2015 deceased was found hanging by his neck from his cell window. Attempts were made to resuscitate, and he was transferred to Princess Royal Hospital, Telford where he was pronounced dead.
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. – <u>First Aid Training</u> (1) Although on the facts of this case it made no difference to the outcome, the first prison officer on the scene was not first aid trained. The evidence at the inquest was that there was no national requirement for all prison officers to be first aid trained provided a certain proportion were. (2) In hanging cases time is of the essence for CPR and if there is any significant delay by reason of the first attending prison officer not being first aid trained there is the risk of future deaths occurring. (3) By a then Rule 43 report dated the 24th February 2012 I wrote to the Governor at HMP Stoke Heath where I stated inter alia "it is a matter of concern that in December 2010 only one of four officers were first aid trained and in February 2012 one was still untrained".

	Bullying (1) There was evidence that bullying was 'rife'. Whilst the majority of the evidence at the inquest indicated that the deceased was not himself being bullied there was some evidence that he was. The prison has a Tackling Bullying Behaviour (TBB) policy but there is concern as to how effective it was implemented on the complaints raised by the deceased himself that he was, in terms, being bullied. (2) The TBB did not explicitly allow for or record that a prisoner, such as the deceased, who was not prepared to name names could nevertheless still be offered support. It is a concern that the reasons given by the various witnesses were not demonstrated to have been considered. (3) At paragraph 19 of the final PPO report it states 'there has been one other self-inflicted death at Stoke Heath, in the last 4 years – in March 2013. In the investigation into that death we found that the prison did not investigate allegations of bullying'. For completeness the central issue at that inquest was in relation to the deceased's mental health. MASH meeting (4) Regardless of whether the TBB policy was appropriately implemented there was evidence that concerns relating to the deceased should have been raised at a MASH meeting. Factors which should have triggered such a referral were: a. History of self-harm in 2014. b. Recorded diagnoses of anxiety and depression. c. An ACCT opened at HMP Featherstone in October 2014. d. The intelligence report raised by the mental health nurse in March 2015. e. The letter handed by the deceased to a prison officer in April 2015. f. The refusal of the deceased to take prescribed medication. g. The refusal of the deceased to attend scheduled GP appointments. It could not be said that any such referral would have changed the outcome but there was evidence that something would have been done.
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 17th June 2016. 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: 1. Hodge Jones & Allen LLP – for the deceased's family 2. Government Legal Department – for the prison service 3. Mills & Reeve LLP – for Shropshire Primary Care Trust 4. Prisons and Probation Ombudsman 5. [redacted] – West Mercia Police 6. To HM Inspectorate of Prisons 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	21st April 2016 J.P. Ellery Senior Coroner