Ms E Whitting
Assistant Coroner for County of Coventry
(Sitting in Warwickshire)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Deputy Director of Custody, NOMS** **2. [redacted] Director of Public Sector Prisons, NOMS**
1	**CORONER** I am Ms E Whitting, Assistant Coroner for County of Coventry (Sitting in Warwickshire)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12 August 2016 an investigation was opened into the death of Andrew David Machin aged 45, a prison officer at HMP Onley in Northamptonshire. The investigation concluded at the end of the inquest on 5 October 2016. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** By hanging from a tree in woods known as Pailton Pastures with a ligature made from heavy duty rope purchased at 15.34 hours at Home base in Rugby, just over an hour after he had been informed of the Prison Service's decision to dismiss him after 18 years of service. He was last seen in the Rugby area at around 15.50 hours that same afternoon which was the 9 May 2016. His body was discovered by police at 18.47 hours on 10 May 2016.
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. – (1)Mr Machin appeared to have had limited support from prison management during the disciplinary investigation process, despite the fact that this process continued for nearly 5 months prior to his disciplinary hearing on 9 May 2016 and he was suspended from his employment throughout this time. (2) Notwithstanding the fact that Mr Machin's death occurred in such close proximity in time to his disciplinary hearing and subsequent dismissal, there had been no internal investigation into the circumstances of that dismissal process to identify whether there had been any errors made or any lessons to be learned from it. This seemed all the more surprising in view of the fact that I was informed at the Inquest that although summarily dismissed, Mr Machin would have still been considered to be an employee until the time of any appeal of that dismissal had elapsed

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 Friday 2 December 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 [redacted] 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	Dated 07 October 2016 Signature Emma Whitting Assistant Coroner for County of Coventry

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