C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Governor, HMP Grendon**
1	**CORONER** I am CRISPIN GILES BUTLER, senior coroner, for the coroner area of Buckinghamshire
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/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23rd December 2015 Senior Coroner Richard Hulett commenced an investigation into the death of Arthur Albert MORLEY, aged 72 years. The investigation concluded at the end of the inquest before me Crispin Giles Butler on 27th March 2017. The conclusion of the jury at the inquest was set out in the Jury's narrative conclusion contained in their answers to a questionnaire. The medical cause of death was 1a Suspension. A copy of the questionnaire is attached.
4	**CIRCUMSTANCES OF THE DEATH** Mr Morley was a prisoner serving an indeterminate sentence. He had transferred to HMP Grendon for a second time in August 2015 to undertake therapy and at the time of his death was on the assessment wing. He had not been allocated to a more permanent therapy wing. Following assessment, the decision was made that he was not suitable for therapy at this time and he was to be returned to his previous prison (Returned to Unit or RTU). The decision was communicated to Mr Morley in a face to face meeting at the end of the morning on 17th December 2015. Mr Morley was found hanging from a pipe in the sanitation area on his landing at approximately 00.49 on 18th December, having accessed the interlocked night sanitation system approximately 80 minutes earlier.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In

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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.

The **MATTERS OF CONCERN** are as follows. –

(1) The death occurred in December 2015. Since then there does not appear to have been a specific audit of possible ligature points on the wings, particularly pipework in the sanitation rooms, which remain accessible at night to prisoners but are out of view of wing staff. There are no current proposals to undertake works to reduce accessibility of ligature points such as open pipes.

(2) The Local Operating Procedure LOP49 requires locking off of shower facilities at night such that prisoners would only have access to toilet facilities. Locking shower facilities could reduce access to possible ligature points. There is some work being undertaken to address the issues that many sanitation room doors cannot be locked but there appears to be no specific timescale or urgency to the implementation of this proposal.

(3) Whilst there was a hot debrief conducted very shortly after Mr Morley's death, there was no cold debrief and no Serious Incident Report. There is due to be a post-inquest debrief but as issues have emerged during the PPO investigation and the Coroner's investigation and inquest, the lack of debriefing and interim incident reports delays the implementation of any necessary learning arising as a result of this incident.

(4) The need to review and amend Local Operating Procedures LOP48 (Communications Room) and LOP49 (Access to Ablutions) has emerged through the investigation and a number of key measures have been introduced, however the need for staff to be able to access, understand and implement revised written protocols remains and there was no particular timescale indicated within which these changes might be made and new LOPs published. Mr Morley's death enabled the identification of shortcomings in knowledge and implementation of existing LOP procedures. There is a concern that staff uncertainty about operational protocols will continue until new LOPs are in place and staff are appropriately trained.

(5) There has been no specific audit of wing and night staff duties to include wing room and sanitation area inspections during lock up. Mr Morley appears to have made use of a chair in the sanitation room, but no witnesses could be certain as to how the chair had got there and from where it had come.

(6) There has been no specific review of verbal and written wing log handover procedures between day and night wing staff with a view to better highlighting and acknowledging key events (such as an RTU decision) relevant to a prisoner on that particular wing.

(7) There has been no review of whether healthcare staff (who have access to a prisoners medical notes and past mental health history) should be involved proactively in

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	RTU decisions.
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 31st May 2017. 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 The Morley Family, via their legal representatives Prisons & Probation Ombudsman HM Inspector of Prisons Care UK, via their legal representatives MoJ, via Government Legal Department [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	**4rd April 2017** **Signed:**

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