**Thomas Ralph Osborne**
**Senior Coroner for Milton Keynes**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: Governor Marfleet HMP Woodhill and [redacted] Head of Health Care HMP Woodhill** |
| 1 | **CORONER**<br><br>I am Thomas Ralph Osborne, HM Senior Coroner for Milton Keynes. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 02/08/2016 I commenced an investigation into the death of Daniel Gary Dunkley, aged 35 . The investigation concluded at the end of the inquest on 28th April 2017. The conclusion of the inquest was a Narrative of Suicide with neglect contributing to his death (copy attached). |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased was found hanging in his cell at H.M.P. Woodhill, Milton Keynes at 14.38 on 29th July 2016. He was then transported to Milton Keynes University Hospital where he subsequently died on 2nd August 2016. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>During the course of the evidence it became clear that prior to Mr Dunkley's death three referrals were made for him to undergo a full mental health assessment. None of the assessments took place prior to his death. The assessment due on the morning that he was found hanging in his cell was never notified to House Unit 2 or indeed to Mr Dunkley. Such assessments are vital to keep those suffering from psychiatric problems to be kept safe and an urgent review of the whole process is necessary. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th July 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br>• Family of Mr Dunkley<br>• Ministry of Justice<br>• Prison and Probation Ombudsman<br>• Care Quality Commission<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 02 May 2017<br><br>Signature_____<br>Thomas Ralph Osborne, HM Senior Coroner for Milton Keynes |