REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr Adrian Thompson, Governor, HMP Wandsworth, Heathfield Road, London. SW18 3HS. Head of Legal Services, St George's Hospital, Blackshaw Road, London. SW17 0QT.
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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** Between the 23rd of May 2017 and 2nd June 2017, evidence was heard before a jury touching the death of Mr **Robert John Richards.** Mr Richards had died whilst an inmate at Wandsworth Prison on 29th July 2014. He was 22 years old at the time of his death. The findings of the jury were as follows: **Medical Cause of Death** 1 (a) Hanging **How, when and where and in what circumstances the deceased came by his death:** On 29/7/2014 at 8:58 am, Robert Richards was found hanging by a sheet from a window in his cell in HMP Wandsworth. He received medical attention and resuscitation in his cell at 9:02 am. He was transferred by LAS to ICU of St George's Hospital, Tooting. He was recognised as life extinct at 21:50 the same day.

	Conclusion as to the death The jury concluded that Robert John Richards died on 29.7.2014 at 21:50 as a result of suicide by using a bed sheet to suspend himself by the neck. No other person was involved. This act led to and caused his death. The following factors contributed to his death: **Bullying:** The failure of HMP Wandsworth to manage and identify bullying within prisoners and processes (ACCT, TASA, Victim Support) did have a contribution to the death of Robert Richards. The unsuitable management of ACCT, specifically around the time of sentencing did contribute to the death of Robert Richards. The failure to prevent inheritance of debt and extortion of prisoner funds may have contributed to Robert Richards's death. **Intelligence:** the failure of HMP Wandsworth to utilise and communicate intelligence information to prison officers may have contributed to the death of Robert Richards. **Training:** The insufficient medical training in prison staff may have contributed to the death of Robert Richards. The lack of training on ACCT and other processes for prison staff resulted in documents not being completed effectively. **Medical:** The insufficiently equipped medical staff at HMP Wandsworth contributed to the admitted failings in the attempted resuscitation. This refers to : (1) Lack of use of a bag valve (2) Empty oxygen cylinder (3) Lack of pads for the defibrillator These shortcomings however were not causative of the death. **Resources:** The reduced staffing levels due to cuts impacted on the ability of prison staff to deliver effectively their care and responsibilities towards prisoners. This results in increased time restraints to complete processes such as ACCT, TASA and Victim Support.
4	**CIRCUMSTANCES OF THE DEATH** Mr Richards died whilst an inmate in the Vulnerable Prisoners unit at Wandsworth. He was there awaiting sentencing for a violent sexual offence .He was regarded by most witnesses as seeming much younger than his chronological age and vulnerable. He had been housed with another sex offender who had past convictions involving the abuse of young men. This man went on to abuse Mr Richard's and then hanged himself probably due to bullying and extortion. (The inquest touching this death is due to be heard.) Following the death of his cellmate, evidence suggested that Mr Richards "inherited "his ex-cellmate's debt and was being bullied. In many ways the extensive findings of the jury in this speak for themselves. There were admitted failings in resuscitation as documented above.

	The evidence was that the system in place to manage bullying in the Prison, TASA, was simply hardly being used throughout the prison as a whole and was not used effectively in this case, despite multiple evidenced situations when it should have been considered at least. These situations included complaints made by Mr Richards of sexual and physical assault and being bullied to carry a mobile phone in his rectum. ACCT was also not effectively applied when it was put in place by the staff, and was not used in situations when it should have been, such as just before he was due to be sentenced. Many of those who gave evidence referred to a shortage of staff impacting on their ability to work effectively and appropriately and that even fewer staff are rostered to work now than at the time of Mr Richards's death. Evidence was taken that vulnerable prisoners on the wing were mixed with those less vulnerable and that bullying was rife. At times prisoners from other wings walked through the wing to access other prison areas. Although bullying was well known, it was not effectively managed with failures in intelligence gathering and dissemination to staff, failures in control of known bullies, and failure to appropriately protect Mr Richards and manage his risk of self-harm. There were failures in effective communication at all levels.
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. That bullying within HMP Wandsworth is not appropriately managed due to inadequate systems being in place, too few staff on duty, poor communication between teams, inadequate staff training, poor recognition of risk and the mixing of vulnerable prisoners with potential bullies. 2. The organisation of the vulnerable prisoners' unit is such that those truly vulnerable are mixed with those prisoners placed there for reasons as drug debt from other wings, who are not vulnerable in other ways and then abuse prisoners such as Mr Richards. 3. That prisoners from other wings pass through the VP unit on a regular basis and thus increase the chance of bullying to the vulnerable prisoners. 4. That the system for cell allocation is inappropriate such that a young and immature and vulnerable man such as Mr Richards was sharing a cell with a prisoner with convictions for predatory sexual behaviour with boys. 5. That training of medical staff in relation to Resuscitation is inadequate. 6. That the system for ensuring restocking of medical supplies such as oxygen after they have been used needs to be reviewed. 7. That the communications interface between the medical staff, those supplying psychological support and psychiatric services needs to be improved, as does the communication of these staff with prison officers, such that risks of self harm and bullying are appropriately communicated and acted upon. 8. That there is a risk assessment undertaken of prisoners in the approach to sentencing so that any increase in risk may be appropriately managed. 9. That security and intelligence systems are upgraded and overhauled such that risks of bullying and crime within the prison that feed into self-harm and suicide by prisoners are reduced and contained appropriately. 10. That the personal officer system be re-established, so that prisoners have a named officer who knows them well. Risks should then be communicated and managed more appropriately within HMP Wandsworth, such that self-harm and suicide of prisoners is reduced.

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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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. [redacted] c/o [redacted] Hickman Rose Solicitors, Aylesbury House, 17-18 Aylesbury Street, London EC1R 0DB 2 Prisons and Probation Ombudsman, PO Box 70769, London SE1P 4XY 3. HM Inspector of Prisons, Clive House, 5th Floor, 70 Petty France, London SW1H 9EX 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	**20th November 2017**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**