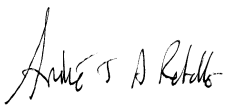
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Michael Spurr Chief Executive and Chief Executive Officer HM Prison and Probation Service Clive House 70 Petty France London SW1H 9EX
1	**CORONER** I am André Joseph Anthony Rebello, Senior Coroner, for the area of Liverpool and Wirral
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 8th April 2016 I commenced an investigation into the death of **Sam MOLYNEUX** , Aged **21**. The investigation concluded at the end of the inquest which started on 4th September 2017 and subsequent days to the 13th September 2017. The Jury concluded that "Sam Molyneux committed suicide. We have found that Sam Molyneux put himself in the position he was found with the intention of ending his life by using a hand-made ligature made from a bed sheet to hang himself from the grill within his cell, H2-8, at 68 Hornby Road on 01/04/16 between 21.15 and 22.10. There was a failure to open an ACCT on 31st March 2016. Sam Molyneux was assaulted in the days leading up to his death by other prisoners. It is unclear as to whether HMP Liverpool and its staff responded appropriately to any assaults against Sam Molyneux. Furthermore, it is more likely than not that bullying in prison contributed at least in part to the death of Sam Molyneux." The medical cause of death was: Ia Asphyxiation due to Ib Compression of the neck due to Ic Hanging by a ligature
4	**CIRCUMSTANCES OF THE DEATH** MOLYNEAUX was a prisoner at HMP Liverpool and was in cell 8 on H wing. This is a drug dependency wing. He was the sole occupant of the cell. He was assaulted by other prisoners on the 27th March 2017. He was subject to basic regime IEP status having broken his observation spyhole and having climbed on to the office roof. He underwent a Governors adjudication on the 31st March 2016, at which he pleaded guilty and handed the governor a letter in which he expressed thoughts of self-harm. On Friday 1st April 2016 MOLYNEAUX was seen at 21:15 hours in his cell and all was in order. At 22:10 hours the prisoner officer was conducting his checks when he has looked through the spy hole and saw that MOLYNEAUX was hanging from torn sheets that had been knotted onto the grills of the window. The officer attempted to gain access

	to the cell but the door had been barricaded, by the use of a table from inside the cell. The door was eventually forced and entry was gained by prison officers, where the ligature was cut and first aid commenced on MOLYNEAUX. Paramedics attended and continued with resuscitation and eventually MOLYNEAUX was pronounced life extinct at 22.55hrs 01/04/2016 by a paramedic.
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. – During the course of the inquest it became apparent that in old prisons not all wings have been adapted to have anti-barricade doors. In this case Mr Molyneux had barricaded his door and this delayed prison staff gaining access to him during a Code Blue Situation. He was not on an ACCT but perhaps should have been given his threats of suicide and self-harm articulated by him in a letter to a Governor on an adjudication the day before his death. Local directions in the Prison during the inquest have addressed this situation in HMP Liverpool at Walton. That said HM Prison and Probation service might wish to consider amending "Management of Prisoners at risk of harm to self, to others and from others (Safer Custody)" to include consideration of where reasonably practicable avoiding locating prisoners behind a door which is not designed to circumvent barricading.
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 10th November 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 Mother of Sam Molyneux HMP Liverpool Lancashire Care NHS Foundation Trust 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **Dated: 13th September 2017**