ANNEX A

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:** 1. **Mr Michael Spurr, Chief Executive National Offender Management Service, 7th Floor, Clive House, 70 Petty France, London, SW1H 9EX** 2. **Rt Hon Jeremy Hunt, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London, SW1A 2NS**
1	**CORONER** I am David Hinchliff, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 26th April 2016 I commenced an investigation into the death of Emily Jayne Hartley age 21. The investigation concluded at the end of the inquest held on 15th January 2018 until 1st February 2018 before a Jury. The conclusion of the inquest was in narrative form, a copy of which is attached.
4	**CIRCUMSTANCES OF THE DEATH** Emily Jayne Hartley was a serving prisoner at Her Majesty's Prison New Hall. On Saturday 23rd April 2016 Emily was allowed out of the confines of the winged building for exercise. She was recorded as being on exercise at 15:00 hours that day, yet CCTV material shows that she left the wing at 14:24 hours with other prisoners. They left the wing through the main wing entrance door and were on exercise. The exercise area extends to the rear of the winged building which is itself a large detached two story block with a grassed area at the rear surrounded by a high perimeter fence. There was a part of this area declared to be "out of bounds" and Emily would have been aware of this. Nevertheless this area can be easily accessed. Once exercise is complete the prisoners should be counted back onto the wing. At 16:45 hours staff realised that Emily had not collected her meal and she could not be found. It was apparent that Emily had not returned to the wing. At 16:50 hours following a perimeter check Emily was located suspended from a torn piece of bed sheet fastened to a steel security gate in a recessed area in the out of bounds section. Emily was cut down, CPR was commenced by prison staff which was continued when Paramedics arrived. Her death was confirmed by Paramedics at 17:43 hours at that location. Emily was the subject of an ACCT plan (assessment, care in custody and team work) and should have been observed at twice per hour intervals. Emily had mental health issues and suffered from an emotionally unstable borderline personality disorder which made her impulsive and prone to self-harm and suicide. Concerns were expressed that the management of self-harm and suicide procedures, in particular the monitoring and recording were seriously deficient and that some of the noted failings were systemic. Information sharing was weak, there was a lack of integrated planning. The supervision of Emily when she died and whilst on Suicide prevention was so poor that she was not found for nearly two and a half hours. There were allegations of bullying when she was on a wing designated as being a therapeutic setting.

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) It became apparent from the evidence of many Prison Officers and Healthcare Workers that Prison was not the appropriate environment for someone with Emily's mental health problems. The emphasis should have been on treatment but within a secure environment which Prison, with the most well intentioned staff, cannot adequately provide.

(2) Coincidentally ten years ago I heard an Inquest into the death of Petra Blanksby, also at New Hall Prison. At the conclusion of this Inquest I made a recommendation pursuant to what was then Rule 43 of the Coroner's Rules 1984. I attach a copy of my Rule 43 recommendations which I repeat in every detail in respect of the death of Emily Jayne Hartley. Furthermore I state that a Prison is not the appropriate place to accommodate Emily and that there should be facilities, particularly in the Prison's female estate, to provide a therapeutic yet secure environment with the emphasis being on treatment.
I repeat ten years later that the Prison's department and the Department of Health should conduct a collaborative exercise to achieve the provision of suitable, secure, therapeutic environments in order to treat those with mental health problems of the nature of those demonstrated by Petra Blanksby ten years ago and now Emily Jayne Hartley. I would refer you to a paper prepared by "Inquest" entitled Preventing the Deaths of Women in Prison and the Need for an Alternative Approach which was published in June 2013 and also a report by of a review of Women with Particular Vulnerabilities in the Criminal Justice System.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that 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 27th April 2018. 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:-

of Harrison Bundey Solicitors
f Mills & Reeve Solicitors
of A2 MOJ Private Law Litigation

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	2nd March 2018