

# **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

	THIS REPORT IS BEING SENT TO:
	The Governor
	HM Prison
	9 St. Loyes Street
	Bedford MK40 1HG
	WK40 THG
1	CORONER
	I am Ian Pears, Acting Senior Coroner for Bedfordshire & Luton
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/part/7/made
3	INVESTIGATION and INQUEST
	On 17 March 2017 I commenced an Investigation into the death of Michael BERRY, aged 34 years. The Investigation concluded at the end of the Inquest on 16 May 2018. The Conclusion of the Inquest was that Michael deliberately chose to suspend himself but the evidence did not fully explain whether or not he intended the outcome to be fatal. The medical cause of death was:
	I a Global hypoxic brain injury
	I b Hanging
	II Depression
4	CIRCUMSTANCES OF THE DEATH
	The Deceased was found hanging from a sheet in the Medical Wing of Bedford Prison on 10 March 2017. When found, he was unresponsive with no palpable pulse and his pupils were unreactive. He received basic life support from the prison staff who achieved return of spontaneous circulation. He was intubated at the scene by the Helicopter Emergency Medical Services Team. Following this he was transferred to Bedford Hospital and admitted to the Critical Care Unit where he remained intubated and ventilated. A CT scan of his head was reported as normal. Sedation was stopped on 14 March 2017 but apart from breathing spontaneously, Michael showed no further signs of any meaningful neurological recovery. The opinion of the Neurologist was that he had sustained an hypoxic brain injury and the prognosis was very poor. Accordingly, life-sustaining treatment was withdrawn on 16 March 2017 and he died very shortly afterwards.
5	CORONER'S CONCERNS
	During the course of the Inquest the evidence revealed matters giving rise to concern. In my
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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) Michael was in Healthcare Cell number 1 which throughout the Inquest was described variously as a "Reduced Risk Cell" or "Safer Cell". It appears that in fact it is not a reduced risk cell but more a "Half Way House" in that the furniture is fixed to the floor. In the cell, however there was a very obvious ligature point that could be avoided, namely the window, which opens inwardly. On the face of it there would appear to be many design solutions that would overcome the need for an opening window that provides such an obvious ligature point.

### 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 OUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this Report, namely by **19 July 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.

- (the deceased's mother)
- Northamptonshire Healthcare 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 Dated 22 May 2018



IAN PEARS
Acting Senior Coroner
for Bedfordshire & Luton