

IN THE MID KENT AND MEDWAY CORONER'S COURT

In the matter of the inquest touching the death of **PAUL DAVID ANTHONY JAMES**

A regulation 28 report – **ACTION TO PREVENT FUTURE DEATHS**

This report is being sent to:- **THE SECRETARY OF STATE FOR JUSTICE**

Copies to:- The Governor, HMP Elmley; The Chief Coroner.

1/ **Coroner** - Christopher Sutton-Mattocks, HM Assistant Coroner for Mid Kent and Medway

2/ I make this report under paragraph 7 (1) of Schedule 5 to the Coroners and Justice Act 2009.

3/ The inquest into the death of Mr James was opened and adjourned on 23/12/16. It was resumed on 9/4/18 and concluded on 18/4/18.

The cause of death was 1a Incised Wound to Abdomen. The conclusion of the jury was death by misadventure. In a discrete question asked of the jury the conclusion was that it had been unreasonable to allow Mr James access to razor blades in his cell.

4/ The circumstances of the death.

Mr James was arrested in Gillingham on 24/4/16 for criminal damage. He was taken to Medway Maritime Hospital as a result of extensive injuries to his left arm due to self harm. When taken into custody at Medway Police Station he told the custody sergeant that on this

occasion he had intentionally self harmed and that he had also tried to harm himself on previous occasions whilst under the influence of drink or drugs.

He was initially remanded in custody at HMP Belmarsh. On 30/6/16 he was sentenced to 2 years and 2 months imprisonment for offences of affray and the breach of a suspended sentence for assault occasioning actual bodily harm. He was received into HMP Elmley on 31/5/16.

On 5/7/16 an ACCT (assessment, care in custody and teamwork report) was opened after Mr James stated that he wanted to take his own life.

On 8/7/16 Mr James was in a three person cell. He cut his arms and thighs . The room was covered in blood. Staff then saw Mr James cut his right forearm and pull out his own organs; fat, vessels and ligaments could be seen. He would not stop. He then found another razor blade and cut his inner thighs. Officers put on full protective clothing and after entering the cell subdued Mr James. Senior Officer Cunningham described it as the worst self harm he had ever seen. An ambulance and an air ambulance were summoned and Mr James was taken to King's College Hospital where he was placed in an induced coma.

Mr James returned to HMP Elmley on 13/7/16. Between that date and the date of his death, 20/12/16, he was the subject of considerable attention from prison health care. That included assistance in the inpatients department, once for some considerable time and specialist care from two consultant psychiatrists. In the latter stages it became clear that he was not taking the drugs prescribed to him.

On 20/12/16 Mr James was found in his cell at 09.50 am having made tentative cuts to his abdomen with a razor blade. He had then made a 17 cm long cut to his abdomen to a depth of approximately 3 cm. Officers, a nurse and a doctor attended but it was clear to them that Mr James had died some time earlier. He was certified dead at 10.03 am.

The Coroner's Concerns

This was a prisoner with a known history of serious self harm even before 8/7/16. On that day he had used razor blades to inflict very serious injuries to himself. He was known to have ceased taking his prescribed medication. He was placed in a single cell and permitted access to razor blades again. Following Mr James being found dead in his cell on 20/12/16 three razor blades were found by [REDACTED], Kent Police, in a search of the cell. The blades had been used to make nine tentative cuts to the abdomen followed by a 17 cm cut. His intestines were exposed on the bed alongside him. The consultant pathologist, [REDACTED], gave evidence that he had died as a result of loss of blood over a period of approximately 20 minutes.

The Matters of Concern

That Mr James was given access to razor blades in all the circumstances.

Action to be taken

Practical difficulties in restricting the supply of razor blades were raised in evidence by the [REDACTED]. They included the following:- razor blades are handed out for reasons of personal hygiene, that they are available from the canteen, that they could be obtained from other prisoners, that other sharp instruments might be used instead and that serious self harm with the use of razor blades is rare.

Action that should be taken to prevent future deaths. There should be further investigation and research undertaken to develop protocols and procedures to deny prisoners access to razor blades in the rare circumstances in which a prisoner is known to have seriously self

harmed with the use of razor blades in the past, and especially when it is known that he/she has self harmed on other occasions

C J SUTTON-MATTOCKS

Assistant Coroner for the County of Kent

27/4/18