	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Michael Spurr** **Chief Executive** **Ministry of Justice** **70 Petty France,London SW1H 9AJ**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 21 February 2017 I commenced an investigation into the death of Christopher Andrew Moss aged 51 years. The investigation concluded at the end of the inquest on 25 February 2019. The conclusion of the inquest was suicide with the main cause of death being haemorrhage from incised injury to left wrist.
4	**CIRCUMSTANCES OF THE DEATH** **Basic: a) Mr Christopher Andrew MOSS was a serving prisoner at HMP Featherstone who died whilst on House Unit 6 on 18th February 2017 as a result of a self-inflicted incision to left wrist.** **Probable: b) Locked cell door and restricted view via the door observation hatch; barricading of cell door.** **Possible: c) Threats; state of mind**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows. – The conclusions of the investigations by the Prisons and Probation Ombudsman led to a suitable action plan being implemented at HMP Featherstone in matters relating to violence reduction, discharge from mental health team and barricade incidents. At the incident when Christopher died initially a hydraulic jack to open the cell door was summoned to the scene when the appropriate equipment was a hooligan bar (it did in fact arrive very soon afterwards). I am aware that there is a gradual process in the prison estate to move towards cell doors that can be opened outwards if

	necessary in addition to normally opening inwards. My concern however is that for doors that are not dual opening prisons should have appropriate equipment available to deal with barricade situations. Should there be a check or audit to ensure that the correct equipment for the relevant doors are located appropriately at prisons?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation has 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 23.4.2019. 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 – Irwin Mitchell solicitors (acting for the family), BLM solicitors (acting for Care UK) and the Government Legal Service (your solicitors). I have also sent it to the Prisons and Probation Ombudsman, Thompsons solicitors (acting for the Prison Officers Association) and the Independent Monitoring Board for HMP Featherstone who may find it useful or of interest. 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	**26 February 2019** ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk