Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Mr Phil Copple, Director General Prisons
HMPPS
102 Petty France
London
SW1H 9AJ
[redacted]

1 CORONER

I am Andre 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 11/10/2017 I commenced an investigation into the death of Carl John Newman aged 23. The investigation concluded at the end of the inquest held from the 2nd to the 6th March 2020.

The jury conclusion of the inquest was: **Carl John Newman died by suicide**

The medical cause of death was found as:
I a Compression of the neck

I b Hanging

I c ----------

II ----------

4 CIRCUMSTANCES OF THE DEATH

The Jury found:
During admission to 68 Hornby Road, Liverpool on the 3rd October 2017 the Person Escort Form indicated that there was no immediate self-harm risks to Carl John Newman, also the Cell Sharing Risk Assessment concluded there was more of a risk to others as opposed to himself. Further, a medical assessment filed by the Mental Health Nurse also drew the conclusion that there was no current risk to himself. The majority of witness statements indicate that Carl Newman was not distraught during his time in the Induction Unit. After 3rd October 2017, there was no known indicators of risk. However, the Day Two Assessment had not been completed in a timely manner, which may have flagged any potential risks.

Between the hours of 9.26am and 9.53am on the 6th October 2017, texts were received and statements indicate that calls were also exchanged between Carl and his former partner. On the 6th October 2017 between the hours of 9.30am and 11.30am, a ligature was fashioned around Carl Newman's neck in the toilet area of cell A5/11. It is believed Carl John Newman initiated this act with the intention of ending his life.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

During the Course of evidence it became apparent that prison staff did not have ready access to training records in particular ACCT & SASH training – one officer engaged in prison reception processes had not had ACCT training for over three years – and surprisingly it was another three years before he underwent SASH training. As HMP Liverpool were present throughout this investigation, the court understands that these training issues are being resolved locally. However this is a national issue and It is important that not only should HMPPS hold training records for those employed in the prison service but that each individual should have a personal training record. It would help if training certificates with expiry dates were issued after all courses with a copy being given to attendees and the record being held by the prison service. This would ensure all officers with current training could work across the prison estate, adding resilience.

What does HMPPS intend to do to ensure that all officers and staff have current training in ACCT and other safer custody processes?

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 01 May 2020. 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 family of Carl John Newman
HMP Liverpool
Spectrum – Healthcare Care provider at HMP Liverpool

I have also sent it to
The Prison and Probation Ombudsman
and
HM Inspectorate of Prisons
Both at
Third Floor, 10 South Colonnade, London E14 4PU
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.

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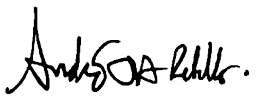

Andre REBELLO
Senior Coroner for
Liverpool and Wirral
Dated: 06 March 2020