ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Governor, HMP Leeds, c/o [redacted], Government Legal Department**
1	**CORONER** I am James Hargan, Assistant Coroner, for the Coroner area of West Yorkshire (E).
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 21st November 2018, Senior Coroner, Kevin McLoughlin commenced an investigation into the death of Wayne Boughen, aged 40. The investigation concluded at the end of the Inquest on Thursday 3rd June 2021. The conclusion of the Inquest was that Wayne Boughen deliberately suspended himself with a ligature around his neck, but the jury were unable to determine his intention in doing so. The medical cause of death was 1a. hypoxic-ischaemic encephalopathy, 1b. hanging.
4	**CIRCUMSTANCES OF THE DEATH as recorded by the jury;** Wayne Boughen was detained in HMP Leeds at the time of his hanging. He was found suspended from a ligature in cell D2-42 at 00:42 hours on 16th November 2018 and died in Leeds General Infirmary on 17th November 2018. Wayne deliberately suspended himself from a ligature and no one else was involved in his death. As to Wayne's intentions the evidence is inconclusive. The wider circumstances of Wayne's death are as follows: 1. Recent (within the 5 weeks leading up to his death) incidents of self-harm, threats of suicide and a claimed suicide attempt. 2. A missed visit from his mother in the days before his death. The reasons for the cancellation of this visit were unclear. Wayne had stated the importance of this relationship to his well-being. 3. The psychiatric evaluation planned for 14th did not take place. No reason has been established. 4. There was an open ACCT requiring among other things (at the time of the hanging) hourly irregular observations. 5. Prison officers differed in their interpretation of 'hourly irregular observations' eg whether that required a maximum of 60 minutes between observations. 6. Wayne was in a standard cell. 7. There were no cells in HMP Leeds meeting the national guidelines for safer cells. 8. Family members and fellow prisoners had raised concerns about Wayne's mental health in the weeks before his death.
5	**<u>CORONER'S CONCERNS</u>** 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. At the time of Wayne Boughen's death, HMP Leeds did not have any cells which were certified safer cells (anti-ligature cells) in accordance with national standards. 2. HMP Leeds still does not have any such certified safer cells. 3. HMP Leeds has a small number of cells which have an increased level of safety as compared with the majority of cells within the prison, but even they do not comply with the certified safer cell standard. 4. In an ordinary cell, Wayne Boughen was able to suspend himself using a ligature fashioned from a prison issue jumper.
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 Wednesday 18th August 2021. 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: 1. [redacted], Practice Plus Group 2. [redacted], Daughter 3. [redacted], Brother 4. [redacted], Uncle 5. [redacted], Ex-partner I have also sent it to the Lord Chancellor Secretary of State for Justice, The Rt Hon Robert Buckland QC MP 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	Signed:  MR JAMES HARGAN Assistant Coroner West Yorkshire (E) Dated: 23th June 2021