REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted], Governor HMP YOI Glen Parva** **Michael Spurr, Chief Executive, National Offender Management Service.** **Rt Hon Elizabeth Truss MP, Lord Chancellor and Secretary of State for Justice.**
1	**CORONER** I am Lydia Brown, assistant Coroner, for the area of Leicester City and Leicestershire 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 25th March 2015 I commenced an investigation into the death of Liam Adrian John Lambert. The Inquest concluded on 7th September 2016.The Jury's conclusion was: Suicide- Narrative Conclusion.(Questions and Answers) 1. Were the alleged incidents of bullying adequately recorded in all required documentation on each occasion? Answer. No. Were all appropriate persons notified to afford a proper opportunity to avoid future occurrences, such as the Acorn workshop staff? Answer. No. 2. ACCT Document. Was this fully completed with all relevant information? Answer. No. Did it accompany Liam on each occasion when he left the unit? Answer. No. Did it identify the relevant issues, needs and risks and adequately plan actions to resolve or reduce these? Answer. No. Were all appropriate individuals or organisations invited to the ACCT reviews on each occasion? Answer. No. Was it appropriate to close the ACCT on 19th March 2015? Answer. No. 3. Are there any other factors or circumstances outside the prison you feel to be relevant? Answer. Lack of family contact, bad relationship with his father in England, Liam's trouble with a restraining order with his girlfriend and the lack of contact with his family in Australia. 4. Was there a delay in identifying the discovery of Liam on evening of 19th March 2015 as requiring a code blue (emergency medical) response? Answer. Yes. If so, did that delay possibly contribute to the outcome? Answer. Yes. Was there a delay by prison staff in assisting paramedics to reach Liam's cell on that night? Answer. Yes. If so, did the delay possibly contribute to the outcome? Answer. Yes.

	Cause of death: 1a Hypoxic brain injury 1b Asphyxia 1c Hanging II
4	**CIRCUMSTANCES OF THE DEATH** Liam arrived in Glen Parva Young Offenders Institution at the beginning of February 2015. His anticipated release date was 1st April 2015. On 12th March he caused minor deliberate self harm and an ACCT document was opened, noting that the reason for his self-harm was due to bullying on the wing. He was identified as being socially isolated as his family were living in Australia. He had no visits and made no telephone calls: an official visitor was planned but did not see him before he died. Liam was assaulted on 2 separate occasions by different individuals, despite being moved from the wing where the bullying had taken place, as these individuals were encountered in general areas of the prison estate. Proper consideration of the risks, the available intelligence and Liam's activities would have avoided these assaults. The ACCT was not fully or properly completed or utilised and was closed inappropriately. On the day Liam ligatured himself, the ACCT was closed, he later that afternoon asked for and was granted a move to a single cell. He was discovered hanging later in the evening. The emergency response of the prison officers was not according to policy, and there was a delay in assisting the ambulance crew to attend scene.
5	**CORONER'S CONCERNS** 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. The ACCT document was not completed fully, did not accompany Liam around the prison as it should have and not all appropriate individuals were invited to the reviews. Available documentary information was not read or used, and pressures of time were cited to explain these failings. Consideration should be given to formally confirming that all necessary documentation has been considered prior to the ACCT review, and to ensure the Officers and Healthcare staff are aware of their responsibilities. 2. This ACCT was only open for a short period. It did not serve Liam's needs properly and was closed before any review system picked up the inadequacies. 3. The Governor provided evidence that resourcing was affecting the ability of officers to carry out their duties regarding keeping prisoners safe from self harm. In this particularly vulnerable population of young men, their safety is paramount and this should be the first consideration.
	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	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday15th November 2016. 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: [redacted] (Mother) [redacted] (Father) Prison and Probation Ombudsman Leicestershire Partnership Trust University Hospitals of Leicester Lester Morrill Solicitors (Representing Mother) Government Legal Department East Midlands Ambulance Service Thompsons Solicitors. 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	**[DATE]** **20th September 2016.** **[SIGNED BY CORONER]**