INQUISITION

An Inquisition taken for our Sovereign Lady the Queen

at Royal Shrewsbury Hospital in the County of Shropshire on the 6th day of April 2011
and by adjournment on 10th day of October 2012 at Wem Council Chambers in the County of Shropshire
Before and by me John Penhale Ellery
Her Majesty's Coroner for Mid and North-West Shropshire Coroner's District
The following matters were found

1.Name of Deceased

Nicholas George Thomas SAUNDERS

2.Injury or disease causing death

Ia **Hanging**

b

c

II

3.Time, place and circumstances at or in which injury was sustained

Nicholas George Thomas Saunders was found hanging from a ligature fixed to a light fitting at HMP/YOI Stoke Heath, B Wing Cell 01-01 Saturday 2nd April 2011. Last seen alive 11.45 a.m. found at 1.44 p.m.

4. Conclusion of the Jury as to the death

The deceased killed himself

See attached Questionnaire

5. Particulars for the time being required by the Registration Acts to be registered concerning the death

(a) Date and place of birth **30 July 1992** **Shrewsbury, Shropshire.**	
(b) Name and Surname of deceased **Nicholas George Thomas SAUNDERS**	
(c) Sex **Male**	(d) Maiden surname of woman who has married
(e) Date and place of death **Second April 2011** **11 Warrant Road, Market Drayton, Shropshire**	
(f) Occupation and usual address **Bar Tender** **15 Albert Gardens, Shrewsbury, Shropshire**	

Signature of Her Majesty's Coroner ..... **John Penhale Ellery**

Signature of Jurors (if present)

....

....

....

....

INQUISITION

An Inquisition taken for our Sovereign Lady the Queen

The following matters were found

1.Name of Deceased Nicholas George Thomas Saunders.

2.Injury or disease causing death

Ia Hanging

b

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II

3.Time, place and circumstances at or in which injury was sustained

Nicholas George Thomas Saunders was found hanging from a ligature fixed to a light fitting at HMP/YOI Stoke Heath, B'wing cell 01-01 Saturday 2nd April 2011, last seen alive 11.45am found at 1.44pm.

4. Conclusion of the Coroner as to the death

Deceased - killed himself

5. Particulars for the time being required by the Registration Acts to be registered concerning the death

(a) Date and place of birth 26th July 1992 - Shrewsbury
(b) Name and Surname of deceased Nicholas George Thomas Saunders
(c) Sex Male
(d) Maiden surname of woman who has married
(e) Date and place of death 2nd April 2011 11 Weccroft Road, Meole Brace, Shrewsbury Shropshire, SY3 9JL
(f) Occupation and usual address Bar Tender 15 Albert Crescent, Shrewsbury Shropshire SY1 1HW

Signature of .....

Signature of Jurors (if present)

.....

L. Owens.

.....

M. Hesp

The jury unanimously

1. ~~Do you~~ consider that the fact that the closed ACCT was not transferred from HMP Woodhill to HMP/YOI Stoke Heath and/or the fact that it did not arrive on B Wing ~~caused or~~ contributed to Nicholas' death?

We have come to a unanimous decision

2. ~~Do you consider~~ that the fact that the prison officers on the wing who gave evidence did not know of Nicholas' previous suicide attempt at HMP Woodhill and the closed ACCT ~~caused or~~ contributed to his death? due to the lack of factual information barely readily available to those responsible for the welfare of Nicholas

3. Do you consider the visitor booking for Sunday 3rd April 2011 showing the names of Shane Jones and Nathan Evans was a computer glitch or a human act?

The jury as a majority (8:1)

4. Regardless of how the visitor booking arose ~~do you~~ consider that it ~~caused or~~ contributed to Nicholas' death?

3, 4 As a jury we feel there is insufficient conclusive evidence to determine whether it was a computer glitch or human error. We feel that further investigation is needed to ascertain what happened.

Questions 1, 2, 3

L. Owen.

R. Heap

Question 4

L. Owen.

J.P. ELLERY

H.M. CORONER FOR THE MID AND NORTH-WEST SHROPSHIRE CORONER'S DISTRICT

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Sent from/please reply to: [√]
JPE/EB

Ms Nicola Waterman,
Ministry of Justice
Offender Safety, Rights & Responsibilities Group
National Offender Management Service
Post point 4.11
4th Floor
Clive House
London SW1H 9HD

30 October, 2012.

Dear Ms Waterman,

Nicholas George Thomas SAUNDERS deceased
Died in Custody at Stoke Heath HMP/YOI – 2 April 2011
Following transfer in from HMP Woodhill
Inquest – Wem Council Chamber – 10-25 October 2012
Rule 43 Report

I wrote to you on the 24th February 2012 in connection with an earlier death at Stoke Heath (MJC 2010) and you replied on the 18th April 2012.

I write again following the death of another prisoner at Stoke Heath HMP/YOI this being the death of the late Nicholas George Thomas Saunders. I concluded the Inquest with a Jury on the above dates. Various issues arose which I wish to draw to your attention.

Nicholas was found deceased in his cell following the lunchtime lockdown at Stoke Heath on Saturday the 2nd April 2011. The Jury found that Nicholas killed himself sometime between 11.45 a.m. and 1.44 p.m. in his cell B1-01 on B Wing.

The Jury also heard evidence as to various issues including three upon which they were specifically asked questions. I enclose a copy of the Inquisition and the Questionnaire as completed by the Jury. The third issue, the Visiting Order issue, was split into two parts.

Transfer of closed ACCT

The evidence was clear that an ACCT which had been opened and re-opened at Woodhill was closed but did not reach Stoke Heath when Nicholas and the core records were transferred on 15 February 2011. As you will see the Jury concluded that that fact contributed to Nicholas' death. It appears that Woodhill never sent the closed ACCT and nor did Stoke Heath, who were aware that an ACCT had been opened, request it.

Knowledge of Officers on the Wing

Secondly, it was clear that whilst there were medical and other officers at Stoke Heath who knew of Nicholas' previous attempt at suicide and the fact that he had been on an ACCT the Officers on the Wing with day to day care of Nicholas did not. Again, you will see the Jury considered that contributed to his death.

Visiting Order Booking

In respect of the Visiting Order you will see that the Jury was unable to determine whether it was a computer glitch or a human act. Regardless of that Nicholas enquired on the Friday and/or Saturday if his mother was coming to visit him that weekend (the Sunday was Mothering Sunday 3rd April 2011). He was told she was not but two of his friends were. In fact his mother had booked the visit on the Wednesday, his friends had not, but in error their names appeared under the unique visiting number for his mother. You will see that the Jury (by a majority) concluded, regardless of how it arose, that that contributed to Nicholas' death.

Lines in cells

Two other issues arose which I wish to draw to your attention and they relate to the means by which Nicholas created and attached the ligature. Firstly, the ligature was created by Nicholas ripping his bed sheets. There was evidence from an Officer on the Wing who said that prisoners could and did create lines made from bed sheets to dry washing. The Officer confirmed that that use was unauthorised but unless there was a particular concern it would not be taken down. That practice may have been local and specific to B Wing and appears to have been operating below Governor level as a Governor confirmed it was unauthorised and she was not aware of it. Apart from damage to prison property creating a line which could be used as a ligature poses an obvious risk to someone who may be feeling suicidal.

Standard light fitting

Secondly, the ligature was attached to the lighting arrangement in the ceiling of the cell. Nicholas had attached a ligature to either end and the ligature and the light fitting were sufficiently strong to take his weight (74 kilograms, nearly 12 stone) with his feet off the ground. It is also similar to the way in which another prisoner (KCRL) died in 2005. The family was concerned that the standard light fitting was a risk to those who might intend to kill themselves and be able to do so at or above head height. I am aware that these concerns can raise policy and resource issues but as a prisoner does not have to be on an ACCT (or relocated to a safer cell) to be at risk of self-harm consideration should be given whether the standard fitting can be improved or modified in a way so as to prevent ligatures being attached.

I draw these matters to your attention under Rule 43 of the Coroners Rules 1984 as amended. I attach guidance notes as to how you should reply and look forward to hearing from you within 56 days.

I am forwarding a copy of this letter to all those stated below.

Yours sincerely,

Copy to: Bhatt Murphy, Solicitors for the family
Mr B. Saunders-Fern, father
TSol, Solicitors for the Prison Service
Mills & Reeve, Solicitors for Shropshire County PCT
Ms Francine Read, MDU Solicitor/Advisor for Dr K Bevan
Thompsons, Solicitors for the Prison Officers Association
Ms Farah Gilani, Solicitor for Shropshire Social Services
Mrs Debbie Henriksen, Milton Keynes Community Health Services
The Lord Chancellor