	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Governor, HMP Featherstone, Wolverhampton, West Midlands**
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 the 2nd day of April 2013 I commenced an investigation into the death of Adam Amos Williams aged 29 years. The investigation concluded at the end of the inquest on the 4th day of July 2014. The conclusion of the inquest was natural causes. The cause of death being sub-arachnoid haemorrhage.
4	**CIRCUMSTANCES OF THE DEATH** Adam Williams was certified dead at New Cross Hospital, Wolverhampton at 17:44 on 6 March 2013. He died from a bleed by the brain. He was a serving prisoner who had sustained recent blows to his head but these are unlikely to have been causative. He collapsed at HMP Featherstone at about 18:45 on 5 March 2013 and was soon attended by staff. An ambulance was called at 18:59 and he was then taken to the hospital in an escort chain.
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) Picking up on recommendation 2 from the Prisons and Probation Ombudsman's report I wonder if there is a training need for nursing staff at the prison regarding communication between healthcare staff in the event of an emergency. Can it be improved be it face to face, over the radio or otherwise? (2) Picking up on recommendation 3 in the Prisons and Probation Ombudsman's report I wonder if the "dynamic assessment" referred to does specifically take into account the need for a prisoner to be restrained at all. Please note that in respect of these first two matters I have since the conclusion of the Inquest received an updated copy of the action plan and these issues may already have been covered. (3) Although I accept that resource factors must be taken into account in this, I

	wonder if it may be beneficial for there to be more CCTV in common areas of the prison such as the gym or CV rooms.
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 Monday 8 September 2014. 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] The Treasury Solicitor The Prisons and Probation Ombudsman Irwin Mitchell, Solicitors Thompsons, Solicitors Corporate Governance Manager IMB at HMP Featherstone HM Inspectorate of Prisons National Offender Management Service 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	**14th July 2014** A A Haigh Andrew A Haigh HM Senior Coroner Staffordshire (South) No. 1 Staffordshire Place Stafford Staffordshire ST16 2LP