HER MAJESTY'S CORONER
for the County of West Yorkshire
(Eastern District)

David Hinchliff LLB LLM DipFMSA

Coroner's Office
71 Northgate
Wakefield WF1 3BS
Telephone: 01924 302180
Fax: 01924 302184
Email: hmcoroner@wakefield.gov.uk

Our Ref: MJW/CS/2597L/10
Please quote our reference on all correspondence

16 December 2014

By email only to: rule43reports@justice.gsi.gov.uk

Chief Coroners Office
11th Floor Thomas More
Royal Courts of Justice
Strand
London
WC2A 2LL

Dear Judge Thornton

Inquest touching the death of William Thomas ANDERSON (deceased)

I refer to the Inquest touching the death of William Thomas Anderson which was concluded by Ms M J Williamson, Assistant Coroner, in our Wakefield Court on 1st October 2014.

A copy of the Regulation 28 Report to Prevent Future Deaths in respect of this case was sent to you on 17th October 2014. I am now in possession of the response and I enclose it for your information.

Yours sincerely

PP Melanie J Williamson. David Hinchliff Senior Coroner.

Melanie J Williamson
Assistant Coroner
West Yorkshire (eastern)

Encls

2597/10

Ministry of JUSTICE

National Offender Management Service

Amy Harbin
National Offender Management Service
Equality, Rights & Decency Group.
4th Floor (post point 4.12),
Clive House
70 Petty France
London SW1H 9HD

Ms Melanie Williamson
HM Assistant Coroner for West Yorkshire

11 December 2014

Dear Ms Williamson,

Thank you for your letter addressed to the Chief Executive of the National Offender Management Service (NOMS), Michael Spurr, concerning the recent inquest into the death of William Anderson who died on 19 September 2010 at HMP Wealstun. Your letter has been passed to Equality, Rights and Decency Group in NOMS, as we have responsibility for the policy on suicide prevention and self-harm management and for sharing learning from deaths in custody. I have liaised with colleagues at Wealstun in formulating this response which addresses in turn each of the matters that you have raised.

Vigilance of wing staff

Your first concern relates to reports of the use of 'hooch' and drugs by prisoners at Wealstun, and the action taken by staff in response to this. This behaviour is clearly unacceptable and staff have been made aware of the findings of this inquest and instructed to ensure that greater vigilance is exercised over prisoners on association. They have also been instructed to report any evidence of the use of 'hooch' or drugs immediately to the Duty Manager and to follow this up on the Intelligence Reporting System, and are able to share any intelligence with the Security department. Any prisoner found making or in possession of hooch, or found in possession of or taking / trading drugs will face prisoner discipline procedures.

Training in the use of breathalyser equipment

Your second concern is that Mr Anderson was not breathalysed on 18 September, and you suggest that all wing staff should be trained in the use of breathalyser equipment. Since Mr Anderson's death additional staff have been trained in the use of breathalyser equipment. It is not considered necessary to train all wing staff, and managers at Wealstun are satisfied that there are sufficient trained staff to undertake testing when it is required.

Staff entries in wing observation books

Your third concern is that information about Mr Anderson's behaviour was not recorded. Wing staff been reminded of the importance of ensuring that all relevant information is recorded in the wing observation book, and in particular to ensure that concerns raised by prisoners about changes in another prisoner's behaviour is recorded and shared with other wing staff. The importance of making appropriate referrals to the Duty Governor, Orderly Officer and/or healthcare professionals following the recording of such information has also been stressed.

Emergency response

Your fourth and fifth concerns are about the use of emergency codes and the time taken to call a paramedic. A Notice to Staff was re-issued to staff in July 2014 (please find enclosed)

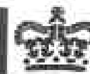
to remind all staff of the emergency code system and of the need to call for paramedic assistance immediately.

I hope you found this letter helpful.

Yours sincerely

Amy Harbin.

National Offender
Management Service



HM PRISON
SERVICE

Public Sector Prisons

HMP WEALSTUN

GOVERNOR'S NOTICE TO STAFF – 133/14 (b)

Title:	Medical Emergency Response Codes
Reference No:	
Implementation Date:	14 May 2014
Expiry Date:	Continuing
Originator:	Elaine Goodwin Head of Health Care
For attention of:	**ALL STAFF**

This order sets out the procedures for Emergency Response Codes as well as to ensure that an ambulance is called in all cases where there are serious concerns about the health of a prisoner.

It is essential that any member of staff who discovers a prisoner who is showing any of the symptoms listed below clearly and concisely convey the nature of the medical emergency simultaneously and contact the communication/control room.

There must not be a delay calling for an ambulance, if a red or blue code is called then the Communication room must automatically call an ambulance they must not wait for the Duty Governor or Healthcare to attend.

The relevant codes must be used when the medical emergency is being called these are detailed below:

Code System	Prisoner's Symptoms	Mandatory Contingency Responses
Code Blue (or Code One)	• Chest Pain • Difficulty in Breathing • Unconscious • Choking • Fitting or concussed • Severe allergic reaction • Suspected stroke	• Communication/Control Room automatically calls an ambulance and awaits updates from the scene • Where available, Duty Nurse attends with necessary equipment and assesses the patient • Where no nurse cover is available, other staff attend with necessary equipment • Gate prepare to receive ambulance • Ambulance escort staff arranged • Escort staff and equipment arranged • Any further action required by the local healthcare commissioner to assist in the preservation of life
Code Red (or Code Two)	• Severe loss of Blood • Severe burns or scalds • Suspected fracture	

National Offender
Management Service

HM PRISON
SERVICE

Public Sector Prisons

If a healthcare professional determines that an ambulance is not required they will inform the orderly officer who will arrange for the ambulance to be cancelled through the control room.

Further information on emergency access to the establishment for ambulance services can been found on the HMP Wealstun and Yorkshire Ambulance Service NHS Trust document and the PSI 03/2013 Medical Emergency Response Codes.

Approved By:	Andrew Dickinson	Date:	24th July 2014