ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Partner with Lester Morrill, Solicitors for and on behalf of the Deceased's family and next of kin** 2. **Michael Spurr , National Offender Management Service for and on behalf of HM Prison Service** 3. [redacted] **Partner with Hempsons, Solicitors for and on behalf of Leeds Community Healthcare NHS Trust** 4. **Chief Coroner**
1	**CORONER** I am Melanie J Williamson, Assistant Coroner, for the Coroner area of West Yorkshire (Eastern)
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On the 22nd September 2010 an investigation was commenced into the death of William Thomas Anderson, aged 35 years. The investigation concluded at the end of the Inquest on the 1st October 2014. The conclusion of the Inquest was a Narrative Conclusion, a copy of which is annexed hereto.
4	**CIRCUMSTANCES OF THE DEATH** In September 2003 the Deceased was remanded into prison custody. On the 27th July 2010 the Deceased was transferred to HMP Wealstun in Thorp Arch, Near Wetherby, West Yorkshire, where he resided until his death in September 2010. On Saturday the 18th September 2010 the Deceased associated with a number of inmates, during which association he took prescriptive medication belonging to others and drank hooch. Prior to final lock up at around 4.30pm/4.45pm, the Deceased appeared, inter alia, to be inebriated and/or under the influence of alcohol/drugs. Some inmates raised concerns as to the Deceased's welfare with Prison staff. At approximately 7.45pm the Deceased was observed to be laid on his bed with his head and neck resting on his wall at relative right angles to his torso and was breathing rapidly. At around 5.45am the following day, namely Sunday the 19th September 2010, the Deceased was observed to be in the same or a very similar position and the Deceased was not detected to be breathing. Prison officers gained access to the Deceased's cell and discovered him to be in a lifeless condition. Paramedic assistance was summoned at 6.31am and arrived at the scene shortly thereafter. The Deceased's death was confirmed by attending paramedics at 6.58am on the 19th September 2010 in Cell C3-G45 at HMP Wealstun, Thorp Arch, Near Wetherby.

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) Evidence was adduced in the course of this Inquest to the effect that in 2010, 2011 and 2012 inmates were having social get togethers on C Wing at HMP Wealstun, in particular at a weekend, during which time drugs were taken and hooch was drunk. Evidence was also heard that this is occurring at the present time at this said prison establishment. In the circumstances, there should be much greater and effective vigilance by Wing staff and Prison Service employees at HMP Wealstun in relation to such get togethers on the Wings during periods of association; (2) The Deceased was not subjected to a breathalyser test at any time during the 18th September 2010. A proportion of, but not all, Wing staff are trained in the use of such breathalyser equipment. Had the Deceased been so breathalysed, more likely than not, it would have been apparent he was not suffering from the effects of alcohol. In the circumstances all Wing staff should be trained in the use of such breathalyser equipment; (3) The Deceased's behaviour and presentation on the 18th September 2010 was not recorded by any member of Wing staff in the C Wing Observation Book. Evidence was adduced in the course of the Inquest as to the importance of recording all relevant information in the said Observation Book, thereby apprising all members of Wing staff on all shifts of all material facts and matters. In the circumstances, all relevant information in relation to, for example, an inmate's behaviour and general presentation should be brought to the attention of all Wing staff and should be done so via an appropriate entry/entries in the Wing Observation Book. All Wing staff (Wing Managers, Prison Officers and Operational Support Grades) should be made aware of the importance of such, and should ensure information is recorded accordingly; (4) The members of staff who observed the Deceased at around 5.45am on the 19th September 2010 did not "put out" a Code Blue. It was explained in the course of the Inquest that Codes Blue and Red are basic emergency codes which have been in existence for very many years. Despite the fact that, in this instance, the failure to call a Code Blue would not have affected the outcome, it is not inconceivable that to omit to use such emergency codes could, in certain circumstances, jeopardise an inmate's chances of survival. In the circumstances, all Prison staff should be fully acquainted with the use of such Codes and should use them accordingly; (5) Paramedic assistance was not called within a reasonable time and no explanation for the delay was provided in the course of the Inquest. Whilst the failure to summons outside medical assistance sooner would not have affected the outcome in this instance, it is not inconceivable that to omit to call for such assistance as soon as possible could, in certain circumstances, jeopardise an inmate's chances of survival. Consequently, emergency services should be summoned at the very first available opportunity, and all Prison staff should be instructed as to the importance of so doing.
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 12th December 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] Messrs Lester Morrill, Solicitors, Michael Spurr, National Offender Management Service and [redacted] Hempsons, 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	**17th October 2014** **MELANIE J WILLIAMSON** **ASSISTANT CORONER** **WEST YORKSHIRE (EASTERN)**