Tony Brown LLM
H M Senior Coroner
North Northumberland

17 Church Street
Berwick-upon-Tweed
TD15 1EE

Tel : 01289 304318
Fax : 01289 303591

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Matt Spencer** **Director** **HMP Northumberland** **Acklington** **Morpeth** **Northumberland**
1	**CORONER** I am Tony Brown, senior coroner, for the coroner area of North Northumberland
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 4th July 2013 I commenced an investigation into the death of Vincent Oliver, age 50 years. The investigation concluded at the end of the inquest on 29th September 2014. The conclusion of the inquest was that Vincent Oliver died from natural causes, the medical cause of death being:- 1a Ischaemic Heart Disease 1b Coronary Artery Atheroma
4	**CIRCUMSTANCES OF THE DEATH** Vincent Oliver was serving a term of imprisonment at HMP Northumberland. A roll check was carried out at 4.00 p.m. on 4th July 2013 and Mr Oliver was recorded as present. At approximately 5.40 p.m., shortly after the cells were unlocked, the lifeless body of Vincent Oliver was discovered in his cell by a fellow prisoner.
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. – The prison officer unlocking Mr Oliver's cell on 4th July 2013 at approximately 5.40 p.m. for the evening meal did not check on his physical well-being by getting a response from him, before moving on to the next cell. This led to Mr Oliver, who had died some time earlier and was affected by rigor mortis, being found by another prisoner when he entered Mr Oliver's cell. There has been a number of other occasions at the prison when appropriate cell unlocking procedures have not been followed and the Prisons and Probation Ombudsman has made recommendations about this previously. I understand that a Prison Director's Order has been issued requiring that on roll check Prison Officers must obtain a response from each prisoner to ensure their physical presence and well-being. My understanding of the procedures is that there is no current requirement for the Officer completing the roll check to record on the roll check report that he or she has complied with the requirements of the above Order.
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 5th 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] and the Treasury Solicitor's Department. 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 09 October 2014** **TONY BROWN** **HM Senior Coroner for North Northumberland**