

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. The National Offender Management Service (NOMS)2. Governor HMP Rye Hill3. Governor HMP Parc,4. The Chief Coroner5. The Family
1	<p>CORONER</p> <p>I am Andrew Roger Barkley, Senior Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 12th December 2014 I commenced an investigation into the death of David James Hallet. The investigation concluded at the end of an inquest on 23rd June 2015. The conclusion of the inquest was that he died of "natural causes"</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The deceased was serving a sentence of imprisonment and during a period when he was transferred to HMP Rye Hill was admitted to hospital and was later diagnosed as suffering from metastatic pancreatic cancer. He passed away on 4th December 2014 at HMP Parc – having been transferred to their palliative care suite.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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:-</p> <ul style="list-style-type: none">• The evidence revealed that in the early part of 2014, there was a nationally designated re-roll for HMP Rye Hill which meant that it would be a designated prison to receive convicted sex offenders.• Initial assessments undertaken during this process indicated that their Healthcare department would be adequately resourced to be able to cope with a influx of additional prisoners.• That was clearly not the case and the standard of care received by this prisoner was found to be inadequate and certainly far below the standard that he might have expected in the community.

	<ul style="list-style-type: none"> • The evidence indicated that one of the primary reasons for this was lack of preparation by the Prison Authorities staff and an inability to cope with the types of prisoners who were transferred to HMP Rye Hill. The clinical review undertaken by Healthcare Inspectorate Wales was critical of the care that he received at HMP Rye Hill and the evidence clearly indicated that a lack of preparation for the re-roll and the lack of adequate resources were the primary reason for this substandard care. • Whilst it is appreciated that HMP Rye Hill may not be subject to a further re-roll it is of concern that other re-rolls nationally may be being considered and which may conceivably give rise to issues similar to those presented in this case.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th August 2015. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner, The National Offender Management Service (NOMS), Governor HMP Rye Hill, Governor HMP Parc and [REDACTED] (Widow) who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>2nd July 2015 SIGNED: [REDACTED]</p>