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:** The Governor, HMP Usk, 47 Maryport Street, Usk. NP15 1XP
1	**CORONER** I am Wendy Ann James, Assistant Coroner, for the coroner area of Gwent
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 2nd March 2015 I commenced an investigation into the death of Thomas Byron Black (d.o.b. 28-02-86). The investigation concluded on 19th November 2015. The conclusion of the inquest was Natural Causes. The medical cause of death being:- 1. (a) Pulmonary thrombo-embolus 1. (b) Deep Vein thrombosis in a man with Factor V Leiden Mutation [heterozygous]
4	**CIRCUMSTANCES OF THE DEATH** On 4th December 2014 Mr. Black was transferred to HMP Usk. On Saturday 21st February 2015 Mr. Black collapsed. Officers took him to his cell and arranged a health care appointment for Monday morning, as health care staff are not on duty at the weekend. They did not seek medical advice. On Sunday 22nd February 2015 Mr. Black's cellmate reported he still felt unwell and had a tight chest. Officers monitored Mr. Black but did not seek medical advice. On the morning of Monday 23rd February 2015, a nurse examined Mr. Black and found no concerns, but arranged to carry out an electrocardiogram test later that afternoon. Just after 1.30 p.m. Mr. Black collapsed. He was conscious at first, but his condition deteriorated and he was conveyed to the Royal Gwent Hospital and he was pronounced dead at 3.21 p.m.
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. – Prison staff did not seek medical advice when it was apparent that Mr. Black was unwell.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18-01-16 . 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] 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]** **[SIGNED BY CORONER]** 24-11-15 WA James .