	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Michael Spurr -Chief Executive** **National Offender Management Service** **Clive House** **70 Petty France** **London** **SW1H 9EX**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 5th January 2016 I commenced an investigation into the death of Ondrej SUHA aged 19 years. The investigation concluded at the end of the inquest on 28th March 2017. The conclusion of the inquest was Accident.
4	**CIRCUMSTANCES OF THE DEATH** Ondrej Suha was a serving prisoner at HMPYOI Brinsford. On 21st December 2015 he was found hanging in his cell. He was taken to New Cross Hospital Wolverhampton and died there on 25th December 2015.
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) Ondrej was discovered hanging in his cell soon after 9pm. In his evidence the Prison officer who was involved in the initial response indicated that he had just started his first night shift (he was experienced with day shifts) but had no specific training for this. I wonder if standard training for Prison Officers should include some limited information about differences in the regime when the prison is in the night/patrol state.** **(2) The initial staff responding to the incident did not have first aid training to enable them to attempt resuscitation. Subsequently many staff at HMPYOI**

	Brinsford have had this training. However I wonder if basic resuscitation should form part of a Prison Officer's training or indeed if the quotas for staff on duty at any one time in a prison with such training should be reviewed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **25th May 2017** 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: • Irwin Mitchell Solicitors for the Family • Government Legal Department for the Prison Service • Staffordshire and Stoke on Trent Partnership NHS Trust • Independent Monitoring Board at HMPYOI Brinsford • Nursing and Midwifery Council 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	**30th March 2017** Signed by:  Andrew A Haigh HM Senior Coroner forStaffordshire (South) No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk