## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **THE REPORT IS BEING SENT TO:**<br>**NHS England, Skipton House, 80 London Road, London SE1 6LH** |
| 1 | **CORONER**<br><br>I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Preston and West Lancashire |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 7th September 2015 an investigation was commenced into the death of Marcin Miroslaw Mazurek aged 32. The investigation concluded at the end of the inquest on 4th October 2017. The conclusion of the inquest was that the deceased had died by hanging. The jury further found that the deceased had spent an inappropriately long time in segregation, that there had been a failure in the proper implementation of ACCT procedures, with no multidisciplinary working and no involvement of mental health and inadequate reporting by discipline and medical teams. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased had become mentally unwell which condition was exacerbated by a very long period in segregation. He began to self-harm and ultimately hanged himself. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>(1) Medical record keeping was of very poor quality<br>(2) The daily medical checks in segregation by members of the nursing team and the tri-weekly checks by the GP team, were frequently not recorded in the medical notes and / or did not take place. |
| 6 | **ACTION SHOULD BE TAKEN**<br>The medical notes of prisoners are often of a poor quality, particularly in the realms of mental health. Although it is the professional responsibility of doctors and nurses to make adequate entries in the medical records of prisoners, nevertheless you might wish to consider a universal system of training and audit across the prison estate in relation to medical note recording.<br>In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by [4th December 2017. I, the coroner, may extend the period. |

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| | 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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely the legal representatives of the family of the deceased, the Prison Service and the current Healthcare provider.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Dated 7th October 2017** **SIGNED**<br><br>**Assistant Coroner** |