ANNEX A

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:** 1. **Mr M Spurr, Chief Executive Officer, HMPPS, 102 Petty France, London SW1H 9EX**
1	**CORONER** I am Jonathan David Leach, Area Coroner for the coroner area of West Yorkshire (Eastern).
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 the 26th February 2016 I commenced an Investigation into the death of Robert Scott McLoughlin, aged 32. The Investigation concluded at the end of the Inquest on 12th October 2018. The conclusion of the Inquest was Misadventure. The medical cause of death was 1(a) Hypoxic brain injury, 1(b) Hanging, (2) Bronchopneumonia.
4	**CIRCUMSTANCES OF THE DEATH** At the time of his death the deceased was an inmate at HMP Leeds. He arrived on the 15th February 2016. Upon arrival an ACCT was opened. On the 20th February 2016 he was found suspended by a ligature. He was taken to The General Infirmary, Great George Street, Leeds where notwithstanding treatment he died on the 25th February 2016. The Jury found that there were errors or omissions in respect of his various aspects of his care. The Jury were of the view that it was possible that the death would have been prevented had these errors or omissions not occurred.
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) The staffing levels at HMP Leeds were very low. On the evening of the 19th February 2016 when Mr McLoughlin self-harmed there was one Officer Support Grade on his wing. In addition there were only six Prison Officers on the night shift. On the morning of the 20th February 2016 the staffing levels were such that there was no Landing Officer on Mr McLoughlin's landing. As a result ACCT reviews did not take place between approximately 0730 hours and 1340 hours.

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 the 14th December 2018. 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 – Mr McLoughlin's family and Leeds Community Healthcare NHS Trust. 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	**19 October 2018** **[SIGNED BY CORONER]** **Jonathan David Leach** **Area Coroner** **West Yorkshire (Eastern)**