## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Governor, HMP Wymott** |
| 1 | **CORONER**<br><br>I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Lancashire and Blackburn with Darwen |
| 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 17th September 2018 an investigation into the death of Brett Anthony Marrs aged 40 was commenced. The investigation concluded at the end of the inquest on 22nd September 2020. The conclusion of the inquest was that the death of Brett Anthony Marrs who died as a result of synthetic cannabinoid and morphine toxicity was drug related. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased who was a long-term drug user was found collapsed in his cell after morning unlock on 4th September 2018. The officer unlocking the cell had not checked on the welfare of the deceased and the two officers who commenced resuscitation had not had any first aid training during their time in the prison service. |
| 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. Two long-serving prison officers who gave evidence at the inquest deposed to the fact that they had never been given first-aid training, including training in resuscitation techniques, during their service as prison officers despite the fact that prior to 2016 such training was meant to form part of core training for prison officers. Evidence was further given that first aid refresher training is to be rolled out but that no date has yet been fixed for completion of such training programmes.<br>These matters are drawn to your attention so that you might consider:<br>(a) Identifying any further officers who have never been given first aid training and rectifying this deficiency<br>(b) Setting a target date for completing refresher training.<br><br>2. CCTV footage viewed at the inquest showed a prison officer conducting a first morning cell unlock on C wing without conducting even the most basic of welfare checks and this despite clear notices from management drawing to the attention of staff the necessity of carrying out welfare checks, particularly at the time of the first morning |

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| | unlock. Evidence was heard to the effect that this was not an isolated instance. Given that notices and reminders appear not to have achieved uniform obedience, you are asked to consider how better compliance with welfare checks can be achieved. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th November 2020. I, the coroner, may extend the period.<br><br>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 family of the deceased and the prison healthcare provider Greater Manchester Mental Health Trust<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 this 23rd day of September 2020**<br><br>**SIGNED** *N.L.Rheinberg* **Assistant Coroner** |