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.** [redacted] Chief Executive of NHS England **2.** [redacted] Chief Executive of Oxleas NHS Foundation Trust **3.** [redacted] Director General Operations HMPPS **4.** [redacted] Governor at HMP YOI Portland
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 9th January 2020 an investigation was commenced into the death of Bradleigh Trevor Barnes, born on the 21st March 1996. The investigation concluded at the end of the Inquest on the 20th October 2022. The Medical Cause of Death was: 1a Ligature Suspension The conclusion of the Inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found suspended by a ligature in his cell at HMP YOI Portland, Portland, Dorset on the 28th December 2019.
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. During the Inquest evidence was heard that:

   i. In the days leading up to Bradleigh's death he barricaded himself in his cell and force was used to remove him from the cell. PSO 1600 is a HM Prison Service document which provides guidance to Prison staff on the use of force. Whilst it can be accessed by others outside the prison, there is no national guidance from the NHS to healthcare professionals about the use of force in prison. Lisa Turner, the Regional Healthcare Service Manager Practice Plus Group (PPG) who currently provide the healthcare at HMP YOI Portland, confirmed it would be of benefit to have such national guidance to assist the healthcare staff when force is used in prison. Healthcare input is critical in the use of force due to risks of positional asphyxia which could lead to a future death as well as the risk of injury.

   ii. At section 6 of PSO 1600 it details the "Role of Healthcare in planned and unplanned use of force" and at 6.11 states that procedures should be agreed at a local level. There is no local operating policy between the prison and the healthcare at HMP YOI Portland. Oxleas NHS Foundation Trust (Oxleas) are to take over the contract for the healthcare at HMP YOI Portland on the 1st December 2022 from PPG.

   iii. [redacted]

2. I have concerns with regard to the following:

   i. There is a lack of national guidance to healthcare staff on the use of force in prison and I request consideration is given by NHS England to providing such national guidance.

   ii. There is no local operating policy on the use of force at HMP YOI Portland between the healthcare and the prison and I request that the Governor of HMP YOI Portland and Chief Executive of Oxleas consider putting a local instruction policy in place.

   iii. [redacted]

	[redacted]
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 19th December 2022. 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: (1) GT Stewart Solicitors on behalf of Bradleigh's family (2) Government Legal Department on behalf of the Ministry of Justice (3) Practice Plus Group (4) [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	**Dated** **24th October 2022**	**Signed** **Rachael C Griffin**