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:** The Governor of HMP Swansea, 200 Oystermouth Road, Swansea
1	**CORONER** I am Kirsten Heaven, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 14 January 2018 an investigation was commenced into the death of Robert Lee Evans, a prisoner at HMP Swansea, who was found deceased in his cell in the early hours of 14 January 2018 after having tied a ligature around his neck. He was 37 years of age at the time of his death. The investigation concluded at the end of the inquest on 13 October 2022. The medical cause of death was: 1a pressure on neck (hanging) The conclusion of the inquest was a narrative conclusion as follows: Considering the information that was known to the prison about Lee, the prison probably failed to adequately assess his risk of suicide and self-harm. During the period from lock up to midnight only, there was probably not an adequate system of checks in place for Lee in light of the fact that he was undergoing alcohol detoxification and on the induction wing and in the early days prison. This probably made a more than minimal contribution to Lee's death. The prison doctor probably failed to review Lee's medical notes sufficiently. This probably made a more than minimal contribution to Lee's death. The prison doctor probably failed to prescribe Lee's antidepressant medication. This possibly made a more than minimal contribution to Lee's death. The prison doctor probably failed to prescribe Lee's detoxification medication. This probably made a more than minimal psychological contribution to Lee's death. The systems and processes in place probably contributed to the failure of the health staff reviewing all records. The prison and medical staff within the prison probably did not take all appropriate steps to safeguard Lee when he was in prison custody, for example by not opening an ACCT, and by the way prescription information was communicated to Lee. This probably made a more than minimal contribution to his death.

4	**CIRCUMSTANCES OF THE DEATH** The deceased was Robert Lee Evans On Sunday 14 January 2018 (in the early hours) Lee was founded just over 24 hours after his arrival into HMP Swansea. Lee was in a cell on his own at his own request. Lee had been released on licence from HMP Swansea on 29 January 2017. When arriving in HMP Swansea Lee was undergoing detoxification from alcohol and had been given certain medication under the patient group directive both in police custody and then in prison. There were historic risk markers for suicide and self-harm on the PER from police custody and on NOEMIS – the prison system. The PER recorded anxiety and depression and that Lee had not had his anti-depressant medication for several days. Lee was not on an ACCT. There was evidence in prison medical records showing that Lee had been prescribed anti-depressant medication for depression and anxiety when in HMP Swansea on previous occasions and that on 29 January 2017 Lee was released from HMP Swansea with a month's supply of this medication. On Saturday 13 January 2018 the prison doctor reviewed Lee's notes but did not prescribe Lee's anti-depressant medication and did not write up Lee's prescription for his alcohol withdrawal medication. Lee was told that the doctor had not written up his alcohol withdrawal prescription and this made Lee anxious at the medication hatch. However, at the nurse's discretion Lee was given his evening dose of his alcohol withdrawal medication. Shortly afterwards Lee can be seen on CCTV speaking to two prison officers in an animated way and for approximately one minute. I have been unable to establish what Lee was saying. Shortly after this interaction Lee can be seen walking in the direction of the area that houses the post box holding a piece of paper and envelope and then returning to his cell empty handed. Lee was locked in his cell at around 4.30 and was not checked until he was founded suspended by a nurse commencing the first of three nightly checks shortly after midnight. After Lee's death a letter was found in the HMP Swansea post box written by Lee to his partner which indicated that at an earlier time Lee was fine but on the other side Lee had written "*they stopped my meds goodbye I quit loved you*". It was clear from the evidence that this letter could only have been posted on the Saturday.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to a 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 make a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 The first **MATTERS OF CONCERN** is as follows: . I am aware that Her Majesty's Chief Inspector of Prisons 2018 inspection report in respect of HMP Swansea stated that. "*there have been four self-inflicted deaths since the previous inspection, all within a week of arrival. This replicated findings at our previous inspection of Swansea*" [S5]. The most current report of Her Majesty's Chief Inspector of Prisons dated 2020 states, "*There had been two self-inflicted deaths since the last inspection, the most recent in December 2019. Both had occurred soon after the prisoners arrived at the prison*" [1.23]. I have heard evidence that it is well known by prison staff and recognised in national Ministry of Justice policy and in HMP Swansea Prison Policy that the very early days are a particularly high-risk time for prisoners particularly those on remand or recalled on licence. This is supported by the findings of the above inspection report. I heard that there is a safer cell on the induction unit and in that cell the whole window unit has been replaced with plastic material that can be slid to allow prisoners to get air from the outside into the cell. I heard evidence that prisoners are not on the

	induction unit for a significant period but that prisoners in the induction unit are in a vulnerable time in custody as they have just arrived in prison. The second **MATTERS OF CONCERN** is as follows: I heard evidence from the two prison officers who appear in the HMP Swansea CCTV as mentioned above. On the evidence I have seen these witnesses were the last members of prison staff Lee spoke to before his death. At all stages into the investigation into Lee's death (prisons and probations ombudsman and coronial) these witnesses have stated that they are unable to assist with what Lee was saying to them hours before his death. I am concerned that immediately following Lee's death and the following day that these highly material witnesses (who were on duty) were not spoken to, did not attend a hot or cold debrief and were not asked to make a first account of events when matters were fresh in their minds. These witnesses did become known to the PPO. As a result, my investigation into Lee's death has been significantly hampered. I am therefore concerned that lessons may not have been fully learnt from the circumstances of Lee's death. I am concerned that if evidence relevant to a death in custody is not immediately captured and considered a situation may be created where evidence is lost which prevents general lessons from being learnt from a death in custody and that this creates a risk that other deaths will occur.
6	ACTION SHOULD BE TAKEN 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 You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 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, The Ministry of Justice, Swansea Bay University Health Board and those representing Lee's family (Canter solicitors). 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	20 October 2022