REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. [redacted] **Governor, HM Prison Wealstun** 1. **The Rt Hon Dominic Raab MP, Secretary of State for Justice**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (E).
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 23rd December 2019 an investigation was commenced into the death of Lewis Steven Johnson, aged 34. The investigation concluded at the end of the Inquest on 2nd December 2022. The conclusion of the Inquest was a Narrative Conclusion that Mr Johnson died due to 1(a) Hypoxic-ischaemia Encephalopathy 1(b) Hanging after being found suspended by a neck ligature at approximately 04:45 hours on 12th December 2019 at HMP Wealstun.
4	**CIRCUMSTANCES OF THE DEATH** Lewis Steven Johnson was held at HMP Wealstun from May 2019 until his death 7 months later. He had been seen frequently by healthcare staff, a keyworker, other prison officers and had been subject to an ACCT for a brief period in October 2019. When found with a neck ligature around 04:45 on 12th December in an unresponsive condition, he was cut down, but the various prison officers present then left him in the cell in a seated position without considering CPR, using a defibrillator or considering whether to place him in the recovery position. Approximately five minutes later another prison officer mentioned CPR. Prison officers then returned to his cell and conducted CPR until paramedics arrived. The paramedics succeeded in restoring Mr Johnson's circulation. He was taken to hospital but following a further cardiac arrest, was pronounced dead at 10:56 on 12th December 2019 at Leeds General Infirmary.
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) HMP Wealstun does not have nurses or other healthcare staff in the prison during the night. (2) The incidence of self-harm incidents amongst prisoners (both in 2019 and today) make such emergencies foreseeable. (3) In the absence of healthcare staff being immediately available, the night patrol staff should be trained to respond effectively to ligature or other self-harm incidents. (4) The OSG officer who encountered the situation involving Mr Johnson around 04:45 hours had not been trained to carry out CPR. (5) The officer acting as [redacted] attended the cell but did not think about CPR, believing Mr Johnson to be already dead (notwithstanding that none of the discipline officers present had any medical qualifications to certify death). He

	had undertaken defibrillator training "many years ago". (6) The four prison officers present in the cell did not discuss the need for CPR. The possibility of using a defibrillator was not mentioned. Mr Johnson was left in the cell in a seated position without the wisdom of placing him in the recovery position being considered. (7) The medical evidence available at the Inquest indicated "Effective CPR more than doubles the chance of someone surviving a cardiac arrest". Furthermore, the Resuscitation Council UK advises "provide chest compressions as soon as possible after cardiac arrest is confirmed". (8) The value of all night patrol staff (particularly in a prison without 24 hour healthcare provision) being trained to provide effective CPR and use a defibrillator competently was recognised at the inquest, along with the wisdom of this being refreshed annually. (9) The inquest noted that there is currently no express direction in PSI 03/2013 or other instruction to carry out CPR pending the arrival of paramedics or other qualified medical professional, when a prisoner is found in an unresponsive condition following a ligature incident.
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 Monday 13th February 2023 (allowing for the forthcoming holiday period). 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) [redacted] (mother) (2) [redacted] (father). I have also sent it to [redacted], Governor, HMP Wealstun who may find it useful or of interest. 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	Kevin McLoughlin KEVIN McLOUGHLIN Senior Coroner West Yorkshire (E) Dated: 2nd December 2022