REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. NHS England, Quarry House, Quarry Hill, Leeds, LS2 7UE**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East).
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 20th April 2021 I commenced an investigation into the death of Stephen Kurt Beadman, aged 34. The investigation concluded at the end of the Inquest on 21st June 2023. The conclusion of the Inquest was a Narrative which included a finding that Mr Beadman committed suicide having been bullied by other prisoners.
4	**CIRCUMSTANCES OF THE DEATH** Mr Beadman, aged 34, was a serving prisoner at HMP Wakefield. He had been diagnosed with a mixed personality disorder along with mixed depression and anxiety. He was prescribed medication. He had a long history of self-harm and in 2020-21 repeated suicide attempts. On 7th April 2021 he was found in an unresponsive state having applied a ligature to his neck. He died the following day, 8th April 2021 in hospital from: 1(a) Hypoxic Ischaemic Encephalopathy 1(b) Cardiac Arrest 1(c) Hanging
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) Evidence was taken at the Inquest to the effect that HM Prison, Wakefield is a maximum-security prison which houses some 750 men, many of whom have significant mental health or addiction issues. 2) Despite this complex cohort of prisoners, the prison only has one day per week of consultant psychiatrist resource. As the professed principle is equivalence of care with the community, this seems not to be achieved, particularly having regard to the psychological make up of the prisoner population. 3) Evidence taken at the Inquest indicated that further senior psychiatric doctor resource would enable the prison to provide better for the needs of the prisoners. 4) For the avoidance of doubt, it is accepted that Mr Beadman himself was able to see the consultant psychiatrist on 19th October 2021 for 1 hour and again on 25th January 2021 (at which time he was discharged). Notwithstanding that his death on 8th April 2021 cannot be attributed to a lack of psychiatric attention, there is a concern that other long-term inmates in the prison are not receiving

	the specialist care they probably need. This in turn gives rise to a concern that other deaths may occur. 5) The Inquest was informed that NHS England are currently reviewing the provision of psychiatric resource at HM Prison, Wakefield. It is hoped that this report can be taken into account during this review.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 2nd September 2023 (to take account of the impending holiday season). 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 of Stephen K Beadman 2) Midlands Partnership University NHS Foundation Trust, [redacted], 3) [redacted], Governor, HMP Wakefield 4) Practice Plus Group, [redacted] I have also sent it to: 1) [redacted], Consultant Psychiatrist 2) [redacted], Government Legal Department 3) [redacted], Governor, HMP Wakefield 4) [redacted], Nottingham University 5) [redacted], HM Prison + Probation Service 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	Signed:  Kevin McLoughlin Senior Coroner West Yorkshire (East) Dated: 23rd June 2023