Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 HMP Styal** **2 MOJ and Inquests Team 1 (Leeds)**
1	**CORONER** I am Charlotte KEIGHLEY, Assistant Coroner for the coroner area of Cheshire
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 08 March 2019 I commenced an investigation into the death of Christine MCDONALD aged 55. The investigation concluded at the end of the inquest on 10 May 2024. The conclusion of the inquest was that: Narrative Conclusion - Suicide - Contributed to by: - Failings in communication and/or information sharing between healthcare staff at HMP Styal. - Failings in communication and/or information sharing between prison staff at HMP Styal. - Failings in communication and/or information sharing between healthcare staff and prison staff. - Failure to pass on information in respect of Christine's daughter's wellbeing. - Failure to assess Christine on her return from Wythenshawe Hospital. - Failure to action Christine's request to see a nurse. - Failures by healthcare to follow the clinical guidance in respect of the assessment and/or treatment of Christine's drug dependency. - Neglect It was also found that the emergency response codes were not used which led to a delay in bringing the required emergency medical equipment, namely oxygen and the emergency bag and there was a significant delay in locating the defibrillator, although these issues did not contribute to Christine's death.
4	**CIRCUMSTANCES OF THE DEATH** Christine McDonald was 55 years old at the time of her death on the 3rd March 2019. On the 1st March 2019 Christine was arrested at her home address and around the time of her arrest had witnessed her daughter fall from third-floor window and was concerned about her. Christine was taken to Blackpool Magistrates Court and sentenced to 12 weeks imprisonment to be served at HMP Styal. Christine had a long history of drug dependency and at the time of her arrest she was known to be a user of Heroin, Crack Cocaine and Amphetamine. On the 2nd March 2019 Christine was taken to Wythenshawe Hospital following concerns raised during a healthcare assessment in HMP Styal. Christine discharged herself from hospital and was returned to HMP Styal. Just after 11pm on the 2nd March 2019 Officers went to speak to Christine in her cell and found her unresponsive, having tied a ligature [redacted]. The emergency

	response codes were not used and consequently, when Healthcare attended, they were unaware that they were attending an emergency and did not have the necessary emergency equipment with them. Although the failure to use the emergency response codes was not a contributory factor in the death, it caused a delay in providing the necessary medical treatment. Christine was taken to Wythenshawe Hospital but sadly passed away the following day with her family by her side.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) I heard evidence during the course of this Inquest in respect of the process for using the emergency response codes, this is something which arises in many cases of this type. I heard evidence in this case that the emergency response code was not used and as a consequence, those responding to the call were not prepared in the sense of emergency equipment, nor were they prepared mentally for the situation they had been asked to attend. I heard evidence in respect of the training and integrity testing that is now conducted to try to simulate the unexpected nature of an emergency, the evidence being that it is very difficult and that no training can fully prepare those staff who are first on scene for what they may find. I also heard evidence relating to measures within the control room, which might assist those first on scene in terms of the use of emergency codes and provide additional safeguards for those whose lives are at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by July 16, 2024. 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 [redacted] 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: 21/05/2024**  **Charlotte KEIGHLEY** **Assistant Coroner for** **Cheshire**