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 Ministry of Justice** **2 His Majesty's Prison and Probation Service (HMPPS)** **3 The Governor of HMP/YOI Swinfen Hall**
1	**CORONER** I am Kelly Dixon, Assistant Coroner for the coroner area of Staffordshire and Stoke-on-Trent.
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 12 April 2023 I commenced an investigation into the death of Luke Mikael PEARCE aged 21. The investigation concluded at the end of the inquest on 16 May 2024. The conclusion of the inquest was that: suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Luke Pearce was found hanging in his cell on 6 April 2023, at HMP/YOI Swinfen Hall. He was 21 years old. Mr Pearce had given no indication to staff that he was at risk of suicide or self harm in the months leading up to his death. Shortly after 5.30am on 6 April 2023, during a routine check, [redacted] The officer called to Mr Pearce but got no response. He looked through the crack of the door and saw Mr Pearce with a ligature around his neck. The officer radioed for urgent assistance but did not use the appropriate coded wording of "Code Blue". An Operation Support Grade attended and briefly entered Mr Pearce's cell before coming out again. When another officer attended, the first officer and OSG told her that she should not enter the cell as it was a crime scene. She contacted a custodial manager for permission to go in and then cut the ligature and lowered Mr Pearce to the floor. The officer and OSG waited outside and did not assist. At 5.40am, more staff arrived and the control room staff called an ambulance. Staff started CPR at 05.42am. Ambulance paramedics arrived at 5.59am and took over CPR. At 6.30am, they pronounced that Mr Pearce had died. There was a delay in staff entering the cell, removing the ligature and starting CPR. This did not contribute towards Mr Pearce's death.
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: That relevant training and guidance to equip staff to understand when and how to enter a cell in a medical emergency, and the appropriate use of Code Blue and Code Red communications in a medical emergency, is not being delivered in a timely manner to appropriate staff.
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 11, 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 **Mother of the Deceased.** I have also sent it to **Prisons and Probation Ombudsman** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 16 May 2024**  **Kelly Dixon** **Assistant Coroner for** **Staffordshire and Stoke-on-Trent**