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:** **The Rt Hon Alex Chalk KC MP, Secretary of State for Justice** **102 Petty France** **London** **SW1H 9AJ** **United Kingdom**
1	**CORONER** I am Peter Nieto, senior coroner for the coroner area of Derby and Derbyshire.
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 23 March 2017 I commenced an investigation into the death of Paul Edward DAY aged 55. The investigation concluded at the end of the inquest on 9 May 2024. Mr Day was a prisoner at HMP Sudbury at the time of his death and as his death appeared unnatural his inquest was a jury inquest. The inquest also examined whether there were any acts or omissions by prison staff that contributed to the death. The inquest engaged Art. 2 ECHR. The jury reached a short-form conclusion of *drug related death* but made a finding of omission which, on the evidence, could not be established as contributory to death.
4	**CIRCUMSTANCES OF THE DEATH** I will only detail those circumstances which are relevant and assist understanding of my concerns. On the night of 22 March 2017 Mr Day was discovered collapsed in a cubicle in the toilet block of the prison wing where he was placed. There was cold water gushing over him from a broken pipe to the toilet cistern which had likely broken during his collapse. The attending prison officers could not detect a pulse or breathing. The senior officer also believed him to be in a state of rigor mortis and considered he was dead. Factors cited by the officer for the belief that rigor mortis was present were: cold body temperature; pallor; the neck and wrist appearing firm when a pulse was felt for. However, it is not apparent that those were good reasons to consider rigor mortis was present as Mr Day was not moved and had been exposed to cold running water, and it was very unlikely that there had been sufficient time for this to have occurred. No CPR was attempted, and Mr Day was left in-situ, without being moved at all until an attending paramedic, who had arrived approximately 15 minutes after the officers first attended Mr Day, pulled him into the corridor and began CPR and subsequent advanced life - support, after which there was a return of spontaneous circulation. Mr Day was taken to hospital but went into a further cardiac arrest and died in the early hours of the morning of 23 March.

	On the post-mortem and circumstantial evidence Mr Day's cause of death was found to be *1a Toxic Effects of Synthetic Cannabinoids.* [redacted] The jury found and recorded that: - *Prison staff who attended Mr Day on the night of 22 March 2017 when he was found collapsed in the toilet cubicle should have performed CPR on him because: -* *- CPR should be attempted in all situations excluding certain extreme circumstances.* *- Staff were unqualified to recognise the signs of rigour mortis which was one of the exclusions.* *- Preservation of life should always be the primary goal.* *Although the jury finds that the prison staff should have performed CPR, the jury does not find on the evidence that this omission contributed to Mr Day's death.* The first bullet-pointed reason given by the jury relates to the HMP Sudbury *Staff Information Notice* at the time (the current Notice is the same), *Guidance to support the decision-making process of whether to perform CPR in prisons.* The guidance stated that: *Resuscitation MUST be started on all people who are found not breathing and/or pulseless unless* one of the following reasons/circumstances applies: *Hypostasis/Lividity; Rigor Mortis; Decapitation; Massive Cranial and Cerebral Destruction; Incineration; Traumatic Hemicorporectomy; Decomposition/Putrefaction.* Three of the four prison staff who attended Mr Day were first aid trained, this included training in performing CPR. The training did not and still does not include assessing for and identifying rigor mortis, or verification of death. HMP Sudbury is an open prison and does not have seven day a week 24-hour healthcare staff presence. On the evidence it was quite possible that Mr Day had reached a point, by the time the prison officers attended him, where CPR would not have prevented his death, notwithstanding the clear opportunity for this to have been attempted.
5	**CORONER'S CONCERNS** During 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: - 1. I understand that the prison guidance re CPR which I have referenced, is in effect guidance provided nationally to all prisons. The inclusion of rigor mortis in the exclusions for CPR is something of an outlier as compared to the other reasons which would clearly and obviously evidence that death had occurred, even to someone without first aid training. In those prisons without 24-hour healthcare staffing prison officer staff are operating under guidance that they are not trained to be able to follow (re rigor mortis). In prisons with 24-hour healthcare staffing it is likely that healthcare staff would attend a resuscitation incident. 2. Given the current guidance, in those prisons without 24-hour healthcare staffing, and where prison officer staff attend a prisoner in a state of collapse who is not breathing and is pulseless, there is the clear potential to mistakenly assess the person to be in a state of rigor mortis, and thus miss the opportunity to undertake CPR and potentially prevent death, because quite clearly they have not been trained to assess for and recognise rigor mortis. This was very clearly illustrated in Mr Day's inquest.

	3. The current CPR guidance does not appear to be appropriate for those prisons without 24-hour healthcare staffing, and in my view presents the real risk that future deaths could occur unless action is taken.
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 05, 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 • The Governor HMP Sudbury • [redacted], partner I have also sent it to • Practice Plus Group, healthcare provider at HMP Sudbury 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: 10 May 2024**  **Peter Nieto** **Senior coroner** **Derby and Derbyshire**