REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **HM Prison & Probation Service** 2. **Ministry of Justice**
1	**CORONER** I am Bronia Hartley, Assistant Coroner for the coronial area of Greater Manchester West.
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 26 January 2023 I commenced an investigation into the death of Ian William Deavall, age 65. The investigation concluded at the end of the inquest on 9 September 2024. The conclusion of the inquest was: Ian William Deavall died as a consequence of a naturally occurring cardiac arrest. There was an admitted failure to arrange for Mr Deavall to be sent to hospital for assessment between 20 and 24 January 2023, however this did not cause or contribute to death on the balance of probabilities. The medical cause of death was: 1. Ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was remanded in custody to HMP Forest Bank on 7 January 2023. He had a known history of ischaemic heart disease and hypotension and was prescribed various medications for the same. The Deceased was housed on the induction wing throughout his time at the prison and shared a cell. Both the Deceased and his cell mate were believed to be at risk from other prisoners and were classed as vulnerable prisoners ('VPs') accordingly. The inquest heard evidence that both VPs and non-VPs are housed on the induction wing and that the recognised risk to VP prisoners when co-located

	with non-VP prisoners is managed by operating two separate regimes to avoid the two demographics coming into contact with one another. On 24 January 2023 the Deceased and his cell mate were locked in their cell when the Deceased suffered a cardiac arrest. His cell mate pressed the emergency cell bell whereupon a non-VP prisoner ('Prisoner A'), who was unlocked and conversing with two other prisoners on the landing adjacent to the Deceased's cell, deactivated the cell bell on the panel outside the cell before resuming his conversation with the other prisoners. After approximately 1 minute Prisoner A walked down to the wing office and alerted officers inside, following which a medical emergency response was initiated. The inquest heard evidence that when an emergency cell bell in the induction wing at HMP Forest Bank is deactivated on the panel outside the cell (i) this cancels the alert in the wing office; (ii) the only means by which staff can ascertain in which exact cell the emergency cell bell has been activated (the light on the panel outside the cell) goes off.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follow: (1) The response to a medical emergency will generally be time critical. (2) The risk that non-VP prisoners will victimise VP prisoners is a recognised one. (3) That prison staff became aware of the medical emergency in the Deceased's case was more by accident than design (depending as it did on the caprice of Prisoner A). There remains a risk that future deaths could occur as it remains the case that emergency cell bells at HMP Forest Bank can be deactivated readily and altogether by other prisoners and no action to implement fail-safe measures is currently proposed.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisations 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 4 November 2024. I, the coroner, may extend the period.

<table>
<tr><td></td><td colspan="2">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.</td></tr>
<tr><td>8</td><td colspan="2">COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: the Family of Mr Deavall, Sodexo Justice Services, Spectrum Community Health CIC and Med-Co Secure Health Services Ltd.

I have also sent it to the Prison and Probation Ombudsman and HMI Prisons 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.

I may also send a copy of your response to any other 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.</td></tr>
<tr><td>9</td><td>Date 9 September 2024</td><td>Signed BRONIA HARTLEY
Assistant Coroner for Greater Manchester West</td></tr>
</table>