# REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted] **– Secretary of State for Justice & Lord Chancellor**<br>[redacted] **– Minister of State for Prisons** |
| **1** | **CORONER**<br><br>I am Mr I M CARTWRIGHT, His Majesty's Area Coroner for the coroner area of Leicester City and South Leicestershire. |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 31 October 2022 I commenced an investigation into the death of Stephen Anthony SLEAFORD aged 49. The investigation concluded at the end of the inquest on 26 September 2024. The conclusion of the inquest was (by way of a narrative conclusion) that:<br><br>"***On the 27th of October 2022, Stephen Anthony Sleaford was found hanging by ligature in his cell at HMP Gartree at 07:12 where he was a serving prisoner. Prior to this, Stephen complained of pains and health issues, including mental health issues. Due to failings of the prison system, not following the adequate protocols, Stephen was unable to receive the health care and support he required and was pronounced dead on the 27th of October 2022 at 08.01.***"<br><br>The cause of death was established as:<br><br>I a Hanging by Ligature<br>I b<br>I c<br><br>II |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br>Stephen Sleaford was born on 15 February 1973 in the Boston area of Lincolnshire and he died on 27 October 2022, at Gartree Prison near Market Harborough, Leicestershire. He was 49 years of age when he died. Mr. Sleaford was a prisoner at Gartree and had been for around 11 years prior to his death. He had been accommodated at a number of prisons, but predominantly at Lincoln and Gartree Prisons. In late May 2022, Mr. Sleaford was transferred to Lincoln Prison, for the purpose of accumulated visits, a process whereby he was moved closer to his family, including his father who was unwell and with whom he was very close, so that visiting would be easier for all. He returned to |

Gartree Prison on 11 August 2022.

Mr. Sleaford saw a prison GP on 25 October 2022, when he complained of struggling with right ankle pain, and had been struggling to sleep since his last co-codamol prescription had ended. On that day, he was prescribed a short course of medication to try to restore sleep. On the same date, a prison healthcare nurse was asked to see Mr. Sleaford due to the suspicion that he was under the influence of an illicit substance, although he was assessed as not being under the influence. A substance misuse worker went to see him the following day, 26 October 2022, because he had been found with fermenting liquid (brewed alcohol) in his cell and an improvised smoking device. He was spoken to by that worker, when Mr. Sleaford declined formal substance misuse intervention.

In the afternoon of the same day, that is 26 October 2022, Mr. Sleaford was seen by a supervising prison officer and his prisoner status was downgraded from 'enhanced' to 'basic' level. He did not react well to that news and told the officer that he would "show [him] basic behaviour" before returning to his cell. Later that evening, the Prison Officer on duty on Alpha wing (where Mr. Sleaford was accommodated) who knew him and appeared to have a good rapport with him, spoke with him at around 9pm and they had a conversation, when he was seen and appeared to be in a good mood. The following morning, that is 27 October 2022, during her shift, the same officer re-attended outside the cell around 5:45am, when she did not see Mr. Sleaford, due to the cell door's observation panel being obscured internally, but she did receive a verbal acknowledgment from him.

Later the same morning, when the day staff were on duty, another officer was unable to get a verbal response from Mr. Sleaford, when outside his cell, so that officer went to obtain advice and colleague assistance. He returned with other staff and entered the cell, where Mr. Sleaford was discovered with a ligature around his neck and was believed to be unresponsive. Prison officer staff waited for several minutes while further staff, including healthcare staff, attended at the cell, followed later by paramedics. Mr. Sleaford could not be revived and his death was confirmed at the scene by one of the attending paramedics, at 08:01 hours on 27 October 2022.

**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:

1) Evidence was heard that the majority of those prison officers who had commenced in their roles prior to 2018 had no first aid/basic life-saving skills and no ability/training in undertaking cardiopulmonary resuscitation ('CPR'). Officers who had completed prison officer training between approximately April 2018 and April 2024 did have first aid training, but there had been no refresher training, subsequently, for that cohort.

2) Evidence was heard that after April 2024, basic first aid training (including CPR training) has been omitted from the foundation training programme for those training to be prison officers, meaning that NO new prison officers will have first aid/related training. I am gravely concerned that this situation (i.e. a lack of such training provided as foundation training), if it prevails, will probably lead to future deaths in prison custody.

3) Following the conclusion of the Inquest, I remain concerned that prison officer staff have an unrealistic expectation that prison healthcare staff will be willing and able to react timeously to any emergency unfolding, meaning there are obvious and crucial gaps in the extent and adequacy of the first/earliest response to any emergency unfolding.

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| | 4) The evidence revealed that despite clear instruction to officers, by way of Notices to Staff from senior management at the prison, to the effect that obscuring cell door observation panels on the inside by prisoners was not permitted practice and was to be challenged and remedied, routine practice by prison officers meant observation panels were permitted to be obscured, without challenge or sanction. This means that a situation prevailed whereby prison officers were unable to routinely see into all cells to check prisoner welfare, but were/are reliant on, and accepted, a verbal response only, which is and remains a significant concern.<br><br>5) I am concerned that there is no, or no adequate, clear understanding by, and/or clear guidance and training provided to, prison officers around when they should enter a prison cell when it is reasonably believed that a prisoner requires immediate care or assistance due to an emergency, medical or otherwise. Evidence indicated that a 'dynamic risk assessment' could be undertaken by any officer who was acting/operating alone, when considering necessary and immediate entry into a cell, whereas the majority of evidence aired was that officers would 'never' enter a prison cell when working alone, due to fears for own safety. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by December 09, 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>1) The Family of the Deceased (namely [redacted] and [redacted]), through their legal representatives.<br>2) Nottinghamshire Healthcare NHS Foundation Trust, as providers of in-prison healthcare at the date of Mr. Sleaford's death.<br>3) The legal representatives of His Majesty's Prison & Probation Service/Ministry of Justice.<br><br>I have also sent it to:<br><br>1) The Governing Governor – HMP Gartree, Leicestershire.<br>2) Practice Plus Group Limited, as current providers of in-prison healthcare (since March 2024).<br>3) The Office of the Prisons & Probation Ombudsman ('PPO').<br><br>who may find it useful or of interest.<br><br>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. |

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| | I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 14/10/2024**<br><br>  <br>**Mr I M CARTWRIGHT**<br>**His Majesty's Area Coroner for Leicester City and South Leicestershire** |