REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. HMPPS** **2. HMP Wandsworth**
1	**CORONER** I am Priya Malhotra, Assistant Coroner, for the coroner area of Inner West London.
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. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London*; which clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** The inquest was opened on 13 July 2021 and concluded at the end of the inquest on 25 April 2024. The conclusion of the jury was a narrative conclusion: *"suicide. Based on the evidence, the following possibly made a material contribution to his death; failure to comply with the prison service instruction to facilitate a phone call within the first 24 hours; insufficient support to secure a PIN."*
4	**CIRCUMSTANCES OF THE DEATH** Daniel Beckford was detained at HMP Wandsworth. He died on 23 June 2023 aged 39 years. His death was confirmed at St George's Hospital, Tooting Road, London. The family requested the deceased is referred to as Daniel. I will reflect this in this report. On 14 June 2021, Daniel was remanded to HMP Wandsworth. He had a history of substance misuse, depression and self-harm, which was known. On 16 June 2021 Daniel took an overdose of his prescribed antibiotic medication. On 17 June 2021, he was found hanging in his cell. At the time of his death, Daniel was being monitored via Assessment, Care in Custody and Teamwork (ACCT). He was transferred via LAS to St George's Hospital and admitted to the General Intensive Care Unit (GICU). He was declared deceased on 23 June 2021. The medical cause of death was: 1a. Hypoxic ischemic brain injury; 1b. Asphyxia; 1c. Ligature compression of the neck; and II Coronary artery atheroma The jury's findings recorded in the Record of Inquest included that there was "*insufficient, regular Basic Life Support training, which resulted in Daniel being placed in the recovery position before CPR (chest compressions) commenced."*
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter 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) The provision and content of first aid training.** The evidence of witnesses revealed an absence of clarity in the first aid training to prison officers on the use of rescue breaths during resuscitation attempts, as per current advice from the Resuscitation Council UK.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 7 August 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, NUCO Training and to Daniel's family. I am also under a duty to send the Chief Coroner a copy of your response. 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	**Priya Malhotra** **Assistant Coroner Inner West London** **11 June 2024**