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 investigation commenced on 14 November 2018. The inquest was opened on 27 November 2018 and concluded at the end of the inquest on 12 April 2024. The conclusion of the jury was drug related death.
4	**CIRCUMSTANCES OF THE DEATH** Yuri Hatton was detained at HMP Wandsworth. He died on 9 November 2018 aged 44 years. His death was confirmed at St George's Hospital, Tooting Road, London. The family requested the deceased is referred to as Yuri. I will reflect this in this report. On 7 November 2018 at approximately 18:25 healthcare staff were called to Yuri's cell who was suspected of taking an opiate overdose. Naloxone was given and the patient was noted to become more alert. He was later seen by healthcare staff at 23:46 and was reported to be awake, alert, breathing easily and watching television from his bed. At approximately 00:10 on 8 November 2018 healthcare staff responded to a call regarding Yuri who was found to be breathing abnormally in his cell. A code blue was called, and cardiopulmonary resuscitation (CPR) was commenced. His airway was maintained, and a defibrillator was used which advised no shock at any time. He was found to be in asystole when the London Ambulance Service (LAS) arrived at 00:20. CPR was continued with return of spontaneous circulation at 00:40. Yuri was intubated, given 200mcg of adrenaline and intramuscular Naloxone was administered with no change in his level of consciousness. He was transferred via LAS to St George's Hospital and admitted to the General Intensive Care Unit (GICU). Whilst on the GICU he remained profoundly unconscious off all sedation and demonstrated features of brain stem death. He was declared deceased at 18:22 on 9 November 2018. The medical cause of death was: 1a. Bronchopneumonia; 1b. Hypoxic-ischaemic encephalopathy; and 1c. Cardiac arrest resulting from the effects of methadone and mixed drug toxicity. The jury recorded in the Record of Inquest the following 4 failures cumulatively possibly contributed to Yuri's death:

	1. *"To call a code blue and call an ambulance by the substance misuse nurse once naloxone was administered;* 2. *To take opportunities to correct the error by the substance misuse nurse by other experienced healthcare staff;* 3. *Inappropriate clinical observations of Yuri post administration of the naloxone;* 4. *Inadequate communications (especially during handovers) between the prison staff between themselves or healthcare staff between themselves".*
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 follows: **(1) Operational Support Grade (OSG) training.** Following the Inquest, I sought further evidence regarding several matters, including OSG training. A statement provided by HMP Wandsworth confirms that of 83 OGSs, only 5 had received HMPPS official training. This is against the background of OSG's only being present on the wings at night, and therefore often the first to respond to any emergency. **(2) The frequency and monitoring of first aid training.** First Aid training is said to be refreshed locally annually. Training logs of some staff members involved in the Inquest did not show centrally all the training received, instead a local training log is said to be kept, but which were absent at the Inquest or post-Inquest. **(3) Recognising unconsciousness.** The First Aid training offered, whilst addressing unconsciousness, is not prison specific. A new induction package was said to be rolled out imminently which will include instructions about what a member of prison staff should do if they believe that a prisoner could be unconscious and will reiterate the instruction to call a code blue in such circumstances. This training has not yet been implemented.
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 Yuri'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**