# 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>**1 OSG** [redacted]<br>**2 HM Prison & Probation Service (HMPPS)**<br>**3 Ministry of Justice (MOJ)**<br>**4 The Governing Governor, HMP Woodhill** |
| **1** | **CORONER**<br><br>I am Crispin Giles BUTLER, Senior Coroner for the coroner area of Buckinghamshire |
| **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 06 June 2023 I commenced an investigation into the death of George EMMETT aged 25. The investigation concluded at the end of the inquest on 26 June 2025. The conclusion of the inquest was that recorded by the jury was that George's death was drug-related.<br><br>The Medical Cause of Death Was:<br>1a) Toxic Effects of Synthetic Cannabinoid<br>II) Coronary Artery Atheroma |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>The jury recorded in relation to when, where, how and in what circumstances George came by his death:<br>Mr George Emmett died after taking synthetic cannabinoid in G-Wing at HMP Aylesbury on 25th May 2023. The death was verified by attending paramedics at 21.38 on that day.<br>On 25th May 2023, George was last observed alive in his cell at 18.17.<br>There was a 12 minute period between being observed unresponsive at 20.34 on the floor of his cell and unlocking his cell at 20.46, after which resuscitation attempts followed, and an ambulance was dispatched at 20.48<br>Paragraphs 5.2 and 5.3 of the applicable Medical Emergency Response Codes, which relate to the summoning of emergency assistance, were only acted upon at 20.47.<br>Due to the ongoing effects of synthetic cannabinoid, it is not possible to ascertain the optimal time at which CPR would have been successful. Therefore, there is insufficient evidence that this lapse of time contributed to George's death. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern) |

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| | During the evidence in person of Operational Support Grade (OSG) [redacted], he discussed his actions at the time of and after first seeing George on the floor in his cell. He was taken to sections of the national HMPPS Medical Emergency Response Codes policy which include:<br>5.2: Local Procedures must ensure that staff understand they should not delay summoning emergency assistance. For example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called;<br>5.3 It is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner and that access to both the prison and the individual prisoner is not delayed;<br>5.4: A representative NHS Ambulance guide for use in the community states that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe blood loss, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected stroke. This must also be the case for prisoners and therefore, in these situations when the medical emergency is called over the radio network, an ambulance must be called immediately;<br>Paragraph 5.7 indicates a number of minimum requirements for local protocols, including to inform staff that if they are in any doubt about the nature of the injury, they must call an ambulance. It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required.<br>The policy also describes the circumstances in which a "Code Blue" should be called including a prisoner who is unconscious.<br>Evidence at the inquest demonstrated a Code Blue should be called over the radio from the cell location where a situation such as that in which George was found has arisen.<br>The evidence of OSG [redacted] did not appear to demonstrate familiarity with the processes set out in this policy at the time of George's death, nor any greater familiarity during evidence given, some two years after George's death.<br>It is understood OSG [redacted] holds a similar role at HMP Woodhill.<br>There is a continuing concern that optimum reaction to an emergency situation involving the health of a prisoner may be compromised if OSG [redacted] were to react in a manner which was not in accordance with any local protocols reflective of this HMPPS Medical Emergency Response Codes policy.<br>The circumstances anticipated by this policy include situations where a prisoner's death may be prevented with appropriate application of an emergency response. |
| **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 August 28, 2025. 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>**Ministry of Justice**<br>**Central & North West London NHS Foundation Trust**<br>**Forward Trust**<br>**Duncan Lewis Solicitors on Behalf of the Family**<br><br>I have also sent it to |

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| | **The Governing Governor, HMP Aylesbury**<br>**Prisons and Probation Ombudsman**<br>**South Central Ambulance Service**<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.<br><br>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: 04/07/2025**<br><br>Crispin Butler<br>**Crispin Giles BUTLER**<br>**Senior Coroner for**<br>**Buckinghamshire** |