GRAEME HUGHES

HIS MAJESTY'S
SENIOR CORONER

SOUTH WALES CENTRAL
CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

Telephone: [redacted]
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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Cwm Taf Morgannwg University Health Board** **G4S Care & Justice Services UK Ltd**
1	**CORONER** I am **Patricia Morgan Area Coroner**, for the coroner area of South Wales Central.
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 25 April 2022 I commenced an investigation into the death of Lewis Rhys Thomas PETRYSZYN . The investigation concluded at the end of the inquest 09/04/2025.

	The jury conclusion of the inquest was that Lewis Petryszyn's death occurred as a consequence of inhalation of drugs. He inhaled them without intending to end his life. **1a Unexpected death from inhalation of synthetic cannabinoids** **1b** **1c** **II**
4	**CIRCUMSTANCES OF THE DEATH** These are recorded as:- On Friday 15th April 2022 between 13:45pm and 14:27pm, Mr Petryszyn died in his shared cell on Alpha 4 Block, HMP Parc, 1 Heol Hopcyn John, Coity, Bridgend, by inhalation of synthetic cannabinoids. The Inquest focused upon:- i. Mr Petryszyn's use of Psychoactive Substances at HMP Parc since 6 May 2021 ii. The steps taken by HMP Parc to safeguard Mr Petryszyn from drug use while in custody until his death on 15 April 2022 iii. The circumstances in which Mr Petryszyn came to ingest psychoactive substances on 15 April 2022 iv. The emergency response to Mr Petryszyn being found unresponsive in his cell on 15 April 2022, and whether there were any missed opportunities to render care. .

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 will 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) There was, and remains, an absence of specified prescribed timeframes in policies and procedures within which intervention, ongoing support, and/or case load allocation to/from Dyfodol must occur for prisoners likely to be at risk of substance misuse. (2) The absence of prescribed timeframes poses the real risk of delayed support and intervention to drug users
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 25th September 2025. 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 family who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response.

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100 Fax/Ffacs (01443) 485862

	The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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	31 July 2025 **SIGNED:**  Patricia Morgan Area Coroner for South Wales Central Coroner Area

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