OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	THIS REPORT IS BEING SENT TO: 1. The Governing Governor, HMP Leeds
1	**CORONER** I am Naomi McLoughlin, Assistant Coroner for the Coroner Area of West Yorkshire (East).
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 18th June 2024, an investigation was commenced into the death of Brian Burrows (also known as Brian Smith), born on 23 June 1980 and died on 15 May 2024. The investigation concluded at the end of the Inquest which held before a jury between 1 and 8 September 2025. The medical cause of death was: 1a Hypoxic Ischaemic Encephalopathy 1b Hanging The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Brian Burrows was admitted to HMP Leeds on 28 March 2024. He experienced a number of self-harm incidents between 22 April 2024 and 9 May 2024 before the incident on 10 May 2024 which led to his death on 15 May 2024. Mr Burrows died as a result of using a ligature.

	Mr Burrows was on an ACCT and was assessed as requiring 3 observations per hour. The inquest heard evidence that the wing where Mr Burrows resided was extremely busy on 10 May 2024 with one officer stating that it was the busiest day of his career so far. There was one officer who was alone responsible for conducting ACCT checks on 3 prisoners on one landing including Mr Burrows. Mr Burrows was not checked between 13:50 and 14:43 despite him being assessed as requiring 3 ACCT checks per hour. Between 14:00 and 14:43, 22 emergency cell bells were activated on the landing where Mr Burrows resided. The inquest heard evidence that prison officers are instructed in training to treat a cell bell as an emergency and not walk past a cell bell when activated for any reason. Prison officers were also aware of the need to perform ACCT checks as required as a priority task. The inquest heard evidence that there was no guidance given to prison officers by senior officers or management about how to prioritise these tasks in such circumstances. Evidence was also heard that during the daily briefings there was no guidance given to prison officers about how to manage such tasks. Additionally, evidence was heard that no training is given to prison officers about making decisions in such circumstances and how to critically assess which task to prioritise.
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) The inquest was told that no training is given to prison officers about decision making in dynamic situations where competing priority tasks needs to be completed namely what to do when faced by a number of emergency cell bells and a number of ACCT checks. (2) The inquest was told that briefings delivered by senior staff on the wing do not assist prison officers by providing guidance on how to complete tasks of competing priority.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or 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 4 November 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.
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	COPIES and PUBLICATION 1have sent a copy of my report to the Chief Coroner and to the following Interested Persons via their legal representatives: 1. Brian's family; 2. Practice Plus Group (PPG). I have also sent it to the following people who may find it useful or of interest: 1. His Majesty's Inspectorate of Prisons; 2. His Majesty's Prison and Probation Service; 3. The Prison and Probation Service Ombudsman. 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. She 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	Signed: [redacted] NAOMI MCLOUGHLIN Assistant Coroner West Yorkshire (E) Date: 9 September 2025