Kate Robertson
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Governor, HMP Berwyn Ministry of Justice c/o Government Legal Department, London
1	**CORONER** I am Kate Robertson, Assistant Coroner for North Wales (East and 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 26 November 2011 an investigation was commenced into the death of Matthew Lucas Sundeep Singh (DOB 13/11/1993) who died on 23 November 2019. The investigation concluded at the end of the jury inquest on 5 November 2025. The conclusion of the inquest was drug related death.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Matthew Lucas Sundeep Singh was a prisoner at HMP Berwyn. He was found unresponsive in his cell at approximately 20:42 hours on 23 November 2019 after consuming a novel psychoactive substance. He died a short time later from a cardiac arrest due to [redacted] abuse.
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 –

	The report from HM Inspectorate of Prisons into HM Berwyn from June 2025 (inspection visit 27 January to 7 February 2025) noted that:- '*The entry and conveyance of illicit items into the prison was a major threat to its stability. In the previous 12 months, there had been over 1,000 reported finds, including 500 relating to drugs. The positive mandatory drug test rate for the previous year was high at 33.5%, and suspicion-led testing had yielded positive results of 77% over the same period. It was not surprising, therefore, that in our survey, 60% of prisoners said it was easy to get illicit drugs at Berwyn*'. Notably, the percentage of prisoners who said it was easy to get illicit drugs at Berwyn 48% in 2019, the year of Matthew's death. It appears that there is continuing availability and use of psychoactive substances at HMP Berwyn despite ongoing initiatives. I consider that the use of psychoactive substances and the significant risks which they pose to the health of prisoners at HMP Berwyn will be the cause of future deaths in the prison.
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 31 December 2025. I, Kate Robertson, 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 Family of the Deceased and to the Chief Coroner. 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 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	Dated 5 November 2025

	[redacted] Signature Assistant Coroner for North Wales (East and Central)