Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Ministry of Justice (MOJ)** **2 HMP Bedford** **3 Northamptonshire Healthcare Foundation Trust (NHFT)**
1	**CORONER** I am Bina PATEL, Area Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 20 February 2024, I commenced an investigation into the death of Edward James HANDS aged 42, who died on the 16 February 2024. The investigation concluded at the end of the inquest on 2 December 2025. The family requested that I refer to the deceased Edward James Hands as Eddie and therefore I will reflect that in this report. The medical cause of death was: 1a Aspiration Pneumonitis 2 Methadone Use The conclusion of the jury inquest was a Narrative Conclusion - After consuming methadone, the major contributing factor in Eddie's death was a lack of follow up care by both healthcare and prison staff. Overall, Eddie's death was contributed to by neglect. On the balance of probabilities, Eddie's death could have been prevented as there was a window of opportunity to intervene. The following factors contributed to the death in a more than minimal way: Insufficient training around the Under the Influence (UTI) protocol; A lack of awareness by prison and healthcare staff in identifying and managing the signs of a UTI case; The availability of staff on the day; High staff turnover, as well as inadequate onboarding of new staff; A lack of cooperation between healthcare and prison management; An omission of discussing the ongoing UTI case during afternoon briefings and/or handovers; An overall lack of accountability in taking ownership of handling the UTI case.

4	***CIRCUMSTANCES OF THE DEATH*** *1) Eddie died on the 16th February 2024 at 1724 in his cell A329, Alpha Wing, HMP Bedford. He died from Aspiration Pneumonitis following consumption of methadone. He was last seen at: 1449, when he was reported snoring in his cell.* *2) Access to mental health support services did not contribute to the death. Access to substance misuse support, although broadly beneficial, would not have directly impacted the outcome.* *3)There was an Under the Influence Protocol (Bedford Staff Community Notice 265/2023) in place at the time of the death. This protocol was not being used at the time, as evidenced by the number of noted UTI (Under the Influence) incidents (34 in January and 15 in February) and the lack of awareness and recording in the protocol by both prison officers and healthcare staff. Methadone administration at the prison was conducted by two members of staff (healthcare and/or prison staff). However, this was applied inconsistently.* *4) Eddie was not prescribed methadone, and it is uncertain how he came to ingest it.* *On 16th February 2024, Eddie's presenting condition was initially managed in line with the protocol with prison staff raising a Hotel 2 call. Healthcare staff responded to this call. The observations conducted by healthcare staff assessed that he was under the influence. At this point, the UTI protocol should have been started by prison staff and/or healthcare staff, and this did not happen. The lack of follow up visits or checks were a failure in his ongoing care. Thereafter, there was a failure by healthcare staff to carry out a follow up medical assessment or by prison staff as per the protocol. In responding to the 'Code Blue', there was not a full response by healthcare, in that only one of the designated staff members attended. Whilst the evidence does not establish that the following matters probably caused or contributed to Eddie's death, it was admitted that there was a failure of healthcare to use suction equipment to clear the airway at the time he was found unresponsive in his cell and in cardiac arrest with stomach contents in his mouth and throat.*
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The evidence at the inquest revealed that the (primary) prison healthcare provider (within the prison) and prison staff are working to different policies and protocols in relation to those suspected to be 'under the influence of illicit substances'; there is confusion and lack of awareness of those working in the prison as to the role and responsibilities and expectations about how to alert and manage a concern that a prisoner may be under the influence. In this instance this confusion resulted in Eddie not being observed; had these checks and monitoring taken place, it would have been clear Eddie was not improving and that a follow up medical assessment was required. This meant his clinical deterioration was not recognised and escalated. It is understood that the NHFT policy is designed to cover the entire Trust and may well, therefore, have relevance beyond Bedford prison. However, it is essential that the policy is clear on what happens when the individual institutions have their own local protocols. Eddie's inquest has revealed how clarity on steps and paperwork required under the policy is essential amongst frontline staff to ensure the safest possible environment for prison residents at Bedford Prison.

6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by April 14, 2026. 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 and to the following Interested Persons **Eddie's Family** **HMP Bedford** **Northamptonshire Healthcare Foundation Trust** **Central & Northwest London NHS Foundation Trust** I have also sent it to **Prisons Probations Ombudsman (PPO)** 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. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 17 February 2026**  **Bina PATEL** **Area Coroner for** **Bedfordshire and Luton Coroner Service**