GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

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

[redacted]

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 Governor of HM Prison Parc**
1	**CORONER** I am David Regan, Assistant Coroner, for the Coroner's 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** A Coronial investigation was commenced on 3rd February 2023 into the death of Ryan Harding. The Investigation concluded at the end of an inquest which I conducted with a jury on 19th – 28th January 2026. The conclusion of the jury was that Mr Harding's death was drug related. The medical cause of death was 1(a) Sudden unexpected death in a

	man with epilepsy (following head injury), and Hashimoto's thyroiditis, who had ingested [redacted] receptor agonists, [redacted].
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as:- "Ryan Harding died between 7th – 8th January 2023 in his cell overnight, as a result of consuming drugs." .
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. While none of those matters directly caused the death of Ryan Harding, 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. – (3) The inquest heard evidence that the windows of Alpha and Bravo blocks did in 2023 and continue to require upgrading in order to reduce the ability of illicit materials including drugs and mobile phones to enter the prison. (3) The gate house continues to require upgrading to enable enhanced security to be afforded to reduce the ability of illicit materials including drugs and mobile phones to enter the prison. (3) On the morning of 8th January 2023, the scheduled morning welfare check did not take place. The evidence of officers was that this was delayed for lack of a staff member and had been delayed on other occasions.
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 3rd April 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 Mr Harding's family and to the following, who may find it useful or of interest: The Chief Executive of the Cwm Taf Morgannwg University Health Board; The Ministry of Justice. 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	4 February 2026 **SIGNED:**  **David Regan** **Assistant Coroner**

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