OFFICE OF THE
ACTING 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]

REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Oliver Longstaff, Acting Senior Coroner for the West Yorkshire (Eastern) coroner area.
2.	**DATE OF REPORT** 07/05/2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. The Ministry of Justice 2. Practice Plus Group You are under a duty to respond to this report within 56 days of the date of this report, namely by 03/07/2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** A serving prisoner in HMP Leeds, who was on an open ACCT document, was moved to the Segregation Unit in the prison after starting a fire in his cell shortly before 1500 hrs on 24/12/2024. Pursuant to PS 1700 he should have had a mental health assessment within 24 hours of his arrival in the Segregation Unit. No such assessment took place. Shortly before 2330 hrs on

	25/12/2024, he was found hanging in his cell on the Segregation Unit and transferred to hospital, where he died on 30/12/2024.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 08/01/2025, I commenced an investigation into the death of Alan Joseph Whelan, aged 41 years… **The medical cause of death was 1a) Hypoxic Encephalopathy; b) Hanging** The deceased died on 30/12/2024 in Leeds General Infirmary, where he had been brought on 25/12/2024 from HMP Leeds, where he had been found hanging in his single-occupancy cell on the Segregation Unit. **Conclusion (Jury's narrative conclusion)** Alan Joseph Whelan was found ligatured in his cell on 25th Dec 2024 and subsequently died on 30th December 2024 at Leeds General Infirmary. It is possible that loss of work was a trigger to Alan's mental state and thought process. Following previous incidents, we feel that observations should have been made more regularly, and any ACCT reviews should have considered previous incidents. It cannot be established that Alan not being more frequently observed probably contributed to his death, but it is possible that it did so. Admission by MoJ The prison officer conducting ACCT observations on Alan on the night of 25th Dec did not comply with the requirement to conduct one check at irregular intervals every 60 minutes. By the time he conducted the check which led to Alan's discovery it had been 1 hour and 11 minutes since the last check. It cannot be established that this finding probably contributed to the death, but (it) may have done so.
8.	**CIRCUMSTANCES OF DEATH** Alan Whelan, a serving prisoner in HMP Leeds who was on an open ACCT document, was moved to the Segregation Unit in the prison after starting a fire in his cell shortly before 1500 hrs on 24/12/2024. Pursuant to PS 1700 he should have had a mental health assessment within 24 hours of his arrival in the Segregation Unit. No such assessment took place. An ACCT review attended by a mental health practitioner was held on the morning of 25/12/2024, but that practitioner gave evidence that an ACCT review was not an appropriate substitute for a 1:1 mental health assessment. The evidence at inquest did not establish whether the failure to conduct a mental health assessment as required by PS 1700 was an oversight or a deliberate decision, to which the resources available in the prison on Christmas Day may have contributed. Shortly before 2330 hrs on 25/12/2024, Alan was found hanging in his cell on the Segregation Unit and transferred to hospital, where he died on 30/12/2024.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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:

	A mandatory requirement that a prisoner on an open ACCT document should have a mental health assessment within 24 hours of being transferred to the Segregation Unit was not complied with. Alan took steps that caused his death after that 24-hour window had closed. There was scant acknowledgment of this breach of a standing instruction from the witnesses who gave evidence to the inquest. The possibility that not carrying out such an assessment made no difference to the outcome is obvious. But that possibility neither explains nor excuses the failure to comply with the instruction, especially where it is unclear whether that failure was inadvertent or deliberate, and if deliberate, with what justification.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Alan Whelan's family's legal representatives 2. The Ministry of Justice 3. Practice Plus Group I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE  **DATE 07 May 2026**