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 Simon Connolly, Assistant Coroner, for the coroner area of County Durham and Darlington.
2.	**DATE OF REPORT** 15 September 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.
4.	**THIS REPORT IS BEING SENT TO** 1. HMP Frankland You are under a duty to respond to this report within 56 days of the date of this report, namely by November 10, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**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.

6.	**SUMMARY OF CORONER'S CONCERN** I am concerned about the robustness and adequacy of the prison's "Secreted Items" policy in force in 2024 and updated as of July 2026 and as regards issues of staff awareness and interpretation of its requirements.
7.	**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.
8.	**INVESTIGATION AND INQUEST** On 16 December 2024 I commenced an investigation into the death of Wayne MILLER aged 36. The investigation concluded at the end of the inquest on 09 September 2026. The conclusion of the inquest was that: Mr Miller was last confirmed to be alive on 13/12/24 at 20:37 and was his usual self. At HMP Frankland on the14/12/24 09:15 cell 1-18 J wing on the morning roll call check Mr Miller was found unresponsive. Upon further investigation, Mr Miller was found deceased by prison staff and confirmed by the appropriate nurse staff who declared Mr Miller was deceased. The decision was made to not resuscitate Mr Miller due to rigormortis and he was cold to the touch with signs of blood pooling. He was found with [redacted] on his chest and face laying face down, later confirmed via the toxicology report that this was a combination of [redacted], these drugs can cause respiratory issues, abnormal hearth rhythms, heart attack and strokes and even death. It was later identified Mr Miller had a remaining [redacted] It was known Mr Miller had issues with drug misuse and was receiving help from the "DART" team at the prison. It was highlighted he was participating, but not at other times.
9.	**CIRCUMSTANCES OF DEATH** Mr Miller was last confirmed to be alive on 13/12/24 at 20:37 and was his usual self. At HMP Frankland on the14/12/24 09:15 cell 1-18 J wing on the morning roll call check Mr Miller was found unresponsive. Upon further investigation, Mr Miller was found deceased by prison staff and confirmed by the appropriate nurse staff who declared Mr Miller was deceased. The decision was made to not resuscitate Mr Miller due to rigormortis and he was cold to the touch with signs of blood pooling.

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10.	**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: Wayne Miller was discovered to be deceased on 14 December 2024 in his cell at HMP Frankland. Post-mortem investigations included autopsy and toxicology which demonstrated the medical cause of Mr Miller's death to be due to the combined effects of [redacted] Mr Miller had a known and well documented history of illicit substance misuse within the prison and he variously engaged with and was supported by substance misuse services although sadly to no avail. I heard evidence about the events of a social visit on 5 December 2024 when Mr Miller was suspected to have received and to have swallowed an illicit item passed to him by a visitor, with the suspected "pass" evident from CCTV footage reviewed at the time. That evidence caused me to investigate, via witnesses, the adequacy and robustness of the prison's "Secreted Items" policy then in force and updated as of July 2026. I was concerned that senior members of prison staff gave differing interpretations as regards the circumstances in which the policy might be triggered as involving a suspicion that a prisoner has secreted an item or only in circumstances where that is evidenced by subsequent investigation. I found the policy to be unclear, confusing and unhelpful in this respect and I noted that the updated 2026 policy read identically to that in force in 2024 on this issue. I was also concerned about the adequacy of the response of staff to the events of 5 December 2024, save as regards investigations by way of body scanning, which did not involve an immediate referral to the healthcare team notwithstanding the policy's identification of secretion of items within the body

	or by swallowing to be "extremely dangerous." This causes me a concern as regards staff awareness and understanding of the secreted items policy which constitutes an important aspect of the prison's strategy to disrupt and prevent the ingress of illicit items and particularly illicit substances into HMP Frankland.
11.	**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: • HMP Frankland • Mother of the deceased 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.
12.	**SIGNATURE** 