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:** **1. Michael Spurr Esq. Chief Executive, National Offender Management Service, 7th Floor, Clive House, 70 Petty France, London, SW1H 9EX**
1	**CORONER** I am Melanie J Williamson, Assistant Coroner for the coroner area of West Yorkshire (Eastern District)
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 the 27th April 2011 I commenced an Investigation into the death of Ryan Patrick John Clark aged 17 years. The Investigation concluded at the end of the Inquest on the 28th January 2014. The conclusion of the inquest was accidental death, the medical cause of death being attributable to 1(a) hanging.
4	**CIRCUMSTANCES OF THE DEATH** On the 30th March 2011 the Deceased was remanded into custody at HMYOI Wetherby where he resided until his death on the 18th April 2011. On the 4th April 2011 the Deceased was located in Cell D4-47. Prior to the Deceased's death he was subjected to bullying and intimidation from other trainees residing on D wing. At approximately 7:30am on the 18th April 2011 the Deceased was discovered in his cell in a lifeless condition with a ligature around his neck. The Deceased was transported to Harrogate District Hospital where his death was certified at 8:50am the same day.
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. – At HMYOI Wetherby (1) The Personal Officer Scheme was not properly implemented and did not operate effectively vis à vis trainees; (2) ACCT checks of a trainee were not made and/or were not made in accordance with the times prescribed by the trainee's ACCT document; (3) The correct procedure when conducting a roll count of trainees was not adopted by

	Prison Officers; (4) Prison Officers were not fully conversant in the administration of first aid and CPR and had not received regular refresher training in relation thereto.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 the 31st March 2014. 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:- [redacted] Deceased's Mother c/o [redacted] Partner with Harrison Bundey Solicitors, Youth Justice Board, Leeds City Council, Prison Officers' Association, Leeds Community Healthcare NHS Trust, GEOAmey (formerly G4S) and to Leeds Safeguarding Children Board. I have also sent it to [redacted] who may find it useful or of interest. 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. 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	**3 February 2014** **Miss Melanie J Williamson** **Assistant Coroner**