REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Governor** **Knox Road** **Norwich** **Norfolk** **NR1 4LU** **Chief Executive** **Serco Group plc** **Serco House** **16 Bartley Wood Business Park** **Bartley Way** **Hook** **Hampshire** **RG27 9U7** **Chief Executive** **Virgin Care Limited** **Lynton House** **7-12 Tavistock Square** **London** **WC1H 9LT**
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner, for the Coroner area of NORFOLK
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 11 November 2013 I commenced an investigation into the death of DARREN WRIGHT, AGE 35 YEARS. The investigation concluded at the end of the inquest on 21 January 2015. The conclusion of the inquest was medical cause of death: 1a) Hanging and conclusion: Mr Wright hanged himself. Contributory Factors: Inconsistencies with the sharing of and access to information across different departments within the Prison system.
4	**CIRCUMSTANCES OF THE DEATH:** Mr Wright was admitted to HMP Norwich on 4 September 2013 following an assault against a family member. It was his first time in prison. He was described by all members of staff and prisoners as "quiet" and "anxious". During October 2 staff members raised concerns regarding his demeanour and he was assessed by mental health staff. He was not deemed at risk of self harm. No ACCT document was opened. He was found dead in his cell on 3 November 2013. Evidence was given that self harm risk assessments tools have been revised/put in place. Steps have been put in place to ensure communication between different staff is recorded so that other members of staff have access. Further training has been instigated regarding when opening an ACCT is appropriate and to ensure all members of staff are aware of procedures.

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. – (1) On receiving Code Blue notification the Staff Nurse did not know where to go and had to call on her radio to be found and then taken to the cell; (2) The Prison Officers attending Mr Wright had not had recent CPR training. It is understood that due to a lack of resources, CPR training has had to be allocated to certain members of staff only. This will result in gaps in CPR-trained Officers available and able to attend emergencies.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 30 March 2015. 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] (wife) 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	**2 February 2015** [redacted] ..... **Senior Coroner for Norfolk**