REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	1. Governor HMP Swaleside
	1. Governor High Swateside
1	CORONER
	I am Patricia Harding, senior coroner, for the coroner area of Mid Kent and Medway
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 22 nd May 2013 I commenced an investigation into the death of Douglas Birch, 46. The investigation concluded at the end of the inquest on 9 th July 2015. The conclusion of the inquest was that Douglas Birch died in his bed at HMP Swaleside between the hours of 19.10 on 14 th May 2013 and 07.10 on 15 th May 2013 of sudden arrhythmic death syndrome. He was found at 12.20 on 15 th May 2013 by prison officers
4	CIRCUMSTANCES OF THE DEATH
	Douglas Birch was a serving prisoner at HMP Swaleside in a single occupancy cell. On 15 th May 2013 after a roll call at 7.10, the cells were unlocked at 08.15 for 30 minutes domestics before being locked again at 08.45. The cells were unlocked at approximately11.35 for lunch and locked again at approximately 12.10. His dead body was not discovered until 12.20 after a prison officer who had delivered mail to his cell without receiving a response raised concerns with a senior officer and the cell was entered. The state of his body was such that it could be established that he had been dead for a number of hours and likely before 08.00. No officer responsible for locking or unlocking his cell had sought to elicit a response from him, believing him to be asleep at the time. This was in contravention of PSI 75/2011
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. —
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	 (1) Prison officers were either not aware of PSI 75/2011 requiring that officers should elicit a response from the prisoner upon unlocking a cell or were aware but did not act in accordance with the order especially where they assumed the prisoner was asleep (2) Prison officers were either not receiving Prison Service Orders and Instructions or if they did receive them, did not read them
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you have the

9	DATE 13 th July 2015 [SIGNED BY CORONER] PJHWCH
	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.
	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Hodge Jones Allen solicitors on behalf of the mother of the deceased, Imran Khan solicitors on behalf of the daughter of the deceased, Government Legal Department, DAC Beachcroft in respect of nurse, Gordons Partnership representing GP. I have also sent it to Prison & Probation Ombudsman who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response.
8	COPIES and PUBLICATION
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 9 th September 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.
7	YOUR RESPONSE
	power to take such action.