for The County of Dorset

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Governor, HMP Portland, 104 Grove Road, Portland, DT5 1DL**
1	**CORONER** I am Brendan Allen, Assistant Coroner for The County of Dorset
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12th November 2014 I commenced an investigation into the death of Wayne Wesley Cornlouer. The investigation and inquest concluded on 23rd September 2016. The conclusion of the Inquest was that Mr Cornlouer committed suicide. The jury also concluded that an ACCT should have been opened following an incident on 14th October, but that this did not more than minimally contribute to the death.
4	**CIRCUMSTANCES OF THE DEATH** Wayne Cornlouer was found hanging in his cell on Collingwood Wing at approximately 5.50 am on 24th October 2014. The officer that discovered Mr Cornlouer called for "Immediate assistance on Collingwood". The evidence suggests that his colleagues arrived at the scene within 5 minutes. It was only at this point that a call was put through to the control room to call for an ambulance.
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. – I understand that the coding system for a medical emergency, code red/code blue, was not part of the Night Orders at the time of Mr Cornlouer's death. However, the Night Orders have since been amended to include this emergency coding. My concern is as to whether or not all staff are aware of the change in the Night Orders.

The Coroner's Court, Town Hall, Bourne Avenue, Bournemouth, Dorset, BH2 6DY
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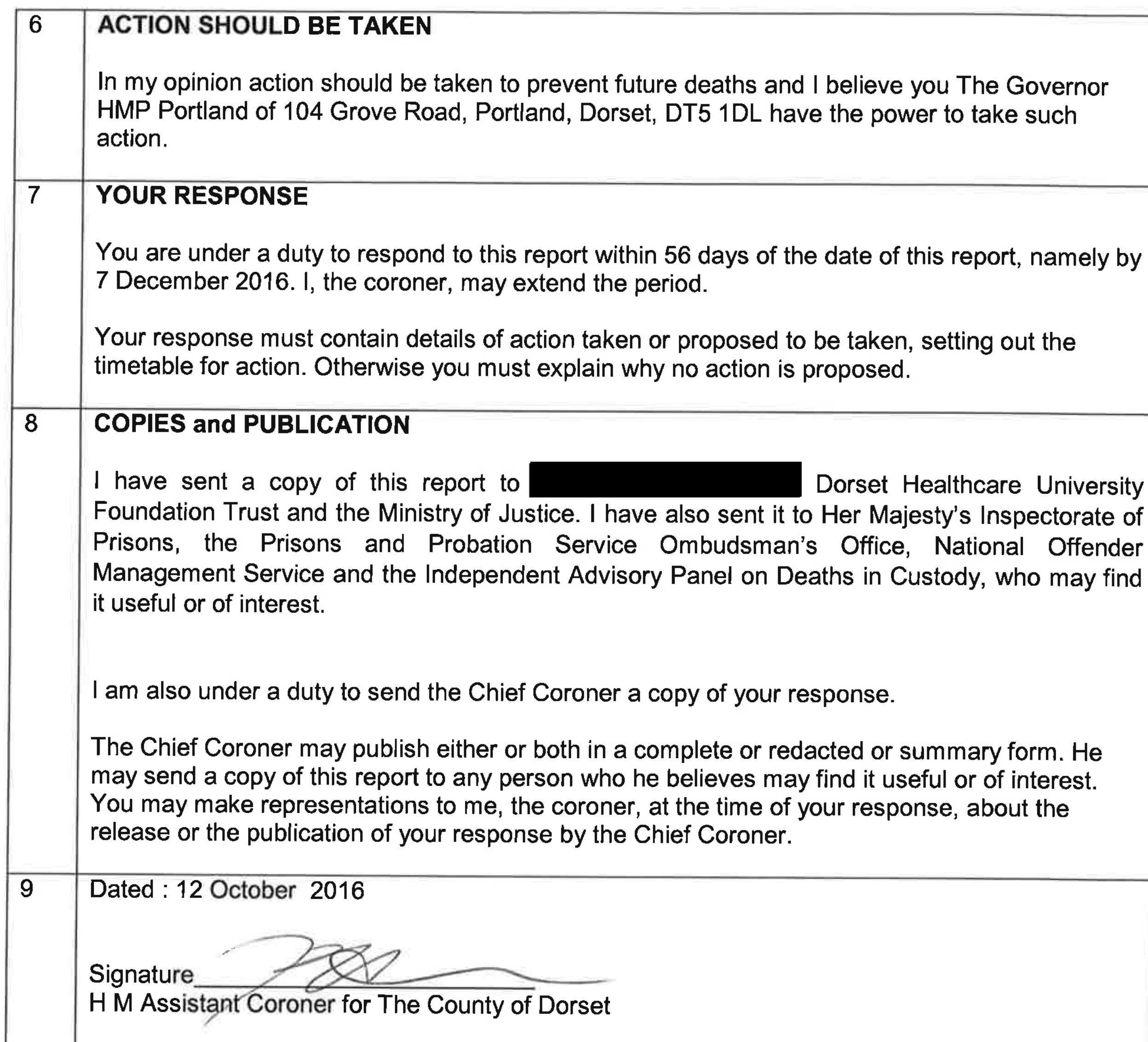

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Governor HMP Portland of 104 Grove Road, Portland, Dorset, DT5 1DL have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 December 2016. 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 this report to [redacted] Dorset Healthcare University Foundation Trust and the Ministry of Justice. I have also sent it to Her Majesty's Inspectorate of Prisons, the Prisons and Probation Service Ombudsman's Office, National Offender Management Service and the Independent Advisory Panel on Deaths in Custody, 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	Dated : 12 October 2016 Signature____________________ H M Assistant Coroner for The County of Dorset

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