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. The Governor HMP Liverpool**
1	**CORONER** I am Julie Goulding Assistant Coroner, for the area of Liverpool and wirral
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 5th January 2015 an investigation was commenced into the death of **Mark LILLIOTT** , Aged **54**. The investigation concluded at the end of the inquest on 15th December 2016. The conclusion of the inquest was Drug Related and the Cause of Death was Ia Heroin Toxicity with Early Pneumonia
4	**CIRCUMSTANCES OF THE DEATH** Mr Lilliot is a 54yr old gentleman who is an in-mate at HMP Liverpool. On the evening of 22nd December 2014, Mr Lilliot was returned to his cell and at 16.30 hours the cell door was closed. At 18.45 hours the cell door was locked as per procedures. At 08.45 hours the following morning, Prison officers unlocked the cell doors on the landing and checked on the welfare of the inmates. On checking on Mr Lilliot they found him on his bed, lying on his side facing the wall covered by a bed sheet. Due to his unresponsive state, staff contacted the on duty Nurse. On arrival and with the help of the staff Mr Lilliot was brought of the bed still on his mattress. The attending nurse found he was still unresponsive with no pulse and that rigor mortis had set in. As a result CPR was not attempted and Mr Lilliot's life was pronounced extinct at 09.12 hours.
5	**<u>CORONER'S CONCERNS</u>** 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. – When the two Prison Officers discovered Mr Lilliott they immediately tried to identify an Officer with a radio to request immediate assistance from HOTEL1 (the urgent nursing response within the prison) and subsequently determining that this was a CODE Blue and therefore an emergency ambulance was also required. The two Prison Officers therefore left the cell to seek the Senior Officer with the radio. It was reportedly noisy on the wing at the time. The Prison Officers tried to shout down from level 5 to attract the Senior Officer who they believed was on level 2 but this action was unsuccessful. One of the Prison Officers therefore left the 5's landing to go down to the lower levels and find

	the Senior Officer, as he passed through level 4 he saw another Prison Officer who he thought might have a radio but he didn't and therefore he proceeded to lean over the landing and shout again to try to attract the attention of the Senior Officer with a radio and again it was reported that the Prison Officers shouts were not heard because of the noise, it was a busy period with prisoners making their way to their daily activity. When the Prison Officer shouted again to get the attention of the Senior Officer he was on this occasion heard and the appropriate radio dispatches were immediately made in respect of HOTEL1 and Code Blue. The delay, albeit relatively short, in accessing a Senior Officer in possession of a radio on this occasion did not affect the outcome, Mr Lilliott was already dead when he was discovered and had been for some time. However, it might not have been the case that the prisoner was already deceased and it might have been the case and it might be the case in the future that the fastest possible response and action to radio for emergency help could make a difference to the outcome.
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. 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] (sister) and [redacted] (Partner) MerseyCare NHS Foundation Trust Liverpool Community health NHS Foundation Trust I have also sent it to HM Inspectorate of Prisons, National offender Management Service, 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	 **Julie Goulding** **Assistant Coroner for the** **City of Liverpool & Wirral** **Dated:16 December 2016**