

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. Governor – HMP Long Lartin</li><li>2.</li><li>3.</li></ol>
1	<p><b>CORONER</b></p> <p>I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 20<sup>th</sup> June 2016 I commenced an investigation into the death of Sidonio Eugenio TEIXEIRA then aged 59. The investigation concluded at the end of the inquest on 7<sup>th</sup> December 2017</p> <p>The conclusion of the inquest was narrative (attached), the medical cause of death being multiple injuries.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Teixeira was murdered in the prison by another prisoner.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>(1) : issues arose in the course of the inquest regarding the adequacy of intelligence, the efficacy of reporting, the appropriateness of analysis, the training of analysts and the need for ongoing audit. These issues and the adequacy of them were reflected in the narrative conclusion reached by the jury. In the course of the inquest a witness produced a previously unseen internal (and critical) report regarding these issues which none of the witnesses had seen previously (including the head of safer custody) notwithstanding that the report had been produced over 12 months previously raising concerns that lessons might not have been shared with appropriate staff.</p> <p>(2) (3)</p>

6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action by conducting a general review of the intelligence processes within the prison</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 6<sup>th</sup> February 2018 I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>Signed</b> </p> <p>-----</p> <p><b>G U Williams</b> <span style="float: right;"><b>12th day of December 2017</b></span></p> <p><b>H M Senior Coroner</b></p>