ANNEX A

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. **Michael Spurr, National Offender Management Service, 102 Petty France, London, SW1H 9AJ**
1	**CORONER** I am JONATHAN DAVID LEACH, Area Coroner, for the Coroner area of West Yorkshire (Eastern) district
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 26th September 2016 I commenced an Investigation into the death of Nicola Jayne Lawrence, aged 38 years. The Investigation concluded at the end of the Inquest on 17th May 2018. The conclusion of the Inquest was a Narrative. She died from 1(a) Methadone Toxicity 2. Multi Drug Administration.
4	**CIRCUMSTANCES OF THE DEATH** At the time of her death the deceased was an Inmate at HMP New Hall. She arrived on the 9th September 2016. She was taking a considerable amount of medication including methadone. She was seen by a number of Health Care staff. No consideration was given by them to the anti-respiratory/depressant effects of the medication on her. On the 24th September 2016 she was found unresponsive. Notwithstanding the efforts of Prison staff, Health Care staff and ambulance staff she died.
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) Some Prison staff had not received any cardiopulmonary resuscitation training. Either as part of initial training or any refresher training. Evidence was received that good quality CPR within the first few minutes of those who stopped breathing or heart stopped was critical.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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, namely by 18 December 2018. I, the Area 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 Person – [redacted] (mother) and Care UK Limited. 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	**23rd October 2018** **JONATHAN DAVID LEACH** **Area Coroner** **West Yorkshire (Eastern)**