Neil Cameron
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: NHS England**
1	**CORONER** I am Neil Cameron, Assistant Coroner for South Yorkshire (East 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. 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 4th December 2015 I commenced an investigation into the death of Daniel Paul Mark Stokes, 34. The investigation concluded at the end of the inquest on 2nd November 2018. The conclusion of the inquest was Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** Daniel Paul Mark Stokes was an inmate at HM Prison, Lindholme, Doncaster. On 30th November 2015, it is reported by another prisoner that the deceased had described taking an amount of MDMA and was acting erratically. The deceased showed features of physical agitation, culminating in cardiac arrest. Despite assistance from prison and paramedic staff, Mr Stokes could not be revived, being declared deceased on the same day at 20:05 hours on the 30th November 2015.
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) Part of the evidence in this case related to the attendance of prison healthcare staff who were in the possession of diazapam, but not trained/authorised to administer it. Whilst there may be good reason for this (ie so that diazapam is available at the scene of an incident if someone attends who is so trained/authorised) nonetheless, the jury which considered the case clearly considered that this amounts to a failure to have proper systems in place. I therefore adopt their view as a matter of concern, such that I consider consideration should be given to the practicality of requiring healthcare staff working within prisons to be trained/authorised to administer diazapam in circumstances where a prisoner may be suffering from the effect of abuse of controlled drugs.

Coroner's Court and Office, Doncaster Crown Court, College Road, Doncaster, DN1 3HS
Tel 01302 737135 | Fax 01302 736365

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 the **28th December 2018.** 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: Tuckers Solicitors, Mills & Reeve Solicitors, Government Legal Solicitors & HM Prison Lindholme. 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 5th November 2018 Signature_____ Assistant Coroner for South Yorkshire (East District)

Coroner's Court and Office, Doncaster Crown Court, College Road, Doncaster, DN1 3HS
Tel 01302 737135 | Fax 01302 736365