Mrs Sarah Louise Slater
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Robert Buckland QC MP** Minister Of State For Justice, The Ministry Of Justice, One Kemble Street London WC2B 4TS
1	**CORONER** I am Mrs Sarah Louise Slater, 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 the 1st March 2018, I commenced an investigation into the death of Darren McGuin. The investigation concluded at the end of the inquest on 26th June 2019. The conclusion of the inquest was the Mr McGuin died from : 1(a) Pulmonary embolism 1(b) Deep vein thrombosis (2) Obesity A short form conclusion of Natural Causes was recorded in Box Four and Box three completed in the following term: Mr Darren McGuin died on the 22nd February 2018 at HMP Lindholme due to the detachment of a deep vein thrombosis, which caused a massive pulmonary embolism. It is more likely than not that Mr McGuin died in his sleep.
4	**CIRCUMSTANCES OF THE DEATH** Mr McGuin (D.O.B 01.01.1980) was a serving prisoner at HMP Lindholme, Doncaster. On the 22nd February 2018, Mr McGuin was found laid unresponsive on the top of his bed in his cell by a Prison Officer who was unlocking the door that morning. The Prison Officer made a "code Blue" emergency call to Healthcare for their urgent assistance. The Prison Officers who were on duty and in attendance that morning had not been trained in basic life support and therefore cardio-pulmonary resuscitation did not commence until a member of health care attended on the wing. Healthcare staff continued with CPR until the emergency services attended who later pronounced Mr McGuin deceased.

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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) There was clearly a delay between Mr McGuin being found unresponsive by the prison officers and the commencement of CPR by members of the healthcare staff. Although, earlier CPR would not have altered the outcome in this particulate set of circumstances, it may on a different occasion. 2) Prison officers will usually be first on scene, particularly if a prisoner is found in their cell and this lack of basic life support training is leading to a delay in the commencement of CPR. The evidence before the Court was that prison officers who's employment either started prior 2005 or after 2017, completed a compulsory three-day Basic Life Support and First Aid course as part of their mandatory training. However, at a date unknown at this time, this training requirement ceased. This inquest has highlighted that there are a number of staff working within the prison service who have never received basic life support training. It is my understanding that there are no efforts being made to identify and provide retrospective training to those members of staff who were appointed during this period of time where basic life support training was not provided. The Ministry of State for Prisons is asked to consider whether it is appropriate for a review to take place to identify and subsequent provide appropriate basic life skill training to all prison staff, who have not received if as part of their mandatory training.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Mr Robert Buckland QC MP 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 **Wednesday 21 August 2019**. 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] Care UK, [redacted] BLM Law 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 26 June 2019 Signature ____________________ Assistant Coroner for South Yorkshire (East District)