**John Adrian Gittins**
**Senior Coroner for North Wales (East and Central)**

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| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO: HMP Berwyn and the Ministry of Justice c/o A2 MOJ Private Law Litigation, Government Legal Department, One Kemble Street, London WC2 4TS |
| 1 | CORONER<br><br>I am John Adrian Gittins, Senior Coroner for North Wales (East and Central) |
| 2 | CORONER'S LEGAL POWERS<br><br>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<br><br>On the 3rd of April 2018 I commenced an investigation into the death of Luke Morris Jones (DOB 4.10.95 DOD 31.3.18) The investigation concluded at the end of the inquest held with a jury on 29th November 2019. The conclusion of the inquest was that it was a "drug related death in circumstances where a systemic failure in HMP Berwyn's systems for preventing drugs entering the prison contributed". The cause of death was recorded as being 1(a) Ventricular Cardiac Arrhythmia (b) Due to taking a synthetic cannabinoid |
| 4 | CIRCUMSTANCES OF THE DEATH<br><br>Luke Morris Jones was a prisoner at HMP Berwyn. On the 31st of March at around 18.08 he was found unresponsive in his room after smoking a novel psychoactive substance and despite medical intervention this resulted in his death which was confirmed at the Maelor Hospital Wrexham the same day. |
| 5 | CORONER'S CONCERNS<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>The report of the Prisons and Probation Ombudsman highlighted that there were concerns regarding the accessibility of drugs within HMP Berwyn and notwithstanding that certain measures had been taken at HMP Berwyn (namely in relation to the installation of a Rapiscan to test some of the incoming mail), evidence at the inquest confirmed that the continuing availability and use of novel psychoactive substances. |

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| | By way of example, the evidence of the prison GP indicated that at least one instance of a prisoner being intoxicated was reported to him each day which he worked and as a result I consider it highly probable that the combination of the accessibility of NPS and the significant risks which they pose to health will be the cause of future deaths at the prison. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th January 2020. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the Family of the Deceased<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 3rd December 2019<br><br>Signature<br>Senior Coroner for North Wales (East and Central) |