REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Cardiff & Vale NHS Trust

1. CORONER

   I am Geraint Williams HM Assistant Coroner, for the coroner area of South Wales Central.

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 October 2017 I commenced an investigation into the death of IAN JAMES WEEKS. The investigation concluded at the end of the inquest on 11th March 2020. The medical cause of death provided was: 1(a) Pressure on the neck consistent with hanging; 2. Synthetic cannabinoid use. The Coroner's conclusion at the end of the Inquest was: A case of suicide

4. CIRCUMSTANCES OF THE DEATH

   These were recorded as:-

   Ian Weeks was remanded into custody at HMP Cardiff on the 7th August 2017. He was assessed by prison and healthcare staff as not being at risk of self-harming or suicide.
   Sometime between 20.20 on the 20th of October and the 21st of October whilst alone in his cell , Cell 13, 2nd floor, F-wing believing that personal relationships had recently broken down he made a ligature from the bed sheet and hung himself from the shower rail in his cell.

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) Although it was recorded on System 1 that Mr Weeks had recently attempted suicide in another prison shortly before his admission to HMP Cardiff no member of Healthcare staff checked the medical records and further that although the GP records which were sent to the prison confirmed that Mr Weeks was prescribed anti-depressants in the community no member of Healthcare

staff noticed this and as a consequence Mr Weeks was not given anti-depressants in HMP Cardiff.

The Healthcare witnesses, including the Head of Healthcare, indicated that a red flag for suicide or self-harm would be of great value for staff who because of insufficient staff and a heavy workload did not have time to review the System 1 record in any or any sufficient detail.

Further it was considered that all System 1 records should be reviewed when an individual is admitted into the prison and that there should be in place a process for doing so.

6. ACTION SHOULD BE TAKEN

   In my opinion action should be taken to prevent future deaths and I believe you and 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 8 May 2020. I, the Coroner, may extend the period upon request. 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 family who may find it useful or of interest.

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.

12th March 2020

SIGNED: *Geraint Williams* Assistant Coroner for South Wales Central