REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Governor HMP Dartmoor** **2. Head of Healthcare HMP Dartmoor**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Exeter and Greater Devon
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** Following the death on 28th February 2017 of Corin Bonaparte aged 23 an investigation was opened. The investigation concluded at the end of an inquest on 6th May 2021. The conclusion of the inquest was that the deceased had died as a result of hanging and that his death was as a result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Corin Bonaparte was a young man facing his first time in prison. He was suffering from anxiety and depression. Not long after his move to HMP Dartmoor on 13th January 2017 his partner ended their relationship which Corin had described as the only good thing in his life. On 28th February 2017 shortly after 4.30 in the afternoon, during the course of a telephone call with his former partner, his former partner told Corin that she did not want to maintain further contact with him. Not long afterwards Corin was found hanging in his cell. Efforts to revive him in the prison and later at Derriford Hospital in Plymouth were unsuccessful.
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) Addressed to the Head of Healthcare and the Governor, HMP Dartmoor Corin sought help from the mental health department at HMP Dartmoor. He revealed to a nurse in the mental health department the fact that he had recently deliberately harmed himself and made this fact known to other mental health workers. An ACCT was not opened despite the provisions in Chapter 2 of PSI 64 / 2011 which made the opening of an ACCT in these circumstances mandatory. In the light of the evidence from relevant witnesses at the inquest hearing it could not be confidently assumed that their actions would be any different if similar circumstances were to arise in the future. This suggested a lack of adequate training. (2) Addressed to the Governor, HMP Dartmoor A witness gave convincing evidence to the effect that the ambulance with Corin

	Bonaparte on board was kept waiting 8 minutes at the main gate while a prisoner escort was found. Although there was no evidence to suggest that this delay in transporting the deceased to hospital contributed to Corin Bonaparte's death, the fact of such a delay was disturbing and suggested that there were inadequate arrangements in place to ensure the swift departure of an ambulance from the prison in a blue light emergency.
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 5th July 2021 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 namely the family of the deceased, the prison service, Practice Plus Group and Devon Partnership NHS Trust I have also sent it to HM Inspector of Prisons 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.
9	**Dated 7th May 2021 SIGNED *N.L.Rheinberg*** **Assistant Coroner**