REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Ministry of Justice.
1	**CORONER** I am John Hobson, an Assistant Coroner for the Coroner area of West Yorkshire (Eastern).
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 4th June 2019, an investigation was commenced into the death of Miss Joanna Daly, aged 35. The investigation concluded at the end of the Inquest held before a jury on 6 July 2021. The jury recorded that the medical cause of death was: 1a Ventricular arrhythmia leading to cardiac arrest 1b Use of illicit cocaine A narrative conclusion was recorded by the jury as follows: 'Joanna's death was drug related. The roll checks carried out by prison staff were adequate. The healthcare checks were not carried out adequately and this could have been a contributing factor to her death'.
4	**CIRCUMSTANCES OF THE DEATH** On 1 June 2018 Miss Joanna Daly was admitted to HMP New Hall following a breach of licence conditions following previous sentencing. She had been released from HMP New Hall on 20 May 2018. Upon arrival, it was noted that she was experiencing withdrawal from drugs. Following nursing and medical assessment, she was taken to the First Night Centre. As with all first night prisoners, night checks were undertaken by healthcare staff. Roll checks were conducted by prison staff. On the morning of 2 June 2019, Miss Daly was found unresponsive in her cell and her death was confirmed.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed a matter 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 matter of concern is as follows: - During the course of the Inquest, the matter of checks undertaken by healthcare staff on prisoners resident for their first night in the prison's First Night Centre was heard in evidence. The jury found that no guidance as to how such checks were to be conducted had been provided to the staff undertaking the checks, and that it was possible that this contributed to Joanna's death. Since Joanna's death, changes within HMP New Hall have been undertaken whereby welfare checks undertaken at the First Night Centre are now completed by prison staff. The new arrangements have been in place since October 2020. Whilst evidence was provided of the key times at which such checks are undertaken, it became apparent that there was no specific guidance provided to prison staff to explain what was required to be undertaken during a welfare check. The particular vulnerability of prisoners resident on the First Night Centre is the reason for such checks. I am concerned about the absence of any specific guidance, in view of the findings of the jury in relation to the night checks that were previously undertaken by the healthcare staff at the time of Joanna's death. This could impact upon the quality of the welfare checks that are now undertaken by the prison staff, in the context of the First Night Centre where prisoners may be particularly vulnerable. I am under a duty to report this matter upon consideration of the evidence as provided to the court.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 22nd September 2021. I, John Hobson, 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 family and Practice Plus Group who were Interested Parties at the Inquest. 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	**Friday 16th July 2021 Signed** .....