REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Governor, HMP Exeter**
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** On 14th July 2021 I commenced an inquest into the death of Carl Lee Walters aged 34. The investigation concluded at the end of the inquest on 21st July 2021. The conclusion of the inquest was that Mr Walters died as a result of intraperitoneal haemorrhage due to a ruptured splenic pseudoaneurysm of undetermined aetiology, the evidence not revealing whether this was naturally occurring or trauma related and if the latter whether the trauma arose out of an accidental blunt force impact or an assault.
4	**CIRCUMSTANCES OF THE DEATH** Mr Walters died suddenly and unexpectedly in his cell. The cause of his death was a ruptured splenic pseudoaneurysm which was most likely to have been trauma related. Although there was no evidence to the effect that Mr Walters had been injured whilst he was in prison the possibility nevertheless existed. As such it was very important that prison CCTV footage should be examined. Further, Mr Walters' cellmate alleged that he had pressed the emergency cell bell on numerous occasions. However, despite the provisions of Chapter 12 of PSI 64/2011 CCTV images had not been preserved and only limited cell bell records had been kept.
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. – The failure to preserve key evidence meant that the inquest could not be as full as it would otherwise have been. If key evidence is not preserved there is an ongoing risk that dangerous conditions or circumstances go undiscovered raising the prospect that appropriate steps to avoid a similar tragedy are overlooked.
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 24th September 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 and the health provider 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 28th July 2021** **SIGNED** *N.L.Rheinberg* **Nicholas Rheinberg** **Assistant Coroner**