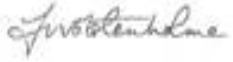
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Governor of HMP Wakefield** **The Minister of State for Prisons and Probation**
1	**CORONER** I am Janine Wolstenholme 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 14th June 2019, an investigation was commenced into the death of Connor Arthur Steven Hoult, aged 24 years, who died on 10th June 2019. The investigation concluded at the end of the inquest on 28th October 2021. The medical cause of death was [redacted] and the conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 10th June 2019 at approximately 6.30am a prison officer did a roll check, and in the very brief observation noted Connor appeared to be [redacted], which was not unusual for Connor or other prisoners. It was assumed he was watching television. Connor's cell was unlocked for the morning at around 8am. The second officer's interaction was no more than a fleeting glance of one to two seconds through the observation panel, where Connor appeared to him to be [redacted] At approximately 8.45am a different (third) officer relocked Connor's cell for the morning session and thought he saw Connor [redacted] appearing to watch television. Again, it was a glance of no more than one to two seconds through the observation panel. At approximately 9.50am the second officer returned to Connor's cell to seize some unauthorised footwear. As the officer entered the doorway of the cell he was able to see Connor was [redacted]. Connor was in the same position as when this officer had observed him at 8am. At the time Connor was found the level of rigor mortis and hypostasis revealed he had been deceased for a considerable number of hours. His eyes were noted to be closed by attending medics looking for, and confirming the absence of, signs of life.
5	**<u>CORONER'S CONCERNS</u>** 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 evidence revealed prison officers are not obtaining, nor did the prison systems require them to obtain, a response from all prisoners during welfare checks. More specifically, during the morning unlock they are not required to, and therefore do not necessarily seek to, obtain a response or otherwise engage with prisoners. In particular, no response is required, and therefore not sought, from prisoners who appear to be asleep in bed, notwithstanding the requirements of PSI 75/2011 (Residential Services). The PSI sets out the fact that residential prison staff play a key role in spotting any signs of distress and will often be the first to pick up information or signs, and should accordingly engage with prisoners in such a way that facilitates the identification of any concerns or distress. Further, paragraph 2.3 of the PSI, namely, "Output No. 3 Prisoners are supported and their daily needs are met" states that prisons are required to have, "clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock". In the absence of such systems prisoners in distress, or otherwise a cause for concern, may be missed.
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 26th January 2022. 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 Connor's mother and partner Her Majesty's Prison and Probation Service Her Majesty's Inspectorate of Prisons The Prison and Probation Ombudsman The Independent Advisory Panel on Deaths in Custody 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	 **30th November 2021**