ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Governor of HM Prison Cardiff**
1	**CORONER** I am David Regan, Area Coroner, for the Coroner's 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** A Coronial investigation was commenced on 8th November 2016 into the death of Robert Ellery. The Investigation concluded at the end of an inquest which I conducted with a jury on 8th – 18th November 2021. The conclusion of the jury was that Mr Ellery died as the result of [redacted] in circumstances where his intentions could not be ascertained. The medical cause of death was [redacted]
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- "Robert Ellery was found [redacted] in his cell on 31st October 2016. Robert had recently self harmed, An ACCT was not opened, zopiclone was prescribed but not administered to him. In addition, there was 19 minutes between the first 999 call and the ambulance service being informed that Mr Ellery had been found [redacted]. It cannot be concluded that such issues caused or contributed to Robert's death."

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) The prison control room was not able to provide the Welsh Ambulance Service with any specific information as to the reason why an ambulance was required for 19 minutes after Mr Ellery was found [redacted] in his cell. This delayed the ability of the ambulance service to despatch a response. While this was not, on the evidence heard by the jury, causative of Mr Ellery's death, it gives rise to a concern that a risk that other deaths will occur. (2) There was no method of communication to allow the Ambulance Service call centre staff to communicate directly with the nurse and officers who were providing basic life support to Mr Ellery. This delayed the relaying of specific information with respect to Mr Ellery's condition by the prison to the Welsh Ambulance Service. It also impeded the ability of the ambulance service operator to provide guidance to those attempting to resuscitate Mr Ellery. This may affect the use of a defibrillator. In circumstances where not all prison staff are trained in the provision of CPR, it might also prevent the ambulance service operator providing instruction to first responders, or reduce the effectiveness of the same.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to improve communication between staff at the side of the patient and the ambulance service 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 21st 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 Mr Ellery's family and to the following, who may find it useful or of interest: The Chief Executive of the Welsh Ambulance Service; The Cardiff and Vale University Health Board 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	**19th November 2021** **SIGNED:** **D Regan** **Area Coroner**