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:** **1. [redacted], Governor, HMP Guy's Marsh** **2. [redacted], Chief Executive of Her Majesty's Prison and Probation Service** **3. Victoria Atkins MP, Minister for Prisons and Probation**
1	**CORONER** I am Stephen John Nicholls, Assistant Coroner, for the Coroner Area of Dorset
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 the 13th June 2018, an investigation was commenced into the death of Kyle Nel, born on the 27th February 1986. The investigation concluded at the end of the Inquest on the 14th December 2021. The Medical Cause of Death was: 1a Aspiration of gastric contents associated with synthetic cannabinoid (5F-ADB) also known as "Spice") use. The conclusion of the Inquest recorded: Misadventure
4	**CIRCUMSTANCES OF THE DEATH** On the 9th June 2018 Kyle, a serving prisoner at HMP Guys Marsh, was found unconscious in his cell 29 on Jubilee wing by his cell mate. The alarm was raised and prison officers attended and CPR was administered, paramedics attended they continued to try to resuscitate him but Kyle was subsequently declared dead.

5	**CORONER'S CONCERNS** During the course of the inquest 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 duty to report to you. The **MATTERS OF CONCERN** are as follows: During the course of the inquest 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 duty to report to you. The MATTERS OF CONCERN are as follows; 1. During the inquest evidence was heard that: i. Concerns about Kyle, his use of PS, the bullying he was subject to and the debts that he incurred, were raised with the prison staff by his mother. Whilst his mother was able to speak to a member of the prison staff, the quality of the response gives rise to concern. The prison has introduced a number of different measures aimed at tackling anti- social behaviour and bullying. There is the Tackling Anti-Social Attitudes (TASA) policy. This is a three- tiered approach dependant on the incident. This ranged from monitoring to consideration of being moved to the segregation unit in the most serious cases. There is also the Custodial Violence Management Model (CVMM). This is a case management approach for managing violent and significantly problematic custodial behaviour. HMP Guys Marsh was the pilot for this scheme. This introduced a specific CNOMIS case note for those who were being managed under the CVMM to allow for entries to be recorded electronically. ii. Evidence was heard that between the various units at the prison there are fences but that prisoners can pass items through the fences between one unit and another. This enables drugs and other prohibited items to be transferred between units. The evidence heard is that this issue is known about but no action has been taken. 2. I have concerns with regard to the following: i) I have concerns that when members of a prisoner's family or friends contact the prison raising concerns as to the health or welfare of a prisoner, there needs to be structured approach and computer record kept of those concerns, the measures taken to deal with the concerns and a formal written response to the family or friends who have raised those concerns. It is understood that while there are

	potential security and confidentiality issues that may arise from this process suitable measures should be considered and implemented. ii) The security fences within the prison estate need to be reviewed and consideration urgently given to prevent drugs and other prohibited materials being passed between prisoners through the fences.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 17 February 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 and to the following Interested Persons: (1) Irwin Mitchell Solicitors (on behalf of Kyle's family) (2) [redacted], Government Legal Dept, One Kemble Street, London WC2B 4TS on behalf of the Ministry of Justice (3) [redacted], Hill Dickinson on behalf of Practice Plus Group, EDP 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** **22 December 2021**	**Signed** S. J. Nicholls **Stephen J Nicholls**