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 of HMP Guys Marsh Prison
1	**CORONER** I am Brendan Joseph Allen, Area 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 28th May 2019, an investigation was commenced into the death of Nicholas Tom Rose, born on the 18th June 1981. The investigation concluded at the end of the Inquest on the 24th March 2022. The Medical Cause of Death was: 1a Airway Obstruction 1b Aspiration of Gastric Content 1c 5F-MDMB-PINACA ("Spice") Intoxication The conclusion of the Inquest recorded by the jury was that Nicholas Tom Rose died as a consequence of misadventure.
4	**CIRCUMSTANCES OF THE DEATH** Nicholas Tom Rose was a serving prisoner at HMP Guys Marsh at the time of his death. He was a resident on Jubilee Wing. On Sunday 19th May 2019 at approximately 8.45 am at the morning "unlock", a welfare check was conducted. Mr Rose was in in bed in his cell at this time. At 12.15pm, when the roll call was conducted, Mr Rose was found deceased in his cell on Jubilee Wing. Mr Rose was still in bed. A post mortem examination, including toxicological analysis of samples of fluid, revealed that Mr Rose had consumed "Spice" prior to his death, which led to the aspiration of gastric content and airway obstruction.

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. During the inquest evidence was heard that: i. When Mr Rose's cell was unlocked on the morning of 19th May 2019 at approximately 8.45 am and the welfare check was conducted, the evidence given was that Mr Rose responded with a "grunt". Evidence was also heard regarding the "Notice to Prison Officers" number 191/2017, issued on 30th August 2017, which requires that a verbal response is elicited from a prisoner during a welfare check. The corresponding "Notice to Prisoners" number 083/2017, issued on the same day, instructs prisoners that they "must give a verbal response such as Good Morning/Afternoon, Hello". ii. Evidence was heard that a "grunt" in response to a welfare check is considered acceptable, and fulfils the requirement for a "verbal response". 2. I have concerns with regard to the following: i. I am concerned that accepting a "grunt" as a verbal response to a welfare check does not fulfil the requirement as set out in the Notice to Prison Officers mentioned above. Such a response gives very limited information upon which a prison officer can assess a prisoner's welfare. Accepting such a response potentially loses sight of the purpose of a welfare check, which must be to check that the prisoner is alive, immediately safe and well; that is, that they are conscious, breathing, not in a state of distress, not in a state of intoxication and that there are not any other factors that might require immediate intervention to prevent harm. A verbal response to a welfare check allows a prison officer to assess if a prisoner has responded in an appropriate manner, giving an indication as to whether the prisoner retains the cognitive function to provide an appropriate response. A "grunt" does not allow such an assessment. Therefore, I have a concern that future deaths could occur if accepting such a response remains the accepted practice.
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, namely 2nd June 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) Harding Evans Solicitors on behalf of Mr Rose's family; (2) Hill Dickinson LLP on behalf of Practice Plus Group; (3) Government Legal Department on behalf of the Ministry of Justice 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** **7th April 2022**	**Signed** **Brendan J Allen**