## **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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

**CORONER'S CONCERNS** 

## REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Vaughan Gething Minister for Health mailto: CORONER I am Colin Phillips, acting senior coroner, for the coroner area of SWANSEA and **NEATH PORT TALBOT** CORONER'S LEGAL POWERS 2 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. **INVESTIGATION and INQUEST** On 11 April 2016 I commenced an investigation into the death of DEAN GARY GEORGE aged 40. The investigation concluded at the end of the inquest before a Jury on 16th March 2020. The Medical Cause of Death was given as 1a) Hanging. The conclusion of the inquest was a narrative conclusion. The Jury found that Dean's death was a suicide caused by hanging and Dean intended to take his own life, some indicators of this were: Expressing suicidal thoughts Withdrawing from social contact Being very down Degree of planning in use of razor blade Previous hanging attempt The Jury found there were contributing factors such as: Withdrawing from opiates against his will Inadequate risk assessment Insufficient info passed between medical and prison staff ACCT training was inadequate with some staff being untrained The opiate detox system was not equitable to what Dean would have access to in the community CIRCUMSTANCES OF THE DEATH The deceased was found hanging in his cell on the 16th March 2016 in HMP Swansea

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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 was that drug treatment in Wales is organised differently to that in England. Integrated Drug Treatment System had not been funded and implemented in Wales. The main difference between English and Welsh prisons is that those arriving from the community who are addicted to opiates but not engaged with community treatment are not automatically offered opiate substitution therapy on the day of arrival. There is a concern over this inequality in health care provision There have been Inquiries into this in the Welsh Assembly the most recent in 2019. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe that the Welsh Assembly 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 by 19th June 2020. 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. **COPIES and PUBLICATION** 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons I have also sent it to Chief Executive of Swansea Bay University Health Board who may find it useful or of interest. 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

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 24.04.2020 [SIGNED BY CORONER]