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:** 1. Mr Michael Spurr Chief Executive National Offender Management Service Clive House 70 Petty France London SW1H 9EX 2. [redacted] Chief Medical Officer, NHS England Department of Health Room 114 Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am David Hinchliff, Senior 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 9th April 2013, I commenced an investigation into the death of Barry Horrocks (aged 65). The investigation concluded at the end of the Inquest on 15th October 2014. The conclusion of the Inquest was death from natural causes. The cause of death being:- 1(a) Intraventricular haemorrhage (stroke) 2 Systemic atheroma and hypertension I concluded that "Barry Horrocks was aged 65 and was serving a 9 year sentence of imprisonment at Her Majesty's Prison, Wakefield. Mr Horrocks suffered with heart related problems, cerebral vascular problem and he had previous strokes. He was on a substantial amount of medication. As a consequence of his medical condition, he had a poor memory, failing eye sight and mobility problems. He had got to the stage where he was struggling to deal with the activities of daily living such as personal hygiene and other aspects of intimate self-care. Although the Inquest has established that there was no comparable provision for Social Services' input as a person with similar problems would enjoy in the community, none of these apparent shortcomings or issues have in

	anyway caused or contributed to Mr Horrocks' death. It is believed that he suffered some sort of cerebral event whilst in his cell on 29th March 2013 which caused him to be admitted to Pinderfields General Hospital where his condition deteriorated and where his death was confirmed at 16.35 hours on 5th April 2013.
4	**CIRCUMSTANCES OF THE DEATH** 1. Barry Horrocks was aged 65 and was sentenced to nine years imprisonment in January 2011. He suffered from a number of physical and mental health problems and he had been diagnosed with Vascular Dementia. 2. Whilst at HMP Wakefield, he was on normal location and received help from a number of prisoner volunteer carers. He became increasingly unable to carry out routine activities of daily living or attend to his more intimate needs such as toileting, dressing and undressing. His personal hygiene was deteriorating. He was struggling to deal with his copious amounts of medication and keeping his cell in an acceptably clean and tidy condition. 3. His deteriorating mental health was attributed to factors such as high blood pressure and previous strokes. This coupled with poor eye sight made him extremely vulnerable whilst in prison. 4. The main concern raised by this investigation was the lack of co-ordinated care for Mr Horrocks. His personal hygiene was allowed to deteriorate in a way that was neither decent nor dignified. For example, there were occasions when through no fault of his own he was incontinent of faeces whilst taking a shower.
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) When Mr Horrocks lived in the community he was supported by local Social Services who provided him with considerable assistance with activities of daily living. He lived in a specially adapted bungalow which was adapted to his individual needs. (2) It was when in Prison that his immediate environment, that is his Prison cell was not in any way adapted to assist with activities of daily living. The "Social Services' input" which was a vital element of his care obviously could not be replicated whilst he was in prison. Such an input though was needed and necessary for his well-being. (3) Mr Horrocks, by virtue of his condition "fell through the net" in that none of the providers of care including health care had responsibility for a man in his condition. I was informed that assistance with intimate aspects of the activities of daily living were outside the remit of prisoner volunteers; the uniform prison officers; and those who provide primary care such as GPs and nursing staff nor, I was told, was it appropriate for him to be cared for in the Prison Healthcare Centre whether as an in-patient or out-patient. Those who provide mental health care and out of hours care did not accept any responsibility for his well-being.
6	**ACTION SHOULD BE TAKEN** My recommendation is that prisoners of Mr Horrocks' age and condition should be

	afforded the care and treatment of those in like circumstances in the community. If it is the case that the Prison Service cannot provide this from their existing resources, then such services should be obtained and commissioned to be enable 'the Social Services' element' that are clearly lacking be provided. Furthermore, the Prison should provide a unit or facility where prisoners in like circumstances can be accommodated in comfort and where facilities for their social and medical care are available. I understand that at HMP Wakefield and I suspect in similar establishments where there is an aging Prison population, there will be many prisoners who through their age and physical and mental infirmity require similar care and treatment.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd January 2015. 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 Ombudsman 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 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	**7th November 2014** **David Hinchliff** **Senior Coroner** **West Yorkshire (eastern)**