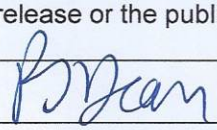
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Head of Health in the Justice System, NHS England** **2. [redacted] Head of Health and Justice, East Anglia Team, NHS England** **3. Mr Jeremy Wright MP, Minister for Prisons**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
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 25th of November 2011 I commenced an investigation into the death in custody of Redmond Johnson, aged 67. The investigation concluded at the end of the inquest on the 13th of May 2014. The conclusion of the inquest was that Mr Johnson died from natural causes, the cause of death being 1a Acute heart failure due to 1b Recent myocardial infarct due to 1c Occlusive coronary artery atheroma with contributory causes of Ischaemic heart disease, chronic renal failure and diabetes, however there were matters that became evident which gave significant cause for concern.
4	**CIRCUMSTANCES OF THE DEATH** Mr Redmond Johnson was a 67 year old gentleman who received a custodial sentence at Ipswich Crown Court and was admitted to HMP Norwich on the 4th of October 2011. He had very significant medical problems including diabetes, obstructive sleep apnoea necessitating overnight assistance, hypertension, congestive cardiac failure, atrial fibrillation, cerebro-vascular disease and transient ischaemic attacks, mild dementia, loss of the right eye, glaucoma of the left eye and laser treatment awaited due to bleeding in the eye, mobility issues due to loss of a toe, chronic kidney disease and carotid artery occlusion. He was transferred back to Ipswich Crown Court on the 25th of November 2011, suffered a cardio-respiratory arrest on arrival and sadly, despite attempts to resuscitate him by escort staff, passed away following transfer to Ipswich Hospital. The Prisoner Escort Record for that transfer back to Ipswich Court, had deemed him fit to be transferred and recorded that he had 'no known medical risks', having been completed at 03.00 that morning by a healthcare professional who had not actually seen Mr Johnson. It was apparent that there were significant failures in the system in place at that time for conducting the assessments themselves, a situation made worse by apparent repeated late notification to the prison of which detainees would require court transfers the next day, and that there had also been failures, in respect of Mr Johnson's general healthcare in custody, to liaise with his community healthcare providers and follow up his external specialist medical appointments, to ensure that tests requested in the prison were conducted, to manage his complex prescription needs and to monitor and record the management of his complex medical needs in an appropriate manner.
5	**CORONER'S CONCERNS** In a person with the medical problems from which Mr Johnson suffered, there is always the risk of a sudden tragic cardiac event and death occurring so whether and, if so, to what extent the failures that became apparent during this investigation contributed to this very sad death could not be established in this individual situation, however, 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) If a detainee has a history of significant medical problems, healthcare professionals undertaking the initial reception assessment should request further information from the General Practitioner and, where necessary, hospital doctors normally involved in the detainee's care to enable appropriate care planning while that detainee is in the custody of the prison service. (2) Reception healthcare should ask about any outstanding hospital or other healthcare appointments and rebook these if necessary. (3) Medication reviews should be conducted, with appropriate pharmacy input if required, if there are complex medication issues that need resolving or clarifying. (4) If medical tests or investigations are requested, there must be clear and adequate documentation to confirm that those investigations have actually been conducted and the results seen by a healthcare professional. (5) There must be a robust and clearly documented process in place when assessing a detainee's fitness to transfer, together with clear arrangements made in respect of any medication that the detainee needs to take while out of the prison's care. (6) Information about which detainees are going to be transferred to court or other locations needs to be delivered to the individual prisons in enough time for a thorough assessment of the detainee's fitness to be transferred (including a face to face assessment if required) to be conducted.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. The changes in the provision and commissioning of healthcare in custody are recognised but I believe that the health and prison services 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 the 15th of August, 2014. 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 Mr Johnson's family. 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	**20-6-14**  **Dr Peter Dean**