	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Governor HMP Frankland** 2. **National Offender Management Service**
1	**CORONER** I am Andrew Tweddle Senior Coroner, for the coroner area of County Durham and Darlington.
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 26th August 2014 I commenced an investigation into the death of Sharon Louise Suki Butcher. The investigation concluded at the end of the inquest on 31st March 2015. The conclusion of the inquest was Natural Causes with a cause of death given as 1a) Ischaemic Heart Disease, 1b) Coronary artery Atheroma, 2) Diabetes Mellitus and Cirrhosis of the Liver.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died of natural causes.
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. – The PPO report highlights an issue relating to the delay in calling for an ambulance as soon as an emergency medical code was broadcast. There was a 10 minute delay and the prisons local protocol for summoning an ambulance was not followed. There have been a series of similar failings in dealing with medical emergencies at HMP Frankland and HMP Durham with either staff using wrong or inappropriate codes, or there being delays in the control room and this recurring issue of lack of clarity in response to a medical emergency could well lead to a fatality in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 by 26th May 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 following Interested Persons HMP Frankland and the National Offender Management Service. I have also sent it to Care UK, [redacted] 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	**[DATE]** 31-12-15 **[SIGNED BY CORONER]**