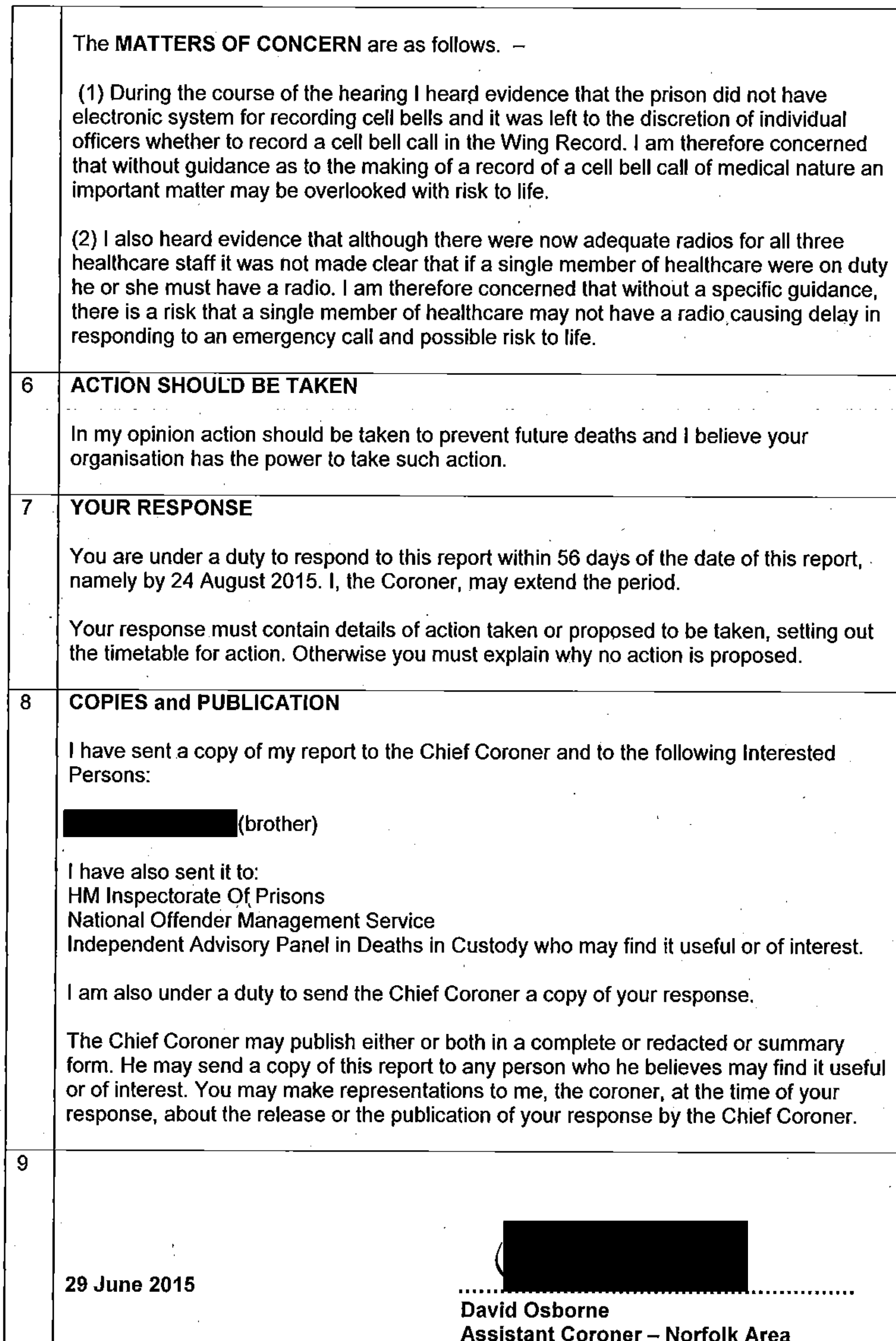
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Head of Safer Custody & Equality** **HMP Wayland** **Griston Road** **Thetford** **Norfolk** **IP25 6RL**
1	**CORONER** I am DAVID OSBORNE Assistant Coroner, for the coroner area of NORFOLK
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 6 October 2011 an Inquest into the death of DAVIN PAUL SHORT aged 46 years was opened. The Inquest concluded at the end of the inquest on 25 June 2015. The conclusion of the inquest was that Davin Short died from natural causes with the medical cause of death being 1a Acute Lobar Pneumonia.
4	**CIRCUMSTANCES OF THE DEATH** Mr Short had been diagnosed and treated for a chest infection on 21 September 2011. At a review appointment on 28 September 2011 it was considered that his infection had resolved. Expert evidence from [redacted] confirmed that Mr Short received appropriate treatment and that his presentation on 28 September 2011 was of a resolved pneumonia. Mr Short rang his cell bell at 03:00 on 4 October 2011 and was spoken to by an officer when he complained of leg pain. He appeared to take advice and get some rest. He was discovered unresponsive in his cell at about 08:15 hours on 4 October 2011, CPR was commenced but he was sadly pronounced deceased by attending ambulance service at 08:43. In the opinion of the pathologist [redacted] Mr Short was deceased when discovered.
5	**<u>CORONER'S CONCERNS</u>** 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 course of the hearing I heard evidence that the prison did not have electronic system for recording cell bells and it was left to the discretion of individual officers whether to record a cell bell call in the Wing Record. I am therefore concerned that without guidance as to the making of a record of a cell bell call of medical nature an important matter may be overlooked with risk to life.

(2) I also heard evidence that although there were now adequate radios for all three healthcare staff it was not made clear that if a single member of healthcare were on duty he or she must have a radio. I am therefore concerned that without a specific guidance, there is a risk that a single member of healthcare may not have a radio causing delay in responding to an emergency call and possible risk to life.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation 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 24 August 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:

█████████ (brother)

I have also sent it to:
HM Inspectorate Of Prisons
National Offender Management Service
Independent Advisory Panel in Deaths in Custody 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.

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29 June 2015

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David Osborne
Assistant Coroner – Norfolk Area