REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Governor of HMP Rochester**
1	**CORONER** I am Kate Thomas, Assistant Coroner for the Coroner's area of Mid Kent and Medway.
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 7th of October 2014 I commenced an investigation into the death of Ronnie Olliffe, aged 34 years. The investigation concluded at the end of the Inquest on the 9th of June 2016. The conclusion of the inquest was a unanimous narrative conclusion by a Jury.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 1.08 am on the 1st of October 2014 Ronnie Olliffe was found collapsed on the floor of his cell at HMP Rochester gasping for breath with a probable pulmonary embolism due to ventricular tachycardia. The Operational Support Grade Worker (OSG) working alone on the Wing that night called for immediate assistance over his radio but did not call a "Code Blue' which would have prompted the Control Room to immediately summon an ambulance. He did not open the cell but waited for assistance. In evidence the OSG explained that he believed that only health care or a more senior officer could make the decision to call an ambulance. Further, whilst he was aware that there was a policy which required a Code Blue to be called where someone was experiencing breathing difficulties, he did not appreciate that it would result in an ambulance

	being called. He did not recall why he hadn't called a Code Blue in these circumstances. Assistance arrived at approximately 1.15 am which included the Night Orderly Officer (Oscar 1) who had had first aid training including the use of a defibrillator. All the officers then tried to assist Mr Olliffe and ascertain what the problem was. Mr Olliffe did not respond to questions and fought efforts by officers to place him in the recovery position. No officer called a Code Blue at any stage. Oscar 1 then took the decision to summon an ambulance, which he did from the Wing Office, pausing to talk to a number of prisoners on the way to try and ascertain what the source of the problem may have been. The call to the Ambulance Emergence Call Centre was made at 1.31.50 am (although there may have been some disparity between the prison CCTV clock and the Ambulance Service of approximately 2 minutes). The Emergency Call Operator wrongly interpreted Mr Olliffe as conscious when told that he was fighting with staff and terminated the call in circumstances where she should have remained on the line to provide ongoing advice including the use of a defibrillator in the event of a collapse. The Operator would have known that the prison had a defibrillator as it was recorded on the ambulance system and would have been flagged up on her screen. Between 1.45 am and 1.56 am Mr Olliffe went limp and ceased to breathe. Immediate CPR was started by the officers present (including Oscar 1) although no officer thought to retrieve or use the defibrillator which was located in the Wing Office. The Ambulance First Responder arrived on site at 1.44 am and was with Mr Olliffe between 1.58 am and 2.01 am. Mr Olliffe was found to be asystole and despite the attempts of two further ambulance crews, including a specialist critical care paramedic. Mr Olliffe never regained a shockable rhythm and was confirmed dead at the scene at 2.32 am. Mr Olliffe was 34 years of age and died from Anabolic Steroid-related Cardiac Hypertrophy. His physical appearance and the weight of his heart were such that he had been abusing anabolic steroids for a number of months at the very least. As a result, his heart was over 50% larger than that of a normal heart for a man of his size and the risk of sudden death was 20% higher. That said, Mr Olliffe was a young man without any history of a heart complaint or any other significant physical illness which would have militated against his recovery from this acute cardiac event. At Inquest it was ascertained that although Mr Olliffe's collapse was not a predictable event, had the ambulance been called when his collapse was first discovered then he probably would have survived. The ambulance crew would have treated the pulmonary embolism and probably avoided his heart going into ventricular fibrillation or cardiac arrest. Further, even

	if he had suffered a cardiac arrest in the presence of the ambulance crew, that too was an event that could have been treated with good prospects of survival. Finally, provided Mr Olliffe had retained a shockable rhythm at the point where he had stopped breathing, had the officers used the defibrillator from the Wing Office then again Mr Olliffe's probably would have survived. The medical cause of death after Post Mortem Examination was recorded as 1a) Anabolic Steroid-related Cardiac Hypertrophy
	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) there was a failure to issue a Code Blue pursuant to both a local and national policy in circumstances where it was appropriate to do so 2) there was a lack of understanding as to what consequences flowed from the issuing of a Code Blue, namely that an ambulance would be summoned immediately 3) there was a failure to consider or use a defibrillator when it was appropriate to do so and when one was available
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 the 12th June 2016, 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 : [redacted] – Next of Kin The Prison and Probation Ombudsman The Care and Quality Commission 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	**Kate Thomas** **Assistant Coroner** **15th May 2016**