ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Governor, HMP Ryehill**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Northamptonshire.
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 18 November 2016 an investigation was commenced into the death of Andrew Crane, age 53. The investigation concluded at the end of the inquest on 25 April 2018. The conclusion of the inquest was that Mr Crane died of natural causes. The medical cause of death was 1a) Acute myocardial insufficiency 1b) Coronary artery atherosclerosis 2) Long term smoking habit.
4	**CIRCUMSTANCES OF THE DEATH** Mr Crane suffered a cardiac arrest in his cell on 16 November 2016 and he died despite efforts at resuscitation. The following non-causative failures were recorded in the conclusion: Mr Crane had previously been noted to have high blood pressure and high blood sugar, but there was a failure by the prison healthcare system to follow up and monitor these results; there was a failure by the ambulance service to ensure that an ambulance was dispatched promptly.
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. – Although both the prison and ambulance service have made amendments to their systems to address other matters of concern which arose during the inquest, the following matters remain: (1) Mr Crane had complained of chest pain shortly before his cardiac arrest. The prison officer did not consider that he was unwell and so asked the healthcare nurse to attend. According to PSI 3/2013 and the prison's emergency response policy, a complaint of chest pain should result in a Code Blue call. There was a lack of clarity amongst witnesses as to what, if any, discretion should be given in these circumstances to a prison officer who thinks that a complaint of chest pain does not require a Code Blue response. (2) A Code Blue was called when Mr Crane collapsed, and at this stage an ambulance

	was called. After this call, it became clear that Mr Crane was not breathing and CPR was commenced, but this further information was not passed to the ambulance service. This information would have changed the priority of the ambulance response.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 17th July 2018. 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: Mr Crane's family East Midland Ambulance Service. I have also sent it to HM Prison and Probation Service who may find it useful or of interest regarding the interpretation of PSI 3/2013. 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: 22nd May 2018** **Philip Barlow**