Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO: Head of Health Care, HMP Woodhill

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 08/08/2018 I commenced an investigation into the death of William VICKERS, aged 37. The investigation concluded at the end of the inquest on 19 July 2019. The conclusion of the inquest was a Narrative Conclusion:

The deceased was detained at HMP Woodhill on 18th July 2018, on arrival he was seen by medical staff and in view of his drug addiction he was taken to the detoxification unit and placed in a double occupancy cell. At some time around 5:30 am on 19th July 2018 he suffered a cardiac arrest of unknown cause and despite resuscitation he suffered hypoxic brain damage and died at Milton Keynes University Hospital on 26th July 2018.

His cause of death was confirmed following a post mortem examination as:

I a Bronchopneumonia

I b Hypoxic Ischaemic Encephalopathy

I c Cardiac Arrest

II Chronic obstructive pulmonary disease

4 CIRCUMSTANCES OF THE DEATH

William Vickers was found collapsed in his cell at HMP Woodhill on the 19th July 2018. There was a delay in gaining access to his cell by prison staff and a delay in an ambulance crew gaining access to him once they had entered the prison but he was successfully resuscitated and taken to Milton Keynes University Hospital but had suffered hypoxic brain damage. He remained in hospital until he passed away on 26th July 2018.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

During the course of the evidence I was concerned that not all staff within the prison, including those within healthcare, were confident in using the AED (Automatic External Defibrillator) and believe that the training of all staff should be reviewed so all are both

familiar and confident in its use.

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 19th September 2019. 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

- The family of Mr Vickers
- HMP Woodhill
- Westminster Drug Project
- Northamptonshire Police
- GEO Amey

I have also sent a copy of the Prison and Probation Ombudsman who may find it 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

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 26 July 2019