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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>[redacted], Operations Manager, The Hull Combined Court Centre, Lowgate, Kingston upon Hull |
| 1 | **CORONER**<br><br>I am Professor Paul Marks BA LLM MD FRCS Senior Coroner for **East Riding and Kingston-upon-Hull** |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 01/02/2017 I commenced an investigation into the death of Hayley Emma GASCOIGNE. The investigation concluded at the end of the inquest 28th June 2018. The conclusion of the inquest was Hayley Emma GASCOIGNE died on the 26th January 2017 at Hull Royal Infirmary, Hull. She died from the natural disease processes listed under the medical cause of death: -<br><br>1a) Acute left ventricular failure<br>1b) Hypertensive heart disease |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>The deceased, Hayley GASCOIGNE, had been in attendance at Hull Crown Court with her parents and sister, regarding a Family Case regarding access to see her child. The matter was to be heard over three days, the day of her death being the second. Hayley's parents and sister have described Hayley as being emotional and upset having had many months of stress and upset following intervention by Social Services and other agencies regarding her children, and as a result of domestic violence from her partner.<br><br>The Court had adjourned for a lunch break at 12:45hrs informing Hayley to be back to continue the hearing at 14:00hrs. She left with her family and attended the local Weatherspoons Pub for lunch, where she consumed an egg and bacon sandwich. She left and arrived back at the court with her family for the continuation of the hearing at 14:00hrs.<br><br>Whilst in court Hayley's father heard her say to him that she had 'tremors in her heart'. The Court case concluded after about half an hour. Hayley was visibly upset with the outcome which was not to her advantage. She left the Court room with her family and walked directly to the female toilets alone. Hayley's mother suggested to Hayley's sister that she should go and check on her, which she did not do, instead, leaving the deceased to have space and time alone.<br>Her sister stated that her Hayley had been gone for about three minutes, but no longer than five minutes before she returned. Hayley sat on a chair next to her |

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| | sister on the upper concourse area of the Court building. The deceased was heard by her sister to say to her that she felt 'dizzy and sick'. Her sister then describes her Hayley as becoming yellow in skin colour and her mouth dropping to one side before her eyes rolled back in her head, her head falling backwards and her body becoming stretched out and rigid. Her eyes and mouth continued to contort until it was realised something was wrong. Court staff intervened and provided medical assistance whilst an ambulance was called, which arrived at the court at 14:28hrs. Haley was conveyed to Hull Royal Infirmary where at 15:38hrs life was pronounced extinct. |
| 5 | **CORONER'S CONCERNS**<br><br>Expert evidence was heard that in the presence of a "shockable cardiac dysrhythmia" such as ventricular fibrillation, the administration of a shock from a defibrillator can restore the normal cardiac rhythm and that the longer the application of such a shock is delayed, the greater the likelihood is that the patient will succumb to this untoward cardiac event. A number of public buildings are provided with defibrillation apparatus, but our preliminary enquiries indicate that the Hull Combined Court Centre did not have one at material times. The Independent Accident and Emergency Expert believes that all buildings should be equipped with such an apparatus given that the quicker a shock is applied the greater the probability is that a patient will survive.<br><br>I would ask you to reply to me within 56 days as to whether the Court Complex now has a defibrillator or whether there are plans in place for such an apparatus to be secured. If there are no plans then I would require you to tell me why this is not being considered given the obvious benefit of having such equipment available in public places. I am copying this report to HM Courts and Tribunals Services to bring the problem of lack of defibrillators in public buildings such as Courts to their attention.<br><br>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. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **26th November 2018**. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>• Derek Winter, HM Senior Coroner<br>• Williamsons Solicitors<br>• Yorkshire Ambulance Servicce<br>• Thompsons Solicitors<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 1st OCTOBER 2018<br><br>Signature:<br>Professor Paul Marks BA LLM MD FRCS Senior Coroner **East Riding and Kingston-upon-Hull** |