ANNEX A

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:** **1. The Head of Healthcare at Her Majesty's Prison, Leeds.** **2. The Medical Director of the Leeds Teaching Hospitals NHS Trust.**
1	**CORONER** I am David Hinchliff, Senior Coroner, for the coroner area of West Yorkshire (East)
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 7th August 2015 I commenced an Investigation into the death of Thomas George Jordan, aged 80 years. The Investigation concluded at the end of the Inquest on 28th June 2016. The Conclusion of the Inquest was:- "Thomas George Jordan was a remand Prisoner at Her Majesty's Prison, Leeds who suffered with a number of chronic medical conditions as befits his age. He became unwell and was admitted to St James's University Hospital, Leeds where his death was confirmed at 1955 hours on 6th August 2015". The cause of death being:- 1(a) Ischaemic Heart Disease (b) Coronary Artery Atheroma 2 Diabetes Mellitus. Conclusion : Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** • Thomas George Jordan was remanded in custody at Her Majesty's Prison, Leeds in April 2015 after breaching his bail conditions. • On the morning of 6th August 2015 his heart rate was fast and irregular. He was therefore admitted to Leeds General Infirmary with central chest pain, breathlessness, fast atrial fibrillation and low blood pressure. He described having felt unwell for the previous three weeks. • Clinically he was dehydrated and showed signs of kidney impairment and severe metabolic acidosis. He was reviewed by a Cardiologist and an ultrasound scan of his heart was performed. Later he was transferred to St James's University Hospital, Leeds, where his condition deteriorated. • He went into cardiac arrest and despite cardiopulmonary resuscitation his death was confirmed at 1955 hours on 6th August 2015.

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. – (1) Healthcare staff at the Prison continued to administer the drug Digoxin for several days after the Clinicians at the Hospital had requested that it be discontinued. (2) There had been a breakdown in communication between the Hospital and the Prison when Mr Jordan was discharged. (3) The problem appears to be at the Prison as there was discharge correspondence sent back with him, but this was not immediately available to Healthcare staff and was not reviewed by them. (4) This was an obvious drug error, but there is no evidence to conclude that this has materially caused or contributed to Mr Jordan's death. (5) I require that the Head of Healthcare at Her Majesty's Prison liaise with the Medical Director of the Leeds Teaching Hospitals NHS Trust to discuss the feasibility of discharge summaries in respect of Prisons being sent to the Prison's Healthcare facility electronically to ensure that any directions and advice as to future care are received promptly and can take immediate effect. (6) Should there be issues of patient confidentiality, this can be addressed by the Prison having a secure email facility dedicated for this purpose.
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 29th September 2016. 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 Head of the Prison Service, the Prisons and Probation Ombudsman and the Chief Inspector of Prisons. 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	**10th August 2016** **DAVID HINCHLIFF** **Senior Coroner** **West Yorkshire (Eastern)**