REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [REDACTED] **Governor, HMP Leeds** 2. **Secretary of State for Justice, the Rt. Hon. Robert Buckland, QC MP**
1	**CORONER** I am Kevin McLoughlin, 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 09/04/21, I commenced an investigation into the death of Guy Clifton Paget, aged 73. The investigation concluded at the end of the Inquest on 23/04/21. The conclusion of the Inquest was that Mr Paget died from natural causes due to 1a oesophageal cancer and 2 urinary sepsis.
4	**CIRCUMSTANCES OF THE DEATH** Mr Paget was a serving prisoner at HMP Leeds. In December 2020, he was diagnosed with terminal cancer of the oesophagus. On 16/3/21 around 13:00 hours, he was found in a confused state in his cell in the hospital wing of the prison. The clinicians responsible for his care decided he should be taken to an outside hospital for treatment. An ambulance was duly brought into the prison. The ambulance could not convey Mr Paget to hospital, however, due to incorrect paperwork being available at the prison gate, which delayed the authorisation for it to leave the prison. In addition, the vehicle gate in the prison malfunctioned and could not be opened. Mr Paget's condition deteriorated and he was pronounced dead at 15:06 hours that day in the ambulance, which was effectively trapped at the prison gate.
5	**<u>CORONER'S CONCERNS</u>** During the course of the Inquest, 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. The prison should have effective systems to facilitate the exit of an emergency ambulance from the prison. 2. In this case a decision was made shortly after 13:00 that Mr Paget needed to be taken to hospital. It should have been made clear to the prison managers that the necessary authorisation to exit needed to be prepared as a matter of urgency. At approximately 15:00 hours, however, this was not in place. 3. It is foreseeable that prisons nationally will need to admit paramedics and ambulance vehicles to attend to prisoners at times of emergency – and may then need to leave with the prisoner in the ambulance. An efficient and tested system to manage this process is essential, in order that serving prisoners are

	provided with an equivalent level of care to that which they could expect in the community.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 17/06/21. 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: **[REDACTED] brother of the deceased** **Yorkshire Ambulance Service.** 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	**23rd April 2021** Kevin McLoughlin