**Mr Sean Horstead**
**Assistant Coroner for Cambridgeshire & Peterborough**

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Minister of State for Prisons & Probation;**<br>**2. [redacted] CEO, Cambridge University Hospitals NHS Foundation Trust** |
| 1 | **CORONER**<br><br>I am Sean Horstead, assistant coroner, for the coroner area of Cambridgeshire & Peterborough |
| 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. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 21st November 2019 I commenced an investigation into the death of **Alvin Roy Black**, aged 59 years. The investigation concluded at the end of the inquest held before a jury at Peterborough Town Hall on 15th December 2020. The conclusion of the inquest jury was one of 'Natural Causes'.<br><br>The medical cause of death was confirmed as: 1a Pulmonary Thromboembolism; 1b Deep vein thrombosis; 1c Thoracic spinal cord stenosis (operated 12.11.2019). |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased was a serving prisoner at HMP Whitemoor.<br><br>He was taken from the prison to Addenbrookes Hospital on 12.11.2019 for planned decompressive surgery on his back. He returned from the hospital on 14.11.2019 and declined to follow medical advice that he remain on the medical wing of the prison overnight, electing instead to return his cell on the Wing.<br><br>At around 11.00 hours on 16.11.2019 Mr Black used his cell bell to summon assistance as he was having trouble breathing and experiencing chest pains. Officers and nursing staff attended the cell: Code Blue was raised and an ambulance called. Mr Black was given oxygen but continued to struggle to breath; he lost consciousness and went into cardiac arrest shortly after 11.30 hours. Staff commenced and maintained CPR until the arrival of East of England Ambulance Service personnel at 12.13 hours. Air Ambulance clinicians arrived at 1228hrs. Life was confirmed extinct at 12.33hrs.<br><br>A Post Mortem examination identified the presence of a "massive" pulmonary embolism likely to have a risen from a coil of blood clotting, probably originating from the leg. The jury found that the blood clot developed at the time of or shortly after surgery providing |

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| | an overwhelming mechanical obstruction to pulmonary circulation which led to fatal cardiac arrest, despite sustained CPR efforts. |
| 5 | **CORONER'S CONCERNS**<br><br>Although not found to have been either possibly or probably causative in the particular circumstances of Mr Black's death, nonetheless during the course of the inquest the evidence revealed two 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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) Extensive evidence was heard concerning the poor state of cleanliness of the Health Care Centre at the Prison. Evidence confirmed that the ground floor of the Health Care Centre was not part of the clinical areas for which the Northamptonshire NHS Foundation Trust, the providers of health care at the Prison, were responsible: this area remained the responsibility of the Ministry of Justice. Whilst Health Care patients would regularly be located there, designated 'vulnerable prisoners' were also routinely resident in this location and, in respect of this cohort, there would be both a high turnover and sometimes challenging hygiene issues accompanying them. The evidence confirmed that the levels of hygiene in the common ways, kitchens, sinks, showers and the cells was poor and that this was of concern to prisoner patients and medical staff alike. Evidence also confirmed that no 'deep cleans' took place in these areas save where blood, vomit or a 'dirty protest' was specifically involved. I am concerned that such poor levels of hygiene give rise to the risk of prisoners returning from surgery, with perhaps compromised immune systems, facing a significant risk of infection, itself giving rise to a risk of future death.<br><br>(2) Evidence disclosed, and was conceded by the Trust, that there had been a missed opportunity for consideration of whether or not anti-coagulation therapy should have been provided to Mr Black following the decision that he remain in Addenbrookes Hospital over-night on the 13th November following his surgery. Although she had been prompted by a pharmacist to review the VTE risk once the decision had been made that it was "unsafe" to discharge Mr Black on the afternoon of the 13th, the Senior House Officer involved failed to conduct the review as required by both NICE and Trust policy. Although this was on the face of it an individual failure by the SHO, I am concerned that (a) the system in place at the time did not pick up on this error; (b) that the SHO's evidence indicated that the course she took was, in her experience, standard practice; and (c) in different clinical circumstances, the failure to ensure that the appropriate review took place gives rise to the risk of future (preventable) death. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **25th June 2021**. 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. |

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| 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>The family of Alvin Black;<br><br>The Ministry of Justice;<br><br>Cambridge University Hospital NHS Foundation Trust;<br><br>Northamptonshire NHS Foundation Trust;<br><br>East of England Ambulance Service.<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 |  <br><br>**HM Assistant Coroner for Cambridgeshire & Peterborough**<br><br>**Sean Horstead**<br><br>**30th April 2021** |