##DW<<ALLTRIM(cSignedBy)>>
##DW<<ALLTRIM(cSignedByTitle)>> for
##DW<<ALLTRIM(cJurisdiction)>>

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) The Governor, HMP Long Lartin, South Littleton, Worcs.** **2) Head of Healthcare at HMP Long Lartin, Practice Plus Group.**
1	**CORONER** I am **David Donald William REID, HM Senior Coroner for Worcestershire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23/01/2019 I commenced an investigation into the death of Richard James Ormond. The investigation concluded at the end of the inquest hearing on 29th April 2021. The conclusion of the inquest was that Mr. Ormond's death was drug-related.
4	**CIRCUMSTANCES OF THE DEATH** On 11.1.19 Mr. Ormond, who had a history of substance misuse whilst in prison, was found in his cell at HMP Long Lartin in a drug-related cardiac arrest. He was transferred to Worcestershire Royal Hospital, where he was declared deceased later that day. A post-mortem examination revealed the following cause of death: 1a synthetic cannabinoid toxicity.
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) During the course of the inquest I heard evidence that: (a) Pursuant to an agreement between HM Prison Service and West Midlands Ambulance Service (WMAS): (i) When a Code Blue or Code Red emergency is phoned through to WMAS by a prison, and no answer can be given by the prison control room to the questions "is the patient conscious?" and "is the patient breathing?", then without further information a Category 2 response will be generated (i.e. average attendance time of c.18 minutes); (ii) Should further information be relayed to WMAS by the prison control room that the patient is either in cardiac arrest or peri-arrest, or not breathing, or fitting, or choking, or that CPR is being administered, WMAS will upgrade the response to Category 1 (i.e. average attendance time of 7 minutes). (b) In Mr. Ormond's case: (i) It was immediately apparent to prison officers who found Mr. Ormond in his cell that

##DW<<corAddress>>
Tel ##DW<<corTel>> | Fax ##DW<<corFax>>

	he was unresponsive and required CPR. When healthcare staff responded to the Code Blue call which went out over the radio, and attended the cell a short time later, they found those officers already giving Mr. Ormond CPR; (ii) The prison control room initially informed WMAS that this was a Code Blue emergency, but were unable to say whether Mr. Ormond was conscious or breathing. The call was therefore given Category 2 status; (iii) There was then a delay of at least 9 minutes before the prison control room provided WMAS with information that Mr. Ormond was not breathing and was requiring CPR, at which point WMAS upgraded the response to Category 1; (iv) In a Safer Custody Learning Bulletin issued in December 2016 to all prison staff, entitled "The Importance of Immediate Emergency Response", the instruction was given to *"Ensure that information on the condition of the patient is passed to the control room as soon as possible so that the ambulance service can be updated."* (v) The 9 minute delay referred to at (iii) above occurred despite the prison officers and healthcare staff who first attended the scene having radios, and therefore being in a position to the control room the information that Mr. Ormond was not breathing and required CPR. 2) The failure to provide WMAS with critical information about Mr. Ormond's condition, which would have resulted in the call being given the highest category of emergency response, did not appear to have been recognized by either HM Prison Service or Practice Plus Group until this inquest hearing. In the circumstances, there is concern that members of the prison and healthcare staff at HMP Long may still not recognize the need to update WMAS with critical information about a patient's condition in similar circumstances.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely **by 30th June 2021**. 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 [redacted] (Mr. Ormond's next of kin). I have also sent it to the following who may find it useful or of interest: 1) HM Chief Inspector of Prisons; 2) Prisons and Probation Ombudsman; 3) Independent Advisory Panel on Deaths in Custody; 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	05/05/2021 Signature  **David Donald William Reid** **HM Senior Coroner for Worcestershire**