REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Governor HMP Preston 2. The Head of Healthcare HMP Preston 3. The Director General of the Prison Service, 102 Petty France London SW1H 9AJ And I am sending a copy of the report to North West Ambulance Service for information purposes
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Lancashire and Blackburn with Darwen
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** An investigation into the death of Thomas Mark Anthony Moffett aged 56 was commenced on 19th August 2019. The investigation concluded at the end of the inquest on 14th January 2022. The conclusion of the inquest was that Mr Moffett had died from natural causes following a cardiac arrest due to metabolic acidosis brought on as a result of profound diarrhoea and vomiting.
4	**CIRCUMSTANCES OF THE DEATH** Mr Moffett had probably been suffering from diarrhoea and vomiting for up to three weeks. Various failures by medical staff including the lack of labelling of a blood sample and the omission of an ECG had led to dangerous levels of metabolic acidosis not being identified in time for Mr Moffett to be saved. Further, due to the inability of healthcare staff to speak direct to ambulance control after an ambulance had been called, accurate details of the patient's condition and the level of the emergency were not adequately communicated
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) The evidence disclosed the need for healthcare and the prison to devise a better means of communication between healthcare personnel at the scene of a medical emergency and the prison control room / ambulance control (2) Similar communication difficulties have already been reported in relation to the inquest into the death of Martin Brown who died at HMP Lancaster Farms and the Prison and Probation Ombudsman has highlighted a delay in the provision of essential

	information to Ambulance Control in the case of [redacted] at HMP Garth who died on 9th December 2020 (3) The fact that communication difficulties have arisen between healthcare and the ambulance service in three recent cases involving prisons in Lancashire may indicate a potentially national problem
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 22nd March 2022. 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 namely the family of the deceased and the North West Ambulance Sevice 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	**Dated this 22nd January** ***Nicholas Rheinberg***