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:

Serco Group Plc Serco House 16 Bartley Wood Business Park Bartley Way Hook Hampshire RG27 9UY

1 CORONER

I am William James Armstrong, Senior Coroner; for the area of Norfolk.

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 the 30th of April 2012 I commenced an investigation into the death of **Ronald Sherlock**, Aged **92**. The investigation concluded at the end of the inquest on the 2nd of August 2013. The conclusion of the inquest was

la Chest infection

Ib Chronic Kidney Disease

Ic Diabetes Mellitus

II Atrial Fibrillation

NATURAL CAUSES

4 CIRCUMSTANCES OF THE DEATH

Ronald Sherlock was a prisoner serving a sentence at HM Prison Norwich. He had been sentenced to life imprisonment in 1979 and been at HM Prison Norwich since April 2005. Mr Sherlock suffered from a number of natural medical conditions including heart problems, high blood pressure, lung disease, prostate cancer, diabetes and Alzheimer's disease. He was being closely monitored and was resident on the older prisoners unit. His health had been deteriorating for some time and he was diagnosed with a chest infection on the 5th of April 2012. On the 24th of April 2012, a healthcare assistant entered his cell to carry out a check and found him unresponsive. Medical help was summoned but he could not be revived and was pronounced dead. No post mortem was carried out and I accepted at the inquest the evidence of the treating doctor that the cause of death was:

la Chest infection lb Chronic Kidney Disease lc Diabetes Mellitus

II Atrial Fibrillation

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed a matter 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 MATTER OF CONCERN is as follows. -

Prisoners accommodated in the Older Prisoners Unit of HM Prison Norwich do not have appropriate access to speech and language therapists who can provide assessments to those with swallowing difficulties and make necessary recommendations as to their medical management including the regulation of fluid and food intake and the provision of a soft diet.

This omission was acknowledged at the hearing by a professional witness for the health service provider of Norwich Prison SERCO.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 60 days of the date of this report, namely by 8 October 20132. 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 Governor of HM Prison Norwich

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 **9 August 2013**