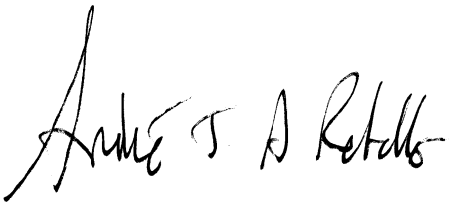
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Prison and Probation Ombudsman** **2 Monck Street** **London** **SW1P 2BQ**
1	**CORONER** I am André Rebello, Senior Coroner, for the area of Liverpool
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 April 2013 I commenced an investigation into the death of **Wilfred Roy ASPINWALL** by opening an inquest under the Coroners Act 1988 , Aged **82**. The investigation concluded at the end of the inquest on 24th June 2014. The conclusion of the inquest was Ia Congestive Heart Failure Ib Hypertensive Heart Disease II Recurrent and Metastatic Lung Carcinoma Wilfred Roy Aspinwall died of Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** Wilfred Aspinwall was a prisoner at HMP Liverpool. He was a frail gentleman with several co-morbidities. Whilst in Prison was residing on the health care ward. He had sustained previous falls at prison and sustained a further fall on 7th/8th March 2013, fracturing his hip and was then transferred to University Hospital Aintree. Whilst in UHA, he has sustained further falls on Ward 35. He suffered a gradual deterioration of health and on Sunday 21st April 2013, Wilfred's breathing became laboured at 0910hours and he sadly died. Medical history included Lung cancer, with part of lung being removed in 1995, renal failure and worsening dementia. There was considerable confusion concerning the cause of death after both a consultant histopathologist and a consultant neuropathologist attributed fatal events to cerebral pathology caused by falls. The Court instructed a consultant neurosurgeon who met with the pathologists reviewed the clinical presentation including scans, where after all three doctors agreed that the death was due to natural causes.
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. – At the inquest hearing it was clear that the PPO report and Clinical Review had not been sent to nor shared with the Healthcare provider at HMP Liverpool. It might be considered good practice for future reports, in all prison fatalities should to be sent to either the head of healthcare and/or the commissioning NHS Trust to ensure that recommendations have an optimal effect.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th August 2014. 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 Family of Mr Aspinwall NOMS HMP Liverpool Liverpool Community NHS Trust 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **Dated: 25th June 2014**