ANNEX A

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:** 1. **Dorset HealthCare University NHS Foundation Trust HQ** [redacted] Specialist Services Manager Dorset Locality Directorate Dorset HealthCare University NHS Foundation Trust HQ Sentinel House Nuffield Industrial Estate Nuffield Road Poole BH17 0RB 2. **NHS England South West** [redacted] Head of Health and Justice Commissioning NHS England South West South West House Blackbrook Park Avenue Taunton Somerset TA1 2PX
1	**CORONER** I am Dr Elizabeth A. Earland, Senior Coroner, for the coroner area of Exeter and Greater Devon.
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 10 January 2014 I commenced an investigation into the death of Hayden Meirion NORTON, otherwise known as Haydn Meirion EVANS, aged 77 years. The investigation concluded at the end of the Inquest on 11 March 2015. The conclusion of the Inquest was Natural Causes, with the Cause of Death being Ia. Ruptured atherosclerotic abdominal aortic aneurysm.

4	**CIRCUMSTANCES OF THE DEATH** Mr NORTON was a prisoner in HMP Dartmoor. On 6th January 2014, Mr NORTON was making baskets in the day (over 50's working normal working day). No problems have been reported throughout the day. In the evening of 6th January 2014, Mr NORTON was in his cell (single occupancy cell) when complained of feeling unwell; believed he was complaining of pain in his left flank. A doctor was called. Mr NORTON became very short of breath afterwards and an ambulance was called at 22:47 hrs. Mr NORTON was with prison staff when he collapsed. CPR was commenced by Prison staff. On collapse, Mr NORTON hit his head. On the arrival of the paramedic crew at 23:12 hrs it was described that Mr NORTON had been complaining of pain his right flank, became agitated and fidgety, hot and sweating. Paramedics have arrived when Mr NORTON was in cardiac arrest (asystole) with CPR ongoing by Prison staff. On examination Mr NORTON's pupils were fixed and dilated, there was no pulse or respiratory effort. Mr NORTON had vomited and had been incontinent of urine. Advanced life support (ALS) was commenced at 23:15hrs; airway inserted with BVM ventilation. Mr NORTON was given adrenalin but was asystolic throughout resuscitation attempts. Death was confirmed at 23:35hrs by paramedic. It is believed that male was taking folic acid for low iron levels and had previous heart related problems.
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. – The Deceased was medically assessed whilst an inmate of HMP Albany (now part of HMP Isle of Wight) on 28 September 2006 and known to have extensive and well documented history of high cholesterol, ischaemic heart disease with episodic angina, two previous myocardial infarctions, blood pressure 220/100. But after arrival at HMP Dartmoor on 15 March 2013, (1) there was no record that his blood pressure was monitored; or (2) that he had been informed of a screening test for aortic aneurysm. He died on 6th January 2014 from a ruptured aortic aneurysm at HMP Dartmoor. (3) There was a delay in calling an emergency ambulance because HMP Dartmoor did not have an emergency code (unlike HMP Exeter) protocol. There was insufficient evidence to say the above were causative of Mr NORTON's death but there would have been an awareness of possible problems to come.
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 8th June 2015. I, the Senior 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. 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	**Signed** ..... **Dr Elizabeth A. Earland** **HM Senior Coroner for Exeter and Greater Devon** **Dated** **13 April 2015**