## **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

## REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Dr Peter Miller, Chief Executive, Leicester Partnership Trust CORONER I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire South 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. **INVESTIGATION and INQUEST** 3 On 14 July 2014 I commenced an investigation into the death of Derick James Stanmore. The inquest concluded on 30 April 2015. The conclusion of the inquest was Natural causes Cause of death 1a Acute myocardial infarction 1b Coronary artery atheroma CIRCUMSTANCES OF THE DEATH Mr. Stanmore was serving a life sentence for murder and was at the time of his death in HMP Gartree. He had a number of recognised medical conditions, including cardiac disease and diabetes mellitus type II. He complained of chest pains on 7th July 2014, and there were 3 encounters with healthcare over the next 3 days, none of which made a potential diagnosis of cardiac problems and none of which resulted in a referral for review. On 10th July 2014 Mr. Stanmore collapsed in his cell and despite prompt and effective CPR and paramedic assistance, he was pronounced deceased shortly after his arrival at Kettering General Hospital. 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. Observations were taken on the morning of Mr. Stanmore's death by a registered nurse. The observations were abnormal and required further action to be taken but this was not recognised. A system similar to the hospital "Early Warning Score" (EWS) may assist the healthcare staff in recognising this and escalating care accordingly. 2. The nurse attending Mr. Stanmore did not access his healthcare records that were available and did not appear to have any information regarding the need for a healthcare assessment. He was therefore taking observations without the benefit of relevant clinical information in order to consider these in context.

Consideration should be given to ensuring all staff have appropriate access whenever possible to information before conducting examinations or observations of prisoners. **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. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 June 2015. 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. COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons. Treasury Solicitors, Governor of HMP Gartree. I am also sending a copy to, NHS England and the Prison and Probation Ombudsman, as they may have an interest in this report 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 2015