

## Mark Andrew Beresford Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Sir Bruce Keogh  National Medical Director NHS England, 6th Floor Skipton House 80, London Road, London SE1 6LH
1	CORONER
	I am Mark Andrew Beresford, Assistant Coroner for South Yorkshire (East District)
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.  http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
	http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 14/12/2010 I commenced an investigation into the death of Adetokunbo Ohisaga Ajakaiye, 28. The investigation concluded at the end of the inquest on 27 May 2016. The conclusion of the inquest was (see attached questionnaire).
4	CIRCUMSTANCES OF THE DEATH  1. Mr Ajakaiye was arrested when he entered the UK through Heathrow Airport, on 13th November 2010. He was seen by a doctor at Heathrow Airport Police Station and was then transferred to Lawcroft House Police Station, Bradford, later that same Day. Mr Ajakaiye was seen by nurses at Lawcroft House Police Station on both 13th November 2010 and 14th November 2010. On all of the above mentioned occasions when Mr Ajakaiye was seen by healthcare staff, he raised the possibility that he was suffering from malaria. On each occasion observations were taken.
	2. Mr Ajakaiye was remanded into custody on 15th November 2010 and was transferred to HMP Doncaster. He was seen by a nurse who carried out the first reception health screen using the standard pro forma which, it was said in evidence, followed a model prepared by again mentioned malaria.
	3. Mr Ajakaiye was seen by a doctor at HPM Doncaster, on 16th November 2010.
	4. Mr Ajakaiye remained at HMP Doncaster until 24th November 2010, on which date he was transferred to Doncaster Royal Infirmary. On the evening of the 24th he was transferred to the Royal Hallamshire Hospital, where he died, of malaria, early on the morning of 25th November 2010.

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. It became apparent, from the evidence, that none of the healthcare staff who dealt with Mr Ajakaiye at HMP Doncaster, had, prior to November 2010, any practical experience of dealing with a patient suffering from malaria and that there was a lack of knowledge and understanding of the signs and symptoms of malaria and of tropical diseases generally in circumstances where, in an era of increased foreign travel and inward migration, the incidence of malaria Is likely to increase.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you Sir Bruce Keogh, 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 22 July 2016. 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 c/o Tuckers Solicitors and of Lupton Fawcett Denison Till Solicitors,
	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 27 May 2016
	Signature Coroner for South Yorkshire (East District)



## Mark Andrew Beresford Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS  THIS REPORT IS BEING SENT TO: - Rt Hon Michael Gove, Secretary of State for Justice, The Ministry Of Justice, 102 Petty France, London, SW1H 9AJ
1	CORONER
	I am Mark Andrew Beresford, Assistant Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
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## **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. When Mr Ajakaiye arrived at HMP Doncaster on 15th November 2010 it appears that his medical records from Heathrow Airport Police Station and Lawcroft House Police Station did not accompany him. The doctor who saw Mr Ajakaiye, on 16th November 2010, stated, in her evidence, that it would have assisted her in her diagnosis had she had those medical records available to her at that appointment. The court heard that, whilst the medical records from previous custodial establishments sometimes accompanied the Prisoner Escort Records, it was not infrequently the case that they did not. 2. It became apparent, from the evidence, that none of the healthcare staff who dealt with Mr Ajakaiye at HMP Doncaster, had, prior to November 2010, any practical experience of dealing with a patient suffering from malaria and that there was a lack of knowledge and understanding of the signs and symptoms of malaria and of tropical diseases generally in circumstances where, in an era of increased foreign travel and inward migration, the incidence of malaria Is likely to increase. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe you The Rt Hon Michael Gove 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 22 July 2016. 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 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; Tuckers Solicitors and Serco Home Analis Lupton Fawcett Denison Till Solicitors.

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 27 May 2016
	Signature Assistant Coroner for South Yorkshire (East District)