| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO:<br><br>1. Care UK, Hawker House, 5-6 Napier Court, Napier Road, Reading, Berkshire RG1 8BW |
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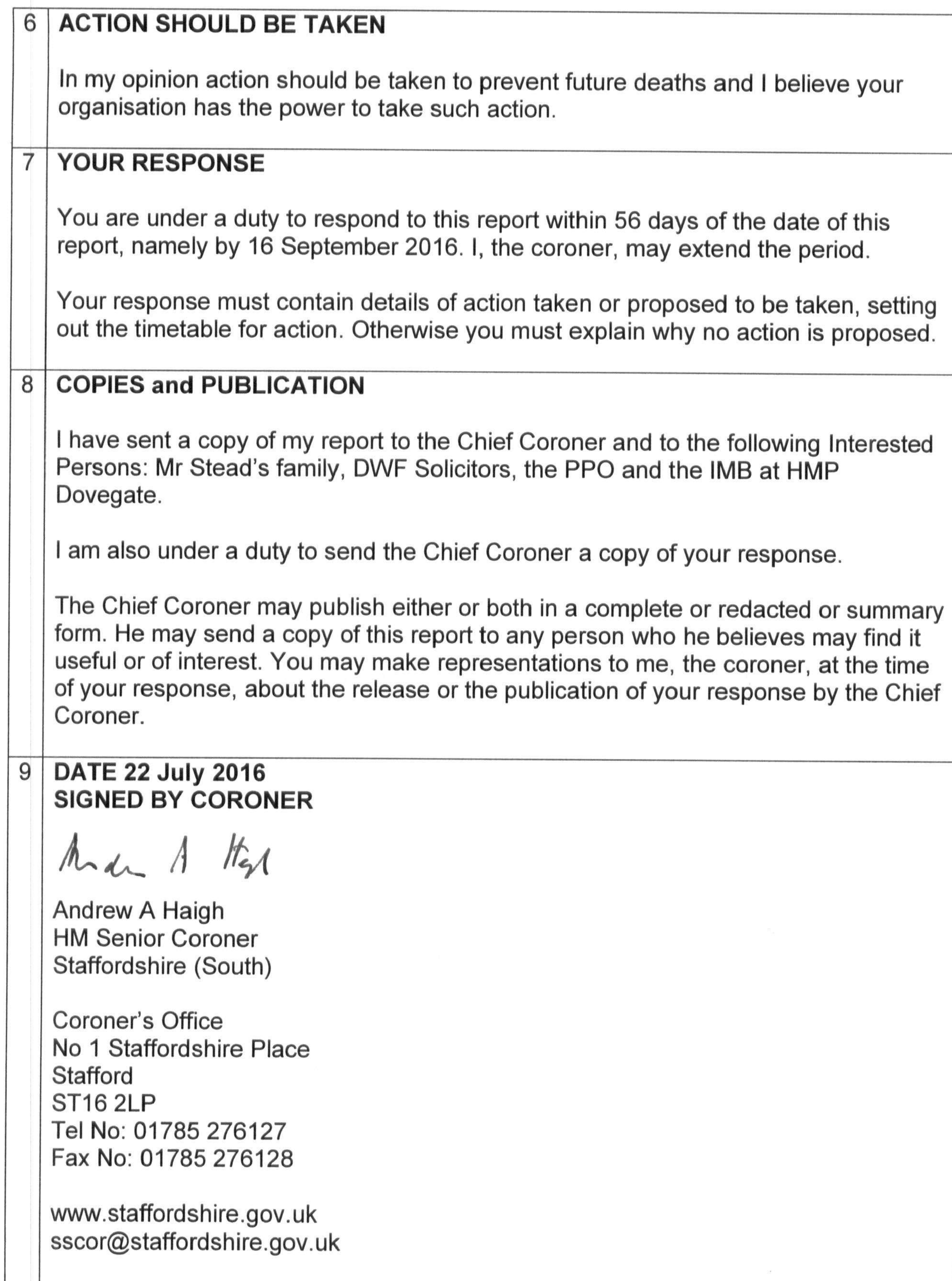
| 1 | **CORONER**<br><br>I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 22 January 2016 I commenced an investigation into the death of Alan George Stead aged 49 years. The investigation concluded at the end of the inquest on 20 July 2016. The conclusion of the inquest was natural causes with the cause of death being given as Ia Haemopericardium Ib Thoracic aortic dissection Ic Ruptured atheromatous plaque. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Stead was a serving prisoner at HMP Dovegate who was taken ill in his cell late evening on 20 January 2016. He was taken to Queens Hospital Burton shortly after midnight but was certified dead there soon after arrival. Death resulted from bleeding from a major vessel near his heart. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows –<br><br>(1) The medical review has identified delays with the taking and testing of blood samples from prisoners at HMP Dovegate. This was not something included in a recommendation in the PPO report but was expressed as a concern by the family at the Inquest. This could have serious consequences in some cases. I wonder if you have looked at this and have done or can do anything to improve the situation with this at HMP Dovegate and indeed at any other prisons where you provide healthcare if this is an issue. |



**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 56 days of the date of this report, namely by 16 September 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: Mr Stead's family, DWF Solicitors, the PPO and the IMB at HMP Dovegate.

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 DATE 22 July 2016**
**SIGNED BY CORONER**

Andrew A Haigh
HM Senior Coroner
Staffordshire (South)

Coroner's Office
No 1 Staffordshire Place
Stafford
ST16 2LP
Tel No: 01785 276127
Fax No: 01785 276128

www.staffordshire.gov.uk
sscor@staffordshire.gov.uk