**Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

**REGULATION 28 REPORT TO PREVENT DEATHS**

**THIS REPORT IS BEING SENT TO: South Central Ambulance Service**

## 1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

## 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 08/08/2018 I commenced an investigation into the death of William VICKERS, aged 37. The investigation concluded at the end of the inquest on 19 July 2019. The conclusion of the inquest was a Narrative Conclusion:

*The deceased was detained at HMP Woodhill on 18th July 2018, on arrival he was seen by medical staff and in view of his drug addiction he was taken to the detoxification unit and placed in a double occupancy cell. At some time around 5:30 am on 19th July 2018 he suffered a cardiac arrest of unknown cause and despite resuscitation he suffered hypoxic brain damage and died at Milton Keynes University Hospital on 26th July 2018.*

His cause of death was confirmed following a post mortem examination as:

I a Bronchopneumonia

I b Hypoxic Ischaemic Encephalopathy

I c Cardiac Arrest

II Chronic obstructive pulmonary disease

## 4 CIRCUMSTANCES OF THE DEATH

William Vickers was found collapsed in his cell at HMP Woodhill on the 19th July 2018. There was a delay in gaining access to his cell by prison staff and a delay in an ambulance crew gaining access to him once they had entered the prison but he was successfully resuscitated and taken to Milton Keynes University Hospital but had suffered hypoxic brain damage. He remained in hospital until he passed away on 26th July 2018.

## 5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

Firstly, I was told during the course of the evidence that the ambulance crew who attended the prison in response to the emergency call, do not have access to the radio system of SCAS. The ambulance which attended is operated by Jigsaw Medical Services which is

denied access to the system. I believe this policy should be reviewed urgently and consideration given to ensure that all ambulance crews have access to the radio system.

Secondly I am concerned that the first response did not include a "paramedic". I believe that consideration should be given to a review to ensure that the first responder to an emergency at the prison should always include a fully qualified paramedic.

**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 19th September 2019. 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 Vickers
- HMP Woodhill
- Westminster Drug Project
- Northamptonshire Police
- GEO Amey

I have also sent a copy of the Prison and Probation Ombudsman who may find it of interest.

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**

**Tom OSBORNE**
**Senior Coroner for**
**Milton Keynes**
**Dated: 26 July 2019**