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. HMP Exeter** **2. HMP Portland**
1	**CORONER** I am Dr Elizabeth Earland, HM 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 the 10th February 2015 I commenced an investigation into the death of Ian Paul Emsley, aged 50 years. The investigation concluded at the end of the inquest on the 3rd September 2015. The conclusion of the inquest was **Natural Causes**. The cause of death being: 1a – **Metastatic Renal Cell Carcinoma**
4	**CIRCUMSTANCES OF THE DEATH** PMH - Metastatic renal cancer. Prev IV drug use (on methadone) , alcohol excess Diagnosed with terminal renal ca Sept 2013 whilst resident in HMP Dorchester. He was transferred to HMP YOI Portland on the 26th November 2013. Moved to palliative care wing HMP Exeter Nov 2014 with life expectancy in terms of weeks. Treatment consisted of steroids and analgesia. Mid Jan 2015 course of Radiotherapy to try and ease symptoms. 29/1/15 deterioration more pronounced and by 1/2/15 was unconscious for majority of the time. Family and Nursing staff were present at approx 1820hrs 1/2/15 when he stopped breathing. Prison Dr attended to confirm death 1930hrs 1/2/15. Police attended no sus circs. An Investigation was opened on 10th February 2014.
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 terminally ill patients will suffer more unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows.

	During the Inquest into Mr Emsley's death from Natural Causes in the palliative care wing at HMP Exeter, the care at HMP Exeter was highly proactive in the last 9 weeks of his life. The care given, in HMP YOI Portland was less so and subject to a number of resource based constraints in end of life care provision. The result being that transfer to HMP Exeter could have been much sooner. **The Clinical Reviewer found that overall it might be helpful for healthcare staff to be given formal guidance or training to assist them in making decisions regarding the assessment of the requirement of restraints and the assessment and decision making of release on compassionate grounds at Multi-Disciplinary Team Meetings involving prison (security) staff and healthcare.** **With lack of formal guidance/or training on the subject healthcare staff were uncomfortable with making decisions on a prisoners risk of re-offending or escape. As a consequence there is a potential for delay in effecting transfer and/or compassionate release for prisoners who are terminally ill, which could also impact on the family.** **When you have had an opportunity to review the current procedures I require a substantive response within the statuary 56 days.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action, please see what I require of you as listed below: **1a - Assessment of the requirement of restraints** **1b - Assessment and decision making on compassionate grounds**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **Monday 2nd November 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. [redacted] – Deceased's Daughter 2. [redacted] – Ex Partner 3. [redacted] – Father 4. The Treasury Solicitors Department 5. The Prisons and Probation Ombudsman 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	**8th September 2015**