REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Governor HMP Lancaster Farms in respect of concerns 1 and 3** **2. The Head of Healthcare HMP Lancaster Farms in respect of concerns 2 and 3**
1	**CORONER** I am Nicholas Leslie Rheinberg assistant coroner, for the coroner area of Lancashire and Blackburn with Darwen
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** An investigation into the death of Martin Thomas Brown aged 50 was commenced following his death on 10th December 2018. The investigation concluded at the end of the inquest on 14th December 2021. The conclusion of the inquest was an open conclusion recording the fact that the cause of death was unascertained but excluding the possibility of suicide, unlawful killing or that the deceased's death was drug related.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 12.15 on Monday 10th December 2018 the deceased was locked in his cell on Coniston 1 wing of HMP Lancaster Farms. He sounded his cell bell and was found by officers screaming in pain shortly after which he collapsed. Healthcare staff attended but although initially appearing to recover, the deceased's condition deteriorated and he suffered a cardiac arrest. Despite resuscitation attempts involving healthcare staff and ultimately ambulance paramedics, the deceased could not be saved and at 2 pm he was declared dead. A post mortem examination failed to reveal a cause of death. It appeared that some prison staff were not fully familiar with the ERIC system (Emergency Response in Custody) and it was revealed that currently some staff had had no training in the system at all. Nursing staff were not fully aware of the level of response to be expected from the ambulance service and the key medical information to convey. Finally, the means of communication between the nursing staff at the scene and ambulance control, involved the passing of information along a chain of non-medical staff leading to a potential for the distortion of important medical information in a process that could be likened to "Chinese Whispers".
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 could 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) For the attention of the Governor, the evidence disclosed a need for the training of prison staff in relation to responses to medical emergencies and familiarisation with the ERIC (Emergency Response in Custody) system

	(2) For the attention of the Head of Healthcare, the evidence disclosed a need for healthcare to liaise with North West Ambulance Service over the handling of medical emergencies involving the ambulance service (3) For the attention of the Governor in partnership with the Head of Healthcare, the evidence disclosed a need to devise a better means of communication between healthcare personnel at the scene of a medical emergency and the prison control room / ambulance control.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th February 2022. I, the assistant 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 namely the family of the deceased and the North West Ambulance Service. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**Dated this 15th day of December 2021** ***N.L.Rheinberg***