Mid Kent and Medway Coroners
Cantium House
County Hall
Sandling Road
Maidstone
Kent
ME14 1XD
[redacted]

Date: 17 January 2023
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Chief Executive of HM Prison and Probation Service;

The Governing Governor of HMP Rochester;

The Chief Executive of OXLEAS NHS Foundation Trust.

1. CORONER

I am Ian Brownhill, His Majesty's Assistant Coroner for Mid Kent and Medway.

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 7 June 2021 I commenced an investigation into the death of John Allen Martin HENDERSON. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Natural causes

1a Ischaemic Heart Disease

1b

1c

II

4. CIRCUMSTANCES OF THE DEATH

Mr Henderson was found dead on his bunk in the morning by other HMP Rochester inmates. His cell mate was concerned that Mr Henderson had not moved and asked another inmate to check on him. When this was done, the deceased was discovered to be cold to the touch and no pulse could be detected. Staff were informed upon this discovery. The Ambulance Service attended and confirmed that Mr Henderson had died.

Following a post mortem it was confirmed that Mr Henderson had died of ischaemic heart disease.

Throughout the inquest, various evidence was heard as to how Mr Henderson had previous acute medical episodes which had required hospitalisation. Mr Henderson was undergoing neurological investigations at the time of his death and was receiving treatment for hypertension.

I recorded on the record of inquest that:

John Henderson was a serving prisoner at HMP Rochester. He had physical health problems which were subject of ongoing treatment and investigation. Those investigations were continuing at the time of his death but had been delayed by administrative issues. At some point late in the evening of 26 May 2021 or early 27 May 2021, Mr Henderson had a sudden and fatal haemorrhage into the wall of the left circumflex artery which caused him to die. Mr Henderson was found in his cell at HMP Rochester on 27 May 2021 having died.

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 **MATTER OF CONCERN** is as follows. –

In my decision at the end of the inquest, I stated, amongst other things:

During the course of evidence, I also established that John was not being monitored any more closely than other prisoners due to his seizure activity. That was confirmed by [redacted] *in the course of their evidence. They indicated to me that sometimes they will be asked to monitor prisoners more closely but this had not been applied to John. Likewise, nobody had checked the welfare of John at the start of the day on 27 May 2021.*

I asked additional questions of witnesses and asked to have sight of policies and procedures in respect of information sharing protocols and procedures in respect of prisoners with chronic conditions, (be is seizure activity, diabetes, cardiac issues). My concern being that there did not appear to be a clear process for prisoners to consent to disclosure of medical information to front line officers so that they could be made aware that a particular prisoner may be prone to sudden or unexpected medical episodes.

My concern was that a prisoner could have a sudden (but perhaps predictable) acute medical episode and front line prison staff may not be made aware of what was causing the issue or how to respond thereto.

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 15 March 2023. 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 Interested Persons to the inquest. I have also sent it to the Prison and Probation Ombudsman who may find it useful or 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.

17 January 2023

Signature 

Ian Brownhill Assistant Coroner for Mid Kent and Medway