Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres for NHS England** **2 Chief CORONER CC OFFICE**
1	**CORONER** I am Crispin Oliver, assistant coroner for the coronial ares of County Durham and Darlington.
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 24 September 2020 I commenced an investigation into the death of Joseph Andrew PRICE aged 28. The investigation concluded at the end of the inquest on 18 January 2023. The conclusion of the inquest was that the death was from Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** On 20 September 2020 Joseph Andrew Price (Andrew), born 05 December 1991, was found dead in his cell on A Wing at HMP Durham. The opinion initially provided by the pathologist was that the cause of death was unascertained. However, having heard evidence at the Inquest of a paternal family history of pre-mature cardiac related deaths, she changed this to Sudden Cardiac Death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) Mr Price (Andrew) was remanded to HMP Durham on 10 September 2020. He died there, aged 28 years, on 20 September 2020. The evidence of the pathologist at the Inquest was that the medical cause of death was Sudden Cardiac Death (this was an amendment from her original opinion that the cause of death was un-ascertained). The pathologist explained that this death would have followed sudden arrhythmia. She concluded thus after hearing evidence of a paternal family history of premature cardiac related deaths. Clearly this is a comparatively rare condition and one where diagnosis is extremely difficult: it occurs in people who are young and physically fit; there can be an absence of clear symptoms before hand. In Andrew's case this was complicated further because he was suffering from what are sadly common problems for prison inmates - he had serious mental health and

	personality disorder issues and was an established abuser of substances - illicit and otherwise. Such symptoms as there might have been (breathlessness and reported chest pains) in the days and hours leading up to his unexpected death were readily confusable and could have been associated with drug withdrawal (he was subject to a methadone care plan) and mental and emotional distress (he was reported to be suffering from extreme anxiety and paranoia). The best, in some cases the only, way to predict a pre-disposition to a death of this nature is by reference it to family medical history of such, or similar, occurrences. Once this is known, the person can then be referred for genetic screening. Sadly, in Andrew`s case no one in healthcare, some of whom had been familiar with him for years from previous terms of imprisonment, had any knowledge of the family history, as it did not feature on system one, and Andrew had never volunteered it. Equally, he had never been asked about it. This is not a criticism, simply a statement of fact made starkly relevant by the circumstances, unusual though they are. The head of healthcare at HMP Durham gave evidence, when asked directly by me, that provision for a question in the reception health screen template about any family history of sudden cardiac death could help to prevent deaths of this kind reccurring at the prison. She, with the health care provider for HMP Durham (Spectrum Community Health), has helpfully and very pro-actively put this into immediate effect locally (at HMP Durham and those other prisons covered by the health care provider). Specifically, the second health screen template (see attached - at pages 7 and 8) now shows that a question with regards family history (FH) of a 'FH: Cardiac Disorder (incl. Sudden Cardiac Death)' has been added to the second reception screen. The updating of the first reception health screen template is currently in hand. Additionally, the health care provider proposed the introduction of a read code specifically for 'FH: Sudden Cardiac Death' in the SystmOne template. This read code does not currently exist in SystmOne and so locally, the health care provider has now added it as a prompt in the read code for 'FH: Cardiac Disorder (XM1Jv)' and add to this '(incl. Sudden Cardiac Death)'. By adding 'FH: Sudden Cardiac Death' as a read code in its own right, it will make it easier to search for and flag on the SystmOne records of prisoners so staff can clearly see and be aware of this previous family history. The purpose of this report to you is that you might take appropriate similar steps nationally.
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 March 16, 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 following Interested Persons [redacted] I have also sent it to [redacted] [redacted]

	[redacted] [redacted] who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 19/01/2023**  **Crispin OLIVER** **Assistant Coroner for** **County Durham and Darlington**