NIGEL S MEADOWS
H.M. SENIOR CORONER
Manchester City Area
Email: coroners@manchester.gov.uk
www.manchester.gov.uk/coroners

H.M. CORONER'S OFFICE
PO Box 532
Manchester Town Hall
Albert Square, M60 2LA
(Visitors please use postcode M2 5BR)
Telephone 0161 219 2222
Fax 0161 274 7329

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London
SW1A 2NS

3 December 2013

Dear Secretary of State,

Re: Horace Cottom (deceased)

Letter written in accordance with paragraphs 37/38 – Chief Coroners Guidance No 5

The above named, who was born on 25th September 1939, died at HMP Manchester on 21st June 2012 as a serving prisoner. He suffered from a number of chronic health conditions, and in particular ischaemic, hypertensive and valvular heart disease. He also suffered with a chronic lung condition. Following his death, I ordered a post mortem as well as toxicology tests.

I was able to resume the inquest on 27th November 2013 without having to sit with a jury as provided by the Coroners and Justice Act 2009 because the evidence suggested that pathologically the deceased died from natural causes and there was no other reason to sit with a jury.

I found that he died from:

1a Pneumonia
1b Ischaemic, hypertensive and valvular heart disease with pseudomembranous colitis

I recorded a conclusion of death by Natural Causes.

During the course of the evidence, it became clear that he had very significant levels of pain relief medication in his system, including opiates, which without further explanation would suggest that he received excessive amounts and/or a massive overdose. However, expert toxicological evidence established that the results were due to his body failing to metabolise (process, break down and excrete) the drugs. Furthermore, in or about March of 2012 after undergoing x-rays in an NHS hospital, he was diagnosed with lung cancer, but was generally too unwell to undergo additional investigations. When he died, it was discovered that

he did not have lung cancer at all, but there was reasonable evidence for the treating doctors to form that opinion. He had a number of admissions prior to his death, the last of which was for several weeks.

At the conclusion of the inquest, I was satisfied that my duty to make a Regulation 28 Prevention of Future Deaths Report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 was not established.

However, the inquest did establish that following his last discharge, it took about 10 days for any discharge information/report to be received at the prison from the NHS hospital. Further enquiries revealed that this was quite common and locally in Manchester the prison service tried to get the discharging doctor to write out in manuscript form discharge information. This is not always successful and results in delay, as well as incomplete discharge information.

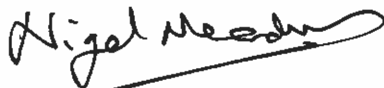
Recently, HMPS changed from using the NHS EMIS GP recording system and introduced what is known as 'System One'. This means that it is certainly easier for a prisoner who moves within the HMPS estate to have their GP records accessed immediately within the prison system.

Locally in Manchester, they also try to use an email system to collect discharge information, but this is not without problems itself. From what I was told at the inquest, it seems that some NHS information can be transmitted directly onto the System One, but for some reason discharge information is not sent.

HMPS caters for an increasing number of older prisoners with chronic health problems who have to attend outside NHS hospitals for investigations and treatment. It is vital that the healthcare professionals in prison have timely and full discharge information so that they can manage the care of the patient prisoner once they are returned to custody. One would hope that there is a simple and user-friendly way in which discharge information could be relayed to all prison healthcare establishments via the NHS. Whilst this has been highlighted as a local issue, I anticipate that it actually will be replicated nationwide. Accordingly, I am writing this letter under paragraph 37 & 38 of the enclosed Chief Coroner's Guidance No. 5 to bring this to your attention.

I appreciate that it will involve a number of others who can assist in resolving the position and therefore I am also going to send a copy of this letter to the Chief Executive of the NHS, the Minister for Prisons, the Director General of HMPS, the Governor of HMP Manchester, as well as the Medical Directors of the major NHS Trusts in Greater Manchester. I sincerely hope a solution can be found.

Yours sincerely



Nigel Meadows
HM Senior Coroner for Manchester City Area