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.** Rt. Hon. Chris Grayling MP, Lord Chancellor and Secretary of State for Justice **2.** Rt. Hon. Jeremy Hunt MP, Secretary of State for Health 3. Sodexo (represented by [redacted] Berryman Lace Mawer LLP) **4.** [redacted] Director, HMP-YOI Forrest Bank **5.** National Offender Management Service
1	**CORONER** I am M Jennifer Leeming, HM Senior Coroner, for the Coroner Area of Manchester West
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 5th May 2011 I commenced an investigation into the death of Lee Terence Curran, 37 years. The investigation concluded at the end of the inquest on 14th February 2014. The conclusion of the inquest was that the death was due to Natural Causes. The medical cause of death being: 1a) Ischaemic heart disease II) Hypotension consequent upon prescribed drug therapy
4	**CIRCUMSTANCES OF THE DEATH** Lee Terence Curran died on the 3rd of May 2011 at Forest Bank Prison Salford where he was in custody. The prime cause of his death was naturally occurring ischaemic heart disease, which had not been diagnosed during his lifetime. Between the 6th of January 2011 and the 22nd of March 2011 inclusive Nurses at the prison were called to treat Lee Terence Curran on five occasions following his having suffered a transient loss of consciousness. On each of these occasions Lee Terence Curran was subsequently seen by a Doctor, but the cause or causes of his various transient losses of consciousness were never diagnosed. Enquiries were not made of persons who might have witnessed those events to discover what had happened, nor was Lee Terence Curran ever given an electrocardiogram. Both of these things were recommended by the National Institute of Clinical Excellence Guidelines for transient loss of consciousness management in adults in force at the time. There is no evidence

	that either or both of these measures, if taken, would have prevented or delayed Lee Terence Curran's death. Whilst Lee Terence Curran was in custody he was prescribed various medications concluding at the time of his death with his being prescribed three particular medications two of which carried a risk of causing a potential side effect of lowering blood pressure. On the 24th of January 2011 Lee Terence Curran was seen by one of the Doctors working at the prison who observed that he had a marking near to one of his eyes that would probably indicate that he had a high level of cholesterol in his blood. High cholesterol levels are associated with coronary artery disease and the Doctor therefore suggested to Lee Terence Curran that he should have a blood test to ascertain his cholesterol level. Lee Terence Curran did not wish to have the test at that time, and such a test was never offered again nor performed. On the 24th of February 2011 one of the Doctors at the Prison referred Lee Terence Curran to a neurologist at Salford Royal Hospital for investigation of the cause of his episodes of transient loss of consciousness, and particularly to ascertain whether or not they were due to epilepsy. This referral was triaged at Salford Royal Hospital and was categorized as non-urgent. Lee Terence Curran was allocated an appointment to attend at the Hospital on the 10th of May 2011 as an outpatient. The timing of this appointment did not comply with the key priority for implementation contained in The Epilepsies Guideline issued by the National Institute for Clinical Excellence, which at that time provided that an individual with a recent onset suspected seizure should be seen within two weeks by a specialist. There is no evidence that an earlier appointment would have prevented or delayed Lee Terence Curran's death.
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 **MATTERS OF CONCERN** are as follows: (1) The Prisons and Probation Ombudsman investigated Lee Terence Curran's death. At the conclusion of that investigation certain recommendations were made, two of which were as follows: a. "The Head of Healthcare should ensure that healthcare staff take full account of family history when arranging clinical investigations for prisoners who report, or are observed to have possible signs of high cholesterol or hypertension." b. "The Head of Healthcare should develop a protocol that is NICE compliant for investigating episodes of loss of consciousness and should ensure that staff conduct clinical investigations of prisoners who experience such episodes." Both of these recommendations were accepted. However the evidence given at the Inquest in relation to the implementation of recommendation a. was that all prisoners coming in to Forest Bank Prison undertake the reception screening process and any prisoner with any identified, or any sign of, hypertension is referred to the hypertension clinic. A full account of the prisoner's family history is then taken at that clinic. There was no

	evidence that any action had been taken to address that part of the Ombudsman's recommendation that related to prisoners (such as Lee Terence Curran) who reported or showed signs of having high cholesterol. Likewise with recommendation b. The evidence given at the Inquest with regard to the implementation of that recommendation was that any individual who had a loss of consciousness would be automatically referred to a Doctor. That action does not encompass the whole of the Ombudsman's recommendation. Particularly it does not ensure that investigations of episodes of loss of consciousness are NICE compliant nor does it ensure that staff conduct clinical investigations of prisoners who experience such episodes. It should be remembered here that Doctors saw Lee Terence Curran on five occasions following episodes of loss of consciousness and the NICE guidelines were not followed at any time. (2) Evidence given at the Inquest revealed a potential need for the training of Prison staff as to the manner in which they make entries in prisoners' medical notes. Expressly, incorrect, and potentially misleading, information had been entered in Lee Terence Curran's medical notes concerning the episodes of loss of consciousness that he experienced. For example a nurse described one such episode as a "petit mal seizure," whilst evidence at the Inquest made it clear that such could not have been the case. In addition those entering information did not make the basis upon which they were entering that information clear, that is they entered information that indicated that they had witnessed an event when they had not. (3) Evidence given at the Inquest also revealed a need for the training of Doctors working in prisons in that Doctors who provided general practice sessions at the prison (and in the community) gave evidence that they were unaware of the NICE Guidelines for Transient Loss of Consciousness Management in Adults and Young People despite such episodes being common in a prison environment. Additionally evidence was given by a Doctor that efforts were not made to fully investigate Lee Terence Curran's episodes of loss of consciousness because, the Doctor explained, it was common for prisoners to claim to have suffered losses of consciousness as a form of drug seeking behaviour.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and 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 22nd April 2014. 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] (represented by Lester Morrill Solicitors) General Medical Council Prison and Probation Ombudsman Mr Derek Winter, HM Senior Coroner for Sunderland I have also sent it to Sir David Dalton, Chief Executive, Salford Royal Foundation Trust 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.	
9	**Dated** **25th February 2014**	**Signed** M Jennifer Leeming. **M Jennifer Leeming**