	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NOMS, Fourth Floor, 70 Petty France, London SW1H 9EX** **2. Department of Health, Richmond House, 79 Whitehall, London, SW1A 2NS**
1	**CORONER** I am Andrew Tweddle, Senior Coroner, for the coroner area 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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 6th January 2014 I commenced an investigation into the death of Zeeyad Hamadi. The investigation concluded at the end of the inquest on 8th January 2014. The conclusion of the inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a prisoner serving a sentence at HMP Frankland. He became unwell and after the prison GP had been unable to make a diagnosis he was transferred to University Hospital of North Durham. Thereafter he was diagnosed with Hodgkins Lymphoma. The deceased sought a transfer to St Bartholomew's Hospital, West Smithfield, London so that he could receive a form of chemotherapy treatment from the world's leading expert in such matters on a private paying basis. There was considerable urgency attached to the proposed move to London as the deceased's health was rapidly deteriorating and medical advice was that treatment should commence as soon as possible. It took some time for arrangements to be completed to facilitate the transfer from UHND to Bart's. The deceased's health deteriorated during this time.
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 evidence disclosed that the deceased had not been weighed at the times of medical appointments and a history of weight loss would have been a useful diagnostic tool. Not all medical consulting rooms at HMP Frankland had scales to do so and doctors/nurses did not routinely weigh patients. (2) It was accepted in evidence that the standard of record keeping in the patient's medical notes was not as good as it could or should have been. There was lack of clarity as to when certain medical information (for example blood tests results) were available for interpretation by a doctor, by paper or electronic means, there was lack of clarity as from the computer printouts of medical records when entries were inputted into the system and were available for view, who was the author of the entry (as opposed to who inputted the data). (3) There was limited liaison between health care staff in HMP Frankland and medical staff at UHND to monitor the deceased's medical condition once he had left the prison. When a decision was made by the deceased to seek treatment in London on a private

	paying basis this information was not speedily communicated to those responsible for health care in HMP Frankland and contact was made by a hospital doctor with a duty governor at the prison who in turn had to refer to the health care manager. Confusion developed as to the basis of the proposed move to Bart's from UHND; whether this was a prison to prison transfer or whether it was a relocation of the deceased from one hospital to another whilst remaining the responsibility of HMP Frankland. There was confusion over the funding arrangements for this proposal; whether the local NHS would be responsible for the medical treatment or the costs of transport, the form of such transport and/or the costs of bed watch. The brother of the deceased confirmed to different people at different times that he would undertake to be responsible for the costs incurred (subject to a challenge by Judicial review) and it took some time for the issues of funding to be identified before being addressed and resolved. There was a lack of clarity of understanding who would be responsible for what and when, so far as money was concerned and who would have the responsibility for payment in the first place prior to reimbursement by the deceased's brother. There was no formal policy in place to deal with the situation. There was lack of clarity in the rules that were referred to in evidence as to how and when a convicted prisoner is entitled to private health care as opposed to a prisoner on remand. (4) Requests by HMP Frankland for mutual aid from prisons in London to provide bed watch office cover were unsuccessful and it was only after the intervention of the governing Governor of HMP Frankland with a senior manager at the high security estate Head Quarters of the prison service that an instruction was given for a London prison to provide bed watch cover. There was a lack of understanding as to and what circumstances the transfer from Durham to London could be facilitated by an NHS ambulance, a private ambulance or an air ambulance. There was no evidence to show bad faith on the part of any of the individuals who were involved in this transfer process but there was no system in place to aid those involved in this process to guide them as to how a transfer should properly be made from an NHS hospital in one part of the country to a hospital in another part of the country where treatment was to be privately funded. There was as a result no single point of contact within the prison (either of a health care or a discipline background) who was able to take ownership of the issue, or a group of people properly designated to take control of such a situation, with the result that inconjunction with the failure for mutual aid to be given the bed watch requirements for a delay to have taken place which could have reduced the deceased's chances of receiving treatment which may have prolonged his life. Evidence was given that not withstanding the fact that the deceased died in October 2010 no policy or guidance has been introduced to assist either prison service staff or health care providers with the issues highlighted by this case which were described in evidence as unprecedented. Although there may be limited occasions when prisoners might have family resources to provide private medical care it is possible that more people will have the benefit of private medical insurance which may be of assistance in similar cases. The use of such private medical care covered by insurance would lead to a reduction in the cost burden imposed on the NHS.
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 3rd March 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.
	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested

	Persons TSOL, One Kemble Street, London, WC2B 4TS, [redacted], Berrymans Lace Mawer, Park Row House 19 – 20 Park Row Leeds, LS1 5JF Ward Hadaway,Sandgate House, 102 Quayside, Newcastle Upon Tyne NE1 3DX Irwin Mitchell, Gainsborough House, 34-40 Grey Street, Newcastle Upon Tyne NE1 6AE [redacted] PO Box 67655, London NW11 1HZ 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	**13th January 2014** **SIGNED BY** **ANDREW TWEDDLE LLB** **H M SENIOR CORONER** **COUNTY DURHAM AND DARLINGTON**