

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>[REDACTED]</p> <p>The Director High Security Prisons Group Carnarvon House HMP Manchester Southall Street Manchester M60 9AH</p>
1	<p>CORONER</p> <p>I am David Hinchliff, Senior Coroner for the coroner area of West Yorkshire (Eastern).</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p> <p>[REDACTED]</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 28th February 2012, I commenced an investigation into the death of Colin John Ireland (aged 57). The investigation concluded at the end of the inquest on 24th October 2014. The conclusion of the inquest was:-</p> <p>1a Pulmonary Thromboembolism b Deep Venous Thrombosis of the left leg c A Fracture to the left hip (operated).</p> <p>Jury's narrative conclusion</p> <p>Having considered the evidence, we the Jury find Mr Ireland's death was accidental in nature and not caused by the action or inactions of any other person or persons at Pinderfields Hospital, Wakefield or HMP Wakefield.</p> <p>On the morning of 11th February 2012, Colin John Ireland accidentally fell while taking routine exercise in the yard at HMP Wakefield. Mr Ireland was then transferred to Pinderfields Hospital, Wakefield and was diagnosed with a fracture of the left femur. On 13th February 2012, Mr Ireland underwent full hip replacement surgery and was discharged on 17th February 2012 to HMP Wakefield's Health Care Centre. On 21st February 2012, Mr Ireland was found collapsed in his cell, after attempts of resuscitation, he was pronounced dead at 0924 hours.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p>

1. Colin John Ireland had been sentenced to life imprisonment with a whole life tariff in 1993. He had been at HMP Wakefield since March 2008.
2. He was a diabetic and there were times when he ignored medical advice in respect of this which led to complications arising from poor management of his diabetic condition and him suffering with poor vision.
3. During icy weather on 11th February 2012 and whilst taking exercise in the exercise yard, Mr Ireland slipped and fell fracturing his left hip.
4. Despite verbal advice from a GP to an experienced nurse that this was a life-threatening condition and that Mr Ireland should have been sent to hospital immediately, there was a delay of three and a half hours whilst a Governor Grade Officer insisted on the attendance of a GP and having made several attempts to obtain permission from the Prison Service Directors for him to leave the Prison having regard to his high security status.
5. Mr Ireland's surgery, which was uneventful, did not take place until Monday, 13th February 2012. He was given the appropriate anti-coagulant drugs to reduce the risk of deep vein thrombosis and pulmonary embolism although there were missed doses which according to Expert evidence on balance of probability did not cause or contribute to his death.
6. He was discharged to the Prison's Healthcare Centre at approximately 5.00 pm on 17th February 2012. He needed considerable assistance with mobility of the activities of daily living. He was meant to receive continued anti-coagulant medication but there were missed doses which according to Expert evidence on balance of probability did not cause or contribute to his death.
7. On the morning of Monday 21st February 2012, whilst using the toilet he was found in a collapsed state. Resuscitation attempts were unsuccessful and his death was confirmed by paramedics at 09.24 hours on 21st February 2012.


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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. That a Governor Grade Officer who had sole responsibility for the running of the Prison challenged the clinical judgement and decisions of both an experienced nurse and the on-call GP who believed that Mr Ireland had fractured his hip and that this was a potentially life-threatening condition and that he should be sent to hospital as an emergency.
2. That the same Governor Grade Officer had difficulty in contacting by telephone [REDACTED] the on-call Operational Manager for the High Security Prison Group to seek permission for Mr Ireland to be sent to hospital. Apparently, [REDACTED] was not responding to her calls. I request that the Director of the High Security Prison Group specifically address this issue in response to this report. Fortunately, the Governor had through his own dealings with [REDACTED] who was then the Director of High Security Prisons, his contact details who was then able to give the relevant permission. I understand that this was an unofficial approach which I do not criticise but would point out that other Duty Governors may not have had access to [REDACTED] number, which would have lengthened the delay. It occurs to me that the on-call system is flawed and

	<p>should be reviewed.</p> <p>3. That the Governor Grade Officers who gave evidence had differing views as to the action to be taken, in particular in relation to seeking approval from the High Security Prisons Group regarding release to hospital in such circumstances. I consider that there should be an agreed protocol for this and that all on-duty Governors should receive appropriate training regarding responding to medical emergencies of all types to ensure a speedy release to hospital when necessary, obviously without prejudicing appropriate security issues. Although the Duty Governor claimed to acknowledge that preservation of life was paramount, he appeared to be more motivated by Mr Ireland's notoriety than to the serious issues of his condition which created an unacceptable delay.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 January 2015. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES]. I have also sent it to [NAMED PERSON] who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>7th November 2014</p> <p style="text-align: right;">  David Hinchliff Senior Coroner West Yorkshire (Eastern) </p>

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	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>[REDACTED]</p> <p>Medical Director Mid Yorkshire Hospitals NHS Trust Trust Headquarters & Education Centre Pinderfields General Hospital Aberford Road Wakefield WF1 4DG</p>
1	<p>CORONER</p> <p>I am David Hinchliff, Senior Coroner for the coroner area of West Yorkshire East.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p> <p>[REDACTED]</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 28th February 2012, I commenced an investigation into the death of Colin John Ireland (aged 57). The investigation concluded at the end of the Inquest on 24th October 2014. The conclusion of the inquest was</p> <p>1a Pulmonary Thromboembolism b Deep Venous Thrombosis of the left leg c A Fracture to the Left Hip (operated).</p> <p>Jury's narrative conclusion</p> <p>Having considered the evidence, we the Jury find Mr Ireland's death was accidental in nature and not caused by the action or inactions of any other person or persons at Pinderfields Hospital, Wakefield or HMP Wakefield.</p> <p>On the morning of 11th February 2012, Colin John Ireland accidentally fell while taking routine exercise in the yard at HMP Wakefield. Mr Ireland was then transferred to Pinderfields Hospital, Wakefield and was diagnosed with a fracture of the left femur. On 13th February 2012, Mr Ireland underwent full hip replacement surgery and was discharged on 17th February 2012 to HMP Wakefield's Health Care Centre. On 21st February 2012, Mr Ireland was found collapsed in his cell, after attempts of resuscitation, he was pronounced dead at 09.24 hours.</p>
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tariff in 1993. He had been at HMP Wakefield since March 2008.

2. He was a diabetic and there were times when he ignored medical advice in respect of this which led to complications arising from poor management of his diabetic condition and him suffering with poor vision.
3. During icy weather on 11th February 2012 and whilst taking exercise in the exercise yard, Mr Ireland slipped and fell fracturing his left hip.
4. Despite verbal advice from a GP to an experienced nurse that this was a life-threatening condition and that Mr Ireland should have been sent to hospital immediately, there was a delay of three and a half hours whilst a Governor Grade Officer insisted on the attendance of a GP and having made several attempts to obtain permission from the Prison Service Directors for him to leave the Prison having regard to his high security status.
5. Mr Ireland's surgery, which was uneventful, did not take place until Monday, 13th February 2012. He was given the appropriate anti-coagulant drugs to reduce the risk of deep vein thrombosis and pulmonary embolism, although there were missed doses which according to Expert evidence on balance of probability did not cause or contribute to his death.
6. He was discharged to the Prison's Healthcare Centre at approximately 5.00 pm on 17th February 2012. He needed considerable assistance with mobility of the activities of daily living. He was meant to receive continued anti-coagulant medication but there were missed doses which according to expert evidence on balance of probability did not cause or contribute to his death.
7. On the morning of Monday 21st February 2012, whilst using the toilet he was found in a collapsed state. Resuscitation attempts were unsuccessful and his death was confirmed by paramedics at 09.24 hours on 21st February 2012.

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CORONER'S CONCERNS

1. Mr Ireland, on admission to Pinderfields General Hospital on 11th February 2012 was prescribed Thromboprophylaxis medication in the form of Clexane 40 mg which he received on 11th, 12th, 14th, 15th and 16th February 2012. Two doses were missed namely 13th and 17th February 2012. Although an Expert opinion is that the two missed doses would not on balance of probability have caused or contributed to his death, I consider that action should be taken to prevent omissions of such important medication and that an explanation should be given as to why the doses were omitted. The Orthopaedic Surgeon who carried out Mr Ireland's operation did not consider it inappropriate for him to be given his Clexane on 13th February 2012 i.e. the day of surgery. Furthermore, a Junior Doctor did not complete a documented risk assessment for venous thromboembolism. Although this did not affect the actual prescribing, I require the Trust to tighten its procedure in ensuring that the appropriate risk assessments are correctly and appropriately completed.
2. Regarding Mr Ireland's discharge to the Prison's Healthcare Centre on 17th February 2012 at approximately 5.00 pm. Mr Ireland was given an inadequate discharge summary which did not make clear that he had not received his anti-coagulant medication, Clexane, that day. Health Care Officers were unaware of this and therefore he did not receive this medication on his return to the Prison that day. The discharge summary should have made it absolutely clear as to the treatment plan once discharged. There was a requirement for physiotherapy, yet no enquiries were made about the availability of physiotherapy during the weekend period, which does not exist at the Prison and therefore alternative arrangements were not considered.

	<p>3. I invite the Trust to review it's discharge procedures generally. Specifically I consider that the discharge of patients late on Fridays when healthcare services and facilities over a weekend period are severely limited, both in terms of Prison health care and in the wider community can be risky. Although I appreciate that hospital places are often scarce and in demand I urge the Trust to consider the merits of avoiding late Friday discharge when enquiries have not been made as to the availability of adequate health care provision over a weekend period. In this instance, Mr Ireland would still have been at high risk of developing a deep vein thrombosis and pulmonary embolism, which in fact he did, which was the cause of his death the following Monday.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd January 2015. I, the coroner, may extend the period.</p> <p>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.</p>
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