REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

NHS England
The Prison Service

CORONER

I am Robert Chapman, Assistant Coroner, for the Coroner Area of Rutland & North Leicestershire

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.

INVESTIGATION and INQUEST

On 19TH March 2013 I commenced an investigation into the death of Jason Edward Lawson, aged 38. The investigation concluded at the end of the Inquest without a jury on 20th November 2014. The conclusion of the inquest was:

The Cause of death was:
1.a. Sudden Unexpected Death in Epilepsy

The Conclusion was:

Narrative Conclusion

Mr Lawson had been diagnosed as suffering from epilepsy and schizophrenia. He had received treatment and medication in both the community and more recently through the healthcare provisions in the various prisons where he had served sentences of imprisonment.
On the morning of the 17th March 2013, whilst at HMP Stocken, Mr Lawson was found dead in his prison cell. His death was certified by a paramedic at 1.19pm on the 17th March 2013. He died from natural causes.

CIRCUMSTANCES OF THE DEATH:

Mr Lawson suffered from epilepsy and schizophrenia and had received treatment and medication in both the community and through the healthcare provisions in the various prisons where he had served sentences of imprisonment. He was imprisoned at HMP Stocken at the time of his death.

On the afternoon of 16 March 2013 he had received a visit from relatives. He appeared to be well. He was locked in his cell at 4.30 that afternoon, was checked by prison officers at around 9pm, and checked again through the night, at around 7.30 on the morning of the 17 March and again at 8.20am when his cell door was unlocked. He was found dead in his cell at about 12.00 noon on the 17th March when he had not attended to collect his lunch.

The time of death is uncertain, but is likely to have been late in the evening of the 16th March or in the early hours of the 17th March. He was certainly dead when the checks were carried out on the 17th March at 7.30am and 8.20am

Subsequent to Mr Lawson's death a Governors Order has been issued requiring welfare checks to ascertain whether the prisoner was breathing or moving. The officers who gave evidence were uncertain about the details of the Order and its application on a

weekend.

Whilst in HMP Stocken Mr Lawson had had a number of epileptic attacks. On one occasion in November 2012 the medical team had suggested he receive 24 hours of constant watch. There had been no medically trained staff available to undertake this during the night and it was done by prison staff. There was no policy in place to cover this eventuality and no provision for an agency nurse or other medical staff to be brought in on a one off basis.

Mr Lawson had received medical and mental health care whilst in HMP Stocken. The difficulties faced by the medical and mental health staff arose out of Mr Lawson's limited intellectual ability, and that he was very variable as to whether he would take his prescribed medication, particularly because he felt it was not helping him and had undesirable side effects. It appears likely that he last took his anti-epileptic medication on the Friday before his death on Sunday. His risk of having an epileptic attack and death as a result was increased by his failure to take the medication regularly.

It was clear from the evidence that a number of members of the healthcare and mental health staff had encouraged him to take his medication, and had taken individual steps to persuade him. However despite the awareness of his frequent failure to take his medication there was no plan, no focus on his compliance and what should be done about it, and no cross team approach between the healthcare and mental health teams.

The distance from some of the wings in the prison to the healthcare centre varies but some wings are 5 minutes' walk away and the prisoners have to wait up to an hour. Some prisoners cannot be bothered to wait. There has been some improvement since Mr Lawson's death in that "healthcare hatches" for the dispensing of medication have been established on some but not all wings.

There were shortfalls in the prescription process where repeat prescriptions ended and were not renewed, and prescriptions lapsed and no plan for review was in place to consider whether the medication should be repeated, especially for antipsychotic medication. There was no system in place either to identify when a prescription had lapsed, or to take action following a prisoner's regular non-attendance.

Changes to the systems have been made following Mr Lawson's death. His non-compliance with medication would now be recognised and escalated to a "Three Pathways Meeting" which would consider ways to tackle non-compliance. However the system still relies on staff recognising that a prisoner has not attended, and there was no computer generated system to alert staff to continuous non-attendance. Similarly the system still relies on staff seeing that prescriptions have lapsed, and that a review was appropriate.

Mills & Reeve are solicitors to Nottinghamshire Healthcare NHS Trust. A letter from Mills & Reeve dated 24 November 2014 is attached, which deals with the ability of the computer system to flag up non-attendance and the imminent expiration of prescriptions.

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 welfare check did not ascertain that he had died. He was certainly dead at the time of the check at 7.30am and 8.20am on the 17th March.

2. On some wings there is still some distance to walk to the medical centre and the time to wait mitigates against prisoners bothering to do attend.

3. The current system relies on healthcare staff/pharmacy staff recognising that prisoners have not attended to collect their prescription, without having a computer driven system to flag up non-attendance.

4. The current system relies on healthcare staff/pharmacy staff recognising that prescriptions have lapsed without having a computer driven system to flag it up.

5. There is no specific policy to deal with the situation where a prisoner needs 24 hour observation from medical staff where the prison is not equipped for constant medical supervision.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the NHS England and the Prison Service has the resources and power to:

1. Prepare the necessary policies and guidelines referred to, and ensure that they are complied with, and
2. Consider alterations to the computer system that would flag up regular non-attendance by prisoners and also the imminent expiration of prescriptions.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th March 2015. 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:

[redacted] and her solicitors
Nottinghamshire Healthcare NHS Trust, and their solicitors
Northamptonshire Healthcare NHS Foundation Trust and their solicitors
The Treasury Solicitors on behalf of The Prison Service

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.

9th January 2015 **[SIGNED BY CORONER]**