ANNEX A

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. **Worcestershire Health & Care Trust** 2. 3.
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 6th November 2013 I commenced an investigation into the death of James Paul COLTON then aged 35 years. The investigation concluded at the end of the inquest on 20 January 2015. The conclusion of the inquest was a narrative the medical cause of death being 1a) carcinomatosis, 1b) malignant melanoma .
4	**CIRCUMSTANCES OF THE DEATH** Mr Colton was a serving prisoner at HMP Long Lartin. In June 2013 he complained of back pain and was diagnosed with a mechanical back problem. His health deteriorated until he became critically unwell on the 29th of August 2913, at which time he was taken to the Alexandra Hospital, Redditch, where he died 2 days later.
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 doctors and nurses at the prison failed to properly diagonose, treat and care for Mr Colton in that they assumed that the diagonosis of mechanical back pain was accurate and took no steps to revisit the diagonosis or to escalate his treatment despite his obvious continuing decline. The failure to consider alternate diagnosis led to them missing his developing cancer and which may, therefore, have contributed to his early death. (2) The procedure and processes for providing Mr Colton with adequate anelgeasia were defective and there were occassions when Mr Colton did not receive Tramadol to control his pain. This meant that his last days in prison were distressing and

	increasingly painful for him to the extent that he was at times unable to get off his bed to receive medication. (3) There appeared to be no continuity of care for Mr Colton, little or no adequate communication as between Healthcare nurses and doctors, and no coherent plan for his care. There appeared to be no appropriate review of Mr Colton's care or treatment. (4) The evidence given was that there was an extremley heavy workload which meant (to quote one of the GP's who gave evidence) that he was unable to get on top of the work that was required of him and that reviewing prisoners in Healthcare was not a priority.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action, specifically, to consider the staffing arrangements at HMP Long Lartin Healthcare to ensure that there adequate doctors and nurses available at all times to give proper care for patients, and further, to consider whether it is in any way appropriate for a consultant psychiatrist to be the responsible individual to monitor the standard of work of GP's at the Health Centre.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] 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	**Signed** [redacted] **G U Williams** **H M Senior Coroner** **20th day of March 2015**