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. **Offender Health Directorate Nottinghamshire Healthcare NHS Trust Westminster House The Wells Road Nottingham**
1	**CORONER** I am Miss Stephanie Haskey, Assistant Coroner, for the Coroner area of Nottinghamshire
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** The death of Paul Hardy was subject to an Inquest from 3-12 November 2014
4	**CIRCUMSTANCES OF THE DEATH** Paul Hardy was a serving prisoner at HMP Lowdham Grange, operated by Serco, when he was confirmed by his local hospital as suffering from urological cancer. Whilst this was not, in the end, the immediate cause of his death, there were delays and errors in process whilst he was under the care of Lowdham Grange which caused unnecessary suffering and distress.
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. That there was a clear failure by Healthcare Staff to act upon instruction given by a visiting Advanced Nurse Practitioner to obtain and process blood and urine samples for the investigation of possible urological cancer. 2. There was a failure to act upon a clear recommendation made by the Prison and Probation Ombudsman's Clinical Reviewer for facilitating the effective obtaining of blood samples for INR monitoring. 3. There was a failure to act upon a clear recommendation made by the Clinical Reviewer that there should be a Significant Event Analysis of the events surrounding the death of Paul Hardy.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 4th February 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: SERCO, as operators of HMP Lowdham Grange Nottingham University Hospitals NHS 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	**[DATE]** 4.2.15 **[SIGNED BY CORONER]** **Stephanie Haskey**