REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England P.O.Box 16738, Redditch, B97 9PT** **2. NHS England, North West Preston Business Centre, Watling Street Road, Fulwood, Preston, Lancashire, PR2 8DY1**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Lancashire and Blackburn with Darwen
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** Following his death at HMP Garth on 12th September 2019 an investigation was commenced in respect of Imre Paul Thomas born on 3rd October 1973. The investigation concluded at the end of the inquest on 29th March 2021. The conclusion of the inquest jury was that the deceased died by misadventure of asphyxia due to aspiration as a result of tramadol and multiple drug toxicity.
4	**CIRCUMSTANCES OF THE DEATH** Sometime prior to 2014 the deceased had fractured bones in his hand. At some point the area had become infected and the deceased was suffering increased levels of pain. In August 2017 the deceased attended a GP appointment at HMP Garth. Pain killing medication in the form of dihydrocodeine was prescribed and an appointment with a consultant orthopaedic surgeon was arranged for November of that year. The appointment was cancelled. In between August 2017 and the deceased's death in September 2019 a total of nine orthopaedic appointments were cancelled, three by the hospital, two by the deceased and four by the prison because the prison was unable to arrange an escort. The deceased complained of increasing levels of pain which he claimed was not met by the prescribed dihydrocodeine. The deceased took to acquiring painkilling medication from other prisoners and his death on 12th September 2019 was as a result of an overdose of tramadol and other prescription medication illicitly obtained. HMP Garth and HMP Wymott stand adjacent to each other on a site in Leyland Lancashire. Together they have a population of over two thousand prisoners. Each week between them they send approximately 35 prisoners out for hospital appointments thereby employing a minimum of seventy officers as escorts at a significant cost to the NHS. As was seen in the present inquest, hospital visits are cancelled for a variety of reasons including lack of officer escorts and hospital cancellations. Such cancellations carry with them a risk of harm to prisoner patients and the cumulative effect of cancellations could potentially give rise to serious untreated illness or death. There are several clinic rooms at the healthcare departments of both prisons which could be used for specialist clinics by visiting hospital consultants thereby avoiding cancellations to the benefit of both prisoner patients and hospitals saved from cancelled or late appointments together with cost savings in respect of prison officer escorts.

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. – Cancelled hospital appointments putting vulnerable prisoners at risk. As the commissioning body you are asked to investigate the possibility of organising special prison clinics for visiting hospital consultants.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st June 2021. 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 namely the family of the deceased and the Greater Manchester NHS Trust. I have also sent it to the heads of Healthcare at HMP Garth and HMP Wymott 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	**Dated 4th April 2021** **SIGNED** *Nicholas Rheinberg* **Assistant Coroner**