REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Michael Spurr, Chief Executive, National Offender Management Service, Clive House, 70 Petty France, London SW1H 9EX.** 2. **Mike Parrish, Chief Executive Care UK, Connaught House, 850 The Crescent, Colchester Business Park, Colchester, Essex CO4 9QB** 3. **Tim Allen, Governing Governor of HMP Durham, 19b Old Elvet, Durham, County Durham DH1 3HU** 4. **Martin Barkley, Chief Executive, Tees Esk Wear Valley NHS Foundation Trust, West Park Hospital, Edward Pease Way, Darlington, County Durham**
1	**CORONER** I am Crispin Oliver, Assistant Coroner, for the coroner area of County Durham and Darlington.
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** Following his death I commenced an investigation into the death of Edward John Devlin. The investigation concluded at the end of the inquest on 24th June 2014. The findings were that Mr Devlin was found dead at HMP Durham at 06.25 on 17th July 2011, that his physical condition by 22.45 on 16th July 2011, when prison officers and nurse attended him, warranted a medical examination/assessment and that no such assessment was carried out. He died as a result of the effects of dihydrocodeine. The conclusion of Jury was "misadventure".
4	**CIRCUMSTANCES OF THE DEATH** 1) Edward Devlin was born on 16th May 1955 and was 54 years old when he was remanded in custody to HMP Durham on 26th July 2010. 2) Mr Devlin had a detailed medical history of Chronic Obstructive Pulmonary Disease (COPD). He had a consultant respiratory specialist. He took regular medication to manage his condition: inhalers, Aspirin, Omerprazole and Simvastatin, Carbocistine, Theophltine; also for pain management, a controlled drug MST (Morphine Sulphate) and oramorph. On the 24th July 2010 prior to arrival at HMP Durham, while in police custody, he had attempted self-harm by taking an overdose of MST and was taken to A & E at West Cumberland Hospital in Whitehaven. On reception at HMP Durham an ACCT was opened. This was closed on 27th July 2010. In prison the MST was dispensed to him "Not In Possession" (that is, the tablets were dispensed to him and taken by him under the supervision of nursing staff, whether registered general nurses or mental health nurses with a prescription card being signed to say the patient had been given the medication). During the day, this was at the wing clinic through a dispensing gate or hatch at which the prisoner patient attended. At other times of the day or when prisoners were locked in their cells, this would be in the course of a medication dispensing round conducted by general or mental health nurses accompanied by discipline staff.

3) On 2nd August 2010 Mr Devlin was discovered by a mental health nurse, and discipline staff, to have hidden MST 1 x 30 mgms and 2 x 20 mgms that he had just been dispensed to him and which he had appeared to have taken. This led to an adjudication on 3rd August 2010, at which his defence was that the dispensing of Not in Possession medication during night state in the prison had not been at regular times and had disrupted his sleep.
4) On 17th August 2010 his prescription of pain relief medication was changed from MST to a) dihydrocodeine Modified Release 120mg two tablets every 12 hours and b) dihydrocodeine (normal) 30 mg twice a day. These were dispensed to him "In Possession", that is, without the requirement that he be supervised actually taking the medication: he would have discretion as to when he took it and in what quantity. This prescription, in terms of the amount of dihydrocodeine and type of tablet, was repeated every few weeks up to 14th July 2011 (the last prescription before Mr Devlin's death). Save for when Mr Devlin was a patient in either University of North Durham Hospital, or on the Healthcare Wing of HMP Durham, when it was "Not in Possession", it was always "In Possession". He would be dispensed a week's (7 days) supply at a time. The dispensing nurse and patient each would initial and sign/counter sign the back of the prescription card known as the "Kardex".
5) From the 27th September 2010 until 20th December 2010 Mr Devlin was assigned to cells in F Wing of Durham Prison. On 20th December 2010 he was admitted to University Hospital North Durham. He was discharged on 3rd January 2011. During his stay as a patient in University Hospital North Durham it was reported by hospital nursing staff to HMP Durham that Mr Devlin had been found hiding medication.
6) On reception back into HMP Durham Mr Devlin was admitted into the Healthcare Wing: this contained a medical centre, a pharmacy and some cell accommodation for patients. He was discharged from the Healthcare Win on 12th January 2011 and assigned to cells on F Wing until 24th June 2011. While on F Wing, as mentioned above, he was dispensed his dihydrocodeine "In Possession" under prescriptions which in terms of pain relief medication repeated the terms of that of 17th August 2010, receiving a week's (7 days) supply at a time.
7) On 23rd June 2011 Mr Devlin was sentenced to 12 years in prison. On 24th June 2011 Mr Devlin was admitted again into Healthcare Wing as a patient. The Deputy Health Care Manager gave evidence that judging from the prescription documentation, which showed a signature where medication was dispensed, in theory he would have run out of dihydrocodeine by the time he was admitted to the Healthcare Wing. She also gave evidence that on admission to the Healthcare Wing he would have been searched and any medication in his possession taken from him. Further she gave evidence that while a patient in the Healthcare Wing his medication was prescribed and dispensed to him on a "Not in Possession" basis: he was supervised while taking it. His prescription "In Possession" was stopped on 24th June 2011, and a new prescription for "Not in Possession" provided on 27th June 2011. His last recorded dose of dihydrocodeine was two 120 mg tablet dispensed at night by a nurse on 12th July 2011.
8) On 13th July 2011 at 17.54, Mr Devlin was discharged from the Healthcare Wing to E Wing cell E1-005. He was still being dispensed medication "Not in Possession" as per the prescription for him while on the Healthcare wing of 27th June 2011, pending a new prescription being provided.
9) On 13th July 2011 at 22.37 hours a nurse noted Mr Devlin refused his medication: Simvastatin 40 mgms, dihydrocodeine 120 mgms x 2 and 30 mgsms tablets, Carbocisteine 375 mgms x 2 caps, Uniphyllin continuous 400 mgsms x 1 tab. Mr Devlin stated he did not need them.
10) At 08.31 hours on 14th July 2011 Mr Devlin refused to go to get his medication. AT 09.56 hours a doctor noted that Mr Devlin moved to the wing from Healthcare and providing a new prescription for the drugs to be dispensed "In Possession". It was established that no medication was apparently dispensed under this prescription however before Mr Devlin died, as the prescription card

(Kardex) did not bear the relevant signatures. At 19.03 hours a nurse saw Mr Devlin. Mr Devlin had not attended clinic for his evening medication. The nurse recorded that when she asked him if he was given his medication in his possession would he take them he said no as he would not eat or take his medication until he was moved to HMP Frankland or died in HMP Durham. He denied suicidal ideation but wanted to be "off E Wing".

11) At 06.04 hours on 15th July 2011 a nurse noted that Mr Devlin had refused his night time medication. At 14.41 on 16th July 2011, Mr Devlin was moved to B wing, cell B2-001. At 22.34 hours on 16th July 2011, a nurse recorded that Mr Devlin refused his medication again. At 23.08 Mr Devlin was moved to E Wing cell E1-009. At approximately 06.25 hours on 17th July 2011, Mr Devlin was found dead in that cell.

12) The initial post mortem report concluded that his was a death from natural causes as Mr Devlin had:-

1a Ischaemic Heart Disease
1b Coronary Artery Atheroma
2 Severe Pulmonary Emphysema

13) However, the forensic toxicology report showed an abnormally high level of dihydrocodeine in the blood (14.9 mg/l) enough to be fatal and consistent with a recent large overdose of the drug prior to death. The pathologist changed his cause of death to effects of dihydrocodeine.

14) [redacted] consultant physician, clinical toxicologist and pharmacologist gave evidence during the Inquest to the effect that it was not possible to conclude on a balance of probabilities when, or over what period of time, the dose had been taken, or at what point it became fatal. Further, that it was not possible to conclude which type of tablet, normal or modified release, had been used.

15) What could be said with certainty was that Mr Devlin had been able to obtain and take enough dihydrocodeine tablets to cause his death. This was against a background whereby: he would have been searched on being admitted onto the Healthcare Wing, from F wing, as a patient on 24th June 2011; his prescription of 27th June 2011 was for medication to be dispensed to him "Not in Possession" while on the Healthcare Wing; this was the operative prescription when he was discharged from the Healthcare Wing on 13th July 2011, onto E Wing; that his medication was to be dispensed to him on a "Not in Possession" basis on 13th, 14th, 15th and 16th July 2011, when he refused it; that in the event apparently no drugs had been dispensed under the "In Possession" prescription of 14th July 2011. So it was available to conclude that Mr Devlin had possibly or probably obtained them from other prisoners, rather than by accumulating them out of drugs that had been dispensed to him "In Possession".

16) With this in mind, it is significant that one of the nurses who was responsible for attempting to dispense medication to him from his discharge from the Healthcare Wing onto E Wing on 13th July 2011 until his death on 17th July 2011 stated that it had been his practice in the case of Mr Devlin when previously on F Wing to slide his medication, including dihydrocodeine, under his cell door. He described how he would take it out of its packaging, fold the strips over, and slide it under the door. He said that his happened in the case of other patients too. He said that no thought would be given as to whether the medication end up in the possession of the intended patient. He said that this was a common practice amongst nursing staff. He did not distinguish between general nursing staff and mental health staff.

17) It should be added that when other discipline and health staff and healthcare manager witnesses were questioned as to whether this ever happened they expressly denied that it did.

5	**CORONER'S CONCERNS**

	During the course of the investigation my inquiries 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) It was stated by a nurse that he had, while dispensing medication to Mr Devlin and other patients on F Wing, slid strips of medication including dihydrocodeine under locked cell doors instead of handing it to the patient. (2) He claimed this was his own common practice and was also common practice amongst nursing staff on F Wing. This was in relation to potentially dangerous and/or tradable drugs like dihydrocodeine. (3) If this were the case, no one would know whether a patient is taking the medication intended for him. (4) Further, other healthcare professionals, assuming that medication was being taken by the patient, could base a future diagnosis upon this which would be potentially flawed. (5) Assessing any other patient would become fraught with uncertainty as healthcare professionals could never know for certain what medication had been taken by him. (6) The concomitant concern with 3, 4 and 5 above would be that the system whereby the dispensing of drugs is recorded by signatures of nurse and patient is either being ignored or subject to forgery. (7) Further, no one would know whether somebody else was appropriating that patient's medication. (8) Depending on the type of medication, this may be traded within the establishment raising security concerns. (9) The drugs could be stockpiled with a view to creating a potentially lethal overdose.
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 16th September 2014. 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 I have also sent it to the following Interested Persons [redacted] Berrymans Lace Mawer, Park Row House, 19-20 Park Row, Leeds, LS1 5JF; [redacted] Solicitor, Litigation and Employment Team A1, Treasury Solicitors Department, One Kemble Street, London, WC2B 4TS [redacted] Lester Morrill incorporating Davies Gore Lomax, 27 Park Square West, Leeds, LS1 2PL; [redacted] Legal Officer and Solicitor, Northern Region, Royal College of Nursing, legal Services, Avalon House, St Catherine's Court, Sunderland Enterprise Park, Sunderland SR5 3XH [redacted] Ward Hadaway Lawe Firm, Sandgate House, 102 Quayside, Newcastle Upon Tyne, NE1 3DX. 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.
	Dated..22/7/14.. **Signed by** ..[signature]...