	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Andrew Selous MP, Parliamentary Under-Secretary of State, Minister for Prisons, Probation and Rehabilitation, Ministry of Justice, 102 Petty France, London SW1H 9AJ.** **2. The Rt Hon Norman Lamb MP, Minister for Care and Support (Prison Services), Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS**
1	**CORONER** I am Karen Harrold, Assistant Coroner, for the coroner area of Portsmouth & South East Hampshire.
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 11th July 2012 an investigation into the death of GARRY GILBEY was commenced. The investigation concluded at the end of the inquest on 4th August 2014. The conclusion of the inquest was recorded as a narrative conclusion as follows: *Mr Garry Victor Gilbey was admitted to hospital from HMP Kingston on 25th June 2012 with a productive cough, weight loss and breathlessness. On admission a chest X-ray showed signs of collapse of the upper lobe of the left lung and later tests diagnosed he was suffering from lung cancer. Despite treatment he died at 08.30 on 3rd July 2012. There were a number of missed opportunities in Mr Gilbey's care and treatment in the preceding months but it cannot be said on the balance of probabilities that Mr Gilbey would have survived or his life would have been prolonged if any or all of the opportunities had been taken.*
4	**CIRCUMSTANCES OF THE DEATH** In 2002, Mr Garry Gilbey was imprisoned for serious offences and was first taken to HMP Manchester. At this time, he told healthcare staff that he had a long standing injury to a nerve in his left arm for which he took pain relief medication. He continued to receive prescribed medication in prison and was also referred for physiotherapy. Mr Gilbey transferred to HMP Kingston in July 2010. Healthcare staff noted his existing health problems and also that he smoked between 20-40 cigarettes a day but he tried to give up smoking in February 2011. In December 2011, Mr Gilbey complained of pain in his upper left arm and was initially prescribed additional pain relief medication. He continued to experience arm pain over the following weeks and saw another doctor. He was prescribed a variety of medication in an attempt to manage the pain. By February 2012, Mr Gilbey told a prison doctor that he had a cough and pain in his left shoulder and back. The doctor who examined him was not sure what was causing the symptoms but indicated he would do some research to see if the symptoms were connected and told Mr Gilbey he would be reviewed again once this was complete. By March 2012, the same doctor spoke to a hospital neurologist and he concluded the most likely cause of the arm pain was carpal tunnel syndrome. However, to rule out the possibility of a rare form of lung cancer he decided Mr Gilbey should have a chest X-ray. However this was never arranged and no one in the prison health care department

	identified that the required chest X-ray had not been performed. On 20 March, Mr Gilbey's shoulder was X-rayed, after a referral by the Modern Matron who as a nurse practitioner wanted a further test to explore whether a bony injury could be causing the ongoing back and shoulder pains. This referral was unrelated to the doctor's intention that Mr Gilbey should have a chest X-ray and therefore purely coincidental. The hospital consultant radiologist who reviewed the shoulder X-ray concluded that it was normal. However, he missed the fact that the plain X-ray did in fact show some changes in the left lung apex which were indicative of upper lobe collapse. In early June, Mr Gilbey reported chest pains and breathlessness, which he said he had been experiencing for several months. His heart was checked and was normal. Mr Gilbey was diagnosed with acid reflux and prescribed medication by the Modern Matron. On 18 June, a prison doctor who examined him considered that his symptoms were highly suggestive of lung cancer. Mr Gilbey was referred to the hospital for further tests and an X-ray appointment was booked for 25 June. Until then, Mr Gilbey was seen most days by health care staff because of his cough and breathlessness. On 22 June he was seen by a nurse consultant during the day short of breath and struggling to get out of bed. Nebuliser treatment was prescribed which eased the symptoms and staff were told to have a low threshold for a medical review if the symptoms should reoccur or worsen. He was seen on 23 June during the day by a nurse due to shortness of breath and an out of hours doctor was called who diagnosed a chest infection and prescribed antibiotics. He attended the clinic on 24 June and requested nebuliser treatment but this was refused. Later the same morning a different nurse attended Mr Gilbey's cell due to coughing and breathlessness and he was nebulised. Details of the nebulising treatment given over the days immediately before admission to hospital were not recorded in the wing log book to alert prison officers to prisoner medical issues. Overnight 24/25th June, two officers attended Mr Gilbey's cell as he was requesting an ambulance because of breathing difficulties. One officer was first aid trained. They did not enter his cell and because he could talk they decided it was not a medical emergency. Finally on the morning of admission to hospital on 25 June Mr Gilbey was given more nebuliser treatment by prison staff. Mr Gilbey had a chest X-ray at hospital later the same day and was admitted as an inpatient that day due to suspected lung cancer. On 27 June, he was told that he had inoperable lung cancer and that he might live for up to 12 months if he received chemotherapy and radiotherapy and two months if he did not. However, Mr Gilbey's health deteriorated much more quickly than anticipated and he died the following week at 8.30am on 3 July.
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 Prison did not have a set policy about when an ambulance should be called. This was left to the judgment of the prison officer(s) making an assessment of the prisoner from outside the cell and whether what they observed amounted to a medical emergency. In addition, it was not clear what amounted to a medical emergency and that the threshold was high. This raises genuine concern in relation to those prisons who do not have 24/7 medically trained staff available to make emergency assessments of prisoners during the night.

	2. In turn this raises concern about the adequacy of training and clarity of what amounts to a medical emergency for those night time prison staff involved in having to make dynamic risk assessment especially for those prisoners who are at higher risk of a chronic condition developing into an acute episode e.g. during the referral period to a hospital especially when a very serious underlying condition is suspected such as lung cancer that has the capacity to affect breathing suddenly even though a prisoner may initially appear to be able to speak. 3. There was no clear or consistent system to flag key healthcare events during the day and there seemed to be a variable practice/policy in place that not all healthcare staff seemed to be familiar with or followed so that less relevant information was recorded such as an additional pillow being supplied yet important information such as nebuliser treatment or having a low threshold for medical review if symptoms reoccur or worsen was not consistently recorded in a way that would enable daytime medical staff to flag prisoner healthcare concerns to night-time prison staff. 4. There were also worrying aspects to prison health care systems including checking that all necessary specialist investigations are fully recorded and carried out as well as results properly checked when they return.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Ministers responsible for prisons and healthcare provision in prison have the power to take such action. Although, HMP Kingston closed on 28 March 2013, I heard evidence to suggest that there are other prisons across the country where healthcare staff are not present on prison premises on a 24/7 basis resulting in prison officers having to carry out dynamic risk assessments at night and similar issues could well arise as in this case.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 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: 1. [redacted] Garry Gilbey's son; 2. [redacted] Hodge Jones & Allen LLP, solicitor for [redacted] 3. [redacted] for the Treasury Solicitor's Department on behalf of HM Prison Service; 4. [redacted] Beachcroft LLP on behalf of Solent NHS Trust; 5. [redacted] Goodrich on behalf of the Practice & [redacted] 6. [redacted] on behalf of [redacted] 7. [redacted] I have also sent it to Ursula Ward, Chief Executive of Portsmouth 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: 10th December 2014 SIGNED:** Karen Harrold