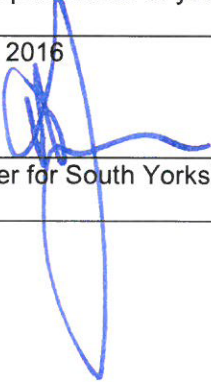




**Nicola Jane Mundy**  
**Senior Coroner for South Yorkshire (East District)**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b> [REDACTED] <b>Governor</b> HMP Lindholme, Bawtry Road, Hatfield Woodhouse Doncaster DN7 6EE</p>
1	<p><b>CORONER</b></p> <p>I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 30 September 2015 I commenced an investigation into the death of Anthony Benjamin Patrick Fraser, 62 . The investigation concluded at the end of the inquest on 8 June 2016. The conclusion of the inquest was Natural causes. The cause of death was 1a. Relapsed Multiple Myeloma 2. Paraplegia, Diabetes, Epilepsy.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Fraser was diagnosed as suffering from multiple myeloma in 2012 whilst an inmate at HMP Lindholme. He received treatment in hospitals in South Yorkshire for this terminal cancer and was kept under regular review of the haematologist from then until the time of his death on the 24<sup>th</sup> September 2015. In August 2015 his mobility became significantly compromised leading to referral to the hospital where investigations revealed that the disease process had significantly progressed and after investigations and MDDT discussions a decision was made that he was for palliative care only and he passed away in the Doncaster Royal Infirmary on the 24<sup>th</sup> September.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>I heard evidence that the medical records on the electronic System One contain a summary overview of a person's medical status which should be sent to A&amp;E Departments where patients have been referred. This information is readily accessible but in Mr Fraser's case when he was referred to A&amp;E on 15<sup>th</sup> August 2015, this information was not conveyed by them to the receiving hospital. I also heard in evidence that there is no system for ensuring that such information is sent and therefore is "hit and miss" as to whether or not it is sent. Whilst I concluded that in Mr Fraser's case this did not affect the ultimate outcome due to him re-attending four days later and given the very aggressive nature of the cancer from which he was suffering, it is clear that for other inmates with different conditions, failure to provide such information may well delay diagnosis or make it extremely difficult to reach diagnosis. Accordingly consideration needs to be given to implementing a system where such information is conveyed for every such inmate in a timely fashion.</p>

	<p>Summary of concerns:-</p> <p>1. Absence of a robust system for conveying summary medical information to receiving A&amp;E departments when inmates are transferred with an acute illness. .</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you [REDACTED] Governor, have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 3 August 2016. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] Mills &amp; Reeve, (Notts Healthcare Trust), [REDACTED] Government Legal Department (MOJ, Lindholme Prison).</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 8 June 2016</p> <p>Signature </p> <p>Senior Coroner for South Yorkshire (East District)</p>