SPECIMEN: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Governor, HMP Hewell, Hewell Lane, Redditch, Worcs B97 6QS.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
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 18th April 2018 I commenced an investigation into the death of Gareth Wycliffe WARBURTON, then aged 58. The investigation concluded at the end of the inquest on 3rd December 2019. The jury returned a narrative conclusion, with the medical cause of death being: 1a Bronchiolitis Obliterans Syndrome; 1b Interstitial lung disease (transplant).
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr. Warburton had undergone a double lung transplant in 2005, and at the time of his arrival at HMP Hewell on 1.4.17 was in good health, although taking a number of different medications to ensure that his body did not reject the transplanted lungs; (2) Due to a prescription error by a member of the prison healthcare team, Mr. Warburton was incorrectly prescribed half his usual dose of an important anti-rejection medication for the period 1.7.17 – 25.8.17. This error probably led to the chronic rejection of his transplanted lungs, resulting in his death on 1.4.18; (3) In addition, the jury found that: (i) A failure in the system in place for writing and screening those prescriptions which were sent out to an external pharmacy probably contributed to Mr. Warburton's death; (ii) Inadequacies in staffing, role allocation and time management within the prison healthcare team in mid-2017 possibly contributed to Mr. Warburton's death; and (iii) Had opportunities to pick up on the prescription error on 14.7.17 and 27.7.17 been taken, it was "highly possible" that the chronic rejection of the transplanted lungs would not have occurred.
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) Letters dated 16.10.17 and 27.11.17 from [redacted] Mr. Warburton's treating clinician at the Queen Elizabeth Hospital, Birmingham to then Governor of HMP Hewell Gareth Sands, highlighting concern about the prescription error, asking for more information about the error, and seeking assurances that Mr. Warburton would continue to receive all required medication, were neither acknowledged nor answered by the Governor; (2) Furthermore, although such letters ought to have been passed on to the prison

	healthcare team, the evidence suggested that this was not done. Investigations carried out by current Governor Anthony Morrow failed to establish what had happened to these letters; (3) As to the suggestion that perhaps these letters were never received by the prison, it was apparent that the same letters had been sent to, and received by, members of Mr. Warburton's family; (4) Accordingly, I am satisfied that it is probable that these letters did reach the prison, but were not dealt with satisfactorily; (5) I am concerned that, as long as there is a risk that letters which seek or contain important information about a prisoner's health and welfare are not dealt with and go unanswered, there remains a risk to prisoners' lives at HMP Hewell.
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 28th January 2020. I, the coroner, may extend that period if requested. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such 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: Leigh Day – solicitors for Mr. Warburton's family; Hill Dickinson – solicitors for Care UK (providers of healthcare at HMP Hewell); Capsticks – solicitors for the University Hospitals Birmingham NHS Foundation Trust. I have also sent it to the Prison and Probation Ombudsman, 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]** 4th December 2019 **[SIGNED BY CORONER]**