	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **G4S** **Medical Services** **Great Bardfield** **Essex** **CM7 4SL** 2. **Spectrum Community Health CIC** **One Navigation Walk** **Hebble Wharf** **Wakefield** **WF1 5RH** 3. **Premier Physical Healthcare** **At The Bus Works** **39-41 North Road** **London** **N7 9DP**
1	**CORONER** I am Andrew Tweddle Senior 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** On 11.11.2014 I commenced an investigation into the death of James Bewick Graham 67 years. The investigation concluded at the end of the inquest on 17th December 2015. The conclusion of the inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Graham was known by prison healthcare providers to have peripheral vascular disease from at least May 2011. He had been treated correctly for peripheral vascular disease associated risk factors after a visit to a consultant in 2012. From 2012 until the date of his admission to University Hospital of North Durham on 20th October 2014 Mr Graham was seen by a number of healthcare professionals on a number of occasions complaining of problems with his left foot. None of the doctors treating him concluded his presenting problems to be a worsening of his peripheral vascular disease which would lead to a referral to secondary care until 17th October 2014. There is evidence which would have justified an earlier referral to secondary care. At the time of his admission to hospital on 29th October 2014 no referral letter had been dispatched to secondary care providers even though Mr Graham's foot had been considered to have deteriorated dramatically. An earlier referral to secondary care would have led to an expert consideration of his symptoms and condition and may have afforded Mr Graham being offered medical treatment. It cannot be determined on a balance ol probabilities when such a referral would have had to have been made to give rise to the possibility of saving his leg (which was amputated on 30th of October 2014) or his life. The earlier the referral the greater the chance of a successful outcome for Mr Graham. A doctor who examined Mr Graham the day before his emergency admissions to University Hospital of North Durham did not consider an early admission to hospital to be appropriate. Mr Graham's medical condition was so compromised that his post operative prognosis was

	poor and he died in University Hospital of North Durham on 2nd of November 2014.
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) It is clear that on 16th October 2014 the deceased was seen by a general practitioner and a podiatrist at more or less the same time. The GP did not fully examine the deceased because he knew he was to see a podiatrist. The podiatrist discovered serious problems with the deceased's foot and planned an urgent referral to the GP and did so by means of an electronic note which was seen by the GP who had seen the deceased immediately prior to the podiatrist, the day after, who then referred the matter to another GP to make a letter of referral and then because of administrative failures not referral to secondary care was made before the deceased died on 2nd November 2014. This shows a total lack of communication between the GP and the podiatrist who should have considered it appropriate to speak to one another whilst the deceased was still present in order to move matters forward effectively. (2)The GP who had most contact with the deceased in a 2 year period considered making a referral to secondary care on 17th October 2014 and instead of making the referral himself, passed the responsibility to make a referral to another GP (who worked one day per week) and who had previously sent a one page letter of referral to secondary care more than 2 years earlier. The GP gave evidence that he thought it appropriate for the original GP to make the referral as that GP had done the first one and was acquainted with the matter. The second GP gave evidence to say that she did not agree with this action because although, in principle, if there had been a recent referral it might have been appropriate for the original referring GP to make a second referral however after 2 years it was "stretching it a bit". There was a lack of ownership and responsibility for the deceased's care and making a referral to secondary care. There needs to be consideration given to the formulation of clear guidance as to which GP and in what circumstances has a responsibility for referrals to secondary care. (3) The GP who agreed to make a referral to secondary care gave evidence that she hand wrote out a letter of referral and handed it to a member of the administrative team for typing and gave verbal instructions that this needed to be dealt with quickly and that if there were any problems she was to be contacted. For an unknown reason the letter of referral was not dispatched. Some consideration has been given to this issue following publication of the PPO report but in the light of the evidence given in court the thoroughness and robustness of that letter of direction, particularly bearing in mind there have been a number of changes to the providers of healthcare in the prison, should be considered.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 [DATE]. 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; Governor HMP Frankland Brasside Durham DH1 5YD [redacted] c/o HMP Frankland [redacted] c/o HMP Frankland 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]** 17.11.15 **[SIGNED BY CORONER]**