Her Majesty's Coroner
Staffordshire (South) Coroner's Jurisdiction

Date: 1.10.2021

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:
Rt Hon Sajid Javid MP
Secretary of State for Health and Social Care
39 Victoria Street
London SW1H 0EU

CORONER
I am Mr Andrew A Haigh HM Senior Coroner for Staffordshire (South)

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST
On 6 August 2019 I commenced an investigation into the death of Stephen Thomas BARTON . The investigation concluded at the end of the inquest. The conclusion of the inquest was 'Natural causes following a lack of proper primary health care intervention and insufficient access to secondary health care' with the cause of Stephen's death being 1a Sepsis 1b Chronic otitis media with cholesteatoma in the right ear'.

CIRCUMSTANCES OF THE DEATH:
Stephen was a serving prisoner found dead in his cell at HMP Dovegate on 27 July 2019. Death resulting from an ear condition.

CORONER'S CONCERNS
During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows:

Stephen missed numerous out-patient appointments. I heard expert evidence from a

hospital consultant indicating that in the great majority of cases there is no way of tracking out-patient appointments in the NHS. This is however done in cancer cases. The consultant felt it should not be too difficult to develop a system of tracking out-patient appointments in non-cancer cases. If realistically this could be introduced it might well save a lot of administrative time and indeed prevent unnecessary deaths.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 26.11.2021 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

Solicitors for: Stephen's family; Serco; Practice Plus; Derby and Burton NHS Trust; Prisons and Probation Ombudsman

I have also sent it to other interested persons who may find it useful or of interest:

Independent Monitoring Board at HMP Dovegate

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 : 1 October 2021

Signature

Andrew A Haigh

Andrew Haigh Senior Coroner for Staffordshire South

1 Staffordshire Place, Stafford, ST16 2LP
Telephone: 01785 276126 or 276127 Email: sscor@staffordshire.gov.uk