ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dorset HealthCare University NHS Foundation Trust** **2. HMP Exeter** **3.**
1	**CORONER** I am Dr Elizabeth Earland, Senior Coroner for the coroner area of Exeter and Greater Devon.
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 29th November 2012 I commenced an investigation into the death of Carl David Roy SMITH, aged 35. The investigation concluded at the end of the jury inquest on 21st – 22nd July 2015. The conclusion of the inquest was **Drug Related Death**. **Mr Smith suffered with drug dependency and died of Methadone Toxicity whilst on a Methadone Stabilisation Programme within HMP Exeter. He was found collapsed and not breathing at 7.15am on 22nd November in Cell C1-01. He died sometime during the night of 21st - 22nd November 2012. Resuscitation stopped at 8.05hrs on the 22nd November 2012.** **Mr Smith had taken illicitly obtained Methadone prior to his death.** **The quality of custodial and welfare checks were insufficient for a prisoner on an ACCT and Methadone Stabilisation Programme.**
4	**CIRCUMSTANCES OF THE DEATH** PMH from GP - Asthma, heroin dependency first noted in 2004, O/D in 2010 (unsure of what). He was last seen by a GP on 10/10/12 with anxiety and depression, denied currently taking drugs and was not on any prescribed meds. He was keen to be given some diazepam but this was declined. His Mother states that he had a long history of drug abuse including heroin, speed, Valium and cannabis. His Mother believes that he had not taken any illegal drugs in the 2 weeks prior to going to HMP Exeter. She states that he has suffered from fits in the past which she thinks is due to detoxing from drugs. Mother's last contact with her son was a letter which she received on approx 19/11/12 in which he stated that he was planning to propose to his Girlfriend. The deceased was at HMP Exeter on remand having arrived there approx 1 week ago. He was due for a court appearance on 22/11. He was at risk of self-harm so was on 30-60 mins obs an in a cell fitted with a camera.

	On the evening of 21/11/12 he was given medication for seizures and detox. On 22/11/12 at 0715 hrs Prison Officer called to him through the cell hatch but got no response so she entered the cell with another prison officer to find him unconscious with no signs of life. CPR was commenced whilst paramedics were called who found that his airway was blocked by vomit, resus attempted but unsuccessful and his death was confirmed at 0805 hrs. Forensic PM with toxicology authd . Post mortem examination carried out during which histological and toxicological samples were retained. An inquest was opened with evidence of identification and adjourned on 27/11/12.
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 **MATTER OF CONCERN** is as follows. – The quality of custodial and welfare checks were insufficient for a prisoner on an ACCT and Methadone Stabilisation Programme and information sharing in relation to the checks made, appeared to be deficient.
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 the action the following - **To Dorset HealthCare and HMP Exeter** 1. To review the systems for information sharing re: those on drug treatment stabilisation programmes for substance misuse IDTS with Prison Officers so that all Prison Officers are aware of prisoners concerned. 2. To review training of Prison Officers as to when they ought to involve HealthCare when prisoners behaviour could be construed as erratic/odd, need assessment by HealthCare BEFORE deleterious consequences occur. **To HMP Exeter** 3. To review training and audit the operation of the ACCT document system so that it is made as robust as possible. 4. To ensure that there is a clear directive on the operation and retention of all CCTV footage which is not just a "live camera" – the Coroner received information that the footage outside the cell had been seen but was not available to the Police when called to investigate.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th September 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] – Deceased's mother 2. Treasury Solicitors Department 3. Prisons and Probation Ombudsman 4. Hugh James Solicitors 5. Devon Partnership Trust 6. [redacted] – Root Cause Analysis Lead Facilitator for Devon partnership Trust 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	**24th July 2015** [redacted]