REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Head of Pharmaceutical Chemistry, Drug Misuse and Novel Psychoactive Substance Unit, University of Hertfordshire, Hatfield, Hertfordshire
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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** Nature Barr (also known as Howard Jeffers) died, aged 43, on 23 February 2016 from unascertained causes. At the time of his death he was detained under the Mental Health Act 1983. The inquest into his death concluded on 5 May 2017; I recorded a narrative conclusion, which is attached.
4	**CIRCUMSTANCES OF THE DEATH** Mr Barr had a longstanding history of mental health problems and polysubstance misuse, including what were then 'legal highs'. At the time of the inquest such substances had been reclassified by the Psychoactive Substances Act 2016 as being illegal. The term 'Novel Psychoactive Substances' (NPS) was used during the inquest. Mr Barr's final period of detention occurred over February 2016. During this admission concerns were raised that he had obtained substances from patients who had been allowed leave off the ward. On 16 February he was found lying in a shower room in an apparently sedated state. He rapidly improved from this condition after a period of monitoring. Mr Barr was later granted escorted leave, which initially proceeded without incident. However, on 22 February he absconded from his escort and was returned to the ward by police. A urine drug screen was negative but his behaviour was described as more 'bizarre' after his return. I heard evidence that NPS cannot be detected through available urine screening. On 23 February his leave was cancelled and he remained unsettled. He was seen to be well at 5pm but was found collapsed and in cardiac arrest at 5.36pm. Resuscitation attempts were began and continued by ambulance services. However, he was pronounced deceased at 6.46pm.

	A police investigation was undertaken into Mr Barr's death. On searching the ward a substance labelled as 'Kronic' was found, . It was also noted that another patient had collapsed the same day and was taken to A&E for treatment. A post-mortem examination was undertaken on Mr Barr but did not demonstrate a cause of death. Toxicological analysis was also performed, both of the substance found by police and of post mortem samples. The substance was not found to be present in Mr Barr's samples, nor were other related compounds. However, I heard evidence that the nature of NPS is such that analysis of these compounds is difficult owing to frequent changes in their components and structure. The concern remained that Mr Barr may have used NPS during his admission to hospital, which may have caused or contributed to his death. However, this could not be substantiated by the available evidence.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern, as described above. In my opinion there is a risk that future deaths may occur unless NPS can be more accurately analysed and detected by toxicological testing. I appreciate that this concern is widely held and that research is being undertaken in order to address this lacuna. In particular, I heard that positive steps have been taken by the NHS Trust involved in Mr Barr's care to form a partnership with the University of Hertfordshire, in order to facilitate research into this area. At the inquest into Mr Barr's death there was no specific evidence adduced which reassured me that steps are being taken to address the risk described above. However, I believe that the Drug Misuse and Novel Psychoactive Substance Unit at the University of Hertfordshire may be able to provide such evidence. This is the reason I judged that my statutory duty to write this report was engaged.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee, has the power to take or may be actively undertaking 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 10 July 2017. 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, Mr Barr's family, Camden and Islington NHS Foundation Trust, Alere Forensics and Imperial College Toxicology Unit. 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	**15 May 2017**  **Assistant Coroner R Brittain**