	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **HMP Durham**
1	**CORONER** I am Jeremy Chipperfield, senior coroner for the coroner area of Country 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.
3	**INVESTIGATION and INQUEST** On the 6th of July 2018 I commenced an investigation, and on the 13th of February 2018 I heard the inquest concerning the death of Matthew David Hamilton. He died as a result of 1(a) toxicity of morphine and his metabolites, and I concluded that his was a drug related death.
4	**CIRCUMSTANCES OF THE DEATH** Whilst in custody at HMP Durham, Matthew Hamilton, a known heroin user, arranged to procure drugs from the wife of a fellow prisoner immediately upon his release. He made that acquisition on the evening of the day of his release; on the following morning he was taken to the emergency department of Darlington Memorial Hospital, suffering from the toxic effects of morphine, and later he died of the same. The deceased had not been provided with the release pack created by the Drug and Alcohol Recovery Team (DART), which includes information on tolerance reduction and the risks of overdose following post-release drugs taking; that document is not provided to known drugs users upon their release unless they have elected to engage with DART services whilst in custody- the deceased had not so engaged. He was not otherwise advised as to the effects of abstinence induced tolerance reduction.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you The **MATTERS OF CONCERN** are as follows. On being released from custody, some users of heroin (and/or other drugs) are unaware of:

	(i) the fact or extent to which abstinence during imprisonment is likely to have reduced their tolerance to heroin (and/or other substances): and/or (ii) that consumption of those substances, at levels which may have been normal for them prior to their period in custody, may prove immediately fatal afterwards.
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 Monday 12th April 2019. 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: - Family of deceased 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	**14 February 2019** JS Chipperfield **JEREMY CHIPPERFIELD**