	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Birmingham Community Healthcare NHS Foundation Trust** **2. Birmingham and Solihull Mental Health NHS Foundation Trust**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
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 06/04/2018 I commenced an investigation into the death of Neil Antony Black. The investigation concluded at the end of an inquest on 18th January 2019. The conclusion of the inquest was: Drug related; illicit drug use. Inconsistent and infrequent physical observations; inadequate interaction between prison healthcare teams resulting in a delay in receiving appropriate treatment and a lack of a clear policy for observations undertaken on prisoners going through the detoxification process contributed to Mr Black's death.
4	**CIRCUMSTANCES OF THE DEATH** Neil Antony Black was remanded into HMP Birmingham on 8th March 2018. On arrival to prison he was assessed by prison and nursing staff where he disclosed extensive alcohol and IV drug use. He was remotely prescribed detoxification treatment, which included several medications and a schedule of twice daily observations for five days to support and monitor his withdrawal from IV drug use. Neil disclosed that he was suffering with a DVT in his right leg. This was not examined by nursing or medical staff. He was also observed to be limping at this point. Neil's observations were irregular and inconsistent, sometimes not completed at all due to the prison being in 'night state' and equipment was not always readily accessible. Despite Neil disclosing his DVT on his arrival, his GP consultation on 9th March did not result in an examination of his leg. Neil was seen on the morning of 10th March looking unwell by IDTS nurses. He did not want his blood pressure taken and no other physical observations were recorded. There is no record of Neil being seen again by nursing staff or medical staff that day despite presenting as unwell. He was also seen by prison staff limping and was not eating meals. He was observed sleeping in his cell at 00.25 on 11th March but no physical observations were taken. Neil was next seen at 10.28 on 11 March, appearing to now be very unwell, dehydrated and was struggling to stand and support himself. The IDTS nurse referred her concerns to the primary care nurses as recorded in system 1 notes. They advised her to continue to push fluids but did not go to examine Neil themselves. The IDTS nurse returned to see Neil in his cell where she completed the expected observations. He was seen again later by another IDTS nurse and continued to appear visibly very unwell. His heart rate was very high; he was hot, sweaty and said how unwell he felt, the nurse recorded concerns for a potential pulmonary embolism. The IDTS nurse referred her concerns to senior primary care nurses in person rather than through hotel 2 emergency call. The primary care nurses failed to go to examine Neil and relayed incorrect medical information to the IDTS nurse requesting support. Neil was not seen at all overnight and his first observations on 12 March showed a significant deterioration in his physical condition. Oxygen saturation levels were taken for the first time at this point and were extremely low. A hotel 2 call was made requesting urgent assistance. This led to an ambulance be in called upon GP's advice. The primary care nurses who responded to the hotel 2 call suspected sepsis immediately. He was admitted via ambulance to City Hospital. Appropriate sepsis treatment started as per hospital policy and initially Neil responded well to this treatment. Extensive testing and screening took place revealing a diagnosis of infective endocarditis and lung abscesses. He started to rapidly deteriorate and was admitted to ITU where he was later mechanically ventilated for respiratory failure. Further deterioration led to multi-organ failure and Neil passed away on 31st March at 12.51.

	Following a post mortem the medical cause of death was determined to be: 1a MULTI-ORGAN FAILURE 1b SEPTIC SHOCK DUE TO STREPTOCOCCAL SEPTICAEMIA, LUNG ABSCESSES, EMPYEMA AND ENDOCARDITIS. 1c INFECTED DEEP VEIN THROMBOSIS, PULMONARY EMBOLUS 1d INTRAVENOUS DRUG USE
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. B wing is the drug detoxification wing at Birmingham prison. Prisoners undergoing drug detoxification see IDTS nurses for drug needs and primary care nurses for health care needs. Prisoners on B wing often have complex mixed needs. The evidence at the inquest confirmed there were no joint handovers despite the nurses being located very close to each other. Consideration needs to be given to joint handovers to ensure those prisoners with joint needs have a coordinated approach. 2. Evidence at the inquest confirmed that there was some animosity between IDTS and primary care nurses. IN addition witnesses were unclear who should undertake what observations on prisoners and for what reason. Consideration needs to be given to improving the relationship and making it clearer who is responsible for what observations. 3. Neil Black came into prison with a DVT in his right leg which was caused by IV drug use injecting into his groins. His groins sites and leg were not examined during his time at the prison. Consideration needs to be given to ensure there is a clear protocol for the examination of injection sites and DVT sites.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 March 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 The family G4S I have also sent it to NHS England, CQC and the Minister for Prisons who may find it useful or of interest. 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	21/01/2019 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**