REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Practice Plus Group, Hawker House, Napier Court, 5-6 Napier Road, Reading, Berkshire RG1 8BW
1	**CORONER** Tanyka Rawden, Assistant Coroner for South Yorkshire (West)
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** On 3 May 2020 an investigation commenced into the death of Jamie Lee Bennett, aged 33 years. The investigation concluded with an inquest heard between 25 April 2022 and 29 April 2022. The Coroner returned a narrative conclusion

4	**CIRCUMSTANCES OF THE DEATH** Jamie Lee Bennett ("Jamie") was born on 10 July 1986 in Sheffield Jamie had a history of heroin and cocaine use dating back to approximately 2016. He had successfully completed a detoxification programme while serving a custodial sentence between 2017 to 2019, but had relapsed on release On 3 September 2019 he was remanded to HMP Doncaster, testing positive for various substances. On 20 September 2019 he was transferred to HMP Moorlands where he remained until he was executively released on 1 May 2020. During his time at HMP Moorlands he refrained from using illicit substances and was not prescribed methadone On 1 May 2020 he was released from HMP Moorlands to be accommodated at Norfolk Park Bail Hostel in Sheffield On 2 May 2020 at 1.35pm Jamie was found unresponsive in his room at Norfolk Park Bail Hostel. He was pronounced deceased by paramedics The medical cause of death at post mortem examination was: 1a. Heroin and cocaine use The narrative conclusion given was as follows: On 1 May 2020 Jamie Lee Bennett was executively released from HMP Moorland. He had been abstinent from drugs and methadone therapy for a period of approximately eight months. As such he was at an increased risk of overdose due to a reduced tolerance There was a failure to formally consider re-toxification with Methadone during his release planning. It cannot be said that this caused or contributed to his death There was a failure to follow the Local Operating Policy for Take Home Naloxone. Jamie Lee Bennett declined Naloxone and signed confirmation of this refusal was not obtained in line with the policy. It cannot be said that this caused or contributed to his death Jamie Lee Bennett was released to Norfolk Park Bail Hostel on Norfolk Road in Sheffield where he was inducted Due to the Exceptional Delivery Model in place in light of the Covid-19 pandemic, Jamie Lee Bennett was not offered a face-to-face appointment with his probation officer on the day of his release, room searches and drug testing were not being conducted at Norfolk Park Bail Hostel and there was no access to a substance misuse team on site This reduced support along with the failure to provide Norfolk Park Bail Hostel with information on release about Jamie Lee Bennett's previous substance misuse, his detoxication history, and that he had refused Naloxone, in addition to the failure to provide the community substance misuse team with his release date resulted in Norfolk Park Bail Hostel not having the opportunity to provide additional support

	Had that additional support been put in place in the days immediately after his release it may have reduced the risk of him using substances and dying as a result Jamie Lee Bennett was last seen on CCTV returning to his room at 1.01am on 2 May 2020 There was a failure to conduct the 7am welfare and curfew check in accordance with procedure in that Jamie was not roused, and it was not confirmed he was breathing. This failure was caused by a lack of training and understanding by staff as to what was expected of them during this check There was a failure to conduct the 12pm welfare check in accordance with procedure in that the check was not carried out until 1.35pm after concerns were raised for his welfare by his family and another resident. That failure was caused by a lack of training and understanding by staff as to what was expected of them with regard to the timing of this check At 1.35pm Jamie Lee Bennett was found unresponsive in bed. There was a delay in calling the emergency services which was caused by the lack of first aid training and staff not being in possession of radio equipment It cannot be said what time Jamie Lee Bennett died as such, it cannot be said the failings in those checks and the delay in calling the emergency services caused or contributed to his death Jamie Lee Bennett was pronounced deceased by paramedics on 2 May 2020 after ingesting cocaine, and an amount of heroin lower than usually encountered in deaths attributed to heroin overdose
5	**CORONER'S CONCERN** During the course of the investigation my inquiries 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. – There were gaps in the information provided by HMP Moorlands to Norfolk Park Bail Hostel, in particular his history of substance misuse and that Jamie had refused Naloxone. The Court heard evidence that information sharing with third parties is in line with national guidelines, but also that there should have been another report by the offender management services that would have been more detailed and would have given this information to Norfolk Park. I do feel that if Norfolk Park Bail Hostel had that information, they would have been in a better position to support Jamie during those first crucial 48 hours and that may have reduced the risk of him using substances and dying It is my view there should be a process by which crucial information about a patient is communicated to the Approved Premise, specifically substance misuse history, any substance misuse work, any detox or re-toxification processes undertaken, and whether the patient has accepted or refused Naloxone and any community drugs services referral. It is my view this will assist the Approved Premise to

	determine the level of support to be offered to a resident, especially those that are released on a Friday and will have limited support from anywhere other than an Approved Premise during the first 48 hours It is my opinion there is a risk that future deaths may occur unless such a process is developed
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 24 June 2020. I may extend this period upon your application and I may vary the recipient of this report on your application that another agency is better placed to address the changes 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: • [redacted] (father of deceased) via his representative at Simpson Millar, Yorkshire House, Greek St, Leeds, LS1 5SH • Care Quality Commission at Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA 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

Mrs Tanyka Rawden
HM Assistant Coroner
29 April 2022

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Ministry of Justice, Justice and Development Division, Litigation Group, Government Legal Department , 102 Petty France, Westminster, London SW1H 9GL
1	**CORONER** Tanyka Rawden, Assistant Coroner for South Yorkshire (West)
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** On 3 May 2020 an investigation commenced into the death of Jamie Lee Bennett, aged 33 years. The investigation concluded with an inquest heard between 25 April 2022 and 29 April 2022. The Coroner returned a narrative conclusion

4	**CIRCUMSTANCES OF THE DEATH** Jamie Lee Bennett ("Jamie") was born on 10 July 1986 in Sheffield Jamie had a history of heroin and cocaine use dating back to approximately 2016. He had successfully completed a detoxification programme while serving a custodial sentence between 2017 to 2019, but had relapsed on release On 3 September 2019 he was remanded to HMP Doncaster, testing positive for various substances. On 20 September 2019 he was transferred to HMP Moorlands where he remained until he was executively released on 1 May 2020. During his time at HMP Moorlands he refrained from using illicit substances and was not prescribed methadone On 1 May 2020 he was released from HMP Moorlands to be accommodated at Norfolk Park Bail Hostel in Sheffield On 2 May 2020 at 1.35pm Jamie was found unresponsive in his room at Norfolk Park Bail Hostel. He was pronounced deceased by paramedics The medical cause of death at post mortem examination was: 1a. Heroin and cocaine use The narrative conclusion given was as follows: On 1 May 2020 Jamie Lee Bennett was executively released from HMP Moorland. He had been abstinent from drugs and methadone therapy for a period of approximately eight months. As such he was at an increased risk of overdose due to a reduced tolerance There was a failure to formally consider re-toxification with Methadone during his release planning. It cannot be said that this caused or contributed to his death There was a failure to follow the Local Operating Policy for Take Home Naloxone. Jamie Lee Bennett declined Naloxone and signed confirmation of this refusal was not obtained in line with the policy. It cannot be said that this caused or contributed to his death Jamie Lee Bennett was released to Norfolk Park Bail Hostel on Norfolk Road in Sheffield where he was inducted Due to the Exceptional Delivery Model in place in light of the Covid-19 pandemic, Jamie Lee Bennett was not offered a face-to-face appointment with his probation officer on the day of his release, room searches and drug testing were not being conducted at Norfolk Park Bail Hostel and there was no access to a substance misuse team on site This reduced support along with the failure to provide Norfolk Park Bail Hostel with information on release about Jamie Lee Bennett's previous substance misuse, his detoxication history, and that he had refused Naloxone, in addition to the failure to provide the community substance misuse team with his release date resulted in Norfolk Park Bail Hostel not having the opportunity to provide additional support

	Had that additional support been put in place in the days immediately after his release it may have reduced the risk of him using substances and dying as a result Jamie Lee Bennett was last seen on CCTV returning to his room at 1.01am on 2 May 2020 There was a failure to conduct the 7am welfare and curfew check in accordance with procedure in that Jamie was not roused, and it was not confirmed he was breathing. This failure was caused by a lack of training and understanding by staff as to what was expected of them during this check There was a failure to conduct the 12pm welfare check in accordance with procedure in that the check was not carried out until 1.35pm after concerns were raised for his welfare by his family and another resident. That failure was caused by a lack of training and understanding by staff as to what was expected of them with regard to the timing of this check At 1.35pm Jamie Lee Bennett was found unresponsive in bed. There was a delay in calling the emergency services which was caused by the lack of first aid training and staff not being in possession of radio equipment It cannot be said what time Jamie Lee Bennett died as such, it cannot be said the failings in those checks and the delay in calling the emergency services caused or contributed to his death Jamie Lee Bennett was pronounced deceased by paramedics on 2 May 2020 after ingesting cocaine, and an amount of heroin lower than usually encountered in deaths attributed to heroin overdose
5	**<u>CORONER'S CONCERN</u>** During the course of the investigation my inquiries 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 evidence was unclear as to who will carry out actions on the task lists on a night shift when a Sodexo worker was replaced by agency staff. There is no audit process in place to ensure staff are carrying out tasks in accordance with the lists issued There are no written instructions on how to conduct welfare checks. There is no audit process in place to ensure staff are conducting welfare checks appropriately It is my opinion there is a risk that future deaths may occur unless there are: • Clear, written instructions on how to conduct welfare checks • Clarity around which member of staff will be responsible for which task list, particularly on a night shift when a Sodexo worker is replaced by agency staff

	• An audit process put in place to ensure staff are carrying out tasks in accordance with the lists issued and in particular are conducting welfare checks appropriately
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 by 31 December 2022. The period of response has been extended given the evidence that Norfolk Park Bail Hostel is closed for refurbishment and will not re-open until the Autumn of 2022. I may extend this period upon your application 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: • [redacted] (father of deceased) via his representative at Simpson Millar, Yorkshire House, Greek St, Leeds, LS1 5SH 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

Mrs Tanyka Rawden
HM Assistant Coroner
29 April 2022