Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Ministry of Justice** **2 NHS England**
1	**CORONER** I am Miss Lorna Skinner QC, Assistant Coroner for the coroner area of Cambridgeshire and Peterborough
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. Coroners and Justice Act 2009 (legislation.gov.uk) The Coroners (Investigations) Regulations 2013 (legislation.gov.uk)
3	**INVESTIGATION and INQUEST** On 21 May 2020 I commenced an investigation into the death of Lewis Martyn POWTER, who died on 10 May 2020 aged 36 years. The investigation concluded at the end of the inquest on 19 July 2022. **Medical Cause of Death** – [redacted] overdose **Conclusion** – Drug related.
4	**CIRCUMSTANCES OF THE DEATH** Mr Powter was an IPP offender who had been diagnosed with emotionally unstable personality disorder and had been addicted to drugs for over 10 years. When in the community, he, in common with a number of IPP offenders, suffered from continued anxiety over the issue of potential recall. On release in November 2019, Mr Powter was put on the Offender Personality Disorder (OPD) pathway - a community based service which is part of a joint national strategy shared between probation and health service providers which have access to a shared computer log system, nDelius, for these purposes. As a result of his substance misuse issues, Mr Powter was also under the care of Change Grow Live ("CGL"), a charitable organisation, and was prescribed Subutex. As a third sector organisation, CGL did not have access to nDelius. A multi-agency meeting in respect of Mr Powter took place between the local NHS Trust, probation and CGL in January 2020. There was no further such meeting about him, despite his ongoing vulnerabilities as described above and: (a) the potential impact of lockdown upon him; and (b) the fact that he reported that he had stopped taking his prescription for subutex and was abstaining from drugs.

	Having abstained from drug-taking for over a month, with the result that he had a reduced tolerance level, Mr Powter died of a self-administered [redacted] overdose on 10 May 2020. At that time, he was experiencing increased anxiety because, as an IPP liable to recall to prison at any time he had, on 4 May 2020, been identified to the police as the perpetrator of an assault and was informed that he would be facing court proceedings in relation to it.
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** that, where an IPP offender with complex needs is released and is not subject to MAPPA, but is subject to multi-agency intervention co-ordinated by the National Probation Service, there is no policy/procedure/guidance encouraging consideration to be given to the issues of whether and when to hold multi-agency meetings for the purposes of sharing information about the offender. The need for consideration to be given to holding such meetings is particularly acute where one of the organisations responsible for delivering care/treatment does not have access to the shared record system used by the other two parties.
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 15 September 2022 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) The family of Lewis Powter (2) Cambridgeshire and Peterborough NHS Foundation Trust (3) Change Grow Live I am under a duty to send a copy of your response to the Chief Coroner and all Interested Persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**Dated: 21/07/2022**  **Lorna SKINNER QC** **Assistant Coroner for** **Cambridgeshire and Peterborough**