	REGULATION 28 REPORTS TO PREVENT FUTURE DEATHS
1.	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2.	**CORONER'S LEGAL POWERS** I make these reports under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INQUEST** On 2nd July 2019 death of Mr Nathan Forrester ([redacted] was reported to the coroner by HMP Thameside. A forensic autopsy was conducted and on 3rd September 2019, an inquest was opened. The listing was delayed by the pandemic. An inquest was part heard and jury dismissed in January 2022 and a fresh inquest heard from 9th until 19th January 2023, before a jury. The medical cause of death was 1a Acute toxic effects of Heroin, Cocaine and Methadone and the jury concluded he died of a drug related death.
4.	**CIRCUMSTANCES OF THE DEATH** He was well known as drug dependent with a history of concealing drugs. He had been released from prison on licence and was recalled and detained again, under the influence of drugs. The intoxication wore off. He was later found dead in his shared cell, having consumed illicit drugs there, after his cell mate alerted officers. Although emergency measures were instigated, at inquest it was determined that he had been beyond resuscitation, when found by officers. A substantial number of actions were taken both by the prison service and local provider of health care to the prison, to prevent future deaths, including installation of a scanner to detect drugs hidden in orifices, training in CPR and increases in night nurse staffing.

5.	**THE CORONER'S MATTER OF CONCERN**

6.	**1. Deaths on top bunks (HMPPS)** The first prison officer to arrive and find Mr Forrester unresponsive to voice, blue and cold, decided she was too small to be able to get him off his top bunk, even with a colleague, and left the cell. A second officer, having confirmed no pulse or response to pain, stated that there was no specific training on how to manage an arrest and CPR of a person on a top bunk. He tried unsuccessfully to bring him down. A third officer attending did not attempt to do so. After some delay, nurses brought him down to floor level when they arrived. The Head of Safer Custody has asked the local health service provider to advise how prison officers should be trained to manage assessment, removal and immediate CPR of a prisoner on a top bunk. The concern is that this training gap may exist in other establishments. **2. Training of nurses in CPR (NHS England)** Nurses attending the Code Blue had no training insertion of an IGel or oropharyngeal tubes, nor was an airway available in the emergency bags. Paramedics reported that resuscitation being provided by nurses was ineffective (too low and too fast) and that they had an inadequate handover. These deficiencies have been addressed locally and all nurses in Oxleas NHS Trust are trained annually to ILS level and airways are available. The concern is that this standard of training of nurses working in detention settings nationally may not be universal. **This REPORT IS BEING SENT TO:** 1. [redacted], Director General Chief Executive HM Prison & Probation Service (HMPPS), 70 Petty France, London, SW1H 9AJ 2. [redacted], Lead Commissioner for Secure & Detained Estate, NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG
7.	**ACTION SHOULD BE TAKEN** The case is brought to the attention of both national organizations responsible for commissioning or provision of CPR training, to enable them to assess whether the dangerous circumstances of this death could be present in other detention facilities and if so to consider the steps

	that need to be taken to reduce the risks of deaths from such circumstances.
8.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday, March 27th 2023. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted]
9.	**COPIES and PUBLICATION** I have sent a copy of my report to the following interested persons: [redacted] for the Family [redacted] Turning Point [redacted] of Capsticks for Oxleas [redacted] of DWF Law LLP for Serco [redacted] for MPS I am also copying it to Royal College of Nursing and the PPO, who may have interest in the matter. I am also under a duty to send the Chief Coroner a copy of your response. He 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.
10.	**[DATE]** **[SIGNED BY CORONER]** **30th January 2023. .....** **A N G Harris**