Regulation 28: Prevention of Future Deaths Report

John Paul Pace – date of death

	THIS REPORT IS BEING SENT TO: Castle Rock Group Forward Trust
1	**CORONER** I am: Dr Jeane Rosa Mellani HM Assistant Coroner for Essex Coroner's Court, Seax House, Duke Street, Chelmsford, CM1 1QH
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29
3	**INVESTIGATION and INQUEST** On 30 July 2020 I commenced an investigation into the death of Mr John Paul Pace. The investigation concluded at the end of the inquest on 25 October 2023. The conclusion of the inquest was a short form conclusion of "Drug Related Death". On 29 November 2019, Mr John-Paul Pace was recalled to prison after being arrested for a drug related offence. He was sent to HMP Chelmsford. When he arrived at Chelmsford, Mr Pace tested positive for both opioids and [redacted]. He was put on a drug detoxification programme and was prescribed methadone (an opiate substitute), which was progressively reduced over the following months. He was under the care of the GP to manage his depression and of the Integrated Drug Treatment Services to manage his drug use. On 28 May 2020, Mr Pace

	stopped taking methadone, before he had completed the methadone reduction programme. He was prescribed medication to help with the expected withdrawal symptoms. Shortly after 8.00am on 22 July 2020 Mr Pace was found unresponsive. An ambulance attended the prison and Mr Pace was certified dead at 8.16am.

4	**CIRCUMSTANCES OF THE DEATH** • Mr Pace was serving a prison sentence at HMP Chelmsford for a drug related offence; • Mr Pace was under the care of the Integrated Drug Treatment Service delivered by Forward Trust and was following a methadone detoxification programme; • Mr Pace decided to stop methadone against medical advice before completing the detoxification programme; • The post mortem examination concluded Mr Pace's likely medical cause of death was "synthetic cannabinoid misuse". The synthetic cannabinoid in question is known as "[redacted]".
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. The organisations responsible for the delivery of drug related services at HMP Chelmsford are Castle Rock Group (CRG) as the main contractor of health related services and Forward Trust as their sub-contractors for the drug treatment element of the service. One of the material issues in evidence was about changes in the discharge pathway for prisoners on methadone detoxification as well as those who decided to stop the detoxification programme before completion. CRG identified the need for this change in their Root Cause Analysis review and their live witnesses provided evidence that this new process is now being followed. Forward Trust provided evidence that this is the new process now embedded in their operating procedure. However, no documentary evidence of this new drug detoxification discharge pathway seems to exist, no protocols, no written procedures, no policy, no addendum to existing policies and procedures.

	It is my concern that this new discharge pathway aimed at providing monitoring and support to prisoners who stop or complete the programme whilst in prison, has not been embedded in your organisations' operating procedure and as such, there is a risk to prisoners in the future as compliance with the new discharge pathway and consistency of operations cannot be ensured.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisations 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. 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 following. ● Mr Pace's family ● The Care Quality Commission ● The MOJ (and HMP Chelmsford) 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	**DATE 13.11.23** **SIGNED BY ASSISTANT CORONER FOR ESSEX – Dr JEANE ROSA MELLANI**