REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Governing Governor HMP Garth** **2. Head of Healthcare HMP Garth**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Liverpool and Wirral
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 24th August 2022 an investigation into the death of Marlin John Burrows aged 45 was opened. The investigation concluded at the end of the inquest on 29th April 2024. The conclusion of the inquest was that the deceased died from multi-organ failure due to serotonin syndrome due to drug toxicity including amitriptyline toxicity. The jury found that the deceased had died as a result of an accident, a failure to consult Tox Base and failing to identify that the deceased was prescribed amitriptyline, contributing to his death.
4	**CIRCUMSTANCES OF THE DEATH** Marlin Burrows was found on 15th August 2022 collapsed in his cell at HMP Garth. Prison and Healthcare staff assumed that he was intoxicated through Psychoactive substances. A quantity of prescribed medication was found in the cell including amitriptyline. Healthcare staff failed to recognise that the drugs were not prescribed for the deceased and failed to consult Tox Base in order to determine the toxicity of amitriptyline if taken in excess. A Welfare Log was opened by prison staff but only completed intermittently and not consulted by medical staff. In the early hours of 16th August 2022 having been in a semi-conscious state for nearly 15 hours the deceased collapsed and died.
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) The existing welfare sheet lacks clarity as to its exact purpose in terms of monitoring a prisoner whose health is of concern. (2) The sheet contains little guidance in relation to its completion. (3) Entries on the sheet made by prison staff appear not to be made known to attending medical staff (4) The nature and operation of the sheet appears not to have been the subject of joint consideration on behalf of both prison and healthcare

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 22nd June 2024 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 namely the family of the deceased. 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	**Dated 30th April 2024** **SIGNED** ***Nicholas Rheinberg*** **Assistant Coroner**