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Date: 19 July 2024
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: OXLEAS NHS FOUNATION TRUST, THE GOVERNOR HMP ROCHESTER

1. CORONER

I am Patricia Harding HM senior coroner for Mid Kent and Medway

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 16 May 2022 I commenced an investigation into the death of Benjamin Noah Frances Harrison. The investigation concluded at the end of the inquest listed 3rd June 2024 with a jury. The conclusion of the inquest was

Accident- Benjamin Harrison having inhaled fumes from a [redacted] causing his death,
Central issues which possibly contributed to the death:
Insufficient healthcare cover at HMP Rochester
Omission of the OSG officer to inform the night orderly officer of Mr. Harrison's appearance after 21.30 on 9th May 2022
Central issues which are relevant to the death but did not cause or contribute to the death:
Omission to arrange a GP review at HMP Elmley after the chronic pain multi-disciplinary team clinic was cancelled
Omission to follow up a referral to the specialist pain team at HMP Elmley
Omission to refer Mr. Harrison to the substance misuse team at HMP Elmley
Lack of communication regarding the handover of Mr. Harrison from HMP Elmley to HMP Rochester and between healthcare staff and prison staff at both prisons

Inadequate number of prison officers on duty on the wing on the night shift at HMP Rochester
Lack of first aid training for OSGs

1a [redacted] Toxicity

4. CIRCUMSTANCES OF THE DEATH

Benjamin Harrison was released from HMP Elmley in January 2021 and recalled on 19th March 2022.

He had been prescribed a number of medications in the community for chronic pain which increased the risk of respiratory and central nervous system depression, namely [redacted], [redacted] and a [redacted].

Whilst at HMP Elmley consideration was given to reducing the medication but this had not been addressed before he was transferred to HMP Rochester on 5th May 2022. Following his arrival at HMP Rochester a GP recommended reduction of the opioid medication and the issue was tabled for discussion at a complex case review meeting on 18th May 2022 how best to effect this.

[redacted] are not recommended for use in prison because of the risks of tampering and diverting. Mr. Harrison had a history of substance misuse and had previously had his prescription stopped for this reason.

On the afternoon of 9th May 2022 Mr. Harrison was administered his medications including a new [redacted].

His cell mate gave evidence that after he returned to his cell Mr. Harrison used a vape pen to heat the [redacted] causing the chemicals within to be released which he then inhaled.

He did this on more than one occasion.

Around 8.35pm an OSG completed a roll check. She saw Mr Harrison lying on the bed and was told by his cell mate that he was ok. She formed the impression that he was likely under the influence of a substance. She did not alert the orderly planning to do welfare checks instead.

She returned to the cell around 9.15 to check on Mr. Harrison. She saw him get off his bed and described his as wobbly/hobbly which he attributed to having hit his leg. She stated he was coherent.

The OSG stated that she returned on two or three further occasions and saw him sitting on the edge of his bed talking to his cell mate.

Around 10pm she asked Mr. Harrison's cell mate if Mr. Harrison was ok as he was lying on the bed and she couldn't see his face. She was told he was asleep and did not make any further enquiry because she thought he would be better sleeping it off.

Neither she nor the orderly could remember if they discussed that Mr. Harrison was under the influence around this time when the orderly came onto the landing.

At around 11.55pm Mr. Harrison's cell mate raised the alarm stating he had realised that Mr. Harrison had not moved for a while. He could not be roused and a code blue was called. Cardiopulmonary resuscitation was commenced and continued until shortly after the arrival of the ambulance when life was declared extinct.

The jury rejected the evidence of the OSG in relation to her observations of Mr. Harrison being alive and well after 9.30 based on the evidence of the cell mate and the pathological evidence as to how long Mr. Harrison had likely been dead.

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) Evidence was given by prison staff that it was not uncommon for prisoners to be under the influence of substances, particularly spice at HMP Rochester.

During the day when it was suspected that someone was under the influence, healthcare would attend to assess whether medical attention or monitoring was required there was however no access to in house health care during the night state.

OSG officers without medical training or knowledge of the prisoner's medical history had to use their own judgement whether to monitor a prisoner or to escalate the matter.

The prison orderly was not notified immediately when someone appeared to be under the influence and that the individual was thought to be under the influence was not documented.

Prison staff did not have any guidance or policy to assist them as to when to escalate matters or what monitoring should be undertaken and staff did not routinely use the GP on call service for advice.

(2) Prison staff did not receive a briefing about prisoners with medication in possession in accordance with PS24/2011

(3) In evidence there were discrepancies between the policies in place and the understanding of healthcare staff as to what information could be shared with prison staff and when it should be shared.

Some healthcare staff in evidence indicated they would not share information about medication in any circumstances.

The healthcare policy and practice of healthcare staff in relation to information sharing does not align with PSI64/2011 that *information can be shared without a prisoner's consent if it is considered necessary to protect the individual or anyone else from the risk of death or serious harm.*

*T*here was no clear process as to how or where the information would be shared and recorded either where a prisoner had consented to information sharing or where consent had not been given but it was nevertheless necessary to share the information.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Oxleas NHS Foundation Trust and Governor HMP Rochester 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 13th September 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 family of Mr. Harrison

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.

19 July 2024

Signature 

Patricia Harding Senior Coroner for Mid Kent and Medway