Report to Prevent Future Deaths

Joseph Benjamin FORBES BLACK (Date of death: 9 August 2023)

	Regulation 28 Report to Prevent Future Deaths
	THIS REPORT IS BEING SENT TO: 1. The Secretary of State for Health and Social Care 39 Victoria Street London SW1H 0EU 2. Chief Executive NHS England Wellington House 133-155 Waterloo Road London SE1 8UG
1	**CORONER** I am Ian Potter, assistant coroner for Inner North London.
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 17 August 2023, an investigation was commenced into the death of Joseph Benjamin FORBES BLACK, aged 39 years at the time of his death. The investigation concluded at the end of an inquest on 23 December 2024. The conclusion of the inquest was 'drug-related death'. The medical cause of death was: 1a acute polydrug toxicity (heroin, cocaine, metonitazine, protonitazine) 1b substance misuse disorder II mental health disorder
4	**CIRCUMSTANCES OF DEATH** Joseph Forbes Black had a longstanding history of harmful substance misuse, against a backdrop of 'unspecified schizophrenia'. He engaged well with the treatment of his schizophrenia and his mental health was considered

	stable in the time leading up to his death. However, despite being aware of available help, support, and treatment in relation to substance misuse, Mr Forbes Black repeatedly declined to engage. On 9 August 2023, Mr Forbes Black was found deceased at his home address. He died as a result of acute polydrug toxicity, which included the taking of heroin that had been adulterated with protonitazene and metonitazene. The presence of 'nitazenes' more than minimally contributed to his death.
5	**CORONER'S CONCERNS** During the course of my investigation and the inquest, the evidence revealed a matter 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 **MATTER OF CONCERN** is, as follows: For context, on 26 July 2023, the Office for Health Improvement & Disparities issued a 'National Patient Safety Alert' (Ref no.: NatPSA/2023/009/OHID) ('the Alert'). The Alert was entitled 'Potent synthetic opioids implicated in heroin overdoses and deaths' and it referred to known nationwide incidents of so-called 'nitazenes' having been found in batches of heroin. The Alert required, certain healthcare providers, to raise awareness of the heightened risks to anyone who may use drugs. There was clear evidence that the risks raised by the Alert were communicated to Mr Forbes Black within the timeframes required. They were communicated by a mental health nurse, who was treating Mr Forbes Black in relation to his schizophrenia. Naloxone, the 'antidote' for opioid overdoses, was not administered in Mr Forbes Black case. This because the circumstances in which he was found did not indicate that the administration of naloxone would be of any use in this instance. Staff at the supported accommodation where Mr Forbes Black lived, had naloxone that they could administer to residents if the staff came across a situation in which the administration was indicated. The evidence revealed that, neither the supported accommodation provider nor the mental health NHS Trust that was treating Mr Forbes Black were permitted to give naloxone kits to their residents/patients who were known drug users. In my experience, from this inquest and others, a significant proportion of illicit drug users are not engaged with or decline to engage with substance misuse services for a number of possible reasons. The evidence in the inquest was that, if a drug-user wanted to have naloxone in their possession as a safety-net measure, they would need to obtain this from a local substance misuse service.

	I am concerned that this set of circumstances raises the risk of future deaths occurring because the provision of naloxone kits could be made more widely available to those most likely to need them. The present situation appears to be that naloxone is most easily accessed through the very service(s) that many drug-users are not engaged with. My concern, based on the evidence heard at this inquest and others that I am aware of, is that this is not a localised matter and is more likely a nationwide issue and that action should be taken more widely. It further seems to me that the need for action is heightened by the increased incidence of heroin having been adulterated with 'nitazenes' (particularly potent synthetic opioid drugs), which increases the risk of drug users unwittingly overdosing.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 27 February 2025. 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: • The solicitors acting on behalf of Mr Forbes Black's family • North London NHS Foundation Trust • The London Borough of Camden 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 summary form. She may send a copy of this report to any person who she 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	**Ian Potter** HM Assistant Coroner, Inner North London 2 January 2025
