REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care** **2. Minister of State for Prisons, Probation and Reducing Reoffending** **3. Governing Governor at HMP Guys Marsh** **4. Chief Executive at Oxleas NHS Foundation Trust**
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
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 22nd November 2022, I commenced an investigation into the death of Sheldon Lawrence Jeans, born on the 24th October 1990 who was aged 32 years at the time of his death. The investigation concluded at the end of the Inquest before a jury on the 22nd July 2025. The medical cause of death was: Ia Idiosyncratic Response to Alcoholic Intoxication and Medicinal Drugs (Pregabalin, Mirtazapine, Dihydrocodeine and Quetiapine) II Partial Postural Asphyxia The conclusion of the Inquest was Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** On the 13th of November 2022 Sheldon Lawrence Jeans, who was a serving prisoner at HMP Guys Marsh was found in a collapsed and unresponsive condition on the floor of his cell. At the conclusion of the Inquest the jury recorded the following under Section 3 of the Record of Inquest:

	How Sheldon passed away due to a idiosyncratic response to alcoholic intoxication and medicinal drugs combined with partial postural asphyxia. When This occurred on or about 13th November 2022. Where Sheldon was in Cell 37, A Spur, Mercia Wing, HMP Guys Marsh, Shaftesbury, Dorset when this incident occurred. Circumstances Based on evidence provided, during 12th November 2022 Sheldon was in a heightened mental state. This was brought on by the impending news of his parole hearing, challenges encountered in his relationship and this combined with his known historical mental health conditions. Sheldon acquired access and consumed non-prescribed drugs. He also acquired access and consumed illicitly brewed alcohol 'Hooch'. Although the levels of these substances on their own would not be fatal, when consumed altogether, they caused a high level of sedation and this combined with Sheldon's body posture resulted in respiratory depression. At no point had it been identified that Sheldon had in his possession or was under the influence of un-prescribed drugs and hooch. This resulted in no additional checks on Sheldon during the night until he was found at 5:10am. Sheldon did not intend to end his life as a consequence of his actions but deliberately consumed these substances.
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 could 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) There is a lack of national policy, and local guidance at HMP Guys Marsh, to inform staff working in prisons of the dangers of illicitly brewed alcohol, also known as hooch. There is also a lack of policy and guidance to assist those working within the prisoner estate with the management and governance of the access to, and use of, illicitly brewed alcohol. Illicitly brewed alcohol is a common substance across the prisoner estate. Evidence was given at the Inquest that in the month of September 2022, 215.5 litres of illicitly brewed alcohol were seized at HMP Guys Marsh. Evidence was given that Hooch continues to be a common problem in prisons. Illicitly brewed alcohol in prison is a substance made from items which are readily and legitimately available to prisoners.

Hooch was described as a very, very dangerous substance during the course of the evidence and as is clear from the cause of his death, was central to the death of Sheldon. Evidence was given that it has sedative effects which if taken with certain medications can increase the sedative effects.

Evidence was given that the policies in place concerning the possession and use of illicit substances within the prisoner estate at the time of Sheldon's death, and those in place now, focus on drugs or medication, but are silent in relation to alcohol. I am concerned that this lack of guidance could lead to a future death in prison custody

(2) Prisoners can have access to certain medication to hold in their possession which could be accessed by other prisoners and there is a lack of national policy, and local policy at HMP Guys Marsh, from a healthcare and prison perspective, around the governance of medication held in possession in the prison estate.

Evidence was heard that when a person is prescribed medication in prison, it can either be taken under supervision, or a prisoner can be provided with the medication to hold in their possession, in their cell.

In these cases, the prisoner is responsible for the safety of that medication. Prior to being provided with medication in their possession a risk assessment is undertaken upon the prisoner to assess the risks associated with the drug and also the risks associated with prisoner. Whilst medications defined as controlled drugs would not be given in possession, it is possible to have medication that could cause death in possession. Although Sheldon was not prescribed the medications that caused his death, evidence was given some of those medications are suitable to be prescribed to a prisoner in possession. It is not known how Sheldon accessed the medication found in his system at the time of his death, other than to say he obtained it at HMP Guys Marsh.

At HMP Guys Marsh, which may not be the case across the prisoner estate, a lockable cupboard is provided in cells for the storage of medication.

Evidence was given that at times cells will be left insecure at HMP Guys Marsh when the prison is in a state of unlock, such as when prisoners collect meals or for example when they go for showers or are out of the cells on association. Evidence was given that prisoners go into each other's cells when they are in a state of unlock. Prisoners could therefore enter another prisoner's cell. If medication is not held securely in a lockable cupboard there is a risk that prisoners who are not prescribed medication, could access medication.

Evidence was given at the Inquest that due to the chaotic life some prisoners lead, even when provided with lockable cupboards, cells at HMP Guys Marsh have been seen to contain medication that is not secure and is strewn all over the cell. The medication in Sheldon's cell at the time of his death was found insecure in a Tupperware container.

	Further, if a medication prescribed to a prisoner is discontinued, evidence was heard that the onus is upon the prisoner returning any excess medication to the healthcare department at HMP Guys Marsh which may be the position in other prisons. The issues around securing of medication held in possession in a cell and the onus being upon prisoners to return unused medication, carries a risk of prisoners accessing unprescribed medication. At the time of Sheldon's death he was not prescribed the medications found in his system and he had in his cell excessive amounts of medication he was prescribed and had previously been prescribed and discontinued. I am therefore concerned the lack of guidance and policy nationally, and locally at HMP Guys Marsh, on storage of in possession medication and what to do when a medication is discontinued to ensure prisoners do not continue to possess left over medication, could lead to future deaths.
"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 19th September 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 via their legal representatives: (1) Sheldon's Family (2) Ministry of Justice/HMPPS/HMP Guys Marsh (3) Practice Plus Group (PPG) (4) Oxleas NHS Foundation Trust (5) Exeter Drugs Partnership (EDP) (6) Change Grow Live (CGL) 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	**Signed**  **Rachael C Griffin** **HM Senior Coroner for Dorset** **25th July 2025**