	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: His Majesty's Prison and Probation Service**
1	**CORONER** I am Emma Brown, Area Coroner for Birmingham and Solihull
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 7 November 2024 I commenced an investigation into the death of Derrion Jack ADAMS. The investigation concluded at the end of the inquest on the 14th November 2025 . The conclusion of the inquest was that the death was drug related.
4	**CIRCUMSTANCES OF THE DEATH** Following a post mortem, the medical cause of death was determined to be: **1a Complications of [redacted] usage** **1b** **1c** **1d** **II** Derrion Adams was received into HMP Birmingham on the 8th April 2024, he had a history of substance mis-use and spent some time on the drug recovery unit but left due to behavioural issues and by the time of his death was housed on K wing, a general wing. In the intervening months he was identified as being under the influence of substances on a number of occasions. On the 31st October 2024 he had been seen to be under the influence of substances by other prisoners during the afternoon but this was not witnessed by prison staff. At 15:53 his cellmate pressed the cell call bell after finding Derrion unresponsive on the cell floor. A prison officer attended the cell at 16:07 and found Derrion in cardiac arrest, members of the prison's medical team attended and then paramedics but he could not be resuscitated and was pronounced deceased at 16:55. Investigations have identified his death was due to toxicity from [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. – 1. The inquest heard evidence from the Head of Drug Strategy and the Head of Safety at HMP Birmingham at the time of Derrion's death. Their evidence included that novel psychoactive substances and other contraband items were able to enter the prison via [redacted] and this continues. The following statements were made in evidence "[redacted] are ruining the safety of the prison". [redacted]. 2. The Heads of Drug Strategy and Safety gave clear and credible evidence that they at HMP Birmingham are doing everything they can using the measures available to them to stop and intercept [redacted] delivering to HMP Birmingham but these measures are often not successful because the sophistication of the criminals using [redacted] to deliver contraband to prisons is "more sophisticated than us". 3. A consequence of the ability of criminals to deliver contraband items into HMP Birmingham is that drugs, including the type of novel psychoactive substances relevant in this case, are available to prisoners. These substances create a risk to life. Consequently, alongside the prison's drug strategy and measures to restrict supply, reduce demand and build recovery the prison has introduced a comprehensive 'Under the Influence Policy' to instruct staff in the appropriate procedure to follow when a prisoner is suspected to be under the influence in order to safeguard the prisoner through involvement of healthcare. Additionally the policy provides for the gathering of information and intelligence about the individual prisoner and the situation in the prison overall. 4. Instances of prisoners being found under the influence and 'code blues' as a result of drugs place a considerable burden on prison staff. This is against a background of prison officers having to face increased demands arising from record keeping and prisoner conduct e.g. increasing inappropriate use of cell bells which require officers to attend the cell. 5. On the day of Derrion's death on K wing at HMP Birmingham the whole prison was experiencing a spike in under the influence incidents and another code blue had occurred on K wing immediately before Derrion's. As a consequence, one officer was out on the wing attempting to lock up approximately 60 men from association on his own as the other available officers were involved in the code blue on K wing or responding to incidents elsewhere in the prison. The evidence of the prison officers on the wing at the time was that the situation felt 'manic' and they seemed 'inundated' with incidents. The evidence was that these sort of 'spikes' are not common but they are not unusual either and when they will occur cannot generally be predicted. 6. The evidence was that HMP Birmingham is operating at its target staffing figures and has measures in place to deploy extra staff to areas of need in response to incidents. Additionally it is hoped that the introduction of tamper-proof vapes will limit use of psychoactive substances. However, my concern is that the current target staffing figures, which are based on historic bench marking and apply nationally, do not take into consideration the additional challenges to prison staff from contraband entering prisons via drones and, in particular, the burden placed on staff as a consequences of prisoners using psychoactive substances and other drugs. This concern is underlined by the fact that the staffing on the wing was not sufficient to ensure the call bell for Derrion's cell was answered within the target time resulting in a delay in identifying and responding to his cardiac arrest. 7. My overall concern is that current staffing benchmarks may not reflect the escalating operational pressures caused by the security threat from [redacted] and intermittent surges in psychoactive substance incidents, leaving prisoner safety and welfare, and that of staff, at significant risk.
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 13 January 2026. 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: [redacted] [redacted](Mr Adams' mother), [redacted] (Mr Adams' father), Ministry of Justice, Birmingham Community Healthcare NHS Foundation Trust, West Midlands Police, Prison and Probation Ombudsmen and Cranstoun Recovery. Additionally the report will be copied to HM Inspector of Prisons who may find it useful or of interest. 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. 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	**18 November 2025** Signature:  **Emma Brown** **Area Coroner for Birmingham and Solihull**