



West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA

Date: 28 May 2025

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Governor of HMP Wormwood Scrubs, Practise Plus Group, BEH, MOJ, Family CORONER

1 I am Lydia Brown for West London
CORONER'S LEGAL POWERS

2 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/ukxi/2013/1629/part/7/made>

INVESTIGATION and INQUEST

On 20 July 2023 I commenced an investigation into the death of Samuel Anthony Donald STEWART. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Drug related death

3 1a Myocardial fibrosis

1b

1c

II Morbid obesity (caused by Olanzapine)

CIRCUMSTANCES OF THE DEATH

4 Samuel Stewart was on remand in HMP Wormwood Scrubs. He was resident in a single cell on the Incentivised Substance Free Living environment "ISFL", which is a wing meant to be free from drugs and residents sign a "contract" of behaviour which includes undertaking regular drug testing, most of which were negative. One test, however, undertaken 6 March 2023 was positive but no steps were taken to discuss this with Sam, to support him or to arrange a multi-disciplinary team meeting with prison and healthcare staff to consider this further.

Sam was found deceased in his cell on 15 July 2023 and there was some drugs paraphernalia within the cell. His cause of death was due to drugs in combination with long term cardiac damage, probably caused by previous drug taking behaviour.

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. -

- 5 Sam had elected to have a place on a "drug free" wing and accepted the conditions of this placement. He accessed non-prescribed drugs (amphetamines) as his test on 6 March 2023 yielded a positive result. No action was taken by either the prison or healthcare.

(1) consideration should be given as to what actions should have been taken, and if this is set out in the national or local policy guidelines

(2) pathways after a positive test result were either not followed or unclear

(3) An opportunity was missed to support Sam and discuss this with him

ACTION SHOULD BE TAKEN

- 6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

- 7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 July 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons family of Sam

- 8 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.

28 May 2025

- 9 Signature



Lydia Brown Senior Coroner for