



	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. ████████ Director of Birmingham Prison2. National Offender Management Service Birmingham3. Andrew Selous MP, Prisons Minister4. Birmingham Community Healthcare NHS Trust
1	<p>CORONER</p> <p>I am Louise Hunt Senior Coroner for Birmingham and Solihull.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 24/04/2015 I commenced an investigation into the death of Dean Ronald Edmund BOLAND. The investigation concluded at the end of the inquest 20th November 2015. The conclusion of the Jury at the inquest was:</p> <p>Dean Ronald Edmund Boland was discovered on the floor in Cell 12, 3rd Landing, B Wing in HMP Birmingham on 17th April 2015 at approximately 3:30 am by his cell mate. He was pronounced dead at 04:12 am.</p> <p>He died of mixed drug toxicity. Heading up to this he self-administered various medication. A combination of prescribed and illicitly obtained medication were found to be present in the samples taken from him and subsequently found in his cell.</p> <p>Dean gained access to these non-prescribed substance and legal highs by exploiting inadequacies within the prison. Searches that are carried out are inadequate.</p> <p>General awareness of drug use and the associated is lacking.</p> <p>Communication between departments concerned with maintaining the well being of drug dependent inmates is poorly implemented.</p> <p>Basic checks concerning the hoarding of medication are not being carried out.</p> <p>Medical regimes are not adequately monitored.</p> <p>Perimeters are poorly protected.</p> <p>This has resulted in a facilitation of a culture of irresponsible drug use within the prisons drug detoxification facility</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Dean Boland was returned to Birmingham prison for a breach of his licence condition on 29/01/15. He had only been released from the prison 2 weeks earlier. He had a known drug addiction. At 03.30 on 17/04/15 he was found unresponsive on the floor of his cell by his cell mate. Prison officers attended and paramedics were called. He was declared deceased in his cell at 04.12.</p> <p>Post mortem examination with toxicology confirmed the following drugs in his system at the time of his death:</p>

Drug name	Normal use	Level found in Dean	Time frame for taking drug	Equivalent number of tablets if applicable	Whether Prescribed by doctor in prison
Methadone	Morphine substitute	0.081 milligrams per litre of blood (mg/l)	Last 2 days	N/A	No
EDDP – breakdown product of methadone		detected			
Buprenorphine - subutex	Drug addiction therapy	0.001 mg/l	Consistent with therapeutic use		Yes
Diazepam	Drug withdrawal symptoms	0.11 mg/l	Consistent with therapeutic use		Yes
Quetiapine	Anti-psychotic drug	0.41mg/l	Used in the hours leading up to death		No
Pregabalin	epilepsy, anxiety disorder and neuropathic pain	1.8mg/l		1 tablet	No
Gabapentin	Epilepsy and neuropathic pain	0.3mg/l	Several hours before death	3 tablets	No
Hyoscine – found in buscopan	Treatment of gastro intestinal disorders	detected			No
5F-AKB48 synthetic cannabinoid	Legal high	detected			No

The following are some of drugs found in his cell. The police confirmed that not all drugs found in the cell were tested.

Type of drug	Normal usage	quantity
Mirtazapine		2 tablets and traces on silver foil
Quetiapine	Anti-psychotic drug	1 tablet
Gabapentin	Epilepsy and neuropathic pain	1 capsule
Pregabalin	epilepsy, anxiety disorder and neuropathic pain	2 capsules
Legal high		509mg package

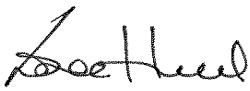
5

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. There was a general lack of awareness and understanding of the drugs issues in the prison by prison officers. Two prison officers who worked on B wing said they were unaware of any problems with prisoners using illicit drugs including general medications. Prison officers need a comprehensive education program to understand what drugs are being used and sold and how prisoners come by those drugs.
2. There is a lack of multi-disciplinary approach to drug issues within the prison. The evidence heard at the inquest confirmed that prison officers, health workers and DART workers do not adequately discuss trends and general drugs issues to ensure all staff are up to date and aware of the problems. It is accepted that patient's confidentiality needs to be maintained but it is essential to discuss trends and significant events in a multi-disciplinary way.
3. General medicine administration does not involve a check of the mouth so prisoners can easily conceal tablets to sell later.
4. Cell searches only take place for a certain number of cells each month on a random basis as prescribed by NOMS, or for targeted cells when there is sufficient intelligence. Intelligence searches only take place when there is at least 2 pieces of intelligence. Given the extent of the drug problem on B wing this seems insufficient.
5. Prisoners on B wing are not viewed or monitored at all overnight unless they are on an ACCT. This gives them a considerable period of time to smoke and use drugs knowing there will be no supervision or observation from prison officers.
6. The prison deploy a security officer to B wing at night (172 prisoners). This person is unable to interact with prisoners and is only there to answer call bells. This seems inadequate given that this group of prisoners are at high risk of drug use particularly at night when there are no cell checks.
7. DART workers are currently unable to access compact drug results as workers are unable to log onto the computer.
8. Prison officers are unaware of positive drug test results and therefore unable to take any action in response.
9. There are several exercise areas at the prison. Only two have netting. Further consideration needs to be given to netting other areas given the number of packages being thrown over the wall and then secreted by prisoners on their person. The inquest heard that only a small proportion of packages are seized as they come over the wall.

	<p>10. The prison should investigate whether 3 prison officer on duty in the exercise area is sufficient for 172 prisoners given the number of packages that are thrown over the walls every week.</p> <p>11. At present there is no ability to search or screen prisoners or visitors for drugs concealed on their person when they come into prison. Given that this is a major source of drugs coming into the prison further consideration need to be given, on a national level, as to how concealed drugs can be identified for example with the use of a full body scanner. The current scanner can only identify metal objects.</p> <p>12. Birmingham prison has 2 drugs dogs who work on a shift pattern. This means not every area in the prison can be covered as only one dog is on duty at any one time. Given that these dogs are the only current mechanism for identifying certain drugs consideration needs to be given to having more dogs so that prisoners and visitors coming into the prison will always be screened.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you G4S have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st January 2016. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family and the PPO.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>25/11/2015</p> <p></p> <hr/> <p>Louise Hunt Senior Coroner Birmingham & Solihull District</p>