ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Stonham Bass** **Stoneham** **2 Gosforth Parkway** **Gosforth Business Park** **Newcastle** **NE12 8ET**
1	**CORONER** I am Lydia Brown assistant coroner, for the coroner area of Exeter and Greater Devon
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 31 March 2016 I commenced an investigation into the death of James Aran Spencer. The investigation concluded at the end of the inquest on 28 November 2016. The conclusion of the inquest was misadventure. The cause of death was multiple drug toxicity
4	**CIRCUMSTANCES OF THE DEATH** The deceased died due to the use of illegal "street drugs" that he self injected following a prolonged period of abstinence from drug use. At the time he was living in a Bail Hostel in accordance with the terms of his license. His previous history of drug use was documented and recognised, although he had claimed to be clean from drug use while in prison and immediately following release. He was seen in his bedroom by the employed support officer the day before he was found deceased, "snoring" and lying partially clothed on his bedroom floor. Drugs paraphernalia was in clear view within the bedroom. The support officer had very little first aid knowledge or training and very little drug awareness and so did not act on these signs and left the deceased alone without requesting immediate emergency medical assistance.
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. – The deceased was found in a classic posture of drug-related collapse, but no action was taken due to inadequate training – "mandatory training" had not been given at the time

	of induction. Support officers working in this role will be likely to encounter this type of situation in a vulnerable population of recently released prisoners, and it is well recognised that the user's tolerance will have decreased after a period of withdrawal and therefore the risk of death significantly increases. The induction policy, the quality of induction of staff and ongoing training updates should all be considered to ensure better awareness of officers, and better safety for residents.
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 15th May 2017. 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 family of James. 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	**[DATE]** 20 March 2017 **[SIGNED BY CORONER]**