	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **G4S** • **HM Prison and Probation Service** • **The Rt Hon David Gauke MP**
1	**CORONER** I am Louise Hunt, Senior 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 06/04/2018 I commenced an investigation into the death of Andrew Stephen Carr. The investigation concluded at the end of an inquest on 30th January 2019. The conclusion of the inquest was:- Drug Related At this time Birmingham prison was facing a serious problem with the ingress of drugs. It is clear to us that this problem was not being adequately controlled. We do not feel that any intelligence was recorded appropriately in order to understand the full extent of the serious drug problem within the prison at that time. Through the evidence we have gathered, it is apparent that there had been no action taken to reduce the risks of prisoners using the plumbing system to send and receive drugs. To conclude, we can confirm that on balance of probabilities, Andrew's death was solely caused by the use of illicit drug use.
4	**CIRCUMSTANCES OF THE DEATH** Andrew Carr was transferred from a Category C to a Category B prison, on the 19th February 2018. There is strong evidence to suggest there was a history of illicit drug use, which we believe he continued during his stay in the Birmingham prison. On 27th February 2018, Andrew was taken to the segregation unit due to a serious assault on an officer. On the night of the 29th March 2018, an officer delivered hot water to Andrew with no cause for concern. At 22:05 the officer checked on Andrew and found him lying in the foetal position on the floor. He completed his rounds returned to Andrews's cell and tried to rouse him which proved unsuccessful. The officer went to find Oscar 1 on foot, unable to find him he proceeded to call the comms office via the telephone on the segregation unit to find his location. Oscar 1 was attending an ongoing medical situation with the staff nurse on duty. As the officer reached their location he waited for them to complete their duties, and proceeded to make their way to Andrew's cell retrieving the blue bag on the way. Oscar 1 attempted to gain a response from Andrew by kicking the door. When no response was gained they proceeded to enter the cell. It was immediately apparent that Andrew was in cardiac arrest and a code blue was called straight away. All attempts to revive Andrew where made and were unsuccessful and he was pronounced dead by the Doctor at 22:53 hrs. It was clear there was a delay on entering Andrews's cell, although this did not change the outcome. From supporting photographic evidence we believe Andrew had received his illegal substances through the plumbing system of the prison. Following a post mortem, the medical cause of death was determined to be: EFFECTS OF A SYNTHETIC CANNABINOID

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 that before his transfer to Birmingham prison on 19/02/18 Andrew had been involved in 4 incidents of taking psychoactive substances resulting in a code blue being called. In addition there was intelligence that he may be giving out drugs. This information was available and passed onto Birmingham Prison - however they were not aware of it and did not record the information. The inquest heard that there was no time to review information of prisoners coming into the prison. This is a major concern as key information may not be identified and this poses a risk to the individual and other prisoners. 2. It had been known for approximately 5 years that drugs and other items could be passed through the plumbing system of the prison. No action was taken before Andrew's death and the inquest heard that no solution had been found to the problem. This raises an ongoing concern for the wellbeing of prisoners and the risk of future deaths. 3. Many problems within the prison related to substances misuse are contributed to by the use of contraband mobile phones. The inquest heard evidence that blocking the use of mobile phones in prison would be very useful in mitigating this risk. NB a recent Regulation 28 report (Ricardo Holgate) raised the issue of the need for CCTV cameras at Birmingham prison and airport style scanners. This inquest raised the same issue and should be linked with that report.
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 29th March 2019. 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 • Birmingham and Solihull Mental Health Trust • Birmingham Community Healthcare NHS Trust • Midlands Partnership NHS Foundation Trust 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	31/01/2019 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**