	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Governor HMP Stoke Heath, Warrant Road, Market Drayton, Shropshire, TF9 2JL. 2. [redacted], Shropshire Community Health NHS Trust, William Farr House, Shrewsbury, Shropshire, SY3 8XL. 3. [redacted] Head of Governance, Forward Trust, Head Office, The Foundary, 17 Oval Way, London, SE11 5RR
1	**CORONER** I am Mrs Joanne Lees, Assistant Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 the 30th October 2017 I commenced an investigation into the death of Jerome Jason Omri JONES, 26 years of age. The investigation concluded at the end of the inquest on the 18th to the 20th July 2018. The conclusion of the Jury in the Record of Inquest (ROI) was a narrative conclusion recorded in Box 4 as: The deceased passed away due to a combination of an underlying heart condition and the effects of a synthetic cannabinoid on his heart. Recorded in Box 3 of the ROI the jury found that 'proactive steps were taken to safeguard Mr Jones prior to the incident but these were ultimately insufficient'.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a serving prisoner at the time of his death in HMP Stoke Heath. He had been transferred there in July 2017. He had a pre existing congenital heart defect and was a known user of New Psychoactive Substances (NPS). He died on 27/10/17 in the Princess Royal Hospital, Telford. Earlier that evening he had been found unresponsive in his cell having been suspected of using NPS. A post mortem revealed the cause of death as 1a) Sudden cardiac death 1b) congenital heart disease with fibrosis of the left ventricle and toxic effect on myocardium. Toxicology found a synthetic cannabinoid known as 5F-ADB in his blood. Between his arrival at Stoke Heath and his subsequent death on 27/10/17, Mr Jones had at least 3 known instances of NPS use the most recent on which was only a week before his death where he received emergency treatment although he was not admitted to hospital. A week later, he was again found unresponsive in his cell and was determined by paramedics to be in cardiac arrest. Despite concerted efforts to save his life by prison staff and paramedics he remained in PEA and was later sadly pronounced dead at 21.10 pm at the Princess Royal Hospital. The inquest focused on the following central issues;

	● The events leading up to the discovery of Mr Jones in his cell on 27/10/17; ● The measures taken by HMP Stoke Heath to manage both his heart condition and his known use of NPS with particular reference to the incident on 20/10/17; ● The measures taken by HMP Stoke Heath to Mr Jones mental health in so far as it related to his drug use; ● How Mr Jones was able to access NPS and what policies and procedures were in place at H M Prison, Stoke Heath to prevent this? ● If there was any delay in calling an ambulance to Mr Jones, the impact of any delay if it is possible to say.
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)During the inquest evidence was heard that apart from some hourly checks by prison officers during the evening of the incident on 20/10/17 (the third known instance of NPS use by the deceased) no other specific checks were made on the deceased leading up to the date of his death . This was a prisoner who had 3 known instances of NPS use within a relatively short space of time. I heard evidence that the requirement for further checks would have had to come from the Healthcare team rather than from prison officers. I was told here is no policy or guidance to cover additional checks for a prisoner in a situation such as this. (2)The inquest heard evidence from two Forward Trust Drug workers who although not medically qualified, considered that Mr Jones was at a 'higher' risk from NPS use due to using NPS with his existing congenital heart defect. I was told there was no method of communicating this to either Healthcare or prison officers to enable further periodic checks to be undertaken particularly in light of the recent incident on 20/10/17. (3)The two Forward Trust Drug workers were only aware of Mr Jones existing heart condition because he disclosed this to them himself. This enabled them specifically to tailor their advice to cover the impact of Mr Jones continued NPS use on his heart. Forward Trust do not appear to have access to prisoner medical records for reasons of patient confidentiality and there does not appear to be any alternative way of ensuring they have all the information about a prisoner in order to help them with their drug use.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation 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 26th September 2018. 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] 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	 Mrs Joanne Lees Assistant Coroner Shropshire, Telford & Wrekin 1st August 2018