	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. G4S** **2. HM Prison and Probation Service** **3. 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 Ricardo Wayne Holgate. The investigation concluded at the end of an inquest on 10th January 2019. The conclusion of the jury at the inquest was: At the time of Ricky's death in March 2018, there was a significant issue with the supply and use of illicit substances within Birmingham prison. There was a failure to adequately control the supply and use of illicit substances within the prison. There was an insufficient ratio of staff to prisoners. The staff were inadequately trained and insufficiently experienced in dealing with the use and effects of illicit substances. There was a failure to rigorously implement the zero tolerance policy on the dealing and use of illicit substances in the prison. In the absence of a formal procedure about how to manage prisoners observed to be under the influence, staff made their own judgment about the response to an individual's use of illicit substances. Management of symptoms and formal reporting of individual use of illicit substances was inconsistent. The staff response to Ricky's use of illicit substances on 25th March was in line with the accepted processes at the time but did not comply with the zero tolerance policy.
4	**CIRCUMSTANCES OF THE DEATH** The jury recorded the following: Ricky was transferred to Birmingham Prison on 7th March 2018 and placed on K wing. At 9:30am on 25th March 2018 a prisoner on K wing was observed under the influence of an illicit substance and returned to his cell. Between 3 and 4pm, during association, Ricky was observed by a prison Officer with red eyes, walking slowly but talking and was thought to be under the influence of an illicit substance. This was not a cause for staff concern. At 16:45, healthcare staff were called to attend a number of prisoners on K wing who were under the influence of suspected psychoactive substances. A verbal report about Ricky was made to them by prison staff. By 5pm, Ricky was locked in his cell having been spoken to, while sat on the toilet, by a prison officer. Roll calls of the wing completed by 09:15pm and in the morning of 26th March by 6am. On the morning of 26th March, during routine unlocking 0f cell K1 -27 Ricky was discovered by a prison officer lying face down on his bunk with no pulse. He was declared dead at 7.54. The post mortem confirmed his death was due to coronary artery thrombosis contributed to by his use of synthetic cannabinoids and prescription codeine.

	Following a post mortem the medical cause of death was determined to be: 1a. CORONARY ARTERY THROMBOSIS 1b. CORONARY ARTERY ATHEROSCLEROSIS 2. COMBINED EFFECTS OF SYNTHETIC CANNABINOID AND CODINE
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 new Governing Governor confirmed that further steps are necessary to improve the management of illicit substance misuse. He confirmed the prison requires CCTV on all wings and airport style scanners – one in reception for prisoners and one in the visitor area. 2. Much progress has been made as a result of the appointment of the Governing Governor Paul Newton. His appointment was for 6 months. He advised at the inquest that there is much more work to do and extension of his appointment would allow further work to be undertaken to reduce the use and supply of illicit substances in the prison and to keep inmates safe.
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 8th 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 Community Healthcare NHS 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	11/01/2019 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**