	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **NHS England** **England.contactus@nhs.net** **NHS England** **PO Box 16738** **REDDITCH** **B97 9PT** 2. **Department of Health and Social Care** **The Rt Hon Matt Hancock MP** Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU
1	**CORONER** I am Jacqueline Devonish, Area coroner, for the Coroner area of Suffolk
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 6 March 2019 I commenced an investigation into the death of Mohammed Shabol AHMED, aged 33. The investigation concluded at the end of the inquest on 14 March 2019. The conclusion of the inquest was that the medical cause of death was unascertained and the conclusion Open. The jury also made the following findings of fact which caused or contributed to the death: a) The system at the prison relied upon the hospital and healthcare to tell the prison what to do regarding prisoner welfare b) There was a serious failure in the sharing of information between the prison, healthcare and the hospital **c)** There was inadequate training in the prison to deal with drug related incidents and their aftermath.
4	**CIRCUMSTANCES OF THE DEATH** Shabol Ahmed, a long-term illicit drug user, had been imprisoned at HMP Highpoint South for offending behaviours linked to his drug use. He was first imprisoned at the age of 18 and had been detained at different prisons. At the time of his death he had been an inmate at Highpoint since 21 June 2012, with a period at HMP Grendon from August 2016 to January 2016. He arrived at Highpoint with a diagnosis of Schizophrenia for which he had been prescribed olanzapine. He also had a Learning Disability. His olanzapine prescription was maintained in prison, although he was not always compliant. The evidence before the inquest was that he may have regularly used Spice in prison and had succumbed to the effects of it on at least three occasions. On two of those occasions he collapsed activating a code blue on 27 May and 18 July 2016. On 18 July he collapsed at 5pm. Healthcare attended and an ambulance transferred him to hospital. The effects of Spice were beginning to wear off by the time the ambulance arrived at 5.15pm. At 6.45pm the ambulance left the prison arriving at the hospital at 7pm. When seen by the Consultant at 7.10pm his observations were

	normal. He required no treatment and was returned to the prison at 9.25pm with no requirements for observation overnight. After having eaten he slept in his cell. The following morning at 6.20am Mr Ahmed was found deceased at roll call.
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 could 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 expert evidence of [redacted] (Emeritus of Forensic Medicine) gave evidence that the use of Spice can prime a person for an allergic reaction. In the case of Mr Ahmed Olanzapine and Spice combined to cause an adverse allergic reaction. He had been prescribed Olanzapine throughout his imprisonment in the knowledge of Spice use. (2) Healthcare records demonstrated that his eosinophilia count was recorded as reduced following a change in medication from Olanzapine to Risperidone. (3) The expert evidence was that it was a very rare side effect but one which the U.S. Food and Drug Administration has warned that drug reaction with eosinophilia and systemic symptoms has been reported with olanzapine exposure. (4) The jury was not able to find that the death was caused or contributed to by the use of Spice. It remains unclear whether the expert opinion is one which is or should be made known to clinicians nationally.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 1 May 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: [redacted] and the Governor of HMP Highpoint. I have also sent it to the Ministry of Justice who may find it useful or of interest. 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	**19 March 2019** Jacqueline Devonish