REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used after an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	The Governor, HM Prison Wormwood Scrubs
1	CORONER
	I am Mr Chinyere Inyama senior coroner for the coroner area of West London
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 24 th April 2016 an investigation was commenced into the death of Harold Chukwunedum Uzomechina then aged 34. The investigation concluded at the end of the inquest on 12 th September 2019. The conclusion of the jury at the inquest was that Mr Uzomechina died a drug related death to which a failure to recognise signs of cardio respiratory depression contributed. A factor preventing such recognition was an inadequate process of physical monitoring during the night state of Mr Uzomechina , the medical cause of death being:
	1a - aspiration pneumonia 1b – cardio respiratory depression 1c - multi-drug toxicity
4	CIRCUMSTANCES OF THE DEATH
	Mr Uzomechina was remanded to HMP Wormwood scrubs on 20th April 2016. At reception health screens, he reported physical and mental health problems as well as longstanding dependence on drugs and alcohol. A prison GP prescribed methadone for management of heroin dependency and chlordiazepoxide for alcohol withdrawal and symptom relief medication. Mr Uzomechina was transferred to the substance misuse stabilisation unit for detoxification. Late at night on 23rd April, Mr Uzomechina's cell mate asked to move cells because he said Mr Uzomechina was snoring so loudly that it was keeping him awake. At 8:55 the following morning, 24th April, officers were unable to wake Mr Uzomechina and a nurse was called. Despite attempts at CPR Mr Uzomechina was confirmed dead at 9:32 am
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. -

- There appeared to be differential treatment of detainees on the substance
 misuse unit at night compared to treatment they received during the day –
 specifically, detainees had the benefit of dedicated prison officers during the day
 time but not during the night.
- The totality of the evidence given by staff suggests that the at-risk population of detainees on the substance misuse unit were not afforded the same level care and attention given to detainees who were formally on an ACCT. This needs to be addressed.

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 16th December 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 Person: The family of the deceased and Care UK

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:** 21st October 2019

SIGNATURE: