REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Dr J Farrar Chief Executive HM Prison and Probation Service 102 Petty France London SW1H 9AJ

1 CORONER

I am Mr Andrew Haigh Senior Coroner for the coroner area of Staffordshire South

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 18 July 2018 I commenced an investigation into the death of Imran Mahmood aged 42 years. The investigation concluded at the end of the inquest on 4 September 2019. The conclusion of the inquest was drug related with the cause of death being morphine/heroin poisoning.

4 CIRCUMSTANCES OF THE DEATH

Imran was a serving prisoner found dead in his cell at HMP Dovegate on the morning of 16 July 2018. He had taken more heroin than his body could cope with. Imran had not engaged with the substance misuse team since 14 March 2018 because the drug he desired was not made available to him due to a national protocol. There was no knowledge of his drug use between 14 March 2018 to the time of his death.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed a matter 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 MATTER OF CONCERN is as follows -

Imran had cooked the heroin he took by using the heating coil in an e-cigarette (vaping device). I have previously dealt with a prison death in similar circumstances. I am aware that prisoners should be allowed e-cigarettes should they want them. However they do present a danger not just by way of drug use but also the ability to start fires. I wonder if e-cigarettes used in the

prison estate could be manufactured so that the heating component is in a sealed unit.

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 30 October 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:

Hudgells Solicitors for Imran's family

DWF Law Solicitors for Serco

Care UK

I have also sent it to the Prisons and Probation Ombudsman and the Independent Monitoring Board for HMP Dovegate 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 4 September 2019

Andrew A Haigh

HM Senior Coroner for Staffordshire (South)

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