Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 NHS England and NHS Improvement
2 Director General HM Prison and Probation Service

1 CORONER

I am Fiona KING, Assistant Coroner for the area of East Sussex

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 19/06/2018 I commenced an investigation into the death of Neville Lewis MCNAIR aged 51. The investigation concluded at the end of the inquest on 28 October 2019. The conclusion of the inquest was:

I a Heroin toxicity with aspiration

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

Mr McNair was remanded into custody at HMP Lewes on 23rd March 2018 where he remained until his death on 16th June 2018. He was found unresponsive in his cell and was not able to be revived following extensive CPR emergency services.

During the process of my investigation it was established that Mr McNair had accessed illegal heroin and had adapted an asthma inhaler in order to inhale it.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

In the Drug misuse and dependence: UK guidelines on clinical management "Orange Book" setting out UK guidelines on clinical management, section 5.4.9.1 states that 'all staff including non-health care staff and operational/security staff should have training in recognising and responding to opiate overdose including using available Naloxone. Naloxone should be available in resuscitation kits and risk assessed areas in the prison so that it can be accessed and administered by clinical and non-clinical staff as per the local protocol.' The Inquest was unable to establish that there was a local protocol and none of the prison staff were aware of the requirement. I am concerned that there is no Naloxone stored on the wings other than in healthcare wing and no prison officers appear to have been trained in its use or know of its existence. I believe this may be a national issue and not limited to HMP Lewes and in these circumstances this report should be seen as a concern for all prisons and NHS staff working in prisons nationally.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/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 31 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 Persons; the family of Mr McNair, Forward Trust, Sussex Partnership NHS Foundation Trust and Governor HMP Lewes.

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

Fiona KING
Assistant Coroner for
East Sussex
Dated: 05 November 2019