Her Majesty's Coroner
Staffordshire (South) Coroner's Jurisdiction

Date: 9 March 2020

Case: 150458

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

1. THIS REPORT IS BEING SENT TO:
Michael Spurr
National Offender Management Service,
Clive House , 70 Petty France,
London, SW1H 9AJ

2. CORONER
I am Andrew A Haigh HM Senior Coroner for Staffordshire South
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 28 December 2018 I commenced an investigation into the death of Robert Anthony BROWN. The investigation concluded at the end of the inquest on 6 March 2020. The conclusion of the inquest was 'Accidental death' with the cause of death given as:
1a Aspiration of Gastric Contents
1b Synthetic cannabinoid receptor antagonists (5F-ADB)

4.CIRCUMSTANCES OF THE DEATH
3a Basic Circumstances: Robert Brown a prisoner at Dovegate was pronounced dead at 9:33 within his cell from drug use on 25th December 2018.
3b Probable Causes: Despite contact with drug misuse staff Robert could not stop taking illicit drugs.
3c: Possible Causes: The evidence did not disclose any possible causative factors.

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. –
Although there was no finding by the Jury that this was causative in respect of the death at times during the inquest it appeared that information in the central NOMIS records, information in the medical System 1 records and information available to the security department at the prison was not available to all staff at the prison who may have benefitted from having it. I did hear helpful evidence from the Head of Safer Custody [redacted] that nationally efforts are being made to develop a system whereby significant

relevant information about a prisoner is available to all staff. There is however no timescale for this. It strikes me that this would be very helpful and might prevent deaths in the future. I wonder if you can give me a progress report about this planned development and an indication as to when it might be implemented.

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 27.04.2020 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:

- Mills Reeve – Solicitors for Care UK and MPFT
- DWF Solicitors - for Serco
- Southerns Solicitors – for the family

I have also sent it to the Prisons and Probation Ombudsman and the Independent Monitoring Board at 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 March 2020

Andrew A Haigh
Senior Coroner for Staffordshire South

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