Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Ministry of Justice 2. The Governor of Her Majesty's Prison Usk
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 27/9/2019 an investigation was opened into the death of Ian Anthony Charles Miller The investigation concluded at the end of the inquest on 9/12/2021 when a jury determined the following: The conclusion of the inquest was recorded as a narrative in the following terms Ian Miller was serving a term at Her Majesty's Prison Usk and was due for release on 27th October 2019. On 20th September 2019 Ian attended a probationary meeting during which he was informed that he would not be able to live at the family home or with his father-in-law. He could not have unsupervised contact with his children, and he might be homeless. Key persons present at the meeting did not have a prior relationship with Ian and did not know how devastating this news would be to him, and he was not placed under closer supervision. On 21st September 2019 Ian Miller took his own life by suicide. Ian [redacted]. Despite efforts by prison staff and the emergency services, Ian could not be revived, and he died in the prison at 16:55 hours.

	<u>The medical cause of death was:</u> 1a) Hypovolaemic shock 1b) Bleeding from radial artery [redacted].
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Ian Miller's death are set out in the narrative provided by the jury and need no further explanation.
5	**CORONER'S CONCERNS** During the course of the inquest, 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: - 1. <u>The management of medication prescribed to prisoners.</u> At post mortem examination the toxicologist determined that there were a number of drugs in Ian's blood and urine that he had not been prescribed. The court was informed that at HMP Usk, all prisoners are required to be capable of managing their own medication. The medications are not kept in a locked facility. The evidence provided clearly indicated that prisoners were trading prescribed medication which had become a form of currency within the prison. Ian's former cellmate indicated this practice was rife and indeed Ian bought medication from other prisoners. Evidence was heard from the Governor / Head of Safety at HMP Usk who informed the court that he was not aware of this practice, and it appears this was also not known by the prison officers. The court was informed that there is a system of randomised checks in place within the prison to attempt to determine whether prisoners are appropriately managing their medication, however prisoners have clearly found ways around this. Whilst the ingestion of unprescribed medication did not contribute to Ian's death, this practice, if left unchecked, clearly puts the lives of other prisoners at risk in the future.
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. <u>I should be grateful if the following information be provided to me:</u> 1. Confirm the steps that the prison is taking to address the risks posed by prisoners at HMP Usk trading prescribed medication.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 02/03/22 I, the Coroner, may extend this 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 necessary.
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) **The family of Ian Anthony Charles Miller** 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 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 05/01/22** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**