Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lewis Petryszyn, a prisoner at HMP Parc, on 15 April 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Lewis Petryszyn died in his cell on 15 April 2022 at HMP Parc. The cause of his death is as yet unascertained. A post-mortem report found no evidence of injury or natural disease. Post-mortem toxicological tests detected therapeutic levels of mirtazapine and olanzapine (an antipsychotic) and two types of psychoactive substances (PS). The pathologist concluded that he could not ignore Mr Petryszyn's use of PS as being relevant to the cause of death. He was 25 years old. I offer my condolences to Mr Petryszyn's family and friends.

Mr Petryszyn had a history of substance misuse but often denied using illicit substances in prison. Prison staff suspected that he was involved in distributing PS in the prison and appropriately acted on intelligence by conducting cell searches and a mandatory drug test. However, I am concerned about the availability of PS at Parc.

I am concerned that staff did not fully utilise the Challenge Support Intervention Plan process (a national model for managing those who are violent or pose a heightened risk of being violent) when it became clear that Mr Petryszyn may have assaulted vulnerable prisoners in relation to PS-related debt. This meant that staff missed the opportunity to put in place support for Mr Petryszyn and to explore the extent of his involvement in distributing PS.

I am also concerned that an officer put documentation about a disciplinary hearing under Mr Petryszyn's cell door 45 minutes before staff found him unresponsive. This should have been handed to him directly in line with local policy. This meant that staff missed a possible opportunity to provide emergency medical care to Mr Petryszyn sooner.

The clinical reviewer considered that the care Mr Petryszyn received at HMP Parc was equivalent to that which he could have expected to have received in the community. However, he found that a non-clinical prescriber prescribed Mr Petryszyn two antidepressants of the same class and that mental health staff did not follow up on a clinical indication that he likely had post-traumatic stress disorder.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **September 2023**

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Summary

Events

1. On 21 April 2021, Mr Lewis Petryszyn was sentenced to just under four years in prison for possession of class A drugs with intent to supply. He was sent to HMP Swansea and was then transferred to HMP Parc on 6 May.

2. On 15 October, a prison GP reviewed Mr Petryszyn and noted that he reported flashbacks of childhood trauma. He noted that Mr Petryszyn likely had post-traumatic stress disorder (PTSD) for which he prescribed fluoxetine (an antidepressant).

3. On 10 December, a pharmacist reviewed Mr Petryszyn's medication and noted that he had reported having an upset stomach since she had increased his dose of fluoxetine. She reduced his fluoxetine and added mirtazapine (an antidepressant).

4. On 6 April 2022, staff conducted an intelligence-based search of Mr Petryszyn's cell and found a 'debt list'. They made a Challenge Support Intervention Plan (CSIP) referral but there is no record of a formal plan. (CSIP is a national model used in prisons for managing those who are violent or pose a heightened risk of being violent.) The following day, staff tested Mr Petryszyn for illicit drugs.

5. On 13 April, staff moved Mr Petryszyn to another unit due to concerns about his behaviour and the possible threat that he posed to other prisoners. There is, however, no record that staff considered a CSIP referral. On 14 April, prison staff received confirmation that he had tested positive for PS. He was placed on report.

6. At 1.40pm on 15 April, a prison custody officer (PCO) went to Mr Petryszyn's cell to give him paperwork about his disciplinary hearing. He told us that he looked through the cell door observation panel, thought that Mr Petryszyn and his cellmate were asleep and slid the paperwork under the door.

7. At around 2.27pm, a PCO went to Mr Petryszyn's cell to deliver a prison shop order. She found Mr Petryszyn slumped on the floor and his cellmate sitting on his bed, staring into space. She shouted to a nearby PCO and tried to get a response from Mr Petryszyn. The other PCO arrived and helped to lay him on the floor. One PCO started cardiopulmonary resuscitation (CPR) while at 2.32pm, the other radioed a medical emergency code.

8. At 2.34pm, a healthcare assistant (HCA) arrived with an emergency medical bag and applied a defibrillator. Additional healthcare staff arrived shortly afterwards and assisted with the resuscitation efforts. At 2.45pm, the first paramedics arrived at Mr Petryszyn's cell and provided emergency care. At 4.03pm, a critical care doctor pronounced that Mr Petryszyn had died.

Findings

9. There was intelligence suggesting that Mr Petryszyn was involved in distributing PS around the prison but little evidence to suggest that he was using illicit substances. While we are satisfied that prison staff appropriately submitted intelligence reports

and acted on these by conducting cell searches and arranging for Mr Petryszyn to have a drug test, we are concerned about the availability of PS at Parc.

10. Olanzapine, a medication that Mr Petryszyn had not been prescribed, was found in his blood, so he must have obtained it illicitly. We consider that the prison's drug strategy needs updating to cover the diversion of prescribed medication.

11. While we are satisfied that staff made a CSIP referral on 6 April following concerns that Mr Petryszyn was bullying others, we are concerned that they did not start a formal plan. We are also particularly concerned that staff did not make a referral on 13 April when he was moved to another unit.

12. The officer who put the disciplinary hearing paperwork under Mr Petryszyn's cell door should have handed it to him in person. Had he done so, he might have noticed that Mr Petryszyn was in need of medical assistance. The clinical reviewer considered that the care Mr Petryszyn received at HMP Parc was equivalent to that which he could have expected to receive in the community. However, he found that a non-clinical prescriber prescribed Mr Petryszyn two antidepressants of the same class and that mental health staff did not follow up on indications noted by a clinician that Mr Petryszyn likely had PTSD.

Recommendations

- The Director should ensure that Parc's drug supply and demand reduction strategy:
  - is up-to-date and properly implemented to help reduce the availability and misuse of illicit substances; and
  - includes measures to address the diversion of prescribed medication.
- The Director should ensure that all operational staff:
  - are aware of when and how to submit a CSIP referral; and
  - consider progressing CSIP referrals regardless of whether a prisoner has been moved to a different location.
- The Director should ensure that documents about disciplinary hearings are given directly to prisoners.
- The Head of Healthcare should ensure that:
  - mental health staff conducting assessments explore potential diagnoses listed in the referral letter; and
  - non-medical prescribers prescribe within their level of competence and follow recommended guidelines.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator obtained copies of relevant extracts from Petryszyn's prison and medical records.

15. The investigator interviewed eight members of staff and one prisoner at Parc and by video conference between 9 May and 14 July 2022.

16. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Petryszyn's clinical care at the prison. The clinical reviewer and investigator jointly interviewed one member of healthcare staff.

17. We informed HM Coroner for Cardiff, Bridgend and Glamorgan Valleys of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Petryszyn's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She asked if his cell bell was activated on 15 April. Prison records show that Mr Petryszyn's cell bell was activated at 12.14pm and reset at 12.15pm. As this was earlier in the day and Mr Petryszyn was observed after this, we do not consider it relevant to his death.

19. Mr Petrysyn's family received a copy of the initial report. The solicitor representing Mr Petryszyn's family wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

20. The initial report was shared with the HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Parc

21. HMP Parc is a medium security private prison run by G4S. It holds around 1,600 prisoners and young adults who are either on remand or convicted.

22. At the time of Mr Petryszyn's death, G4S Medical Services provided primary physical and mental health care services at Parc. However, on 16 December 2022, Cwm Taf Morgannwg University Health Board took over physical and mental health services. There is 24-hour general healthcare and palliative care facilities. A local GP practice provides GP services, including a daily clinic and out-of-hours cover. Three healthcare staff are located in the prison at night.

HM Inspectorate of Prisons

23. The most recent inspection of Parc was in November 2019. Inspectors found that most health services remained reasonably good, although secondary mental health provision was poor. Many prisoners described access to health services and treatments as problematic, but inspectors found an appropriate range of primary care services. Since their last inspection in January 2016, a comprehensive drug supply reduction policy had been developed and a range of measures to reduce the availability of drugs, including body and post scanners, had been introduced, and this was having positive results. The supply reduction policy was part of a wider drug treatment and support strategy.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to February 2019, the IMB noted that tackling the supply of drugs into the prison was an ongoing high priority for management.

Previous deaths at HMP Parc

25. Mr Petryszyn was the twelfth prisoner to die at Parc since April 2020. Nine of the previous deaths were from natural causes and two were drug-related. There were no similarities with the findings of our investigations into the previous deaths. There have been four natural causes deaths, one self-inflected death and one unclassified death at Parc since Mr Petryszyn's death.

Psychoactive substances

26. Psychoactive substances (PS, previously known as 'legal highs') are a problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high

tolerance of pain and a potential for violence. Besides evidence of dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

HMP Swansea

27. On 21 April 2021, Mr Lewis Petryszyn was sentenced to just under four years in prison for possession of class A drugs with intent to supply and was sent to HMP Swansea. He had a history of substance misuse but following assessment, the substance misuse team decided that he did not meet the criteria for intervention.

HMP Parc

28. On 6 May, Mr Petryszyn was transferred to HMP Parc as part of his sentence progression. A nurse conducted an initial reception screen and recorded that Mr Petryszyn had a history of substance misuse. However, he declined a referral to the substance misuse service.

29. On 29 June, a Prison Custody Officer (PCO) visited Mr Petryszyn for a keywork session. She recorded that he said he felt safe and did not report any concerns. (Mr Petryszyn had a total of 11 keywork sessions at Parc.)

30. On 28 September, officers searched Mr Petryszyn's cell, which he shared with another prisoner, after a search dog indicated the presence of illicit substances. Officers found four litres of prison-brewed alcohol (known as hooch) and placed Mr Petryszyn on report.

31. On 15 October, a prison GP reviewed Mr Petryszyn. He noted that Mr Petryszyn said that flashbacks of being assaulted as a child were causing him to wake up at night. The GP noted that Mr Petryszyn likely had post-traumatic stress disorder (PTSD) and prescribed fluoxetine (an antidepressant).

32. On 8 November, a pharmacist reviewed Mr Petryszyn's medication and noted that Mr Petryszyn did not feel fluoxetine was working. She increased his fluoxetine and made a mental health referral.

33. On 10 December, the pharmacist conducted a medication review and recorded that Mr Petryszyn reported ongoing anxiety and said that he had had an upset stomach since she increased his fluoxetine. She reduced his fluoxetine and added mirtazapine (another antidepressant).

34. On 18 December, staff submitted an intelligence report after they observed Mr Petryszyn with lacerations to his face. He said that he had fallen, had lots of issues and needed to be moved from the wing. Later that day, prison staff moved Mr Petryszyn from unit A1 to unit A2.

35. On 30 December, a support and engagement practitioner contacted Mr Petryszyn on his cell phone for a welfare check. She recorded that he had recently moved to another unit, Cynnwys Unit (for prisoners with learning difficulties who need extra support) and felt more settled. He also said that he wanted to work towards getting a prison job as he struggled with being in his cell for long periods of time.

2022

36. On 10 January 2022, the pharmacist saw Mr Petryszyn for a medication review. She noted that he reported some improvement in his mood and was happy for his medication to remain the same.

37. On 3 February, a search dog indicated the possibility of illicit substances in Mr Petryszyn's cell. Officers searched the cell and found around 10 litres of hooch. They placed him on report.

38. On 11 February, prison staff submitted an intelligence report which said that there was a lot of activity around Mr Petryszyn's cell. It also said that staff had suspended him from his job as a unit painter as they suspected he was obtaining items from the servery to make hooch. The next day, officers searched Mr Petryszyn's cell and found an excessive number of canteen (prison shop) items.

39. On 13 February, an Inreach mental health nurse visited Mr Petryszyn to conduct an initial assessment. She recorded that he had felt at risk from other prisoners while he was on a standard unit but was more settled in Cynnwys unit. She added that he remained compliant with his medication and concluded that he did not need any changes to his treatment. There is, however, no record that she considered PTSD.

40. On 1 March, an officer visited Mr Petryszyn for a keywork session and recorded that he said that he felt safe on Cynnwys unit and had a good relationship with the other prisoners.

41. On 10 March, prison staff conducted a search of Mr Petryszyn's cell and found a sheet of paper which they suspected was infused with PS. Mr Petryszyn was placed on report, but it later transpired that the paper tested negative for PS and staff dismissed the charge.

42. On 11 March, an assistant psychologist saw Mr Petryszyn for a PS rapid response review, but he denied using illicit substances in prison.

43. On 6 April, prison staff conducted an intelligence-based search of Mr Petryszyn's cell and found a 'debt list'. They also found two broken mops, paper which they suspected was infused with PS and an improvised smoking device. Mr Petryszyn and his cellmate were placed on report.

44. Later that day, an acting operational manager made a Challenge Support Intervention Plan referral (CSIP, a national case management model for managing those who are violent or pose a heightened risk of being violent). He recorded that there was intelligence to suggest that Mr Petryszyn was assaulting vulnerable prisoners on the unit and dealing PS but there is no indication about what action would be taken.

45. On 7 April, staff conducted a suspicion-based mandatory drug test on Mr Petryszyn. Later that day, a substance misuse worker saw him for a PS rapid response review. At interview, she told the investigator that Mr Petryszyn admitted to using PS at night and that she gave harm reduction advice.

46. On 10 April, prison staff submitted an intelligence report stating that a prisoner was in significant debt due to smoking all the PS he was selling for Mr Petryszyn.

47. On 13 April, staff moved Mr Petryszyn to A4 unit due to concerns about his behaviour and the possible threat that he posed to other prisoners. However, there is no record that they considered a CSIP referral.

48. On 14 April, Mr Petryszyn tested positive for PS. They placed him on report and noted that a disciplinary hearing would not take place before 16 April. Later that day, prison staff submitted an intelligence report which said Mr Petryszyn's cell smelt of PS when they returned his cellmate from the segregation unit.

Events of 15 April

49. At 11.00am, prison phone records show that Mr Petryszyn called a friend and asked if anyone had put money in his account. At 11.55am, he phoned his mother and asked her to put £10 into another prisoner's account. He also said that he was "not selling anything anymore as he had moved back to the main block".

50. At 12.31pm, CCTV footage shows that a PCO opened Mr Petryszyn's cell door to conduct a routine check. She told the investigator that she could not remember seeing anything unusual. (CCTV footage was two minutes slow and the timings have been amended to reflect this.)

51. At interview, the cellmate told the investigator that shortly after they were locked in their cell for the afternoon, Mr Petryszyn offered him PS. He said that they smoked the PS through a pipe and that he fell asleep. He added that at one point, he woke up briefly and saw Mr Petryszyn being sick in the toilet but thought nothing of it.

52. At 1.40pm, a PCO went to Mr Petryszyn's cell to give him his disciplinary hearing paperwork. He told us that he looked through the cell door observation panel, saw Mr Petryszyn and his cellmate lying on their beds asleep. He said that he did not have any concerns about their welfare as it was common for prisoners to have an afternoon nap and he slid the paperwork under the cell door.

53. At 2.27pm, CCTV footage shows that PCO A walked towards Mr Petryszyn's cell to deliver a prison shop order. She opened the door and found him on the floor in a kneeling position, with his head facing the window while Mr Mathias was sitting on his bed, "staring into space". She saw that one of Mr Petryszyn's legs was blotchy and went onto the landing and shouted for PCO B, who was nearby. She returned to the cell and tried to get a response from Mr Petryszyn by nudging his back and calling his name. At 2.30pm, PCO B arrived and noticed that his face was blue. She laid him on the floor with PCO A's help. PCO A established that Mr Petryszyn was not breathing and started CPR.

54. At 2.31pm, PCO B tried to radio a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties) but her radio did not send the message. She asked PCO A for her radio and called a code blue at 2.32pm. Additional prison staff arrived immediately, escorted the cellmate out of the cell and helped with the resuscitation effort.

55. At 2.34pm, a Healthcare Assistant (HCA) arrived with emergency medical equipment and applied a defibrillator. More healthcare staff, including several registered nurses, arrived shortly afterwards and helped with the resuscitation effort.

56. At 2.40pm, an ambulance arrived at the prison and at 2.45pm, the first paramedics arrived at Mr Petryszyn's cell. The paramedics helped staff to move Mr Petryszyn onto the landing for easier access and provided emergency care. At 4.03pm, a critical care doctor pronounced that Mr Petryszyn had died.

Contact with Mr Petryszyn's family

57. At 4.20pm, the prison appointed a prison chaplain as the family liaison officer. At 6.00pm, the prison chaplain and a prison manager visited Mr Petryszyn's mother, his named next of kin. They broke the news of Mr Petryszyn's death and offered support.

58. The prison chaplain supported Mr Petryszyn's mother until his funeral, which took place on 7 May. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

59. After Mr Petryszyn's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

60. The prison posted notices informing other prisoners of Mr Petryszyn's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Petryszyn's death.

Post-mortem report

61. The post-mortem report found no evidence of injury or natural disease considered sufficient to cause Mr Petryszyn's death. Post-mortem toxicological analysis of his blood and urine detected therapeutic levels of mirtazapine and olanzapine (an antipsychotic) and two types of PS (ADB-BUTINACA and MDMB-4en-PINACA). The pathologist concluded that while he could not say whether there was any interaction between the drugs detected, he could not ignore the use of PS as being relevant to the cause of death.

Findings

Psychoactive substances

62. The post-mortem report concluded that the presence of PS in Mr Petryszyn's system could not be ignored when considering its relevance to the cause of his death. Mirtazapine and olanzapine were also present in his blood. Mr Petryszyn was not prescribed olanzapine so he must have obtained it illicitly.

63. Mr Petryszyn had a history of illicit substance misuse and was suspected of being involved in the distribution of PS. We are satisfied that for the most part, prison staff submitted appropriate intelligence reports and acted on them by conducting cell searches and a suspicion-based drug test. Mr Petryszyn admitted to taking PS once, during a PS rapid response review on 7 April, and we are satisfied that a drugs worker gave him appropriate harm reduction advice.

64. HMPPS's Drug Strategy, published in April 2019, highlights the importance of building a picture of the security risks to enable prisons better to target their resources to tackle them. At the time of Mr Petryszyn's death, Parc had a drug and alcohol strategy dated 2019-2020. (The prison told us that they were updating the strategy and gave the investigator a draft version dated 2022-2023). The 2019-2020 strategy acknowledged that the use of PS had substantial implications for prisoners' health and sets out measures to target PS trafficking, including the use of intelligence, mobile phone detection technology, scanning prisoners' mail and upgraded CCTV of the external perimeter of the prison.

65. However, we are concerned that staff smelt PS coming from Mr Petryszyn's cell on 14 June, eight days after PS was removed from his cell and one day after he had been moved to another unit. This suggests that he did not have much difficulty obtaining more PS. We are concerned that despite a comprehensive drug strategy and measures to stop the supply of illicit substances, the strategy was out of date and Mr Petryszyn was seemingly able to easily obtain illicit drugs. We therefore consider that that more needs to be done to address the issue of drugs at Parc.

Diverted medication

66. Olanzapine, an antipsychotic which is highly tradeable in prison, and which had not been prescribed to Mr Petryszyn, was found at a therapeutic level in his system after his death, although it was not listed as a cause of death. We are concerned that the drug strategy in place at the time of Mr Petryszyn's death and the proposed new strategy do not cover the diversion of prescribed medication. We make the following recommendation:

    The Director should ensure that Parc's drug supply and demand reduction strategy:

    - **is up-to-date and properly implemented to help reduce the availability and misuse of illicit substances; and**
    - **includes measures to address the diversion of prescribed medication.**

Violence reduction

67. When staff received intelligence on 6 April that Mr Petryszyn was involved in the distribution of PS and was bullying other prisoners, they appropriately made a CSIP referral. However, there is no record that they considered starting formal CSIP procedures. We consider that staff missed an opportunity to explore Mr Petryszyn's behaviour in more detail and to establish the extent of his involvement in distributing PS.

68. Moving Mr Petryszyn to another cell on a different unit on 13 April was not sufficient. Prison staff should have made a CSIP referral but missed another opportunity to explore his behaviour and put in place a plan that might have resulted in added support. We therefore make the following recommendation:

The Director should ensure that all operational staff:

- **are aware of when and how to submit a CSIP referral; and**
- **consider progressing CSIP referrals regardless of whether a prisoner has been moved to a different location.**

Issuing disciplinary hearing documents

69. An officer put Mr Petryszyn's paperwork about his disciplinary hearing under his cell door on 15 June. Although a safer custody co-ordinator confirmed that it was a local requirement that staff must hand documents about disciplinary hearings to prisoners directly, the officer told the investigator that he started his role mid-way through the COVID-19 pandemic and was told to slide them under cell doors. He also said that some officers opened cell doors to deliver them.

70. The officer should have tried to wake Mr Petryszyn so that he could hand him the document about the disciplinary hearing directly. This was particularly important as Mr Petryszyn shared a cell and staff should have made sure that the correct prisoner received it. Had he done so, he might have noticed that Mr Petryszyn was under the influence and needed medical help.

71. While we cannot know whether early intervention would have changed the outcome for Mr Petryszyn, it would have allowed for access to potentially life-saving treatment. We make the following recommendation:

The Director should ensure that adjudication documents are given to directly prisoners.

Clinical care

72. The clinical reviewer concluded that the clinical care that Mr Petryszyn received at Parc was equivalent to that which he could have expected to receive in the community. Healthcare staff reviewed him when needed and he was seen for a PS rapid response review following intelligence that he was suspected of using PS. However, he found some areas for improvement, namely the prescribing of dual antidepressants by a non-medical prescriber and the failure of staff to acknowledge the possibility of PTSD at an initial mental health assessment.

73. The clinical reviewer considered that the pharmacist should not have prescribed Mr Petryszyn mirtazapine and fluoxetine in combination. He noted that the National Institute for Care Excellence (NICE) Clinical Knowledge Summary (CKS) for use of antidepressants stated that only a doctor with specialist experience should prescribe this class of antidepressants (selective serotonin reuptake inhibitors) together. He added that young people were particularly at risk of adverse effects from this class of medication and that they could lead to an increase in impulsivity.

74. The clinical reviewer also considered that while Mr Petryszyn had a mental health assessment on 13 February 2022, there was no record that the primary reason for the referral, the possibility of PTSD, was considered. We agree with the clinical reviewer that PTSD should have been explored and the outcome recorded in Mr Petryszyn's medical record. We make the following recommendation:

The Head of Healthcare should ensure that:

- **mental health staff conducting assessments explore potential diagnoses listed in the referral letter; and**

- **non-medical prescribers prescribe within their level of competence and follow recommended guidelines.**

Inquest

75. At the inquest, which took place on 9 April 2025, the Coroner concluded that Mr Petryszyn died as a consequence of the inhalation of drugs.

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