REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1.** HM Prison Service (NOMS) **2.** North Tees and Hartlepool NHS Trust **3.** Tees, Esk & Wear Valley NHS Foundation Trust
1	CORONER I am Anthony Gerard Eastwood, Assistant Coroner, for the coroner area of Teesside.
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 31 March 2009 I commenced an investigation into the death of Andrew Ronald Hall aged 41 years (date of birth 6 June 1967). The investigation concluded at the end of the inquest on 13 June 2013. The conclusion of the inquest was that Andrew Ronald Hall killed himself while the balance of his mind was disturbed and the cause of death was contributed to by negligent. The jury also recorded their findings in a narrative form a [redacted]
4	CIRCUMSTANCES OF THE DEATH Between 19.20 hours and 19.35 hours on 27 March 2009 in cell 5 of Health Care Unit at HM Holme House Prison the deceased caused incised wounds to his neck causing hypovolaemic shock which caused his death. On the said date the deceased was an inmate detained lawfully at Her Majesty's Prison Holme House.
5	<u>CORONER'S CONCERNS</u> During the course of the inquest the 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 set out below. I have for ease of reference highlighted in bold type where a particular body or organisation is specifically referred to, and in brackets at the end of the entry, where the jury were silent but where I consider the body or organisation being referred to has responsibility to deal with it – 1. In the assessment of risk and risk management the jury found (inter alia) information provided by **mental healthcare nursing** staff to **Prison Officers** was not correctly documented. 2. There was inadequate communication between members of the **Mental Health team** as to the deceased's condition and the level of risk of self-harm.

	3. There was inadequate communication between members of the **Mental Health Team** and the **Healthcare Unit staff** as to the deceased's perceived condition and level of risk of self-harm. 4. There was inadequate communication between the **Mental Health In Reach Team** and the **mental care unit staff** as to the type and level of observation required when the deceased was re-admitted to the Healthcare Unit on 23 March 2009. 5. Insufficient attention was paid by **healthcare professionals** to the system 1 entries. 6. That **both mental health staff and general nursing staff** inadequately took into account the entry made by [redacted] 7. That a post-closure interview in accordance with the (then) ACCT policy should have been conducted. (**Prison staff, healthcare staff and Mental Health team**) 8. Medication was not administered to the deceased on 23 March 2009 and 24 March 2009 as prescribed. (**Medical healthcare staff)** 9. The deceased was not adequately observed between 6.30pm and 7.30pm on 27 March 2009. **(Healthcare staff/Prison discipline officers)** 10. The quality of CCTV images within the healthcare unit was inadequate. **(prison service)** **11.** Arrangements for staff members to use the CCTV screens were absent. **(Prison service & Healthcare staff)** **12.** There was infrequent observation of the CCTV screens on 27 March 2009. **(Prison service & Healthcare staff)** 13. Generally the training and induction to **visiting Psychiatrists** in respect of the ACCT process was relevant to the circumstances in which the deceased died. 14. The practice of **healthcare professionals** regarding the reading of previous system 1 entries was also relevant to the circumstances in which the deceased died. 15. The awareness of prison policies in relation to the use of camera cells was also relevant to the circumstances in which the deceased died. **(Prison service & Healthcare staff)** 16. The training and instructions given to **prison officers and nursing staff** regarding use of and manipulation of the CCTV image was also "relevant" to the circumstances in which the deceased died.
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 [9th May 2014]. 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 the deceased, Andrew Ronald HALL [and see panel 1 above]. 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	12 th March 2014 [SIGNED BY CORONER]

[redacted]