	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Spectrum Community Health** **2. National Offender Management** **3. G4S**
1	**CORONER** I am Andrew Tweddle Senior Coroner, for the Coroner area of County Durham and Darlington.
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 02.06.2015 I commenced an investigation into the death of John Brandon Betteridge, 43 years. The investigation concluded at the end of the inquest on28.06.2016. The conclusion of the inquest Suicide including a medical cause of death of 1a) Pressure on the Neck due to 1b) Hanging. The jury also concluded that the fact that the deceased did not have his prescription medication during his time of imprisonment during his time at HMP Durham possibly contributed more than minimally to his death. The jury concluded that the deceased should have been subject to an open ACCT at the time of his death. The jury also concluded that the fact that the deceased was not on an open ACCT at the time of his death probably contributed more than minimally to his death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was remanded to HMP Durham on Friday 22nd May 2015. At an initial health screening it was recorded that he had a history of drug use and that he was taking prescribed medication for depression and anxiety but did not have any medication with him. He had self-harmed a long time previously but it was said had no current thoughts of suicide. He tested positive for the use of opiates. He was told that he would not be able to receive any prescribed medication until the prison GP could check the situation with his community GP which would not be until the following Tuesday as this was a bank holiday weekend. On the night of 23/24th May the deceased self-harmed. An ACCT was opened. Some 9 hours after the ACCT was opened the ACCT was closed. Healthcare staff were not present at the ACCT closure. The jury found that the deceased hung himself as an act of suicide on the night of Monday 25th May and was found dead at roll call in his cell at 4.55 am on the morning of Tuesday 26th May.
5	**CORONER'S CONCERNS** 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 as follows. – (1) A member of the Healthcare staff indicated that at the time of the death, though she was working in the prison, she had not received any ACCT training. I was told that ACCT training is now part of Healthcare staff induction training. A prison GP with 11 years' experience of working in prisons stated that he had never received ACCT training though he had opened ACCTs. A Senior Officer who chaired the first review of the

	ACCT (at which the ACCT was closed) believed it was good practice but did not know it was mandatory that healthcare staff should be present at such a review. The inquest has shown that notwithstanding that the ACCT system has been in existence for a number of years, some staff were working without having received any training and some either had not had sufficient training or had forgotten it or were not applying it with the result that mandatory provisions in the ACCT process were not being adhered to. The inquest has indicated a clear training need.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 25th August 2016 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:- [redacted] HMP Durham 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	**Dated**...30-11-16..... **Signed**...[signature] **HM SENIOR CORONER** **COUNTY DURHAM AND DARLINGTON**

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. National Offender Management Service** **2. NHS England**
1	**CORONER** I am Andrew Tweddle Senior Coroner, for the Coroner area of County Durham and Darlington.
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. (see attached sheet)
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4	**CIRCUMSTANCES OF THE DEATH** The deceased was remanded to HMP Durham on Friday 22nd May 2015. At an initial health screening it was recorded that he had a history of drug use and that he was taking prescribed medication for depression and anxiety but did not have any medication with him. He had self-harmed a long time previously but it was said had no current thoughts of suicide. He tested positive for the use of opiates. He was told that he would not be able to receive any prescribed medication until the prison GP could check the situation with his community GP which would not be until the following Tuesday as this was a bank holiday weekend. On the night of 23/24th May the deceased self-harmed. An ACCT was opened. Some 9 hours after the ACCT was opened the ACCT was closed. Healthcare staff were not present at the ACCT closure. The jury found that the deceased hung himself as an act of suicide on the night of Monday 25th May and was found dead at roll call in his cell at 4.55 am on the morning of Tuesday 26th May.
5	**CORONER'S CONCERNS** 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 as follows. – The deceased arrived at prison on a Friday evening of a bank holiday weekend. It was thus not possible for healthcare staff to be able to make contact with a community GP to verify what prescription drugs (if any) the deceased was receiving. The jury concluded that the fact that the deceased was denied his medication possibly contributed to his death. Evidence was given that it is proposed that changes will be made to the relevant computer systems to enable suitably qualified healthcare staff to be able to access GP

	records (with patient consent) out of hours and at weekends and at bank holidays in a similar way that GP's can do in the community. No fixed date was known as to when such a system would be fully implemented and operational. The evidence clearly indicates there is a need for such a system to be implemented and operational without delay.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
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9	**Dated**..30-VI-16... **Signed**..... **HM SENIOR CORONER** **COUNTY DURHAM AND DARLINGTON**

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5	**CORONER'S CONCERNS** 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 as follows. – It became clear in evidence that once an ACCT had been closed, despite instructions in Prison Service instructions to the contrary, it was not being left in the wing office but was taken as a matter of routine to the safer custody office where it would be processed further. Thus, wing staff were denied the opportunity of learning potentially important background information about prisoners on the wing and in their care from that closed ACCT, particularly bearing in mind that a post closure review is mandatory.

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