	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Michael Spurr, Chief Executive, National Offender Management Services, Clive House, 7 Petty France, London SW1H 9EX.** 2. [redacted] **Governing Governor, HMP Durham, 19b Old Elvet, Durham, County Durham DH1 3HU** 3. [redacted] **Head of Compliance, GEOAmey, PECS Limited, The Whittle Estate, Cambridge Road, Leicester LE8 6LH** 4. **Mick Parish, Chief Executive, CARE UK, Connaught House, 850 The Crescent, Colchester Business Park, Colchester, Essex C04 9QB** 5. [redacted] **National Clinical Director, G4S, Medical Services, Great Bardfield, Essex, CM7 4SL**
1	**CORONER** I am Crispin A Oliver Senior assistant 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 29th August 2014 the investigation commenced into the death of Derek Thomas, born 9th January1965. He died on the 28th August 2014 at 15.04 hours at HMP Durham. The medical cause of death was 1a Pressure on the neck caused by 1b Hanging. The investigation commenced on the 29th August 2014 and the inquest was opened on 29th September 2014. There was an inquest hearing at which the jury found that Mr Thomas had died as a result of suicide. Further it was more likely than not, that the following issues possibly contributed to the cause of Mr Thomas's death; 1. The completed suicide/self help self harm warning form ("SASH") was received at the prison at the time of Mr Thomas's arrival on the 21st July 2014 and that it was overlooked by prison staff and healthcare staff; 2. The person escort record form ("PER") was inadequately completed in respect of the risk of self harm/suicide and that the information it did contain was not adequately read by either prison staff or healthcare staff. Having already indicated that I was considering a possible Regulation 28 Report, I adjourned the inquest to the 14th December 2015 when it would be closed, and the investigation conclude. I invited written submissions and statements of evidence by the interested parties to be submitted by 4.30 p.m. on the 11th of December 2015. I am aware that although not represented at the inquest hearing, Care UK are on notice of the outcome on 4th December 2015. I am also aware that G4S Medical Services who took over provision of healthcare services HMP Durham from 1st April 2015, who were not represented at the hearing of the inquest have also been put on notice of the outcome.
4	**CIRCUMSTANCES OF THE DEATH** Derek Thomas was convicted on the 21st of July 2014 with indecent assault. He was placed on remand pending sentencing. He arrived at and entered HMP Durham as a prisoner ~~Durham~~ at 17.45 that day and went through reception from 18.30, first night thereafter first night induction, was handed to a nurse at 22.00 and medical assessment with a nurse from 00.01 on 22nd July 2014.

	Before departing from Newcastle Quayside Crown Court information suggesting suicidal intent was relayed to GEOAmey escort staff by Mr Thomas's barrister which was referred to both on the SASH form and in the history and events section of Mr Thomas`s PER form. On the findings of fact made by the jury, together with the uncontested evidence at the inquest in Mr Thomas's case there were at least 6 departures from correct procedure by three agencies: A. A GEOAmey officer failed to complete the PER form property by: 1. Not placing a tick in the "SASH box" on the front of the PER form; 2. Not properly completing the risk indicator page to highlight the comment from the barrister; 3. Not including the SASH form on the escort handover page. B. The GEOAmey officer failed to wait for a signed copy of the SASH (such being agreed evidence of all the GEOAmey prison witnesses). C. A reception officer overlooked the existence of the SASH amongst the documents handed over by GEOAmey staff. D. A reception officer failed to read the history and events section of the PER. E. A member of healthcare overlooked the SASH on Mr Thomas's file; and a member of healthcare failed to read the history and events section of the PER. All of these occurring during the course of Mr Thomas's reception and first night induction at HMP Durham on the 21st -22nd July 2014.
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. – If any one of the matters A-E had been done, the information suggesting suicidal intent would have come to prison and healthcare staff attention. On behalf of the prison and GEOAmey counsel have provided skilfully argued, informative, written submissions. It is pointed out that HMP Durham already has a system in place for ensuring the risks of suicide and self harm are properly communicated to it by escort contractors. Further that the circumstances in reception on the 21st July 2014 were departed from due to human error in particularly extreme circumstances in which a exceptionally large number of prisoners were received into the prison at one time. It has since been underlined by Governors Notice issued to all staff that the PER form should be read, and that it is a potential disciplinary offence to contravene this. On behalf of GEOAmey it has been submitted that the deficiencies with regards to the completion of the forms and waiting for a signed copy of the SASH form is acknowledged. It is further submitted that GEOAmey has the deficiencies in mind in terms of ongoing training and that there is a pilot programme commencing 17th November 2015 involving a new PER form, incorporating the SASH form. The submissions exhibit a witness statement from Thomas Airey, Head of Compliance at

	GEOAmey, which sets out in detail the work being undertaken in relation to training and the new PER form/SASH form. The matters of concern that I have, the above submissions and statement notwithstanding, are: (1) That the circumstances on the 21st July 2014 at the reception included an inexperienced officer being on duty in conditions which were particularly onerous. It was described as the busiest he had ever seen by another more senior officer who was called away to deal with an incident, just at the time Mr Thomas was arriving in reception. Prison staff were adamant that another officer would have filled the gap left (although the identity of the substituting prison officer was not provided). These circumstances were clearly very demanding but they were not unforeseeable and may be repeated in future. When the procedures were "stress-tested" in the way they were on 21st July 2014, they failed so that a SASH form went unnoticed. (2) That the GEOAmey staff and Prison reception staff (including very experienced officers with both) had conflicting impressions of which Prison Officer (the one dealing with the warrants and Core record alternatively the one dealing with the property and the PER) was supposed to be the recipient of the SASH form. Training and refresher training as to their own procedures notwithstanding, there is a lack of appreciation by GEOAmey escort staff of the prisons`s reception procedures. There is a lack of awareness by prison staff of GEOAmey staff`s ignorance of them. Alternatively, the prison reception staff develop the procedures without keeping GEOAmey staff informed. There is a tangible sense of one hand not knowing what the other is doing. (3) That Prison reception staff in their evidence were adamant that a SASH form could never have been overlooked. However, prison staff at every level could provide no detailed, documented and tracked, account for how the SASH form had reached the prison records for Mr Thomas. There is an over reliance on the fidelity of the system, even when it has failed. No questions were asked at any stage on 21st July 2014, when it it passed from GEOAmey staff, to reception staff, to healthcare, or thereafter as to how a SASH form had arrived in the prison without being previously noticed. (4) That the above concerns are not addressed by, and go beyond, the Governor`s Notice to Staff of 8th December 2015. (5) That the above concerns go to the issue of the inter-operability of GEOAmey and prison and healthcare procedures, which is not yet addressed by any of the agencies. I note that the pilot scheme is designed to improve "information sharing" between agencies. I am concerned that this case provides a paradigm example of not just a failure in communication between agencies but a deeper failure in properly appreciating each other`s procedures and potential weaknesses where they are supposed to inter-connect. Looked at holistically, the system is demonstrated to be dysfunctional in this case.
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 10TH February 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] (next of kin of Derek Thomas), [redacted] on behalf of the Treasury Solicitor, A1 MOJ Private Law Litigation, Government Legal Department, One Kemble Street, London, WC2B 4TS, [redacted] at BLM Kings House, 42 Kings Street West, Manchester, M3 2NU, [redacted] at BLM, Kings House, 42 Kings Street West, Manchester, M3 2NU, [redacted] at BLM, Park Row House, 19-20 Park Row, Leeds, LS1 5JF. 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	**15TH DECEMBER 2015** **[SIGNED BY CORONER]**