	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Director of National Operational Services, National Offender Management Service** 2. **HM Inspector of Prisons** 3. **Independent Advisory Panel on Deaths in Custody**
1	**CORONER** I am Crispin A Oliver, 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 26th July 2017 I commenced an investigation into the death of John Mayhew, 56 years old. The investigation concluded at the end of the inquest on 28th November 2018. The conclusion of the inquest was that John Mayhew died from 1a) Hanging at HMP Durham on 15th January 2017 and the conclusion was Suicide plus a narrative that included that inadequate efforts were made to obtain information relevant to risk to Mr. Mayhew including from probation officers.
4	**CIRCUMSTANCES OF THE DEATH** John Mayhew was a license revokee. He returned to custody at HMP Durham on 17th December 2016 and died there on 15th January 2017 as a result of self inflicted hanging. He had a recent history of suicide attempts and had attended an acute mental health unit in Hull in December 2016. The details of the recent suicide attempts (most recently in November 2016) and admission between 6th and 13th December in an acute mental health unit in Hull were contained in the OASIS system reports. After reception and induction into HMP Durham on 17th December 2016 John Mayhew was interviewed on 19th December by a probation officer who is a member of the "through the gate team" whose job it is to assess the needs of new prisoners. During the course of the interview, which the probation officer said lasted an unusually long time (45-60 minutes), Mr Mayhew made comments concerning potential self harm/suicide which the probation officer found very concerning and which led her to open an ACCT. At the initial case review several hours later, the attendees did not include this probation officer. She was not invited to attend, nor was any attempt made to communicate with her (before, during or afterwards) by those who conducted the pre-review assessments and attended the review, namely a prison officer assessor, a mental health nurse and a Band 4 prison officer as ACCT case manager. The pre review assessments by ACCT assessor and the mental health nurse, repeated and confirmed in the review itself with the Case Manager, formed an impression as to the level of risk that was clearly divergent from that of the probation officer, even on the basis of the details she had recorded on the ACCT form. The ACCT was closed immediately and there was no Care Map. In the course of the evidence during the Inquest hearing, it was explored as to why the probation officer who had initiated the ACCT, and who had access to the OASIS system which contained evidence of previous suicide attempts and very recent mental health inpatient treatment, not otherwise available, was not in attendance at the initial case review, not being invited. Further, as to why no attempts were made to communicate with her about the ACCT. Reference was made to PSI64/2011 " Management of

prisoners at risk of harm to self, to others and from others. (safer custody)". In particular at page 27 of the said PSI there is the following:

"First Case review

The first case review must: be held within 24 hours of the ACCT plan being opened, ideally immediately after the assessment interview. Be attended and chaired by the Residential Manager, or equivalent and/or the case manager (if different), the assessor, whenever possible, a member of staff who knows the prisoner e.g wing officer, the person who raised the initial concern, healthcare, and any other member of staff who has or will have contact with the at risk prisoner and who can contribute to their support and care eg staff from probation, education, carats, psychology etc. The review should be timely and not unduly delayed to ensure full attendance. If invited participants cannot attend in person, exceptionally, they can provide a written account of their input".

Evidence was forthcoming from prison discipline staff and mental health staff that attendance of an ACCT initiator in an initial case review is simply not done at HMP Durham, alternatively that it might be done if the initiator of the ACCT was a prison officer on the wing. Evidence was given that this was a function of the requirement to have the ACCT case review completed within the mandatory 24 hours, sometimes in circumstances where there is a great deal of pressure on staff. However, it was clear from the evidence that it is exceptional for an ACCT initiator to attend or even to be invited to an initial review. Ultimately, towards the end of the inquest, a prison governor gave evidence on this point saying that it was not "routine to contact the initiator of an ACCT" with a view to inviting that person to an initial case review at HMP Durham. Furthermore, the prison governor stated that this applied also to other prisons that she had worked in, and whom she had contacted in relation to giving evidence on this point over the course of the inquest hearing. These included HMP Northumberland, HMP Low Newton, HMP Frankland. Obviously, these prisons are different to HMP Durham, and have differing pressures operating on the staff. So the explanation that is given in relation to HMP Durham (large influxes of new to custody prisoners going through reception at the same time, lower staff to prisoner ratio, frequent turn-over, or "churn" of prisoners) will not apply to, say HMP Frankland.

It further became evident over the course of the inquest, and was the subject of submissions that the wording of PSI 64/2011 as quoted in the above extract is not entirely clear. It commences with "the first case review must", which effectively makes that which follows thereafter mandatory. It then later goes on to say "...be attended and chaired by the residential manager, or equivalent and/or the case manager (if different), the assessor, whenever possible, a member of staff who knows the prisoner eg wing officer, the person who raised the initial concern, .."

Do the words "whenever possible", which create a proviso, refer to the assessor or the member of staff who knows the prisoner? Alternatively the member of staff who knows the prisoner and also the person who raised the initial concern?

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. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) Clarification is needed as to how to construe the part of PSI64/2011 dealing with first case review of an ACCT assessment, in particular the proviso in the words "whenever possible" as to which type of potential attendee it might apply.
(2) Consideration should be given to re-drafting this part of the PSI.
(3) Consideration might thereafter, be given, as to providing guidance on how this part of the PSI, if modified, should be applied in practice by all staff in all prisons.

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 5th February 2019. 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 Person: [redacted] BM Law [redacted]-Ward Hadaway, [redacted] Farleys, [redacted] Keoghs, [redacted] David Gray, [redacted]-Trowers, [redacted]-Humber NHS Foundation Trust, Lesley [redacted] Government Legal. I have also sent it to Susan Hamilton who may find it useful or of interest. 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	**[DATE]** 11/12/18 **[SIGNED BY CORONER]** [signature]