	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NOMS, Prison Service, Equality Rights and Decency Group, Fourth Floor, 70 Petty France, London SW1H 9EX**
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 17th December 2016 I commenced an investigation into the death of Michelle Barnes. The investigation concluded at the end of the inquest on 23rd October 2016. The conclusion of the inquest was 1. Michelle deliberately hanged herself but at the time she did so her intention is unclear. 2. On a balance of probabilities (that is to say it is more likely than not) the fact that Michelle Barnes was not on an open ACCT at the time of her death probably contributed more than minimally or trivially to her death. 3. On a balance of probabilities (that is to say it is more likely than not) the decision to terminate visits to University Hospital of North Durham (made on the 15.12.2015) probably contributed more than minimally or trivially to her death. 4. On a balance of probabilities (that is to say it is more likely than not) the lack of further input from the mental health team at HMP Low Newton in the period 02.12.2015 – 16.12.2015 probably contributed more than minimally or trivially to her death.
4	**CIRCUMSTANCES OF THE DEATH** Michelle was sentenced to two years imprisonment and arrived at HMP Low Newton on 25th June 2015. She was found to be pregnant at a first reception health screening on arrival. An ACCT was opened immediately upon arrival at the prison and this was closed on 23rd July. A second ACCT was opened on 28th September and closed on 30th November 2015. Her baby was born on 11th December 2015, she returned to prison after giving birth on 13th December 2015 and was found dead in her cell on 16th December 2015.
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. – After the prison made a decision to prevent Michelle from further visiting her child in hospital, two officers who did not know Michelle and who Michelle did not know particularly well, were tasked to tell Michelle the news and to further confirm her child was to be taken into care. The senior of those officers, chose not to open an ACCT, notwithstanding she described Michelle as being very upset and crying but instead made

	an entry in the wing observation book that staff were to "offer support". It should have been clear to all that Michelle was likely to be upset upon receiving such news. Nothing was documented to indicate or to explain what "support" could or should be offered by staff. There was no clear plan as to what the officer meant by the entry or to what should be delivered. Is there some means of offering support short of an ACCT, was an issue raised by the evidence.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 19th December 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 Governor, HMP Low Newton G4S, c/o [redacted] Tees, Esk and Wear Valley, c/o [redacted] Ward Hadaway Solicitors Michelle's father 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	**SIGNED H M SENIOR CORONER**..... **County Durham and Darlington** **DATED**.....24-X-16.....