	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Governor - HM Prison Durham**
1	**CORONER** I am James E Thompson, assistant coroner, for the coroner area of County Durham & 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.
3	**INVESTIGATION and INQUEST** On 9th September 2019 I commenced an investigation into the death of CHARLIE BRIAN TODD, 18 years. The investigation concluded at the end of the inquest on 9th September 2021. The conclusion of the inquest was Misadventure. The medical cause of death was; 1a Pressure On Neck 1b Hanging The Jury set out their findings as; Mr Charlie Brian Todd was in HMP Durham and was admitted to SACU on 2/9/19 just after 10am that day. He was found by staff members in his cell at 16:04 hanging by a ligature around his neck. Resuscitation was commenced but was unsuccessful and unfortunately, he was pronounced dead at 1652 on 2/9/19.
4	**CIRCUMSTANCES OF THE DEATH** On 2nd September 2019 Mr Todd, a prisoner at HMP Durham , was subject to an adjudication hearing which resulted in him being awarded a period of cellular confinement within the Segregation & Care Unit (SACU) within the same prison. He was confined in a cell within the SACU that morning and was to be the subject to regular hourly checks. At just after 4pm the same afternoon he was discovered to have ligatured in his cell and despite efforts to resuscitate him, he died at 4.52pm that day.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – During the course of the inquest evidence was heard from a number of witnesses of the supervision and staffing arrangements within SACU. The overall position was that there was no supervising officer present on a day to day basis to ensure key tasks were always allocated or completed, and officers, including officers not posted to the SACU, but covering for a shift, were required to allocate various tasks between themselves on an adhoc basis. On the 2nd September 2019 the document setting out which hourly checks had been undertaken in the SACU was incomplete. No check on Mr Todd's cell took place at 3pm that day. Evidence was heard that staffing levels can vary, with officers being occupied on tasks which meant hourly checks could not always be completed. Whilst there is auditing of the hourly checks retrospectively, there is no 'real time' system which would alert officers and their supervisors to checks being incomplete for a prisoner/s as the record of checks are paper based and held in the SACU, as well there is no constant supervising officer present or other system there to ensure compliance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 15th November 2021. 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: Messrs BLM on behalf of G4S Messrs Hill Dickinson on behalf of Spectrum Messrs Ison Harrison on behalf of [redacted] I have also sent it to the Prisons & Probation Ombudsman who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**Signed:**  **James E Thompson** **Dated:** 21st September 2021