Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Director General Prisons** **HM Prison and Probation Service** **8th Floor Ministry of Justice** **102 Petty France** **London** **SW1H 9AJ**
1	**CORONER** I am Crispin 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.
3	**INVESTIGATION and INQUEST** On 23 July 2020 I commenced an investigation into the death of Michael Raymond SMITH aged 31. The investigation concluded at the end of the inquest on 09 November 2022. The conclusion of the inquest was: Misadventure. And the jury added this narrative to that conclusion: A) The fact that the scanner revealed he was plugged with drugs; B) The manner in which control and restraints, and the strip search were conducted, and a failure to de-escalate; C) The absence of any mental health assessment during Michael's arrival in reception and being discovered suspended in his cell; D) The absence of a medical assessment during Michael's arrival in reception and being discovered in reception; and E) Michael's use of drugs, [redacted] during his time on SACU The above were all contributions that were more than minimal, negligible or trivial and probably contributed to Michael's death. Each presented and opportunity to do something, or not do something, that would have probably prevented Michael's death.
4	**CIRCUMSTANCES OF THE DEATH** Michael entered HMP Durham on 10 July 2020. Body scan revealed he was plugged with packages. He was transferred to SACU. There was control and restraint incidents on the way an on arrival, where he was strip searched. He was placed and remained on 3 man unlock for his entire time there. At 17.45 on 11 July he was discovered self-suspended. Paramedics achieved the return of spontaneous circulation, but he died at University Hospital North Durham on 13 July 2020. The medical cause of death was:

	1)a) Hypoxic brain injury b) Cardiorespiratory arrest c) Hanging Toxicology on hospital admission bloods showed toxic levels [redacted]
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) Between his arrival in SACU at 18.37 on 10 July 2020 and his being discovered self suspended with a ligature at 17.45 on 11 July 2020 there, Michael was subject to a 3 man unlock. On the morning of 11 July, a Saturday, there were 3 officers on duty on SACU. This did permit his cell to be unlocked for a meal to be delivered and for a cursory one and a half minute conversation with a nurse that fell short, on her evidence, of an actual medical examination. On the afternoon of 11 July there were only one or (briefly) two officers on SACU duty per the staff duty log, albeit, as CCTV footage shows, more officers did attend intermittently for specific tasks. The SACU staff duty log shows only one officer on duty for the whole afternoon to 17.00. In any event medical assessments of Michael were not undertaken at any stage while he was on SACU, the reason being given that he was on three man unlock. It appears that there were never sufficient staff available for a dedicated medical assessment to be undertaken. This notwithstanding that evidence from prison officers and a nurse was that during the course of the afternoon Michale`s presentation had become "angrier" and "bizarre". In fact, it is now known, he had been ingesting toxic amounts [redacted], an unlicensed drug, he had secreted into the prison (his being detected at reception as plugged led him to SACU). [redacted] is a highly potent [redacted] which effects judgement and lowers inhibitions. The jury subsequently concluded that the absence of medical, and mental health, assessments, and the use of the [redacted] (which was never diagnosed), contributed to the Michael`s death. From 17.00, when patrol state commenced, there was clearly only one officer on duty and present. When she discovered Michael self suspended that officer made a perfectly defensible dynamic assessment, electing not to enter the cell unsupported. She made ready to enter for when back up arrived. In the event, partly because there was another discipline incident unfolding on a different wing, this took 2-3 minutes. There were only 16 prison officers available while on patrol state across the entire prison, and they were already at full stretch, and probably beyond it (the Tactical Resources Unit from Doncaster were en route). The evidence was that without knowing precisely when Michael self-suspended any such delay could not be held, on a balance of probabilities, to have entered the chain of causation death. However, the fact remains that there was a delay consequent to Michael being on a three man unlock but there being only a single officer available on SACU while in patrol state. It is reasonable to conjecture that this could have made the difference between life and death in this case, and the repetition of these circumstances could well do so in future. In your response dated 15 November 2021 to the Regulation 28 report of HM Assistant Coroner James Thompson of 21 September 2021 following the Inquest into the death of Charlie Brian Todd at HMP Durham, you wrote, amongst other things: "There is clear management oversight of the SACU". This is not what the evidence in the instance case showed. Rather, what it made clear was that: 1) the SACU staff log plus CCTV further demonstrated that HMAC Thompson`s point to you

	that "officers, including officers not posted to SACU, but covering for a shift, were required to allocate various task between themselves on an ad-hoc basis" was an ongoing problem, and this appears to be still ongoing; 2) NOMIS record keeping was unhelpfully sparse ("you would expect more" was the evidence of SACU manager); 3) the daily log was under-utilised as a multi-disciplinary tool, and this appears to be ongoing. You also stated: "I am confident that the staffing levels and supervisory arrangements in place are sufficient to deliver all of the SACU`s regime". This, too, is clearly not the case. Staffing levels remain the same. Safeguarding of prisoners is compromised as a consequence. With a three man unlock imposed, there should be three officers available at all times to ensure safety. Staffing levels at HMP Durham should be increased.
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 January 05, 2023. 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] I have also sent it to [redacted] 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 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 by the Chief Coroner.
9	**Dated: 10/11/2022**

Crispin OLIVER
Assistant Coroner for
County Durham and Darlington