



Newcastle and North Tyneside  
Miss Georgina Nolan  
HM SENIOR CORONER  
Civic Centre , Barras Bridge , Newcastle Upon Tyne , NE1 8QH

Date: 29 May 2024

## REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

**THIS REPORT IS BEING SENT TO: Secretary of State for Justice, [REDACTED]**  
**CORONER**

1 I am **Karen Dilks, Assistant Coroner for Newcastle and North Tyneside Coroners**  
**CORONER'S LEGAL POWERS**

2 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.

<http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7>

<http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made>

### **INVESTIGATION and INQUEST**

On 19 October 2021 I commenced an investigation into the death of Christopher Alistair MACGILLIVRAY. The investigation concluded at the end of the inquest . The jury reached the following conclusion:

3 Christopher MacGillivray hanged himself by a ligature whilst under the influence of a combination of Cocaine and alcohol.

1a Pressure on the neck

1b Hanging

1c

### **II**

### **CIRCUMSTANCES OF THE DEATH**

4 Christopher Alistair MacGillivray had a long history of Drug and Alcohol issues and attempted suicide and self-harm complicated by the impact of a brain injury sustained in an assault in 2018.

He was charged with criminal offences for which he was granted conditional bail and subject to a curfew.

He was also managed by Probation Service under the terms of a Probation Order for an earlier offence.

On 9th October 2021 he was remanded in custody to HMP Durham for breach of his curfew. His arrest was precipitated by a member of the public who contacted police raising concerns for his welfare having seen him standing on the edge of a bridge.

On 10th October Christopher Alistair MacGillivray reported thoughts of self-harm to prison staff.

Suicide and self-harm prevention procedures known as ACCT (Assessment Care in Custody and Teamwork) were implemented.

He was placed on hourly observations.

On 12th October Christopher Alistair MacGillivray was released on bail by Magistrates following a hearing via remote link. The ACCT was then closed.

There was no direct communication from Prison to his Probation Officer/Manager in respect of his release and his risk of self-harm.

On 14th October Christopher Alistair MacGillivray was found hanging in his home where his death was confirmed.

### **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:

(1) The prison service instruction (PSI) 64/2011 sets out the procedures that must be followed to manage prisoner safety. The Annex sets out a mandatory process for the planned release of a prisoner who has been on an ACCT.

5 Offender Management in Custody (OMiC) guidance provides for direct communication between Prison Offender Manager and Community Offender Manager in respect of prisoners at risk of self harm for SENTENCED PRISONERS ONLY.

(2) The PSI is silent in respect of unplanned releases for 'prisoners on remand' with a known risk of self-harm and who may be released at short notice.

There is no apparent direction/mandatory procedure for communication of the known risk of self-harm for unplanned release.

(3) There is a risk of future deaths of prisoners in the category as at para 2 above. Urgent amendment to PSI/Annex and OMiC is required to set out procedures that must be followed in the management of the unplanned release of prisoners at risk of self-harm/suicide.

### **ACTION SHOULD BE TAKEN**

6 In my opinion action should be taken to prevent future deaths and I believe you Secretary of State for Justice, Alex Chalk 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 24th July 2024. 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.

**COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Family of Christopher Alistair MacGillivray, Sodexo, Probation Service and Cumbria, Northumberland Tyne & Wear Trust (CNTW).

- 8 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.

29 May 2024

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Karen Dilks, Assistant Coroner for Newcastle and North Tyneside