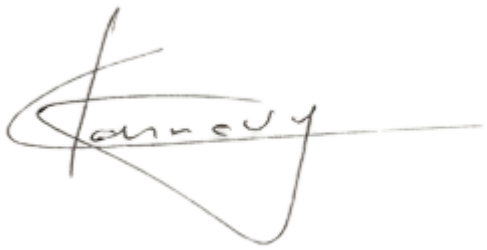
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted]
1	**CORONER** I am Simon CONNOLLY, 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 10/11/2022 12:04an investigation was commenced into the death of Russell Ian IRVINE 22/07/1971 00:00:00. The investigation concluded at the end of the inquest on 21/06/2024 14:36. The conclusion of the inquest was that Hanging - 7 November 2022 - HMP Durham, cell E3-03, Old Elvet, Durham, DH1 3HU. See Attached: We believe on the balance of probabilities that Mr Irvine had the intentions and took his own life on the evening of 7 November 2022 by hanging in his prison cell, [redacted] Mr Irvine also left a note in which he stated he was of sound mind. Based on the evidence provided, the facts state that a number of policies and processes were not actioned or put I place correctly. It is evident that Mr Irvine had previously documented risk factors for suicide and self-harm, however these factors were not identified by prison staff during the reception screening process. It is evident that not all of the actions taken by healthcare were in compliance with the relevant policies. It cannot be established on the evidence that these failings caused or contributed to Mr Irvine's death..
4	**CIRCUMSTANCES OF THE DEATH** Hanging - 7 November 2022 - HMP Durham, cell E3-03, Old Elvet, Durham, DH1 3HU. See Attached: We believe on the balance of probabilities that Mr Irvine had the intentions and took his own life on the evening of 7 November 2022 by hanging in his prison cell, [redacted]

	Mr Irvine also left a note in which he stated he was of sound mind. Based on the evidence provided, the facts state that a number of policies and processes were not actioned or put I place correctly. It is evident that Mr Irvine had previously documented risk factors for suicide and self-harm, however these factors were not identified by prison staff during the reception screening process. It is evident that not all of the actions taken by healthcare were in compliance with the relevant policies. It cannot be established on the evidence that these failings caused or contributed to Mr Irvine's death.
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) Russell Ian Irvine died three days after his entry into HMP Durham on 4 November 2022 following his licence recall into custody, about which he protested and told reception healthcare staff that he had refused food and fluids for the previous two days. The evidence demonstrated that this information was not escalated in accordance with established policy which meant that Mr Irvine's food and fluid intake was not adequately or at all monitored by prison wing staff. As to food and fluid monitoring generally and notwithstanding the availability of internal policies mandating necessary action in cases of known food and fluid refusal, evidence from prison officers at inquest was to the effect that no formal policy existed to monitor and identify whether a prisoner had collected their meal and so had necessary sustenance at least available to them. The absence of such policy was identified by the Prison and Probation Ombudsman during its investigation as to the circumstances of Mr Irvine's death and this formed a recommendation within the Ombudsman's report. HMP Durham's response to this recommendation was the introduction of process and form to record instances when a prisoner failed to collect their meal as a means of monitoring their intake. Evidence from a prisoner Governor was to the effect that she was not aware that such a process or form was in use at any other establishment within the nationwide secure estate, enquiries having been made to substantiate this. The concern is that other such establishments operate without the advantage of the safeguard now employed at HMP Durham with the risk of future deaths occurring elsewhere evident.
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 September 13, 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.
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] **HMP Durham** 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: 22/07/2024**  **Simon CONNOLLY** **Assistant Coroner for** **County Durham and Darlington**