	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Prison Service, Cleland House, Page Street, London SW1P $LN** **2. Care UK, c/o Clyde & Co, Chancery Place, 50 Brown Street, Manchester M2 2JT**
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 3rd December 2013 I commenced an investigation into the death of Kirk Duboise. The investigation concluded at the end of the inquest on 5th December 2013. The conclusion of the inquest was Mr Duboise was found dead in his cell at HMP Durham on 13/2/13 and a narrative conclusion was returned "The deceased intentionally took his own life. The deceased was not correctly assessed at HMP Durham. An ACCT should have been opened at reception by prison staff."
4	**CIRCUMSTANCES OF THE DEATH** The deceased arrived at HMP Durham when there was with him a prisoner escort report form highlighting self harm issues and also a suicide/self harm warning form again highlighting self harm issues. The deceased had clear self harm marks on his arms. Prison and health care staff at reception did not see both of these documents and did not open an ACCT. Mr Duboise committed suicide in his cell approximately 8 hours after arriving at HMP Durham. No other member of staff opened at ACCT in the intervening period. The Jury concluded that an ACCT ought to have been opened at reception by prison staff. Notwithstanding training which states that an ACCT can be opened by any member of staff at any time the practice of at least one senior officer at reception was that he would not open an ACCT unless at reception the incoming prisoner was subject to constant watch observations. This practice was confirmed by an experienced mental health nurse who saw the deceased as part of the reception process. Evidence was given that the reception process has, since the deceased's death in February 2013, been changed. A prison governor confirmed that the correct code words had not been used when the deceased was found hanging in his cell which resulted in in their being a delay before an ambulance was summonsed.
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. – (1) The delay in summonsing an ambulance. (2) That not all relevant forms were seen by those involved in the reception process one of whose duties at such time was to properly assess the risk of self harm of the new

	prisoner, particularly a prisoner who had not been in custody before.
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. 1. To ensure that all staff who may become involved in an emergency situation know the appropriate protocols to be followed (both discipline and health care staff) to ensure that there is no delay in an ambulance being summonsed in an emergency situation. 2. That training be given and where necessary repeated to ensure that all staff know that an ACCT can be opened at any time by any member of staff wherever they believe the circumstances so demand. 3.That those involved in the reception process and further in induction, have access to all relevant documents so that they are best equipped to make an informed decision on the risks of the prisoner before them committing an act of self harm and/or suicide.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st January 2014. 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 Rule 43 office and to the following Interested Persons [redacted] and [redacted]. 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	**6th December 2013** **HM Senior Coroner** **County Durham and Darlington**