	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. NOMS, Equality Rights and Decency Group, National Offender Management Service, Fourth Floor, 70 Petty France, London SW1H 9EX 2. Tees, Esk, Wear Valley NHS Foundation Trust, Trust Headquarters, West Park Hospital, Edward Pease Way, Darlington DL2 2TS 3. Care UK, Hawker House, 5 – 6 Napier Court, Napier Road, Reading, RG1 8BW
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 Geraldine Liege Kilborn aged 37 years. The investigation concluded at the end of the inquest on 5th December 2014. The Jury could not determine the Deceased's intention when she hung herself. The Jury concluded that following an ACCT review, the deceased was not appropriately located at the time of her death and that she would not have ended her life when she did, irrespective of her location.
4	**CIRCUMSTANCES OF THE DEATH** Immediately upon entry into HMP Low Newton, the reception screen nurse deemed the deceased to be of high risk of self-harm and advocated a constant watch. Over the next 22 days prior to her death the deceased self-harmed repeatedly with many of the attempts being deemed by staff as being genuine attempts to take her own life. There were a series of ACCT reviews. For a time she was on constant observations, on normal location, in healthcare safer cell and healthcare normal cell. One ACCT review had no mental health staff input when such staff had asked to be present and somewhat incredulously, in evidence the ACCT case manager stated that he did not know that mental health care staff were available to attend on the day in question. At the time of her death mental health care staff did not work weekends and at two critical ACCT reviews, there was no mental health input into the reviews. Several mental health witnesses described tensions between mental health and wing staff, one such witness calling wing staff "dinosaurs". Senior key members of the last two ACCT reviews were unaware of the detailed entry made in system one notes by a Consultant Psychiatrist and did not take her views into account. On one of these two key reviews, which was attended by a senior general nurse, she did not share with the other review team members the knowledge that she had of the said system one Consultant Psychiatrist entry. The Jury was critical of the Prison's care of the deceased.
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) There was a clear breakdown in sharing of information known to the mental health

	team with other members of some ACCT reviews. Evidence was given that there has been a change in service provision contracts since the death of the deceased and that mental health staff will now work weekends. Nevertheless, it is vital that in appropriate cases where a prisoner is on an ACCT and has had substantial mental health input that they both attend relevant ACCT reviews and their opinions are given sufficient weight. It is noted that mental health nurses never chair such ACCT reviews as case manager and this case has revealed that even in attendance, their views might not be given sufficient weight. (2) Witnesses confirmed that they often did not read much of the ACCT document prior to the ACCT review and relied more upon input of other attendees who might know the prisoner and upon their face to face assessment of the prisoner at the time. In this case, some ACCT review members had limited day to day experience of the deceased, whose temperament and presentation could change "like a light switch" and therefore face to face presentation could well be misleading. Thus in cases where the ACCT review was dealing with a particularly complex and challenging prisoner and where an enhanced review was called for, it would seem appropriate for further consideration to be given to the question of review panel membership generally as well as, as above, mental health input in particular.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th February 2015. 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 [redacted] Care Quality Commission who may find it useful or of interest. 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	**Signed**...[signature]... **A Tweddle LLB, H M Senior Coroner** **County Durham and Darlington** **Dated**...10 - XII - 14...