	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** 2. **G4S, Legal Department, The Manor, Manor Royal, Crawley, West Sussex**
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 15th September 2014 I commenced an investigation into the death of Kevin Anthony Forster. The investigation concluded at the end of the inquest on 21st October 2015. The conclusion of the inquest was:- 3. Kevin was found dead in his prison cell at HMP Durham on 14th September 2014. Kevin was appropriately located in F-Wing upon his entry into HMP Durham on 10th September 2014. After seeing Kevin at 22:00hrs on Saturday 13th September 2014 the response of healthcare staff with regard to Kevin was not appropriate. The level of on-going medical supervision by healthcare staff during the remainder of that night was not appropriate. The level of observation given by discipline staff from 02:00 – 06:00 hrs was appropriate. The decision at 02:00hrs not to search Kevin's cell that night was appropriate. 4. Drug Related
4	**CIRCUMSTANCES OF THE DEATH** The deceased entered HMP Durham after having hidden within his body drugs. During the night of 13th/14th September 2014, the deceased (and his cell mate) took many of these drugs. He was noticed by discipline staff and healthcare staff to be under the influence of an unknown substance. No thorough or clinical assessment of his condition was undertaken. There was confusion as to the appropriate means of summoning the senior on-duty healthcare officer and a lack of appreciation of the risk posed by the deceased when he was found at approximately 06:50hrs on 14th September 2014, shortly before he died.
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. It was clear from evidence that there is a serious drug problem in HMP Durham. This has led to a degree of complacency and acceptance by staff of that situation. 2. Healthcare staff were unaware of what, if any, drugs policy was in place at the

	time. A policy known as a "Drugs Overdose Policy" which had, in various guises been in operation since 2008 included a definition of overdose as the "purposeful or accidental act of ingesting an amount of a drug or substance that may cause harm to health". As such, the ingestion of unknown drugs is de facto harmful to health and would constitute an overdose which should lead to the triggering of the Overdose Policy. Both discipline and healthcare staff were unaware of the policy, the "overdose" definition and the prescribed steps which should then ensue. 3. Upon obtaining the contract for healthcare at HMP Durham, G4S have instituted have implemented a new policy, but evidence was given that staff had not been given any formal training on it, though the document (running to 12 pages) had been emailed. Evidence indicated that there was still a lack of appreciation of the detail of the policy now in force. 4. The evidence indicated that there was a lack of guidance as to how staff should react when faced with a person who had overdosed; no local procedures as envisaged by the policy were disclosed, what should be done when there is no indicator as to what substance had been ingested and what would be the appropriate level of observations recognising that (Policy paragraph 8.1) symptoms may develop later. 5. Given the apparent scale of the drug problem in HMP Durham, it would seem to be prudent for there to be a clear and workable policy and one which staff that healthcare staff is able to implement with discipline staff knowing sufficient to be able to identify in what circumstances healthcare staff need to become involved. 6. There was a lack of an on-going treatment plan prepared for the deceased by nursing staff who attended on him and there was inadequate recording that they had done and what they had to do. 7. Discipline staff summoned healthcare staff and perhaps not appreciating the significance of the apparent health of the deceased, did not call for the on-duty nurse to attend as an emergency, but just asked for the nurse to attend. Such an oversight could lead to a delay which in certain circumstances might be very significant. 8. The evidence indicated that there was a delay (albeit a short one) in either healthcare or discipline staff calling for an emergency ambulance to attend and/or whether code blue as an expression was used. Other inquests have clearly identified issues at the establishment about the calling of an emergency ambulance. 9. As mentioned earlier the evidence indicated that there was a degree of complacency about prisoners presenting under the influence of drugs and the risks associated therewith (at handover one officer said to another "there are some prisoners sleeping it off"). Due to the scale of the issue, the potential risk to health of a prisoner is such that there needs to be absolute clarity of response and care for prisoners who so present. The evidence indicated that a more integrated approach between healthcare staff and discipline staff would be beneficial notwithstanding there were good lines of communication between the two.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 23rd December 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 the following Interested Persons [redacted] Governor, HMP Durham Head of Healthcare, HMP Durham Ben Hoare Bell Solicitors Clifford Johnson Solicitors TSol Berrymans Lace Mawer Solicitors Thompsons Solicitors 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	**Dated**.....28.X.15..... **Signed**.....A Tweddle..... **ANDREW TWEDDLE LLB** **HM Senior Coroner** **County Durham and Darlington**