	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **HM Prison Service, NOMS, Fourth Floor, 70 Petty France, London SW1H 9EX** 2. **G4S, Medical Services, Great Bardfield, Essex, CH7 4SL** 3. **Tees, Esk & Wear Valley NHS Foundation Trust, West Park Hospital, Edward Pease Way, Darlington DL2 2TS**
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 8th February 2017, I commenced an investigation into the death of Margaret Atkinson. The investigation concluded at the end of the inquest on 19th January 2017. The jury concluded that it was not reasonable for staff not to have gone into her cell earlier – i.e. that they should have gone into the cell earlier. The conclusion was "Margaret killed herself but at the time she did so her intention is unclear."
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a long history of mental health illness. She received considerable mental health services input during her periods of imprisonment at HMP Low Newton. She was regularly seen with items, sometimes articles of clothing or curtains around her neck with such items at times being described as "ligatures". She was on an ACCT at the time of her death. She was not on, and never had been on, a constant watch. Mental health staff assessed her, including a Consultant Psychiatrist as low risk of suicide. She was located in the Prison's healthcare wing. On the night of 24th January 2016, two senior prison officers and an experienced nurse saw her in her single cell with an article of clothing around her neck. They talked with the deceased and asked her to remove the item of clothing from around her neck but she declined to do so. None of the three members of staff thought this to be a high-risk situation and none thought it appropriate to enter the cell on an emergency basis. After staff had observed her in this position on at least three occasions over quite an extended period of time, staff decided to enter the cell to remove the article of clothing, but still not believing the situation to be serious. They were talking to her as they entered the cell expecting her to respond. The clothing around her neck was easily removed and at that time, staff became concerned and found the deceased to be unresponsive. CPR was attempted. Paramedics found her in a state of cardiac arrest but were able to restart the heart. She was taken to a local hospital but did not regain consciousness and died on 02.02.2016. The jury found that it was not reasonable for staff not to have entered earlier than they did, i.e. they should have entered the cell earlier. The evidence indicated lack of clarity in the words used to describe the articles around the deceased's neck at various times and this made the assessment of risk more difficult. As a result, of the fact that this became common behaviour perhaps was at least in part, a reason for the jury concluding that there was an inappropriate assessment of risk, which led to a delay in staff entering her cell in the night in question. Also, giving the deceased's behaviour over a period of time, there was a miss-assessment of risk particularly bearing in mind that staff knew the deceased's behaviour could be predictably unpredictable and that she could act impulsively without a full appreciation of the risks and consequences of her actions

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 case revealed issues and difficulties about how situations were described and the choice of appropriate language with the corresponding difficulties resulting therefrom in assessing risk. Furthermore, as there was unusual behaviour over an extended period of time there was an acceptance of such behaviour as being normal and would not be considered as illustrative of increased risk unless there was a significant departure from that already unusual (or bizarre behaviour as it was described in evidence). HMP Low Newton have issued interim guidance to endeavour to address the matter and G4S likewise. A copy of the G4S guidance is attached. This appears good. I believe it needs to be shared throughout the prisoner state generally and not just in the North East cluster of prisons where G4S provides healthcare.
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 28th March 2017. 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 Care Quality Commission [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	**Signed**..... **Andrew Tweddle, LLB.** **H M Senior Coroner** **County Durham and Darlington** **Dated 30 January 2017**