Regulation 28: Prevention of Future Deaths report

William DAVIES (died 16.06.14)

	THIS REPORT IS BEING SENT TO: **1. Mr Kevin Reilly** **Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 23 June 2014, I commenced an investigation into the death of William Davies, aged 67. The investigation concluded at the end of the inquest on 3 November 2014. I made a determination that death came about from natural causes, being: 1a) coronary artery atherosclerosis.
4	**CIRCUMSTANCES OF THE DEATH** Mr Davies was found unresponsive in his cell at HMP Pentonville.
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. There seems to be confusion in the prison regarding the requesting of an ambulance after a level one (i.e. regarding a potentially life threatening situation) call has been made by a prison officer. 1. I have been told in other inquests (and delay in HMP Pentonville ensuring ambulance attendance has been a feature since the first prison death inquest I heard in Inner North London, on 30 September 2013) that prison comms should call an ambulance as soon as they have been notified of a level one. However, the prison duty governor on the day of Mr Davies' death, [redacted] said that when he arrived two or three minutes after the prison officer who found Mr Davies had contacted comms, no ambulance had been called. [redacted] told me that he did not know why this was, though he was duty governor that day and the most senior person from the prison in court. 2. The whole process of attending a prisoner with a life threatening condition seemed unclear to the prison general practitioner (now GP lead) giving evidence. She assumed that a prison officer had responsibility for calling an ambulance, but she was not sure. The GP also did not know that she was allowed to verify the fact of death, and told me that, as a consequence, she carried on with CPR after she knew that Mr Davies had died. And if the GP lead has not got a good understanding of the procedures in place, then other GPs in the prison may not have either.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 12 January 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • HM Inspectorate of Prisons • National Offender Management Service 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 05.11.14