Regulation 28: Prevention of Future Deaths report

David Andrew Llewellyn O'GARRO (died 02.06.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **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 6 June 2012, my predecessor, Shirley Anne Radcliffe, commenced an investigation into the death of David Andrew Llewellyn O'Garro, aged 34 years. The investigation concluded at the end of the inquest on 13 June 2014. I made a narrative determination, attached.
4	**CIRCUMSTANCES OF THE DEATH** Mr O'Garro suffered a sudden death in epilepsy. At the time of his death, he occupied a single cell at HMP Pentonville, and so nobody was with him to raise the alarm when he suffered what is likely to have been a final seizure.

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. The nurse who carried out the first reception screen of Mr O'Garro did not complete a cell sharing risk assessment (CSRA) indicating that he should share a cell, though she told me she knew that a person with epilepsy should not occupy a cell alone. She completed the computer record indicating that he was fit for any cell occupancy. No HMP Pentonville CSRA was ever found for Mr O'Garro. During the inquest: - one prison nurse appeared at times completely unfamiliar with the CSRA, and wholly unclear as to how to ensure (in 2012 or now) that prisoners with epilepsy would have a cellmate; - a prison doctor said that a locum doctor working at the prison might not even complete a CSRA because s/he would not know how the prison works; - one of the prison officers was unsure how a message from healthcare regarding cell sharing would reach any particular officer if s/he was away on the day it was entered into the observation book. Whilst I appreciate that you are making significant changes to the reception process for new prisoners, there appeared at inquest to be a lack of clarity and shared understanding among those working at HMP Pentonville.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and the healthcare providers for HMP Pentonville 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 13 August 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] David O'Garro's auntie • 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** 16.06.14