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Coroner MS Hassell
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Inner North London
St Pancras Coroner's Court
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25 July 2016

Dear Coroner ME Hassell,

Regulation 28: Prevention of Future Deaths report, Samuel Rodney Darren Blair (died 02.08.2015)

We hereby respond to your Rule 28 report issued to Care UK following the inquest into the death of Mr Rodney Blair. Care UK would like to express its condolences to Mr Blair's family and friends.

Care UK is the main provider of healthcare services at HMP Pentonville. There is a sub-contracting arrangement in place with Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT) in respect of mental health services. Our response addresses the matters of concern which relate to our staff and services. It should be read in conjunction with the separate response provided by the BEH-MHT.

The actions below form part of the overall action plan across healthcare between both providers.

Matter of Concern 1. *Although the assistant psychologist who triaged Mr Blair in prison on 2 July 2015 asked him about his alcohol dependency, she did not ask him about drug use, nor did she record asking him about his mood or any suicidal thoughts.*

Response: We refer to the response provided by BEH-MHT and we will collaborate with them to ensure that the action plan outlined in their response is implemented and that all healthcare staff are aware of the plan.

Matters of Concern 2, 3 & 4.

Response: We refer you to the response provided by BEH-MHT as these concerns are relating to their services rather than the services of Care UK.

Matter of concern 5.

Response: This concern is a matter for the prison and accordingly, we will leave it for them to respond.

Matter of Concern 6. *The prison nurse on call for emergencies, call sign Hotel 7, who was called to attend Mr Blair after he had been found hanging did not acknowledge the radio call for several minutes, despite numerous attempts by prison control. When she finally did acknowledge the*

emergency, there was a delay of up to approximately 15 minutes before she was at Mr Blair's side.

Response: We set out below a timeframe which we have compiled from the written evidence and with reference to the evidence heard at the inquest hearing and which suggests that the time taken was less than 15 minutes.

In his witness statement of 2 August 2015, [redacted] states that he arrived at Mr Blair's cell at 7.35pm. He states that officer [redacted] was on the landing and officer [redacted] and nurse [redacted] were in the cell. He states that he assisted [redacted] in giving breaths and compressions with them swapping roles. He states that he "again" makes a call to Hotel 7 who he estimates arrives after 10 minutes and attaches the defibrillator. He states that the first paramedic arrives at 7.50pm.

PCO [redacted] is the first officer to arrive at Mr Blair's cell. In his PPO evidence, he states that he discovers Mr Blair at 7.30 pm. PCO [redacted] states that he shouted at the top of his voice because he did not have a radio and that PCO [redacted] arrived in around a "minute or two". PCO [redacted] does not call a level 1 (code blue) because he did not have a radio.

PCO [redacted] states that she hears PCO [redacted] calling her name and asking her to go to Mr Blair's cell. She asks him why and he asks her to rush down. According to her account, by the time that she arrives, PCO [redacted] has entered the cell and cut the ligature. PCO [redacted] asks PCO [redacted] to raise a level 1 incident which she states that she does. PCO [redacted] then states that officers rush down. She mentions PCO [redacted] and [redacted] who she says radios to request an ambulance. PCO [redacted] says that she then calls to nurse [redacted] PCO [redacted] says that [redacted] responds and states that he has to go and get the bag - which he does before going to Mr Blair's cell. Once he arrives, PCO Soli's account is that Mr Blair is moved to the landing.

In PCO Haslam's PPO statement, he says that after arriving, going into the cell and talking to PCO [redacted] about whether Mr Blair had a pulse, he runs upstairs and explains to Xavier what has happened.

In his PPO interview, [redacted] states that around 7.30 p.m., he hears his name being called and that he responds by asking what the matter is. He is asked to "come down" to Mr Blair's cell and the tone causes him to go upstairs to get his bag and oxygen before going back downstairs to the cell. [redacted] assesses Mr Blair, checks for a pulse, eases him to the floor and starts compressions. He then asks the officers to call another member of healthcare staff. [redacted] states that he does compressions for 2 or 3 minutes before an officer asks about a mask and that they had been doing compressions and using the mask for around 7 minutes before Hotel 7 arrived. [redacted] states that he then goes to get the defibrillator. He states that they then attach the defibrillator for instructions "several times" (and it advises to continue compressions). He estimates that the paramedics arrives 10 or 15 minutes later.

In oral evidence at the inquest hearing, [redacted] stated that it took him about 2 minutes to arrive at Mr Blair's cell after hearing his name being called and collecting the emergency bag.

In oral evidence, PCO [redacted] stated that it was at 7.34pm that PCO [redacted] made a call to the prison control room to call for assistance regarding an imminent threat to life. However, we know that PCO [redacted] did not have a radio and so he could not have made such a call.

PCO [redacted] stated that he attempted to contact Hotel 7 and that it took her 3-4 minutes to respond. PCO [redacted] was aware that there had been another incident at the prison where a prisoner had set fire to their cell and PCO [redacted] was aware that there was already another nurse in attendance at Mr Blair's cell. PCO [redacted] states that the first paramedic arrived at the prison within 6 or 7 minutes at 7.46pm.

At the time, Hotel 7 was attending another incident and treating another patient on a different wing. Upon acknowledging the call from PCO [redacted] in her PPO interview, Hotel 7 states that she went via A wing to collect the emergency response bags and that it took her five minutes to arrive at Mr Blair's cell.

According to LAS records, the call for an ambulance connected at 7.40 p.m. and paramedic G199 was with Mr Blair at 7.50pm. When he arrived, there was a nurse and an officer carrying out CPR, another nurse (presumably Hotel 7) was maintaining an airway and the defibrillator was attached.

Although in her statement Hotel 7 states that she received a code blue at approximately 7.30pm, according to the written and oral evidence, this time is inaccurate.

In summary, PCO [redacted] arrives at Mr Blair's cell at 7.30 p.m. This time appears to be consistent across the PPO interviews. The LAS records show that the first paramedic arrives in the cell at 7.50 p.m. The window is therefore one of 20 minutes.

Having arrived at the cell at 7.30 p.m, PCO [redacted] finds Mr Blair hanging. He enters the cell and cuts the ligature although the evidence indicates that he does not enter the cell until a colleague arrives. Upon discovering Mr Blair, he shouts for help but does not say why and he does not have his radio to issue the relevant level 1/code blue call. PCO [redacted] arrives within a few minutes and PCO [redacted] tells her what has happened and asks her to radio the alert. It is not clear whether this is the code blue that Hotel 7 hears but this call must have been made several minutes after 7.30pm. According to PCO [redacted] the earliest this call was made is 7.34 p.m. By 7.50pm, only 16 minutes later, when the paramedics arrive at the cell, Hotel 7 has already arrived, is maintaining an airway and the defibrillator is attached. [redacted] statement is that he collects the defibrillator after Hotel 7 arrives. It therefore appears that the time it took Hotel 7 to arrive at the cell was less than 15 minutes. If it was Mr [redacted] instructions to the control room that resulted in the code blue (and the 999 call as per PCO [redacted] account), then he arrived at the cell after [redacted] who states that he arrived at 7.35 p.m. If the code blue call went out at around the same time as the 999 call (7.40 p.m.) then Hotel 7 must have arrived in less than 10 minutes.

In any event, any delay on the part of Hotel 7 was as a result of her being located in a different wing and treating another patient following another incident. It would therefore have been entirely correct to ensure that her patient was clinically stable before leaving to attend another incident where a clinician was already in attendance.

Matter of Concern 7. *The substance misuse nurse in the detoxification wing did respond immediately. He took the emergency bag with him to Mr Blair's cell, but did not take the defibrillator stored in the same room as the bag. He later had to leave Mr Blair to retrieve the defibrillator, because it is stored in the nurses' room and only nurses have the key.*

Response & Actions:

As can be seen from the PPO interviews and as was heard during the inquest hearing, the nurse was called for assistance but not informed by the officers as to what the nature of the emergency was. He was also not aware of any code blue call at the time. He therefore collected the emergency bag. After attending Mr Blair's cell and identifying the nature of the emergency, he went back to the nurses' room to collect the defibrillator. Hotel 7 had already arrived at this point and was assisting Mr Blair when the nurse left Mr Blair's cell to collect the defibrillator.

However, to ensure that there is no misunderstanding of emergency procedures in the future, we have implemented the actions outlined in the table below for all healthcare staff.

Matter of Concern 8. *The nurse (a mental health nurse rather than a general nurse) began resuscitation. He gave evidence that he started chest compressions and continued these for two minutes until a custodial manager arrived, without the intention of ever stopping to re-check Mr Blair's pulse. He said that, whilst his basic life support certification was current at the time of Mr Blair's death, his intermediate life support certification was not, and is still not. It is currently at least three years out of date.*

Response & Actions:

Care UK Cardiopulmonary (CPR) Resuscitation Policy in the Training section (section 7) states:

- 'As a minimum, all staff within Care UK should be provided with Basic life Support (BLS) training on induction. This should be maintained by participating in regular practice sessions within the workplace and by mandatory annual updates in BLS'.
- 'The resuscitation team members will immediately mobilise to the location and perform BLS, ILS or ALS according to their ability'.
- 'All Healthcare staff are expected to recognise cardiac arrest, call for help and initiate BLS'.

The nurse concerned was trained in Basic Life Support (BLS) but not Intermediate Life Support (ILS). As such, staff trained to BLS level are not expected to check a pulse as per the Resuscitation Council UK 2015 guidelines. The nurse was therefore acting within the scope of his practice and competence. However, as detailed in the table below, we have implemented a training plan to ensure that, by December 2016, most healthcare staff will be ILS trained and that refresher trainings will occur yearly.

Matter of Concern 9. *That nurse gave a description of the code blue and code red system of describing an emergency that was markedly different from the understanding given by the prison governor and the London Ambulance Service. I heard that the codes blue and red are even described on posters within the prison. It therefore appears that a nurse within the prison healthcare team has the wrong understanding of basic prison healthcare emergency procedures.*

[redacted]