London Ambulance Service NHS
NHS Trust

Executive Office
Headquarters
220 Waterloo Road
London
SE1 8SD
[redacted]

RECEIVED
20 JUL 2016

Ms Mary E Hassell
Her Majesty's Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

Our Ref: [redacted]
Your Ref:

14 July 2016

Dear Ms Hassell

RE: Regulation 28: Prevention of Future Deaths Report arising from the inquest into the death of Samuel Rodney Darren Blair

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 19 May 2016, bringing to my attention the matters of concern arising from the death of Mr Samuel Rodney Darren Blair on 2 August 2015 not 2 August 2016 as stated in the title and paragraphs 5.5 and 6 of your Report:

"After Mr Blair was found hanging, the officer in the prison control room did not give the prison gate location for the ambulance at the very outset of the 999 call to London Ambulance Service, but instead did so part way through the call.

The LAS controller did not ask at the very outset.

The ideal would be for the information to be given at the very beginning of any emergency call.

(I wrote to HMP Pentonville on 16 September 2016 in connection with the death of another prisoner about this issue. I appreciate that work on this matter is on-going.)"

The letter to HMP Pentonville on 16 September 2015, relating to Mr H was also addressed to me. In my reply of 13 November 2015 I confirmed the actions taken by the London Ambulance Service NHS Trust (LAS) after the death of Mr H to ensure that the LAS attend the correct prison gate when called to HMP Pentonville. Shortly before the inquest into the death of Mr H changes were made to the LAS's Computerised Gazetteer, used in the Emergency Operations Control (EOC), to record that there was more than one vehicular entrance to HMP Pentonville, namely the Roman Way Gate and North Wall Gate. The postal address of both entrances, were added to the Gazetteer. Following the inquest into the death of Mr H it was requested that HMP Pentonville staff were prompted and reminded to say at the beginning of a 999 call which entrance LAS staff were to use. Unfortunately these actions occurred after the call to Mr Blair on 02 August 2015.

I have been assured by the LAS's Deputy Director of Operations (Control Services), [redacted] that in early May 2016, when the refresher training for 2016/17 for staff in EOC began, a session was included that made specific reference to HMP Pentonville and of the requirement that when a call from HMP Pentonville was received, at the start of the call the emergency medical dispatcher was to seek confirmation of the gate the LAS should attend. This training is in process and due to be completed in November 2016.

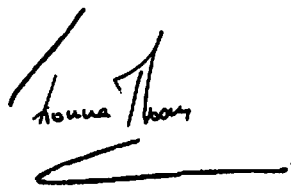
On 26 May 2016 our Senior Quality Assurance Manager, Control Services, and other LAS senior managers, met senior prison staff to discuss matters of mutual interest for the LAS and HMP Pentonville to promote effective communication and joint working. I am advised that these meetings will continue.

Our Medical Director, [redacted] has confirmed that the Regulation 28 Report from the inquest into death of Mr Blair will be shared with the National Ambulance Service Medical Directors Group to facilitate wider learning by UK Ambulance Services.

I hope that this reply is helpful to you and to Mr Blair's family in explaining all that we have done to address your matters of concern.

We offer our sincere condolences to Mr Blair's family.

Yours sincerely



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