Regulation 28: Prevention of Future Deaths report

Samuel Rodney Darren BLAIR (died 02.08.16)

	THIS REPORT IS BEING SENT TO: **1. Mr Mike Parish** **Chief Executive** **Care UK** **29 Great Guildford Street** **London SE1 0ES** **(see all points save for 5.5)** **2. [redacted]** **Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT** **(see points 5.5 and 5.6 only)** **3. Dr Fionna Moore** **Chief Executive** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London SE1 8SD** **(see point 5.5 only)**
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 August 2015 I commenced an investigation into the death of Rodney Blair, aged 40 years. The investigation concluded at the end of the inquest earlier today. The jury made a narrative determination, which I attach, concluding that death came about by way of suicide, with several contributing factors. The medical cause of death was: 1a suspension by ligature.
4	**CIRCUMSTANCES OF THE DEATH** Rodney Blair was remanded in custody at HM Prison Pentonville on 30 June 2015. He had a history of paranoid schizophrenia, alcohol dependency, multiple drug use and depression. At no time did any member of staff at HMP Pentonville suspect that Mr Blair had thoughts of taking his life. On Sunday, 2 August 2015, he was found hanging in his cell.
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. 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. 2. She later uploaded to the computer system the collateral history she had been sent as a Word document, but did not input any of it into the main body of the records, nor did the psychiatrist who made the note at the multi disciplinary team meeting in prison on 7 July 2015 at which Mr Blair was discussed. 3. There is no record from that meeting of any discussion or management plan for Mr Blair's schizophrenia. 4. There is no record from that meeting or any other time, of any consideration of or management plan for Mr Blair's depression.

Most particularly, there is no record that it was ever recognised by the healthcare staff at HMP Pentonville that Mr Blair had been prescribed and had been compliant with the prescription of an anti depressant before his incarceration.

The assistant psychologist who obtained the history of a prescription of anti depressant medication did not refer Mr Blair to a prison GP for consideration of this.

Mr Blair was never offered any continuation of his citalopram prescription. The plan in the community had been to continue the prescription, but there is no record that this was ever considered by healthcare staff at HMP Pentonville.

5. 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 ongoing.)

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.

   (I wrote to HMP Pentonville on 16 September 2016 in connection with the death of another prisoner about a different nurse, but also in the role of Hotel 7, who did not respond to an emergency alarm as soon as it was activated.)

7. The substance misuse nurse in the detoxification wing did respond immediately. He took his 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.

	8. That nurse (a mental health, rather than general nurse) began resuscitation. He gave evidence that he started chest compressions and continued these for two minutes until a custodial manager arrived, without any 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. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your organisations 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 25 July 2016. 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 • National Offender Management Service (NOMS) • HM Inspectorate of Prisons • [redacted] Rodney Blair's mum & stepdad • [redacted] assistant clinical psychologist • [redacted], mental health nurse

	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** 19.05.16