Regulation 28: Prevention of Future Deaths report

John WILLIAMS (died 26.06.16)

	THIS REPORT IS BEING SENT TO: **1. Mr Mike Parish** **Chief Executive** **Care UK** **29 Great Guildford Street** **London SE1 0ES** **(see points 5.1, 5.2, 5.3 and 5.5)** **2. [redacted]** **Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT** **(see points 5.4 and 5.6)** **3. Professor Sir Bruce Keogh** **National Medical Director** **NHS England** **PO Box 16738** **Redditch B97 9PT** **(see points 5.3 and 5.5)** **4. Mr Michael Spurr** **Chief Executive** **National Offender Management Service** **Clive House** **70 Petty France** **London SW1H 9EX** **(see points 5.3 and 5.7)**
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 1 July 2016, one of my assistant coroners, Richard Ian Brittain, commenced an investigation into the death of John Williams aged 54 years. The investigation concluded at the end of the inquest on 24 March 2017. The jury made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Mr Williams hanged himself whilst a prisoner at HM Prison Pentonville, however, he had told members of staff that he would do so if his perceived needs were not met, rather than with the aim of taking his life.
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. The first reception nurse who saw Mr Williams when he entered HMP Pentonville gave evidence that he had no thoughts of self harm or suicide, but she recorded that he had. It appears she may benefit from additional training and/or supervision. 2. There was no second reception screen conducted. If Mr Williams was not brought to healthcare staff for his second reception screen then healthcare staff needed to follow this up. 3. The first reception nurse did not make the referral to the mental health team (though this took place in any event because the court diversion team had already made the referral). I heard that it is now done automatically when that box is ticked on the system, and I wonder whether other prison healthcare providers would benefit from such a system.

4. Mr Williams said to several members of staff that he would self harm or hang himself if he wanted something done and it was not happening quickly enough (rather than because he actually wanted to die.)

   This was recorded on his assessment, care in custody, teamwork (ACCT) document. Some prison officers did not seem familiar with the very important contents of the ACCT, not even the inside cover.

   The senior officer in charge on the weekend of Mr Williams' death did not look at the inside cover or record any events within. Again, It appears there may be benefit in additional training and/or supervision.

5. Mr Williams also told the member of Phoenix Futures who saw him that he felt cannabis gave him what the mental health team did not. However, the staff member felt he did not have the training or experience to explore either of these issues in greater depth.

   It may be that Phoenix Futures staff would benefit from additional training, perhaps alongside prison healthcare staff.

6. The issue of the difference between a code blue and a code red is one about which I have written before.

   One senior prison officer said in evidence that if she did not know the difference between a code blue and a code red, then there would be some serious concerns. She did not.

   She had been given a small card describing code blue and code red (a card which another officer kept about her person and even produced from the witness box), and she still retained that card. However, she had never considered it worthwhile to read.

   She said in court that she still thought it appropriate that she had never read the card.

7. The prison officers did not have even the most basic first aid and cardiopulmonary resuscitation (CPR) training. I am aware from other inquests that this is not provided at a national level.

   I have written about this before. It seems a significant gap, even allowing for the fact that there are always two trained nurses on site.

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 29 May 2017. 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 Mark Lucraft QC, the Chief Coroner of England & Wales • HM Inspectorate of Prisons 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** 28.03.17