Regulation 28: Prevention of Future Deaths report

Robert Thomas GINN (died 29.11.18)

	THIS REPORT IS BEING SENT TO: 1. [redacted] **Medical Director, and** [redacted] **Director of Health and Justice** **Care UK Limited** **29 Great Guildford Street** **London SE1 0ES** 2. [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 13 December 2018, one of my assistant coroners, William Dolman, commenced an investigation into the death of Robert Ginn, aged 54 years. The investigation concluded at the end of the inquest yesterday. The jury made a narrative determination, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH**

	Mr Ginn hanged himself in his cell at HM Prison Pentonville. He was discovered by an operational support grade at around 1.05am on 29 November 2018. She raised the alarm and the two Care UK nurses on call for emergencies overnight (Hotel 7 and Hotel 12) attended to lead the resuscitation attempt.
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. I was able to view via body worn camera (BWC) footage part of the resuscitation attempt, and I had the benefit of evidence from a senior London Ambulance Service (LAS) paramedic who had also viewed it. 1. The nurse (Hotel 12) who gave evidence at inquest said that Mr Ginn was cold when she got to him, but the LAS paramedic who arrived later was confident that he was still warm, and his temperature was recorded as 34.7°C. 2. Throughout the resuscitation attempt captured on BWC, no staff member checked Mr Ginn's breathing. It is possible that the breathing was checked before the commencement of the bodycam footage, and indeed one of the prison officers said he checked it at the outset, but the footage ran for nearly eleven minutes before the London Ambulance Service arrived and took over, and it was not checked in that time. 3. At inquest, one of the nurses said that she looked at Mr Ginn's chest at the outset, but she did not put her cheek to his mouth to listen and feel for breath in order to confirm he was not breathing. 4. After the first two minutes of footage, the oxygen mask that had been in place was taken off and no further efforts were made to oxygenate Mr Ginn. 5. Given that Mr Ginn's heart had stopped beating, he must have stopped breathing as well. A full, effective, nurse led resuscitation attempt should have included an attempt to oxygenate throughout.

	Hotel 12 said that she did not do this because Mr Ginn's jaw was too stiff to insert an airway, but the LAS did so without any difficulty. And if he had been cold and stiff when they arrived, the LAS paramedics would not have commenced resuscitation. In any event, an oxygen mask can be applied even if there is stiffness (as it was here, but then it was removed two minutes into the resuscitation and nearly nine minutes before LAS took over). 6. Chest compressions given by different members of staff were variable and some, including those of one of the nurses, were sub optimal. At one point, chest compressions were given by a staff member sandwiched between Mr Ginn and the wall, where there was not enough space to be effective. 7. No attempt was made by either of the nurses to coach the prison officer to improve the quality of chest compressions. 8. One of the nurses (Hotel 7) did not administer chest compressions at all. She did not give evidence at inquest and so the reason for this is unclear. 9. The defibrillator pads were incorrectly applied by the nursing team, rendering the defibrillator reading unreliable. In fact, it was highly unlikely that Mr Ginn could have been saved, whatever the quality of resuscitation attempts, but that might not be the case for another prisoner – or visitor, or member of staff. This is the fifth occasion in five years that I have written to Care UK about the quality of first aid at HMP Pentonville. Given that fact, I wonder whether consideration could be given to nurses wearing bodycams and activating these in emergency situations?
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 30 December 2019. 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 • Care Quality Commission for England • HM Inspectorate of Prisons • National Offender Management Service • [redacted] Mr Ginn's sister • [redacted], Mr Ginn's wife 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** 30.10.19 **SIGNED BY SENIOR CORONER** ME Hamell