Regulation 28: Prevention of Future Deaths report

Carl Robert FOOT (died 09.12.14)

	THIS REPORT IS BEING SENT TO: **1. [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 11 December 2014, I commenced an investigation into the death of Carl Robert Foot, aged 33 years. The investigation concluded at the end of the inquest on 23 October 2015. The jury made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Mr Foot was found hanging in his cell at HMP Pentonville. • That morning, he had been told that he would be moving cells to a different wing. This was simply to accommodate his methadone prescription, but he did not want the move and was angry as a consequence.

	• He then racially abused a prison officer and was put on a basic regime. His television was taken away. • He later realised that he had not been taken to court that day as he should have been. The jury concluded that Mr Foot did not actually intend to take 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. Between 1.53pm and 2.51pm on the afternoon of his death, Mr Foot rang his cell bell 13 times. On occasion, including the last occasion, it was left up to 27 minutes before being answered by a prison officer, rather than within the expected five minutes. Mr Foot was found at 3.18pm by a passing prison officer. He was resuscitated, but died four days later in hospital. If he had been found earlier, he would have had a better chance of survival. 1. The jury found that there was an inadequate response by prison officers to the cell bells, and that this was a contributory factor in Carl Foot's death. 2. Once a cell bell has been pressed, unless they remember hearing it and the time of hearing it, officers on the landing have no way of knowing when the bell was pressed, in other words, how long the prisoner has been waiting. That makes it more difficult to prioritise appropriately. 3. In terms of learning lessons for the future, which may include learning by individual officers as well as on a systemic basis, there was no exploration immediately after Carl Foot's death of the cell bell log and all those who heard/answered his bell that afternoon. By the time of inquest, memories had faded.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your organisation 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 2 January 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 • HM Inspectorate of Prisons • National Offender Management Service • Probation and Prisons Ombudsman • [redacted] mother of Carl Foot 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** 26.10.15