Regulation 28: Prevention of Future Deaths report

Samuel Rodney Darren BLAIR (died 02.08.15)

	THIS REPORT IS BEING SENT TO: **1. Mr Michael Spurr** **Chief Executive** **National Offender Management Service** **Clive House** **70 Petty France** **London SW1H 9EX**
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 **MATTER OF CONCERN** is as follows. The prison officers who found Mr Blair hanging did not have current basic life support training and so were not able to commence cardiopulmonary resuscitation (CPR) before the arrival of nurses. One officer tried to take Mr Blair's pulse, but was unclear about the correct procedure for this. This is a situation that I have noted before at HMP Pentonville. I have not made a prevention of future deaths report in the past, because I am aware that the fact that there is no mandatory first aid (including CPR) training for all prison officers is a nationally made, resource led decision. However, it seems to me that you, as the decision maker regarding not providing such training, should be aware of the impact that this may have on the prison population.
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 • HM Inspectorate of Prisons • HM Prison Pentonville • [redacted] Rodney Blair's mum & stepdad 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