Regulation 28: Prevention of Future Deaths report

Tedros Habtom KAHSSAY (died 19.01.16)

	THIS REPORT IS BEING SENT TO: **1. Mr Mike Parish** **Chief Executive** **Care UK** **29 Great Guildford Street** **London SE1 0ES** **2. [redacted]** **Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT** **3. 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 21 January 2016, I commenced an investigation into the death of Tedros Habtom Kahssay, aged 29 years. The investigation concluded at the end of the inquest yesterday.

	The jury made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Tedros Kahssay killed himself by hanging in HM Prison Pentonville, having been admitted a month earlier on a charge of murdering his pregnant partner.
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. I list the **MATTERS OF CONCERN** below, though I am conscious that some of these have now been the subject of remedial action. **Person Escort Record** 1. The person escort record (PER) and appended report of the forensic medical examiner (FME) that accompanied Mr Kahssay to HMP Pentonville did not accompany him to nurse reception screening. **Circumstances of the Index Offence** 2. The index offence is recorded on the PER (and inputted onto the prison computer system NOMIS, though not the healthcare computer system SystmOne), but not the circumstances. The circumstances – perhaps from the indictment read out in court – may be potentially helpful to healthcare and possibly also to discipline staff in prison. This is not clear cut, because the logistics of obtaining the information and making it available to those who need it are complex; prosecutions must not be compromised; and there is the potential for making a prisoner's mental state worse by probing the circumstances. However, it seems that this is an issue that is worthy of consideration, preferably at a national level. **General Practitioner Records** 3. The general practitioner records were never obtained (an issue that I have raised in the past), despite there being a system in place for Pentonville healthcare administrative staff to do this. Whilst that did not impact upon Mr Kahssay's care, it might for another prisoner.

Nurse Reception Screening

4. The first reception screen template contained questions that carried an inherent ambiguity, in that they related to a change in personal and family circumstances, which must always be the case when a person is incarcerated and therefore does not assist in determining which prisoners are at an increased risk.

   (I did hear at inquest that any prisoner on a charge of murder will now be the subject of a psychiatric assessment.)

5. Both nurses conducting reception screening talked often in evidence about not being able to do anything other than accept the answers given by the prisoner. They did not seem to bring any objective analysis to the screening. The process of nurse screening appeared at times to be a tick box exercise.

6. The second reception (well man) screening nurse did not explore the history of depression recorded, he said because the prison general practitioner had not prescribed any medication for depression. On reflection, the nurse thought that he should have asked about it.

Resuscitation

7. The resuscitation led by the two nurses occupying the positions of primary (Hotel 7) and secondary (Hotel 12) leads for emergency healthcare in the prison that night, was significantly lacking in the following ways.

   - The nurse with primary responsibility for emergency care in the prison did not have a proper understanding of the nature of a code red and a code blue prison medical emergency. (I have raised this issue in the past.)

   - One minute and twelve seconds elapsed after nurse arrival before any substantive care was given. The action during that one minute and twelve seconds did not appear to progress the resuscitation attempt.

   - There seemed no clear demarcation of roles and responsibilities during the resuscitation. Of course these may change as those giving resuscitation tire, but the changes seemed haphazard.

   - There was no checking for breath or airway manoeuvre at the outset or at any time during the resuscitation.

   - There was no checking for pulse at the outset, before commencing chest compressions, or at any time during the resuscitation.

	The lead nurse attempted to justify this by saying that she had not wanted to waste time. This was despite the first action upon finding the casualty being to apply a blood pressure cuff, on the basis that this was part of the nurse assessment. • When giving evidence, the lead nurse appeared to conflate the casualty who is in cardiorespiratory arrest with the casualty who is merely unconscious. She repeatedly talked about the need to give cardiopulmonary resuscitation (CPR) to an unconscious casualty. She said that, at the time she started chest compressions, she did not know whether Mr Kahssay was breathing or not breathing. • When CPR was given, chest compressions were ineffective, being too quick and too shallow. • There was only one brief attempt to use an ambubag, the majority of the resuscitation taking place without airway assistance or with a non rebreathe oxygen mask. • It appeared that one oxygen cylinder was empty, as it had to be changed for another. The nurse leading the resuscitation described it as chaotic. That is indeed how it appeared to me from her description and from viewing the bodycam footage. I was and remain very gravely concerned, not in this respect for Mr Kahssay who was in fact already dead when resuscitation commenced, but for anyone else in the prison in need of first aid.
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 6 February 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 • [redacted] friend of Tedros Kahssay 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** 06.12.16