	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **MARK ANTHONY DOYLE (died 28 March 2017)** **THIS REPORT IS BEING SENT TO:** **1.** [redacted]**,** **Acting Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT** **(See points (1) and (4))** **2. Mr Michael Spurr,** **Chief Executive** **HM Prisons and Probation Service** **Clive House** **70 Petty France** **London SW1H 9EX** **(See point (4))** **3.** [redacted] **Managing Director** **Care UK** **29 Great Guildford Street** **London SE1 0ES** **(See points (2) and (3))**
1	**CORONER** I am Heather Williams QC, Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 5 April 2017 an investigation was commenced into the death of Mark Anthony Doyle, aged 45 years old. The investigation concluded at the end of the inquest on 12 December 2017. The jury found that Mr Doyle died on 28 March 2017 at University College London Hospital, as a result of injuries earlier sustained when he suspended himself from the bars of his cell window at HMP Pentonville with a ligature. The jury made a narrative determination that his intention at the time was unclear; and that his death may have been caused or contributed to by errors in the identification and recording of the anniversary of his son's death on his ACCT; his inappropriate transfer

	from F Wing; and an undue delay in responding to his cell bell on the evening of 21 March 2017. The medical cause of death was found to be: 1a post cardiac arrest hypoxic ischaemic brain injury; 1b ligature compression to the neck.
4	**CIRCUMSTANCES OF THE DEATH** See section 3 above; Mr Doyle was found suspended by a ligature attached to the bars of his cell window on the evening of 21 March 207. Following emergency resuscitation he was taken to University College London Hospital, where he remained until his death on 28 March 2017 from injuries sustained by his suspension with the ligature.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) Although recent developments regarding multi-disciplinary involvement in ACCT case reviews and quality assurance ACCT checks are encouraging (as described to me by [redacted], Head of Safer Custody), I remain concerned that the following failings were apparent in the ACCT case reviews concerning Mr Doyle conducted on 10 and 20 March 2017, but are not addressed / adequately addressed by the recent initiatives (including the new Weekly Quality Assurance Check): • Insufficient appreciation of the importance of identifying and recording trigger factors for a particular prisoner on their ACCT inside front cover; • Officers undertaking case reviews without reading recent entries on the ACCT daily record relevant to risk; • Officers determining the frequency of observation levels for an ACCT prisoner without considering relevant material in the ACCT file; • The ACCT reviewer failing to appreciate the value of involving at least one member of the prison staff who knows the prisoner; and • Circumstances in which a prisoner's family could or should be contacted as part of the ACCT review process were poorly understood. (2) Although, [redacted], Head of Healthcare, described how healthcare staff have received recent encouragement to make entries on a prisoner's ACCT in relation to matters that could bear on risk, I am concerned that this does not go far enough to change past practice and ensure that relevant information is shared, in light of the prison staff's lack of access to System One records and the infrequent occasions that Care UK staff made entries on Mr Doyle's ACCT daily record. (3) Decisions that prisoners are fit to be transferred from F Wing are made and conveyed to prison staff by the charge nurse on duty that morning annotating by hand a list of the prisoners on the Wing. There appears to be no clear criteria for assessing when a prisoner is fit for transfer; the information that should be considered in making this determination is left to the discretion of the decision maker; and there is no process for recording the decision, the reasons for it or the identity of the decision maker in the prisoner's records or otherwise. (4) There is no mandatory first aid training for existing (as opposed to new) prison officers. I was informed that Orderly Officers and OSGs have / are being provided with first aid training, but I am concerned this remains a serious lacuna. I appreciate it is a nationally made resourcing decision and that it has been raised previously, but I raise it for further consideration; in light of the limited number of prison and nursing staff on duty overnight, there is a real prospect of medical emergencies arising where no trained first aider is available.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 13 February 2018. 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 Chief Coroner and to the following Interested Persons • [redacted], the sister of Mark Anthony Doyle (via her solicitors, Hickman and Rose); • Barnett, Enfield & Haringey Mental Health NHS Trust 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**18 December 2017**