Regulation 28: Prevention of Future Deaths report

Tyrone GIVANS (died 26.02.18)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Acting Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT** **2. Mr Mike Parish** **Chief Executive** **Care UK** **29 Great Guildford Street** **London SE1 0ES** **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 8 March 2018 I commenced an investigation into the death of Tyrone Givans, aged 32 years. The investigation concluded at the end of the inquest yesterday.

	The jury made a narrative determination, which I attach, concluding that Mr Givans hanged himself in his cell at HM Prison Pentonville, his intentions being unclear. His medical cause of death recorded was: 1a suspension by ligature.
4	**CIRCUMSTANCES OF THE DEATH** Mr Givans was a chronic alcoholic and drug user; he suffered with long term anxiety and depression; he was homeless; and he was profoundly deaf. He handed himself in to Islington Police Station on 5 February, was arrested for assault occasioning actual bodily harm, interviewed on 6 February and remanded by Highbury Magistrates into custody on 7 February 2018, at which point he was admitted to HMP Pentonville. He said before his hearing on 7 February that he would kill himself if returned to prison, though he later told prison staff that he had said this to try to avoid being remanded in custody. During a previous custodial sentence he had been noted as having an elevated risk of self harm.
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. 1. Mr Givans' former cell mate gave evidence that he had seen Mr Givans smoking Spice in their cell on two or three occasions, saying that its use is common within the prison. The jury heard that Spice often makes the user scared and paranoid, and can provoke immediate, extreme and uncharacteristic behaviour. Drugs are of course a problem in all prisons and dealing with them a great challenge, but Spice poses a particular danger in all sorts of ways, both in Pentonville and across the prison estate. 2. A past spelling error meant that there were two sets of NOMIS prison records for Mr Givans. This meant that there were then two sets of SystmOne healthcare records.

	This meant that staff did not have access to records of the assessments conducted before 8 February 2018. However, later consultations were not paused to make enquiries about this. The nature of the IT error was discovered after Mr Givans' death, but at the time, staff did not seem to recognise the significance of having no earlier records. Evidence was given that NOMIS in its present form is unsatisfactory and does not lend itself to human intervention. The jury found that the IT system was unfit for purpose. 3. Some members of discipline and healthcare staff did not appreciate that Mr Givans was deaf, although others did. He was not formally referred to the prison equalities officer and there was a general lack of awareness of the role of equalities officer. There was a delay in seeking Mr Givans' hearing aids and it took two weeks for one to be brought in by a family member. Whilst systems in HMP Pentonville have changed since Mr Givans' death, such a situation might exist in prisons elsewhere. There remains no equalities/disabilities questionnaire for completion on prisoners' arrival to the prison. The first night form could be adapted, but this would be an exercise to be undertaken nationally.
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 25 March 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 • HM Inspectorate of Prisons • [redacted], mother of Tyrone Givans 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** 23.01.19