IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Serena Nicolle
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** Alex Chalk MP Parliamentary Under Secretary of State Ministry for Justice 102 Petty France London SW1H 9AJ
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An investigation into the death of **Serena Nicolle** was commenced on 12 September 2018 and an inquest into her death was opened on 19 February 2019. The inquest was resumed on 20 April 2021 and concluded on 27 April 2021. The medical cause of Mrs Nicolle's death was: 1a. Ventricular Arrythmia 1b. Hypertensive Heart Disease 2. Diabetes Mellitus, Sleep Apnoea, Obesity, Stress The inquest concluded with a short form conclusion of 'Natural Causes'.

5	**CIRCUMSTANCES OF THE DEATH** On 31 August 2018 Mrs Nicolle was remanded in custody to HMP Bronzefield, having never been to prison before. On 3 September 2018 she died in her cell due to Hypertensive Heart Disease. Mrs Nicolle's death was contributed to by her chronic conditions of Diabetes, Sleep Apnoea and Obesity, all of which contributed to the development of her Hypertensive Heart Disease. Mrs Nicolle was suffering from stress in the days leading up to her death, which contributed to her suffering a Ventricular Arrythmia in the context of her underlying Hypertensive Heart Disease. HMP Bronzefield is a privately run female prison operated by Sodexo Justice Services (SJS).

6	**CORONER'S CONCERNS** The Coroner's concerns are as follows: At the conclusion of the inquest the court found that: i) Mrs Nicolle was last known to be alive at 12:40 on 3 September 2018; ii) At an unknown time between 12:40 and 16:11 she suffered a cardiac arrest whilst she was in her cell; iii) At 16:11 a prison custody officer observed Serena Nicolle through the cell hatch at which time she was lying unresponsive on the floor. The prison custody officer then returned to the cell at approximately 16:30 with a prison nurse. iv) At 16:30 the prison nurse looked in at Serena Nicolle through the hatch in her cell door and incorrectly believed that she could see movement in her abdomen and chest and therefore erroneously assessed that she was breathing, when in fact she was already deceased. v) Shortly thereafter a prison custody officer also looked in at Serena Nicolle through the hatch in her cell door and also incorrectly believed that she could see movement in Mrs Nicolle's abdomen and chest and erroneously assessed that she was breathing, when in fact she was already deceased. vi) At 16:35 the cell door was opened and CPR was commenced initially by prison staff and subsequently by the attending paramedics. However, the resuscitation attempts were unsuccessful and Mrs Nicolle was declared deceased at the scene. During the course of the inquest the court heard evidence that observing the movement of an individual's chest and abdomen through a cell hatch is a standard procedure for checking whether they are breathing, in circumstances where they are not otherwise moving or responding to prison staff. The court heard that this is the position across the prison estate and is not limited to HMP Bronzefield. The court also heard evidence from expert witness Dr [redacted], a Consultant Cardiologist, who stated that in his opinion it is very difficult to assess whether somebody is breathing or not by looking for movement in the chest/abdomen from a distance.

	The Coroner is concerned that on 3 September 2018 two members of prison staff assessed that Mrs Nicolle was breathing when she was in fact deceased, and that in doing so they followed standard procedures which are in place across the prison estate. Whilst these errors did not contribute to Mrs Nicolle's death, the Coroner is concerned that were similar errors to occur in the future, it would present a risk of future deaths, particularly given Dr [redacted] evidence that it is difficult to assess whether somebody is breathing or not by looking for movement in the chest/abdomen from a distance. The **MATTER OF CONCERN** is: 1. The observation of an individual's chest/abdomen through a cell door hatch may be an unreliable method of checking whether they are breathing, in circumstances in which they are not otherwise moving or responding to prison staff, and therefore gives rise to the risk of future deaths. 2. Consideration should be therefore be given as to whether additional policies, procedures, guidance or training ought to be introduced across the prison estate to address this risk.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mrs Nicolle's family ([redacted]) 3. Sodexo Justice Services 4. Central and North West London NHS Foundation Trust 5. Cimmaron UK 6. Dr [redacted] 7. Prisons and Probation Ombudsman
10	**Signed:** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 22nd day of June 2021**