Regulation 28: Prevention of Future Deaths report

Amarjit SINGH (died 21.11.21)

<table>
<tr><td></td><td>THIS REPORT IS BEING SENT TO:

1. [redacted]
Prison Governor
HM Prison Pentonville
Caledonian Road
London N7 8TT

2. [redacted]
Chief Executive Officer
Practice Plus Group (PPG)
Hawker House
5-6 Napier Road
Reading
Berkshire RG1 8BW</td></tr>
<tr><td>1</td><td>CORONER

I am: Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner’s Court
Camley Street
London N1C 4PP</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 30 November 2021, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Amarjit Singh, aged 41 years. The investigation concluded at the end of the inquest on 8 September 2023.

At inquest, the jury made a determination of death by natural causes, contributed to by neglect.</td></tr>
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4	**CIRCUMSTANCES OF THE DEATH** Mr Singh's death was epilepsy related. He was found dead in his cell at HMP Pentonville on the morning of 21 November 2021. In the middle of the night his cellmate had rung the emergency cell bell and told the prison officer who came to the door that Mr Singh had suffered a fit. However, the prison officer did not then seek medical attention for Mr Singh and the cell door remained locked shut for the rest of the night.
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. There are many issues about which I would have made a prevention of future deaths report, had I not been told that systems have been radically overhauled since Mr Singh's death. I heard that the environment in which he was not assessed as he should have been upon entry and re-entry to prison, and in which he was never seen medically as a whole person, has completely changed. The prison officer who did not seek medical attention for Mr Singh was investigated and found guilty of gross misconduct. However, some points remain outstanding. 1. The completion of the cell sharing risk assessment was described by the extremely experienced nurse who completed it, as careless. 2. Though I was told that training for prison staff in how to deal with fits is to be given at HMP Pentonville in October 2023, I heard that there is only a *hope* that prisoners will also receive some guidance in what to do if their cellmate suffers a fit. Apparently, this has already been implemented in HMP Brixton. 3. Whilst the fact that not all prison officers receive ongoing first aid training is a national resourcing issue, the level of first aid understanding of some prison officers at HMP Pentonville seemed surprisingly low.

	One officer told me that it did not cross his mind to start CPR in the three minutes it took nurses to arrive after Mr Singh was found not breathing. (Mr Singh had been assessed by a custodial manager as having died, but the other officer did not know this at the time.) A different officer told me he did not know that there is a difference between a person who is unconscious and a person who is dead.
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 13 November 2023. 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. • [redacted], brother of Amarjit Singh • [redacted], HMPPS Director General Operations • HHJ Thomas Teague QC, Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER**

	18.09.23	ME Hassell