Prevention of Future Deaths Report

George Kyriacos Petrou (date of death: 1 March 2021)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: 1. **Chief Executive Officer** **Barnet, Enfield and Haringey Mental Health NHS Trust** **Block 2B** **St Ann's Hospital** **St Ann's Road** **London** **N15 3TH**
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North London.
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 19 March 2021, an investigation was commenced into the death of George Kyriacos Petrou, then aged 56 years. The investigation concluded at the end of an inquest heard by me between 30 September 2024 and 11 October 2024. The inquest concluded with a short-form conclusion of suicide. The medical cause of death was: 1a partial suspension
4	**CIRCUMSTANCES OF DEATH** George Petrou was remanded in custody on 21 March 2019 at HMP Pentonville, pending a trial at the Crown Court. He was convicted of multiple offences in late 2020. On 26 February 2021, Mr Petrou was sentenced to 22 years' imprisonment via a video link hearing. Mr Petrou left the hearing prior to hearing his sentence being handed down by the Judge. Throughout 2019 and 2020, Mr Petrou had been placed on an 'ACCT' (suicide prevention measures) on four separate occasions. He had profound mental health concerns dating back many decades, which included a long history of depression, previous self-harm and past attempts at suicide.

	During his time in HMP Pentonville, there was no evidence that Mr Petrou had self-harmed or made previous attempts at suicide. He was received care in relation to his physical health and was under the care of the mental health in-reach team (provided by Barnet, Enfield and Haringey Mental Health NHS Trust (the Trust)). Receiving a long custodial sentence was a potential matter of concern for George Petrou. He was seen by staff from the Trust on the day of his sentencing hearing and the following day. Mr Petrou was found deceased in his cell at HMP Pentonville on 1 March 2021, having partially suspended himself by ligature in the bathroom of his cell.
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 could occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows: 1) Evidence from members of staff at the Trust, working in the prison at that time, gave the distinct impression that there were a number of members of the mental health in-reach team that placed significant weight on a prisoner telling them that they did not want to be placed on any form of suicide watch and/or ACCT. This was contrary to the guidance, policy and procedures in place. While not being placed on an ACCT was not a causative factor in Mr Petrou's case, it nonetheless raises a risk of death in the future. In my view, witnesses from the Trust provided insufficient reassurance that this matter has been addressed.
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 the report, namely 6 December 2024. 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 the following: • [redacted] – Mr Petrou's daughter • Hudgell Solicitors ([redacted]) – solicitors acting on behalf of Mr Petrou's family • Practice Plus Group – primary care provider at HMP Pentonville • Ministry of Justice / HMP Pentonville • Care Quality Commission • Prison and Probation Service Ombudsman 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. She may send a copy of this report to any person who she 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **25 October 2024**