REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Governor, HMP Pentonville, Caledonian Road, London, N7 8TT** **2. [redacted], Group Chief Executive, Serco, Serco House, 16 Bartley Wood Business Park, Bartley Way, Hook, Hampshire, RG27 9UY** **3. Secretary of State for Justice, Ministry of Justice, 102 Petty France, Westminster, London, SW1H 9AJ** **4. The Minister of State for Prisons, Parole and Probation, 102 Petty France, Westminster, London, SW1H 9AJ**
1	**CORONER** I am Jonathan Stevens, Assistant Coroner, for the Inner North London coroner area.
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 Coroner's (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 26th July 2023, 1commenced an investigation into the death of Gareth Chumber-Kelly (aged 33). The investigation concluded at the end of a 10-day inquest before a jury on 30th January 2026. The conclusion of the inquest was: **The deceased took his own life and the risk of his doing so was not recognised, nor were appropriate steps taken to try to prevent him from doing so.** The jury found that: *'Gareth came to his death via suspension [redacted] in HMP Pentonville. Gareth was pronounced dead at University College Hospital on 17th July 2023.* *The jury finds that Gareth's medical history and immediate circumstances posed a clear risk to his life. This risk was clearly identified outside the prison, but due to a range of failings was not engaged with or addressed by the prison. As such, Gareth was not given the necessary support to preserve his life. Specifically, the failures included inadequate review of medical records, the failure to ensure the continuity of important information in the transfer of care, a failure to provide Gareth with any of the mental health support available or timely provision of a welfare call. Insufficient checks were given to the risk of ligature in Gareth's cell.*

	The jury also finds that the low levels of staffing and subsequent lockdown during crucial hours of Gareth's time in prison had a cumulative impact. Other contributing factors included the lack of staff training and inadequate cover during break hours." Medical cause of death was found to be: 1 (a) Suspension
4	**CIRCUMSTANCES OF THE DEATH** Gareth Chumber-Kelly was taken into custody at HMP Pentonville on Thursday 13th July 2023. Prior to his arrival he had spoken to a Forensic Mental Health Practitioner at the Court Liaison and Diversion Service and told her he would take his own life if he was remanded in prison. The Forensic Mental Health Practitioner was concerned about the risks of self-harm and she sent a hard copy of her Liaison and Diversion Report, together with a Suicide and Self Harm ('SASH') warning form to the HMP Prison Pentonville via Serco, together with copies by e-mail to the mental health services team operating within the prison. For reasons that were not established, there was no evidence that the hard copy of the Liaison and Diversion Report was with the documentation that was received by the prison staff on Mr Chumber-Kelly's arrival at Pentonville, although the SASH form was received. The court heard, however, evidence that it was quite common for forms that were supposed to accompany prisoners to go missing. Mr Chumber-Kelly had a known history of self-harm when he had previously been in prison, and had previously attempted suicide on two occasions whilst in the community. He had a history of opioid dependence and was suffering from withdrawal symptoms from drugs. On Friday 14[01] July 2023 Mr Chumber-Kelly self-harmed (on two occasions) and he was put on an ACCT (Assessment, Care & Custody Teamwork) and put on hourly observations, although the evidence was that not all observations were carried out despite having been recorded as done. In the morning of Monday 17th July 2023 Mr Chumber-Kelly's cell-mate woke to found him standing with a noose around his neck but was able to 'talk him down'. Later that same morning Mr Chumber-Kelly's cellmate awoke again and found Mr Chumber-Kelly hanging [redacted] . He pressed the cell alarm bell (at 12.35). A prison officer, who had worked at the prison for 24 years, arrived at the cell, called a 'Code Blue' emergency and cut Mr Chumber-Kelly down, but did not attempt any CPR. A second officer arrived shortly afterwards and also failed to render any CPR. Prison healthcare staff then arrived and commenced CPR, pending the arrival of the emergency services. Mr Chumber-Kelly was taken by ambulance to University College Hospital in London where despite further administration of life support measures, he was pronounced dead.
5	**CORONER'S CONCERNS** HM Chief Inspector of Prisons produced a report in August 2025 following an unannounced inspection of the prison carried out from 30th June - 10th July 2025.

The report noted that since the last inspection (in July 2022) there had been 5 self-inflicted deaths (one of which was Mr Chumber-Kelly) and that 3 of those deaths had occurred in 2025.

The report noted that deficiencies repeatedly identified in the ACCT process were not given sufficient attention and staff had very limited knowledge of prisoners in their care or the reasons why they were on an ACCT.

The report noted that the survey that they had conducted revealed that 38% of prisoners felt suicidal on their arrival at the prison.

It was clear from the evidence that many prisoners have complex mental health issues and that the incidence of mental health issues in HMP Pentonville is much higher than generally in the community.

The Chief Inspector of Prisons in his letter to the Lord Chancellor and Secretary of State of 16th July 2025, whereby he invoked the Urgent Notification Process because of the poor performance at HMP Pentonville, advised that HM Inspectorate of Prison had inspected HMP Pentonville on 5 occasions since 2015 (2015, 2017, 2019, 2022 and 2025) and on all but one of those inspections the prison scored T (the lowest possible rating) for safety - the exception being 2022 when the prison scored '2', which is still 'not sufficiently good'.

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) The court heard evidence from prison staff that the reception process at HMP Pentonville was inefficient and slow and that paperwork would be sometimes be lost. This creates a risk to the safety and well-being of prisoners as the documentation accompanying the prisoner as they are conveyed to prison may contain (as was the case with Mr Chumber-Kelly) very important information about the prisoners which is relevant to ensuring all appropriate steps and measures are put in place to protect them. The Governor at HMP Pentonville told the court that no steps have been taken to address this recurrent problem, and the risk of important documentation being lost, and there has been no dialogue with Serco to address this issue.

(2) The court heard evidence that 2 prisoners had died by ligature suspension (on 17.6.2021 and 1.3.22) prior to Mr Chumber-Kelly's death, and that since then a further 5 prisoners have died by ligature suspension (one of which was Mr Chumber-Kelly). The Governor of HMP Pentonville told the court that Suicide and Self harm training for prison staff had been suspended during Covid and had never been re-started notwithstanding that 38% of prisoners arriving at HMP Pentonville said they felt suicidal and notwithstanding that 7 prisoners have died by ligature suspension since June 2021. The failure to train prison officers in the risks and management of suicide and self-harm creates a risk of future deaths.

(3) The court heard evidence that the first two officers on the scene failed to provide any form of basic life support despite having received training on how to do so. Both officers described how they panicked and did not know what to do. The

	court heard evidence from a consultant paramedic from the London Ambulance service with extensive experience in resuscitation who explained that for every minute without CPR there is a 10-22% drop in survival rates. It is critically important that the first person on the scene in such emergency situations (who will almost always be prison officers) are properly and regularly trained in basic life support so that they are able to render such aid immediately on arrival. The Governor of the prison told the court that no refresher CPR training had been provided to prison staff since 2023 notwithstanding the 5 deaths of prisoners by ligature suspension that have occurred since. This is deeply concerning given that this very same issue was raised in a Prevention of Future Deaths Report by Mary Hassell, HM Senior Coroner of Inner North London on 18th September 2023 relating to the death of Amarjit Singh and yet in the 2 % years since that PFD was issued there is ***still*** no mandatory basic life support training for prison officers. The failure of the prison to provide regular, mandatory basic life support to all prison officer creates a risk of future deaths.
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 7th April 2026. 1,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: (i) The Family of Mr Chumber-Kelly (ii) Practice Plus Group (iii) North London Foundation Trust (iv) Phoenix Futures (v) North East London Foundation Trust (vi) Together UK (vii) The Prison & Probation Ombudsman 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	9th February 2uzu — —

HM CORONER

Mr. S.D.P. Stevens HM Assistant Coroner

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