Regulation 28: Prevention of Future Deaths report

Sean Perry WILLIAMS (died 27.03.24)

	THIS REPORT IS BEING SENT TO: **1. Chief Executive Officer** **Serco Prison Transport Services (Serco)** **2. Commissioner** **Metropolitan Police Service (MPS)**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court
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 11 April 2024, one of my assistant coroners, Ian Potter, commenced an investigation into the death of Sean Williams, aged 47 years. The investigation concluded at the end of the inquest on 13 February 2026. The jury made a narrative determination at inquest, a copy of which I attach. The medical cause of death was: 1a acute left ventricular failure 1b acute cardiac arrhythmia
4	**CIRCUMSTANCES OF THE DEATH** Sean Williams died in the back of a Serco van outside Thames Magistrates' Court.

	He was being transported from court to HMP Thameside, but at 18.06 hours he began to fit. The prisoner escort spoke to the van driver and the driver returned to the entrance of the court car park (it was now after hours), arriving at 18.11 hours. Mr Williams suffered a cardiac arrest at 18.15 hours from which he did not recover.
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. **For the MPS** The MPS had already recognised before inquest that, following Mr Williams' detention, he was not seen by a custody nurse for 23 hours. However, there was another sub optimal element of his care that did not appear to have been identified. The custody nurse who reviewed Mr Williams on two separate occasions in the twelve hours immediately before he attended court, did not on the second occasion take any observations of Mr Williams' vital signs before (or after) prescribing dihydrocodeine, and did not record any part of Mr Williams' clinical picture. Despite having prescribed dihydrocodeine for drug withdrawal, when giving evidence in court the nurse was unable to describe the signs and symptoms of withdrawal. **For Serco** By 18.11 hours, the Serco van that was transporting Mr Williams had returned to the court car park entrance and the driver had got out of the cab and into the back of the van. At that point, neither the escort nor the driver opened the door to Mr Williams' cell to administer first aid - at the very least to relieve his slumped, squashed position to try to deal with any potential airway obstruction. At 18.15 hours when he stopped showing any signs of life, they still did not open his door. They only opened his door at 18.23 hours, removing him from the cell at 18.24 hours, and administering chest compressions at 18.25 hours. The driver did not press the emergency button in the cab to alert the operations control centre of the situation. The Serco crew did call the London Ambulance Service from the van, but were unable to give the postcode of their location.

	I put it to the Serco driver that the focus of the two Serco crew members seemed to be on talking to the three other prisoners in their cells, on phone calls, in fact on anything except getting Mr Williams out of his cell to see if the crew could help him. The driver agreed. The Serco driver eventually administered chest compressions but could not face giving rescue breaths. He seemed to have forgotten that he had a face guard hanging from his belt. Despite evidence from Serco that they were satisfied with the first aid training that was given to the two officers, the jury found that: - the Serco first aid training was inadequate; - it did not include a video of a seizure; - it did not sufficiently emphasise the urgency of potentially life saving measures such as use of the recovery position; - the Serco assessment of the first aid knowledge and competence of its staff was inadequate; - Serco failed to provide clear guidance on the emergency button procedures; - Serco's policy appeared to conflict with its training slides about whether staff should or are even permitted to drive a casualty direct to hospital; - Serco gave insufficient emphasis on urgency and the paramount importance of preserving life.
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 20 April 2026. 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.

	• The family of Sean Williams • The Ministry of Justice • HM Inspectorate of Prisons • HM Prison and Probation Service • The Health and Safety Executive • HHJ Alexia Durran, the 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. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 20.02.26 *ME Hassell*