RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy (2026)].

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, ME Hassell for the Coroner Area INNER NORTH LONDON in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of **Rickie Poon** that concluded on **26 March 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **Practice Plus Group (PPG)** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE** 21st MAY 2026
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: **For HMP Pentonville** The jury found that the following failures at HMP Pentonville in the ACCT (assessment care in custody and teamwork) process contributed to Mr Poon's death: • the ACCT process was not managed and implemented properly, e.g. supervising officers did not consistently acquaint themselves with case notes or history when completing reviews; record keeping was inadequate; agreed actions were not consistently implemented; and ACCT reviews lacked structure and consistency; • accountability was insufficient, e.g. there was no follow up when actions were missed in the ACCT document, sign offs were completed inaccurately, hand overs were not completed between staff, and an

important email was not read or followed up on;

- there were gaps in training and knowledge, e.g. ACCT training had expired and prison staff overly relied on Rickie's presentation;

- the ACCT was closed too soon.

The jury also found that the level of ACCT observations was reduced inappropriately, but they were unclear as to whether this impacted on the outcome.

I recognise that there have been many changes at HMP Pentonville since Mr Poon's death just over a year ago, but I consider it important to bring the jury's findings on causative failures specifically to your attention.

For PPG

The nurse who was on duty for medical emergencies on the night that Rickie was found hanging (call sign Hotel 7), attended immediately upon a code blue alarm being raised. She found prison officers undertaking cardiopulmonary resuscitation (CPR), and so, despite the fact that she had formed the firm and correct view that Mr Poon was dead and that CPR was completely futile, she then undertook chest compressions and continued it.

I did not explore with the nurse the competence of the CPR given.

The nurse's actions could not have had an impact on the outcome because Mr Poon was already dead when she arrived. However, conducting CPR on a person who had clearly died was not professional or appropriate, it did not afford Mr Poon dignity or privacy, it was neither acceptable nor kind.

What concerns me particularly for the future is that there might be an occasion when a CPR attempt that is less than fully competent does have the potential to impact on the outcome.

I sent PFD reports to PPG's earlier incarnation, Care UK, and/or HMP Pentonville about the nature of attempts at resuscitation in respect of the following deceased:

- William Davies (2014)

- Adil Habib (2015)

- Samuel Blair (2016)

- Tedros Kahssay (2016)

- Amir Faizi (2018)

- Robert Ginn (2019)

I recognise that I made the last of these reports over six years ago and I have

	heard descriptions of many changes since then, but I consider that I would be failing in my duty if I were not to flag up this issue now. I hope that by doing so, such a situation will be less likely to arise in the future.
3.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. [If no action is proposed please explain why here]. *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* We do not propose to respond to the points raised above in respect of HMPPS and HMP Pentonville as these matters are for separate organisations. In respect of the concern raised for PPG and the CPR attempt in this matter, we are disappointed that it was inappropriate given the presentation of Mr Poon. However, we are glad to hear that you are aware of the changes and improvements made over the last few years. It is important to note that all clinical staff are trained to ILS (Immediate Life Support) standards. This is a RCUK accredited course for healthcare professionals to manage patients in cardiac arrest before the ambulance team arrives. It focuses on the ABCDE approach, airway management, and safe defibrillation. All staff are expected to complete this training which is done yearly to ensure ongoing competence. This is also subject to audit, which currently shows a 74% compliance rate. Anyone who does not have the training in date would not be assigned to an emergency radio and would be expected to book and complete the training as soon as possible. There is a session booked on the week commencing 25th June 2026 which will raise the compliance to over 90%. The ILS course is delivered by an external provider, but PPG have worked with the company who deliver this training, so the course does include a module on recognition of life extinct (ROLE) and has done since 2021. In this case, the nurse in question did have her ILS training in date and therefore had completed the necessary training to carry out her duties. Whilst we agree in this case that CPR should have been stopped given Mr Poon's presentation, it must be recognised that stopping CPR in such circumstances is a difficult decision to make. As per the letter sent to His Majesty's Coroner by the Head of Healthcare during the inquest, this will be explored further with the nurse in question and additional measures have been put in place to support them and aid in improving their practice. This case is also due to be discussed with the Director of Nursing in an upcoming meeting about resuscitation detailed later in this response. Guidance on the distinctions between verification of the fact of death, certification of death, and the appropriate clinical responses to observations is already embedded in the annual Immediate Life Support (ILS) training. A dedicated module on this topic was specifically developed for PPG and has been included in the training programme since 2021. Alongside mandatory training, regional education sessions have been delivered to further support staff in developing clarity and confidence in these areas. We also routinely distribute updated guidance from national bodies, including the Resuscitation Council and NICE, to ensure alignment with current best

	practice. In addition, we consistently reflect on relevant incidents through both hot and cold debriefs, as well as ongoing reflective practice sessions. These forums provide opportunities for staff to discuss the practical differences between verification, certification, and clinical decision-making, reinforcing learning and supporting continuous improvement. A purple alert (which is a companywide safety notification) was published for all Heads of Healthcare to action, which clarified the organisational position on cardiopulmonary resuscitation following updated guidance by NHSE on 19 March 2026, which is being actioned in line with the deadline given in the alert. A copy of this alert is attached to this response for ease of reference. The purple alert highlights to all services within Practice Plus Group (PPG) that we fully support the national HMPPS/NHSE guidance that cardiopulmonary resuscitation (CPR) should begin immediately when an individual is unresponsive, not breathing and/or has no pulse, unless there are unmistakable signs of irreversible death. However, it recognises that PPG's clinical training model differs from the national assumption that prison healthcare staff are trained only to Basic Life Support (BLS) level. Since 2021, PPG has delivered both BLS and Immediate Life Support (ILS) training across its Health in Justice workforce. The ILS programme includes formal training in Recognition of Life Extinct (ROLE), enabling clinicians to make safe, defensible decisions about when resuscitation would be futile. Under this framework: BLS-trained staff are required to commence CPR immediately unless there are clear, catastrophic signs incompatible with life. If uncertain, they must begin CPR and escalate to an ILS-trained clinician. ILS-trained clinicians are expected to apply their enhanced clinical judgement, including ROLE principles, to determine whether CPR is appropriate. Where resuscitation would be futile, they may withhold or cease CPR, provided the decision is clinically justified and properly documented. In any situation of doubt, CPR should still be initiated. The site has already implemented this guidance locally. A reminder has been issued to all staff to ensure clarity on the distinction between BLS and ILS expectations and the correct application of ROLE principles. In light of the Prevention of Future Deaths (PFD) report, the site has also requested a meeting with the Regional Director and the Director of Nursing, due to be held in June 2026. The purpose of this meeting is to: • Review the guidance in the context of the PFD. • Consider whether further scoping is needed as we have members of clinical staff who may have adjustments for example, where this guidance is less clear in the context of the overall service. • Assess safe staffing numbers trained to ILS/ROLE in light of these restrictions and overall staffing picture. As a service, we are committed to further strengthening our resuscitation response following the issues highlighted in the PFD. To support this, we are introducing multidisciplinary, scenario-based training by July 2026. This programme will involve healthcare staff, prison staff, and prisoners where appropriate, ensuring that learning is shared across the whole custodial environment and that all parties understand their roles during a medical

	emergency. RCUK guidelines recognise that CPR may be stopped when it becomes clear that continued efforts are futile, for example, when there is no return of spontaneous circulation despite appropriate interventions, or when the clinical picture confirms irreversible death such as Rigor Mortis. Embedding these standards into scenario-based training will help ensure that clinicians apply consistent, evidence-based decision-making when determining whether to continue or cease resuscitation and the aim is to give them the confidence to make these decisions as these scenarios will pre-expose them to situations where they may have to make a decision to stop CPR, in a multidisciplinary scenario. The Head of Healthcare has also discussed this regionally and there will be further learning sessions delivered within the region on ROLE, for staff to join in bitesize learning sessions online, this had been delivered previously, so is already available.
4.	**DETAILS OF FURTHER ACTION PROPOSED** *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* Copy of Purple Alert
	SIGNATURE [redacted] **Medical Director**