

**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 **Peter Campbell** that concluded on **10 March 2026**.

1.	<p><b>RESPONDENT</b></p> <p>In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, <b>Practice Plus Group (PPG)</b> provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.</p>
2.	<p><b>DATE OF RESPONSE</b></p> <p>6 MAY 2026</p>
3.	<p><b>CONFIRMATION OF CORONER'S MATTERS OF CONCERN</b></p> <p>The <b>MATTERS OF CONCERN</b> were identified in the report are as follows:</p> <p><b>For HMPPS and Pentonville</b></p> <p>In the narrative conclusion, the jury recorded a failure to prevent drugs from entering the prison.</p> <p>Every witness at inquest who expressed a view gave evidence that drugs are rife within Pentonville, as they are across the prison estate. They enter attached to drones and in throw overs; via prison officers, visitors and prisoners; and, to a lesser extent these days, in the post. Spice, a drug many times more potent and dangerous than cannabis, is impregnated onto pieces of paper so that it can be smoked. It has infiltrated the prison population with enormous reach and with potentially devastating consequences for the prisoners themselves and for others - there is a risk of prisoners leaving prison in a worse state than when they went in, a state that may of course be</p>

reflected in violent reoffending.

Initially, I was not going to include that failure within my prevention of future deaths report, because the availability of drugs in prison seems such a huge and intractable problem. However, on reflection it seems to me that it would be complacent to view the size of the problem as prohibitive. Perhaps the size of the problem dictates only the size of the solution required.

At inquest, I heard about other aspects of the prison regime that were sub optimal, but it appeared that since Mr Campbell's death, the staff at Pentonville had taken steps to address these.

However, the mass availability of drugs apparently persists without abatement. This is not in any way peculiar to Pentonville, but Pentonville is an exemplar.

### **For Phoenix and PPG**

Mr Campbell collapsed in prison on 18 September 2024 as he had done before following the use of spice, and the prison and healthcare staff responded to this as an emergency code blue. The ambulance service was called and he was immediately conveyed to hospital where he was resuscitated.

The jury found a failure by the prison drug service to provide a meaningful interaction with Mr Campbell between the collapse on 18 September 2024 and the fatal collapse on 3 October 2024. This was partly because a visit was not arranged promptly, a systemic issue that since seems to have been addressed.

However, I also heard evidence that, when the Phoenix recovery worker did go to see Mr Campbell on 1 October 2024 in an attempt to promote harm minimisation:

- She did not read any part of his medical records before she saw him, and she did not know whether she was meant so to do. She was.
- She spoke to him through the hatch in the cell door, with his cellmate present. This was her normal practice, but she was not able to say why. It should not have been.
- She did not have any meaningful discussion with him about his drug use, either the use that led to his collapse on 18 September 2024 or his use generally. She should have.
- She gave him various pieces of harm minimisation guidance in keeping with her training, including the advice to avoid using drugs whilst alone. This advice was later confirmed as within policy by the Phoenix head of service. However, it does not seem to take account of the fact that

	<p>smoking a drug in a small cell with a cellmate puts the cellmate at risk.</p> <ul style="list-style-type: none"> <li>• Mr Campbell told her that he was not under the influence at the time. The recovery worker was not wholly convinced, but she did not return later that day or the following day to see if better engagement was possible. She should have.</li> <li>• She did not know whether her interaction with Mr Campbell was in accordance with her training. I was told that it was not. She had not received further training or changed her practice since his death.</li> <li>• The drug recovery worker was the last healthcare worker to see Mr Campbell before his fatal collapse from drugs and did so just two days before that occurred. However, the gaps in her care of Mr Campbell were not identified by the investigation following his death by Phoenix and PPG (or by the Prisons and Probation Ombudsman).</li> <li>• She had not changed her practice since Mr Campbell's death, but any gaps in her care of other prisoners had also not been identified in the following year and a half, either by routine supervision or by audit. I heard that audits are undertaken of the medical records only.</li> </ul> <p>Therefore, the first time that Phoenix and PPG recognised a drug recovery worker's failures to follow their procedures over at least a year and a half, was at the inquest</p>
3.	<p><b>DETAILS OF ACTION TAKEN</b>, how has the concern been addressed. [If no action is proposed please explain why here].</p> <p><i>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.</i></p> <p>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.</p> <p>Likewise, the points raised under the heading for Phoenix and PPG mainly relate to Phoenix Futures and the steps taken by one of their employees. Whilst we work closely with Phoenix as one of our subcontractors at Pentonville and work together to improve services and continue our strong working partnership, we do not propose to comment on their service or individual employees. We understand that Phoenix will be responding to the points raised separately.</p> <p>The latter 2 bullet points raised however, do touch upon PPG and our internal processes for post incident reviews. It is important to note, as identified by the learned Coroner, that the PPO investigation also did not identify the issues raised. Our internal process for learning reports are thorough and of great importance to us as an organisation. We carry out multiple reports into all deaths in custody in order to identify issues and areas of good practice, and to learn lessons and implement change where required.</p>

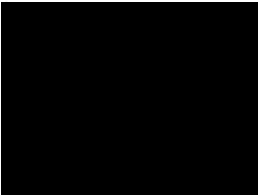
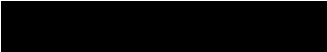
As noted, we conduct a number of responses to any event where learning points may arise and this is always completed for any death in custody across all PPG establishments. Learning responses can include:

- Swarm Huddles – this is a rapid, informal team-based meeting held shortly after an incident to build a shared understanding of what happened, capture early learning and identify any immediate safety actions.
- Hot debrief – this takes place immediately after a clinical event to identify early learning points but also to support staff involved.
- Post-Incident Initial Review (PIIR) – this is a structured discussion conducted within 72 hours of an incident. It seeks to understand what happened and why, explore outcomes and promote learning. This involves staff directly.
- Clinical Case Review (CCR) – this is a structured multi-disciplinary discussion after an event to learn from both successes and failures. It explores the care provided, identifies any contributing factors, examines systems and gains a broader insight into any specific safety themes, pathways and/or processes. This investigation process aims to foster a culture of continuous improvement and sustainability of good practices.
- Patient Safety Incident Investigation (PSII) – this is a formal systems based investigation triggered by incidents that pose significant safety risks or have potential for further learning. This follows on from a PIIR and CCR where further review may be considered beneficial or necessary.
- Thematic Reviews – used to analyse a group of related incidents.
- Other investigations include; complaint reviews, HR matters and professional regulation reviews.

For all deaths in custody a PIIR and CCR is completed, and a PSII is completed on occasion where deemed necessary by the patient safety team. There may be some exceptions where a CCR is not completed but this would only be where the death was expected and no issues arise from the PIIR, or post-release deaths, again where no issues arise out of the PIIR. These reports are thorough and include a multi-disciplinary approach. As will have been seen in the CCR for Peter Campbell this includes stakeholders from Phoenix Futures, BEH and HMPPS, as well as PPG managers and medical leads. A chronology of the care is reviewed and it identifies areas that went well and what could have been done better. Subcontractors and organisations which we work closely with are included to promote wider learning and obtain different perspectives which is vital to build a culture of good communication and collaboration within the establishments we operate.

As part of the processes staff involved in the patient's care are spoken to, interviewed or asked for statements so that their perspectives are taken into consideration. We will continue to seek the views of staff who had significant interactions with patients involved in a DIC or other incident, as well as those who may have been the last or latter interactions.

We continue to work closely with Phoenix Futures, specifically at HMP Pentonville, and have a strong working relationship with them. They continue to provide a vital resource to patients at HMP Pentonville and we are provided with assurances regarding their services, staff and management. The review of

	<p>subcontractors such as Phoenix Futures is managed via Practice Plus Groups 'Standard Operating Procedure for management of Sub-Contracted Services'. This formalises a local, regional and national process that is adhered to by HMP Pentonville. Additional regional scrutiny will be implemented at HMP Pentonville for the following 6 months to ensure that the SOP is being implemented correctly and any issues arising from either organisation can be addressed quickly and effectively.</p> <p>In respect of investigations undertaken by PPG generally, the organisation has strengthened its governance arrangements to support more consistent and balanced decision-making regarding the appropriate level of investigation. A weekly national decision-making forum has been introduced to review medium to high-risk patient safety incidents and determine appropriate level of learning response i.e. whether a Patient Safety Incident Investigation (PSII) or other structured review methodology is required.</p> <p>In addition, senior clinical leaders now provide quality assurance and sign-off for all patient safety incident investigations to ensure appropriate clinical scrutiny, learning and response to incidents.</p>
4.	<p><b>DETAILS OF FURTHER ACTION PROPOSED</b> <i>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.</i></p> <p>For additional resource about our incident response and patient safety team, please find the attached:</p> <ul style="list-style-type: none"><li>• Patient Safety Incident Response Plan PPG HIJ services 2025-2026</li><li>• PPG HIJ Patient Safety Governance Position Statement – March 2026</li></ul>
	<p><b>SIGNATURE</b></p> <p></p> <p></p> <p><b>Medical Director</b></p>