

## Regulation 28: Prevention of Future Deaths report

Peter Asher CAMPBELL (died 08.10.26)

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li><b>1. Chief Executive HM Prison and Probation Service (HMPPS) Ministry of Justice</b></li><li><b>2. Governor HM Prison Pentonville (Pentonville)</b></li><li><b>3. Chief Executive Phoenix Futures (Phoenix)</b></li><li><b>4. Chief Executive Practice Plus Group (PPG)</b></li></ol>
1	<p><b>CORONER</b></p> <p>I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 17 October 2026, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Peter Campbell aged 36 years. The investigation concluded at the end of the inquest yesterday. The jury made a determination that death was drug related, and also gave a narrative that I attach.</p> <p>The medical cause of death was recorded as:</p>

	<p>1a pneumonia and ischaemic hypoxic brain injury</p> <p>1b cardiac arrest</p> <p>1c toxic effects of [REDACTED]</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On 3 October 2024, Mr Campbell collapsed in his prison cell at Pentonville whilst with his cell mate, having smoked [REDACTED]. He was a frequent user of [REDACTED]. Despite immediate attempts at resuscitation and conveyance to hospital, he died five days later.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> 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. [REDACTED], a drug many times more potent and dangerous than cannabis, [REDACTED] [REDACTED] 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 reflected in violent reoffending.</p> <p>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.</p> <p>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.</p>

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 [REDACTED], 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 smoking a drug in a small cell with a cellmate puts the cellmate at risk.
- 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.
- 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.

	<ul style="list-style-type: none"> <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>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 May 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the following.</p> <ul style="list-style-type: none"> <li>• the family of Peter Campbell</li> <li>• North London NHS Foundation Trust</li> <li>• Prisons and Probation Ombudsman</li> <li>• HM Inspectorate of Prisons</li> <li>• HHJ Alexia Durran, the Chief Coroner of England &amp; Wales</li> </ul> <p>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.</p>

	<p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>				
9	<table><tr><td><b>DATE</b></td><td><b>SIGNED BY SENIOR CORONER</b></td></tr><tr><td>11.03.26</td><td></td></tr></table>	<b>DATE</b>	<b>SIGNED BY SENIOR CORONER</b>	11.03.26	
<b>DATE</b>	<b>SIGNED BY SENIOR CORONER</b>				
11.03.26	