

Regulation 28: Prevention of Future Deaths report

Rickie Wai Kee POON (died 13.03.25)

	<p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. The Governor HM Prison Pentonville2. The Chief Executive Practice Plus Group (PPG)
1	<p>CORONER</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>CORONER'S LEGAL POWERS</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>INVESTIGATION and INQUEST</p> <p>On 17 March 2025, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Rickie Poon, aged 38 years. The investigation concluded at the end of the inquest on 26 March 2026. The jury made a determination at inquest of death by suicide, plus a narrative that I now attach.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Following his arrest and suspension from the job of a police officer, Rickie Poon made a serious attempt on his life on 19 January 2025, was detained under section of the Mental Health Act, then remanded in custody at HM Pentonville on 13 February 2025. By this time he had been dismissed from work. Exactly one month after his arrival in prison, he was found hanging in his cell.</p>

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 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.

	<p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • William Davies (2014) • Adil Habib (2015) • Samuel Blair (2016) • Tedros Kahssay (2016) • Amir Faizi (2018) • Robert Ginn (2019) <p>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.</p>
6	<p>ACTION SHOULD BE TAKEN</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>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 June 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>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the following.</p>

	<ul style="list-style-type: none"> • the family of Rickie Poon • North London NHS Foundation Trust (interested person) • the Metropolitan Police Service (interested person) • HM Inspectorate of Prisons • HM Prisons and Probation Service • HHJ Alexia Durran, the Chief Coroner of England & Wales <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. 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 style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">DATE</td> <td style="width: 50%; border: none;">SIGNED BY SENIOR CORONER</td> </tr> <tr> <td style="border: none;">30.03.26</td> <td style="border: none; text-align: center;"></td> </tr> </table>	DATE	SIGNED BY SENIOR CORONER	30.03.26	
DATE	SIGNED BY SENIOR CORONER				
30.03.26	