Regulation 28: Prevention of Future Deaths report

Adil HABIB (died 31.10.14)

	THIS REPORT IS BEING SENT TO: **1. Dr Fionna Moore** **Chief Executive** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London SE1 8SD**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 3 November 2014, I commenced an investigation into the death of Adil Habib, aged 30 years. The investigation concluded at the end of the inquest earlier today. The jury made a determination that this was an accidental death, when Adil Habib died in the search area of HM Prison Pentonville at 16:54 hours on 31 October 2014 by acute respiratory failure due to mechanical obstruction of his upper airway by a foreign object.
4	**CIRCUMSTANCES OF THE DEATH** Mr Habib died following a full search conducted after a visit. During the search, he was the subject of control and restraint, but managed to put a small package, later found to contain crack cocaine, in his mouth. He choked on this and died.

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. When a prison officer at HMP Pentonville rang 999 to ask that paramedics attend the prison, the caller did not immediately offer the location of the prison gate that London Ambulance Service should attend. Whilst there is of course an issue for the prison in terms of offering the information, it would be helpful for LAS call handlers to be provided with a drop down menu showing the alternative gates when they input the prison details. I understand that the LAS computer system has been augmented in this respect since Mr Habib's death for HMP Pentonville, but not for the other London prisons. Perhaps that would be a useful exercise?
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your organisation 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 6 November 2015. 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. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Association of Ambulance Chief Executives (AACE) • National Ambulance Service Medical Directors (NASMeD) • [redacted] and [redacted], parents of Adil Habib • [redacted] partner of Adil Habib

	I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 16.09.15