Regulation 28: Prevention of Future Deaths report

Adil HABIB (died 31.10.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT**
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 yesterday. 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. I heard evidence at inquest that there is no training for prison officers that specifically covers the risk of prisoners choking as a result of attempts to conceal an item from prison officers, most especially during a search and/or control & restraint. It seems to me that this is a significant omission, and it would be helpful if such training were mandatory and refreshed regularly. I have written to the National Offender Management Service as provider of prison officer training about this but, in addition, I wanted to bring this direct to your attention. It may be some months before there is any change to the national training offered. I have given a great deal of thought to reporting to you regarding the fact that there is no mandatory first aid (including CPR) training for all prison officers. However, I heard evidence that this is a nationally made, resource led decision, and takes into account the 24 hour availability of nurses within the prison. Upon reflection, it seems to me much more important that the gap in officer training regarding choking is filled appropriately. The nurse who was on call as Hotel 7 at the prison did not respond to the emergency alarm that was activated at the start of the control & restraint of Mr Habib, as she should have. Instead, she only responded once a Level 1 emergency was radioed. I appreciate that this nurse no longer works at HMP Pentonville and that your team has taken steps to remind all nurses operating as Hotel 7 of their responsibility to respond to every alarm immediately. The prison officer who rang 999 from the control room did not immediately offer the LAS call handler the location of the prison gate to which the ambulance should be driven. I understand that your team has taken steps to remind all officers working in the control room that they must do this. I understand also that your team has an ongoing conversation with London Ambulance Service to enable best care to be given to those in the prison in need of paramedic attention.
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 • HM Inspectorate of Prisons • [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