Regulation 28: Prevention of Future Deaths report

Terence Darren ADAMS (died 09.11.15)

	THIS REPORT IS BEING SENT TO: **1. Mr Mike Parish** **Chief Executive** **Care UK** **29 Great Guildford Street** **London SE1 0ES** (points 2 to 6) **2.** [redacted] **Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT** (point 1 only)
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 12 November 2015, I commenced an investigation into the death of Terence Darren Adams, aged 43 years. The investigation concluded at the end of the inquest on 20 July 2016. The jury made a narrative determination, which I attach.

4	**CIRCUMSTANCES OF THE DEATH** Mr Adams committed suicide by hanging himself in his cell at HM Prison Pentonville.
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. 1. I heard at inquest that the prison escort record (PER) that accompanies each prisoner to HMP Pentonville (and which in the future will be forwarded to healthcare staff), is not checked on arrival and thereafter to ensure that, as it progresses through the prison, it includes the attachments described within the document, for example the risk assessment conducted by the police. This seems an unhelpful omission. 2. The general practitioner (GP) who saw Mr Adams when he first arrived at HMP Pentonville did not have the key for the first night reception template when she considered the information contained therein. Mr Adams scored 8. The GP did not know that the advice on the template for scores of 6 and over was to admit the prisoner to inpatient healthcare. 3. Neither the nurse nor the GP conducting the first night reception interviews was clear about the status of the first night reception template. The nurse, particularly, talked about it being a document referring to historical matters, whereas the reality is that it encompasses both past and relevant current issues. The document did not give any indication on the face of it that its instructions are advisory rather than mandatory. 4. Mr Adams told the GP that he had been suicidal on and off for twenty years, but she did not explore with him the potential triggers for this. In fact, one such trigger was incarceration. 5. On the morning he died, Mr Adams should have attended his second reception screen, also known as the well man clinic. When he did not arrive, the healthcare nurse did not attempt to find out why or to secure his attendance.

	6. The root cause analysis (RCA) conducted by Care UK after Mr Adams' death in November 2015, and finalised in February 2016, was not shared with HM Coroner until part way through the inquest, and then only following the accidental discovery of its existence by two of the inquest advocates. It had not been shared with HMP Pentonville's head of safer custody governor; nor even with the deputy head of healthcare of Care UK itself. Its existence had not been disclosed to HM Coroner. These are significant failures, and it seems to me are an obstacle to learning lessons that may prevent future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 26 September 2016. 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 • Care Quality Commission for England • HM Inspectorate of Prisons • National Offender Management Service • Independent Advisory Panel • [REDACTED] children of Terence Adams 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**
	26.07.16	