REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Practice Plus Group, Hawker House 5-6 Napier Court, Napier Rd, Berkshire RG1 8BW. 2. Resuscitation Council UK, 5th Floor, Tavistock House North, Tavistock Square, London. WC1H 9HR.
1.	**CORONER** I am Lorraine Harris, Assistant Coroner, for the coroner area of South Yorkshire (East).
2.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INVESTIGATION AND INQUEST** On 15th November 2017 I commenced an investigation into the death of Darren Adams (DOB 30th March 1962). The investigation concluded at the end of the inquest on 28th April 2021. The conclusion of the inquest was suicide, the medical cause of death was 1a Hypoxic Brain Injury 1b Hanging.
4.	**CIRCUMSTANCES OF THE DEATH** On 7th November 2017 Darren Adams was transferred from HMP Garth (HMPG) to HMP Lindholme (HMPL). It appears he believed, incorrectly, that there was a Vulnerable Prisoner Unit (VPU) at HMPL. Staff at HMPG accepted Mr Adams had asked about a VPU but the fact there was no such unit at HMPL was not relayed back to him. There was no evidence to say that he would have been placed on a VPU even if there had been one at HMPL. Mr Adams had a history of being unsettled when moved, even within a prison. The jury found that there was insufficient information regarding Mr Adam's on his transfer and arrival at HMPL. Within 24 hours of arrival his mental health deteriorated to such an extent he was placed on an ACCT. There were insufficient records of his behaviour in the ACCT and a full picture of his mental health was not recorded. Darren was alive at 0641 hours on 12th November 2017 but discovered ligatured in his cell at 0738 hours. The officer discovering Mr Adams waited for additional staff assistance before attempting to enter the cell however Darren had erected a barricade at his door which caused an additional slight delay in accessing him. Once the door was opened and barricade removed nursing staff from prison healthcare entered the cell. The nursing staff carried out a clinical assessment but misdiagnosed him,

	believing him to have hypostasis and rigor mortis. They decided not to commence CPR. The nurses had previously been advised by the Prison Service and Probation Ombudsman against commencing CPR when someone is obviously deceased. They referred to the guidance "Guidance to support the decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centre (IRC)". When paramedics arrived their clinical assessment found no hypostasis, no rigor mortis and they also stated he was still warm. They commenced CPR and obtained a return of spontaneous circulation 4 times, the last as he was conveyed to Doncaster Royal Infirmary (DRI). Once at DRI, after a period of observation and tests Mr Adams was declared dead at 13th November 2017.
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 could 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. The Nursing Staff misdiagnosed hypostasis. It was apparent in evidence that they did not have a sufficient understanding of the process and how to identify it. 2. The Nursing Staff misdiagnosed rigor mortis. It was apparent in evidence that they did not have a sufficient understanding of the process and how to identify it. 3. Management of the nurses accepted in evidence that more focus on the identification of those conditions should have been covered in better depth during the nurse's life support training. 4. It was seen during the evidence that definitions in Annex A of the document "Guidance to support the decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centre (IRC)" could be confusing, for example the word "mottling" was interpreted by different people in different ways (both lay and medical).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 24th June 2021. I, the Assistant 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 Chief Coroner and the following interested persons: - The family – represented by Ison Harrison Solicitors - HMP Lindholme – represented by Government Legal Department I have also sent it to the following people who may find it useful or of interest: - Her Majesty's Inspectorate of Prisons - Her Majesty's Prison and Probation Service - The Prison and Probation Service Ombudsman - Independent Advisory Panel on Deaths In Custody
	I am also under a duty to send a copy of your responses to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send your responses to any other person who I believe may find it useful or of interest. 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 Assistant Coroner, at the time of your response, about the release or the publication of your response.
9	Lorraine Harris (Signed Electronically) 29th April 2021