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Mrs L Harris
HM Assistant Coroner for South Yorkshire (East District)
Coroner's Court and Office
Crown Court
College Road
Doncaster
DN1 3HS

16 June 2021

Dear Mrs Harris

**Regulation 28: Prevention of Future Deaths report, Darren Adams (Deceased)**

Thank you for your Regulation 28 Prevention of Future Deaths Report issued to Practice Plus Group following the inquest touching upon the death of Darren Adams at HMP Lindholme. Practice Plus Group would like to express its condolences to Mr Adams' family and friends. Below you will find each of the matters of concern addressed in turn:

**Matter of Concern 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.

**Response**: This is addressed in the response to matter of concern 3.

**Matter of Concern 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.

**Response**: This is addressed in the response to matter of concern 3.

**Matter of Concern 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.

**Response**: Practice Plus Group acknowledges the matters of concern raised and that they relate to insufficient understanding by staff in identification of hypostasis and rigor mortis. In order to address the concerns raised the following actions have been taken:

- Practice Plus Group mandates annual Intermediate Life Support Training (ILS) for all clinical staff in recognition of their critical role in providing pre hospital life support. Non clinical staff are trained in Basic Life Support and agency staff are required to have undertaken ILS training and can access the training provided by Practice Plus Group. The curriculum for PPG's ILS training has been adapted by our training provider to include prison specific scenarios. The training is delivered by Resuscitation Council accredited trainers. Following this inquest, the training provider has spoken to staff who have been involved in resuscitation decision-making scenarios to hear their experiences and understand the issues that are faced, including the challenges of diagnosing hypostasis. Our training provider has amended the content of the previously provided ILS course to include:

  (i) 45-minute theoretical session on assessment and presentation, factors for consideration and recognition of rigor mortis and lividity; and

  (ii) Mandatory scenarios where decision-making is required (previously these were optional).

  This change in curriculum has been agreed will take effect from July 2021.
  Supplementary, additional education days have been developed for on-site training of clinical staff. These include a range of resuscitation scenarios to build staff confidence and encourage participation in group learning exercises; this is in addition to the ILS training provided. These simulation days are in the process of being rolled out across PPG's sites, prioritising those where issues have been identified. A simulation training event at HMP Lindholme is being scheduled for the end of September 2021.

  Records of training attendance and emergency scenario simulation events are kept on our Learning Management System to provide assurance of compliance with PPG requirements.

**Matter of Concern 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).

**Response**: This guidance was issued by the National Offender Management Service (NOMS), Royal College of Nursing (RCN) and the Royal College of General Practitioners (RCGP) in March 2016. Therefore, the terminology sits outside the control of Practice Plus Group. For Practice Plus Group we will:

- Teach clinical staff on how to diagnose death
- Teach our staff the practical meaning of the terminology used in the Resus Council UK guidance
- Raise the matter to NHS England by way of correspondence to indicate the concerns raised during this inquest.

Practice Plus Group will ensure that any revisions to the guidance are taken into account in our training.

Practice Plus Group are committed to providing a high quality healthcare service at HMP Lindholme and to ensuring that those detained there are as safe as possible and receive the best quality care. Practice Plus Group is deeply sorry that Mr Adams died while receiving care from our service and we will ensure that the lessons learnt are not just implemented at HMP Lindholme but across Practice Plus Group’s services.

I trust that the above responses provide the information that you require but please do not hesitate to contact me if Practice Plus Group can be of any further assistance.

Yours sincerely

[redacted]

[redacted]

**National Medical Director, Health in Justice Practice Plus Group**

[redacted]