

Regulation 28: Prevention of Future Deaths report

Mujahid Adam (died 21.3.2025)

	<p>THIS REPORT IS BEING SENT TO:</p> <p>(1) [REDACTED], The Governor, HMP Pentonville, Caledonian Road, London N7</p> <p>(2) The Secretary of State for Justice, Ministry of Justice, 102 Petty France, Westminster, London SW1H 9AJ</p> <p>(3) The Minister of State for Prisons, Parole and Probation, 102 Petty France, Westminster, London SW1H 9AJ</p>
1	<p>CORONER</p> <p>I am: Edwin Buckett Assistant Coroner Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 27th March 2025 Assistant Coroner Saba Naqshbandi KC began an investigation into the death of Mujahid Adam who died aged 20, on the 21st March 2025 at University College Hospital, Euston Road, London NW1 following his transfer there from HMP Pentonville.</p> <p>The investigation concluded at the end of a 7-day inquest, on 24th February, 2026 conducted by myself, Assistant Coroner Edwin Buckett sitting with a Jury at Bow Coroner's Court.</p> <p>The jury made a determination at inquest that the deceased died as a result of suicide with a number of possible contributory causes to his death.</p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The Jury findings as to the circumstances of death were recorded in the Record of Inquest at <u>Paragraph 3</u> as follows:</p> <p>“Mr Adam had a history of low mood and mental health issues.</p> <p>He was facing a serious criminal charge and possible deportation.</p> <p>He was the victim of a violent assault in a previous cell, and possibly fearful of transfer to another wing.</p> <p>He made a suicide attempt by ligature on 19.2.2025.</p> <p>He was placed on constant watch and under the ACCT process and he was getting regular assessments.</p> <p>[REDACTED]</p> <p>On 15.3.2025, no adequate observation was made on his cell between 11.42 and 12.18.</p> <p>At 12.18, prison staff discovered him hanging in his cell.</p> <p>The Code Blue signal was delayed, as was cutting him down.</p> <p>Resuscitation was attempted and he went to University College Hospital.</p> <p>He was declared dead on 21.3.2025.”</p> <p>The conclusion of the Jury as to the death was recorded on the Record of Inquest at <u>Paragraph 4</u> as follows:</p> <p>“Mr Adam’s unstable mental health possibly contributed to his death.</p> <p>There was a failure to perform observations at an appropriate frequency, in accordance with the ACCT policy.</p> <p>There was a delay in calling Code Blue and cutting him down.</p> <p>These matters possibly contributed to his death.</p> <p>The cell’s condition possibly provided a greater opportunity to attempt suicide.”</p>
5	<p>CORONER’S CONCERNS</p>

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.

Evidence was given that:

1. If a prisoner was on 15-minute observations, a record of the observation checks on that prisoner would be made by a prisoner officer tasked with the responsibility for carrying out those checks.
2. That individual would write down those checks alongside their name, on a Form which was attached to the AACT Form in the office on the Wing. It was stated that it was not practicable to note observation checks as and when they occurred, because the officer concerned was not allowed to take the ACCT Form on the wing.
3. Furthermore, on rare occasions a record of such 15-minute checks might be made 'in one go' at the end of a shift. In other words, this could lead to more than 25 separate entries being written up in one go (assuming the same officer was expected to complete checks over 7 hours in a shift).
4. What amounted to a satisfactory observation of a prisoner is not defined by the prison. Evidence was given by a prisoner officer that he carried out checks at some distance away from the cell door. He stated that he did not always walk up to the door and look in, but relied upon the fact that he could see through the Perspex Outer cell door as the Inner Metal cell door was fully open.
5. The cell in which Mr Adam had been placed was in a state of disrepair. It was possible to access hidden scraps of bedding material for making a ligature, in a gap in the wall, where the u-bend of the toilet entered the wall.
6. Although the cell was subject to a daily "accommodation and fabric check" it was probable that this disrepair, in this location in this cell was missed by prison staff carrying out AFCs.

I am concerned that:

- (a) The recording of observations of 15-minute checks is not contemporaneous and is prone to inaccuracy. It relies on a prison officer walking from the cell to the wing office to record

	<p>observations, every 15 minutes, which may not be realistic if a prison officer has other duties to perform;</p> <p>(b) There is no clear definition of what constitutes an “observation” and how this should be done by staff at the prison when someone is on 15-minute observations;</p> <p>(c) The cell occupied by Mr Adam is one of a handful of special cells in the prison which are used for vulnerable prisoners on constant watch or on 15-minute observation. It was in a state of disrepair and gave access to the hidden material from which a ligature could be made. Despite daily AFCs, that disrepair was not noted although this was a special cell.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion, action should be taken to prevent future deaths and I believe that you and/or your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st May 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the following.</p> <ul style="list-style-type: none"> • HHJ Alexia Durran KC, the Chief Coroner of England & Wales • The Family of Mujahid Adam • The Prisons & Probation Ombudsman (PPO). <p>I am under a duty to send the Chief Coroner a copy of your response.</p> <p>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</p>

	representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	DATE 3.3.2026 SIGNED BY ASSISTANT CORONER <i>Edwin Buckett</i>