

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am David REID, HM Senior Coroner, for the coroner area of Worcestershire.
2.	DATE OF REPORT 27 July 2026
3.	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.
4.	THIS REPORT IS BEING SENT TO 1. The Governing Governor, HMP Hewell, Hewell Lane, Redditch, Worcestershire You are under a duty to respond to this report within 56 days of the date of this report, namely by September 21, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	SUMMARY OF CORONER'S CONCERN

	Measures have still not been taken at HMP Hewell to ensure that all persons working at the prison have received proper training in (a) the risk of suicide and/or self-harm in prisoners; and (b) the Assessment, Care in Custody and Teamwork (ACCT) process within prisons.
7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 03 December 2024 I commenced an investigation and opened an inquest into the death of Adam Eaton CLARK aged 36. The investigation concluded at the end of the inquest on 23 July 2026. The conclusion of the inquest was that: Narrative Conclusion - Mr. Clark died as a result of suicide. See Questionnaire: 1. When Adam arrived at HMP Hewell on 30.10.24, should the Supervising Officer who spoke to him in reception have recorded in his NOMIS prison record: (a) the fact that his Person Escort Record (PER) form contained a warning that he was at risk of suicide and self-harm? YES (b) the fact that his Person Escort Record (PER) form contained details of his previous attempts at suicide and/or self-harm? YES (c) the fact that he (the Supervising Officer) had decided not to open an ACCT for Adam, together with the reasons for that decision? YES If your answer to any of Questions 1(a)-(c) above is YES, go to Question 2. If all your answers to Questions 1(a)-(c) are either NO or CANNOT SAY, go to Question 3. 2. If your answer to any of Questions 1(a)-(c) above is YES, did that failure or those failures together possibly cause or contribute to Adam's death? YES 3. Should the Supervising Officer in reception on 30.10.24 have opened an ACCT document for Adam at that point? NO If your answer to Question 3 is YES, go to Question 4. If your answer to Question 3 is NO or CANNOT SAY, go to Question 5. 4. If your answer to Question 3 is YES, did the prison officer's failure to open an ACCT possibly cause or contribute to Adam's death? YES/NO/CANNOT SAY 5. In relation to Adam's initial healthcare screening appointment on his

	arrival at HMP Hewell on 30.10.24: (a) did the nurse who conducted that appointment look at Adam's PER document and the information within it set out at 1(a)-(b) above? CANNOT SAY If your answer to Question 5(a) is YES, go to Question 5(c). If your answer to Question 5(a) is NO or CANNOT say, go to Question 5(b). (b) if your answer to Question 5(a) is NO or CANNOT SAY, should the nurse have looked at his PER document before or during that appointment? YES If your answer to Question 5(b) is YES, go to Question 5(c). If your answer to Question 5(b) is NO or CANNOT SAY, go to Question 7. (c) If your answer to 5(a) or 5(b) is YES, should that nurse have opened an ACCT document for Adam at that point based on the information contained in the PER and the information provided during the healthcare screening appointment? NO If your answer to Question 5(c) is YES, go to Question 6. If your answer to Question 5(c) is NO or CANNOT SAY, go to Question 7. 6. If your answer to Question 5(c) is YES, did the nurse's failure to open an ACCT possibly cause or contribute to Adam's death? YES/NO/CANNOT SAY 7. In relation to Adam's Cell Sharing Risk Assessment (CSRA) appointment on his arrival at HMP Hewell on 30.10.24: (a) did the prison officer who conducted that appointment look at Adam's PER document and the information within it set out at 1(a)-(b) above? CANNOT SAY If your answer to Question 7(a) is YES, go to Question 7(c). If your answer to Question 7(a) is NO or CANNOT say, go to Question 7(b). (b) if your answer to Question 7(a) is NO or CANNOT SAY, should the prison officer have looked at his PER document before or during that appointment? YES If your answer to Question 7(b) is YES, go to Question 7(c). If your answer to Question 7(b) is NO or CANNOT say, go to Question 9. (c) If your answer to 7(a) or 7(b) is YES, should that prison officer have opened an ACCT document for Adam at that point? NO If your answer to Question 7(c) is YES, go to Question 8. If your answer to Question 7(c) is NO or CANNOT SAY, go to Question 9. 8. If your answer to Question 7(c) is YES, did the prison officer's failure to open an ACCT possibly cause or contribute to Adam's death? YES/NO/CANNOT SAY
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	9. Should Adam's behaviour on 21.11.24 and 26.11.24, which was witnessed by his maths tutor, have resulted in an ACCT being opened for him, whether by the tutor or by anyone else? YES If your answer to Question 9 is YES, go to Question 10. If your answer to Question 9 is NO or CANNOT SAY, go to Question 11. 10. If your answer to Question 9 is YES, did the failure to open an ACCT possibly cause or contribute to Adam's death? YES 11. Had entries been made on Adam's NOMIS prison record, ought the prison officers who decided to move Adam to Houseblock 4 on 30.11.24 have been aware of: (a) his previous history of attempts at self-harm and/or suicide? YES (b) his behaviour and comments to his maths tutor on 21.11.24 and 26.11.24? YES If your answer to either/both of Questions 11(a)-(b) above is YES, go to Question 12. 12. If your answer to either/both of Questions 11(a)-(b) above is YES, did that failure or those failures together possibly cause or contribute to Adam's death? Put another way, if the officers who decided to move Adam to Houseblock 4 on 30.11.24 had been aware of that information, are they likely to have taken action which may possibly have saved Adam's life? YES 13. Had entries been made on Adam's NOMIS prison record, ought the prison officers who witnessed the deterioration in his mental health following his move to Houseblock 4 on 30.11.24 onwards have been aware of: (a) his previous history of attempts at self-harm and/or suicide? YES (b) his behaviour and comments to his maths tutor on 21.11.24 and 26.11.24? YES If your answer to either/both of Questions 13(a)-(b) above is YES, go to Question 14. 14. If your answer to either/both of Questions 13(a)-(b) above is YES, did that failure or those failures together possibly cause or contribute to Adam's death? Put another way, if officers witnessing the deterioration in Adam's mental state following his move to Houseblock 4 on 30.11.24 had been aware of that information, are they likely to have taken action which may possibly have saved Adam's life? YES
9.	CIRCUMSTANCES OF DEATH

	On 1.12.24 Mr. Clark died after suspending himself by a ligature [REDACTED]
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: During the inquest, it became apparent that a maths tutor at HMP Hewell, who had noted significant concerns about the deceased's mental health at the end of November 2024 (only a week before he died), had not received any training about (a) the risk of suicide and/or self-harm in prisoners, or (b) the Assessment, Care in Custody and Teamwork (ACCT) process which is designed to protect those prisoners at increased risk of self-harm, since she had started working at the prison in June 2024. Her line manager within the education department at the prison had not herself received any such training when she worked at the prison between December 2022 and September 2025. I heard evidence from the Head of Safety at the prison that there were still staff working at the prison who had not received this training, that he was "reasonably confident" that those staff members had been identified, and that measures had been put in place to address this "training deficit" within the next 4 weeks (i.e. by 19.8.26). This has been a recurring issue in inquests into deaths in custody in Worcestershire, and it is of considerable concern that it has still not been resolved.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1) Harrison Bunday solicitors (representing [REDACTED] the deceased's mother and sister); 2) [REDACTED] (the deceased's father and sister); 3) Midlands Partnership NHS Foundation Trust; 4) Practice Plus Group; 5) HM Inspectorate of Prisons; 6) The Independent Advisory Panel on Deaths in Custody. I also have a duty to send a copy of the report to the Chief Coroner.

	You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE 