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Date: 24 January 2022
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

HMP Swaleside (care of Government Legal Department)

1. CORONER

I am Patricia Harding Senior Coroner for Mid Kent and Medway

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 28 November 2018 I commenced an investigation into the death of Idris HABIB. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Narrative: Idris Habib took his own life when he hung himself in his cell, B1 - 18, but his intention in doing so is unclear. On 16th November 2018 Idris Habib set a fire in his cell and stated that he wanted to kill himself. There was a failure to open an ACCT following this, however it can not be concluded that these factors contributed to his death.

1a Hanging

1b

1c

II

4. CIRCUMSTANCES OF THE DEATH

Idris Habib was transferred to HMP Swaleside from HMP Pentonville on 15.11.2018. There were no issues identified on induction in respect of his mental or physical health, there was however a history of Habib expressing to prison staff that he was being bullied and threatened and requests to be moved or segregated.

Shortly after arrival at HMP Swaleside Mr. Habib indicated that he wanted to be moved from the induction wing as he was under threat from the people that he had been transferred from HMP Pentonville with.

On 16.11.2018 he summoned assistance because he had cut himself whilst fashioning a weapon from plastic cutlery that he stated he needed for protection. An hour later he set fire to his cell. On both occasions he stated that he was being bullied. He stated at one point that he wanted to kill himself but did not repeat this when subsequently questioned following these events. He was given reassurance about his safety and was moved to a different wing. The prison investigated Mr. Habib's concerns and found no evidence to support the allegation of bullying or threats.

Over the next few days and 'self-secluded', rarely leaving his cell. Two other prisoners (one a mentor) agreed to look after him and provide him with support.

At 7am on 20th November 2022 he was seen at the back of his cell at the early roll call. He was in the same position when the mentor prisoner went to see him and realised he was suspended.

Cell B1-18 had been recently vacated by another prisoner and police who searched the cell after the death found containers belonging to a previous occupant. Quetiapine and trihexyphenidyl hydrochloride containers were empty when found but a box of simvastatin contained a blister pack with 7 tablets inside. It is not known whether the other containers were empty when Idris Habib was placed in the cell. Toxicological tests conducted following the death was negative for these substances.

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) Medication from the previous occupant of cell B1-18 was found in the cell following the death of Mr Habib

(2) There was a disconnect between HMP Swaleside's local policy and the Prison Officer

Entry Level Training in respect of roll checks

(3) That measures put in place following Mr. Habib's death to ensure welfare checks are conducted are not overlooked and are documented as having taken place

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe 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 **23rd March 2022** 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 Chief Coroner and to the following Interested Persons -Solicitors acting on behalf of the family, Healthcare services at the prison

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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

24 January 2022

Signature 

Patricia Harding Senior Coroner for Mid Kent and Medway