REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Governor of HMP Swansea, 200 Oystermouth Road, Swansea The Ministry of Justice, 102 Petty France, London, SW1H9AJ The Chief Executive of Swansea Bay University Health Board, 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot SA12 7BR
1	**CORONER** I am Kirsten Heaven, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 13th September 2016 an investigation was commenced into the death of Khalid Abiaz, a prisoner at HMP Swansea who died in his cell on 13th September 2016 after having tied a ligature around his neck. He was 40 years of age at the time of his death. The investigation concluded at the end of the inquest on 16th June 2022. The medical cause of death was: 1a pressure on neck (hanging) The conclusion of the inquest was as follows: An excessively elongated immigration process lasting 17 years has led to a significant amplification of Khalid's well documented mental health and housing issues. This cycle of a lack of adequate housing to keep him safe and erratically prescribed medication would have had a negative effect on his mental health. At times where risks by agencies involved were identified there was a failure to ensure that Khalid had the relevant medication and housing to keep him safe. There was a systemic failure to consider historic assessment about his mental health; rather agencies focussed on current presentation with apparent disregard and curiosity about historical data. Khalid led a chaotic life and had a history of drug and substance use and had multiple contacts with Government agencies. .Khalid had demonstrated on many occasions threats to self harm and harm others which were well document on Government systems. An unsympathetic and desensitised penal system with inadequate access to this data held by relevant agencies and poor processes to ensure this data is reviewed and actioned probably led to a situation in prison of Khalid having the opportunity to take his own life. Khalid was at risk of suicide upon arrival at prison; the prison and nursing staff followed an inadequate process without proper consideration and communication of all relevant documentation and historical data that would have presented additional information and

	enabled the risk to be further considered. On balance of probability by the fact that Khalid blocked the door and hung himself it is our belief that he intended to commit suicide
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Khalid Abiaz Khalid was a Somalian asylum seeker with an outstanding asylum appeal who on release from immigration detention in July 2016 experienced homelessness and three attempts to take his own life following which he was detained on each occasion under s.2 of the Mental Health Act 1983 (MHA). Khalid had a long history of mental health issues and had been assessed on 3rd August 2016 by a consultant psychiatrist as posing a significant risk to himself and others. On 8th September 2016, following a threat to kill himself [redacted] in the context of trying to get prescribed medication at a medical clinic in Cardiff, Khalid was detained by South Wales Police ('SWP') under s.136 MHA and assessed under s.2 MHA at University Hospital Llandough. Khalid was not considered as meeting the criteria for detention under s.2 MHA and so was released with no medication. On 10th September 2016 Khalid was arrested and charged by SWP in respect of the incident on the 8th September 2016. He was then remanded into custody and sent to HMP Swansea on 12th September 2016 with warning markers on his prison escort record for threats of suicide and self-reported mental health issues. An ACCT was not opened in reception and Khalid was found suspended in HMP Swansea by a ligature in the early hours of 13th September 2016.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to a 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 make a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 The **MATTERS OF CONCERN** are as follows: 1. I heard evidence that following a review in 2015 changes to the ACCT document and process were piloted in 10 establishments in 2019 and this included HMP Swansea. As a result a revised ACCT version 6 and accompanying policy guidance was issued. This revised guidance makes clear that an ACCT must be opened by any member of staff who receives information that indicates a prisoner may be currently at risk of self-harm or suicide and that this information may come from a prison escort. However, this requirement is not new. It was clear in my view from the HMP Swansea Suicide and Prevention Policy that was in place at the time of Khalid's death that a warning marker for suicide on a prison escort record ('PER') should result in the opening of an ACCT. The prison officer who saw Khalid first in reception gave evidence that he was an experienced prison officer with over 20 years-experience of working in prisons including 18 years at HMP Swansea. At the time when Khalid came into custody he was an ACCT assessor and remains in this role. He saw Khalid's PER which stated that Khalid had recently made threats to kill himself and was alleging mental health issues and he saw the NOEMIS transfer report which contained reference to historic ACCTs that Khalid had been on in custody and an act of cutting and ligaturing by Khalid 9 months before in December 2015. He did not open an ACCT but referred to the nurse who also did not open an ACCT. In his evidence the Prison Officer stated that if a prisoner came into custody now in 2022 with a warning on his PER stating that he has recently made threats to kill himself then this would not be enough to trigger the opening of an ACCT. This view is inconsistent with the mandatory revised ACCT policy guidance that I have set out above. This indicates that the system for training on

	ACCT in HMP Swansea is inadequate. The Prison Officer could not recall whether his ACCT training was up to date. His training records show that he was ACCT trained in 2005, 2008, 2011 and 2014 and I am told there was training on the new ACCT document that is not recorded in the training records and a further up-skilling session with staff date not specified. I did hear that training was difficult during the Covid 19 pandemic in HMP Swansea, however, ACCT training is required to be carried out with much more frequency than the training provided to the officer on reception and staff should understand the warning markers that require an ACCT to be opened. I am concerned that unless prison officers are provided with frequent ACCT training which is kept up to date then there remains a risk of similar deaths occurring in the future in HMP Swansea. 2. I heard evidence from the nurse who saw Khalid on reception. This person is an experienced mental health nurse who is now a charge nurse on bank. The nurse told me that he still does at times work through the bank as a mental health nurse in HMP Swansea. At the time of Khalid's death the Nurse was the mental health nurse working on reception and he completed the first reception health screen for Khalid and he did not open an ACCT. It was unclear what documents the nurse had seen on reception for Khalid but he did not asked prison staff if he could see any documents. The Nurse gave evidence that even if he had known that there was a suicide warning marker on Khalid's prison escort record this would not have been enough combined with what Khalid said to him to open an ACCT, he relies on Khalid's presentation. Khalid had been assessed by a consultant psychiatrist as a significant risk to himself a matter of weeks before he was seen by the Nurse in reception. HMP Swansea prison staff and the Nurse were not aware of this information but even if the Nurse had known this information his evidence was that this would not necessarily have been enough for him to open an ACCT, he would consider presentation. The revised ACCT version 6 and accompanying policy guidance set out above makes clear that an ACCT must be opened by any member of staff who receives information that indicates a prisoner may be currently at risk of self-harm or suicide and that this information may come from a prison escort. The answers of the Nurse raise a concern around the level and adequacy of the training on ACCT. The Nurse stated that he has reflected on his practice but that he still places emphasis on what the prisoner says and how they present when considering whether to open an ACCT. I heard evidence that bank nurses were supervised in the prison but that training on ACCT remained the responsibility of HMP Swansea. I am concerned that a bank nurse may not receive access to ACCT training including at the required regularity and I am concerned that unless this happens there remains a risk of similar deaths occurring in the future in HMP Swansea
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 15 August 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, The Home Office, Cardiff and Vale University Health Board, Ministry of Justice, South Wales Police, Swansea Bay University Health Board 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.
9	20 JUNE 2022 .....