ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Governor, HMP Belmarsh** **2. The Chief Executive, Oxleas NHS Trust**
1	**CORONER** I am Philip Barlow, assistant coroner for the coroner area of Inner South London
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 14 January 2020 I commenced an investigation into the death of Liridon Saliuka, age 29. The investigation concluded at the end of the inquest on 3 November 2022. The conclusion of the inquest was suicide. The medical cause of death was partial suspension.
4	**CIRCUMSTANCES OF THE DEATH** Mr Saliuka had been a prisoner on remand at HMP Belmarsh since July 2019. He had sustained significant injuries in a car accident in 2018. He had been placed in a medical cell with a hospital bed and mattress. On 31 December he was moved to an ordinary single cell without a special bed or mattress. Mr Saliuka objected to the move because he believed he needed a special mattress to alleviate the pain from his injuries. On 2 January 2020 he hung himself in his cell. The cell move went ahead despite a governor's recommendation that it be postponed pending clarification of the medical assessment. There was confusion and misunderstanding between prison staff, healthcare staff and social services as to: • the extent of Mr Saliuka's disability • who was responsible for assessing it • what adjustments were required • who had recommended adjustments This also created confusion for Mr Saliuka who believed that he had been assessed for a special mattress and that this entitlement was being taken away by way of punishment. The jury's conclusions were as follows: • There were repeated failings to consistently recognise the fact and extent of Mr Saliuka's disability resulting in further failure to implement reasonable adjustments, specifically relating to the provisions of an adequate mattress and to conduct an adequate medical assessment, prior to completing the move from the medical cell. • There were significant failures in the co-ordination of Mr Saliuka's care, with inadequate record keeping.

	• There were numerous instances of ill treatment of a discriminatory and dismissive nature, along with an insufficient willingness to address Mr Saliuka's concern. • We consider the above to have negatively impacted on Mr Saliuka's mental health and thus constitute contributing factors to Mr Saliuka's suicide.
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 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. – 1. **To the Governor of Belmarsh and to the Chief Executive of Oxleas.** There was no clear documentation (accessible by prison staff, healthcare and social services) of the adjustments that were required for the prisoner's disability, 2. **To the Governor of Belmarsh**. There was a lack of disability awareness amongst prison staff of all levels. For example, there was an assumption that a prisoner could not be disabled because he used the gym and had good upper body strength.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 28 December 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: • Mr Saliuka's family • Royal Borough of Greenwich • Change Grow Live I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**8 November 2022** **Philip Barlow**