	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Birmingham and Solihull Mental Health Foundation Trust, NHS England (Health and Justice), and the Phoenix Partnership (Leeds) Ltd.**
1	**CORONER** I am Emma Brown, HM Area Coroner for Birmingham and Solihull
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 1 February 2022 I commenced an investigation into the death of Jai SINGH. The investigation concluded at the end of the inquest on the 10th March 2023. The conclusion of the jury at the inquest was; Suicide The following matters probably caused or contributed to Mr Singh's death: * The failings of safer custody to appropriately communicate and document family concerns to other staff within the prison. * The failure to use interpretation services to effectively communicate with Mr Singh by both the custodial and the healthcare teams. * The failure to communicate relevant information within and between the custodial team and the healthcare team * The failings to appropriately open, re-open and carry out the ACCT process. * The failure to carry out sufficient and thorough welfare checks. * That Mr Singh did not undergo an assessment for section 48 transfer. * A significant lack of rigor in respect to the completion of official prison and healthcare documentation. * That Mr Singh was not admitted to ward 2 and remained on a residential wing. The following matters possibly caused or contributed to Mr Singh's death: * Failings to heed and communicate family concerns by both the custodial team and the healthcare team. * The failure to allocate an individual community psychiatric nurse as a single point of contact following the opening of an ACCT.
4	**CIRCUMSTANCES OF THE DEATH** Jai Singh died at City Hospital on the 28th January 2022 having been admitted after he was found in cardiac arrest in his cell at HMP Birmingham on the 27th January 2022. Mr. Singh had asphyxiated due to placing a bag over his head. He received CPR from prison staff and paramedics and was resuscitated but had suffered irreparable brain and organ damage. Mr. Singh had been detained at HMP Birmingham on the 21st September 2021 whilst on remand awaiting trial for the murder of his wife. From the time of his admission Mr. Singh's family were concerned that he was suffering from a severe mental health condition and raised this in numerous emails and telephone calls to safer custody. The content of calls and emails was not recorded on NOMIS casenotes for the information of the custodial team and was not consistently communicated to the mental health team. The information that was passed to the mental health team was not clearly recorded in the SystemOne

journal for all clinicians to see. Consequently, the opportunity to identify risk and open an ACCT document was missed.

From an early stage Mr. Singh was reporting psychotic behaviour to community psychiatric nurses and was noted to be behaving unusually by custodial staff but he denied any active suicidal or self-harming thoughts. His cellmate and a Chaplain raised concerns about his behaviour but still an ACCT book was not opened.

On the 22nd November 2021 an ACCT book was opened after Mr. Singh reported wanting to kill himself. The ACCT assessment, reviews and care plan were deficient leading to the ACCT being closed prematurely on the 30th November 2021. The post closure process was also inadequate. During the time Mr. Singh was at HMP Birmingham he had a number of welfare checks due to family concerns but these were superficial and perfunctory and never carried out with an interpreter even though Mr. Singh's English was poor. Consequently, his risk was not adequately assessed.

Following an assessment on the 3rd December 2021 a Consultant Forensic Psychiatrist instructed by Mr. Singh's criminal defence team identified that Mr. Singh was suffering with auditory hallucinations, low mood, tiredness and suicidal ideation and made a diagnosis of schizophrenia with an effective element. The Psychiatrist made a referral to a secure inpatient unit, The Hatherton Centre, for a transfer under section 48 of the Mental Health Act. The referral was sent to the Hatherton Centre but was not sent to HMP Birmingham straightaway. The referral to the secure unit was not accepted because it was made by an independent psychiatrist rather than the prison's mental health team. The mental health team at HMP Birmingham were, however, contacted on the 13th December 2021 by a psychiatrist from the Hatherton Centre who stated that there had been a request for assessment for transfer and asked for further information. He was given misleading information that Mr. Singh was "coping well" and therefore informed the mental health team that an assessment would not be carried out. No note was made of the conversation with the Hatherton Centre psychiatrist and no action was taken to investigate and pursue a section 48 transfer. The information provided by the independent Consultant Forensic Psychiatrist and the history of psychotic symptoms in SystemOne records ought to have resulted in an assessment by the Hatherton Centre. An assessment would have been likely to result in section 48 transfer. Whilst Mr. Singh remained at HMP Birmingham awaiting transfer he ought to have been under the care of the mental health team and housed on ward 2 (the mental health inpatient wing).

Mr. Singh continued to report that he was hearing voices, hallucinating, struggling to sleep and low in mood. He was reviewed by GPs at the prison on the 29th November, 13th December, 4th January and 25th January who prescribed antidepressants and sleeping medication which Mr. Singh reported were not working.

On the 14th January 2022 a prison Consultant Psychiatrist determined that Jai Singh required urgent admission to the inpatient psychiatric ward for assessment. However, the admission was not facilitated and Mr. Singh remained on a residential wing. The decision not to admit Mr. Singh to the ward was not recorded in his SystemOne records. Mr. Singh received no further input or support from the mental health team. When he was seen by a GP on the 25th January 2022 it was identified that medication was not helping and Mr. Singh needed to be seen by a psychiatrist but the GP thought he was going to be transferred to Ward 2 and therefore took no further action.

All actions taken following Mr. Singh being found in cardiac arrest on the 27th January 2022 were appropriate.

	Following a post mortem the medical cause of death was determined to be: **1a Hypoxic-ischaemic brain damage** **1b Multi-organ failure** **1c Cardio-Pulmonary arrest due to asphyxia** **II**
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. A multitude of factors contributed to Mr. Singh's death across the custodial and healthcare teams within HMP Birmingham. Many steps have been taken by all organisations with responsibility for Mr. Singh's safety and health during his time at HMP Birmingham to rectify failings that have been identified such as the consistent failure to use interpreters, poor communication and record keeping within and between teams, the absence of meaningful engagement with Mr. Singh's family, insufficient consideration of family concerns and failings in the use of the ACCT system. 2. Much of the evidence at the inquest focused on the central issue of repeated missed opportunities to identify that Mr. Singh required admission to the prison's inpatient ward, ward 2, and assessment for section 48 transfer to a medium secure unit (which would have been likely to result in transfer to a medium secure unit). The consequences of the failure to transfer Mr. Singh to an inpatient setting were compounded by the fact that he was not taken onto the mental health team's caseload promptly and therefore did not have the benefit of an allocated CPN and the oversight and input of a mental health multi-disciplinary team. Many steps have been undertaken by Birmingham and Solihull Mental Health Trust (who provide mental health services within the prison) to minimise the risk of such a situation occurring again. 3. However, there are two features of the mental health care provided to Mr. Singh that create a risk to the lives of others that have not yet been rectified: i. the fact that the mental health team multi-disciplinary team (MDT) does not include a psychiatrist; and ii. the absence of any ongoing risk assessment documentation for patients with mental illness within the SystemOne records at HMP Birmingham. 4. In Mr. Singh's case it is my conclusion that it is likely that if a psychiatrist had been at a mental health MDT meeting held on the 19th January 2022 they would have identified that he needed to be admitted to ward 2 without further delay. At the very least the need for urgent review by a psychiatrist and CPN would have been recognised and facilitated which would in turn have led to admission. CPNs in Mr. Singh's case continually failed to identify the significance of repeatedly and consistently reported psychotic symptoms and consequently he did not receive adequate assessment and treatment which increased his risk of self harm and suicide which in turn was not sufficiently identified. The absence of a psychiatrist at the MDT creates a risk that the significance of some symptoms and presentations will not be recognised and further deaths could occur due to lack of appropriate assessment and treatment. 5. Other electronic health care records systems used in mental health settings have a

	rolling risk assessment document that clinicians are required to review and update at certain points in a patient's management. The risk assessment document provides a prompt to clinicians to formally consider risk and come to a reasoned, documented conclusion that then feeds into decision making. The record also provides a reliable, easily accessible source of risk history. No such facility is in use on SystemOne at HMP Birmingham. Further, the evidence given was that such a system is not being used routinely across mental health care within the prison estate and is not provided as standard on SystemOne. This creates an ongoing risk to life arising from under-estimation of risk as a result of clinicians not formally considering and assessing current risk levels, and salient risk history not being easily accessible. It is understood by Birmingham and Solihull Mental Health Trust that it should be possible to create a specific risk assessment record within SystemOne and this is being considered locally. However, the evidence given was that this issue should be highlighted nationally and that the developers and distributors of SystemOne should be involved so as to ensure the best available solution is identified.
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 11 May 2023. 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: 1) The sisters of Jai Singh, [redacted] 2) Children of Jai Singh, [redacted] 3) Ministry of Justice (MOJ) 4) Birmingham Community Health Care (‘BCHC’) 5) Birmingham and Solihull Mental Health Foundation Trust (‘BSMHT’) 6) Prisons and Probation Ombudsman (‘PPO’) 7) Midlands Partnership NHS Foundation Trust (‘MPFT’) 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	**15 March 2023**

	Signature:  **Emma Brown** **Area Coroner for Birmingham and Solihull**