Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], His Majesty's Prisons & Probation Service (HMPPS)**
1	**CORONER** I am Crispin Giles BUTLER, Senior Coroner for the coroner area of Buckinghamshire
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 15 March 2019 I commenced an investigation into the death of Haik Patrick NIKOLYAN aged 21. The investigation concluded at the end of the inquest on 12 July 2023. The jury recorded a narrative conclusion which stated: Haik was a vulnerable person with Autism Spectrum Disorder, who committed suicide following failures by those organisations who had responsibility to protect him from harm. He had a documented history of mental health difficulties, self-harm, depression, anxiety, suicidal thoughts and suicide attempts. The decision to withdraw prescription medications managing his depression without a documented risk assessment or enhanced monitoring was not in his best interest and led to him experiencing psychological withdrawal symptoms, exacerbating his anxiety and depression. The insufficient security at the prison allowed illegal drugs to circulate which contributed to his bullying and exploitation and created a barrier to accessing prescription medication. The prolific bullying, exploitation and humiliation that Haik experienced in prison contributed to his declining mental health. Policies, procedures and interventions put in place to safeguard him were ineffective, ill-advised and at times absent. This resulted in ineffective communication, between the Prison, Health and Mental Health services which meant information was recorded but inconsistently shared and acted upon effectively. Furthermore, the absence of a process for escalating concerns put him at heightened risk. Due consideration for the complexities that Austism Spectrum Disorder can present were not appropriately addressed. Due to a lack of adequate training and the absence of a clinical psychologist, some of his behaviours were interpreted to be dangerous rather than the presentation of Autism Spectrum Disorder. This resulted in the interventions that were in place being ineffective, and incompatible with Haik's needs and therefore this was an unsuitable custodial environment for him.
4	**CIRCUMSTANCES OF THE DEATH** Haik committed suicide [redacted] and was found unresponsive in his cell in the early hours of 11th March 2019 at HMYOI Aylesbury (as it then was).
5	**CORONER'S CONCERNS**

	During the course of the investigation my inquiries 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: (brief summary of matters of concern) HMP Aylesbury transitioned from a High Security Young Offenders Institution (a role it had undertaken for many years) into a Category C Training Prison after the time in which Haik Nikolyan had been an inmate. This has led to a quite different cohort of prisoners with different and additional issues to be addressed in their management and healthcare needs. Staffing changes have also occurred over the period, although the physical prison infrastructure is largely the same with some wing refurbishments being undertaken from time to time. Healthcare provision is also being undertaken by different providers today. Following the conclusion in March this year of an Inquest into the death of another young prisoner, Anthony McNally, at Aylesbury (which occurred in January 2021), a letter was written by me to the Governor in which I noted, inter alia, that the evolution to Category C status required time and resources and was not without significant challenges going forward. I was then (as now) interested to hear that appropriate resources continued to be sought and deployed by the prison to continue the work, from prison and healthcare perspectives, adapting to the Category C status, ensuring the safety and wellbeing of prisoners, staff and those with cause to visit the prison going forward. Some three months further on, my concerns are heightened to the extent that a death may result in a variety of circumstances through the continuing significant issues HMP Aylesbury is encountering in recruitment and retention of experienced prison staff, particularly Grade 3 officers. Although initial steps are being taken towards implementation of a new neurodiversity plan, including the management of prisoners with autistic traits (pertinent to the circumstances of the death of Haik Nikolyan in 2019) and some recruitment has just taken place, without appropriate resources specifically in this area and within the broader staff cohort, there will be difficulties in maintaining this important work. The evidence heard at this Inquest in July 2023 indicates that general staffing levels are likely to impact upon the operation of the daily regime, training and reaction to individual incidents, against a background of increasing levels of violence and access to illicit substances, resulting from the changing cohort of longer-term and older prisoners within this Category C institution. The indication in evidence was that addressing these issues and continuing to address these issues is a matter for His Majesty's Prisons and Probation Service, working with HMP Aylesbury.
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 10th October 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 Family of Haik Nikolyan 2. Ministry of Justice 3. Practice Plus Group (formerly Care UK) 4. Barnet, Enfield & Haringey Mental Health NHS Trust 5. Midlands Partnership NHS Foundation Trust I have also sent it to: 6. Governor [redacted], HMP Aylesbury 7. HM Prisons & Probation Ombudsman 8. The family of Anthony McNally who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 15/08/2023** Crispin Butler **Crispin Giles BUTLER** **Senior Coroner for** **Buckinghamshire**