REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Director at HMP Belmarsh, Western Way, Thamesmead, London, SE28 0EB. The Head of Healthcare (Practice Plus Group) at HMP Belmarsh, Western Way, Thamesmead, London, SE28 0EB. Rt Hon Suella Braverman KC MP, The Secretary of State for the Home Department, 2 Marsham Street, London SW1P 4DF. Amy Rees, Director General Chief Executive HM Prison and Probation Service (HMPPS), 102 Petty France, London, SW1H 9AJ. Rt Hon Alex Chalk KC, MP, Lord Chancellor and Secretary of State for the Ministry of Justice, 102 Petty France, London SW1H 9AJ [redacted], Chief Executive Officer of Practice Plus Group, Hawker House, 5-6 Napier Court, Napier Road, Reading, Berkshire, RG1 8BW.
1	**CORONER** I am Jenny Goldring assistant coroner, London Inner South jurisdiction.
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** 1. The death of Manoel Messias Santos ("Mr Santos") was reported to the coroner by HMP Belmarsh on the date of his death, 2 November 2020. . 2. A forensic post-mortem was conducted on 5 November 2020. The medical cause of death of MS was 1a: Hanging 3. On 24 February 2021 an Inquest was opened into the death of Mr Santos and an Article 2 Inquest was heard between 11 September 2023 and 25 September 2023 with a jury. The jury concluded with a narrative conclusion incorporating a conclusion of suicide. 4. I considered Prevention of Future Death ("PFD") evidence (written and oral) on 27 September 2023.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Santos was a Brazilian national who lived in the United Kingdom since 1997. He applied for indefinite leave to remain in 2004 but this was rejected in the same year. 2. He had a history of severe mental health issues. 3. Mr Santos was remanded to HMP Highdown on 29 October 2019, being transferred to HMP Belmarsh on 26 November 2019. On 6 May 2020, Mr Santos was sentenced to two years' imprisonment and was due to be released on 27 October 2020. 4. On 5 October 2020, the Immigration Service served an IS91 notice of a decision to detain on Mr Santos. This meant he would not be released from prison at the end of his sentence whilst his deportation was considered. A Stage 1 letter had been served on 28 December 2018 but a Stage 2 letter had not been served. There was also an outstanding appeal in the First-tier immigration Tribunal. 5. Mr Santos wrote a letter on a bail form outlining his concerns about returning to Brazil, referring to his sexuality and his health. This was sent by the prison to a charity assisting immigration detainees on 29 October 2020. 6. In the early hours of 2 November 2020, the night officer found Mr Santos hanging in his cell during a routine check. Staff tried to resuscitate him. Ambulance staff

	arrived. Mr Santos was declared dead at 3.30am. In summary, the jury found as follows: • That Mr Santos' understanding of his immigration position at the conclusion of his custodial sentence made a material contribution to his death. • There was a failure to notify Mr Santos of the incoming IS91 form and its significance. • The central issue was communication between Mr Santos and the various agencies involved with him. By 16 October 2020 Mr Santos understood he would be detained at the end of his sentence but was confident his bail application would lead to resolution. However in the days prior to his death he told a fellow prisoner he believed he was to be placed in immigration detention and deported within days. • Confusion amongst the agencies involved in communicating with Mr Santos is likely to have played a vital role in his change of understanding but it was difficult to pinpoint the role that information passed to Mr Santos played in changing his understanding of his position. There were no adequate notes of a meeting on 22 October 2020 with Mr Santos and his prison and community offender managers. However it was clear that his view of his circumstances changed and he decided to end his life and deliberately did not clearly communicate his intent to those around him.
5	<u>CORONER'S CONCERNS</u> During the Inquest, the evidence revealed matters giving rise to concern. A number of these have been addressed and do not require a PFD report. I have also considered a report by HM Chief Inspector of Prisons, "The experience of immigration detainees in prisons," dated September 2022. Some of the key concerns in that report mirror concerns I came to independently having heard the evidence in this Inquest. Published responses to the report suggest some concerns are being addressed, albeit it is not clear if they have been resolved. 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. Although the specific issues below were not left to the jury as "causative matters" in this Inquest, I am concerned about the potential impact of these issues in other cases. **<u>Timing of IS91 notification.</u>** 2. The timing of the notification to Mr Santos by the SSHD that he was not to be released at the end of his custodial sentence but was to be held on immigration detention pending a decision on deportation. The SSHD target for notification is 30 days prior to release. In this case it was 8 days late. I heard PFD evidence that this 30-day target is not met in 40% of cases and that 83% of cases are notified within 7 days of the end of the sentence. I am concerned at the potential uncertainty and distress caused to Foreign National Offenders ("FNOs") by notification at this stage. **<u>Signposting legal advice about immigration matters</u>** 3. Mr Santos signed a form on 24 October 2020 to receive support from a charity supporting immigration detainees. Bail forms were sent to them by the prison on 29 October 2020. 4. I am concerned as to how access to legal advice is facilitated and signposted. 5. In PFD evidence, I was informed that FNOs (in a similar position to Mr Santos) are now entitled to 30 minutes of free legal advice following a High Court decision in February 2021. In HMP Belmarsh, this entitlement is displayed on a notice in each Houseblock. I am concerned that displaying a notice is insufficient to draw this entitlement to the attention of FNOs. I do not know if this is a wider issue in other prisons. Understanding of

	immigration status, including appeal and bail procedures and is complex. Access to legal advice is vital to prevent confusion. **Communication between agencies** 6. Communication issues between the agencies dealing with immigration and sentence planning may lead to confusion and uncertainty for FNOs. 7. I appreciate that any legal advice to FNOs should be from a legal adviser. I am encouraged that the probation service (who employ community offender managers) is seeking to develop a cohort of probation officers specialising in FNOs and immigration. There are now 201 SPOCs across 12 regions and a hub lead developing this model and leading engagement with the SSHD. There is no such model in the prison in respect of "prison offender managers" who also liaise with the SSHD about FNOs. **Delays by SSHD and Probation and failure to obtain information.** 8. I am concerned at the potential impact of delays/failure to obtain information in other cases. In Mr Santos' case there were delays by probation in allocating a community offender manager and providing an up-to-date OASYS report. There were also delays by the SSHD progressing Mr Santos' case, including issue of the Stage 2 letter, failure to obtain medical records and delay in requesting the OASYS report. 9. I am encouraged that there is now a centralised system (and form) for the SSHD to request OASYS reports from probation although it is not clear the extent to which requests are going through this system. Consent to obtain medical information is sought from FNOs at an induction meeting by Immigration Prison Teams ("IPTs"). Further IPT officers attend prisons and play a key role in obtaining this type of information. However it is not clear what systems are in place to facilitate the obtaining of medical information. **The SSHD Internal report** 10. The SSHD disclosed an Internal report into Mr Santos' case midway through the Inquest, which was not on his Home Office file. The lawyers representing the SSHD were unaware of this report. The head of FNO Returns Command only became aware of it the preceding week and understood it had been disclosed. 11. The report detailed delays and issues in Mr Santos' case and the SSHD then made formal admissions of the relevant (non-causative) failures which were recorded by the jury in the Record of Inquest at my direction. 12. This report was dated February 2021 and listed action points for the relevant department. Although I am told that these are now being addressed, I am concerned that important learning points (which could prevent future deaths) were not disseminated and actioned as they should have been. **Opening cell doors at night** 13. In evidence there was a continued misunderstanding that the policy did not apply to Operational Support Grade (OSG) officers and it was understood that they should never open cell doors at night. This was despite the PPO report dated December 2021 (at paragraph 73) requesting this be addressed. 14. The prison stated in PFD evidence that all staff will be instructed as to the policy in terms of opening cell doors at night (which requires a dynamic risk assessment). 15. I remain concerned that this appears to be a longstanding belief held by experienced officers.
6	**ACTION SHOULD BE TAKEN** Action should be taken by **The Secretary of State for the Home Department, HMP Belmarsh, His Majesty's Prison and Probation Service, the Ministry of Justice and Practice Plus Group**: 1. Consideration as to whether FNOs can be notified at an earlier stage of their sentence that they are not going to be released. (**SSHD**)

	2. Consideration as to how to ensure there is effective signposting and facilitating of access to legal advice for FNOs. (**HMP Belmarsh, HMPPS, MOJ**) 3. Consideration as to how to ensure more effective communication/information exchange between the SSHD and the prison and Healthcare. (**HMP Belmarsh, HMPPS, MOJ, SSHD, Practice Plus**) 4. Consideration to be given as to why the Internal report dated February 2021 was not disseminated/placed on the Home Office file and to ensure this does not occur again. (**SSHD**) 5. Consideration as to how to ensure OSGs are aware that the policy on opening cell doors at night applies to them as well as prison officers. (**HMP Belmarsh, HMPPS, MOJ**)
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 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 [redacted] (Government Legal Department) representing the SSHD [redacted] (Government Legal Department) representing the MOJ [redacted] ([redacted]) representing Oxleas [redacted] representing Practice Plus Group [redacted] (Change Grow Live) [redacted], Independent Chief Inspector of Borders and Immigration HM Inspectorate of Prisons Independent Advisory Panel on Deaths in Custody 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	**3rd October 2023**