Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Abdullah Popalzai died 29 November 2019

	THIS REPORT IS BEING SENT TO: **1. [redacted], Chief Executive Officer, NHS England, PO Box 16738, Redditch, B97 9PT**
1	**CORONER** I am Sarah Bourke, HM Assistant Coroner for the coroner area of Inner North 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 4 December 2019, I commenced an investigation into the death of Abdullah Popalzai (20 years). The investigation concluded at the end of the inquest on 29 November 2023. The conclusion of the inquest was that the medical cause of death was 1a Suspension. A conclusion of suicide with an additional narrative was returned by the jury. The Jury found "*Mr Popalzai died in his cell in the inpatient wing at HMP Pentonville on 29 November 2019. He was suspended from a ligature [redacted]*"

	The accompanying narrative read as follows: [redacted]. *If the cover had been properly present and secured with security screws, Mr Popalzai would not have been able to attach the ligature to this point.* *An ACCT was not opened for Mr Popalzai. If an ACCT had been opened, staff on the healthcare wing would have had greater visibility of the self-harm risk to Mr Popalzai identified by the psychiatrist at court.* *Mr Popalzai was recommended to be admitted to a hospital facility. If a suitable bed and transport had been available earlier, Mr Popalzai could have received urgent medical treatment for his acute psychosis as advised by multiple medical practitioners.* *It is likely that Mr Popalzai became aware during the night of 28 November 2019 of his impending transfer on 29 November 2019. Mr Popalzai had stated on multiple occasions that he would hang or kill himself if he were to be transferred to a hospital.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Popalzai was a remand prisoner at HMP Pentonville. A Mental Health Act assessment carried out at the Magistrates Court on 24 September 2019 decided that he should be detained under Section 2 of the Mental Health Act. However, as there were no hospital beds available at the time that Mr Popalzai's case was heard, he was remanded in custody to HMP Pentonville. Mr Popalzai was transferred to the inpatient wing at HMP Pentonville on 29 September 2019. There were significant barriers to communicating with Mr Popalzai as he spoke predominantly in Pashto. Throughout his time in the inpatient unit, Mr Popalzai was acutely psychotic. He was aggressive and most interactions with psychiatrists, healthcare staff and prison officers took place through the cell door. Mr Popalzai consistently refused to take any medication as he did not accept that he was mentally ill. Mr Popalzai stated on several occasions that he would hang himself if transferred to a psychiatric hospital. On 9 October 2019, Mr Popalzai was assessed by a psychiatrist who found that he was psychotic and needed to be transferred to hospital for treatment under section 48 Mental Health Act 1983. The Crystal Ward, which is the psychiatric intensive care unit at the Newham Centre for Mental Health, was identified as the appropriate unit. A second assessment was carried out by a psychiatrist from the Crystal Ward on 18 October. The 2nd psychiatrist agreed that Mr Popalzai should be detained on the Crystal Ward for assessment and treatment under section 48 Mental Health Act on 24 October 2019. However, there were no beds available on Crystal Ward at that time. On 21 November 2019, the Crystal Ward advised that a bed would become available the following week. A warrant authorising transfer was

	issued by the Ministry of Justice and arrangements were made for Mr Popalzai to be transferred to the Crystal Ward on the afternoon of 29 November 2019. At around 12.30 pm on 29 November 2019, Mr Popalzai was found hanging in his cell. Attempts were made to resuscitate Mr Popalzai but his death was confirmed by paramedics at the scene. The psychiatric evidence was consistent that: 1) the only effective treatment for Mr Popalzai's psychosis was anti-psychotic medication; 2) anti-psychotic medication could not be given to him against his wishes in a prison setting. As a result, he needed to be transferred to an appropriate psychiatric unit. 3) Mr Popalzai's mental health deteriorated in the time that he was waiting for a psychiatric bed to become available. I also heard evidence that a significant number of prisoners from HMP Pentonville were transferred to psychiatric units under the Mental Health Act each year. I was told that the experience of psychiatrists at the prison was that the target time of 14 days from 1st assessment to transfer set out in the statutory guidance was seldom met. I was also told that significant delays in beds becoming available were extremely common and delays of up to 6 months were not unheard of.
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 **MATTER OF CONCERN** is as follows. – 1) Prisoners who are acutely psychotic and refusing treatment that requires transfer to hospital under the Mental Health Act are being left untreated and at risk of further deterioration due to a shortage of suitable psychiatric hospital bed spaces becoming available in a timely way.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 1 April 2024. 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: • Ministry of Justice • Practice Plus Group (Previously Care UK) • Barnet, Enfield and Haringey NHS Foundation Trust • East London NHS Foundation Trust • The Prison and Probation Ombudsman I have also sent it to the North East London NHS Foundation Trust who may find it useful or of interest. 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	**SARAH BOURKE** **HM Assistant Coroner** **5 February 2024**