| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT**<br><br>**FUTURE DEATHS.**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. [redacted], HMP Coldingley**<br>**2. [redacted], Minister of State for Prisons, Parole and Probation.**<br>**3. [redacted], CEO NHS England**<br>**4. [redacted], CEO Parole Board** |
| 1 | **CORONER**<br><br>I am Caroline Topping Assistant Coroner, for the coroner area of Surrey. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST**<br><br>An inquest into the death of Mr Haydar Jefferies was opened on the 4th April 2023 and resumed with a jury on the 11th November 2024. The inquest was concluded on the 29th November 2024.<br><br>The jury concluded that Mr Jefferies died on the 5th March 2023 at Frimley Park Hospital, Frimley and the medical cause of his death was:<br><br>1a. Hypoxic Brain Injury and Bilateral Pneumonia<br>1b. Suspension<br><br>They concluded with a narrative conclusion and found that:<br><br>**MATERIAL CAUSES**<br><br>Haydar died as a result of tying a ligature around his neck. It is not possible to determine his intention.<br><br>The following are facts that, on the balance of probabilities, have been found to have happened and have made a material contribution to Haydar Jefferies' death:<br><br>Between the 18th February 2023 and the 1st of March 2023, Haydar was suffering from psychosis as referenced by the expert psychiatrist. The fact that Haydar was an IPP prisoner and that his parole hearing was delayed more than minimally contributed to the development of this psychosis, due to the psychological stress.<br><br>In February 2023, during Haydar's detainment at HMP Coldingley, there was a serious failure by the custodial staff to record risk relevant information in regard to his presentation. Specifically, concerns raised by his family through numerous telephone calls and concerning comments made by Haydar to custodial staff. There was an additional failure to |

ensure that risk relevant information was shared with prison officers and clinical staff.

Between the 18th and 27th February 2023, there was a serious failure to refer Haydar to the Mental Health team. This was despite evidence showing acknowledgement and intent to make a mental health referral on more than one occasion. By 17.30 on the 28th of February 2023, Haydar was floridly psychotic as evidenced by the expert psychiatrist. The proper response would have been to ensure his immediate safety by putting him on constant supervision and taken him to an external place of safety due to Coldingley's unsuitable provision of safer cells. That none of this was done represents a serious failure by HMP Coldingley custodial staff.

There was a failure to undertake a substantive mental health assessment on the 28th February 2023 following the morning referral from custodial staff and the subsequent CSU review. A mental health review was booked in for the following day which was inadequate.

**POSSIBLE CAUSATIVE MATTERS**
The following are matters which we have found possibly occurred and more than merely speculatively made a material contribution towards Haydar's death but we have not found on the balance of probabilities:

Such records as were made were across multiple systems with different levels of access, no set expectation of cross referencing and reliant on individual initiative and curiosity to be found. The clinical staff at HMP Coldingley were lacking this initiative and curiosity and thereby missed a pattern of behaviour that they could have identified and used to drive better-informed clinical decisions at point such as the brief CSU rounds and reviews.

When the allegation that led to Haydar's recall was no longer being pursued, there was an opportunity for the Secretary of State to consider an executive release, which was not taken. The IPP parole decision could have been made on "on papers" without the need for a meeting, and this too was declined.

The training for custodial staff at HMP Coldingley is inconsistent and inadequate with regard to mental health presentation. The ACCT document and process is unsuitable for a mental health crisis of this kind.

**NEGLECT**
The death was contributed to by Neglect.
This is in relation to a failure to share risk relevant information with clinical staff and procure mental health intervention for Haydar between the 18th and the 27th February 2023 and a failure to procure medical attention for Haydar after he suffered acute mental health deterioration on the evening of the 28th February 2023.

**SYSTEM FAILURE**
The death was caused or more than minimally contributed to by the failure on the part of the Ministry of Justice to ensure there was a system in place for the recording of the family concerns raised in telephone calls to the prison.

**ADMITTED FAILURES**
It is admitted that HMP Coldingley ought to have automatically conducted five observations per hour because an ACCT was opened for Mr Jefferies whilst he was on the CSU. It is accepted that only two observations were conducted per hour.

| | |
|---|---|
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>**Haydar Jefferies was sentenced to imprisonment for public protection ("IPP") in 2006. He was released in 2013. Haydar then integrated into the community, married and was working as a publican. Following the death of his spouse and his father in 2021 Haydar attempted suicide. In January 2022 allegations were made against him and he was recalled to prison under the terms of the IPP. By April 2022 the allegations were not being pursued. An Executive Release order request was made and declined. In order to be released from prison Haydar had to attend a parole board hearing. The parole board decided that a hearing in person was required.**<br><br>**In May 2022 Haydar disclosed he had made a ligature. A parole board hearing was fixed on the 13th October 2022.The parole board hearing was vacated owing to the unavailability of the chair person. The next parole hearing was listed for the 2nd March 2023. The extended period of detention was detrimental to Haydar's health and he stated to clinical staff he felt hopeless and helpless after his cancelled parole hearing.**<br><br>**On the 28th December 2022 Haydar was transferred to HMP Coldingley from HPM Bullingdon. Haydar travelled with prisoners who were aware Haydar had come from the vulnerable prisoners wing and made inaccurate assumptions about reasons for being on the wing.**<br><br>**On arrival at HMP Coldingley Haydar's mental health was reviewed and appeared stable.**<br><br>**On 10th February 2023 the Government rejected IPP resentencing.**<br><br>**On the 12th February 2023 Haydar asked to be segregated for his own safety in the care and separation unit (CSU). This move was supported by a call from Haydar's mother concerned about his safety. On the 14th February Haydar reported low mood and was unwilling to restart previously prescribed medication for depression.**<br><br>**The Independent Monitoring Board (IMB) visited Haydar on February 15th 2023 following the Government rejection of the proposed IPP resentencing. Haydar reported that he had lost hope'.**<br><br>**From the 18th February 2023 Haydar developed severe depression with psychosis. Haydar's family made several calls to the prison from 18th February 2023 onwards raising concerns about his safety and deteriorating mental health. These calls were not recorded in any prison records.**<br><br>**Haydar made various statements to individual prison staff from 18th February 2023 onwards, which were symptomatic of deteriorating mental health and development of psychosis, including many which were not recorded in any prison records.**<br><br>**A number of statements about Haydar's presentation were recorded across a disparate landscape of on and offline recording systems. On the 19th February custodial staff acknowledged the need to refer Haydar to mental health. This referral was never made despite being recorded as having been completed in prison records.**<br><br>**On the 26th February 2023 custodial staff identified the need to request a mental health review following Haydar's delusional allegations towards staff. Haydar then experienced auditory and visual hallucinations and reported them to his family and custodial staff. This further evidence of psychosis was not recorded. At this** |

**time, Haydar was also not taking part in the CSU regime, remaining in his cell at all times.**

**Prior to the 28th February 2023 neither the information in the family calls nor the concerning statements made to individual prison officers were shared with clinical staff or other prison staff and no referrals were made to the mental health team in relation to Haydar.**

**On the morning of the 28th February 2023, Haydar told custodial staff he had made peace and was ready for staff to kill him. An email referral, followed up by a phone call, was made to the mental health team for Haydar to be seen as soon as possible on the morning of the 28th February 2023. No mental health assessment was conducted that day.**

**In the afternoon of the 28th February 2023 Haydar attended a CSU review. During the review Haydar requested a mental health assessment. As part of the review documentation, the CSU algorithm was completed as 'no psychosis'. Evidence provided by an expert witness determined that in fact Haydar was psychotic from 18th February 2023, and on the morning of the 28th had demonstrated red flag behaviour. The CSU review document was not fully completed. The box relating to mental health concerns was left blank.**

**At around 16.30 on the 28th February 2023 Haydar was observed in his cell, flushing his head down the toilet, naked, on all fours, barking like a dog and he said a female officer had told him to behave like this. At this stage Haydar was floridly psychotic.**

**An ACCT was opened at 17.30. The ACCT was not fully completed with a justification for Haydar to remain in CSU. No Defensible Decision log was completed. No medical advice was sought and no medical treatment obtained for Haydar on the evening of the 28th February 2023. The medical team were still on site at the time the ACCT was opened. Observations were incorrectly set at 2 per hour and only constant observations would have been sufficient to ensure safety.**

**Haydar remained on the CSU. This was not appropriate, outside provision should have been sought. During CSU observation, Haydar was found to be slumped over the toilet in his cell. At 2.40 on the 1st March 2023 Haydar was found in cardiac arrest having self -ligatured in his cell. Paramedics attended within minutes and resuscitated Haydar and transported him to Frimley Park Hospital where he was admitted at 04.45 on 1st March 2023.**

**Haydar had sustained a hypoxic brain injury. Haydar was pronounced dead at 15.11 on the 5th March 2023 at Frimley Park Hospital. His death was caused by hypoxic brain injury and pneumonia.**

**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:

Evidence was provided by HMP Coldingley and Central North West London NHS Foundation Trust ("CNWL") in relation to the matters found

| | |
|---|---|
| | by the jury. The organisations have taken the matters that led to Haydar's death seriously.<br><br>CNWL are putting in place protocols and training to ensure that staff are better informed before assessing and reviewing prisoners on CSU.<br><br>HMP Coldingley are in the process of amending their safer custody policy but to date this has not been produced.<br><br>I therefore remain concerned as follows:<br><br>In relation to HMP Coldingley:<br><br>1. There is no system in place to ensure that information provided in telephone calls in relation to a prisoner's welfare is recorded.<br>2. Matters of concern in relation to prisoners are recorded across a number of different records and there is a risk that the information is missed and not disseminated in daily briefing sheets.<br>3. There is no composite document for clinicians to review to see all relevant information recorded by custodial staff about a CSU prisoner for the proceeding 24 hour period.<br>4. There is no system in place to check that referrals to the mental health teams requested by senior members of the prison staff have in fact been made.<br>5. Custody staff are not trained in mental health presentations and are unable to recognise red flag indicators of declining mental health.<br><br>In relation to HMP Coldingley and NHS England:<br><br>6. Outside of weekday office hours there is no clinical mental health provision. Overnight staffing levels are such that it is difficult for prisoners in mental health crisis to be taken to hospital. As a result:<br>a.) custodial staff take decisions about how to keep prisoners safe overnight without the necessary clinical knowledge to assess the risks presented by their mental health conditions.<br>b.) it is not possible for medication to be obtained to alleviate any acute mental health symptoms between 6.30 pm and 7am the following morning.<br>7. The ACCT process is not designed nor effective to protect prisoners in acute mental health crisis who do not appear to be suicidal.<br><br>In relation to the Parole Board:<br><br>8. Imprisonment under an IPP is a recognised suicide risk. The delay in dealing with the IPP parole hearing exacerbated the risk. There is currently no process in place to expedite face to face parole hearings for IPP prisoners when allegations leading to their recall have been withdrawn and no criminal action is being considered. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report,<br>namely by 14th February 2025 . I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting outthe timetable for action. Otherwise, you must explain why |

| | |
|---|---|
| | no action is proposed. |

| | |
|---|---|
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>Mr Jefferies Family<br>Central North West London NHS Foundation Trust ("CNWL")<br><br>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.<br><br>I may also send a copy of your response to any other person who I believe may find ituseful or of interest.<br><br>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 usefulor of interest.<br><br>You may make representations to me, the coroner, at the time of your response, aboutthe release or the publication of your response. |
| 9 | **Caroline Topping 20th December 2024** |