	H M Coroner, London Inner South **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** **THIS REPORT IS BEING SENT TO:** 1. Rt. Hon Michael Gove MP, Lord Chancellor and Secretary of State for Justice, Ministry of Justice, 102 Petty France, London, SW1H 9AJ 2. Mr Will Tuckley, Chief Executive, London Borough of Tower Hamlets, Mulberry Place, 5 Clove Crescent, London, E14 2BG 3. [redacted] Director of Fitness to Practice Directorate, General Medical Council, 350 Euston Road, London NW1 3JN
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South
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	**INQUEST** An inquest hearing at Southwark Coroner's Court touching the death of: **Imran DOUGLAS, who died on 13th November 2013, in HM Prison, Belmarsh, Case Ref: 002952-2013** was concluded before a jury on 3rd November 2015. The jury's conclusion as to the death was suicide.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances that the jury recorded are complex and lengthy, despite the direction to be brief, reflecting multiple contributing factors to the death. They are laid out in an attached Record of Inquest, to enable the Ministry of Justice to understand the systemic failings throughout his detention, especially in the light of the Harris Review. Four particular significant contributory factors are relevant to this report: i) A lack of Transition Planning ii) Systemic lack of communication between and within almost all agencies iii) The problem of overlapping data bases, not all accessible to every agency iv) Problems in handling the deceased at HMP Belmarsh In summary of the circumstances, Mr Douglas suffered from brain injury, after a car accident aged 16. He suffered impulsivity, mood swings, and suicidal ideation afterwards. He was arrested and charged with murder aged 17, and entered custody in a special training centre, where his Youth Offending Team (YOT) worker recorded risk of suicide and a previous attempt. He was closely monitored and means of self harm removed and this was documented in a Suicide and Self Harm Form (SASH). The YOT recorded in a Placement Form on 29/05/13 that Mr Douglas would kill himself, using his clothes for suspension, if he is given a long sentence, and this was included in subsequent Placement Forms available on the E Asset System. He was admitted under s48/49 MHA for psychiatric assessment, but the psychiatrist had no recollection of seeing the SASH form, recorded no significant deliberate self harm and concluded he was of low suicide risk and not mentally ill, but vulnerable and impulsive on discharge. He was to be transferred to Feltham A YOI on 17th September. It appeared that neither Feltham staff, nor the YOT attended the CPA meeting, nor was his mother invited, so that the records did not represent the YOT worker's concerns about his risks nor his past suicidal behaviour. Feltham records never included the SASH, nor the YOT worker's

concerns, and there was a dispute as to what discussions did take place between the YOT worker and a lead prison officer. Risk assessments and placement forms including suicidal behaviour and his medium risk of self harm were available to Feltham staff on the E Asset system. The prison officer agreed that had she seen them, an ACCT would have been opened (This is a prison suicide risk warning form, leading staff alerts and to close supervision). Despite a recommendation that he should have mental health supervision, and not knowing the past history, a nurse at Feltham discharged him from the mental health team.

There was a failure of Transition Planning, with social workers not being invited to a Transition meeting and the Head of Young People failing to contact the Youth Justice Board (YJB), Population Management Unit (PMU), nor Feltham B, despite his approaching his 18th birthday on 11th October. He attended court on 7th October, where he changed his plea to guilty and was observed to have a change of mood. On 7th, YJB sent three Service Placement Confirmations to YOT, Feltham and escort staff, which indicated then that he was a suicide risk and he returned to Feltham A. His offender supervisor did not see him between plea and sentence and there was no apparent consideration of the impact of his change of plea to guilty. The YOT worker thought a Transition Plan had been made, in line with his wishes, for him to transfer to Feltham B, when he appeared in court for sentencing on 8th November 2013 and that the YJB would organize this. A YJB spokesperson explained that she had no power to do this, as it was outside the young offenders estate and Mr Douglas was no longer a young offender. The Feltham Governor thought the plan was for him to return to A and later transfer to B, but this was not written down anywhere. In the event, the deceased was sent to court on 8th, with all his belongings, with no indication of suicide risk nor "endorsement" on his prison escort record that he was to return, which the jury concluded meant he was not to return to Feltham A. He received an 18 year sentence, which was much longer than he anticipated and the YOT and escort staff were concerned about the effect of the sentence on him. His behaviour change led to an escort officer opening a suicide and deliberate self harm warning form. A YJB spokesperson advised that Feltham A had no authority to accept an adult, although on the phone to escort staff, they had agreed to have him back, they declined when the PMU rang. The court heard that Feltham A had 40 vacancies, but Feltham B was full, and the PMU allocated him to go to Belmarsh. The deputy director of Public Sector Prisons expressed surprise at this decision; the YOT worker agreed it was not a suitable placement. The jury recorded that there was no hot line between YJB and PMU for urgent borderline cases, nor a protocol to specifically speak to the YOI governor.

In Belmarsh two officers and a nurse saw him in rapid succession, registering no concerns about his state of mind or age, with a nurse disregarding the court staff suicide warning form (it is noted that this nurse is no longer in the UK nor on the UK GNC register). No discipline staff, nor health care staff considered he needed an ACTT opening, although the duty governor considered it should have been, on the basis of his sentence and age alone. Had the warning form been seen by the First Night Centre, it was widely agreed that an ACCT would have been opened, but it never was.

He received a medical assessment by a doctor who did see the court suicide warning form, but thought there was no risk of self harm, no need for observation nor referral, with no documentary evidence of history or examination and whose only records entry was "feels ok". Another nurse relied heavily on the prisoner's denial of suicidal intent. The jury noted that staff in Belmarsh did not have access to the E Asset system in YOIs. On the next day he was seen by a nurse whose secondary assessment was perfunctory and conducted without consultation with his electronic medical records (This nurse is not currently registered with the GNC). He was classed as a Vulnerable Prisoner due to high media interest, but officers were not initially aware of this and he was confined to his cell for 23 hours a day before his suicide on the fifth day in HMP Belmarsh.

5	**CORONER'S CONCERNS** Many of the weaknesses and failures that were found have been addressed by stakeholders, by the time of the inquest. Nevertheless, the evidence revealed matters that still give 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. The system of placements at transition The YOT worker said that it was a problem having a sudden change of duties aged 18 and it would better if legal duties were kept in parallel with their work until the Transition Plan was completed. The Head of Placements and Safeguarding at YJB was taken to an extract of the YOT worker's reflections on the operation of the transition system, in which she said that historically there was an approach that when you are 18, our role just stops, (that did not occur here). The famous civil servant, [redacted] said that "*officials are the servants of the public and the official must not try to foster the illusion it is the other way round*". She was asked whether Imran Douglas had to fit into the system rather than the system serve him. She agreed that a more flexible policy was needed. She agreed that the Transition Process was bureaucratic, and to work, it depended on good will. She agreed that there was an inherent risk from the statutory change of duties at 18, especially when staff were under pressure, but was concerned if legislative change adds to bureaucracy. The Deputy Director of NOMS agreed that it made no sense that there was an legal hand over of roles at 18 years: it would be better if handover of responsibility took place when the Transition Plan was completed. I consider that there is an outstanding risk that, when a rising 18 enters the criminal justice system with insufficient time for the normal Transition Plan, and especially when staff are under pressure, that even with the changes in placements from courts that have been made, and the *Joint National Protocol*, the knowledge and expertise of the YOT and YJB may not be properly considered in a placement if the legal duty for placement has passed to the PMU before the Plan is complete. The Secretary of State is asked to consider whether a *person based* rather than *rule based* system would be safer, by legislating to allow flexibility for YJB and YOTs to decide when the duty for placement is passed to the PMU, in line with the completion of the person's Transition Plan, rather than rigidly on the 18th birthday. 2. The adequacy of knowledge and interagency working between social care in London Borough of Tower Hamlets and the secure estate. Evidence pointed to a disconnection between Looked After Child pathway planning and Transition Planning. A social worker said that the LAC plan was "potentially informative" but did not matter if it was not completed, but that now it is regarded as key and should be shared. One social worker said she did not know what a Transition Plan was. The current Head of Children's Social Care at LB Tower Hamlets said that staff pressures at the time had eased somewhat, but that under her leadership the interface with the secure estate was through the YJB and so social workers do not directly talk to the secure estate staff. This was despite the requirement for the two to work together in the *Youth to Adult Transitions Framework*. Given the lack of documented communications of risks and concerns between YOT and Feltham in 2013, this evidence throws doubt on the reported improvements in training and changes in interagency communication have been put into operation since. 3. The adequacy of electronic communication systems between agencies The jury criticised the lack of access of HMP Belmarsh to the E Asset system and the fact that key documents from the Secure Training Centre were never accessed by the secure estate. The lack of a universal system of records throughout the offender's pathway results in information on risk not being known to others and may contribute to future deaths.

	4. The competence of a medical practitioner, who no longer is employed in health care in HMP Belmarsh, but is on the GMC register and may practice elsewhere and as a general practitioner. The GP did not record history or examination or propose any interventions despite being aware of the young age, long sentence and suicide warning from court. The clinical review conducted as part of the Prison and Probation Ombudsman's Report concluded that health care provision in HMP Belmarsh was below the standard expected. The GMC Fitness to Practice Directorate is asked to consider whether an assessment of his clinical practice is indicated.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that these organizations have the power to take such action. The attention of the Ministry of Justice is drawn to concerns 1, 2 and 3 The attention of the London Borough of Tower Hamlets is drawn to concern 2. The attention of the General Medical Council is drawn to Concern 4. (Details of the identity of the doctor are disclosed under separate cover).
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 23rd of February 2016. 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: The legal representatives of all interested persons were [redacted] of Hickman and Rose for [redacted] (Father), [redacted] of Bindmans LLP for [redacted] (Mother), [redacted] of Government Legal for HMP Belmarsh and HMP Feltham, [redacted] of BLM Law for HMP Belmarsh Healthcare and HMP Feltham Healthcare Care UK, [redacted] of Government Legal for Youth Justice Board, [redacted] for Serco (Transport), [redacted] for Metropolitan Police, [redacted] for Prison Officers Association, [redacted] for London Borough of Tower Hamlets. I am also sending this to and [redacted] Prison Probation Ombudsman clinical reviewer and the General Practitioner in attendance at HMP Belmarsh. 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	**[DATE]** **[SIGNED BY CORONER]** Written: 18.12.15 Sent: 29th December 2015