	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Home Office** **2. G4S** **3. Urban Housing Services**
1	**CORONER** I am Louise Hunt, Senior Coroner for **Birmingham and Solihull**
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 08/02/2019, I commenced an investigation into the death of Aram Ali Mustafa. The investigation concluded at the end of an inquest on 19th June 2019. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had entered the UK illegally on 09/04/18 and had been deported to Italy on 29/10/18. At the time he was deported he stated he would kill himself – however, he was deported successfully. He returned to the UK illegally on 30/01/19 claiming asylum and was placed in initial accommodation in room 227 at Stone Road hostel. On 02/02/19 concern was raised about his welfare by a local shop owner who stated he had expressed suicidal thoughts. Security staff at Stone Road arranged for him to attend City hospital where he was assessed by a mental health nurse. He denied any suicidal thoughts and was noted to have depressive and anxiety symptoms. The assessment concluded there was no clinical need for urgent treatment or hospital admission. He was referred back to the NHS practice that supports all asylum clients for further treatment. He had failed to attend an appointment at the practice on 01/02/19 but he had a further appointment booked for 04/02/19. On 04/02/19 he attended a charity located at Stone Road at 09.45 to complete paperwork for his immigration application however he left before his appointment started. He attended the medical practice at 14.44 and complained to the receptionist that he had problems with dental implants. He was taken to see a dentist at the health centre who could not help. He then stated to an interpreter that he was feeling depressed and suicidal. As a result he was booked to see the GP but he was not present in the reception area when the GP called him for his appointment. He returned to the reception desk at 16.00 which was closing time where the GP and receptionist saw him. He was again complaining about his dental implants. They booked him a further appointment for 13.00 the following day to see the GP and a CPN. There were no concerns about his safety at this time. He returned to room 227 at 16.28. CCTV confirmed his roommate tried to gain access to the room at 17.20 and 17.39 but failed. At 23.00 his roommate used a key to enter the room and found him hanging by a scarf from the fixed wardrobe. Security staff attended and paramedics arrived at 23.09 but he was declared deceased 23.10. He left a note indicating his intentions.. Following a post mortem the medical cause of death was determined to be: HANGING
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving 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. When he had first illegally entered the UK Mr Mustafa was deported to Italy on 29/10/18. Just before he was deported he confirmed he would kill himself if he was deported. He was provided with 1:1 constant watch and was successfully deported. When he re-entered the UK on 30/01/19 he was seen by a member of the immigration compliance and enforcement team who

	completed paperwork for the national asylum accommodation unit who in turn completed a service commission form requesting initial accommodation. The service commission form recorded that he had urgent medical needs and was a safeguarding concern however no detail was provided. Neither G4S nor Urban housing services requested any further details. A system needs to be put in place to ensure organisations provide sufficient details for providers to understand the nature of safeguarding concerns and health care matters. If there are GDPR concerns these could easily be addressed by a consent form at the time the person is first seen. 2. The events on 29/10/18 when he made a threat to kill himself were not logged with the safeguarding hub as he was about to be deported. There needs to be a system to ensure all safeguarding matters are logged regardless of where the person is in the system
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 15th August 2019. 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:- Family and Virgin Care. 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	19/06/2019 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**