REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Home Office**
1	**CORONER** I am Lydia Brown Acting Senior Coroner, for the Coronial area of West 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 23rd February 2018 I commenced an investigation into the death of Ketheeswaren KUNARATHNAM . The investigation concluded at the end of the inquest on 10th December 2021. The conclusion of the inquest was Medical cause of death 1a Hanging Conclusion Suicide There were shortcomings from all organisations. Healthcare did not carry out their daily checks, prison officers did not carry out their conversations, as set in the Assessment, Care in Custody and Teamwork document. Immigration Officers did not attend to Mr Kunarathnam's requests in good time, particularly in the weeks leading up to his death. The Immigrations Officers did not take into account Mr Kunarathnam's specific needs. He did not take bad news well and reacted badly to it. This wasn't always factored in when dealing with him and his particular worries surrounding his immigration. The Assessment, Care in Custody and Teamwork document was not always carried out effectively by all staff. For example, dates and times were missed while Mr Kunarathnam was in Wormwood Scrubs Prison. If conversations took place, they were not always recorded. Comments and discussions were not explicit, ad comments had no framework and remained unstructured. A lack of training and resources played a part. All agencies worked on different operating systems and records, the lack of communication, basic training and resources made it challenging for them to work as one cohesive unit. Significant staff workload contributed to the issues around affective communication and recordkeeping
4	**CIRCUMSTANCES OF THE DEATH** After being tortured in Sri Lanka, Mr Kunarathnam was given indefinite leave to remain as a refugee in the United Kingdom. He was detained on the sixth September 2017 at Her Majesty's Prison Wormwood Scrubs in West London. Mr Kunarathnam was detained for 28 days. Following this he was kept in further detention by the Home Office due to a deportation order. After completing his 28

	day sentence, there were alternative pathways at every stage, and the relevant agencies did not fully explore these. Mr Kunarathnam was not managed when he was on an assessment, care in custody and teamwork document by the multiple agencies responsible for his care, There was evidence of poor record keeping, communication and untimely responses. There was a failure to follow prison procedural systems. High staff workload appeared to play a crucial factor. The prison did monitor Mr Kunarathnam early in his stay and records state this. A pattern of food refusal is evident and not considered later in his detainment. At this point, the introduction of a food refusal log should have been appropriate, given the history - a failure on a multi agency level. The prison staff didn't appropriately review his mental health. For example, according to the mental health team, multiple prison stays, under different names meant that Mr Kunarathnam's records were not easy to find. Records were lept but often not shared with others at the correct time. The core failure is communication for several reasons: one includes patient confidentiality. It meant that non-health professionals were not party to Mr Kunarathnam's entire and current medical state. The mental health team mentioned that Mr Kunarathnam was an 'impulsive ma who reacts badly to information he finds distressing'. His considered actions, often coupled with impulsive behaviour, sent mixed messages to the parties involved - including his mentions of suicide and food refusal. Mr Kunarathnam had made a bail application. A Home Office representative recognised that information on it could form the basis for an asylum application. Nothing in writing or on record suggests that anyone from the Home Office discussed this with Mr Kunarathnam. It is not entirely clear to the Jurors if Mr Kunarathnam had all the information he needed to make an asylum application. Regarding bail, his immigration status and rights of appeal, Mr Kunarathnam was kept informed by being invited to Assessment, Care in Custody and Teamwork reviews and paperwork delivered to his cell. It is unclear whether the Home Office carried out the required reviews and as such vague whether they would assess any risk. On the twenty third of February 2018 Mr Kunarathnam was found hanging in his cell at Her Majesty's Prison Wormwood Scrubs.
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 **MATTERS OF CONCERN** are as follows. – During the inquest it became apparent that a certain number of prisoners in HMP Wormwood Scrubs were detained for deportation reasons after the conclusion of their prison sentence. There seemed to be a marked disparity between the information and advice available to a detained prisoner, compared with a free individual or one in a deportation centre. There was a paucity of available information and the letters sent out by the Home Office were written in legal English with no offer of translation or "plain English" assistance. Individuals in the community could access the internet, Law centres, citizens advice or any other sources of assistance that were not available to detained prisoners due to the restrictive regime, putting them at a disadvantage. Communication between the prison officers and home office officials and immigration staff was ineffective and frequently not evidenced at all. Pieces of paper were lost, phones were unanswered with no answer phone facility, email addresses were unavailable due to incompatible systems and there was no audit trail of attempted communications or the reason why these were unsuccessful. Many requests made by or on behalf of the prisoner were not dealt with in a timely manner or at all.

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 22nd March 2022 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

1. [redacted] **– Partner of the deceased**
2. [redacted] **– Bhatt Murphy Solicitors**
3. **Barnet, Enfield and Haringey MHS NHS Trust**
4. **Home Office Immigration**
5. **Practice Plus Group**

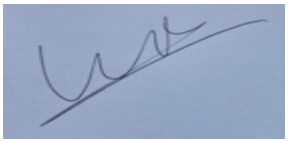
I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

Signed **Dated 26th January 2022**



HM Acting Senior Coroner West London Jurisdiction