	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) Secretary of State for Justice, Ministry of Justice (2) Chief Executive, Birmingham and Solihull Mental Health Trust
1	**CORONER** I am Mr James Bennett, HM Area 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 2 February 2021 I commenced an investigation into the death of SAIFUR RAHMAN. The investigation concluded at the end of a jury inquest held between 9-20 May 2022.
4	**CIRCUMSTANCES OF THE DEATH** The jury's factual finding: Saifur Rahman was a recognised drug user. It was reported that he was using mamba which contributed to the decline in his mental health. On the 16 November 2020, he was remanded at HMP Birmingham and on the 21 November he was admitted to the health care ward for a period of assessment. In early December he was diagnosed with Bi-polar disorder with mixed affective state and was treated with medication. Saifur Rahman's presentation on ward two was varied. At times he was amicable and would engage with others, at other times he was unpredictable and uncommunicative. He occasionally expressed odd beliefs and aggressive behaviours. However, he showed no self-harm or suicidal ideation. An A.C.C.T. was not considered necessary. In early January 2021 he was non-concordant with his medication. On 9 January he was moved to cell H3-15 due to damage and graffiti of his previous cell. On the 17 January, his unlock status was increased to custody manager plus three prison officers in full personal protective equipment. This was a consequence of his previous aggressive and anti-social behaviour. A relative telephoned the prison on 18 January, parties to the conversation report different accounts. However, it resulted in an application form for an additional number being added to Saifur Rahman's contacts. An officer presented the form at the cell and conducted a welfare check. The outcome of his last psychiatric assessment on 19 January was for Saifur Rahman to remain on healthcare, to record compliance with his medication and continue to monitor behaviour. The assessment raised no concerns regarding self-harm or suicidal ideation. Mr Rahman's presentation on the 20 January leading up to the incident raised no cause for concern. He was last seen alive at approximately 16:25 hours when he was delivered a meal through his cell door hatch. At approximately 17:00 hours during the medicine round, he could not be seen through the cell door hatch and he did not respond when called. The observation hole into the internal toilet recess had been damaged via a burn mark and crack. There was no evidence as to how or when this happened. The dome mirror was also missing, so it was not possible to see into the recess area. The prison officers expected to be assaulted on entering the cell, from the toilet recess. Therefore, unlock status was followed and cell entry occurred at around 17:13 hours. Mr Rahman was found [redacted]

	[redacted] He was lifted, placed on the floor and found to be in cardiac arrest. The prison officers commenced CPR. From the evidence given, it is likely that cardiac arrest occurred between 16:37 hours and 17:10 hours. The code blue call was delayed by up to a minute, but this did not contribute to his death. Prison nurses arrived and assisted with CPR. A defibrillator was applied but detected no shockable rhythm. Paramedic arrived at H3-15 at 17:35 hours. Return of spontaneous circulation was achieved but he remained unconscious and was taken to City Hospital, arriving at 18:16 hours. He remained very unwell and despite continued treatment died on 23 January 2021. Post-mortem examination confirmed there had been a sufficient period of reduced blood and oxygen supply to the brain, resulting in irreversible injury. It is known that when commissioned H3-15 was intended for infectious prisoners who needed to shower in isolation. The shower was decommissioned but the shower head was left in situ. It is unknown when or why it was decommissioned. In November 2017 H3-15 was taken out of use following damage to the cell, including damage to the dome mirror and the bed. In July 2020 H3-15 began to be used again without the mirror. No explanation was provided as to why. The 2020 cell [redacted] risk assessment conducted by the mental health trust did not identify the disused shower head in H3-15. The process was non-standard and conducted over the telephone due to Covid-19 restrictions. Following a post-mortem the medical cause of death was confirmed as: 1a Hypoxic/Ischaemic encephalopathy 1b External neck compression 1c [redacted]. The jury's conclusion: Saifur Rahman died from [redacted] which caused external neck compression which led to hypoxic/ischaemic encephalopathy. Mr Rahman's intention when fashioning the [redacted] was to commit suicide. There was a clear thought process in creating a [redacted] from his [redacted]. Given his diagnosis of Bi-polar disorder with mixed affective state, he displayed impulsive behaviour and made rash decisions. This contributed to his intention in fashioning the [redacted]. It was inappropriate to use H3-15, given it had a [redacted] was not replaced after it had been damaged. The risk assessments conducted by the mental health trust were insufficiently recorded due to ineffective sampling methods, non-identification of cell differences and reliance on historical records. The prison weekly fabric checks conducted by custody managers were insufficiently recorded.
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. <u>Calling a "code blue"</u>: the evidence revealed that the safety critical code blue call – automatically triggering an emergency response - was delayed by up to 2 minutes. The evidence was inconsistent on whether the cell entry briefing included the identification of an extra officer with a radio, and why therefore an

officer in full person protective equipment ran out of the cell and across the ward to where she had left her radio to call the code blue. Delayed code blue calls have been a repeated problem at HMP Birmingham despite it being raised by the Prison and Probation Ombudsman and coroners in earlier regulation 28 reports. My ongoing concern is that delayed code blue calls will continue, and consideration should be given to the effectiveness of training in light of the evidence given by the prison officers at the inquest.

2. Cell history: the evidence revealed that cell fabric history - including fabric changes, damage and repairs - is safety critical information. Information about the history of cell H3-15 was lost or unclear as it transversed control of the prison changing from G4S to national control in 2018-2019 and there was no prison master/central record. My ongoing concern is that HMP Birmingham does not currently have a master/central record of cell history and relies on Amey who have a national contract for cell fabric changes and repairs. The evidence was unclear on whether the prison would have access to this safety critical information if the third party contractor changed.

3. NHS annual [redacted] risk assessment: the evidence revealed that the mental health trust assessors had historically only dip-sampled a selection of the 15 x 2 cells on health care ward 2 (physical health) and ward 3 (mental health). They did not record which cells had been visually checked and relied in part on second-hand information from the prison about cell fabric and design. There had not been effective communication between the prison and health care staff. Generally, the trust had 140+ buildings across its entire estate to assess, this was done by two members of the health and safety team, and the assessment of the health care unit at HMP Birmingham was expected to be completed over several hours on one day. I was provided with a verbal undertaking that the trust would now visually inspect all 15 x 2 cells annually. However, this relies exclusively on the co-operation of the prison who have competing tensions given the operationally dynamic and challenging environment, especially if cells are occupied during the assessment. My ongoing concern is that there is no formalised process between the prison and mental health trust to visually inspect each cell. It is recognised prisoners housed on ward 2 and 3 are at a much greater risk of suicide than the general prison population, and general public as a whole, and will spend a great deal of time unobserved in the 15 x 2 cells. Therefore, in my view, visually inspecting 30 cells is not disproportionate to the level of risk and is not comparable to assessing an outpatient building in the community. The dynamic and challenging environment means it is likely all cells cannot be inspected on one visit. Visually inspecting each cell therefore needs to be properly planned and resourced by both the prison and mental health trust and consideration needs to be given to a formal process.

4. Prison [redacted] risk assessment: the evidence revealed that dynamic daily and weekly prison officer cell fabric checks did not identify the risks with cell H3-15. The evidence from the mental health trust was that as their risk assessment is

	annual and the environment on ward 2 and ward 3 is dynamic and can quickly change, the prison needs to undertake its own [redacted] risk assessment. I was provided with a verbal undertaking that the head of safer custody will undertake the first annual prison cell [redacted] risk assessment visually inspecting all 15 x 2 cells 6 months after the NHS risk assessment, and delegate twelve monthly thereafter, resulting in alternating 6 monthly risk assessments. My ongoing concern is that there is no formalised process and consideration needs to be given to how results of the prison [redacted] risk assessment is communicated to, and acted upon, by the mental health trust.
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 21 July 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following interested persons: (1) Mr Rahman's family. (2) Prison and Probation Ombudsman. (3) West Midlands Police. I have also sent it to the following who may find it useful or of interest: (1) Care Quality Commission. (2) Prison Governor, HMP Birmingham. (3) INQUEST. 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 of report: 26/5/22  Mr James Bennett HM Area Coroner for Birmingham and Solihull