REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Secretary of State for the Home Department,** [redacted] 2. **The Secretary of State for Justice, care of** [redacted] **Chief Executive** [redacted] 3. [redacted] **Clinical Director, TPP, TPP House, 129 Low Lane, Horsforth, Leeds LS18 5PX** 4. **Mr Simon Stevens, Chief Executive Officer of NHS England, care of NHS England Legal Team, 4W08 4th Floor, Quarry House, Leeds LS2 7UE**
1	**CORONER** I am Richard Furniss, assistant coroner for the coroner 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** An investigation was commenced into the death of Tarek Mahmood CHOWDHURY, born 13 May 1952, who died on 1 December 2016. The investigation concluded at the end of the inquest before a jury on 25 March 2019. The conclusion of the inquest was that the Deceased, while being detained at Heathrow Immigration Removal Centre (IRC), was unlawfully killed by another detainee. As part of its conclusion, the jury expressed concerns about the sharing of information between prisons and IRCs , and about the operation of the SystmOne healthcare technology which is used in prisons and IRCs.
4	**CIRCUMSTANCES OF THE DEATH** On 1 December 2016, while detained in Heathrow IRC, the Deceased was beaten to death by another detainee. The assailant was subsequently convicted of manslaughter by reason of diminished responsibility resulting from a drug-induced psychosis. The focus of the inquest was on the assailant, who had a long history of criminality, including offences of violence, and of mental health problems. After serving a sentence of imprisonment, the assailant was kept in HMP Wormwood Scrubs pending removal from the UK. However, as a result of a shortage of prison beds for Foreign National Offenders awaiting deportation, he was transferred first The Verne IRC (as it then was) and from there to Heathrow IRC. First, the jury found (and witnesses from the Home Office admitted) that the assailant should never have been transferred to an IRC. Obviously, had he remained in prison, he would not have been at Heathrow IRC and the Deceased would not have been killed. The assailant was selected for transfer to The Verne IRC by the Home Office's DEPMU, because DEPMU lacked information about him from Mercury Intelligence, NOMIS,

	OASYS, etc, which was not provided to it by HM Prison & Probation Service (HMPPS) - in particular, the fact that he had attacked another prisoner with a table leg the very day before he was selected for transfer from prison to an IRC. It became clear, moreover, that there is a general lack of information sharing between prisons and IRCs when a prisoner is transferred to an IRC. This hinders the ability of IRC staff to manage former prisoners. Prison staff are reluctant to share Mercury intelligence with IRCs. The inquest heard that the Mercury system is likely to be rolled out to IRCs in the near future. However, other sources of information (such as NOMIS reports and OASYS) will still not be available. Secondly, whenever an individual first arrives at an IRC, it is compulsory for a nurse to provide a clinical screening in relation to both physical and mental health. Where the new detainee has previously been in custody, this should be facilitated by reference to previous SystmOne records. It became clear, however, that where a new detainee has come from a prison, nurses in IRCs are not able immediately to access previous SystmOne records; they say they cannot do so until a process of "merger" occurs overnight. In this case, it meant that the nurse who screened the assailant when he arrived at Heathrow IRC was unaware of his mental health history (and the assailant lied about it). We heard evidence that a nurse can indeed gain immediate access by inputting the new detainee's prison number (available from the Person Escort Report). However, if it were as simple as that, any nurse in an IRC could access the records of any prisoner at any time (ie, whether or not that prisoner was coming to an IRC), as long as s/he had the prison number. Plainly, this is not the case. There must, therefore, be a moment at which the IRC nurse is authorised to look at a prisoner's records by using his prison number. However, we were unable to establish the mechanism for that, and the suspicion is that it does not occur prior to the new detainee's arrival from prison - and that is why the nurses at Heathrow IRC are saying that they do not have access during the initial screening process. There may also be a training issue here.
5	**CORONER'S CONCERNS** As set out above, 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) That there is a failure to share information about prisoners who are to become detainees, between HMPPS and the Home Office's DEPMU, and between HMPPS and staff in IRCs. The rolling out of Mercury intelligence to DEPMU/IRCs will not solve this problem if other information (in particular NOMIS and OASYS) is still not available to DEPMU/IRCs. This concern is addressed both to the Ministry of Justice (HMPPS) and to the Home Office (DEPMU/IRCs). (2) That SystmOne is not operating adequately when new detainees arrive at IRCs. There are concerns both about the technology itself of SystmOne; about the process of authorising a nurse in an IRC to see records of a former prisoner; and about whether trainers are able adequately to train nurses in respect of these issues. These concerns are addressed to NHS England, which is understood to commission and supply SystmOne; and to TPP, which is the technology company which is understood to have developed SystmOne.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisations 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 Tuesday 28 May 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: (1) The family of the Deceased (2) Mitie Care and Custody Ltd, which operates Heathrow IRC (3) Central and North West London NHS Foundation Trust, which provides healthcare at Heathrow IRC 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	**2 April 2019**  **Richard Furniss, Assistant Coroner**