PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the death of a man at Colnbrook Immigration Removal Centre in July 2011

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the death of an immigration detainee at Colnbrook immigration removal centre (IRC). The man died from a ruptured aorta. I offer my sincere condolences to his family and friends.

The investigation was carried out by one of my investigators. Two clinical reviewers were commissioned to produce an independent clinical review on the care the man received. I apologise that the report has been delayed.

The man arrived in the United Kingdom on 14 June 2011 from Philadelphia. He sought entry to the UK as a tourist but, after a short interview, was refused entry as a 'doubtful visitor'. Efforts to return him to Philadelphia proved unsuccessful and might well have been better managed. This resulted in him spending a considerable amount of time in detention, first at Harmondsworth IRC and later at Colnbrook, where he died.

The man's high blood pressure was appropriately identified at Harmondsworth but he was not a compliant patient. Unfortunately, this was not adequately followed up. In addition, his mental health deteriorated while in Harmondsworth but this went largely unnoticed until his transfer to Colnbrook. He was transferred without medical records. Although staff at Colnbrook appropriately identified his apparent mental ill health and an appointment was made for him to be seen by a psychiatrist for a full mental health assessment. He died before the appointment.

The clinical reviewers do not believe that the man's death could have been prevented as he had refused treatment for his long standing high blood pressure. However, the investigation is critical of medical staff at Harmondsworth for not following up adequately on the man's non-compliance with the offered treatment. It is also of considerable concern that staff at Harmondsworth failed to respond to the clear signs of deteriorating mental health. Indeed, there appears to have been a troubling lack of awareness of mental health issues, even amongst clinicians.

Accordingly, the report makes a number of recommendations intended to ensure that lessons are learned from the weaknesses in the management and treatment of the man prior to his untimely death. These include the need for better immigration casework handling and liaison with consulate staff, the avoidance of unnecessary night time transfers, improvements to information sharing between removal centres and the particular need for Harmondsworth to improve mental health awareness training amongst its staff

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2012**

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SUMMARY

1. The man arrived into the United Kingdom on 14 June 2011, from Philadelphia, USA. He sought entry to the UK as a tourist for 13 days. Concerns were raised after he was uncooperative at the immigration control, and his baggage was found to consist of a small cardboard box with a coat and cut throat razor. He was refused entry as a visitor.

2. He was detained overnight at Harmondsworth Immigration Removal Centre (IRC) prior to removal. When the man returned to the airport the next day, he refused to board the plane and returned to Harmondsworth whilst alternative flight arrangements were made. The next morning, 16 June, the man refused to leave Harmondsworth saying that he wished to claim asylum. UKBA staff cancelled his flight and maintained detention.

3. An asylum screening interview was booked for the man to attend on 22 June, and a fax was sent to the Detainee Escorting and Population Management Unit (DEPMU) to arrange his transfer to the airport for that day. However, despite a fax being sent, DEPMU failed to set up a movement order to escort the man to the airport for his interview. The man's interview was rescheduled for the next day, 23 June. The next day he refused to leave Harmondsworth. Heathrow immigration failed to rebook his interview, leaving his file dormant for 11 days.

4. On 4 July, the man contacted immigration informing them that he wished to withdraw his asylum application. The next day Heathrow immigration decided that a 'fit to fly' assessment should be obtained. They were told 12 days later that "all detainees are presumed to be fit to fly unless advised otherwise".

5. The man was seen by the Harmondsworth locum GP on 16 July, after he complained of chest pains. On examination, he was found to have dangerously high blood pressure. He was sent to Hillingdon Hospital.

6. On arrival at hospital, he gave a five year history of high blood pressure. Hospital records show that on examination, his blood pressure was dangerously high at 237/149. An electrocardiogram (which tests electrical activity in the heart) showed left ventricular hypertrophy, an enlarged heart caused by high blood pressure. The man refused to have blood tests or a chest x-ray, but agreed to take one dose of amlodipine to help control his blood pressure. That afternoon he discharged himself from hospital against advice.

7. On his return from hospital that evening, the man was located on healthcare. The Harmondsworth locum GP visited him the next morning. Discharge information had not been received from the hospital, and the GP failed to contact them to enquire as to the care he had received or if any follow-up care was required. The GP failed to prescribe antihypertensive medication believing "he would have refused to take it", later discharging him to his wing. Prior to his discharge from Harmondsworth healthcare, the man refused to have his blood pressure checked; promising staff that he would get it checked the next day, this being 18 July. However, this was not followed up. The next time the man was seen by healthcare was nine days later.

8. The man's psychiatric condition deteriorated significantly whilst in detention, with the emergence of behavioural problems, abuse and threatening behaviour. As a result, he was removed from normal location and placed into segregation. Staff did not explore any possible medical reasons for his deteriorating behaviour.

9. On 24 July, staff at Harmondsworth arranged a swap with a detainee at Colnbrook. The man was transferred on 27 July. Prior to the transfer, Colnbrook were unaware of the man's recent hospital admission and current state of health. The man arrived without his medical records.

10. After concerns were raised during the reception health screen, the man was seen by Mental Health Nurse A for a mental health assessment the next day. The nurse instructed staff that "until he is fully assessed by the psychiatrist, he is "unfit for normal location". The man was placed in a single room. All rooms in Colnbrook have bunk beds (2 beds). However, because of the nurse's concerns the man did not share a room, thus making it a single room.

11. On the day the man died he was seen by DCO A at approximately 7.30am when she took his breakfast pack to him. At 8.28am, DCO B observed the man through the viewing panel of the door, and noted on the observation sheet outside his room "appears asleep". At 9.27am, DCO C checked on the man. She recorded that the man was sat on his bed in a slumped position. A medical response was called for over the radio at 9.28am, with an ambulance being called three minutes later. Cardiopulmonary resuscitation (CPR) was commenced immediately and continued until 10.15am. However, staff were unable to resuscitate him.

12. The man's next of kin were informed by the American Embassy. His body was later returned to his family on 17 August.

13. This report discusses issues surrounding the man's care at both Harmondsworth and Colnbrook. We have made recommendations concerning the education of staff in the Mental Capacity Act, night-time transfers between the detention estates, the flow of information between UKBA, Harmondsworth and Colnbrook in the management potentially vulnerable detainees, and the importance of record keeping.

THE INVESTIGATION PROCESS

14. The investigation was opened on 4 August 2011, when the investigator, issued notices announcing the investigation to staff and immigration detainees. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No-one came forward.

15. During the opening visit, the investigator collected copies of the man's immigration files, including his medical records. She visited the healthcare unit, viewed the man's room, and introduced herself to the staff on the wing.

16. The investigator returned to Colnbrook Immigration Removal Centre on 16 September to interview five members of staff. She met United Kingdom Border Agency (UKBA) Centre Manager and SERCO Contract Director (the Contract Director oversees the running of the establishment on behalf of UKBA) during this visit.

17. Throughout the investigation, feedback has been given to the UKBA centre manager. On completion of her investigation, the investigator wrote to the UKBA centre manager, the SERCO contract manager, the UKBA Centre Manager for Harmondsworth, and the GEO Contract Director at Harmondsworth, highlighting areas of potential concern.

18. A clinical review of the man's care at Harmondsworth and Colnbrook was carried out by the two clinical reviewers. Clinical reviewer A was asked to examine the medical care received by the man, and clinical reviewer B (a consultant psychiatrist) was asked to focus on the psychiatric aspects such as issues relating to mental capacity.

19. There was a delay in appointing a clinical reviewer. Due to a potential conflict of interest, the original reviewer had to be replaced. The clinical reviewers were subsequently appointed and the clinical reviews were received on 12 and 18 November. This delay, in turn, led to the investigation report being delayed.

20. A family liaison office contacted the man's mother, his next of kin, to inform her of the investigation and to provide her with an opportunity to raise any issues about the care her son received. She asked that the following be considered:

    - Why was the American Embassy not notified immediately after the attempt for a turn-around was not successful?

    - Information regarding her son's stay at Harmondsworth and his behaviour at that time.

    - Information regarding her son's visit to the hospital on 16 July.

21. The man's mother said her son was receiving mental health services in the United States having been diagnosed with paranoid schizophrenia. This is one of the reasons she believes her son did not answer the questions addressed to

him when he entered the UK. She said even when on his medications, he was very cautious to what he told people. He also traveled on whim with no set agenda.

22. The man's mother said she was concerned her son was unable to make an informed decision when he was hospitalised on 16 July having been detained for over a month without his medication. She questioned why staff failed to recognise the change in his behavior during this time. The man's mother believes if staff had noted his change in behaviour and carried out a mental health evaluation, his mental illness would have been quite obvious as he acted quite differently when not on his medications. The man's mother is concerned her son was moved to a different facility because of his inability to get along with other residents. She said that when on his medications, her son was not racial and his aggressive behavior should have acted as a warning to staff.

23. The man's mother feels that staff at Harmondsworth "dropped the ball" when it came to her son's health issues which include both physical and mental health. She said that, without his medications, the man would have become more and more paranoid and unable to get along with others. He also suffered from severe anxiety attacks when not on his medications which would have led to hypertensive crisis. The man's mother said it is her experience that people tend to avoid confronting mental health issues because it makes them uncomfortable, and therefore ignore the signs. However, she feels this issue cannot be ignored when someone is responsible for an individual's well-being.

24. The man's mother described her son as a sweet, kind and gentle man when on his medications. She further commented that she hoped the investigation leads to changes in the way UKBA staff look at their residents and consider training staff in mental health issues and what to look for.

25. After receiving the draft report the man's families' legal representative made extensive written submissions. We have responded to these outside of this report. None of these have led to changes being made to the report or significant investigative work being carried out.

26. This report will be forwarded to the coroner to assist in their enquiries.

HARMONDSWORTH IMMIGRATION REMOVAL CENTRE

27. Harmondsworth is a purpose built, long-term centre where detainees are accommodated, pending resolution of their cases. The centre is managed by the GEO Group Limited on behalf of UKBA. A total of 615 adult males can be accommodated at the centre at any one time.

28. Harmondsworth is the principal centre for male Fast Track asylum cases. The Fast Track asylum process is for people whose cases UKBA believe can be determined quickly. It is also used as a base to gather detainees going out on charter flights.

29. Facilities within the centre include, a world faith centre including several prayer rooms, a gymnasium, and an adult education centre which is staffed by permanent teaching staff. The centre provides a wide range of courses such as arts, crafts, English, computers and IT.

30. 24 hour medical care is provided on site by means of a special medical centre which comprises of three hospital-type wards, observation rooms, isolation rooms and general practice rooms. Nursing staff cover a 24-hour period on a rota system, with locum doctors runing morning and afternoon surgeries during the day. An external dentist and psychiatrist attend on a weekly basis to tend to any relating medical matters. The GEO Group currently sub-contracts healthcare services to Primecare.

31. The combination of facilities at Harmondsworth means that they can accommodate the full spectrum of male immigration detainees, including asylum seekers, ex-prisoners, people with health needs or disabilities and those taking part in drug detoxification programmes.

32. An Independent Monitoring Board (IMB) is appointed to each IRC by the Minister for Immigration to ensure standards of decency and care are maintained. They are required to produce an annual report to the Minister about the IRC, highlighting good practice and flagging up areas of concern. Their latest report was published in 2010. The IMB commented that

> "The board continues to be concerned about the number of people who end up being detained for very long periods of time. UKBA detention services staff do not systematically monitor this on a local level and the UKBA team at Harmondsworth, for example, does not see collecting or analysing such information, or using it to press caseworkers, as part of its role."

33. The IMB also raised concerns that the mental health needs of detainees were not being met adequately, given the particular stresses of being held in detention. They commented that "detainees with significant mental health needs sometimes languished at Harmondsworth because external beds cannot be found for them or because their needs while significant, do not warrant their being sectioned under the Mental Health Act."

34. In addition to this they raised concerns about the use of Elm House, this being a wing in Harmondsworth being used for Rule 40 (separation) and Rule 42 (segregation) commenting that the cells used for Rule 40 and 42 were interchangeable. They commented that although those on Rule 40 were housed with their door unlocked or open, the bare nature of the rooms and their isolation from the rest of the centre make the distinction between the two rules limited.

35. The most recent published report by Her Majesty's Chief Inspector of Prisons (HMCIP) was dated January 2010, following an announced inspection. Inspectors made 60 recommendations relating to healthcare and said:

> "Detainees complained of difficulties in accessing health services and of lack of care from nursing staff. Inpatient care was poor, with little focused care from staff. Primary mental healthcare was inadequate and there was limited access to secondary mental health care".

36. Inspectors commented that primary mental health services were limited to GP consultations and some nurse consultations, but that "there was no dedicated RMN [Registered Mental Nurse] time". It was noted that there was no separate mental health training for centre staff. They were told that ACDT training (ACDT training is the learning how to monitor and support prisoners assessed as at risk of suicide or self harm) provided an element on mental health, but this training was not provided by health services staff. The inspectors made a recommendation that "there should be mental health awareness training for all centre staff".

37. An area of concern also highlighted by the inspection was that clinical records were paper based, were poorly collated and managed, and there was no tracking system of any kind. They commented that "the quality of entries was sometimes poor, with illegible entries, signatures and staff designations".

COLNBROOK IMMIGRATION REMOVAL CENTRE

38. Colnbrook is built to category B prison standard (suitable for those who do not require maximum security, but for whom escape needs to be made very difficult). The Centre was built so that difficult detainees from the whole detention estate could be managed with close supervision and care. Colnbrook also has a short term holding facility (STHF). The STHF is used by UKBA to reduce reliance on police facilities and to provide a short term assessment and induction facility prior to moving a detainee to the main centre. The centre can accommodate both adult males and females.

39. The centre is managed by SERCO on behalf of UKBA. Colnbrook is in operation 24 hours a day and there are no restrictions on the number of moves in and out per day.

40. 24 hour medical care is provided on site by SERCO Health, with nursing staff covering the 24-hour period on a shift system. The healthcare centre has a small in-patient facility, with six beds, to care for more serious medical

conditions. Colnbrook provides access to GP services, nursing care and clinics, dentist, opticians, chiropody, psychiatric services and a substance misuse programme. GPs are provided by the Farnham Road Medical Centre, Langley, Berkshire.

41. Facilities include a range of classrooms for educational use. Colnbrook operates a detainee transferable skills program to assist detainees learn new skills for future life after Colnbrook. Religious facilities include a Muslim prayer room and a multi faith room. There is also a sports hall, gym, outdoor sports area, internet facility, and a cinema area.

42. The Independent Monitoring Board (IMB) for Colnbrook issued its most recent report in 2010. In the report, they commented,

> "The Board acknowledge that the new Healthcare Manager at CIRC has made a positive difference to the morale of the Healthcare team at CIRC and there are signs of improvement, particularly in the treatment of mental health issues, nevertheless this remains an area of high concern to the Board".

43. The most recent published report by HMCIP was dated August 2010. This report detailed an unannounced follow-up inspection to review any actions taken following an announced inspection in November 2008. As a result of this they commented that,

> "There was a high need for mental health support and detainees could be referred to mental health services by staff or self-refer. All referrals were seen initially by a registered mental health nurse (RMN). The waiting list for August 2010 showed that detainees had waited up to seven days for a first appointment, and one detainee had waited 13 days. There was no dedicated space for mental health nurse clinics and nurses told us that it was often difficult to find a suitable private space to see patients."

44. As a result, inspectors recommended that "there should be protected time and space for mental health clinics, to ensure timely appointments".

45. Following the unannounced inspection in 2008, inspectors recommended that "Colnbrook STHF should not hold women detainees". During the follow-up inspection in 2010, inspectors observed a male and female detainee in the same common area of the STHF, with no direct supervision. They commented that "The STHF remained an inappropriate place to hold women". This observation is also relevant to an issue highlighted during this investigation.

KEY EVENTS

46. The man arrived into the United Kingdom on 14 June 2011, on flight US728 from Philadelphia, USA. Immigration records show that, when he reached the immigration control at London Heathrow Terminal One, he was seen by immigration officer (IO) A at 10.20am.

47. All non EU (European Union) passengers are required to fill out an immigration landing card giving their name, nationality and intended address whilst they are in the UK. The reverse of this card is normally reserved for written notes made by the IO. IO A noted on the back of the man's landing card that he sought entry to the UK for two weeks to visit Scotland, Germany and Poland on holiday. However, despite his specific travel plans, he had no accommodation booked, or onward ticketing to show that he planned to travel to these places. The man had a return ticket to Philadelphia booked for 27 June. At this point, he refused to answer any more questions.

48. IO A sought assistance from her colleague, IO B. IO B continued to question the man, who explained that he was a labourer by trade, but had been unemployed for roughly one year. He lived with his mother in Philadelphia and had no friends or family in the UK. IO B noted that the man's behaviour was 'abnormal', that he would not maintain eye contact, and was on occasion aggressive when questioned, challenging IO B's authority to question him about his stay in the UK.

49. After initial questioning, immigration records show that IO B and IO A were not satisfied that the man was a genuine visitor to the UK, and issued him with immigration form IS81. This form, under Paragraph 16 (Schedule 2) of the Immigration Act 1971, gives power to an immigration officer to authorise detention pending examination or further examination (further questioning). The IS81 was issued to the man at 10.40am.

50. IO B referred his concerns in relation to the man to Chief Immigration Officer (CIO) A, who authorised further examination, including a search of the man's baggage. At 10.55am, the man was escorted to the baggage hall, where his luggage was found to consist of a small cardboard box containing a coat and a silver cut throat razor. The man explained that he had travelled with so few belongings (despite wishing to travel for 13 days) as he liked to 'travel free' and would buy clothes on his travels.

51. On completion of the baggage search, the man was fingerprinted, photographed and asked to wait in a secure waiting area. He was issued with immigration forms IS91R and IS86. An IS91R must be given to all detained passengers to explain that they are being detained, and the grounds for that decision. The IS86 explained why he was fingerprinted.

52. At 11.45am, IO B made a call to Homeland Security (American border security, who have staff based at Heathrow Airport) asking if they could do a background check on the man and let him know if they found anything of concern.

53. IO B attempted to interview the man at 12.15pm that afternoon. Initially he refused to participate in the interview. After the reasons for the interview were explained, he agreed to be interviewed. He explained that he had no plans in the UK and had only wished to have a smoke, a beer and a meal. He asked for his passport to be returned to allow him to either return home or to travel to Europe. He explained that he didn't like flying, but that it was the only way he could travel overseas. The interview was terminated at 12.32pm. He refused to sign the interview sheet to confirm what had been discussed.

54. IO B discussed the details of the interview with CIO B and, at 12.35pm, it was decided that the man should be refused entry to the UK as a doubtful visitor.

55. CIO B spoke to IO B about the man's uncooperative behaviour. CIO B said that, despite his failure to comply with requests to answer questions, he had not been violent. He had not threatened anyone, and there was no record of him causing harm to others in America, or having mental health issues. It was decided that a mental health assessment was not required and a note was made in the man's immigration file to reflect this.

56. After the man was refused entry to the UK, a flight was booked for him to return home. The next available flight back to Philadelphia with US Airways was at 5.10pm that evening. However, immigration records show that despite this, a flight was booked for 12.20pm on flight number US279 the next day. Immigration form IS82a was served on the man explaining the reasons he had been refused entry, and confirming the details of his return flight.

57. At 6.30pm, the man informed immigration that he would not return to America. He said that that he didn't like flying and that he wouldn't be flying again. He was asked if he had any medical problems that prevented him from flying, and he replied, "No".

58. Contact was made with the Detainee Escorting and Population Management Unit (DEPMU) at 7.06pm to arrange for the man to be detained overnight until his flight the next morning. (DEPMU is responsible for the co-ordination of detention in immigration detention accommodation). Accommodation was found at Harmondsworth.

59. A call was received from Homeland Security at 7.35pm. The officer informed immigration that checks had revealed that the man was known to the police authorities in America. It was confirmed that he had convictions for unlawful carrying of weapons, obstruction and disorderly conduct.

60. At 10.15pm, the man was collected by immigration escorts and taken to Harmondsworth, arriving at 11.20pm. When he arrived at Harmondsworth, a reception health screen was conducted. During the reception health screen (which was conducted in the early hours of the next morning, 15 June) Nurse A noted that his blood pressure was 108/ 94. The man told the nurse that he did not suffer with high blood pressure, diabetes, mental health problems or any kind of heart condition. He confirmed that he was not taking any kind of

medication at present, and was allergic to penicillin and sulphur. The nurse wrote on the reception health screen

> "Seen in reception, states fit and well. Appears stable in mind, good eye to eye contact. Communicating effectively, states not suicidal, denies any thoughts of DSH [deliberate self harm] or suicide."

61. A note was made in the man's medical record by Nurse B to say that he was anxious about being sent back to America, and had said that he would refuse to get on his flight home. At this time he was given a room in F wing, the induction wing.

62. The man was collected from Harmondsworth at 7.05am that morning (15 June), and taken back to Terminal One at Heathrow for his flight home. The man was asked to wait in the secure holding room until his flight.

63. Shortly after his arrival, at 8.30am, the man spoke to IO C announcing that he was afraid of flying and informed staff that he would refuse to get on his flight home. The man also announced that he was not an American national. It was explained to him that if he refused to get on his flight he would be escorted by United States (US) Air Marshals and thus met by US immigration on arrival back into the USA. He asked to speak to an 'American'.

64. At 10.15am, an officer from Homeland Security went to Terminal One to speak to the man. The officer again explained his options for returning home, but the man announced that he did not believe the officer was an 'American' and turned his back on him.

65. A call was made to Northside police station (which is the main police station at Heathrow Airport) at 11.47am to ask if they could assist in walking him to the plane. The man's flight was booked for 12.20 that day, but by the time immigration staff managed to speak to someone at the police station it was too late, as the escorting officers had already left to accompany detainees to other flights. The man did not return on his scheduled flight that day.

66. Immigration records show that, after the man missed his flight, a call was made to US Airways to discuss other possible flights. During this conversation, the agent from US Airways informed UKBA staff that if they had called earlier and got him to the plane, the covert (undercover) US Marshals (American security officers) could have assisted in the removal.

67. The man was escorted back to Harmondsworth and given a room on Gorse (G) Wing. A new flight was booked for the next day, 16 June at 12.20 on flight US729.

68. At 2.25pm, IO D spoke to the station manager at US Airways to discuss the man's removal. The station manager said that the flight the next day would have 3 US (covert) Marshals on and, if the police could assist in escorting him to the flight, the Marshals could keep an eye on him during the flight. A note

was made in the man's immigration file to say that the police should, as before, be contacted on the morning of his removal.

69. The next morning, 16 June, the man refused to leave Harmondsworth saying that he wished to claim asylum. At 7.25am, a fax was sent to immigration at Heathrow Terminal One, informing them of the man's wish to claim asylum. It was decided by IO E to maintain detention, cancel his flight for that afternoon and transfer his file to Heathrow Central Casework Unit (HCCU) to action his asylum claim.

70. HCCU is based at Heathrow Terminal Three. The first entry in his file was made on 18 June. Later that day, a note was made in the man's file to say that before he could be considered for fast track (an expedited asylum process) he would need to have his initial asylum interview (known as screening). A diary action was made on his file to arrange a screening interview with the man, and a referral to be made to the fast track department.

71. A minute on CID (Case Information Database, UKBA's central computer system) on 21 June recorded that a request was sent by fax to DEPMU asking that the man be brought from Harmondsworth to the airport for his asylum screening interview on 22 June, at 11.30am. Despite a fax being sent, DEPMU failed to set up a movement order for the escort. The man's interview was rescheduled for 23 June at 10am.

72. On 23 June, the man refused to leave Harmondsworth to attend Heathrow Airport for his asylum screening interview. HCCU sent a fax to Harmondsworth asking the man to contact them to explain his reasons for not wanting to attend his interview. On 27 June, HCCU sent another fax, this time addressing it to immigration staff at Harmondsworth. In this fax they asked that someone speak to the man, to ask him why he refused to attend his interview and if he still wished to claim asylum. HCCU received no response.

73. No further action was taken on the man's file until 4 July, when the man called HCCU to say that he no longer wished to claim asylum. The man said that he would leave the UK, but would not return to the USA. CIO C noted in the man's immigration file the next day that, "although not documented as having any psychiatric condition, pax [passenger] does give the impression of not being completely rational in his thinking". The CIO sent a fax to Harmondsworth on 5 July asking that the man be examined by medical staff to ascertain if he was fit to fly. He also made a note to say that escorts should be considered to assist in the man's removal, commenting that contact should be made with Homeland Security to discuss using US Air Marshals.

74. The man had now been in detention for 21 days, and because of this a detention review was conducted by HCCU. In this review, it was noted that the man's detention was "HRA [Human Rights Act] compliant and necessary to prevent unlawful entry into the UK and to facilitate removal".

75. On 11 July, the man attended the library. Detention Custody Officer (DCO) D noted in his wing history sheet that "The man came into Library two this

morning and his manner seemed very odd, he didn't seem with it somehow and kept muttering to himself".

76. The request for a 'fit to fly' assessment was not followed up by HCCU and thus his immigration file was not actioned for a further eight days. On 13 July, CIO C contacted Harmondsworth to check on the progress of the man's assessment. The CIO was told that due to staff shortages his request had not been actioned, but that he would now arrange for this to be done.

77. At 1.30am on 16 July, the man kept pressing the intercom in his room shouting that he needed to come out for fresh air. DCO E explained to him that this wasn't possible. After the man complained of feeling 'itchy' and claustrophobic, the DCO sought permission from the night manager to allow the man to come out of his room for a few minutes. Permission was granted, and after the DCO opened the door, the man came out, sat down on a chair and then immediately got up and went back into his room.

78. DCO E was concerned about the man's odd behaviour, and asked Nurse A, who was working the night shift, to come and see him. At 5.10am, the nurse attended the man's room. However, the man refused to let either the DCO or the nurse enter his room, accusing her of being a nun, asking what her religious status was. The nurse explained that she was a nurse from healthcare and she had come to see if he was ok.

79. The man refused to speak to Nurse A, and in the morning she explained her concerns during her handover to the day staff in healthcare, suggesting that he should be seen by the doctor that day. The man was later seen by the locum GP at Harmondsworth. During his consultation, the GP noted that he was told by the man that he "suffers from blood pressure which he control[s] by spiritual means". The man told the GP that during the night he had suffered with piercing pain in his chest and ribs, and that he thought he would have a heart attack.

80. The man's blood pressure was taken which showed a reading of 191/118, this being extremely high. The locum GP at Harmondsworth made a note in the man's medical notes to say that his (the man's) chest was clear, and that he was confused but fully co-ordinated. The man's blood pressure was checked for a second time, and was recorded as 203/145. It is unclear what time he was seen by the GP, or at what time his blood pressure readings were taken, as the GP did not note the time on the man's medical record.

81. As a result of the man's dangerously high blood pressure, the locum GP at Harmondsworth referred him to Hillingdon Hospital. The referral fax showed that the man's blood pressure had again risen to 240/143.

82. Hospital records show that the man arrived at Hillingdon Hospital at 4.02pm. On arrival, he refused to have blood tests or a chest x-ray as recommended by hospital staff. He did, however, agree to have his blood pressure taken, showing 237/149 and to take amlodipine, a drug to help reduce his blood pressure. An electrocardiogram (a test showing electrical activity in the heart)

showed left ventricular hypertrophy, an enlarged heart caused by high blood pressure.

83. The hospital checked the man's blood pressure at 6.35pm that evening and records show that due to the earlier prescribed amlodipine his blood pressure had reduced slightly, now being 229/139.

84. Later that day, the man discharged himself from hospital against medical advice. Before he left, hospital staff explained the seriousness of his condition, explaining that dangerously high blood pressure could be fatal in some cases. The man confirmed that he understood this, and a note was made in his hospital records to say that "patient has capacity". (For someone to have capacity they must understand information given to them, retain that information long enough to be able to make a decision, and be able to weigh up this information to make a decision).

85. On arrival back at Harmondsworth, the man was located in the inpatient unit in healthcare. At 8.20pm that evening he refused to see the nurse saying he was 'fine' and that he just wanted to sort out his immigration problems.

86. Following the escort to hospital a note was made in the man's wing history sheet advising that, "Staff to monitor on escorts as the man kept playing with the handcuffs and asking for them to be loosened or removed … He made a comment to the cuffed officer asking, 'who's arm would break' whilst playing with the cuffs".

87. At 9.50am the next morning, the locum GP at Harmondworth visited the man. At interview, the GP said that Hillingdon Hospital had failed to send a discharge note detailing the care given to the man the day before. The GP was aware of how dangerously high the man's blood pressure had been the previous day. However, despite this, the GP did not contact the hospital to obtain any discharge information, or prescribe him any medication to help reduce his blood pressure.

88. The man asked to be discharged back to his wing, saying that he was now okay. A note was made in his medical records that

> "Still refuses to go to hospital, or any investigations done. Claims fell playing football and injured ribs – nothing to see. Wants painkillers for it. Promises to get BP checked tomorrow. To observe any deterioration in his health, to discharge to wing"

89. The man was discharged back to his own wing later that day, 17 July. Despite being aware that the man had self discharged from hospital with a potentially fatal condition, no mental state or capacity assessment was recorded by the locum GP at Harmondworth prior to him allowing him to return to the wing.

90. The same day, HCCU contacted Harmondsworth again in response for their request for a 'fit to fly' assessment. 12 days after it was first requested, HCCU were told that all detainees are presumed 'fit to fly' unless advised otherwise.

In response, HCCU sent a fax to Harmondsworth asking that the man be spoken to, advising him that a flight was to be booked for his return to Philadelphia.

91. The man failed to attend Harmondsworth healthcare on 18 July to have his blood pressure checked. His failure to attend was not followed up, and he next saw healthcare staff on 26 July.

92. On 24 July, two entries were made in the man's wing history sheet by DCO F. She noted his 'strange' behaviour, saying that he was "whispering and muttering to himself". Later that day, the man complained that the TV in his room wasn't working. DCO G attended his room and found that the aerial had been removed. After the DCO fixed the TV, the man was seen ripping the plug off the TV cable. He told the officer that his TV was broken, and left the room. The DCO noted in an incident report that he asked the man to return to his room but that he became "rude and incoherent", and was abusive to staff calling them 'red necks', 'white trailer trash' and using other offensive terms to describe black officers. The man was placed on 'rule 40' (removal from association) from Gorse (G) Wing and taken to Dove Wing, the care and separation unit (CASU). It was noted on an incident summary sheet that this was "for his own protection".

93. The same day, the Deputy UKBA Manager at Harmondsworth emailed the UKBA Centre Manager at Colnbrook, asking if they would consider doing a head-to-head swap involving the man and a Colnbrook detainee.

94. On 26 July, after continually being racist and abusive towards staff, and urinating on the floor of his room, the man was placed on 'rule 42' this being in segregation. All detainees who are placed into segregation have to be seen by the doctor once a day. The man refused to see the locum GP at Harmondsworth that day.

95. An entry was made in the man's wing history sheet on the morning of 27 July. The entry said that "shows very bizarre behaviour. Apart from that slept through the night. No issues". The locum GP at Harmondsworth visited later that day to visit all of those currently on segregation. The man again refused to see him.

96. An immigration officer from HCCU reviewed the man's case on 27 July. A note on the man's immigration port file said that "we should discuss with Homeland Security and arrange air marshals to escort and set RD's [removal directions]". It was noted that the case should be reviewed by a chief immigration officer.

97. Also on 27 July, the UKBA centre manager agreed the head-to-head swap. She emailed to the deputy UKBA manager at 1.12pm, confirming she would arrange the transport for the transfer. At 9.50pm the man was collected from Harmondsworth by SERCO (Colnbrook) escorts. DCOs H, I and J collected the man from Harmondsworth and escorted him into the escort van. They were advised by GEO staff (who run Harmondsworth) that they were arranging for the man's paperwork to be collected and delivered from the reception area.

DCO K drove the escort vehicle to the main exit, where he was met by GEO gate staff and handed the man's paperwork.

98. As Harmondsworth and Colnbrook are situated on neighbouring sites, the man arrived at Colnbrook at 9.55pm. On arrival, the man advised staff that he did not want to be seen by a female nurse and, because of this, Nurse C, a male nurse, was asked to conduct his reception health screen. The man's health screen was conducted at 10.10pm that evening.

99. When he arrived at reception, Nurse C was advised that Harmondsworth had failed to include the man's medical record in his transfer papers. The nurse advised them that he would conduct the reception health screen, and then chase the records when he had finished.

100. During the health screen, Nurse C noted that he was "very odd and peculiar in [his] demeanour". The man told the nurse that he had a history of hypertension (high blood pressure), but then refused to have it checked. The nurse told the investigator at interview that the man was happy to talk to him, answering all the questions required during the health screen, until he caught sight of his name badge. The nurse is a mental health nurse, and this was detailed on his name badge. The nurse explained that the man walked over to him to have a closer look, and asked him if he was a mental health nurse. The nurse confirmed that he was, but was there to conduct his reception health screening, not as a mental health nurse. The man explained that he didn't have any mental health issues, and that he didn't want to see him anymore. The nurse explained that at this point he had to cut short the reception screening.

101. The man had arrived from segregation at Harmondsworth. Nurse C had concerns in relation to the man's mental health. A room share risk assessment was completed, and because of his racist and sexist behaviour at Harmondsworth, he was placed in a single cell "in view of risk to others". A referral was made for the man to be seen by the doctor the next day. The man was escorted to the short term holding facility (STHF) room 19.

102. At 11.00pm. Nurse C phoned Harmondsworth healthcare asking them to fax over the man's healthcare records. At 11.40pm, Harmondsworth faxed only the discharge letter from Hillingdon Hospital.

103. The next day, 28 July, the man refused to see the doctor and signed a medical disclaimer to say that he did not want a medical consultation. Later that morning, at 10.55am, the man was seen by the mental health nurse for a mental health assessment. The man declined this assessment, with the mental health nurse writing in his notes, "declined assessment claiming that he does not have any mental health issues and therefore does not want to be seen. Appeared suspicious in demeanour looking around and refused to sit in the chair".

104. After the mental health nurse saw the man, he completed immigration form IS91RA Part C. This form is used to add any supplementary information that comes to light that may indicate a change to the detainee's risk assessment.

The nurse wrote, “[The man] was admitted from segregation unit in H/worth [Harmondsworth]. He is believed to be sexist and will not engage with mental health service. Until he is fully assessed by the Psychiatrist, he is “unfit for normal location”. The nurse wrote the words “unfit for normal location” in capital letters to emphasise the importance of this instruction. As a result, the man remained in the STHF for the duration of his stay. An appointment was made for the man to be seen by a psychiatrist on 4 August.

105. On 29 July, IO F from HCCU noted on the man’s file to say that the case had now been reviewed by CIO C. He had agreed that the best option would be to remove the man from the UK with escorts using a public expense removal (PER).

106. The Immigration Act 1971 (Paragraph 8(1) schedule 2) requires the carrier (airline) to remove from the United Kingdom (or make arrangements for the removal of) a person refused leave to enter the UK. The airline is required to pay for the costs incurred by this removal. A note was made in his immigration file to say that escorts would be arranged the next day.

107. Short term accommodation is normally only used for new entrants. Due to the confined space and restricted regime, all detainees in short term accommodation are subject to hourly observations. At 7.36am on 31 July DCO A opened the man’s door to bring him his breakfast. She unlocked his door, knocked and entered. The DCO detailed in her police statement that, upon opening the door she saw the man lying on the bottom bunk. She greeted him and asked if he was ok, explaining that she had come to bring his breakfast. The man did not reply, staring at her as he got up out of his bed. The DCO said that she placed his breakfast on the table in his room and left.

108. DCO B looked through the viewing panel of the man’s door at 8.28am, and noted on the ‘hourly observational log’ outside his room that he “appears asleep”. Shortly after the DCO asked to be relieved from the wing to sew on a loose button on her shirt. DCO H took her place.

109. At 9.27am, DCO C conducted a visual check on the man’s room. At this time Nurse C was on her medication round, walking down the corridor. The DCO looked through the viewing panel and saw the man “sitting in a strange position”. She explained that he was sat at the edge of the lower bunk with his back towards her, slumped forward with his legs crossed. She asked the nurse to come and have a look. The DCO was new to Colnbrook, was still awaiting her full security clearance and was not authorised to have a set of keys. The nurse looked through the viewing panel and called DCO I over to assist. At 9.28am, Officer I and the nurse entered his room. The DCO walked towards the man, stopping roughly two feet away to see if he could see him breathing. Seeing no movement, he approached, placing his left hand on the man’s back to shake him to see if was asleep. The DCO explained that he was “cold to the touch”. The DCO immediately called for a medical response over his radio, and helped the nurse to roll the man onto his back. They noticed that he had purple patches all over his face.

110. The mental health nurse, Nurse D and Nurse E attended at 9.31am, carrying the emergency response bag, oxygen cylinder and defibrillator. The doctor at Colnbrook, arrived three minutes later. The mental health nurse commented that on arrival he found the man to be 'non responsive to painful stimuli, cold to the touch and cyanosed' (having a bluish discoloration of the skin and fingernails caused by a deficiency of oxygen in the blood). After assessing the man's condition, Nurse C requested that an emergency ambulance be called. SERCO Duty Manager who had arrived at the same time as healthcare staff, instructed nurses to commence CPR. However, cardiopulmonary resuscitation (CPR or mouth to mouth resuscitation) was started on the bed, and SERCO Duty Manager suggested that the man was moved onto the floor. Defibrillator (a device to deliver a controlled burst of electricity to restart the heart) pads were attached to the man's chest and he was found to be asystolic (asystole occurs when there is no electrical activity present in the heart). CPR was continued until paramedics arrived at 9.43am. After he was assesed, the man was moved out into the corridor to allow more space to treat him. The doctor and paramedic staff took it in turns to conduct CPR and administer oxygen. CPR was conducted for a total of 31 minutes, and five doses of adrenaline were administered.

111. At 10.15am, it was decided that as there were no signs of life, resuscitation should be stopped. To maintain his dignity, the man was covered with a sheet and screens were placed around him. The five remaining detainees on the wing were unlocked and moved to another wing, and the corridor was sealed and guarded by a SERCO officer to await the coroner and police.

112. Harmondsworth had still not sent the man's medical records to Colnbrook. At 10.31am that morning another request for them was made, and UKBA member of staff, UKBA centre manager walked across to collect them.

113. A hot debrief (a meeting to discuss what had occurred) was conducted at 2.00pm that day with all staff involved with support being offerred. HCCU were informed of the man's death, and contacted Homeland Security to ask for their help in locating his next of kin. Homeland Security asked HCCU to call the American Embassy duty officer, who would be able to assist. On 1 August, the American Embassy located the man's mother and father, and passed their contact details to UKBA.

114. The Deputy Director for Detention Services, contacted the man's mother to inform her of the death, and to express his condolences. With the assistance of a funeral home in Berkshire, and on request from the family, the man's body was returned home on 17 August, on a flight from Heathrow to Newark.

115. A notice to staff and residents was put up around the centre informing them of the man's death. Staff were invited to speak to a member of the care team if they required any additional support, with residents being directed to a member of the stay safe team.

116. A post-mortem was conducted on 3 August. The preliminary post-mortem report gave a provisional cause of death as a ruptured dissection of the thoracic aorta caused by hypertension.

ISSUES

Immigration delays

117. In relating the circumstances surrounding the man's death, it is important to discuss the reasons why he was still in detention six weeks after being refused entry as a visitor to the United Kingdom. It is the normal procedure to remove someone in the man's situation on the next available flight, and therefore six weeks is a considerable delay.

118. The initial cause of delay was the man's refusal to fly. While different methods of ensuring he boarded a flight were discussed, staff were unable to finalise these arrangements. The man then sought asylum, which meant that attempts to remove him were suspended pending the outcome of his asylum application.

119. After the man withdrew the asylum application on 4 July, he said that he would leave but would not go back to the USA. Immigration staff at Heathrow asked for a "fit to fly" assessment to be completed before they set further removal directions, but this was not done, or chased, for over 10 days.

120. Both delays are unfortunate. Effecting removal from the UK is often difficult, but it is not in the interests of UKBA or the detainee to be held in detention longer than is necessary. We make two recommendations. One is aimed at ensuring that appropriate escort arrangements are in place at the earliest opportunity, which would increase the chances of a timely removal. The intention of the second is to ensure that "fit to fly" assessments are completed quickly.

The Director of UKBA Detention Services should ensure that all UKBA staff responsible for setting removal directions for detainees are aware of the need to make appropriate escorting arrangements at the earliest opportunity

The Director of UKBA Detention Services should ensure that fit to fly assessments are completed quickly.

Hospital/ lack of monitoring

121. On 16 July, during a consultation with the locum GP at Harmondsworth, the man complained of piercing chest and rib pains during the night, and that he thought he would have a heart attack.

122. The man's blood pressure was taken on three occasions that day, the first reading showing 191/118. As a result of the man's dangerously high blood pressure, the locum GP at Harmondsworth referred him to Hillingdon Hospital. The man was taken by escort to the accident and emergency department that afternoon. The case referral fax showed that at the time of referral the man's blood pressure had increased, now showing a reading of 240/143. It is unclear what time the man saw the GP, or at what time his blood pressure was taken as the GP failed to note this in his medical record.

123. When he returned from hospital, the man was located in healthcare. The locum GP at Harmondsworth visited the man the next morning. At interview, the GP said that no discharge note was received from the hospital, nor did he make any attempt to obtain one. The investigator has since seen a copy of the discharge paperwork, as this was provided to Colnbrook on the evening of the man's transfer. However, it is unclear when this arrived at Harmondsworth, or if the information was reviewed by anyone from healthcare, as it was not date stamped. In response to this, we make the following recommendation,

The Head of Healthcare at Harmondsworth should ensure that a robust, auditable system is adopted to draw to the attention of relevant clinicians all appropriate letters and other external documents, and that these are dated and their receipt recorded.

124. The locum GP at Harmondsworth also confirmed that antihypertensive medication was not prescribed on the grounds that "he [the man] would have refused to take it". However, it was noted in the medical notes that he had requested painkillers from the GP that morning for a pain in his ribs. It appears that painkillers were not prescribed. Clinical reviewer A commented that the GP "should have been more proactive given the gravity of his patient's condition", and that he

> "should have prescribed appropriate antihypertensive medication whether or not the patient was accepting it. This would at least have ensured that the man was at least offered medication on a daily basis and would have triggered closer follow up of his serious condition".

125. The same day, the man asked to be discharged back to his own wing. He refused to have his blood pressure checked; promising staff that he would get it checked the next day, this being 18 July. At interview, the locum GP at Harmondsworth commented that he was always chaperoned by a healthcare assistant, who would record any test or follow-up requests made during the consultation, before handing these over to colleagues for action. However, the GP made a note in the man's medical record prior to his discharge back to his wing to say, "Promises to check BP checked tomorrow. To observe any deterioration in health". In the event, he failed to do so. It is not clear who was supposed to ensure that this blood pressure check was done. In response to this we make the following recommendation:

The Head of Healthcare at Harmondsworth should ensure that there is a robust handover procedure which provides continuity of care across the healthcare team.

126. On 24 July, the man was placed on 'rule 40' (removal from association) and taken to Dove Wing, the care and separation unit (CASU). Two days later, due to inappropriate behaviour, he was placed on 'rule 42', meaning he was placed in segregation. Detainees on rule 40 and 42 are accommodated on the same wing, the only difference being whether their room door is locked or not. The

clinical reviewer commented that, despite the man's previous medical history, "there is no medical record of any assessment of his fitness for segregation".

127. All detainees in segregation must be seen by a doctor on a daily basis. On 26 July, the locum GP at Harmondsworth recorded in the man's medical notes, "refused to see me". The man again refused to be seen the following day.

128. The locum GP at Harmondsworth said at interview that he explained to the man the importance of having his blood pressure checked. However, there is no such record of any conversation in the man's medical notes. We make the following recommendation:

The Head of Healthcare at Harmondsworth should ensure that staff make a timed, accurate record of any meaningful contacts with detainees

129. After reviewing the care the man received, clinical reviewer B commented that "Attempts should be made to appoint a medical officer at Harmondsworth into a substantive role. Without prejudice to the locum GP at Harmondsworth, a regular member of medical staff could build links with staff and improve continuity of care, which at present is lacking"

Mental Health

130. When the man arrived at IO B's desk on 15 June, it was noted that his behaviour was 'abnormal', that he would not maintain eye contact, and was on occasion aggressive when questioned. When his bags were searched, on examination his luggage was found to consist of a small cardboard box containing a coat and a silver cut throat razor.

131. Later that morning, an officer from Homeland Security came over to Terminal One to speak to the man. The American officer spoke to the man about his removal from the UK. The man told him that he did not believe he was an 'American' and turned his back on him.

132. Clinical reviewer B, commented that,

> "It seems unusual for a US citizen to arrive at Heathrow with only cash and a cut throat razor. Given the odd effect and social interaction at airport immigration, in my opinion there are already grounds for considering whether he may have some form of mental disorder".

133. The man was later taken to Harmondsworth to be detained overnight. During the reception health screen, Nurse A noted he did not suffer with high blood pressure or mental health problems. He confirmed that he was not taking at kind of medication at present.

134. It has since come to light that during this reception health screen, the man did not give a full account of his medical history. The man's mother informed the family liaison officer, that he had been diagnosed with paranoid schizophrenia, and was taking medication for this.

135. On 4 July, the man called HCCU (Heathrow Central Casework Unit) to say that he no longer wished to claim asylum. He said that he would leave the UK, but would not return to America, saying he would go 'elsewhere'. CIO C made a note in the man's immigration file the next day to say that, "although not documented as having any psychiatric condition, pax [passenger] does give the impression of not being completely rational in his thinking". The CIO spoke to Harmondsworth about his concerns, asking for a fit to fly assessment.

136. On 11 July, the man attended the library. A note was made in his wing history sheet by DCO D to say "the man came into Library 2 this morning and his manner seemed very odd, he didn't seem with it somehow and kept muttering to himself". Clinical reviewer B commented in his clinical review that "this account may represent the first evidence of a relapsing mental state since his detention at Harmondsworth".

137. In the early hours of 16 July, the man kept pressing the intercom in his room shouting that he needed to come out for fresh air. After the man complained of feeling 'itchy' and claustrophobic, DCO E allowed the man to come out of his room for a few minutes. He sat down on a chair and then immediately got up and went back into his room.

138. DCO E was concerned about the man's odd behaviour, and asked Nurse A who was working the night shift to come and see him. At interview, the DCO explained that this was not the first time he had observed odd behaviour. He commented that he had previously witnessed the man place a piece of clothing on his head and wearing it like a turban.

139. When Nurse A arrived, the man refused to let either DCO E or her enter his room, accusing her of being a nun, asking what her religious status was. The nurse explained at interview that on reception she had no concerns for his physical or mental health. However, when she was asked to see him that morning, "from my observations and my experience…" she was concerned that he may have a mental health problem. She explained her concerns during her handover to the day staff that morning, suggesting that he should be seen by the doctor that day.

140. The man was seen by the locum GP at Harmondsworth later that day. During the consultation, the man complained of chest pains in the night, saying that he chose to control his blood pressure by 'spiritual means'. The GP found the man's blood pressure to be dangerously high, and as a result of this he was sent to outside hospital. Later that afternoon, after refusing treatment the man discharged himself from hospital against medical advice. Clinical reviewer B commented in his review that,

> "In England there is an assumption of capacity; an adult has the right to make (even detrimental) decisions about his own life, whether or not the reason for that choice is irrational, unknown or non-existent. Under the Mental Capacity Act 2005, a person lacks capacity if he is unable to make a decision for himself … because of an impairment of or a

> disturbance in the functioning of the mind or brain. The ability to make a decision rests on understanding the information relevant to the decision, retaining it, using or weighing that information as part of the process of making the decision, and communicating the decision. The clinicians involved [at Hillingdon Hospital] were unaware of the possibility of impairment in the functioning of BD's [The man's] mind or brain. No criticism attaches to this".

141. Hospital staff explained the dangers of discharging himself with untreated hypertension, and determined that he had capacity to decline treatment. The clinical reviewer B commented that

> "The relationship here between the clinician and BD [the man] was governed by common Law, namely that treatment without consent would constitute battery. If they had been aware of the full picture they may have been grounds to consider a psychiatric opinion…and may have cast further light on the reasons for his refusal to accept treatment and how he weighed the information as part of the process of making his decision".

142. The next day, the man was discharged back to his own wing later that day, this being 17 July. Despite being aware that the man had self discharged from hospital with a potentially fatal condition, no mental state or capacity assessment was recorded by the locum GP at Harmondsworth prior to allowing him to return to the wing. Anti-hypertensives were not prescribed, as he believed he would not take them. At interview the GP confirmed that whilst he understood the principles of capacity, he had not heard of the Mental Capacity Act.

143. This is of concern. Clinical reviewer B commented that the man's psychiatric condition deteriorated from this point, with the emergence of behavioural problems, abuse and threatening behaviour. He said that, "This is likely to have been symptoms of schizophrenia. It was not conceptualised as such". In addition to this he explained that "prescriptions should be made on the basis of need and not the anticipated concordance with it". If medication is refused, the reasons for this should be explored by healthcare staff, and "a review of a patient's capacity should be triggered in such circumstances". He recommends that "Staff should receive teaching and training to understand the Mental Capacity Act, and that the locum GP at Harmondsworth needs to attend similar training and address this issue urgently as part of his 'continuing professional development' programme". In response to this we make the following recommendation:

The Head of Healthcare at Harmondsworth should ensure that all medical staff, including locum GPs, are up to date with mental health awareness and mental capacity legislation.

144. On 24 July, two entries were made in the man's wing history sheet, the first being by DCO F who noted his 'strange' behaviour, saying that he was "whispering and muttering to himself". The second entry related to the man

vandalising the TV in his room becoming “rude and incoherent”, and being racist to staff regardless of their colour. The man was placed on ‘rule 40’ (removal from association) and taken to Dove Wing, the care and separation unit (CASU). He was moved to CASU “for his own protection”.

145. The same day, a member of the IMB, visited the man. She made a note of her meeting, and the investigator was provided with a copy to assist in her investigation. In these notes she commented that she had heard about the man by reputation, recalling being told that he was too disruptive to have around other detainees. She recalls being told that Harmondsworth were planning on moving the man as soon as possible, giving her (the member of the IMB) the impression that there was hostility towards him by staff.

146. On 26 July, after continually being racist and abusive towards staff, and being found urinating on the floor of his room, he was placed on ‘rule 42’, or segregation. All detainees who are placed into segregation have to be seen by the doctor once a day. The man refused to see the locum GP at Harmondsworth.

147. Clinical reviewer B, commented that

> “A review of the non-medical records from 18 July indicates a significant change in BD’s [the man] behaviour. Over this eight day period he has been noted to be rude, aggressive and incoherent. He made implied threats to staff and has been openly racist and sexist in his abuse of others. He was noted to have strange and bizarre behaviour.... muttering to himself and accused staff of looking at him like he was an idiot. The locum GP at Harmondsworth’s assessment on 26 July does not reference his apparent deterioration. It appears that there was no consideration given to why his behaviour had changed and why he was now causing unrest to other detainees. In my opinion there were clear grounds by this point to consider a psychiatric assessment with a view to a transfer for an inpatient assessment”.

148. An entry was made in the man’s wing history sheet on the morning of 27 July. The entry was made to say “shows very bizarre behaviour”. The locum GP at Harmondsworth visited the unit later that day to visit all of those currently on segregation. The man again refused to be seen. Despite the events detailed above, and the man’s continued refusal to be examined, no mental health assessment was considered. The clinical reviewer B commented in his review that, “it is clear at this stage that there were significant concerns relating to BD’s [the man’s] behaviour and there was a clear plan to move his care elsewhere”.

149. The in 2009 the independent Bradley Report provided a detailed a review of people with mental health problems or learning disabilities in the criminal justice system, which appears equally relevant to those in immigration detention. In particular, the review examined the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services and the barriers to such diversion.

150. Clinical reviewer B commented in his clinical review that Lord Bradley recommended as part of his report that 'awareness training on mental health and learning disabilities must be made available to all prison officers'. The clinical reviewer B said that, "My impression of Harmondsworth is that there was a lack of awareness of how mental illness may present and there was an inability to see problem behaviours stemming from abnormal mental states". The man's schizophrenia and deterioration at Harmondsworth went largely unnoticed. The clinical reviewer B commented that, "Though the Bradley Report does not focus on staff at immigration removal centres (IRCs), I note that IRC's similarly vulnerable and dispossessed populations with high rates of mental disorder, and the same recommendation should apply".

151. Clinical reviewer A also commented that detention custody officers should receive further mental health awareness training in addition to ACDT (suicide and self-harm awareness) training. He said that "the deterioration in the man's mental state could have been brought to the attention of mental health staff earlier had the informal concerns of several DCOs been expressed with confidence". In response to this, we make the following recommendation:

The GEO Contract Director at Harmondsworth should ensure that all staff who are in direct contact with detainees receive further mental health awareness training, in addition to ACDT training.

152. After Harmondsworth agreed a head-to-head swap, the man was transferred to Colnbrook on 27 July. The UKBA deputy manager arranged the swap, and in an email to the investigator confirmed that the move was requested by GEO staff (the company contracted to run Harmondsworth). She said that she was unaware of any medical issues preventing the transfer. Clinical reviewer B commented that "it appears that there was a breakdown in communication between management and medical staff leading to a decision to transfer a detainee without medical oversight and with no medical records. This was unacceptable". In response to this, we make the following recommendation:

The Contract Directors at Harmondsworth (GEO) and Colnbrook (SERCO) should ensure that detainees are not transferred without their medical needs being taken into account, and that their medical records accompany detainees during transfers

153. During the man's reception health screen at Colnbrook, the nurse made a note to say that he was "very odd and peculiar in [his] demeanour". At interview the nurse commented that on arrival he recalled the man being dishevelled, odd in appearance, arriving with only one shoe. The man told the nurse that he had a history of hypertension (high blood pressure), but then refused to have it checked. After being seen by the mental health nurse the next day, a referral was made for the man to be seen for a full psychiatric assessment. The clinical reviewer B commented that

> "The assessment of BD [the man] at Colnbrook is in contrast to the management at Harmondworth. Over the first two days, despite not

having medical records other then the assessment at A&E, they had a high index of suspicion of mental illness, referred him for a psychiatric assessment and completed paperwork stopping his movement to normal location. This was an appropriate intervention made by staff at Colnbrook. The assessments made by [nurse] on the man's reception health screen and the mental health nurse were prompt and examples of good practice".

154. Clinical A commented that Immigration Removal Centres would benefit from a continuous, transferable, computerised medical record as is now available in almost every other Primary Care environment. A continuous medical record might have led to increased concern earlier in the progress of the man's mental deterioration. This would also have been assistance to staff when the man transferred from Harmondsworth to Colnbrook, as discussed in the next paragraph. In response to this we make the following recommendation:

The Director of UKBA Detention Services should ensure that an electronic medical record system is introduced by healthcare providers in every immigration removal centre

The man's transfer from Harmondsworth to Colnbrook

155. On 24 July, the UKBA deputy manager emailed the UKBA Centre Manager at Colnbrook, asking if they would consider doing a head-to-head swap. The UKBA deputy manager explained to the investigator that GEO had requested the move, as they had concerns about the man's non-compliant behaviour. She explained that head-to-head swaps were normally agreed to allow staff to have respite, and to give difficult detainees a fresh start in a new place.

156. The man's head to head swap with another detainee was agreed on 27 July at 1.12pm, when the UKBA centre manager sent an email to the UKBA deputy manager confirming that she would ask SERCO staff if they could facilitate the transfer. At 9.50pm, that evening the man was collected from Harmondsworth by SERCO escorts.

157. The HMCIP report of August 2010, recommended that "detainees should not be subjected to avoidable night-time transfers around the detention estate". The original agreement for the head to head swap was sent by the UKBA centre manager at 1.12pm. However, the man was not moved until 9.50pm. This meant that he arrived at Colnbrook late in the day and still had to go through the reception procedures before being allocated a room. There appears no reason why this move to a neighbouring establishment could not have been completed much earlier. We therefore make the following recommendation.

The Director of UKBA Detention Services should ensure that detainees are not subjected to avoidable night time moves around the immigration estate

158. The man was transferred from Harmondsworth to Colnbrook on 27 July. Prior to the transfer, Colnbrook were unaware of the man's recent hospital

admission, and current state of health. In addition to this, he arrived without his medical records. When the investigator asked why Colnbrook were not made aware of the man's recent hospital admission, the UKBA Deputy Manager said,

> "Our office [UKBA] is not routinely made aware of any medical in-confidence issues when a detainee is returned from hospital and where hospital treatment may have been refused. I do not recall him [the man] being located in healthcare and do not recall ever being made aware of any significant issues which may prevent a transfer to another location".

159. The UKBA Deputy Manager also commented that she was unaware of the issue with the man's medical records, explaining that detainee medical records should be prepared in advance of any known transfer as per the GEO contract.

160. When the nurse who did the health screening was interviewed he commented that a detainee arriving without medical records was a problem. He said that when he telephoned healthcare at Harmondsworth to enquire about the man's missing medical notes, he was advised by the nurse on duty that they were unaware that the man had been transferred. The nurse said that someone in segregation would be visited everyday by the onsite doctor, and therefore healthcare staff should be aware of any intended transfer.

161. Roughly one hour after the man arrived at Colnbrook, the nurse phoned Harmondsworth healthcare asking them to fax over the man's healthcare records. Harmondsworth did not send the records, although they did fax the discharge letter from Hillingdon Hospital. If SERCO had been made aware of the man's previous hospital admission, they could have been made aware that his medical records were missing and made arrangements for them to be collected or sent over. In response to this we make the following recommendation:

The Director of UKBA Detention Services should ensure that healthcare staff are made aware of all transfers at the earliest opportunity allowing them to prepare detainees' medical records for transfer.

Medical response

162. On the day the man died he was seen by DCO A at approximately 7.30am when she took his breakfast pack to him. Although he did not speak to her, he was alive at this time. At 8.28am, DCO B observed the man through the viewing panel of his door, and noted on the observation sheet outside his room "appears asleep". She recalled at interview that he was sitting on his bed with his back towards the wall, with his knees slightly bent. She explained that she had seen him in this position previously so was not concerned.

163. At 9.27am, DCO C checked on the man. She recorded that he was sat on his bed in a slumped position. A medical response was called over the radio at 9.28am with an ambulance being called three minutes later. Cardiopulmonary

resuscitation (CPR) was commenced immediately and continued until 10.15am when he was pronounced dead.

164. It appears that initial attempts at CPR were conducted on the man's bed. The duty manager commented in his SERCO statement that "I instructed the team to commence CPR which they did. However, they commenced [this] on the bed so I suggested that we moved the man to the floor". Clinical reviewer A commented that, after inspection of the beds at Colnbrook, he found this to be "satisfactory because the bed base was solid and the mattress thin. I have inspected similar beds in Colnbrook. It would be normal practice to place the unresponsive patient on the floor for CPR if the bed was soft as CPR would otherwise be ineffective".

165. In a previous death in custody investigation at Colnbrook, the defibrillator was not brought by healthcare staff when the emergency response was called. It is pleasing to see that when the emergency response was called on this occasion the defibrillator was brought to the scene. Clinical reviewer A commented that, "Attempts at resuscitation were timely and appropriate".

The man's location whilst at Colnbrook

166. The man was transferred to Colnbrook on 27 July. After concerns were raised during the reception health screen, he was seen by mental health nurse for a mental health assessment the next day.

167. After the mental health nurse reviewed the man, he completed immigration form IS91RA Part C. On this form the nurse wrote, "The man was admitted from segregation unit in H/worth [Harmondsworth]. He is believed to be sexist and will not engage with mental health service. Until he is fully assessed by the Psychiatrist, he is "unfit for normal location". In response to the nurse's recommendation, the man remained in the short term holding facility. The actions taken by the nurse were appropriate and should be noted as good practice.

168. The man was deemed by staff to be racist and sexist. However, despite this, whilst watching CCTV footage the investigator viewed a black woman being escorted from the room directly opposite to that of the man's, this being room 20. The most recent published report by HMIP made a recommendation that: "The short-term holding [STHF] facility should not hold women". Since this report was published, Colnbrook has opened 'Rose Unit', a unit specifically for female detainees. The investigator contacted the SERCO investigator asking why, despite Rose Unit being open, this lady was placed opposite the man, enquiring if a risk assessment was conducted prior to her being placed in the short term holding facility. The SERCO investigator explained that, "Rose Unit was closed down as we had insufficient staff on the night shift in question". He commented that no risk assessment was conducted prior to the females from Rose Unit being moved, "as they are not sharing rooms…. And females do not associate with males; hence there was no issue to house the black female opposite a racist or sexist".

169. The SERCO investigator confirmed that the residents in the STHF were allowed an hour of fresh air in the morning and afternoon, with 'down time' at 12.45 and 5.45pm for a further hour. The room movements for the female in question show that on this occasion she only remained in STHF for one night. He commented that the man would not have been aware who was in the room opposite him. However, when the investigator attended Colnbrook as part of her investigation, she visited the STHF. She noticed that a card had been placed next to the door of room 20, advising staff to be considerate, making them aware that a female was in that room. Despite the SERCO investigator's assurances that a risk assessment was not necessary, one clearly should have been done. In response to this we make the following recommendation:

The Contract Director at Colnbrook should ensure that, if it is unavoidable that female detainees have to be relocated from Rose Unit to a different location, risk assessments are conducted to ensure their safety and wellbeing

Consular Contact

170. Immigration Directorate Instructions (IDI) Chapter 31 section 1(17), Detention and Detention Policy in Port Cases - Notification of detention to Consulates and High Commissions states that,

> "When a person is likely to be detained for more than 24 hours he should be asked if he wishes his High Commission or Consul to be notified of his detention. If he does Immigration form IS94 should be sent by first class post to the appropriate representative of the High Commission or Consulate".

171. In addition to this, the UK has a bilateral consular convention relating to detention with a number of countries, one of these being the USA. This convention imposes an obligation on detaining authorities to notify the consular representative of a detainee even if the detainee has not requested this.

172. The man claimed asylum on 16 June, two days after his arrival into the UK. We understand that current instructions are that a person's High Commission or Consulate should not be informed of a person's asylum application. However, he was detained for a total of 48 days, and withdrew his asylum application on 4 July. He died on 31 July, and prior to his death he was not asked if he wished the American Embassy to be informed of his detention. UKBA staff also did not contact the US Embassy as per IDI Chapter 31 (section 1(17)). We, therefore, make the following recommendations:

Heads of Casework at Terminal One and Heathrow Central Casework Unit should ensure that, when a person is likely to be detained for more than 24 hours, staff ask them if they wish their High Commission or Consulate to be notified of their detention.

Heads of Casework at Terminal One and Heathrow Central Casework Unit should ensure that if the detainee is from a country covered by the

bilateral consular convention, staff should notify the consular representative even if the detainee has not requested this.

CONCLUSION

173. The man arrived into the UK on 14 June 2011. The man's mother has confirmed that at this time he was undergoing treatment for schizophrenia and high blood pressure. It is unclear if the man was taking his prescribed medication at this time.

174. After being found with dangerously high blood pressure on 16 July, the locum GP at Harmondsworth referred him to hospital in a timely fashion as per NICE guidelines (National Institute for Health and Clinical Excellence) 'dealing with patients with accelerated (malignant) hypertension'. However, after he discharged himself no efforts were made to obtain copy of his discharge information, informing healthcare staff what had occurred whilst in hospital. In addition to this, the GP failed to prescribe anti-hypertensive medication, believing that he would not take it. It was noted by clinical reviewer B that the man's psychiatric condition deteriorated from this point with the emergence of behavioural problems, abuse and threatening behaviour which were "..likely to have been symptoms of schizophrenia". Due to an evident lack of mental health awareness, staff at Harmondsworth failed to look beyond the man's bad behaviour and did not address the root cause of the problem.

175. The man was transferred from Harmondsworth to Colnbrook on 27 July, apparently to provide staff with respite from him. He was moved without medical records or advice about his previous hospital admission, although his dishevelled appearance did lead staff at Colnbrook to make a mental health referral. The man died four days later. The preliminary post-mortem report showed a cause of death as 'ruptured dissection of the thoracic aorta', this being a possible complication caused by untreated hypertension. Clinical reviewer A commented that:

> "I do not believe that the man's death could have been prevented as his refusal to accept treatment for his blood pressure would have been difficult to manage in the necessary timescale whether or not he retained mental capacity, and whether or not he had been transferred to a mental health facility. While I am not an expert in vascular medicine, it seems likely that the stated five year history of hypertension is relevant in the development of the fatal aneurysm".

176. Arrangements for the man's removal were not expeditious and he spent some 6 weeks in detention. Clinical reviewer B concluded that "It remains matter for speculation to what extent his blood pressure was worsened by his unfortunately long detention".

RECOMMENDATIONS

To the Director of UKBA Detention Services

1. The Director of UKBA Detention Services should ensure that all UKBA staff responsible for setting removal directions for detainees are aware of the need to make appropriate escorting arrangements at the earliest opportunity.

   Deputy Director, Head of Detention Operations (UKBA) has accepted this recommendation.

2. The Director of UKBA Detention Services should ensure that fit to fly assessments are completed quickly.

   Deputy Director, Head of Detention Operations (UKBA) has accepted this recommendation.

3. The Director of UKBA Detention Services should ensure that an electronic medical record system is introduced by healthcare providers in every immigration removal centre.

   Not Accepted. UKBA commented, We would like to be in a position to implement such a system however there are logistical and resource constraints but we will work with the Department of Health, now that it has started to take responsibility for healthcare commissioning from us, to identify whether this can be taken forward.

4. The Director of UKBA Detention Services should ensure that detainees are not subjected to avoidable night time moves around the immigration estate.

   Deputy Director, Head of Detention Operations (UKBA) has accepted this recommendation.

5. The Director of UKBA Detention Services should ensure that healthcare staff are made aware of all transfers at the earliest opportunity allowing them to prepare detainees' medical records for transfer.

   Deputy Director, Head of Detention Operations (UKBA) has accepted this recommendation.

Harmondsworth

1. The Head of Healthcare at Harmondsworth should ensure that a robust, auditable system is adopted to draw to the attention of relevant clinicians all appropriate letters and other external documents, and that these are dated and their receipt recorded.

   GEO responded with,

All correspondence received relating to a detainee is married up with their medical file, stamped with the date of receipt and presented to the GP. The GP then has to sign that they have seen the report by signing it and recording any recommendations on the document i.e. file further review etc.

2. The Head of Healthcare at Harmondsworth should ensure that there is a robust handover procedure which provides continuity of care across the healthcare team.

   GEO responded with,

   The names of the staff taking the handover will be named on the handover document to acknowledge that they were present at the handover and understood the content. Handovers take place at each shift change in order to up date staff on any detainees causing concern

   Target date for completion 1 June 2012

3. The Head of Healthcare at Harmondsworth should ensure that staff make a timed, accurate record of any meaningful contacts with detainees.

   GEO responded with,

   Each clinician/member of staff will be audited on a rolling programme The audit is set against a set of standards used by Primecare though out the secure estate. Training on documentation which complies with GMC/NMC and Primecare standards will be delivered to all staff.

   Target date for completion 1 July 2012.

4. The Head of Healthcare at Harmondsworth should ensure that all medical staff, including locum GPs, are up to date with mental health awareness and mental capacity legislation.

   GEO responded with,

   All clinicians will have the e learning package devised by the Training and Governance and Quality Team within Primecare made available to them The GP's will also be given the opportunity along with permanent staff to attend the same training which will be delivered face to face.

   Target date for completion 1 September 2012

5. The GEO Contract Director at Harmondsworth should ensure that all staff who are in direct contact with detainees receive further mental health awareness training, in addition to ACDT training.

   GEO responded with,

We are in consultation with providers to decide on the most effective way to deliver this training to all staff

Programme to be commenced by 01/07/2012

6. The Contract Directors at Harmondsworth (GEO) and Colnbrook (SERCO) should ensure that detainees are not transferred without their medical needs being taken into account, and that their medical records accompany detainees during transfers.

   GEO responded with,

   Healthcare to Healthcare handovers will be put in place for any transferring detainee with complex medical needs. Medical Records are now copied and sent with the detainee when they leave the centre. Escorting and Reception staff check and sign the escorting paperwork to reflect the presence/absence of medical records. Any absences are addressed at the time.

   Target date for completion 1 June 2012.

Colnbrook

1. The Contract Directors of Harmondsworth (GEO) and Colnbrook (SERCO) should ensure that detainees are not transferred without their medical needs being taken into account, and that their medical records accompany detainees during transfers.

   SERCO have accepted this recommendation. A letter has been sent out by Head of Operations, UKBA Detention Services in August 2011 reminding staff that "is essential that all documents accompany detainees when they transfer to ensure that the receiving centre are aware of all known risks and medical conditions".

2. The Contract Director at Colnbrook should ensure that, if it is unavoidable that female detainees have to be relocated from Rose Unit to a different location, risk assessments are conducted to ensure their safety and wellbeing

   SERCO have accepted this recommendation commenting that, to address this there is a standing risk assessment that in the event of a requirement to locate female residents in any location other than the Rose unit, all male residents will be relocated from the immediate area to ensure privacy and decency. In effect this means if we need to locate in the STHF, the corridor used will be isolated and only female residents located there.

UKBA

1. Heads of Casework at Terminal One and Heathrow Central Casework Unit should ensure that, when a person is likely to be detained for more than 24 hours, staff ask them if they wish their High Commission or Consulate to be notified of their detention.

   Deputy Director, Head of Detention Operations (UKBA) has accepted this recommendation.

2. Heads of Casework at Terminal One and Heathrow Central Casework Unit should ensure that if the detainee is from a country covered by the bilateral consular convention, staff should notify the consular representative even if the detainee has not requested this.

   Deputy Director, Head of Detention Operations (UKBA) has accepted this recommendation.