

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in July 2013 at  
Pennine House Short Term Holding Centre,  
Manchester Airport**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man at Pennine House, an immigration short term holding centre on 26 July 2013. He was 43 years old. A post-mortem report indicated that the man died from ischaemic heart disease. I offer my condolences to his family and friends.

The investigation was carried out by the investigator and a clinical reviewer reviewed The man's clinical care at the centre. Staff at Pennine House cooperated fully with the investigation.

On 20 July 2013, the man, a citizen of Pakistan, was detained at Pennine House immigration short term holding centre as he had overstayed his leave to remain in the country. There was no indication that the man had any health problems when he arrived. The man was due to return to Pakistan on 28 July. However, on 26 July, he reported having pains in his shoulders and chest and a nurse examined him and took clinical observations. Initially, his blood pressure and pulse rate were low, but these quickly returned to normal and the nurse advised the man to rest in his room. Shortly afterwards, the man's roommate became concerned that his breathing was laboured and called for help. The man then became unconscious. Sadly, the centre staff and paramedics were unable to resuscitate him and he died.

While the man's death appears to have been sudden and unexpected, there are some lessons to be learnt from this sad event. The man spoke very little English and I am concerned that a professional interpretation service was not used to help obtain a medical history when he arrived or when he reported feeling unwell. The clinical assessment shortly before his death was not appropriately recorded, his case was not discussed with a GP and neither was a referral to hospital considered. The emergency response was poorly coordinated and an ambulance was not called immediately as it should have been. I am also concerned that initial contact with the man's family was not handled as sensitively as it should have been.

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**

**June 2014**

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## SUMMARY

1. The man, a citizen of Pakistan, came to the United Kingdom on 13 May 2006 and was granted permission to stay until 1 April 2007. The man did not return to Pakistan and remained in the United Kingdom illegally.
2. On 20 July 2013, the man was arrested at his home in Manchester, served with detention papers and given notice that he would be returned to Pakistan. The man told the immigration officers that he did not speak any English.
3. Later that day, the man was taken to Pennine House, a short term holding centre at Manchester Airport, to await removal from the country. The man told the nurse who carried out a reception health screen that he spoke Urdu and a little English. The nurse did not use an interpreter. The man told the nurse that he had been prescribed a vitamin D supplement by his GP which he had not taken for a while but otherwise he had no current health concerns.
4. Shortly after 3.00pm on 26 July, the man went to see the nurse as he felt unwell and had pain and discomfort in his shoulders. The nurse did not use an interpreter. The nurse checked the man's blood pressure and pulse rate, which were low. She asked the man to lie down on the examination couch and raise his legs and gave him two paracetamol tablets. Shortly afterwards, she checked his blood pressure again and found it was within the normal range. The man said he felt better and the nurse advised him to lie down in his room and rest and she would check him later. She did not consult a GP or consider that he needed to go to hospital.
5. At about 4.15pm, the man's room mate became concerned that the man was not breathing properly and called a custody officer. The officer found the man sitting up on his bed, propped against the wall and unresponsive. He immediately called the nurse and other staff to help. The nurse arrived quickly but she did not bring medical emergency equipment as she was unaware of the nature of the incident. After she examined him, she found that the man was not breathing. An ambulance was called and an officer began cardiopulmonary resuscitation. Paramedics took over the resuscitation attempts when they arrived at 4.26pm, but declared the man dead at 5.30pm.
6. The investigation found that interpreting services were not used when they should have been at Pennine House. This was particularly important during a nurse's examination on the day the man died and we cannot be certain that an accurate account of the man's symptoms was obtained. The nurse did not seek further advice from a doctor and the man's medical record was not updated appropriately after the consultation. Because there was confusion about the nature of the emergency, an ambulance was not called as quickly as it should have been. Staff at Pennine House did not have any next of kin details for the man. When the man died, staff at Pennine House asked an employee from Manchester Airport to inform his family by telephone which was contrary to guidance and an inappropriate way of informing the man's family of his death.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and detainees at Pennine House about the investigation and asking anyone with relevant information to contact him. No one responded.
8. NHS England appointed a clinical reviewer to review the man's clinical care at Pennine House.
9. The investigator visited Pennine House on 1 August and obtained copies of the man's records. Greater Manchester Police conducted a criminal investigation into the circumstances surrounding the man's death and the PPO investigation was suspended until 8 October 2013 while this investigation took place. We regret the consequent delay in issuing this report. The police shared relevant interview statements with the investigator and the investigator interviewed ten members of staff at Pennine House.
10. HM Coroner for Manchester was informed of the investigation and provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.
11. One of the Ombudsman's family liaison officers, contacted the man's family and explained the investigation process.
  - The man's sister-in-law asked what happened between 3.00pm and 5:30pm, and asked why an ambulance had not been called earlier.
  - The man's brother-in-law gave the family liaison officer information about his last phone call with him. He said that the man spoke very little English and he had interpreted for the nurse by telephone when she had assessed the man on the day he died. He asked whether there was a professional interpretation service for staff.
12. The man's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. They pointed out one omission that has been added to paragraph 36.

## **PENNINE HOUSE SHORT TERM HOLDING CENTRE**

13. Pennine House is a short-term holding facility near Terminal Two at Manchester Airport. It is run by a private contractor, Tascor, on behalf of the Home Office. The facility is one of only two residential short term holding facilities in the immigration estate and holds up to 32 adult foreign nationals subject to immigration control against whom the Home Office is taking enforcement action. On the ground floor, there is a reception area with a medical room. Upstairs, there is a single corridor of bedrooms.
14. The average stay of a detainee at Pennine House is around three days and detainees are not expected to stay longer than seven nights. Staff can use a professional telephone interpretation service. There are welfare checks every hour and all staff carry radios, are first aid trained and carry resuscitation aids on their belts.
15. Tascor Medical Services provide a 24 hour nursing service staffed by a registered general nurse. There are no GPs, but a doctor can be consulted by telephone. There is no electronic medical recording system. All detainees receive a health screening to ensure they are fit to be detained in the facility.
16. There have been no previous deaths at Pennine House.

### **Her Majesty's Inspectorate of Prisons**

17. Her Majesty's Inspectorate of Prisons last inspected Pennine House in May 2013. Inspectors found that the telephone interpretation service was not always used when it was required.

### **Independent Monitoring Board**

18. Each immigration holding or detention facility has an Independent Monitoring Board of unpaid volunteers from the local community who help to ensure that detainees are treated fairly and decently. In its most recent report, for 2012, the North and Midlands Independent Monitoring Board commented that its main concern was the limited nature of the reception area and the impact this had on staff, detainees and visitors.

## KEY EVENTS

19. The man was a citizen of Pakistan and had been born there in 1970. He arrived in the United Kingdom on 13 May 2006 with a work permit valid until 1 April 2007. On 27 September 2007, he applied to extend his stay. The application was refused with no right of appeal. The man did not leave the UK and continued to live and work here.
20. On 20 March 2013, the immigration authorities received information about the man and at 8.00am on Saturday 20 July, immigration enforcement officers arrested the man at his home in Manchester. He was served with immigration enforcement papers stating that he had overstayed in the UK. He was taken to an immigration office at Dallas Court, in Salford. The man told the officers that he was fit and well.
21. At 9.00am, an immigration officer, and an assistant immigration officer, interviewed the man. The assistant immigration officer later told the police that they had used an Urdu interpreter from a telephone interpretation service. The man did not appear distressed and was quiet and compliant. He said that he lived with his two brother-in-laws in the UK, and his wife and children lived in Pakistan. He said that he had not gone back to Pakistan because he had lost his passport but was now willing to buy his own flight ticket home. He said that he had experienced pains in his arms, legs and chest for the previous four years for which his GP had prescribed vitamin D tablets, which he had finished, but otherwise he was fit and well.
22. The immigration officer recorded on the IS91 form (the authority to detain someone under the Immigration Act 1971) that the man had no physical or mental health concerns but said that the man suffered from pains in his arms, legs and chests and that his GP had prescribed vitamin D tablets. (Some vitamin D tablets were found in his property.) The man was placed in a holding room to wait to be taken to Pennine House. A movement notification form was completed and given to the Tascor detention custody officers (DCO) who were responsible for escorting the man.
23. In his police statement, a custody officer, said that he had been at Dallas Court when the man arrived that morning, although he normally worked at Pennine House. The man had told him that he did not speak any English so the custody officer had explained to the man in Urdu what would happen when he was taken to Pennine House. The man was given something to eat and drink and made a telephone call. The custody officer then went back to Pennine House.
24. The man arrived at Pennine House at 3.30pm. A DCO greeted the man and received the IS91, IS276 (Immigration Detainee movement notification form) and Person Escort Record (PER<sup>1</sup>) from the escorting officer. The DCO said the man was calm and quiet and appeared to speak a little English. The custody officer told the reception duty officer that the man did not speak any English.
25. At 3.45pm, a nurse carried out a reception medical screen and recorded that the man spoke Urdu, although he said he spoke a little English. The nurse said in his police statement that the man spoke sufficient English for him to

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<sup>1</sup> PER -This is a form that accompanies detainees on all journeys from and between criminal justice agencies. It serves as a communication tool about risks a detainee poses on escort or transfer.

understand his questions. His blood pressure (146/90<sup>2</sup>), heart rate (90bpm<sup>3</sup>) and temperature (36.8 degrees<sup>4</sup>) were recorded on the assessment and were within the normal expected range.

26. The nurse noted that the man indicated that he did not have any drug, alcohol or mental health issues. He said that his GP had prescribed a vitamin supplement, but that he had not taken any for about six months. The nurse noted that the man was stressed, quiet and co-operative but was fit to be detained and for travel. The man's level of observation was recorded as hourly, the standard welfare check for detainees at Pennine House.
27. The reception duty officer completed the booking-in process and the custody officer offered to interpret for the man. The reception duty officer recorded on the PER that the man had seen the nurse, and there were no reported issues. He recorded in the man's Reception Report that he was Pakistani, spoke Urdu, was Muslim and required Halal food. The man was offered and made a telephone call at 4.05pm and received a welfare pack which included an information booklet (written in a number of different languages including Urdu) and toiletries. The man was given his mobile telephone. The officer did not ask the man for the details of his next of kin.
28. Another DCO then took the man upstairs to complete his induction. The DCO said that he had asked him if he could speak English to which the man nodded his head and mumbled. The DCO took this to mean that the man had some understanding of English and therefore did not think that he needed to use the telephone interpreting service. The DCO explained the regime at Pennine House to the man and showed him around. He said that the man frequently nodded his head but he did not speak. Another detainee then greeted the man in Urdu, and they appeared to know each other so the DCO asked him to act as an interpreter.
29. The DCO completed a detention information log sheet which is kept in the staff kitchen area and is used to maintain a record of meals offered to the detainee and any other key information about them. The DCO noted on the log that the man spoke Urdu.
30. Between 21 July and 26 July, no concerns were raised about the man. Another DCO told the investigator that he had met the man on 23 July. He described him as a quiet man who sometimes found it difficult to understand English. Other staff also described the man as quiet.
31. The man bought his own ticket to Pakistan, to depart from Manchester Airport on 28 July. In preparation for the man's departure to Pakistan, a nurse conducted a medical screen on 25 July. He noted that the man's temperature was 36.8C, his blood pressure 146/90 (slightly higher than the normal range) and that the man did not have any concerns about his health.

## 26 July 2013

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<sup>2</sup> Normal average blood pressure is considered as 120/80 for a healthy adult. Blood pressure can range from 120/70 to 140/90 depending on physical stress or time of day.

<sup>3</sup> The normal rate for an adult male is between 60 and 100 beats per minute.

<sup>4</sup> The average male body temperature is 37Celsius .

32. On 26 July, the man declined his breakfast but had lunch at 12.20pm. The DCO was in the dining area at around 3.05pm when another detainee, who was with the man, told him that the man was not feeling well. He said that the man had pains in his shoulders and both arms and needed to see the nurse. The man sat down at a dining room table and at one point rested his head on the table. The DCO contacted reception staff to tell them that the man wanted to see the nurse and he was asked to take the man down to see another nurse. The DCO said that the man looked weary but was able to go downstairs without any problem.
33. The nurse told the investigator that the man walked into the room without any help and told her that he was not feeling well. The nurse said that despite the man's limited English, he expressed himself well enough for her to understand him and she did not use an interpreter.
34. The nurse said that the man was not short of breath. He did not say he was in pain but touched both his shoulders and showed signs of discomfort. She observed him rub his right arm and he then indicated that his left arm was sore. He said that he had not had these symptoms before. The nurse made a note of the man's basic observations but did not record them or the time the observations were done in his medical record at the time. (The police later retrieved the measurements from the recording machines.) His blood pressure was 82/44 which was significantly low, his pulse was 50bpm which was low and his temperature was 36.6 degrees which is slightly lower than usual. As the man's blood pressure was low, she told him to lie down and elevate his legs on the couch. She checked that he had been eating and he said that he had had lunch. The nurse gave the man two paracetamol (500mgs) tablets and some water.
35. The nurse said the man spoke to someone in Urdu on his mobile telephone twice while she was examining him. (The police later established that the man had spoken to one of his brothers-in-law and said he was not feeling well.) The nurse told the investigator that she asked the caller if the man had had the pain before. There was a lot of noise in the background on the telephone and she did not get a response. She said she was concentrating on monitoring the man so she put the telephone down on the bed. A few minutes later, another of the man's brothers-in-law rang him. The nurse said she spoke to the man's brother-in-law on the phone, who said that the man had told him he was feeling better. The man's brother-in-law asked if the man could have more paracetamol later, and something to help him sleep. The nurse gave the man two Kalms herbal sleeping tablets. She told the investigator that she did not perceive that the man was in any pain.
36. The man's brother-in-law told us that the man had told him that his blood pressure was low and he had pains in his chest and was struggling to breath. The man's brother-in-law said he had explained this to the nurse, who asked if the man had any history of heart problems. The man's brother-in-law said that he had told the nurse that the man had been to see his GP who had said he had vitamin D deficiency. He did not know whether the GP had prescribed the man any other medication. The man told his brother-in-law that he was dying, was not comfortable at Pennine House, had not slept in two days and wanted something to help him sleep. He said that no one understood him at Pennine House.

37. The nurse said she checked the man's blood pressure and pulse rate again at 3.15pm. She did not record these observations in his medical record but wrote them on a piece of paper. At the time, the man's blood pressure was 142/94 and his pulse was 61bpm, which was in the normal range. He was not in discomfort when he raised his arm and told the nurse that he was feeling better. The man said that he felt okay to return to his room and left the medical room unaided.
38. A nurse told the DCO that the man's blood pressure had been low but had now returned to normal. She said that the man should go to his room and lie down and that she would see him later. (The nurse made a retrospective entry in the man's medical record about her examination later that evening at 7.00pm after he had died.) The DCO took the man upstairs just after 3.30pm, and told him to lie down. The man nodded, and went to the toilet first. The DCO updated the detention information log. He recorded that the man had been seen by the nurse and had pains in his arms. His blood pressure was "down" and he had been told to rest.
39. At 3.37pm, the man returned to his room from the toilet. A DCO, was in the kitchen preparing the evening meals and saw the man walk past. He said he called to the man to ask him if he wanted his evening meal, which is served around 5.00pm. The man gestured that he did not want anything.
40. Another resident shared a room with the man. He told the police that, at about 4.14pm, the man was lying in his bed talking to someone on his mobile phone (we do not know who he was talking to) when he started to breathe heavily. He became concerned and alerted the DCO, who was in the kitchen. The resident could not speak much English and beckoned to the DCO to follow him. The DCO locked the kitchen door and followed the resident.
41. The DCO went into their room and saw the man, who was sitting up on his bed with his back propped up against the wall. His eyes were fixed. The DCO could not get a response from the man and was unsure if he was breathing. He told the investigator that he radioed a "medical emergency", stating that a nurse was required immediately.
42. The officer in charge told the investigator that he responded to the DCO's radio request and arrived seconds later. He said that the man's forehead was beaded in sweat and his skin was warm. The officer in charge could not find a pulse so he also radioed to ask the nurse to attend.
43. The nurse responded to the first radio message and took the blood sugar and blood pressure recording machines with her. She arrived at 4.16pm. She said she did not take the emergency equipment bag as the radio message did not indicate it was an emergency.
44. The officer in charge radioed staff in reception and asked them to request the airport emergency paramedics to attend. The paramedics received the call at 4.19pm. The DCO ensured that all the other detainees were kept in the television room and then went to the man's room to assist his colleagues.
45. The nurse said that the man was unresponsive. The officer in charge, assisted by the DCO and another DCO, placed the man on his side. The officer in

charge told the investigator that the nurse was unable to find any signs of life, but the nurse said that, initially, the man was still breathing. She said that she found a pulse and measured his blood pressure as 179/139. However, she said that the man stopped breathing when he was placed on his side, so he was moved onto his back. The officer in charge then began cardiopulmonary resuscitation (CPR) using chest compressions. The nurse checked the man for signs of life intermittently, but did not find any.

46. Paramedics arrived at 4.26pm. They moved the man to the floor, assessed him and attached their defibrillator before continuing resuscitation. The officer in charge left the room to telephone the Tascor Control Centre Manager and the Acting Service Delivery Manager to inform them of the incident.
47. More paramedics arrived at Manchester Airport Terminal Two. The customer service officer at Manchester Airport took them to Pennine House where they arrived at 4.41pm. The paramedics were unable to resuscitate the man and confirmed his death at 5.30pm. They said that his death was likely to have been heart related. As he was a Muslim, the customer service officer asked the paramedics to cover the man and turn his head towards the right.
48. The officer in charge secured the man's room, contacted the police and the Independent Monitoring Board and updated the Tascor Operational Control Centre. The police arrived at 5.42pm. The Tascor Service Delivery Manager, arrived around 6.00pm followed by the Tascor Head of Overseas Operations and Specialist Operations at 6.25pm. A senior executive officer at the Home Office Detainee Escorting and Population Management Unit (DEPMU) in Manchester, was informed of the man's death.
49. A manager and the officer in charge told the other detainees about the man's death and offered support.
50. Around 7.45pm, two managers held a debrief meeting with all staff who were offered support through counselling services. The Manchester Airport Chaplain, the Reverend George Lane, spoke to staff individually.

### **Contact with the man's family**

51. A manager arrived at Pennine House for the start of her shift as duty manager at around 5.50pm. She tried to contact the man's family but found there were no details recorded of the man's next of kin. She contacted Dallas Court and was given his brother-in-law's details. The manager said that she then discussed with the Service Delivery Manager and the officer in charge what to do. Although the customer service officer was not an employee of either Tascor or UKBA they asked him to break the news to the man's brother-in-law because he spoke Urdu.
52. The customer service officer spoke to the man's brother-in-law between 5.55pm and 6.20pm and told him about the man's death. They spoke in both Urdu and English. The man's family said they intended to come to Pennine House immediately. At 6.30pm, the Service Delivery Manager telephoned the manager to inform her that the man's family would shortly be arriving at Pennine House. The Service Delivery Manager also spoke to the man's sister-

in-law on the phone at 6.40pm, who also wanted to visit Pennine House immediately.

53. The manager arrived at Pennine House around 7.15pm and the other manager briefed her. The manager said that the other manager told her that the airport customer service officer, had informed his brother-in-law about the man's death. She told the investigator that she did not know who had authorised the customer service officer to do this and initially she had assumed that it was the police who had spoken to the man's brother-in-law.
54. Before 8.00pm, several members of the man's family arrived at Pennine House. The manager went to see them and informed them that they would be unable to come inside to see the man's body as the police were still investigating the incident. Further police then arrived and about eight members of the man's family were now outside the building. The senior police officer, the Service Delivery Manager and manager updated them about the police investigation, the post-mortem process and the subsequent release of the man's body. The manager gave the family her contact details and said she would act as the main point of contact for them.
55. Over the next few days, the manager kept in regular contact with the man's family. In accordance with the Detention Services Order 02/2012, financial assistance was offered towards the funeral and repatriation of the man's body to Pakistan, which took place on Thursday 1 August 2013.
56. A post-mortem examination was conducted on 27 July and concluded that the man's cause of death was ischaemic heart disease.
57. The manager conducted an internal review of the circumstances surrounding the man's death and identified that there should be improvements in the use of the telephone interpreter service. A log to record use was introduced. The manager also recommended that the death in custody contingency plan should be reviewed.

## ISSUES

### Interpreting services

58. When he was arrested and taken to Dallas Court, the man said he did not speak any English. Home Office staff used a professional telephone interpreting service to interview him at Dallas Court. There is no evidence that the interpreting service was used by Tascor staff at any time while he was at Pennine House.
59. The officers who carried out the man's reception screening said that they would use the interpretation service if they felt a detainee did not speak or understand sufficient English. The custody officer was present for some of the reception procedures and was able to interpret as he spoke Urdu. However, the DCO began the man's induction in English until he asked another resident who spoke Urdu to assist. Until then, the DCO had assumed that the man spoke English as he had nodded his head and mumbled when spoken to.
60. We are particularly concerned that an interpreter was not used during the man's contact with healthcare staff. The man's brother-in-law told the Ombudsman's family liaison officer that the man felt that no one had understood him when he became ill.
61. It is difficult to see how staff can be sure that they have accurate information from a detainee if they cannot communicate with them effectively. This is an even more important consideration when the detainee presents with a medical issue. We have been unable to establish how frequently staff at Pennine House use the approved interpreting service as they do not record this in a log. We note that HM Inspectorate of Prisons found at the last inspection that professional interpretation services were not used when they needed to be. We make the following recommendation:

**The Director General of Immigration Enforcement should ensure that the a professional interpreting service is used at Pennine House whenever important information needs to be conveyed to detainees with limited understanding of English and for all healthcare interactions with such detainees.**

### Clinical care

62. The clinical reviewer reviewed the standard of the man's clinical care at Pennine House and concluded that it was below the standard he would have expected to receive from NHS care in the community. The reasons are set out below.

#### Clinical record

63. The clinical records at Pennine House are paper-based and the man's reception health screen document contained some poor and illegible entries. On 26 July, the nurse checked the man's basic observations twice during a 26 minute consultation, but she did not make a record of the consultation and the results of the observations until after the man's death. This is not an

acceptable standard. Observations carried out during a consultation should be documented at the same time or as soon as possible afterwards.

64. The Nursing and Midwifery Council publish guidance on record keeping. Among the principles of good record keeping, they highlight that:
- Handwriting should be legible
  - All entries to records should be signed, with the name and job title printed alongside the first entry
  - The date and time should be entered on all records. This should be in real time and chronological order, and be as close to the actual time as possible.
  - Entries should be factual and not include unnecessary abbreviations or jargon
65. Tascor's own guidance states that all clinicians should maintain comprehensive and contemporaneous medical records. Good record keeping skills are important as this reduces misunderstandings and misinterpretations. We make the following recommendation:

**The Director General of Immigration Enforcement should ensure that the healthcare provider at Pennine House maintains medical records in accordance with national professional guidelines and in particular that clinical observations are recorded immediately.**

Clinical care on 26 July 2013

66. The man's Tascor medical records do not indicate that he had any signs of any heart-related problems, although he had said at Dallas Court that he had suffered from pains in his arms, legs and chest and had seen a GP. When the nurse first took his observations on 26 July, he had significantly low blood pressure and indicated that he had pains in his arms and shoulders. (Although his brother-in-law, to whom he spoke by telephone during the consultations, said that the man had told him that he had chest pain.) The clinical reviewer commented that, with this blood pressure reading, it would have been standard medical practice to have taken the measurement again and, if it was still low, to have sought further medical advice. This appears to be the procedure that the nurse followed. As the second blood pressure reading was not low she did not seek further help.
67. In his clinical review, the clinical reviewer recommends that, as there is no GP presence at Pennine House, Tascor should consider installing an ECG (electrocardiography) machine (which records electrical activity in the heart) and which nurses can then use to decide whether further intervention is necessary. While an ECG machine might be helpful, we are not convinced that one is necessary in a facility such as Pennine House where relatively few detainees are held for short periods. When detainees report chest pain indicative of cardiac problems we consider it is preferable that an emergency ambulance should be called immediately, as would happen in the community.
68. The nurse told the investigator that she did not think that the man was exhibiting any signs of having a heart attack. In these circumstances, it is unlikely that she would have used an ECG machine even if one had been

available. The nurse appropriately took the man's clinical observations. She did not consider that he had the symptoms of someone who was having a heart attack. We accept that the man's original low blood pressure reading seems to have returned to a normal reading shortly afterwards, but as the nurse could not communicate properly with the man we cannot conclude that she had a full and accurate account of his symptoms. The clinical reviewer noted that, when a patient has some form of chest pain and a recorded low blood pressure, it is important to get more detailed history. We have made a recommendation about the use of interpretation services above.

69. It does not appear that the man had obvious symptoms of someone who was having a heart attack and to that extent the nurse's response seems satisfactory. However, her assessment was significantly hampered by the lack of reliable information from the man about how he was feeling. She did not consult a GP. We have found that there is no clear guidance to nurses at Pennine House which outlines the circumstances in which they should seek the advice of a GP. Nurses will always have to use their own professional judgement about when to seek help, but we consider that it would be useful to give some guidance about when this would be expected, including when detainees report pain which could be indicative of cardiac problems. We make the following recommendation:

**The Director General of Immigration Enforcement should ensure that the healthcare provider at Pennine House gives clear guidance to nurses outlining the circumstances when they should seek the input of a GP and when they should use emergency services.**

#### **Emergency response on 26 July**

70. When the man was found unconscious in his room at 4.14pm, there was poor radio communication about the exact nature of the emergency incident. The DCO was unsure whether the man was breathing and said he called a "medical emergency", stating that a nurse was required immediately. The officer in charge said that the DCO's radio request stated "assistance required room two". CCTV showed that the officer in charge arrived at the man's room within seconds. He told the investigator that he could not find a pulse on the man's neck, although he observed that the man's forehead was covered in beaded sweat and his skin was warm. The officer in charge and the DCO had both recently had first aid training.
71. The nurse said that she responded to a radio call for a nurse to attend room two. She said that as the call did not refer to an emergency, she did not take the emergency bag. She arrived at room two a minute and a half later (4.16pm). An ambulance was not called until 4.19pm. Although the man was in a collapsed state, the nurse did not immediately request that someone should bring the emergency medical bag.
72. Tascor's own procedures do not clearly set out the steps staff should follow when discovering and responding to an emergency. They have a list of radio codes, but have not instructed staff when to use them or what to do when the code is used. As a result, the custody officers did not use an emergency code when the man was found unresponsive, and an ambulance was not called for several minutes afterwards. We cannot say whether this would have made any

difference to the outcome for the man, but it is essential that there are clear emergency procedures which all staff understand. This is a matter we have raised in a number of previous deaths in immigration detention. We make the following recommendation:

**The Director General of Immigration Enforcement should ensure that a protocol is introduced at all places of immigration detention setting out staff responsibilities in an emergency and that a Medical Emergency Response Code protocol is introduced which:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

### **Family Liaison**

73. Tascor's admission procedures do not require staff to record next of kin information when someone is detained. Fortunately, staff at Dallas Court had recorded a telephone number for the man's next of kin. We consider that it is important that staff in immigration detention facilities are able to contact next of kin quickly in an emergency.
74. Following a death in an immigration removal centre in 2011, we recommended that United Kingdom Border Agency (UKBA) – which was then responsible for these matters - ensured that detainees in removal centres were encouraged to give next of kin details on arrival, repeating a previous recommendation from a death in 2005. UKBA accepted the recommendation and said that detainees were now asked for the information on arrival, during the initial health screening and during induction. A detention service order was issued in November 2013 which specifically now requires reception staff to ask for emergency contact details.
75. The man gave his brother-in-law's contact details when he was taken to Dallas Court. However, he does not seem to have been asked for the information at Pennine House, and this information was not passed on at the time so it was not immediately available when needed. Despite the response to our previous recommendation, there was no apparent expectation at Pennine House that staff should record next of kin details at Pennine House. As this is now an explicit requirement of a detention service order we make no further recommendation.
76. Detention Services Order 02/2012 states that head of operations (deputy director) in Detention Services should be appointed immediately as the named point of contact for the family of the deceased. As an interim measure, the on-call senior manager for detention services can act on behalf of the head of operations until they are available. The order notes that, in most cases, the police should notify the next of kin.
77. In this case, a manager took on this role, but only after the man's brother-in-law had been informed of his death. She was therefore not involved in deciding

who should make the first contact with the man's next of kin. The customer service officer who undertook this task, was not employed by Tascor or the Home Office. He was a customer service adviser for Manchester Airport and had brought the paramedics from the airport terminal to Pennine House. He had never met the man, knew very little about detention centres and had never been to Pennine House before. It appears that he was asked to break the news of the man's death to his family because he spoke Urdu.

78. We consider it was inappropriate to ask the customer service officer to notify the man's next of kin of his death and staff at Pennine House should have followed the provisions of Detention Service Order 02/2012. This is a matter about which we have been critical before in other cases of deaths in immigration detention. We make the following recommendation:

**The Director General of Immigration Enforcement should ensure that, in the event of death of a detainee, staff liaise with families in line with the provisions of Detention Service Order 02/2012.**

## RECOMMENDATIONS

1. The Director General of Immigration Enforcement should ensure that a professional interpreting service is used at Pennine House whenever important information needs to be conveyed to detainees with limited understanding of English and for all healthcare interactions with such detainees.
2. The Director General of Immigration Enforcement should ensure that the healthcare provider at Pennine House maintains medical records in accordance with national professional guidelines and in particular that clinical observations are recorded immediately.
3. The Director General of Immigration Enforcement should ensure that the healthcare provider at Pennine House gives clear guidance to nurses outlining the circumstances when they should seek the input of a GP and when they should use emergency services.
4. The Director General of Immigration Enforcement should ensure that a protocol is introduced at all places of immigration detention setting out staff responsibilities in an emergency and that a Medical Emergency Response Code protocol is introduced which:
  - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
  - Ensures staff called to the scene bring the relevant equipment; and
  - Ensures there are no delays in calling, directing or discharging ambulances
5. The Director General of Immigration Enforcement should ensure that, in the event of death of a detainee, staff liaise with families in line with the provisions of Detention Service Order 02/2012.

**The Home Office Immigration Enforcement have accepted all the recommendations.**