Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tomasz Dudak a detainee at The Verne IRC on 23 March 2017

A report by the Prisons and Probation Ombudsman

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Tomasz Dudak died on 23 March 2017 as a result of a severe head injury sustained following an epileptic seizure at The Verne Immigration Removal Centre (IRC). Mr Dudak was 33 years old. We offer our condolences to Mr Dudak's family and friends.

Staff at The Verne called an ambulance when Mr Dudak collapsed and hit his head as a result of an epileptic seizure shortly after his arrival at The Verne in the early hours of 22 March. Paramedics and a IRC custodial manager agreed that Mr Dudak did not require a transfer to hospital and he remained at The Verne to be monitored regularly by staff. The nurse at The Verne recorded in her notes that she disagreed with this decision. Around two hours later, Mr Dudak was found suffering a further epileptic seizure. He was taken to hospital but died the following day.

The decision on whether or not to take Mr Dudak to hospital following his collapse was ultimately a clinical decision to be made by the South Western Ambulance Service and was not the responsibility of The Verne. We are unable to say to what extent the custodial manager (who was not medically trained) may have sought to influence this decision.

We consider that the clinical care provided to Mr Dudak by healthcare staff at The Verne was equivalent to that which he could have expected to receive in the community.

We found that the member of staff who found Mr Dudak suffering a further epileptic seizure did not call a medical emergency code, resulting in a delay of about 10 minutes in calling an ambulance. However, we are unable to say whether this, or the earlier decision not to take Mr Dudak to hospital following his collapse, affected the outcome.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **February 2017**

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Summary

Events

1. Mr Tomasz Dudak, a Polish national, was encountered sleeping rough by police and immigration officers in the early hours of 21 March 2017. He was arrested and taken to a police station where he was detained under immigration powers for misusing his EU treaty rights. He told police that he was epileptic but had run out of his epilepsy medication. He also said he suffered with depression and had alcohol dependency.

2. At 7.36pm, Mr Dudak was transferred to The Verne Immigration Removal Centre, where he arrived at 00.50am on 22 March. At roughly 2.30am, in The Verne's reception area, Mr Dudak had an epileptic fit causing him to fall to the floor and hit his head. An ambulance was called at 2.45am.

3. Paramedics arrived at 3.03am. The nurse at The Verne thought Mr Dudak should be taken to hospital but a decision was taken that Mr Dudak should remain at The Verne and be observed regularly. At around 4.10am, Mr Dudak was taken to the induction wing. An Operational Support Grade (OSG) was asked to check Mr Dudak every 30 minutes, making a log of her observations.

4. At 4.25am, the OSG found Mr Dudak having a seizure. She called for assistance but did not call a medical emergency code. Staff called for an ambulance at 4.35am, which arrived 18 minutes later. Mr Dudak was taken to Dorset County Hospital at 5.20am. Mr Dudak had a bleed on the brain and later that day was transferred to the intensive care unit at Southampton Hospital. At 4.40pm, Mr Dudak was administratively released from immigration detention. He died at 5.05pm the following day, 23 March 2017, as a result of a severe head injury.

Findings

5. We accept that the nurse at The Verne disagreed with the decision not to take Mr Dudak to hospital after his collapse. We are concerned that the process by which this decision was made was unclear. The clinical reviewer was satisfied that the clinical care provided to Mr Dudak by healthcare staff at The Verne was equivalent to that which he could have expected to receive in the community. We have, however, made two recommendations about dealing with differences in opinion on whether or not to transfer detainees to hospital.

6. The OSG asked to monitor Mr Dudak was not fully briefed on how to identify any deterioration in his condition. She failed to call an emergency medical code when she found him having a seizure, although measures have since been put in place by The Verne to remind staff of medical emergency code procedures.

Recommendations

- The Centre Manager, the Quality and Safety Team for Dorset Healthcare University NHS Foundation Trust and South Western Ambulance Service should work together to produce a joint protocol for immediate and subsequent action to be taken (including how to document and report to senior

management) where there is any difference in clinical opinion about transporting a patient to hospital.

- The Centre Manager should ensure that the senior manager completing the handover sheet accurately records any differences in opinion about a decision not to transfer a detainee to hospital and the actions taken at the time to resolve the issue.
- The Centre Manager should ensure that staff undertaking observations on detainees who are unwell are fully briefed on their medical condition and how to identify if medical attention is required.
- The Centre Manager should ensure that all operational staff are up-to-date with their first aid training.

The Investigation Process

7. The investigator issued notices to staff and detainees at The Verne IRC informing them of the investigation and asking anyone with relevant information to contact her. No one responded

8. The investigator obtained copies of relevant extracts from Mr Dudak's immigration and medical records.

9. The investigator interviewed five members of staff at The Verne on 25 April 2017.

10. NHS England commissioned a clinical reviewer to review Mr Dudak's clinical care at The Verne. The clinical reviewer attended all interviews conducted.

11. We informed HM Coroner for Dorset of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator wrote to Mr Dudak's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. We did not receive a reply to this letter.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

The Verne IRC

14. The Verne is an immigration removal centre (IRC) which is run by Her Majesty's Prison and Probation Service. It holds up to 580 foreign national men who face immigration enforcement action. Dorset Healthcare University Foundation Trust provides 24-hour nursing healthcare cover. Emergency 'out of hours' doctor cover is also provided.

15. On 10 October 2017, the Home Office announced that The Verne will close as an IRC from 31 December 2017 and reopen as a prison during 2018.

HM Inspectorate of Prisons

16. The most recent inspection of The Verne was in March 2015. Inspectors reported that health provision was reasonable for most, although access had been impacted by staff shortages. All new detainees received a comprehensive health assessment where their capacity to understand and consent to treatment and information sharing were identified. Telephone interpretation was used regularly for detainees who were not fluent in English during health consultations and in reception.

17. It was noted that many detainees had exhausting and unnecessary overnight transfers to the Centre. Most detainees said that escort staff were respectful, but delayed or confused escort arrangements were not uncommon. The inspectorate recommended that detainees should not be escorted during the night unless this was required for urgent operational reasons.

Independent Monitoring Board

18. Each immigration removal centre has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that detainees are treated fairly and decently. In its latest annual report, for the year to 31 December 2016, the IMB reported The Verne to be a well-run establishment where, in the main, detainees are treated with decency, fairness and respect.

19. The Board recognised that a large proportion of the detainees arriving at The Verne have come straight from a reporting centre or having been arrested by Immigration Enforcement and many arrive with few possessions and often without any medication they have been prescribed. The Board had become increasingly concerned at the frequency and numbers of night moves (which they believed to be inhumane and an unfair practice). This has been discussed with both Home Office, Centre staff and DEPMU (Detainee Escorting and Population Management Unit), who have all been supportive in trying to encourage Tascor to reduce these moves in all but exceptional circumstances.

Previous deaths at The Verne IRC

20. Mr Dudak was the second detainee to die at The Verne since 2015, the first from natural causes. The investigation into Mr Dudak's death was suspended for a short time pending test results requested by the Coroner. While it was suspended, The Verne had a third death. Our investigation into the

circumstances of this death also found failings in the use of the medical emergency code system.

Key Events

21 March 2017

21. Mr Tomasz Dudak, a Polish national, was arrested by police and immigration officers in the early hours of 21 March 2017. He was found sleeping rough in a public car park and arrested by immigration officers for misusing his treaty rights as an EU national. He was taken to Croydon Police Station.

22. Police custody paperwork shows that Mr Dudak was under the influence of alcohol and had epilepsy. Mr Dudak told police that he had run out of his epilepsy medication.

23. Mr Dudak was examined by a police doctor at 11.10am that morning. He told the doctor that he had epilepsy which was controlled by taking Depakine, a medication that his mother sent from Poland. He also had depression and alcohol dependency. The doctor recommended that while in police custody, Mr Dudak should be checked every 30 minutes. The doctor gave Mr Dudak 10mg of diazepam at 11.35am and 7pm.

24. At 7.36pm Mr Dudak was taken by Tascor escorting staff to The Verne Immigration Removal Centre (IRC). He was checked hourly and offered food and water during the journey. The Immigration Person Escort Record (PER) held by Tascor showed that Mr Dudak had epilepsy, depression and suffered from alcoholic seizures (seizures caused by alcohol withdrawal).

22 March 2017

25. Mr Dudak arrived at The Verne at 00.50am on 22 March 2017. He saw a nurse at 1.16am for an initial health screen. Mr Dudak's English was poor and the nurse used Language Line, an interpretation service, during her consultation. She noted that Mr Dudak had epilepsy and alcohol dependency, and referred him to The Verne's specialist alcohol treatment service.

26. On completion of the health screening, Mr Dudak returned to the reception area to complete reception paperwork. At roughly 2.30am, while standing at a desk being interviewed by an officer, Mr Dudak had an epileptic seizure and fell to the floor. The officer heard, "an enormous crack", a sound that he described (in a statement) as not only frightening but made him feel sick inside.

27. The nurse and a healthcare assistant (HCA) heard Mr Dudak fall to the floor and immediately attended. Mr Dudak's epileptic seizure lasted for around one minute. The nurse examined Mr Dudak and found a small amount of blood in his mouth (believed to be from a small cut to his lip) and a small cut to the back of his head which was bleeding. She cleaned the cut on his head and asked for an ambulance to be called. The ambulance was called at 2.45am.

28. A rapid response car arrived at The Verne at 3.03am, followed shortly afterwards by an ambulance. The paramedics were escorted to the reception area by a custodial manager (CM). Mr Dudak had now regained consciousness but, according to the nurse and other IRC staff, he was confused. A paramedic noted that Mr Dudak had a "small abrasion on [his] occipital area" (on the back of the

head) and completed a neurological examination. During this examination Mr Dudak vomited. The nurse told the paramedic that based on Mr Dudak's alcohol dependency, his head injury and epilepsy he should be taken to hospital for observations.

29. While being examined Mr Dudak asked to go to the toilet. An officer and the HCA escorted Mr Dudak to the toilet. He was "a little wobbly" and confused, and when he went to sit on the toilet, the officer had to tell him to take his jeans down after he tried to sit on the toilet fully clothed.

30. At 3.59am, a decision was taken that Mr Dudak did not require a transfer to hospital and that he should be monitored by staff at The Verne. There are differing opinions as to how this decision was reached. The paramedics said that the decision was reached in agreement with IRC staff who were happy to keep Mr Dudak under observation at The Verne. However, the nurse said that she told the paramedics that she thought Mr Dudak should be taken to hospital but she was overruled by the CM. The CM said that the decision not to take Mr Dudak to hospital was a clinical decision and that the paramedics' opinion took precedence over the nurse's.

31. The paramedic provided IRC staff with a head injuries leaflet and recommended that Mr Dudak be monitored every 15 minutes. The leaflet gave advice on what symptoms to look for after a head injury that would require medical assistance. Symptoms listed in this leaflet included things such as vomiting, confusion and loss of balance or problems walking. Paramedics left The Verne at 4.22am.

32. At around 4.10am, an officer and the CM escorted Mr Dudak to the induction wing. A senior officer (SO) gave an operational support grade (OSG) the head injuries leaflet provided and asked her to check Mr Dudak every 30 minutes, making a log of her observations. The CM asked the nurse to check Mr Dudak hourly.

33. At 4.25am, the OSG went to check Mr Dudak. She found him in his bed suffering a seizure and having difficulty breathing. His lips were white and he had been incontinent of urine. She immediately radioed the SO asking him to attend the wing, while moving Mr Dudak into the recovery position to help open his airway. She did not call a code blue (a medical emergency code used when a detainee is unconscious or having breathing difficulties). An officer attended but was unable to rouse Mr Dudak and radioed for healthcare assistance.

34. The nurse and the HCA attended immediately and requested an ambulance, which was called by the Control Room at 4.35am. The ambulance arrived at 4.53am. Mr Dudak was taken to Dorset County Hospital at 5.20am. He was not restrained during the escort.

35. Mr Dudak was diagnosed with a bleed on the brain and was transferred to Southampton Hospital at 9am for surgery. He later moved to the hospital's intensive care unit. At 4.40pm, Home Office form IS106 was faxed to IRC staff at the hospital authorising Mr Dudak's temporary release. Home Office form IS96 was also served on Mr Dudak which required him to report to immigration officials at Croydon Reporting Centre on 22 June 2017. Mr Dudak died at 5.05pm on 23 March 2017.

Contact with Mr Dudak's family

36. The Home Office Family Liaison Officer telephoned Mr Dudak's brother on 22 March to tell him Mr Dudak was in hospital. She tried to contact Mr Dudak's brother again the following morning to explain that his condition had deteriorated. She was unable to contact him so left a voicemail.

37. She spoke to Mr Dudak's brother at 12.30pm on 24 March to inform him that his brother had died. She met with him on 28 March to offer support and answer any questions he may have.

38. Mr Dudak's body was repatriated to Poland. His funeral took place on 24 April 2017. Her Majesty's Prison and Probation Service contributed towards the funeral costs in line with national policy.

Support for detainees and staff

39. After Mr Dudak's death, support was offered to all staff involved in the emergency response. The IRC posted notices informing other detainees of Mr Dudak's death, offering support. Staff reviewed all detainees assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Dudak's death.

Post-mortem report

40. The post-mortem report showed that Mr Dudak died as a result of a severe head injury as a consequence of an epileptic seizure. The report noted brain swelling with extensive cerebral contusion (bruising of the brain tissue) with burst frontal lobes and left temporal lobe (brain haemorrhages).

High Court judgment

41. On 14 December 2017, the High Court ruled that the Home Office's policy of using rough sleeping as an indicator that the person was misusing EU treaty rights was unlawful. The Home Office has not appealed the judgment.

Findings

Decision not to transfer Mr Dudak to hospital

42. Although IRC staff called an ambulance when Mr Dudak collapsed and hit his head in reception, a decision was taken not to transfer him to hospital. There are differing views about how this decision was reached.

43. South Western Ambulance Service NHS Foundation Trust (SWAST) conducted a root cause analysis of the incident and concluded that there was agreement to keep Mr Dudak in The Verne and observe him there. The Executive Medical Director for SWAST, told the clinical reviewer that, while agreement would be normal, paramedics are trained to take autonomous clinical decisions about transferring to hospital. Therefore, the decision whether or not to take Mr Dudak to hospital was the responsibility of the Specialist Paramedic. The clinical reviewer covers this further in his report.

44. The nurse told us that she felt very strongly that, based on Mr Dudak's epilepsy and lack of medication, his head injury and alcohol dependency, he should go to hospital. She noted in Mr Dudak's medical record that she disagreed with the decision not to take him to hospital and other staff corroborated her account. A serious incident review report completed by Dorset University Healthcare NHS Foundation Trust concluded that the nurse was overruled by the CM and the paramedic crew in collaboration.

45. Since Mr Dudak's death, the Head of Healthcare at The Verne has put in place a new system in the event of differing views on whether or not to transfer a detainee to hospital. Under the new system, the nurse in charge will contact the duty doctor out of hours for a second opinion. While this new system is good practice we still make the following recommendation:

    The Centre Manager, the Quality and Safety Team for Dorset Healthcare University NHS Foundation Trust and South Western Ambulance Service should work together to produce a joint protocol for immediate and subsequent action to be taken (including how to document and report to senior management) where there is any difference in clinical opinion about transporting a patient to hospital.

46. The IRC Duty Manager Handover sheet for 22 March states that there was "no requirement [for Mr Dudak] to go to hospital" and does not show that there was a difference of opinion between staff working that night. We make the following recommendation:

    The Centre Manager should ensure that the senior manager completing the handover sheet accurately records any differences in opinion about a decision not to transfer a detainee to hospital and the actions taken at the time to resolve the issue.

47. We consider that it was ultimately the responsibility of the Specialist Paramedic to decide whether or not to take Mr Dudak to hospital. This decision was not for staff at The Verne and was outside their control. The clinical reviewer found that

the clinical care provided to Mr Dudak by healthcare staff at The Verne was equivalent to that which he could have expected to receive in the community.

48. The clinical reviewer noted that although in general, the earlier a head injury is treated, the better the outcome, it is not certain that the delay in conveying Mr Dudak to hospital decreased his chance of survival.

Observations

49. Once the decision was taken to keep Mr Dudak at The Verne, it was agreed that he would be checked by IRC staff every 15 minutes and that a nurse would conduct a neurological assessment every hour.

50. The OSG told us she was asked to observe Mr Dudak every 30 minutes (although she checked him after 15 minutes). She was given the head injuries leaflet to read. (The leaflet instructs people to dial 999 if they see signs of confusion, inability to understand instructions, or vomiting. The clinical reviewer commented in his report that Mr Dudak had all three of these symptoms when the leaflet was given, the first two possibly being compounded by his language difficulties.) The OSG said at interview that Mr Dudak looked 'poorly' and was unsteady on his feet when he was escorted to the induction wing by the CM and an officer. She was unaware of his epilepsy or that he had been sick (one of the symptoms mentioned in the leaflet) and it was not explained what she should do apart from "observe him and make a log of it". The OSG said that she was not up-to-date with her first aid training, with her last first aid course being "quite a few years ago". We make the following recommendations:

The Centre Manager should ensure that staff undertaking observations on detainees who are unwell are fully briefed on their medical condition and how to identify if medical attention is required.

The Centre Manager should ensure that all operational staff are up-to-date with their first aid training.

Emergency response

51. When the OSG found Mr Dudak having a seizure and experiencing breathing difficulties at 4.25am, she did not call a medical emergency code blue. Had she done so, an ambulance would have been called immediately. Instead, there was a delay of 10 minutes as an ambulance was not called until the nurse and the HCA arrived at approximately 4.35am.

52. The OSG told us at interview that she was aware of the emergency code system but panicked when she found Mr Dudak having a seizure. She knew her manager was close by and radioed him for help while moving Mr Dudak into the recovery position.

53. Since Mr Dudak's death, The Head of Residence and Safety has arranged for emergency code cards (designed to be attached to IRC keys) to be issued to all staff explaining the emergency code system. Six monthly notices to staff have also been introduced to ensure that all staff are made aware of and understand their responsibilities during medical emergencies as outlined in the local Medical

Emergency Response Code Protocol. In light of this we do not make a recommendation.

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