Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tarek Mahmood Chowdhury, a detainee at Colnbrook Immigration Removal Centre

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

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

Mr Tarek Chowdhury died on 1 December 2016 at hospital as a direct consequence of an assault by Detainee A at Colnbrook Immigration Removal Centre (IRC). I offer my condolences to Mr Chowdhury's family and friends.

This is a tragic case. Mr Chowdhury was a 64-year-old Bangladeshi national. He had no history of violence or any previous convictions and had been at Colnbrook only two days before he was killed. He did not know Detainee A and had done nothing to provoke his violent assault on him.

Detainee A, is an Iraqi national. He had committed a number of criminal offences and had spent some years in prison before being transferred to the immigration removal estate pending deportation. While in custody, he displayed aggressive, anti-social and violent behaviour towards staff and other prisoners and detainees. He also had a history of mental health problems.

Although it is not possible to say whether Detainee A was mentally ill when he attacked Mr Chowdhury, I am concerned that his mental health was not properly assessed while he was detained. He had been referred for a mental health assessment at another IRC a month before the killing, but healthcare staff failed to pick this up when he was transferred to Harmondsworth and Colnbrook IRCs and, as a result, no assessment took place.

I am also concerned that prisons did not share intelligence about Detainee A's violent behaviour with IRC staff, and that IRC staff did not take effective action when he displayed violent and anti-social behaviour towards other detainees in the days leading up to his attack on Mr Chowdhury.

I also found that the emergency response by healthcare staff at Colnbrook was inadequate.

I have made recommendations to address these failings which the Home Office, HM Prison and Probation Service (HMPPS) and the Heathrow Immigration Removal Centre Manager should act upon.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **January 2019**

Contents

Summary 1
The Investigation Process 4
Background Information 5
Key Events 7
Findings 14

Summary

Events

1. Mr Tarek Mahmood Chowdhury was a Bangladeshi national who arrived in the UK in 2004 and was refused leave to remain. On 24 November 2016, he was taken to Campsfield House Immigration Removal Centre (IRC). On 29 November, Mr Chowdhury was transferred to Colnbrook IRC. He had no history of violence or any previous convictions and had not been in prison or immigration removal centres before.

2. Detainee A, an Iraqi national who arrived in the UK illegally in 2002. He was granted Exceptional Leave to Remain (ELR) in the UK but became liable for deportation in December 2013 after he committed a number of criminal offences. Detainee A transferred between different prisons and immigration removal centres including Harmondsworth IRC on 9 November 2016 and Colnbrook IRC on 23 November. While in custody, Detainee A displayed aggressive, anti-social and violent behaviour towards staff and other prisoners and detainees. The day before he assaulted Mr Chowdhury, Detainee A had a fight with another detainee and an incident with his room-mate. Detainee A also had a well-recorded history of mental health issues and interventions.

3. On 1 December, at around 8.44am, Detainee A entered a room in the induction unit where Mr Chowdhury was speaking with other detainees. He asked for a lighter, became agitated and assaulted Mr Chowdhury. Another detainee asked for help and officers and nurses attended. Paramedics arrived at 9.06am, started cardio-pulmonary resuscitation (CPR) and, at around 10.56am, took Mr Chowdhury to hospital. In the afternoon, Mr Chowdhury's condition deteriorated and he was transferred to the Emergency Department at a different hospital. He was pronounced dead at 9.24pm.

4. On 13 November 2017, Detainee A was sentenced to 20 years imprisonment, 15 in prison and five on extended licence, for the manslaughter of Mr Chowdhury.

Findings

5. The clinical reviewer found that Detainee A should have had a full mental health assessment while detained. He criticised healthcare staff at Harmondsworth and Colnbrook IRCs for not reading the available medical information on Detainee A, for not referring him for a mental health assessment, and for not formally considering the need to review, and possibly re-start, his anti-psychotic medication.

6. A further concern is that when Detainee A transferred to Colnbrook IRC, staff did not have access to his Mercury intelligence file recording his history of violent behaviour in prison and at The Verne IRC. This was because prisons do not regularly share Mercury intelligence reports with immigration removal centres that are not run by HM Prison and Probation Service (HMPPS). We are concerned that, in the absence of such information, the assessment of Detainee A's risk to himself and others at Colnbrook could not have been fully accurate.

7. Detainee A was responsible for two incidents of anti-social behaviour the day before he killed Mr Chowdhury. These should have triggered actions in line with the Colnbrook's anti-bullying strategy - specifically, closer monitoring of Detainee A. Staff at Colnbrook appeared to have assessed Detainee A's risk to others on 30 November in isolation and without regard to his recent challenging behaviour recorded in the Detainee Management System (DMS). (This is a management system which includes records maintained by the residential officers or any member of staff who has had any relevant interaction with a detainee.)

8. After the attack on Mr Chowdhury, the emergency response by healthcare staff was inadequate. They did not assess Mr Chowdhury's condition properly and failed to recognise his clinical deterioration. There was a considerable delay in the nurses bringing equipment to the room and in administering oxygen. Healthcare staff did not begin CPR and did not provide suitable life support to Mr Chowdhury. There was also a delay by the control room of about five minutes in calling the ambulance after the first officer at the scene radioed a medical emergency.

9. Some officers involved in the emergency response were not well supported after Mr Chowdhury's death and were not invited to a hot-debrief. We are not satisfied that the expectations of DSO 08/2014, *Death in Detention*, were fully met in this regard.

Recommendations

- The Home Office and HMPPS should agree a consistent approach to the sharing of Mercury intelligence reports between prisons and all immigration removal centres, including those that are not run by HMPPS, in order to provide staff in removal centres with the information they need to help them assess the risk that detainees pose to themselves and others.

- The Home Office should ensure that healthcare providers and staff in the immigration detention estate share information about risks relating to detainees' mental health when they move between immigration removal centres.

- The Head of Healthcare at Heathrow IRC should ensure that healthcare staff review the SystmOne records thoroughly during reception to guarantee continuity of healthcare for detainees and the identification of their mental health needs.

- The Centre Manager of Colnbrook IRC should ensure that staff respond effectively to anti-social and violent behaviour by detainees in line with the Centre's violence reduction policy and anti-bullying strategy.

- The Head of Healthcare at Colnbrook IRC and Central and North-West London NHS Foundation Trust (CNWL) must ensure that all healthcare staff undertake Immediate Life Support (ILS) training which covers quality CPR, airway management and the recognition of clinical deterioration.

- The Centre Manager and the Head of Healthcare at Colnbrook IRC should ensure that all staff are made aware of and understand DSO 09/2014, *Medical Emergency Response Codes,* and their responsibilities during medical emergencies as outlined in the Local Medical Emergency Response Code Protocol, so that staff efficiently communicate the nature of a medical emergency and there is no delay in calling ambulances.

- The Centre Manager should ensure that all relevant mandatory actions in DSO 08/2014, *Death in Detention*, are completed after a detainee's death. In particular, staff involved in an emergency response should be adequately supported and debriefed by a senior member of staff.

The Investigation Process

10. The investigator, issued notices to staff and detainees at Colnbrook IRC informing them of the investigation and asking anyone with relevant information to contact him. One detainee responded.

11. The investigator visited Colnbrook on 8 December 2016. He obtained copies of relevant documents and medical records.

12. The PPO investigation was suspended pending the police investigation and disciplinary hearings held by Central and North-West London NHS Foundation Trust (CNWL) which concluded in February 2018.

13. The investigator interviewed seven members of staff, including two nurses with the clinical reviewer, and reviewed police disclosure including the statements and incident reports from four detainees and five other members of staff.

14. NHS England commissioned a clinical reviewer to review the clinical care provided to Mr Chowdhury and Detainee A at Colnbrook.

15. We informed HM Coroner for West London of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers, contacted Mr Chowdhury's next of kin, to explain the investigation and to ask whether the family had any matters they wanted the investigation to consider. The family wanted to know:

    - whether the perpetrator had mental health issues and history;
    - whether the perpetrator had any previous convictions and disciplinary records while detained at Colnbrook;
    - whether the perpetrator required special monitoring or management to ensure the safety of other detainees;
    - what policies and procedures were in place at Colnbrook to manage violent incidents and detainees and whether they were adequate; and
    - whether the emergency response was adequate.

17. Mr Chowdhury's family received a copy of the initial report. Her legal representatives Deighton Pierce Glynn Solicitors made some comments about the report findings and investigation. We made additions and amendments to this report as a result. We have provided further answers to their comments in the covering letter enclosing this report.

18. The Home Office also received a copy of the initial report. Their response to our recommendations and action plan is annexed to this report. They made some accuracy comments and we have made amendments to the initial report accordingly.

Background Information

Heathrow Immigration Removal Centre (Colnbrook site)

19. Heathrow Immigration Removal Centre (IRC) is an immigration removal centre in west London and comprises two separate buildings known as Harmondsworth IRC and Colnbrook IRC. From 1 September 2014, Mitie Care & Custody have managed both Colnbrook and Harmondsworth IRCs under contract from the Home Office. Colnbrook IRC holds about 340 detainees. Central and North-West London NHS Foundation Trust (CNWL) provides physical and mental health services. There is a six-bed Enhanced Care Unit for detainees with mental health, substance misuse and social care needs.

20. The induction unit at Colnbrook is a short-term holding facility where new detainees stay for a maximum of seven days before moving to residential units. The induction unit has a mirrored layout on the ground and first floors, and has 40 rooms. The second floor is an annex, which has ten rooms. Room 5, where Mr Chowdhury was killed, is a two-man room with bunk beds on the left and a shower and toilet on the right.

HM Inspectorate of Prisons

21. The most recent inspection of Colnbrook was conducted in February and March 2016. Inspectors reported some improvement since the previous inspection. However, there remained much to do and healthcare was a particular concern. Care for those with severe mental health needs was generally good, but inspectors were concerned that those with such severe illnesses were in detention at all.

22. The regime in the induction unit had improved but the environment was poor and unwelcoming. Overall levels of violence were not high and the number of reported fights and detainee-on-detainee assaults was relatively low. In the six months before the inspection, there had been 15 assaults on detainees - a rate of four per 100 of the population. The number of reported fights, four in the previous six months was lower than at the previous inspection in 2013.

Independent Monitoring Board

23. 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 December 2017, the IMB was critical that individuals with identified serious mental health illness continued to be detained at Colnbrook. They also criticised the mixing of individuals with serious criminal records with detainees without any convictions. This led to an increase in gang activity and incidents of violence, making it more difficult for staff to protect victims of bullying, extortion and violence.

Previous deaths at Colnbrook

24. We have investigated one previous death at Colnbrook since 2014. In that investigation we found deficiencies in the staff use of the emergency code system and in the clinical care provided to the detainee.

Mental Health definitions

25. Psychosis is a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality. 'Acute' psychotic symptoms include delusions, hallucinations, and perceptual and behavioural disturbances, usually accompanied by agitation and distress. 'Transient' psychotic symptoms are of short duration and may include acute symptoms or lower intensity symptoms (such as memory and concentration problems, unusual behaviour and ideas, disturbed communication and affect, and social withdrawal, apathy and reduced interest in daily activities).

26. A personality disorder is a disorder in which the individual's personal characteristics cause regular and long-term problems in the way that they cope with life and interact with other people and in their ability to respond to emotion.

27. An adjustment disorder is a group of symptoms, such as feeling stressed, sad or hopeless, that can occur after a stressful life event.

28. The symptoms of various psychiatric disorders can overlap so it can be difficult to come to a definite diagnosis. A 'differential diagnosis' reflects this.

Rewards and Incentives (IEP) Scheme and the 'strikes' system

29. Colnbrook operates a Rewards and Incentives (IEP) Scheme and a 'strikes' system. The IEP scheme has two-tiers: Enhanced Level (High) and Standard Level (Low). On arrival at the IRC, all detainees are given Enhanced status, the which offers a highest level of facilities and privileges. They are expected to maintain a good standard of personal behaviour, room cleanliness and compliance with Home Office instructions. Failure to maintain the required standard will lead to a review of a detainee's status and demotion to the Standard Level of privileges.

30. Staff are expected to issue 'strikes' to detainees who do not comply with the rules. The award of two strikes results in a detainee being demoted to Standard Level. Repeated poor behaviour could then lead to the detainee being sent to the Care and Separation unit (CSU).

Key Events

Mr Tarek Mahmood Chowdhury

31. Mr Tarek Mahmood Chowdhury was a Bangladeshi national who arrived in the UK in 2004. Mr Chowdhury was refused leave to remain in the UK and, in September 2016, he refused to return voluntarily to Bangladesh.

32. On 24 November 2016, a Home Office immigration enforcement team arrested him. He was taken to Campsfield House Immigration Removal Centre (IRC) later that day.

33. An Escort Officer recorded in Mr Chowdhury's movement notification (a document that describes the movement of detainees between locations) that Mr Chowdhury had arthritis in his right knee. He did not record any other concerns or risk factors. Mr Chowdhury's detention warrant did not indicate any other concerns or risk factors. Mr Chowdhury had no history of violence or previous convictions and had not been in prison or immigration removal centres before.

34. On 29 November, Mr Chowdhury was transferred to Colnbrook IRC for an interview with the Bangladeshi High Commission (which would effectively start the process of removing him from the UK). Officers recorded no concerns on Mr Chowdhury's Person Escort Record (PER), a document that accompanies detainees when they move between police stations, immigration premises and IRCs.

35. At his initial health screening at Colnbrook, Mr Chowdhury told a nurse that he had arthritis in his knee but was not taking any medication. The clinical reviewer found that there were no known community GP records for Mr Chowdhury. The nurse referred him to an IRC GP who reviewed him the next day. Mr Chowdhury said that he had no mental health issues, no disabilities and no thoughts of suicide and self-harm. She recorded that Mr Chowdhury had no history of alcohol or substance misuse. Mr Chowdhury was located in the induction unit, where new detainees stay for five to seven days before moving to a normal residential location in the IRC.

36. On 30 November, an IRC GP, reviewed Mr Chowdhury who repeated that he had arthritis of the right knee and said he might have diabetes. The IRC GP noted that Mr Chowdhury's blood pressure was raised but his heart, lungs and abdomen were fine. The GP planned an electro-cardiogram (ECG) of the heart, daily blood tests and a diabetic screening for Mr Chowdhury, but these examinations did not take place before Mr Chowdhury was killed the next day.

37. During the week that Mr Chowdhury stayed at Campsfield House and Colnbrook, officers did not record any issues and did not submit any Incident Reports about him.

Detainee A

38. Detainee A is an Iraqi national. He told immigration officials he had arrived in the UK illegally by lorry through Dover in October 2002. He applied for asylum the same day but his application was refused in November 2002. He was, however, granted Exceptional Leave to Remain (ELR) until 7 November 2006. (ELR is granted when it is not possible for a person to return to his country of origin.)

39. From January 2011 onwards, Detainee A was convicted of a large number of offences, including theft and harassment of his ex-girlfriend. By December 2013 he had received an aggregate total of over 12 months imprisonment over the previous five years and was consequently made the subject of a deportation order. (This was served on him on 22 October 2014.)

40. In April 2014, Detainee A was sentenced to two further concurrent terms of 12 months imprisonment for affray and possession of a knife in a public place and he was transferred between various prisons including HMP Wormwood Scrubs and HMP Belmarsh. In 2015, intelligence reports recorded that Detainee A was believed to be the perpetrator of several violent incidents against other prisoners and staff.

41. Detainee A has a history of mental health issues. In 2005, he was admitted to a Psychiatric Intensive Care Unit (PICU) and was monitored by the Community Mental Health Team (CMHT). In 2008, he was given a differential diagnosis of adjustment disorder and personality disorder, and in 2012 he was given a provisional diagnosis of schizophrenia, with a differential diagnosis of anti-social personality disorder. At the time he was prescribed olanzapine, an antipsychotic medication.

42. In July 2015, Detainee A was referred to the mental health team at HMP Wormwood Scrubs after he chose to stop taking olanzapine. In August 2015, he was assessed as having no active depressive or psychotic disorder and having the capacity to decide to stop taking his medication.

2016

43. From February to May 2016, Detainee A was involved in several violent incidents in prison, including threatening to stab a nurse at Wormwood Scrubs and disturbing Muslim prayers. An imam banned him from prayers for four weeks. He also threatened an officer, saying that he was going to “sort her out” because he had not been unlocked by the gym staff. The officers and the imam submitted Mercury security reports.

44. On 15 July, Detainee A completed his sentence and was transferred from Wormwood Scrubs to Colnbrook IRC pending his deportation. On arrival, a DCO requested his Mercury security intelligence file from HMP Wormwood Scrubs. The prison refused to share it with him. The DCO recorded that the prison told him about Detainee A’s incident with the imam during prayers and that he had displayed extremist thoughts.

45. On 17 July, Detainee A was due to be removed from the UK but the removal was postponed due to his disruptive behaviour. A further unsuccessful attempt was

made on 26 July. On 29 July, he was transferred back to Wormwood Scrubs where he remained for six weeks, detained under immigration law.

46. On 10 September, Detainee A was transferred to Harmondsworth IRC and, four days later, to Colnbrook. On 13 September, he pushed another detainee against a wall in the barbershop area and directed homophobic comments at him. He was moved to the Care and Separation Unit (CSU) under Rule 40 of the Detention Centre Rules 2001. This provides for removal from association where it appears necessary in the interest of security or safety. An officer opened an anti-bullying log in respect of him, issued an Incident Report and gave him a 'strike' under the IEP Scheme.

47. A further attempt was made to remove Detainee A on 14 September, but this failed when he disrupted a scheduled removal flight. An officer noted in his PER that he had been abusive to an officer and had a history of disruptive behaviour on planned removals.

48. In his Room Sharing Risk Assessment, an officer assessed that Detainee A could safely share a room with another detainee at Colnbrook, on the grounds that he had not committed any life-threatening assaults.

49. Following the failed removal, Detainee A was transferred back to HMP Wormwood Scrubs where he attacked a prisoner with a table leg and was placed on the basic level of IEP. On 21 September, he received a further sentence of one year's imprisonment for affray and possession of a pointed article.

50. On 12 October, Detainee A was transferred to The Verne IRC (which is operated by HMPPS), where he remained until 9 November. During a health screening, he told a nurse, incorrectly, that he had not received any treatment from a psychiatrist in the community or in prison. She planned to refer him for a mental health assessment because he said that he had self-harmed. She assessed that he was fit for any location, work and room occupancy and staff continued to assess him as being able to share a room.

51. Seven days later, Detainee A set off the fire alarm at 6:40am. A DCO recorded that he had said that the alarm was false, although he also told detainees that he could "see the fire". She recorded that other detainees had said that his behaviour had been erratic and that he was "crazy". She submitted a Mercury security intelligence report.

52. On 29 October, A DOC referred Detainee A to the mental health team because he was behaving strangely. He had entered the wing office stating that there was an officer outside "beating detainees up" but there was no such officer. She submitted a Mercury security intelligence report. Eight days later, the mental health team planned to assess him and added him to their waiting list for triage. However, he was transferred before the assessment took place.

53. On 9 November, Detainee A was transferred to Harmondsworth IRC, where he remained for 14 days. During the initial health screening, a nurse recorded that he did not mention any previous history of mental illness. He also said, falsely, that he had had no previous contact with psychiatric services, although there was a well-documented history of mental health interventions in his medical records.

The nurse did not check Detainee A's medical history on the SystmOne record fully and did not, therefore see that he had been referred to the mental health team at The Verne. She did not refer him to the mental health team at Harmondsworth. A DCO assessed that Detainee A could share a room.

54. On 11 November, Detainee A disrupted another scheduled flight to Iraq. A week later, a detainee reported that he had taken other people's clothes out carelessly at the laundry and put them on the floor. When challenged, he became disrespectful and abusive towards a DCO. On 19 November, he was very aggressive in the servery during lunch, shouting and disturbing other detainees. Three DCOs recorded the incidents in his Detainee Management System (DMS) History Sheet. They asked him to calm down and behave according to the Centre's rules.

55. On 22 November 2016, Detainee A behaved inappropriately towards a female member of staff (making sexual comments and touching her hair). When the Detention Custody Manager (DCM) spoke to him about this, he became aggressive. Two DCMs submitted an incident report, downgraded his IEP level to standard, excluded him from employment for 28 days and placed him in the CSU under rule 40 of the Detention Centre Rules.

23 to 30 November 2016

56. On 23 November, Detainee A was moved to Colnbrook IRC for the third time. On 25 November, a DCO recorded that he was verbally abusive towards other detainees during breakfast. He intervened to de-escalate the situation.

57. On the afternoon of 30 November, Detainee A had a fight with another detainee in the exercise yard. The detainee had just arrived in the unit and did not know him. A DCO intervened to de-escalate the situation. She said that Detainee A appeared very withdrawn. She made a record in his DMS History Sheet. The Custodial Manager (CM) resolved the conflict by mediating between the two detainees. The CM told the investigator that Detainee A agreed to behave and to stay away from the other detainee. He said he told him that if there were any further incidents between the two, then both would be relocated to the CSU. No one issued an incident report or recorded this event properly. He was not given an IEP strike.

58. Later, at around 6.10pm, Detainee A put on his new room-mate's clothes. He also put his bedding outside the room. The DCM decided to place him on single occupancy in his own room and referred him for a mental health assessment because of his odd behaviour. The DCM submitted an incident report.

Events of Thursday 1 December 2016

59. CCTV footage shows that at 8.43am on 1 December, Mr Chowdhury entered Room 5 allocated to Detainee B and Detainee C and other detainees. Detainee C was alone in his room when Mr Chowdhury arrived. He said they had a "general conversation" and Mr Chowdhury left. Mr Chowdhury then returned to Room 5, Detainee B also entered and the three started to talk.

60. At 8:44am, CCTV footage shows Detainee A entering Room 5. He asked Detainee B and Detainee C for a lighter but became agitated and started to shout

at Mr Chowdhury. Detainee C said he told Detainee A that Mr Chowdhury could not speak English, did not smoke and did not have a lighter. Detainee A then slapped Mr Chowdhury in the face, causing him to fall backwards into the bottom bed of the room's two-bed bunk, and continued punching Mr Chowdhury in the face repeatedly.

61. At 8.45am, Detainee B left the room. Detainee C, who remained, said he asked Detainee A to stop punching Mr Chowdhury and tried unsuccessfully to grab Detainee A's arm. He left the room seconds later and asked Detainee D, another detainee, to help. Detainee D entered Room 5 and saw that Detainee A was still punching Mr Chowdhury in the head and body with both hands. He said he asked Detainee A what he was doing, and he stopped punching Mr Chowdhury and left the room. Detainee D said that when he entered Room 5, Mr Chowdhury was bleeding profusely. At around 8.46am, Detainee D pressed the emergency bell in the room and shouted for assistance.

62. Seconds later, two DCOs arrived at the room. The DCO said that when he arrived at Room 5 he noted that there was blood near the door handle and immediately asked for assistance over the radio saying, "First response, Oscar 1 to induction unit". He then entered and saw Mr Chowdhury on the bed on his back, with his head pointing towards the door and his feet touching the floor. He saw a lot of blood and said that he used his radio again to call a medical emergency, code red (indicating that a detainee has severe loss of blood). He said he put Mr Chowdhury into the recovery position and checked for a pulse but found none.

63. A nurse, who heard the medical emergency call over the radio, arrived on the first floor of the induction unit shortly afterwards and found many detainees and officers in front of Room 5. CCTV shows that healthcare staff arrived at Room 5 at 8.48am, seconds after a third DCO arrived. The nurse told the investigator that when he entered the room he saw Mr Chowdhury in the recovery position on the lower bed of the bunk. He said that there was blood all over Mr Chowdhury's face and blood on the bed. He said that he tried to shake Mr Chowdhury and asked him if he could hear him, but blood was coming out of his mouth and Mr Chowdhury did not respond.

64. The nurse asked a DCO to request an ambulance and she did at around 8.50am, as recorded in the control room log. The ambulance service records show that the immigration removal centre requested the ambulance at 8.51am and that they dispatched four vehicles. The first arrived at Colnbrook eight minutes later.

65. At around 8.53am, a second nurse arrived at the scene without the emergency bag or the oxygen cylinder. A third nurse then arrived with the emergency bag but not the oxygen cylinder. The first nurse went to fetch the oxygen cylinder and returned about two minutes later. There was a considerable delay in beginning oxygen administration to Mr Chowdhury and it appears that healthcare staff did not use suction to remove blood from the airway, or use an airway. Healthcare staff did not move Mr Chowdhury off the bed and did not start CPR.

66. At 9.06am, paramedics arrived at Room 5. They found that Mr Chowdhury was not breathing and had no pulse. Mr Chowdhury presented with a cardiac arrest. Paramedics moved him to the corridor and started CPR. By 9.20am paramedics

had performed a full examination of Mr Chowdhury: his temperature was very low and there was no spontaneous respiration or blood pressure.

67. At 10:56am, paramedics took Mr Chowdhury to hospital, arriving at around 11.08am. A Home Office official, recorded a temporary discharge of Mr Chowdhury from Colnbrook's care to hospital. Two DCOs then arrived at the hospital. Mr Chowdhury was in a critical condition and had life-threatening injuries. He was kept alive artificially. At around 4.36pm, Mr Chowdhury was transferred to the Emergency Department at a different hospital. At 9.24pm, he was pronounced dead.

Contact with Mr Chowdhury's family

68. At around 10.30am on 1 December 2016, a Home Office family liaison officer (FLO), contacted Mr Chowdhury's next of kin (a family friend) and Mr Chowdhury's sister. He informed them that Mr Chowdhury was in a critical condition.

69. At around 2pm, the Home Office FLO went to hospital, met Mr Chowdhury's family and stayed with them until Mr Chowdhury died. He continued providing support to Mr Chowdhury's family and, on 7 December, together with the Police Family Liaison Officer, he visited Mr Chowdhury's family in person, offering further support.

70. On 20 January 2017, Mr Chowdhury's funeral took place after his body was repatriated to Bangladesh. The Home Office contributed to the costs of repatriation and of the funeral, in line with Home Office guidelines.

Support for detainees and staff

71. After Mr Chowdhury's death, the centre's manager debriefed 18 members of staff. Two DCOs told us that there was no staff care support team in place at the time of the incident.

72. IRC Colnbrook posted notices informing other detainees of Mr Chowdhury's death, and 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 Chowdhury's death.

Post-mortem report

73. The pathologist concluded that Mr Chowdhury died as a direct consequence of a blunt force trauma assault, resulting in head and facial injuries and associated complications. Toxicology analysis detected no alcohol or drugs in Mr Chowdhury's body.

Police investigation and sentence

74. After the incident, Detainee A told the police that he did not know Mr Chowdhury and that he had attacked him because Mr Chowdhury was in the process of "raping his sister in the room". He said he remembered pushing Mr Chowdhury to the floor but nothing else.

75. On 3 December 2016, Detainee A was remanded to HMP Wormwood Scrubs. On 8 May 2017, he pleaded guilty to manslaughter on the grounds of diminished responsibility, two psychiatrists having concluded that at the time of killing Mr Chowdhury he was suffering from a mental disorder. On 29 June 2017, he was admitted to a secure mental health hospital, under the Mental Health Act 1983 for further assessments.

76. On 11 September 2017, a consultant forensic psychiatrist, completed a report on Detainee A. She concluded that he was not currently exhibiting any evidence of psychosis and that there were no grounds for him to be detained under the Mental Health Act. The next day, he was transferred to HMP Belmarsh.

77. On 13 November 2017, Detainee A was sentenced to 20 years imprisonment for the manslaughter of Mr Chowdhury: 15 in custody and five on extended licence. The judge also ordered that he should be deported at the end of his sentence.

Central and North-West London (CNWL) NHS Trust disciplinary investigations

78. CNWL NHS Trust conducted a disciplinary investigation into the clinical response of two of the nurses who attended to Mr Chowdhury. In February 2018 the investigation concluded that the nurses had made an inadequate assessment of Mr Chowdhury's condition, failed to recognise the deterioration in his condition, failed to take the oxygen cylinder to Mr Chowdhury's room (delaying the provision of oxygen in the resuscitation attempt), and failed to monitor Mr Chowdhury adequately after the incident.

79. The actions of the two nurses were deemed to constitute gross misconduct and a breach of the Trust Clinical Code of Conduct. They were dismissed from the Trust.

Findings

Mr Ahmed's mental health care

80. Detention Services Operating Standards state that IRCs must provide primary care services for the observation, assessment, and management and care of detainees with mental healthcare needs. Detention Service Order (DSO) 01/2016, *Medical Information Sharing*, states that subject to relevant medical confidentiality, staff have a duty to consider information sharing where it is relevant to the identification of a risk of self-harm or suicide or to an individual's healthcare needs.

81. Detainee A had a history of mental health issues which was well documented in his records. In 2005, he had spent time in a mental health hospital and was monitored by the CMHT. In 2008, a psychiatrist said that he suffered from personality disorder with acute and transient psychotic symptoms. There was also a provisional diagnosis of schizophrenia in 2012.

82. On 30 October 2016, an officer at The Verne IRC referred Detainee A to the mental health team for assessment because she had concerns about his behaviour and, on 7 November, the mental health team there added him to the waiting list for triage.

83. When Detainee A transferred to Harmondsworth IRC on 9 November, there was no communication between the immigration centres on his current mental health concerns. However, the referral to The Verne's mental health team was recorded in his SystmOne medical records and the clinical reviewer considers that this should have prompted a referral to the mental health team at Harmondsworth. The clinical reviewer has expressed concern that the nurse did not check Detainee A's records properly at the initial health screening at Harmondsworth and did not note the mental health referral. As a result, she did not take any action and did not refer him for a mental health assessment at Harmondsworth.

84. During his time at Harmondsworth Detainee A disrupted another attempt to remove him, was aggressive to staff and other detainees and behaved inappropriately to a female member of staff. His behaviour led to him being placed in the CSU.

85. Following his transfer to Colnbrook on 23 November, Detainee A's behaviour continued to give cause for concern and officers and detainees had concerns about his mental health. A DCO said that Detainee A was very withdrawn on 30 November, the day he started a fight with another detainee without apparent reason. A DCM referred him for a mental health assessment the same day because of his odd behaviour towards his room-mate. Detainee C said that Detainee A often spoke to himself and that he thought he had a mental health problem.

86. The clinical reviewer concluded that he was unable to say whether Detainee A had an enduring mental illness at the time he killed Mr Chowdhury. He considered, however, that he should have undergone a full mental health assessment when he transferred to Harmondsworth in early November. He was

concerned that healthcare staff at Harmondsworth and Colnbrook did not give sufficient attention to the available medical information about Detainee A, and did not formally consider the need to review, and possibly re-start, Detainee A's anti-psychotic medication.

87. DSO 01/2016, *Medical Information Sharing*, refers to the Enforcement Instructions and Guidance (EIG) and highlights the importance of staff considering all relevant factors, including any history of physical or mental ill health, to decide on the need for initial or continued detention. Any significant changes to the physical or mental health of a detainee that may impact the decision to detain or remove must be notified to the Home Office case owner as a matter of urgency.

88. We are concerned that, as healthcare staff did not assess Detainee A's mental health while he detained, they missed an opportunity to identify any critical changes in his mental health, to enable the Home Office case owner to review the suitability of his on-going detention. We make the following recommendation:

The Home Office should ensure that healthcare providers and staff in the immigration detention estate share information about risks relating to detainees' mental health when they move between immigration removal centres.

The Head of Healthcare at Heathrow IRC should ensure that healthcare staff review the SystmOne records thoroughly during reception to guarantee continuity of healthcare for detainees and the identification of their mental health needs.

Intelligence and information-sharing

89. Detainee A was in prison, with occasional releases, for long periods between February 2012 and July 2016 and, while in custody, had an extensive history of aggressive and violent behaviour towards staff and other prisoners. At the end of 2015, he threatened to stab a nurse, fought and assaulted other prisoners, was banned from Muslim prayers because he caused disturbances, behaved aggressively and threatened staff.

90. In July 2016, five months before he killed Mr Chowdhury, he was transferred from HMP Wormwood Scrubs to the IRC estate. On arrival at Colnbrook IRC, a detention custody officer requested his Mercury security intelligence file from Wormwood Scrubs but the prison refused to share the file (although some information was shared verbally).

91. Although his Mercury security file did not contain any specific intelligence to indicate that he was going to gravely injure another person, there was relevant information about staff concerns about his mental health and his history of violent behaviour. Supporting intelligence and assessments highlighted Detainee A's assaults on staff and referred to several negative case notes about violence against other prisoners, and references to his displaying extremist thoughts and tendencies on occasions.

92. The Head of Security at Colnbrook at the time of Mr Chowdhury's death, told the investigator that most prisons refuse to share Mercury intelligence reports because Colnbrook is not run by HMPPS. He told the investigator that he thought prisons should share this information and that, ideally, all immigration removal centres should have a Mercury terminal to enable them to submit and review intelligence reports without restrictions. He also said that he had raised this issue with the Home Office but no clear progress has been made.

93. We are concerned that when Detainee A transferred to Colnbrook, IRC staff did not have all the information available about the history of violent behaviour contained in his Mercury intelligence file. In the absence of such information, it was not possible for IRC staff to make a full assessment of his risk to himself or others. We consider that this information should have been shared with staff at Colnbrook, and we make the following recommendation:

The Home Office and HMPPS should agree a consistent approach to the sharing of Mercury intelligence reports between prisons and all immigration removal centres, including those that are not run by HMPPS, in order to provide staff in detention centres with the information they need to help them assess the risk that detainees pose to themselves and others.

94. However, even in the absence of the Mercury intelligence, IRC staff were aware that Detainee A had a history of violent offending, had been disruptive and aggressive in prison, had disrupted attempts to remove him and had been placed in the CSU and made subject to anti-bullying procedures after assaulting another detainee on 13 September. In these circumstances it is difficult to understand why IRC staff assessed him in September 2016 as suitable to share a room with another detainee – and continued to do so until the DCM moved him to a single room the day before Mr Chowdhury was killed.

Bullying and violence reduction

95. Colnbrook's violence reduction policy at the time of Mr Chowdhury's death stated that all detainees, staff and others should feel safe and able to function effectively, free from fear of violence, threatening behaviour and intimidation or bullying. One key objective of the policy was to reduce violent offending and prevent victimisation. The policy said that all forms of conflict, bullying and violence must be addressed and tackled effectively.

96. Colnbrook also has an anti-bullying strategy to tackle incidents of physical violence, insults, threats and intimidation as well as sexual humiliation and abuse. It sets out an anti-bullying procedure which involves supervision of perpetrators. For instance, stage one of the anti-bullying monitoring procedure requires staff to supervise perpetrators for two to four days from the day of a violent incident, then review and continue monitoring them for a further seven days.

97. On 30 November, the day before Detainee A killed Mr Chowdhury, he had what the CM described as "a physical altercation" with another detainee. A DCO said that she and other staff intervened. We are concerned that the DCO did not make an incident report or make a proper record of the incident. We are also

concerned that the CM, who mediated between the two detainees, did not issue an IEP strike and did not consider monitoring Detainee A.

98. Later in the evening, Detainee A was rude to his room-mate, put on his room-mate's clothes and left his bedding outside the room. The DCM spoke to him and decided to place him in a single room. He issued an incident report but took no further action. The DCM said that the incident involving Detainee A's room-mate did not justify sending him to the CSU, but he did not consider whether it was necessary to monitor him closely or to issue an IEP disciplinary 'strike' either.

99. There is no structured disciplinary system at immigration removal centres comparable to the adjudication system in prisons. The Head of Security at Colnbrook told us that, for this reason, one of the key mechanisms to manage violent detainees at Colnbrook is the IEP/strike system. The local violence reduction policy states that any detainee who displays antisocial behaviour in a way that is abusive or causes offence or harm to other individuals, must be challenged through the IEP scheme, or with a period of 'time out', which means sending the detainee to the CSU. We are concerned that while Detainee A was at Heathrow IRC, records show that he was only challenged with IEP strikes on two occasions: on 18 July because he refused to attend activities, and on 13 September 2016 because he made homophobic comments towards another detainee.

100. The DCO said that Detainee A was displaying strange behaviour at Colnbrook and that people were afraid of him. Detainee C, told a police officer that he did not know Detainee A well but also said that he and other detainees were afraid of him. The DCO told the investigator that she was surprised that managers did not send Detainee A to the CSU on 30 November under Rule 40 of the Detention Centre Rules. After the tragic events of 1 December, she said that she was not surprised that Detainee A had attacked another detainee because she had noted how his behaviour was becoming increasingly dangerous.

101. HM Inspectorate of Prisons found in its last inspection in March 2016 that allegations of bullying were not sufficiently monitored at Colnbrook and that the IEP system was largely irrelevant. In the Inspectorate's survey, half of their respondents said that they felt unsafe and about a quarter said other detainees had intimidated or victimised them.

102. Although we do not think that staff could have foreseen that Detainee A would assault another detainee so violently on 1 December, we believe that staff should have paid more attention to the obvious signs of his disturbing and escalating behaviour at Harmondsworth and Colnbrook. Staff dealt with his behaviour and violent incidents in isolation, did not monitor him and did not take effective action in line with the violence reduction policy and anti-bullying strategy. We consider that staff should have acted more robustly to prevent Detainee A from causing further harm, in line with Colnbrook local policies. We make the following recommendation:

The Centre Manager of Colnbrook IRC should ensure that staff respond effectively to anti-social and violent behaviour by detainees in line with the Centre's violence reduction policy and anti-bullying strategy.

Emergency Response

103. We share the clinical reviewer's view that the emergency response by healthcare staff was inadequate. They did not properly assess Mr Chowdhury's condition and failed to recognise his clinical deterioration. There was a considerable delay in bringing and administering oxygen. Healthcare staff did not commence CPR procedures and did not provide suitable life support.

104. The clinical reviewer said that, given such an inadequate response, the care provided to Mr Chowdhury was not equivalent to the care he would have expected to receive in the community.

105. The CNWL disciplinary panel found that although it was not possible to say whether Mr Chowdhury would have survived if the nurses had acted appropriately, their failings could only have had an adverse impact on Mr Chowdhury. We repeat the clinical reviewer's recommendation:

The Head of Healthcare at Colnbrook IRC and Central and North-West London NHS Foundation Trust (CNWL) must ensure that all healthcare staff undertake Immediate Life Support (ILS) training which covers quality CPR, airway management and the recognition of clinical deterioration.

106. DSO 09/2014, *Medical Emergency Response Codes*, contains mandatory instructions for communicating the nature of a medical emergency efficiently, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It clearly states that staff must be made aware of, and understand this order and their responsibilities during medical emergencies. Colnbrook local policy clearly states that control room staff must call for an ambulance automatically when staff radio either a code red or blue.

107. There was a delay of about five minutes in calling the ambulance after the DCO discovered Mr Chowdhury bleeding in his room. We found from the DCO, and two nurses, that there was confusion among staff about when an ambulance should be called during an emergency. Contrary to national orders, they said that some officers would wait for a nurse or manager to confirm that an ambulance was required, even if an emergency code was radioed. We make the following recommendation:

The Centre Manager and the Head of Healthcare at Colnbrook IRC should ensure that all staff are made aware of and understand DSO 09/2014, *Medical Emergency Response Codes,* and their responsibilities during medical emergencies as outlined in the Local Medical Emergency Response Code Protocol, so that staff efficiently communicate the nature of a medical emergency and there is no delay in calling ambulances.

Support for staff

108. DSO 08/2014, *Death in Detention*, states that the centre's manager must ensure that a hot debrief is held with the staff involved in the emergency response immediately after any death in detention. DSO 08/2014 also states that centre

managers must ensure that they have procedures in place to support both staff and detainees appropriately, for example by providing the opportunity for face-to-face meetings, chaplaincy team support, healthcare team support, Samaritans or bereavement help lines.

109. The DCO, who was the first officer to discover Mr Chowdhury unresponsive and bleeding, told the investigator that he was not invited to a debrief after Mr Chowdhury's death and that he did not feel adequately supported by senior staff. The DCM, who was also involved in the emergency response, also said that he was not invited to a hot debrief and did not feel well supported. The nurses involved in the emergency response did not participate in the debrief. Two officers told the investigator that at the time of Mr Chowdhury's death, there was no staff care support team at Colnbrook and that any staff welfare concerns were dealt with by the human resources manager.

110. Although we recognise that some action was taken to offer support to some members of staff involved in the emergency response, we are concerned that not all officers involved felt that they received the support they needed after Mr Chowdhury's death. We are therefore not satisfied that the expectations of DSO 08/2014 have been fully met in this case. We make the following recommendation:

The Centre Manager should ensure that all relevant mandatory actions in DSO 08/2014, *Death in Detention*, are completed after a detainee's death. In particular, staff involved in an emergency response should be adequately supported and debriefed by a senior member of staff.

Psychoactive Substances (PS)

111. The police told the investigator that, during the criminal proceedings, Detainee A told psychiatrists that he had taken psychoactive substances (PS) before killing Mr Chowdhury.

112. There is no other evidence that Detainee A had taken PS. He refused to allow police officers to take a blood sample and it was not possible to ascertain whether he had taken illegal substances. Prison and IRC staff made no record or references to him having been under the influence of drugs while in detention and he did not have a history of substance misuse.

113. In their last inspection of Colnbrook in March 2016, HM Inspectorate of Prisons found some evidence of an increase in the availability and use of PS at Colnbrook. The Colnbrook IMB also reported an escalation in PS use. The Head of Security at Colnbrook told the investigator that PS is a problem at Colnbrook but that the security department is aware of it and is taking active steps to address it, for example by using trained dogs during robust searches. We welcome these steps and encourage the Centre Manager to continue working on ensuring that there are effective and developed supply and demand reduction strategies at Colnbrook to reduce the availability of PS.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141