Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marcin Gwozdzinski a detainee at Heathrow Immigration Removal Centre on 7 September 2017

A report by the Prisons and Probation Ombudsman

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

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.

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 Marcin Gwozdzinski was found hanging in his room at Heathrow Immigration Removal Centre (IRC) on 3 September 2017 and he died in hospital four days later. He was 28 years old. We offer our condolences to Mr Gwozdzinski's family and friends.

Mr Gwozdzinski was a Polish national who was facing deportation from the UK after committing a number of criminal offences. He had been detained at Heathrow IRC for over six months when he was found hanging. It was unclear to us why he had been detained for such a long period and we found that the reasons for his continued detention were not properly communicated to him.

Mr Gwozdzinski became increasingly frustrated and distressed at the IRC. Three days before he was found hanging, staff began suicide and self-harm prevention monitoring but stopped it the next day.

We found that staff failed to properly assess Mr Gwozdzinski's risk of suicide and stopped monitoring him prematurely. They also failed to restart suicide prevention measures when Mr Gwozdzinski presented as highly distressed the day before he was found hanging.

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
Acting Prisons and Probation Ombudsman **May 2018**

Contents

Summary

Events

1. Mr Marcin Gwozdzinski was remanded to prison custody on 26 November 2016 on charges of assault and criminal damage. Due to his offending history, he had been recommended for deportation back to Poland once criminal matters had concluded. He arrived at Heathrow Immigration Removal Centre (IRC) from HMP Wandsworth on 13 February 2017.

2. On three occasions during May and June, Mr Gwozdzinski was suspected of being under the influence of an illicit substance. Intelligence reports (IR) were submitted but healthcare staff were not informed.

3. On 13 June, the Home Office recorded that Mr Gwozdzinski had provided a possible release address and indicated that this could be considered once court matters had concluded.

4. On 19 July, Mr Gwozdzinski appeared at court in relation to the offences of criminal damage and assault. The court did not impose any further sentence due to the time already spent on remand and he was returned to Heathrow IRC.

5. On 31 August, staff started suicide and self-harm monitoring (Assessment, Care in Detention and Teamwork – ACDT procedures) after Mr Gwozdzinski became distressed. He told staff he was frustrated at being in detention and that he wanted to die. Staff stopped ACDT monitoring the next day after staff decided that Mr Gwozdzinski's distress was due to toothache and that he was no longer at risk as a dental appointment had been requested.

6. On 2 September, Mr Gwozdzinski made a number of calls to the ambulance service and appeared very distressed. A nurse made a referral to the mental health team but no one restarted ACDT monitoring.

7. On 3 September, Mr Gwozdzinski was heard smashing things in his room. Another detainee alerted staff but no action was taken and Mr Gwozdzinski was locked up as usual at 1pm. At around 2pm, an officer unlocked Mr Gwozdzinski's room but she did not look in. Mr Gwozdzinski was found by another detainee hanging from the TV bracket in his room at around 2.15pm. Staff attended and cut down Mr Gwozdzinski before the first response nurse arrived and started cardiopulmonary resuscitation (CPR). IRC staff and two other nurses continued with resuscitation attempts until paramedics arrived. The paramedics were successful in resuscitating Mr Gwozdzinski and transferred him to hospital. However, he died in hospital four days later, on 7 September.

Findings

8. We found that staff failed to properly assess Mr Gwozdzinski's risk of suicide and self-harm. Staff stopped ACDT monitoring prematurely and, when Mr Gwozdzinski showed signs of further distress, they failed to consider restarting ACDT monitoring.

9. We found it very difficult to establish the reasons for Mr Gwozdzinski's prolonged period of detention and the reasons were certainly not communicated to him. We consider that this was a significant contributory factor to his distress and frustration.

10. There was a delay in staff starting CPR because the first medical responder did not attend with all the necessary equipment. The clinical reviewer was, though, unable to say whether this affected the eventual outcome.

11. We found that there was a lack of information sharing between IRC staff and healthcare staff. Mr Gwozdzinski was found to be under the influence of illicit substances on three occasions but healthcare staff were not informed. Neither were they informed when Mr Gwozdzinski was subject to ACDT monitoring.

Recommendations

- The Centre Manager should ensure that IRC staff manage detainees at risk of suicide or self-harm in line with DSO 6/2008, including that they:
    - assess the level of risk based on all available information and known risk factors and not on a detainee's presentation, and record the reasons for the decision;
    - ensure ACDT reviews are multidisciplinary, including input from both healthcare and the Home Office caseworker, where appropriate;
    - ensure that healthcare staff are informed of all open ACDT plans.
- The Centre Manager should review the process for making IRC staff aware of detainees in the post-closure period of an ACDT plan so that they can be alert to any possible increase in risk and the potential need to restart ACDT monitoring if necessary.
- The Home Office and Centre Manager should ensure that all detainees are fully informed of the reasons for their ongoing detention, especially those detained longer than six months, by:
    - ensuring there is an effective flow of information between the Home Office caseworker and the on-site Home Office team so that comprehensive and accurate information is communicated to the detainee;
    - ensuring that detainees have an easily accessible point of contact where they can discuss their individual cases and that the process for using the service is clearly communicated.
- The Centre Manager and Head of Healthcare should review the emergency response procedures**,** ensuring that staff are aware of the mandatory requirements set out in DSO 09/2014, and addressing:
    - the role of the appointed medical responder in a medical emergency and, in particular, the equipment they should take with them when responding;
    - the induction and ongoing training programme for IRC and healthcare staff, especially those expected to take on the role of appointed medical responder.
- The Centre Manager and Head of Healthcare should review protocols for sharing information between IRC staff and healthcare staff, in particular for substance

misuse and mental health concerns which may give rise to an increased risk of suicide and self-harm.

The Investigation Process

12. The Investigator issued notices to staff and detainees at Heathrow IRC informing them of the investigation and asking anyone with relevant information to contact her. Several detainees contacted the Ombudsman's office expressing concerns about conditions at the IRC and the risk of further deaths, but no one provided specific information about Mr Gwozdzinski's death.

13. The investigator obtained copies of relevant extracts from Mr Gwozdzinski's detention and medical records from the IRC. She and an Assistant Ombudsman also met staff at the Home Office's Criminal Casework Team and obtained copies of relevant paperwork relating to Mr Gwozdzinski's detention.

14. NHS England commissioned a clinical reviewer to review Mr Gwozdzinski's clinical care at the IRC.

15. The investigator and the clinical reviewer jointly interviewed 16 members of staff at Heathrow IRC. The investigator and the Assistant Ombudsman separately interviewed one detainee. The interviews took place between September and December 2017.

16. We informed HM Coroner for West London of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Gwozdzinski's next of kin, via an interpreter, to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Gwozdzinski's family wanted to know if the police were investigating and asked to see a copy of CCTV footage. They raised a number of questions, including:

    - Why did the Home Office not contact them about releasing Mr Gwozdzinski to their address?
    - Why did no one offer him help when he asked for it?
    - Why did no one hear him demolishing his room just before he hanged himself?
    - Why did the Home Office only release him when he was on life support at the hospital?

18. A copy of our initial report was sent to the Home Office and to Mr Gwozdzinski's family. Mr Gwozdzinski's family did not point out any factual inaccuracies but they raised other queries which have been addressed in separate correspondence. We have made some changes to this report after the Home Office pointed out some factual inaccuracies.

Background Information

Heathrow Immigration Removal Centre (IRC)

19. Heathrow IRC is Europe's largest immigration detention facility. It is located a few hundred metres from Heathrow Airport and comprises two adjacent sites, Harmondsworth and Colnbrook. Since the start of a new contract in September 2014, both sites have been run for the Home Office by Care and Custody, a division of the Mitie Group. Mr Gwozdzinski was located at the Harmondsworth site which holds up to 661 male detainees. Central and North West London (CNWL) NHS Foundation Trust provides all healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of the Harmondsworth site at Heathrow IRC was in October 2017. Inspectors said that the IRC failed to progress significantly since their last inspection in 2015 noting that, for the third consecutive inspection, there were failings in the areas of safety and respect. Although there had been some improvement, this was not of the scale or speed required and, in some areas, there had been a deterioration. Inspectors acknowledged the challenges faced by staff due to the large number of detainees with mental health problems and those defined as vulnerable. They found that healthcare staff were unable to meet the high level of mental health need. Compared to other IRCs, there was a high number of detainees who said that staff did not treat them with respect and the standard of accommodation remained below an acceptable standard. Many detainees reported feeling a sense of purposelessness and boredom. Despite this, levels of self-harm were lower than in other centres and most detainees at risk of suicide or self-harm said they felt supported. Inspectors found that some people had been detained for excessive and unacceptable periods of time although, positively, the on-site immigration team made a good effort to engage with detainees.

Independent Monitoring Board

21. Each IRC 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 annual report for the year to 31 December 2016, the IMB repeated previous recommendations for an independent body to review the cases of detainees held at the IRC for more than six months. They were also critical of the Tascor escort service, saying they received many complaints from detainees affected by transport turning up late or not at all. The IMB had ongoing concerns about the provision of healthcare services and said this was due to staff shortages and a reliance on agency staff. The IMB said that suicide and self-harm monitoring operated well and suggested that the significant increase in those being monitored between 2015 and 2016 was due to good practice and awareness. They considered that incidents of self-harm were low, relative to the throughput of detainees.

Previous deaths at Heathrow IRC

22. Mr Gwozdzinski was the second detainee to take his life at Heathrow IRC since February 2016. The previous investigation into the death of a detainee at the

Colnbrook site identified concerns about the suicide and self-harm monitoring process and the emergency response.

Assessment, Care in Detention and Teamwork (ACDT)

23. ACDT is the Home Office care-planning system used to support detainees at risk of suicide or self-harm. The purpose of ACDT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the detainee. After an initial assessment of the detainee's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary review meetings involving the detainee. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACDT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACDT process and any relevant observations about the detainee should be written in the ACDT booklet, which accompanies the detainee as they move around the centre. Guidance on ACDT procedures is set out in Detention Services Order (DSO) 6/2008.

Key Events

24. Throughout this report, we have referred to Mr Marcin Gwozdzinski by the name on his birth certificate, as advised by his family after his death. However, during his time in prison custody and immigration detention, he was known as Mr Maciej Marcin Jackowski.

25. Mr Gwozdzinski was remanded to prison custody on 26 November 2016 on charges of criminal damage and assault. He was sent to HMP Wandsworth. Mr Gwozdzinski had committed previous offences and had been in prison before.

26. On 26 November, the Home Office notified Mr Gwozdzinski that he would be deported to Poland once police and court matters had been concluded. On 13 February 2017, he was transferred from Wandsworth to Heathrow IRC. At reception, he said that he had no history of substance misuse or mental health issues and no thoughts of suicide or self-harm.

27. On 18 February, Mr Gwozdzinski was seen by the on-site Home Office team for induction. He did not provide next of kin details or a release address and said he wanted to go back to Poland as soon as possible. On 22 February, the Criminal Casework Team in the Home Office carried out a paper detention review and informed Mr Gwozdzinski that he would remain in detention until outstanding criminal matters were concluded. Mr Gwozdzinski signed a disclaimer confirming that he intended to return to Poland and that he did not wish to appeal against his deportation.

28. On 23 March, Mr Gwozdzinski submitted a request to see an on-site Home Office representative to discuss his case. Around the same time, the Criminal Casework Team carried out a further detention review and the on-site representative saw Mr Gwozdzinski to serve the paperwork and discuss his case as requested. The representative said that Mr Gwozdzinski told him that he no longer wanted to be deported as he had a baby on the way.

29. On 7 April, Mr Gwozdzinski was due to attend court in relation to the outstanding criminal matters. However, due to an error on the part of the escort service (Tascor), no transport was provided and he did not attend. The court adjourned the matter to 19 May. The next detention review carried out on 21 April informed Mr Gwozdzinski that a barrier to his removal was “impending prosecutions awaiting an outcome”. It stated that he was unable to attend court on 7 April “due to unforeseen circumstances” but did not elaborate. The on-site Home Office team served the paperwork via internal post.

30. On 19 May, Tascor again failed to provide transport to take Mr Gwozdzinski to his adjourned court hearing. A detention review carried out the day before stated, “You are to appear before Croydon Magistrates on 19 May 2017”, and informed Mr Gwozdzinski that he would remain in detention awaiting the outcome of the criminal matters. The detention authorising officer expressed concern about the length of time Mr Gwozdzinski had been detained and said that deportation should go ahead as soon as the court matters had concluded. Mr Gwozdzinski was served with the paperwork for this detention review on 20 May via internal post, by which time he had again missed his court appearance. The court found

Mr Gwozdzinski guilty of the offence of assault in his absence (he had already pleaded guilty to criminal damage) and set a sentencing date of 19 July.

31. On 27 May, 1 June and 24 June, Mr Gwozdzinski was suspected of being under the influence of an illicit substance. On 29 May, following a room search, he was found to be in possession of a number of prohibited items, including hooch (alcohol made or obtained illicitly). Intelligence reports (IRs) were submitted for all four incidents but healthcare staff were not informed.

32. The on-site Home Office team sent an email to the Criminal Casework Team on 13 June providing a proposed release address in the UK for Mr Gwozdzinski. It is not clear how or when this address was obtained from Mr Gwozdzinski. The Criminal Casework Team told the investigator that they would have requested this address because of concerns about the length of Mr Gwozdzinski's ongoing detention and to explore the possibility of releasing him on bail. However, they were unable to trace the address and there is no evidence that they took any further steps to verify the address with Mr Gwozdzinski. The next detention review took place on 15 June. Detention was authorised by an Assistant Director in the Home Office who also expressed concerns about the length of time Mr Gwozdzinski had been detained and asked that the Criminal Casework Team take a more proactive approach to urgently progress his deportation or release. The on-site Home Office staff served the detention review paperwork on Mr Gwozdzinski via internal post.

33. On 29 June, Mr Gwozdzinski was served, in person, with a Deportation Order which was dated 24 May. The case note made by the on-site Home Office representative states that Mr Gwozdzinski was angry, saying that the Home Office had delayed serving him with the Order. However, he later told the representative that he wanted to return to Poland at once. A further detention review was carried out on 13 July and Mr Gwozdzinski was served with the paperwork, via internal post, informing him that he could return to Poland as soon as the outstanding court matters had been resolved.

34. On 19 July, Mr Gwozdzinski appeared at court for sentencing in relation to the offences of criminal damage and assault. The court did not impose any further sentence as he had spent several months remanded in custody and in detention. He was returned to Heathrow IRC.

35. On 10 August, the Criminal Casework Team sent another detention review to Mr Gwozdzinski confirming that he had attended court on 19 July and that he would be deported to Poland as soon as the criminal matters had been concluded. The paperwork did not clarify the nature of the outstanding matters nor did it mention any forthcoming court appearances. However, the internal Home Office paperwork, which was not shared with Mr Gwozdzinski, indicated that Mr Gwozdzinski had been due to attend court on 1 August in relation to a previous failure to attend but he did not go as he said he was unwell. It is not clear where this information came from as, although there is a request for Tascor to take him to court on 1 August, there is nothing noted in his detention record to say he was unwell. The detention review paperwork was served on Mr Gwozdzinski by internal post.

36. On 24 August, Mr Gwozdzinski attended an appointment with a dental officer. He said he had been experiencing disturbed sleep due to dental pain. She diagnosed a dental infection. She removed two of his teeth, at his request, and prescribed pain relief.

37. According to Mr Gwozdzinski's computerised medical records, on 25 August a nurse sent a request to the mental health team asking them to review Mr Gwozdzinski after he said he was feeling stressed. The nurse told the investigator that he remembers speaking to Mr Gwozdzinski on that date but he could not recall sending a specific request to the mental health team. The mental health manager said that he had overlooked the request.

38. On 27 August, Mr Gwozdzinski was seen by a doctor who prescribed amoxicillin antibiotics and co-dydramol pain relief for his dental pain. Mr Gwozdzinski had a further appointment booked with the GP on 30 August but he did not attend. The reason for this appointment is not clear from his records.

39. On 28 August, staff noted in Mr Gwozdzinski's detention record that his room-mate, had threatened to hurt him if he did not move out of their room. Records show that Mr Gwozdzinski had been sharing a room with him since 16 August. Another detainee who was Mr Gwozdzinski's friend, told the investigator that Mr Gwozdzinski's room-mate often acted strangely and talked about the devil. He said that Mr Gwozdzinski's behaviour had changed since he started sharing a room with him and that he had encouraged him to request a move away from him as he was worried about the effect he was having on him. The records show that Mr Gwozdzinski was moved from his room-mate's room on 28 August, but then returned there on 29 August. There is no record of the reasons for this and no evidence that the room-mate's threat towards Mr Gwozdzinski was passed onto security staff.

40. On the morning of 31 August, a detention custody officer noticed Mr Gwozdzinski looking unhappy so she offered to talk to him privately. He told her that he was frustrated at being in detention. She said he was distressed and tearful, saying that he was worried about his mental health and that he wanted to die. She was concerned about his presentation and what he had said to her, so she completed a Concern and Keep Safe form to begin the process of ACDT monitoring. Her manager, endorsed the form around 10.00am to say that he had contacted healthcare by telephone to ask them to see Mr Gwozdzinski but there is no evidence that this information was received by healthcare. He also recorded that Mr Gwozdzinski declined a room move and a phone call to his family.

41. At 12.05pm on 31 August, a manager completed an initial ACDT assessment with Mr Gwozdzinski. She noted that Mr Gwozdzinski was depressed over a lack of attention from the healthcare team and he said he had received no treatment for toothache. She concluded that the only action needed was for Mr Gwozdzinski to see a dentist. Later that day, Mr Gwozdzinski requested a room move and he was moved from the room he shared with his room-mate to room B210, a single occupancy room.

42. At 1.00pm on 1 September, Mr Gwozdzinski attended his first ACDT case review which was chaired by the residential manager and also attended by the safer community manager. The ACDT documentation erroneously stated that the

manager who completed an initial ACDT assessment attended this review but she had in fact only provided verbal input. The residential manager and the safer community manager concluded that Mr Gwozdzinski's main problem was his teeth and noted the caremap to say that a request had been made for him to see the dentist. They assessed Mr Gwozdzinski's risk of suicide or self-harm as low and decided to stop ACDT monitoring. The case review lasted three minutes.

43. On 2 September, Mr Gwozdzinski was seen by a nurse. The nurse noted that Mr Gwozdzinski had been late for his appointment and that he was irate and threatening. The nurse said that Mr Gwozdzinski was demanding an ambulance be called for him but, on examination, he could find no medical reason why Mr Gwozdzinski needed an ambulance. He noted that he was unable to reason with Mr Gwozdzinski and he was concerned about his mental health. He made a referral to the mental health team.

44. Later that day, Mr Gwozdzinski made numerous calls directly to the ambulance service from his mobile telephone. The ambulance log showed that Mr Gwozdzinski was not clear about why he needed an ambulance, but at one point he said to the controller that he needed a drip. An officer in the IRC control room said he cancelled the ambulance as Mr Gwozdzinski first needed to be assessed by healthcare. A detainee, who was Mr Gwozdzinski's friend, said that staff asked him to act as interpreter and tell Mr Gwozdzinski that he should not call an ambulance. He said that Mr Gwozdzinski was very distressed and tearful and he had never seen him like that before. The nurse recalled speaking to Mr Gwozdzinski to tell him that he could not call the ambulance. He could not recall specifically asking any other detainee to act as interpreter but he agreed there were other staff and detainees present in the office.

45. Around 12.50pm on 3 September, another detainee went to Mr Gwozdzinski's room after he heard him banging around and smashing things in his room. He said that Mr Gwozdzinski was upset, saying that he had been waiting three weeks for the Home Office to check a release address and he felt no one was listening to him. He said that Mr Gwozdzinski spoke about hurting himself or someone else and he was concerned enough to speak to an officer (Officer A) about him. He said that Mr Gwozdzinski had gone outside to have a cigarette so he called Officer A and showed him the broken items on the floor in Mr Gwozdzinski's room.

46. On his way back to his room, Mr Gwozdzinski asked another officer (Officer B) for a broom but she did not have one that he could use. She said she did not know why he wanted the broom but was not concerned about him in any way as he seemed to be in good spirits. Mr Gwozdzinski was locked up as usual at 1pm by Officer A. He said that Mr Gwozdzinski seemed fine and that, despite what the detainee had just told him and the broken items on the floor, he had no concerns about him.

47. Officer B began to unlock the detainees at around 2pm. She did not look into Mr Gwozdzinski's room when she unlocked it and she returned to the office once she had finished unlocking all the detainees. At approximately 2.10pm, the general alarm was pressed and a detainee went into the office to tell staff that Mr Gwozdzinski was trying to kill himself. She ran from the office and called for

assistance over the radio. Officer A followed closely behind and they both went into Mr Gwozdzinski's room where they saw him hanging from the TV bracket. He had used a cable and a belt as a ligature. Two other detainees were lifting his body to take the weight off so Officer A assisted in doing this while Officer B cut the ligature.

48. Officer B then radioed a code blue (a medical emergency code used to indicate that a detainee is unresponsive and requires an ambulance) and the ambulance was called at 2.20pm. Officer A thought Mr Gwozdzinski was breathing and put him in the recovery position. A nurse arrived at 2.20pm and assessed Mr Gwozdzinski before starting cardiopulmonary resuscitation (CPR) at around 2.25pm. Two further nurses and three IRC staff members also attended and assisted with CPR until paramedics arrived at around 2.35pm. Mr Gwozdzinski was resuscitated and transferred to hospital but he died in hospital on 7 September after life support was withdrawn.

Events after 3 September 2017

49. On 4 September, while Mr Gwozdzinski was on life support at the hospital, the Home Office signed an IS.106 Release Order, granting Mr Gwozdzinski unconditional release from immigration detention. The Home Office staff we spoke to were unable to tell us why this decision was taken.

50. On the same day, the Mental Health Manager responded to a nurse's referral to the mental health team (made on 2 September) saying that Mr Gwozdzinski would need to be seen by the GP first and then re-referred to the mental health team if symptoms persisted. The Mental Health Manager also noted that Mr Gwozdzinski was in hospital.

51. The PPO received several complaints, some of which were anonymous, about Mr Gwozdzinski's death and the conditions at Heathrow IRC. Some complaints were sent directly to the PPO and some through the Polish Embassy in London who also expressed concerns. The concerns were around Mr Gwozdzinski's poor mental health and the perceived lack of care from IRC staff.

Contact with Mr Gwozdzinski's family

52. Mr Gwozdzinski's brother was listed as his next of kin and a duty manager contacted him by telephone around 5.15pm on 3 September to let him know that Mr Gwozdzinski had been taken to hospital. The Deputy Centre Manager, and the Home Office appointed family liaison officer, later met with Mr Gwozdzinski's family at the hospital while Mr Gwozdzinski remained on life support. The Home Office paid for the repatriation of Mr Gwozdzinski's body to Poland for his funeral, but the family declined a contribution from the Home Office towards his funeral costs as they said these costs would be covered by their own insurance policy.

Support for detainees and staff

53. Staff involved in the emergency response were debriefed individually by a duty manager. Some staff said that they were offered support by the IRC's Human Resources department and by other colleagues.

54. The Centre Manager posted a notice for detainees informing them of Mr Gwozdzinski's death and offering support. Staff reviewed all detainees assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Gwozdzinski's death.

Post-mortem report

55. The pathologist found that Mr Gwozdzinski's death was caused by pneumonia as a result of a hypoxic ischaemic brain injury following hanging. No toxicology tests were undertaken so the presence of alcohol or illicit drugs could not be confirmed.

Findings

Identifying and managing risk of suicide and self-harm

56. We found that staff failed to properly assess Mr Gwozdzinski's risk of suicide and self-harm and stopped ACDT monitoring prematurely.

57. The Detention Custodial Officer started ACDT monitoring on 31 August because Mr Gwozdzinski was tearful, saying he was worried about his mental health and wanted to die. Later that morning, at the ACDT assessment interview, the only caremap action identified for Mr Gwozdzinski was the need for him to see a dentist. There was no mention of any concerns about his mental health and no referral to the mental health team.

58. The first ACDT case review was held the following morning. No healthcare staff attended, in spite of the requirement for a multidisciplinary approach and the need to inform healthcare of every new ACDT plan. Again, the focus was on the need for Mr Gwozdzinski to see a dentist and, as an appointment had already been requested, a decision was taken to stop ACDT monitoring. We consider this was premature. Firstly, because it was closed such a short time after Mr Gwozdzinski was found to be in a very distressed state. Secondly, because he had not been assessed by healthcare staff within that period and no one from healthcare had attended the case review. Thirdly, because although a dental appointment had been requested, Mr Gwozdzinski had not been seen by a dentist when the decision to close his ACDT was taken. We consider that staff failed to demonstrate that Mr Gwozdzinski's level of risk had reduced when they decided to stop ACDT monitoring. We are also concerned that the case review lasted only three minutes.

59. The day after ACDT monitoring was stopped, Mr Gwozdzinski repeatedly telephoned for an ambulance. When staff called him to the office to tell him that he must not do this, he was distressed and crying. His friend, a fellow detainee, and a nurse said they were concerned about his mental health at that time. The nurse was not aware that Mr Gwozdzinski had recently had an ACDT plan closed as it was not recorded on his medical notes, but he made a referral to the mental health team. We consider that staff should have considered restarting ACDT monitoring given Mr Gwozdzinski's obvious distress and the fact that he was awaiting an assessment by the mental health team.

60. On 3 September, another detainee said that Mr Gwozdzinski spoke about hurting himself or someone else and he was concerned enough to speak to Officer A about him and to show him the broken items in Mr Gwozdzinski's room. Officer A took no action in response. He said that Mr Gwozdzinski seemed fine and he had no concerns about him at lock up. There was no requirement for Mr Gwozdzinski to be monitored during the lunchtime lock up as he was not on an ACDT. Officer A and Officer B were both unaware that Mr Gwozdzinski's ACDT plan had recently been closed. The Safer Community Manager told us that staff were not immediately aware of detainees in the post-closure period of an ACDT plan and they would have to log onto the computer system to check for themselves. He could not be sure if staff did this all the time, but he said it was their responsibility to do so. No one who spoke to Mr Gwozdzinski after 31

August was aware that he was in the post-closure period of an ACDT plan. We make the following recommendations:

The Centre Manager should ensure that IRC staff manage detainees at risk of suicide and self-harm in line with DSO 6/2008, including that they:

- **assess the level of risk based on all available information and known risk factors and not on a detainee's presentation, and record the reasons for the decision;**
- **ensure ACDT reviews are multidisciplinary, including input from both healthcare and the Home Office caseworker, where appropriate;**
- **ensure that healthcare staff are informed of all open ACDT plans.**

The Centre Manager should review the process for making IRC staff aware of detainees in the post-closure period of an ACDT plan so that they can be alert to any possible increase in risk and the potential need to re-start ACDT monitoring if necessary.

Communication with Mr Gwozdzinski about his detention

61. Mr Gwozdzinski complained to staff that he was frustrated at his continued detention and this was causing him distress. He was also frustrated at the lack of progress towards his release after he had provided a release address (his brother's address in the UK).

62. We found it difficult to get a clear understanding of the reason for Mr Gwozdzinski's continued detention after his court appearance on 19 July. The outstanding criminal matters in respect of the charges of assault and criminal damage, for which he was originally remanded to custody, were concluded at that hearing. It is not clear why he was not deported to Poland at that stage. Instead, it appears that the Home Office placed the deportation proceedings on hold pending the resolution of further criminal matters, but we have been unable to establish precisely what these were. Staff in the Home Office's Criminal Casework Team did not appear to have a clear understanding of what the outstanding criminal matters were, and their links with the courts and other criminal justice agencies seemed weak. The Home Office told us that it was often difficult for them to obtain up to date information about impending prosecutions because of delays in updating the Police National Computer and difficulties in identifying the relevant police or court contacts. While we acknowledge that the Criminal Casework Team made some attempts to establish the status of the criminal matters in Mr Gwozdzinski's case, we consider that the systems for gathering this information were ineffective. Although detention reviews were held at regular monthly intervals and Mr Gwozdzinski was provided with the relevant paperwork, this did not properly explain to him why he continued to be detained.

63. The on-site Home Office team passed on the Criminal Casework Team's detention reviews to Mr Gwozdzinski by internal post but they had limited direct contact with him about his case. Mr Gwozdzinski was twice prevented from attending court because there was no transport to take him there, but no one explained this to him and he received no apology.

64. Mr Gwozdzinski and his family believed that he had been asked to provide an address for possible release but no one told him how long this might take or if there was anything preventing his release to the address. We found evidence that Mr Gwozdzinski provided a release address in June 2017 but the Criminal Casework Team could not trace the address. There is no evidence that anyone went back to Mr Gwozdzinski at any time to explain the difficulties they had tracing the address or to offer him the opportunity to clarify it. Mr Gwozdzinski allegedly told other detainees, that he had provided an address to the Home Office more recently than June 2017 but we have not been able to find any evidence of this.

65. Although the on-site Home Office team operate a drop-in surgery where detainees can speak to a representative about their case, we found the process for using the system was confusing. In Mr Gwozdzinski's case, two requests he made were returned saying "denied", yet he was told to go along to the drop-in session. Given that for many detainees, including Mr Gwozdzinski, English is not their first language, the communication could be clearer to avoid misunderstanding and frustration. We consider that this process should be reviewed in order to provide a service that is easily accessible and provides a timely, informative interaction with a Home Office representative.

66. We consider that the lack of communication with Mr Gwozdzinski about the reasons for his continued detention would have been a source of confusion and frustration for him, which is borne out by statements he later made to others and an apparent decline in his mental health in the weeks leading up to his death. We make the following recommendation:

The Home Office and Centre Manager should ensure that all detainees are fully informed of the reasons for their ongoing detention, especially those detained longer than six months, by:

- **ensuring there is an effective flow of information between the Home Office caseworker and the on-site Home Office team so that comprehensive and accurate information is communicated to the detainee;**
- **ensuring that detainees have an easily accessible point of contact where they can discuss their individual cases and that the process for using the service is clearly communicated.**

Emergency response

67. The emergency response was captured on CCTV and body-worn camera. The clinical reviewer commented that staff responded promptly and did their utmost in a high pressured, difficult situation that most of them had not faced before. However, she was critical of the fact that the resuscitation attempt lacked leadership and coordination.

68. A nurse, who was the first medical responder, arrived with an emergency bag but he did not have the oxygen or defibrillator with him, both of which are required for resuscitation. These items arrived slightly later with the second medical responder. The clinical reviewer said that nurse who was the first medical

responder spent a considerable amount of time assessing Mr Gwozdzinski before starting CPR and, during that time, he did not administer oxygen in line with the healthcare provider's medical emergency procedure.

69. There was a five-minute delay between the first medical responder's arrival and the start of active resuscitation. However, the clinical reviewer could not say whether a more coordinated resuscitation attempt would have changed the outcome for Mr Gwozdzinski. We make the following recommendation:

The Centre Manager and Head of Healthcare should review the emergency response procedures, ensuring that staff are aware of the mandatory requirements set out in DSO 09/2014, and addressing:

- **the role of the appointed medical responder in a medical emergency and, in particular, the equipment they should take with them when responding;**
- **the induction and ongoing training programme for IRC and healthcare staff, especially those expected to take on the role of appointed medical responder.**

Substance misuse and information sharing

70. The IRC's Substance Misuse Policy states: "The Centre Manager and Care & Custody staff of Heathrow IRC are committed to reducing levels of drug and alcohol misuse amongst detainees in our care". It goes on to say that there will be a multidisciplinary approach to tacking substance misuse, including close liaison with the healthcare provider, stating: "…treatment and support will be offered to those identified with issues of drug and alcohol misuse". Although Mr Gwozdzinski was suspected of being under the influence of illicit substances on three occasions, and found to be in possession of equipment to make hooch, this information was not shared with healthcare or Phoenix Futures who provide substance misuse support for detainees. We make the following recommendation:

The Centre Manager and Head of Healthcare should review protocols for sharing information between IRC staff and healthcare staff, in particular for substance misuse and mental health concerns which may give rise to an increased risk of suicide and self-harm.

Unlock procedure

71. When Officer B unlocked Mr Gwozdzinski's room at 2.00pm, she did not look into his room. She told the investigator that she was not aware of the need to visually check on detainees at unlock, unless the person was on an ACDT plan. We found that, prior to Mr Gwozdzinski's death, no guidance existed to ensure staff made a visual check on all detainees at unlock. We are aware that such guidance has now been produced and was issued to staff in October 2017. We therefore make no recommendation on this point.

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