

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Redouane Bouamama a detainee at Heathrow IRC on 2 December 2018

A report by the Prisons and Probation Ombudsman

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*



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

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

Mr Redouane Bouamama, an Algerian national, died at Heathrow Immigration Removal Centre (IRC) on 2 December 2018 of a heart attack. Mr Bouamama was 51 years old. I offer my condolences to Mr Bouamama's family and friends.

I am satisfied that the care Mr Bouamama received at Heathrow IRC was equivalent to that he could have expected to receive in the community. He had no relevant health concerns during his time there, and healthcare staff could not have foreseen or prevented his death from underlying heart disease.

However, I am concerned that when his condition deteriorated, staff did not call an emergency medical code on the radio, and that as a result the emergency response was less well-organised than it should have been.

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

Sue McAllister CB
Prisons and Probation Ombudsman

August 2019

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Summary

Events

1. On 20 February 2018, Mr Redouane Bouamama, an Algerian national, was transferred to Heathrow Immigration Removal Centre (IRC), following a prison sentence. He was detained pending deportation. He had no health concerns on his reception, and no relevant health concerns during his time at Heathrow.
2. On 2 December, at approximately 2.30pm, two officers saw Mr Bouamama as he was coming down the stairs. He was struggling to breathe and felt dizzy but improved after a short rest. Another officer arrived and observed that Mr Bouamama had deteriorated, so went in person to fetch help from the nearby healthcare unit.
3. Two nurses responded immediately, with a third joining them a little later. Shortly afterwards, Mr Bouamama's breathing and pulse stopped. A nurse started cardiopulmonary resuscitation and requested a defibrillator, while an officer called for an ambulance from his mobile phone at 2.42pm. Another nurse heard officers looking for the defibrillator and brought it with her. Nurses continued life support until an ambulance arrived.
4. At approximately 2.50pm, the first ambulance crew arrived. Paramedics continued to try to resuscitate Mr Bouamama but he was pronounced dead at 3.29pm.

Findings

Clinical Care

5. We agree with the clinical reviewer that the care Mr Bouamama received at Heathrow IRC was equivalent to that which he could have expected to receive in the community.
6. Mr Bouamama did not declare any health concerns when he arrived at the IRC and never presented with any symptoms which could indicate heart disease. Healthcare staff could not have reasonably foreseen the underlying condition which led to his heart attack and death.

Emergency response

7. We are satisfied that an ambulance was called promptly. However, we are concerned that staff did not call an emergency medical code over the radio when Mr Bouamama's condition deteriorated in their presence. This meant that healthcare staff did not take all the necessary emergency equipment to the scene.

Contact with Mr Bouamama's family

8. While we accept that the IRC's family liaison officer acted in good faith when she informed a friend of Mr Bouamama's that he had died, we are concerned that this was not in line with the required IRC procedure.

Recommendations

- The Director and the Head of Healthcare at Heathrow IRC should ensure that all staff are made aware of, and understand, their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a detainee to ensure that the emergency response is not delayed.
- The Home Office should ensure that the family of deceased detainees are informed according to the provisions of DSO 08/2014.

The Investigation Process

9. The investigator issued notices to staff and detainees at Heathrow IRC informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator, accompanied by a member of the PPO support team, visited Heathrow IRC on 3 January 2019. They obtained copies of relevant extracts from Mr Bouamama's detention and medical records. They also interviewed four members of staff.
11. NHS England commissioned a clinical reviewer to review Mr Bouamama's clinical care at Heathrow IRC.
12. We informed HM Coroner for West London of the investigation. He gave us the results of the post-mortem examination, and we have sent him a copy of this report.
13. The investigator wrote to Mr Bouamama's cousin to explain the investigation and to ask whether he had any matters the family wanted the investigation to consider. He did not reply to our letter.
14. The initial report was shared with the Home Office, who pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

Heathrow Immigration Removal Centre (IRC)

15. Heathrow IRC is Europe's largest immigration detention facility. It is located a few hundred metres from Heathrow Airport and comprises two separate buildings, formerly known as Harmondsworth IRC and Colnbrook IRC, accommodating up to 1,038 men and 27 women. Since 2014, both sites have been run for the Home Office by Mitie Care and Custody, a division of the Mitie Group. Mr Bouamama was located at the Harmondsworth site which holds up to 676 male detainees. Central and North West London (CNWL) NHS Foundation Trust provides all healthcare services.

HM Inspectorate of Prisons

16. The most recent inspection of the Harmondsworth site at Heathrow IRC was conducted in October 2017. Inspectors said that the IRC had failed to progress significantly since its 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 noted that detainees were often critical of healthcare services, but found that these were generally adequate, with the exception of mental health services.

Independent Monitoring Board

17. 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 December 2017, the IMB expressed its concern that it had not received a response to its previous report in good time. The Board was also concerned at having to repeat its previous recommendations.
18. The IMB found that detainees were critical of the provision of healthcare services, but that the IRC generally met its targets for seeing nurses or GPs in good time. The Board recognised that the NHS Trust had significant problems recruiting staff, in common with the NHS generally in London.

Previous deaths at Heathrow IRC

19. Mr Bouamama was the second person to die at Heathrow IRC in the past three years, and the first to die of natural causes in that time. We made a recommendation about the IRC's emergency response in the previous case (which was a self-inflicted death).

Key Events

20. On 13 November 2017, Mr Redouane Bouamama, an Algerian national, was sentenced to 26 weeks imprisonment for sexual offences. On 13 January 2018, an order was signed authorising his detention following release from prison, pending deportation.
21. On 20 February, Mr Bouamama was released from prison and admitted into detention at Heathrow IRC.

Mr Bouamama's medical history at Heathrow IRC

22. A nurse reviewed Mr Bouamama at a health screen on his reception at Heathrow. She recorded that he had no physical health concerns, and was not in receipt of any prescribed medication.
23. In June, Mr Bouamama expressed concerns about his mental health. A mental health nurse reviewed him and found he was suffering from anxiety. She referred him to a consultant psychiatrist.
24. In July, a consultant psychiatrist concluded that Mr Bouamama did not require specialist intervention and referred him back to primary care. On 20 July, a nurse recorded that Mr Bouamama was upset about not having been seen in person by the psychiatrist and had paid to see a private psychiatrist.
25. In August, Mr Bouamama declined a further assessment with the consultant psychiatrist and, on 22 August, he declined further involvement with Heathrow's mental health team. A nurse noted that Mr Bouamama appeared "calm, happy, engaged well".
26. During his time at Heathrow, Mr Bouamama rarely sought medical help for physical health concerns.
27. On 30 June, a GP saw him following complaints of groin pain. The GP noted that everything appeared normal but that Mr Bouamama should be referred to the hospital if he experienced severe pain. The GP also referred Mr Bouamama for an ultrasound scan. On 17 August, a nurse noted that Mr Bouamama refused to attend the hospital for a scan. He signed a disclaimer but there is no record of what this scan was for.
28. On 23 August, Mr Bouamama told a nurse that he had a painful spot inside his nostril and a sudden onset of back pain. She noted that Mr Bouamama had a small nose polyp. A GP prescribed Mr Bouamama ibuprofen gel for his back and a nasal spray.
29. On 2 November, Mr Bouamama complained of painful cold sores and was prescribed an antibiotic cream. On 10 November, a nurse noted that he complained abruptly that the cream was not working and requested a different one. A nurse gave him an antiseptic mouthwash and scheduled a medication review. On 24 November, a nurse reviewed him and gave him a herbal antihistamine. She also referred him to a dentist.

Events of 2 December 2018

30. During the afternoon of 2 December, three Detainee Custody Managers (DCMs) and the acting Duty Shift Manager (DSM – the person responsible for the overall running of the site) were in a meeting in a ground floor office at the Harmondsworth site. DCM A recorded that at approximately 2.20pm, they were alerted to raised voices in the corridor outside and went to investigate. They were delayed leaving the office due to a faulty door, and once they got out there were no residents in sight. DCM A had recognised Mr Bouamama's voice so went to his residential block at Gorse House to investigate.
31. Detention Centre Officer (DCO) A was employed in the security office, which permitted him to carry his own mobile phone. In interview, he said that he was performing security checks with DCO B when they met Mr Bouamama in a stairwell at Gorse House. DCO A said that Mr Bouamama grabbed him and said that he felt dizzy. He said that he had just run up the stairs and was having breathing difficulties. DCO A asked him to sit down and advised him to breathe easily.
32. DCO B recorded that they met Mr Bouamama at approximately 2.30pm, and that he seemed out of breath and pale in colour. She noted that he appeared to regain colour after following DCO A's advice to sit down.
33. Shortly afterwards, DCM A met them on the stairwell. He recorded that Mr Bouamama was sitting propped against the wall with his eyes closed, and that he was mumbling and incoherent. DCM A recorded that he decided to walk the short distance to the nearby healthcare unit to fetch help. He noted that this was because of his perception of the severity of Mr Bouamama's condition, and because "in the past it has taken response nurses 'some time' to attend the required location". (DCO A told the investigator that the healthcare unit was half a flight of stairs, two doors and about 30 metres away from where they were.)
34. When DCM A got to the healthcare unit, he met Nurse A who told him that Nurse B was the emergency response nurse. Nurse B and Nurse C accompanied him back to Mr Bouamama.
35. Nurse B took the response bag but noted that she did not take all the emergency equipment because she was confused at the absence of a code blue emergency over the radio. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing. It triggers the immediate attendance of healthcare staff, and for the control room to call for an ambulance.) Nurse B recorded that when she arrived, Mr Bouamama was sitting unaided. His eyes were closed but blinking, and he was pale and clammy. She noted that his clinical observations were abnormal but that Nurse C was unable to get a blood pressure reading because of the way Mr Bouamama was sitting.
36. Nurse A had remained in the healthcare unit where she was running a clinic. He noted that after 15-20 minutes, Nurse C returned to the unit looking for a wheelchair. They swapped roles to allow him to assess Mr Bouamama in person. On his arrival, Nurse A observed that Mr Bouamama's face was pale, so he quickly collected oxygen and attached this to Mr Bouamama. He asked officers to lift Mr Bouamama onto the landing where it was flat.

37. Nurse A recorded that shortly after they moved Mr Bouamama, his breathing and pulse stopped. Nurse A asked DCO A to call an ambulance and immediately started cardiopulmonary resuscitation (CPR). He also asked an officer to collect an emergency response bag from the healthcare unit.
38. DCO A told the investigator that he had already called for an ambulance from his mobile phone shortly after Nurse A arrived. He said that as soon as Nurse A said that Mr Bouamama was not breathing, he called again and updated the operator about the deterioration in Mr Bouamama's condition. DCO A said that an emergency code was not called earlier because it had not been an emergency at that point: it was simply the case that Mr Bouamama felt dizzy. He said that when Mr Bouamama's condition deteriorated, it was quicker to telephone for an ambulance directly rather than calling an emergency code on the radio. DCO A said that he also informed the control room that an ambulance was on the way.
39. The control room log records that DCO A called an ambulance at 2.41pm, and that the Duty Shift Manager was informed. It also noted that this was not called as a medical response, and no code was given. The ambulance log records that first call was received at 2.42pm, the first ambulance was despatched at 2.43pm, with the second at 2.44pm and the third at 2.45pm.
40. In interview, the DSM said that he was in the office when an officer rushed in to inform him that Mr Bouamama had collapsed on the stairs at Gorse House.
41. DCM B normally worked at the Colnbrook site. In interview, he said that he was asked to get a defibrillator, but was not familiar with the site and could not find one. He said he returned shortly afterwards, by which time someone had already fetched one.
42. Nurse D was holding a clinic when Mr Bouamama collapsed. In interview, she said that she had a radio but did not hear an emergency call or request for healthcare assistance. Nurse D said that she heard officers in the healthcare unit shouting that they needed a defibrillator. She asked her patient to leave the room, then collected a defibrillator and followed the officers with it.
43. Nurse A noted that Nurse D arrived with the second emergency response bag. He asked DCO A to take out the defibrillator and attach it to Mr Bouamama while he continued with CPR. Nurse A recorded that it immediately advised giving a shock to Mr Bouamama but that he was wary of staff being on the metal staircase and holding the railing. He instructed everyone to stand clear and administered the shock. He then continued with CPR until paramedics arrived.
44. The ambulance log records that the first crew arrived at 2.48pm, the second at 2.49pm, and the final crew at 3.05pm. At 3.02pm, the log documented that Mr Bouamama had had a witnessed cardiac arrest; that staff gave CPR and three shocks were delivered by the IRC's defibrillator; that a further shock was delivered from the ambulance equipment and that staff continued to assist in resuscitating him. Paramedics pronounced Mr Bouamama dead at 3.29pm.

Post-mortem report

45. The post-mortem report concluded that Mr Bouamama died from left ventricular failure (a heart attack) caused by calcific aortic stenosis (where a heart valve becomes narrowed and stiff because of a build up of calcium).

Contact with Mr Bouamama's family

46. On 2 December at 4.15pm, a senior officer from Home Office Immigration Enforcement (HOIE) called a Home Office family liaison officer (FLO) to inform her of Mr Bouamama's death. He asked her to act as the FLO. The senior officer could not find details for Mr Bouamama's next of kin on his record. The FLO found the contact details for Mr Bouamama's third cousin and used these as next of kin details.
47. At 4.34pm, the FLO called Mr Bouamama's cousin but got no answer and did not leave a message. She located a telephone number for a friend and called him. There was no answer and she did not leave a message. At 5.27pm, the second friend returned the call and said that he was Mr Bouamama's third cousin. The FLO informed him of Mr Bouamama's death. He agreed to act as his next of kin. Mr Bouamama's friend said he would call back later when he had spoken to other relatives.
48. The FLO liaised with Mr Bouamama's friend, who sent details of an organisation that dealt with repatriation to Algeria. On 7 December, the organisation collected Mr Bouamama's body and took it to Heathrow Central Mosque prior to him being transported back to Algeria.
49. Mr Bouamama's funeral was held in Algeria on 9 December. The Home Office contributed to the cost in line with national guidance.
50. The FLO told us that Mr Bouamama had declined to give details of his next of kin despite being asked on several occasions. She said that the IRC cannot compel detainees to provide details and there was no way of finding his next of kin's details through other channels.

Support for detainees and staff

51. After Mr Bouamama's death, the DSM debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
52. The IRC posted notices informing other detainees of Mr Bouamama'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 Bouamama's death.

Findings

Clinical Care

53. We agree with the clinical reviewer that the clinical care Mr Bouamama received at Heathrow IRC was equivalent to that he could have expected to have received in the community. Mr Bouamama's death was caused by a pre-existing heart condition which was not known on his admission to Heathrow. He did not declare any health concerns at his reception, and never presented with any symptoms which could indicate heart disease. Healthcare staff could not have reasonably foreseen the underlying condition which led to his cardiac arrest.

Emergency response

54. Detention Services Order (DSO) 09/2014, *Emergency Medical Response Codes*, requires IRCs to have a medical emergency response code protocol, with a code blue indicating that a prisoner is unconscious or having breathing difficulties, and a code red indicating that a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance and healthcare staff to attend with the appropriate emergency equipment.
55. The DSO says that all IRC staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The DSO makes it clear that an emergency code should be called over the radio network during medical emergencies.
56. We are satisfied that staff acted appropriately when they first found Mr Bouamama unwell. His condition did not present as serious at that stage, and he appeared to recover after sitting down and controlling his breathing.
57. However, we are concerned that officers did not then call an emergency code once Mr Bouamama's condition deteriorated. When DCM A arrived, he considered Mr Bouamama needed urgent medical attention but nonetheless took the decision to walk to the healthcare unit to get assistance rather than calling a code blue emergency. He said he decided to do this because it was quicker.
58. DCO A called for an ambulance directly using his mobile phone and did not radio a code blue. He also said, he decided to do this because it was quicker. This meant that an ambulance was requested without delay and DCO A was able to liaise directly with the ambulance service to pass on information about Mr Bouamama's condition. He also appropriately updated the control room to ensure the ambulance crew were not delayed in getting access to the IRC or to Mr Bouamama.
59. However, we are concerned that because a code blue was not called, the emergency response was slower and less well organised than it should have been. The Duty Shift Manager was not alerted by the call over the radio as he should have been. Healthcare staff have a protocol for responding to a medical emergency code and did not follow it in this case because no code was called.

Nurse B said that she did not take all the emergency equipment at that stage because no emergency code had been called. Officers were sent to search for a

defibrillator, but could not find one. Nurse D only became aware of the emergency when she overheard officers looking for a defibrillator. It was only at this point that she was able to assist in Mr Bouamama's care by bringing the defibrillator to his aid.

The Director and the Head of Healthcare at Heathrow IRC should ensure that all staff are made aware of, and understand their responsibilities, during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a detainee to ensure that the emergency response is not delayed.

Contact with Mr Bouamama's family

60. DSO 08/2014, *Deaths in Detention*, requires the onsite or on-call HOIE Manager for the centre to inform the duty family liaison officer (FLO) by telephone of any death in an IRC as a matter of urgency. The DSO also says that:

“The FLO role will start from the point that news of death is broken to the named next of kin; this will be done by the police and **not** the Home Office FLO. If there is a delay with the police notifying the named next of kin, the Home Office FLO should raise this with the Head of Detention Operations who will make a decision on how to proceed, in consultation with the police. The FLO will maintain contact from this point onwards and provide practical support and information where appropriate and as requested by the named next of kin. If the named next of kin does not want contact, their wishes must be respected.”

61. It is clear from the emphasis placed on the word 'not' that the intention is that the initial family contact should be made by the police and not by the Home Office FLO. It is also clear that the Home Office FLO should discuss any potential delay with the Head of Detention Operations before taking action themselves.
62. The FLO did not follow the requirements of the DSO. There was no next of kin listed in Mr Bouamama's record so the FLO initially tried to contact the only person listed in his records, without success. She then found contact details for another person and immediately telephoned him, and then delivered the news of Mr Bouamama's death when he returned her call a short time later. There is no evidence of any attempt by the police to inform Mr Bouamama's next of kin, or of any discussions with the police about how best to proceed.
63. The FLO told us that she was aware that it was the duty of the police to inform families of a detainee's death. She said that she had experienced delays in the past with families being notified, and that she called Mr Bouamama's friend's number while she was trying to find details for his next of kin. She explained that in the circumstances, she decided to inform his friend on the phone when he returned the call.
64. We accept that Ms Judge acted in good faith. However, we consider that contact with Mr Bouamama's family did not follow the requirements of the DSO. If experience suggests that the procedures set out in the DSO do not work well in

practice, the procedures should be reviewed. We make the following recommendation:

The Home Office should ensure that the family of deceased detainees are informed according to the provisions of DSO 08/2014.

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