Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Prince Fosu, a detainee at Heathrow Immigration Removal Centre, on 30 October 2012

A report by the Prisons and Probation Ombudsman

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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.

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

Mr Fosu died on 30 October 2012 of cardiorespiratory collapse associated with sickle cell trait at Harmondsworth Immigration Removal Centre (which was run by GEO Group at the time). He was 31 years old. I offer my condolences to Mr Fosu's family and friends.

There was initially some uncertainty about the cause of Mr Fosu's death and the investigation was suspended until two post-mortem examinations were concluded in 2013. A lengthy police investigation into the circumstances of Mr Fosu's death followed and we had to suspend our investigation while that took place. In November 2018, the CPS informed my office of their decision not to proceed with a criminal prosecution, and we took up our investigation again shortly thereafter.

These delays, which were outside our control, mean that we are issuing this report six and a half years after Mr Fosu's death.

The circumstances of Mr Fosu's death are shocking and I very much regret that the lengthy delay will inevitably diminish the impact of this report and make it more difficult to hold those involved properly to account.

This is a very troubling case. Mr Fosu spent six days at Harmondsworth, and apart from his first few hours, he spent his time segregated, living naked in a room dirty with faeces, urine and uneaten food, without a mattress or bedding. He did not eat for much of this time and rarely engaged with staff.

I am very concerned about the standard of care that Mr Fosu received. No one referred him for a mental health assessment or even seemed to consider whether there might be any underlying physical or mental ill health conditions affecting his behaviour.

Although his segregation should have been independently reviewed every 24 hours by a Home Office manager, the manager who conducted these reviews did so without seeing or speaking to Mr Fosu herself and relied on what she was told by unit staff. I consider this to have been unacceptable.

Mr Fosu's wellbeing should also have been assessed by the doctors who visited the unit each day. I am very concerned that apart from one very brief interaction on 25 October, the doctors also failed to see or speak to Mr Fosu.

Although unit staff described Mr Fosu's behaviour as "very bizarre", they appear to have become de-sensitised to the signs of possible mental or physical distress. There were several omissions from what I consider to be the basic requirements of caring for a

detainee who has been segregated. No one considered whether there were any health reasons to prevent Mr Fosu being segregated, and the reviews of his segregation and reintegration planning were poor. I am particularly troubled that Mr Fosu lived in an unfurnished room without proper justification or review, which I consider to be inhuman and degrading. I consider that IRC managers were responsible for a culture which I can only describe as uncaring.

Finally, I also have serious concerns about the care Mr Fosu received on the morning of his death. Some scheduled welfare checks were either not completed or seemingly not completed to the required standard and, when staff eventually opened the room, it was apparent that Mr Fosu had been dead for some time. Although we cannot know whether earlier intervention would have changed the outcome for Mr Fosu, the failure to check on him adequately meant that potential opportunities to save him were missed.

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 **June 2019**

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Summary

Events

1. On 21 April 2012, Mr Prince Fosu, a Ghanaian national, was granted temporary admission to the United Kingdom while he appealed against a decision to refuse him entry to the country. He was required to report fortnightly to a police station but stopped doing so in October. On 21 October, he was arrested while running naked in the street. In police custody Mr Fosu spent time naked and urinated on the floor of his cell.

2. On 24 October, Mr Fosu transferred to Harmondsworth Immigration Removal Centre (IRC) ahead of his scheduled deportation on 5 November. United Kingdom Borders Agency (UKBA, previously the branch of the Home Office responsible for border control) staff sent Mr Fosu's police medical records to Harmondsworth in advance and highlighted that a mental health assessment had been recommended. Despite this, no one referred Mr Fosu to Harmondsworth's mental health team in Reception or at any other time.

3. A few hours after he arrived at Harmondsworth, Mr Fosu assaulted a member of staff. He was placed under restraint and taken to Elm Unit, the Centre's separation unit, where he was 'temporarily confined' (segregated) under Rule 42 of the Detention Centre Rules 2001. Elm Unit staff removed Mr Fosu's bedding and mattress because he had been violent. They were not returned for the remainder of his life.

4. On 25 October, Mr Fosu was naked in his room and dirtied the cell with faeces and urine. He lived in such conditions for the remainder of his life. He did not always eat meals, and there is no record that he ate anything at all after 26 October. Mr Fosu was often recorded as lying on the floor or under his bed.

5. An IRC doctor visited Elm Unit each day but, other than a brief interaction on 25 October, the doctor did not speak to, or see, Mr Fosu. A Home Office manager also visited the unit each day and reviewed Mr Fosu's continued segregation without seeing or speaking to him. No one questioned whether Mr Fosu might have a physical or mental ill health condition affecting his behaviour.

6. Staff are required to complete a welfare check every 15 minutes on any detainee who is temporarily confined. The checks completed during the morning of 30 October noted that Mr Fosu was lying naked on the floor of his cell for at least two hours. He did not respond to any attempts by staff to communicate with him, although they recorded that they had seen him move. No one completed the required welfare checks at 11.30am or 11.45am. At 11.57am, a detainee custody officer (DCO) became concerned for Mr Fosu and raised the alarm. At 12.07pm, a response team went into Mr Fosu's room and found he had died. Rigor mortis was present and it appears he had been dead for some time.

Findings

Clinical care

7. We recognise that managing Mr Fosu's complex and difficult behaviour presented staff at Harmondsworth with challenges. However, we consider that the care he received fell considerably below acceptable standards. Despite his consistently bizarre behaviour, no one referred him for a mental health assessment at any time and the standard of care he received from IRC doctors when they visited Elm Unit was unacceptably poor.

8. The Home Office managers who authorised Mr Fosu's continued segregation also failed to satisfy themselves of his wellbeing and simply relied on what they were told by IRC staff. On-site Home Office managers did not see or speak to him themselves and we consider that they failed to carry out their important role of providing an independent review. We consider that this was unacceptable.

9. It appears that staff from various disciplines assumed that Mr Fosu understood what he was doing and was purposefully behaving as he did, rather than considering whether there might be any other underlying cause.

Management of Elm Unit

10. We are also concerned about failings in the management of Elm Unit and Mr Fosu's temporary confinement under Rule 42. No one assessed whether there were any health reasons for not confining him, and there was no multidisciplinary review of his confinement or specific plan to identify his issues and reintegrate him into normal accommodation. We are particularly concerned that Mr Fosu was allowed to live in an unfurnished room seemingly without any reasonable justification or review.

11. It appears that staff in the unit had become de-sensitised to possible signs that a detainee might have mental or physical health problems, and we consider that managers were responsible for what we can only describe as an uncaring culture.

Events of 30 October 2012

12. We are also concerned about the actions of staff on the morning of Mr Fosu's death. Important welfare checks were not completed as required, and we are not satisfied that those that were completed fully ensured Mr Fosu's welfare. It is probable Mr Fosu had been dead for some time when staff eventually opened the room and actively checked him. We cannot say with certainty that it would have made a difference to the outcome, but the failure to intervene earlier meant there were missed opportunities to prevent Mr Fosu's death.

Recommendations

- The Director of Home Office Immigration Enforcement should:
  - ensure that Home Office staff employed in contracted out IRCs properly understand their role and the importance of acting independently, and are properly trained to carry out this function; and

- conduct an investigation into the way in which the deputy UKBA managers exercised their responsibilities in reviewing Mr Fosu's continued temporary confinement, with a view to taking disciplinary action if necessary, and inform the Ombudsman of the outcome.

- The Centre Manager and Head of Healthcare should ensure that staff manage detainees temporarily confined under Rule 42 in line with national guidelines, including that:
  - an appropriate member of healthcare staff completes a health screen within two hours of relocation under Rule 42 to assess whether there are any health reasons not to confine the detainee;
  - a multidisciplinary team reviews the temporary confinement every 24 hours to consider whether the temporary confinement remains necessary, whether there are any health reasons to advise against continuing confinement, and to agree plans to end the temporary confinement and return the detainee to association;
  - staff offer all activities and regime to which the detainee is entitled, record whether the detainee participates in the activity and any reasons, if given, why they do not, ensure that the multidisciplinary team are aware of any refusals, and make appropriate referrals; and
  - detainees who are undertaking a dirty protest are provided with a mattress and bedding.
- The Director of Home Office Immigration Enforcement should issue national guidance on the circumstances in which a detainee can be held in unfurnished accommodation, including that:
  - unfurnished accommodation must only be used for the shortest possible time and only to hold very violent or refractory detainees;
  - the use of unfurnished accommodation must be authorised by managers from HOIE and the IRC, and must be reviewed at least every 24 hours; and
  - an appropriate member of healthcare staff must assess whether there are any health reasons not to place the detainee in unfurnished accommodation; and
  - a copy of the guidance is sent to the Ombudsman.
- The Director of Home Office Immigration Enforcement should refer the GP's to the General Medical Council for failing to see or speak to Mr Fosu or to assess his wellbeing.
- The Centre Manager and Head of Healthcare should ensure that doctors working at the Centre:
  - have a full understanding of their role; and
  - see and speak to detainees in Elm Unit in order to satisfy themselves that they are in good physical and mental health.

- The Centre Manager and Head of Healthcare should ensure that all staff are aware of the circumstances in which a mental health referral is appropriate.
- The Centre Manager and Head of Healthcare should ensure that detainees refusing food or fluids are managed in line with national guidelines.
- The Centre Manager should ensure that staff complete and record Rule 42 welfare checks in line with local and national policy, and satisfy themselves at each check that the detainee is breathing and does not need immediate medical assistance.
- The Centre Manager should ensure that staff complete an emergency access plan for all detainees temporarily confined on Rule 42 who are undertaking a dirty protest.
- The Centre Manager should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including that they enter rooms as quickly as possible in a life-threatening situation.

The Investigation Process

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

14. The investigator and another investigator visited Harmondsworth on 6 November 2012. They obtained copies of relevant extracts from Mr Fosu's IRC and medical records.

15. The investigators interviewed 14 members of staff, three detainees and the Chair of the local Independent Monitoring Board (IMB) at Harmondsworth between November 2012 and January 2013.

16. On 22 November 2012, the investigators invited all the Ghanaians who were detained in Harmondsworth at the time to a meeting to discuss concerns that they had raised anonymously. Only one of the 13 men invited attended the meeting. The investigators provided feedback to the Centre manager, and followed this up in writing.

17. NHS England commissioned a clinical reviewer to review Mr Fosu's clinical care at Harmondsworth.

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

19. We initially suspended our investigation because preliminary post-mortem tests were unable to establish a cause of death. Following receipt of the post-mortem report, our suspension continued while the Metropolitan Police investigated the circumstances of Mr Fosu's death. In April 2017, the Crown Prosecution Service (CPS) announced that the GEO Group and Nestor Primecare were to be prosecuted under the Health and Safety at Work Act in relation to Mr Fosu's death. On 30 October 2018, the CPS announced that it was reversing its decision. We subsequently reopened our investigation. We very much regret that these delays, which were outside our control, have delayed the publication of this report.

20. One of the Ombudsman's family liaison officers (FLO) contacted Mr Fosu's family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. The FLO, the other investigator and an Assistant Ombudsman, subsequently met with several members of Mr Fosu's family and their legal representative. Mr Fosu's family raised the following questions which they wished the investigation to address:

    - what handover did the police provide the United Kingdom Border Agency (UKBA) on Mr Fosu, and did UKBA have any contact with him in police custody?
    - how did Mr Fosu travel to Harmondsworth and were there any issues in transit?

- why was Mr Fosu not scheduled for deportation until 5 November when he had been arrested two weeks earlier?
- what was the purpose of the daily UKBA visits when Mr Fosu was in Harmondsworth, and how did he behave during these visits?
- what were the conditions in Mr Fosu's room in Elm Unit? In particular, was it cold, with no heating or bedding provided to Mr Fosu?
- what was Mr Fosu's mental and physical condition on 30 October, and did Harmondsworth's staff treat him appropriately?
- did Mr Fosu have the opportunity to contact his family when he was at Harmondsworth?
- why did Harmondsworth not break the news of Mr Fosu's death directly to his father, given that they had his telephone number?

21. We shared the initial report with the Home Office. They pointed out some factual inaccuracies and we have amended this report accordingly.

22. We also shared the initial report with Mr Fosu's family and their solicitor. They did not make any comments.

Background Information

Harmondsworth Immigration Removal Centre (IRC)

23. At the time of Mr Fosu's detention, Harmondsworth IRC, as it was then known, was run by the GEO Group on behalf of the Home Office, and Nestor Primecare provided healthcare services.

24. Elm Unit, where Mr Fosu lived for nearly all his time at Harmondsworth, is a six-room unit used to keep detainees separated from other detainees. The unit holds detainees removed from association in the interests of safety and security (under Rule 40 of the Detention Centre Rules) or 'temporarily confined' (segregated) following a violent or refractory incident (under Rule 42).

25. Since September 2014, Harmondsworth IRC and the adjacent Colnbrook IRC have been run as a single establishment – Heathrow IRC - on behalf of the Home Office by Care and Custody, a division of the Mitie Group. Central and North West London (CNWL) NHS Foundation Trust provides all healthcare services.

HM Inspectorate of Prisons

26. The last inspection of Harmondsworth before Mr Fosu died was conducted in November 2011. Inspectors reported that separation was used frequently and they saw little evidence of rigorous reintegration planning or case management. They also found that healthcare was a major area of concern, with mental health needs under-identified.

27. The most recent inspection of the Harmondsworth site at Heathrow IRC was conducted in October 2017. Inspectors reported that the use of segregation on Elm Unit had increased and detainees were being segregated for too long. They found that segregation was sometimes used inappropriately, as a punitive measure, when detainees had shown no signs of refractory behaviour.

28. Inspectors also reported that many detainees found healthcare provision was inadequate. They found that mental health services were insufficient to meet the high level of demand and emergency response arrangements were disjointed.

Independent Monitoring Board

29. 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 2011, the IMB reported that healthcare had been "unacceptably poor" but had begun to improve during the reporting year. They highlighted that detainees with mental ill health often moved frequently between healthcare and Elm Unit without finding alternative suitable accommodation. They found that the number of detainees temporarily confined under Rule 42 had more than doubled in the reporting year, without a clear explanation for the increase.

30. In its latest annual report, for the year to December 2017, the IMB reported that it did not have any significant concerns about the use of Rule 40 and Rule 42 to segregate detainees, although some detainees with mental ill health were

inappropriately detained in the segregation unit. The Board reported that detainees held in the segregation unit were treated correctly.

Previous deaths at Heathrow IRC

31. Mr Fosu was the second detainee to die at Harmondsworth since 2011. In our report into the previous death, we found that Home Office staff did not break the news of the death to the next of kin as quickly or effectively as they might have done. We have subsequently investigated the deaths of a further three detainees at Harmondsworth. There were no significant similarities between these other deaths and Mr Fosu.

Temporary Confinement

32. Rule 42 of the Detention Centre Rules 2001 allows for a "refractory or violent" detained person to be temporarily confined (segregated). The Rules state that a detained person shall not be confined as a punishment or after he has ceased to be refractory or violent. They state that a detained person shall not be confined for longer than 24 hours without a direction in writing given by an officer of the Secretary of State. (This means someone employed by the Home Office rather than the contractor running the Centre.) The direction must state the grounds for confinement and the time during which it may continue, which must not exceed three days before review.

33. The manager of the Centre, a representative of the Home Office, and a Centre GP must visit all detainees in temporary confinement at least once per day.

Key Events

7 April 2012 – 23 October 2012

34. Mr Fosu arrived in the United Kingdom on a flight from Ghana on 7 April 2012, travelling on a business visa. The United Kingdom Borders Agency (UKBA, previously the branch of the Home Office responsible for border control) refused him entry to the United Kingdom. He was detained in Harmondsworth IRC the following day, where he lodged an appeal against the decision to refuse entry. At an initial health screen, Mr Fosu said he had no physical or mental health issues.

35. On 21 April, Mr Fosu was released on temporary admission to the UK while his appeal was investigated. He had to report fortnightly to the police station in Kettering, where he lived with a family friend. On 7 September, Mr Fosu's appeal was dismissed. He was given documentation stating that he would be removed from the UK on 5 November. Mr Fosu last reported to the police on 1 October.

36. On 21 October, Northamptonshire police arrested Mr Fosu for a public order offence after they found him running naked down a street in Kettering. A police doctor assessed Mr Fosu that afternoon. Mr Fosu denied having any physical or mental health issues or having consumed any drugs or alcohol. He said he could not remember what had happened and the doctor recorded that he appeared confused when asked where he lived. A police officer noted in the detention log that "the doctor is of the opinion that there could be mental health related issues".

37. A UKBA officer saw Mr Fosu at the police station and served him with an IS91 document, which authorised UKBA custody. The public order offence was not proceeded with.

38. Mr Fosu's father visited him on 21 October. Mr Fosu's father told us that he was informed that his son would be voluntarily removed to Ghana on 24 October and that the immigration authorities had his passport and a valid ticket. UKBA told the investigators that this was not the case and that removal directions had already been set for 5 November.

39. On 22 October, a police doctor assessed Mr Fosu when he complained of pain in his ankle. The doctor prescribed paracetamol but Mr Fosu chose not to take it. Later that day, police officers recorded that Mr Fosu was naked, shouting and had urinated on the floor.

40. A consultant psychiatrist visited and assessed Mr Fosu that afternoon. He concluded that Mr Fosu was not suffering from an acute mental illness and recommended that he was fit to travel.

41. On 23 October, at 8.51am, UKBA Detainee Escorting Population Management Unit (or DEPMU, which is responsible for all moves within the immigration estate) was informed that Mr Fosu was being detained at Corby Police Station. DEPMU requested a copy of the mental health assessment conducted the previous day. It also emailed UKBA at Harmondsworth to ask them to accept Mr Fosu for detention and indicated that a further mental health assessment had been recommended. (It is unclear when this assessment was requested or by whom.)

The email stated: "[Mr Fosu] has valid documentation for removal pending this assessment".

42. A UKBA area manager told us that the expectation is that all referrals are accepted by IRCs unless there are extenuating circumstances that prevent an IRC from doing so. At 11.49am, deputy UKBA manager at Harmondsworth, emailed Primecare Healthcare and GEO managers' generic inboxes to state that Mr Fosu had been accepted for detention at the IRC. She included the medical information provided by the police. She told us that she expected the healthcare managers, along with administrators, to see this email.

43. DEPMU completed a 'movement notification' form before Mr Fosu's move. This form is sent to the relevant IRC and provides basic details about the detainee and an outline of any risks (medical or otherwise) he or she might present. DEPMU noted that Mr Fosu had urinated in his police cell and was "showing signs of mental illness" but had been found fit for detention and transport.

44. The police told Reliance Secure Task Management, the escort contractor responsible for transporting Mr Fosu to Harmondsworth, that he had shown signs of unusual behaviour, such as taking his clothes off, but was not violent. The police also said that Mr Fosu had had a full mental health assessment and been deemed fit for detention. The Reliance risk assessment noted that Mr Fosu was to travel alone and that his behaviour and any associated risks should be assessed on arrival. He was due to be transferred on 23 October but this was postponed until the following day due to the lack of an available escort crew.

24 October

45. Reliance officers recorded that, when they arrived at the police station, Mr Fosu was in his room naked and covered in what appeared to be vomit, urine and dried food. They asked for some clothes from the police which they helped him put on, although Mr Fosu would not put his arms through the sleeves. Mr Fosu left the police station with the Reliance escort at 7.25am. Reliance staff did not record any events or incidents of note during the journey to Harmondsworth.

46. A Person Escort Record (PER) accompanies each person when they move between a police station and IRC and includes information about their risks. A police custody officer recorded in Mr Fosu's PER that there were no specific risks, but wrote "see medical notes". The Deputy Director at Reliance, told us that police medical notes are normally attached to the PER and could only be opened by medical staff on arrival at Harmondsworth.

47. The police medical record was included in the records given to us by Harmondsworth. The Primecare Contract Manager at Harmondsworth said she did not know when it had arrived. However, the earlier emails between DEPMU, UKBA and Primecare indicate they sent this before Mr Fosu's arrival at Harmondsworth, and the Deputy Director at Reliance told us that the notes should have been attached to the PER.

Arrival at Harmondsworth

48. A Detention Custody Officer (DCO) was working in Reception at Harmondsworth that day. He told us that Reception staff received the movement order from DEPMU which stated that Mr Fosu would arrive that morning and was on a "dirty protest".

49. A residential manager was duty manager at Harmondsworth on 24 October. The Reception Manager told him that Mr Fosu had a 'marker' as being on dirty protest. She asked if they should take Mr Fosu to Elm Unit or to Reception. The residential manager advised them to assess Mr Fosu on arrival and, if compliant, he should go to Reception. If not, they should take him to Elm Unit.

50. The residential manager said he asked the reception manager to ensure that the reception nurse considered Mr Fosu's mental health and determine whether he should be admitted to the healthcare inpatient unit, or whether the dirty protest was an intentional "behavioural" matter. (We did not interview the reception manager as she was on long term sick leave.)

51. Mr Fosu arrived at Harmondsworth at 9.45am. Another detainee arrived at Harmondsworth at the same time as Mr Fosu. He said that Mr Fosu did not seem "normal", held onto a rail and did not speak to anyone.

52. In Reception, Mr Fosu had a shower and put on some clean clothes. The DCO tried to search his property with him, as is standard practice. He told us that Mr Fosu's behaviour was "slightly bizarre", for example he lay down on a table when asked to sit down. The DCO said he stopped the search as he was unsure whether Mr Fosu understood what he was doing.

53. At 11.30am, a nurse completed an initial health assessment. Mr Fosu did not disclose any previous physical or mental health issues and said he was not taking any medication. He declined to see an IRC doctor for further assessment. The nurse did not make any onward referrals and Mr Fosu did not see a doctor or have a mental health assessment. The nurse told us she was sure that Mr Fosu could understand her and that he was quiet and answered the questions she asked him with a "yes" or "no". She said that Mr Fosu told her he was always quiet and said he was "fine".

54. The nurse told us she was not given the police medical record and was not told of the residential manager, request that she assess Mr Fosu's mental health. She said she was unaware that Mr Fosu had been on "dirty protest". She said she had no concerns about Mr Fosu's mental health and would have referred him to the mental health nurse immediately if she did have. After the assessment, the residential manager asked the nurse whether Mr Fosu had any problems communicating with her. She said that his English was good.

55. A DCO completed a room-sharing risk assessment. He recorded that Mr Fosu "arrived on dirty protest, seems spaced out and can be unresponsive". The nurse completed the healthcare section and indicated there was no increased risk. The DCO authorised Mr Fosu as a standard risk, meaning he could share a room with another detainee.

56. The residential manager said that the reception manager had telephoned him and told him that Mr Fosu had complied, had had a shower and that the nurse had no concerns about his mental health.

57. A DCO received Mr Fosu on Fir Unit around lunchtime. He told us that Mr Fosu seemed "quiet" and "drawn back". He said that Mr Fosu appeared to be writing text messages on his mobile telephone and largely ignored the staff who issued him with his bedding and other items. A short while later, the DCO saw Mr Fosu again and said he seemed "livelier" and was talking to another detainee on the unit.

58. Officers allocated Mr Fosu a room with another detainee. After he arrived in the room, Mr Fosu asked him why he (Mr Fosu) was there. The detainee said he did not know and took Mr Fosu downstairs to find someone to speak to. Around two or three minutes later, Mr Fosu came back and repeated the question. The detainee said Mr Fosu did not speak good English and did not seem to understand what he said to him.

59. At around 4.00pm, Mr Fosu asked the DCO who had received him on Fir Unit for a 'voluntary return form' which is a scheme that allows detainees to return home with financial assistance. The DCO gave Mr Fosu the form and advised him to fill in as much of it as he could. Mr Fosu said "thank you" and left the office.

60. At around 4.30pm, Mr Fosu returned to his room. The detainee was also in the room and said Mr Fosu started shouting (in a language the detainee did not understand) and banging his mirror. Three DCO's were in the unit office when they heard shouting from Mr Fosu's room. They, along with another DCO, ran to Mr Fosu's room.

61. One of the DCOs said Mr Fosu was shouting, spitting, slapping the mirror and stamping his feet. He said it was like a chant and he could not understand what Mr Fosu was saying as it was not in English. The investigators reviewed the CCTV from the camera outside Mr Fosu's room. There is no sound but it shows Mr Fosu being very animated in his room. It is not possible to see exactly what happened after this due to the angle of the camera.

62. On arrival at Mr Fosu's room, the officers tried to remove Mr Baron, but were unable to get him past Mr Fosu safely and he therefore remained sitting in the corner of the room, uninvolved in events that followed. The officers stayed at the door. One of the DCOs tried to talk to Mr Fosu but said he did not appear to be listening. Another DCO also tried to talk to Mr Fosu, as he spoke the same language, but said that Mr Fosu ignored him.

63. The Reception DCO went to Mr Fosu's room as he was a member of the response team. As he had spoken to Mr Fosu in Reception, he went into the room to see if he could calm Mr Fosu down. He said that, in his experience, sometimes detainees respond more positively to a member of staff that they recognise.

64. The DCO said he called Mr Fosu's name twice. After the second time, Mr Fosu turned around to face him and punched him in the chest and to the side of the head. All four DCO's restrained Mr Fosu, who continued to struggle. The Duty

Operations Manager handcuffed Mr Fosu. While sitting, Mr Fosu spat blood at a one of the DCOs.

65. A group of Ghanaian detainees published a statement on the internet after Mr Fosu's death, alleging that an officer named "XXX" assaulted him while he was being restrained. The officers to whom we spoke said they were not aware of any injury to Mr Fosu. The DCO who Mr Fosu spat blood at (the only officer present named XXX) told us that he did not assault Mr Fosu and did not realise that he had blood on his shirt until after the incident. The other detainee was in the room throughout and his account of events was consistent with that of the officers.

66. Mr Fosu was then stood up. Mr Fosu continued to struggle against officers as he left the room, and dropped to his knees as he went down the first flight of stairs. The officers therefore lifted him down the remaining stairs, with a DCO swapping for the Reception DCO, who had injured his shoulder in the struggle. They took Mr Fosu to Elm Unit. The DCO who joined the restraint on the stairs said that they made several attempts to de-escalate the situation on the way to Elm Unit, but Mr Fosu did not respond.

67. The DCO at whom Mr Fosu spat blood went on leave the following day. He had previously booked this leave and it was not connected to the incident with Mr Fosu, as the Ghanaian detainees alleged in their statement.

Arrival on Elm Unit

68. When Mr Fosu and his escort arrived at Elm Unit, the nurse who had earlier seen him in Reception checked that Mr Fosu was breathing and then left him in his room. She said she could not complete a physical examination as Mr Fosu was wearing handcuffs and continued to be aggressive. She said she did not see any blood coming from Mr Fosu's mouth or elsewhere. The nurse told us she was not concerned about the change in Mr Fosu's behaviour from Reception because this often occurred when detainees moved between units.

69. Officers removed Mr Fosu's bedding and mattress. The duty manager said this was because Mr Fosu had been violent towards staff and might use the mattress to block the observation panel. This would mean staff would have to enter the room to view Mr Fosu and therefore put themselves at risk of assault. He said that if Mr Fosu had complied they would have given him a mattress and bedding but, since he did not, they did not return his mattress and bedding at any stage.

70. The nurse completed a 'report of injury to a detainee' form, which is a standard procedure following the use of control and restraint. She noted that Mr Fosu had no injuries and did not need any treatment.

71. At 4.45pm, the deputy UKBA manager and the Duty Operations Manager completed the authorisation for Mr Fosu to be held in temporary confinement for 24 hours (under Rule 42 of the Detention Centre Rules 2001). The deputy UKBA manager said this was based on information provided by GEO staff and by the Duty Operations Manager. They recorded on the Rule 42 documentation:

> "Mr Fosu you have been placed onto Rule 42 for assaulting a member of staff, trying to bite and spit at officers assisting with your relocation to Elm

and you have now started a dirty protest by throwing urine at the door. You will remain on Rule 42 for twenty-four hours and will be assessed as to your suitability to return to enhanced regimes."

72. Harmondsworth's Rule 42 procedures state that staff should start a Detainee Individual Support Plan (DISP) as soon as possible. The aim of the document is to support the detainee to enable him to return to ordinary accommodation as soon as is practicable. The Head of Residence described it as a plan of the behaviours expected of a detainee before he can move to a residential unit from Elm Unit. Mr Fosu did not communicate with officers and therefore did not contribute to the DISP.

73. Local instructions require Elm Unit staff to complete a welfare check of all detainees held on Rule 42 every 15 minutes. An Elm Unit DCO told us that the officers on duty shared the checks between themselves and whoever was free at the time would complete them.

74. At 5.30pm, the duty manager and a DCO a DISP. The duty manager told us he tried to speak to Mr Fosu through the observation panel of his room. He said that Mr Fosu was chanting incoherently. The duty manager said that Mr Fosu had trousers on but nothing on his torso and he had urinated over himself and in the room. He asked Mr Fosu if he knew why he was in Elm Unit and whether he wanted a shower. The duty manager said it was difficult to ascertain how much Mr Fosu understood and difficult to fully assess him.

75. The duty manager noted that Mr Fosu had been relocated under Rule 42 because he had assaulted staff. He also noted that Mr Fosu had thrown urine around his room. He noted as actions that Mr Fosu "will have access to all facilities and regime available on R42" and "be encouraged to comply with staff and cease non-compliance". Due to Mr Fosu's violent behaviour the duty manager instructed that three members of staff and a manager should be present when they needed to open his door.

76. Unlike other detainees, those temporarily confined on Rule 42 are not allowed a mobile telephone. Staff therefore took Mr Fosu's telephone from him when he arrived on Elm Unit. Detainees held on Elm Unit are allowed to use a public or office telephone to make two calls each day and should be offered this facility by staff.

77. An Elm Unit DCO said that Mr Fosu did not speak to officers that evening. She said that sometimes he hid underneath the table although he did accept his evening meal. The DCO said that it could be "quite normal" for detainees to hide as the 15-minute checks were quite "disturbing".

25 October

78. Each day, Elm Unit staff complete a Rule 42 checklist to indicate that they have offered each detainee everything to which they are entitled. This includes three meals a day, a shower, exercise, a visit from UKBA, a visit by the residential manager and an assessment by a doctor.

79. Mr Fosu's history sheet has two entries for 25 October, both of which are untimed. The first, by a DCO, said: "Messed the room with food, stripped naked,

dirty protesting, sleeping under the bed, talking to himself." The other, by another DCO, said: "Mr Fosu was repeatedly asked by a manager in the presence of the response team if he wanted breakfast, if he wanted fresh air, if he wanted to come out of his room to shower and change clothes. He was totally unresponsive and stayed under his bed."

80. At 9.00am, a GP visited Elm Unit. He told us that his role was to assess any physical or mental health problems that detainees have. He said he does this by asking them whether they have any symptoms. The GP added that he does not always have the opportunity to review a detainee's medical record before seeing them for the first time. He said officers tell him how the detainee has been behaving and he also has access to the Rule 42 paperwork.

81. The GP could not remember whether Mr Fosu's door was open or if he spoke to him through the observation panel. He asked Mr Fosu if he wanted to see a doctor and Mr Fosu replied "no". He thought that Mr Fosu was lying in bed under a duvet. (This cannot have been the case as officers had removed Mr Fosu's bedding.) He told us that Elm Unit staff did not raise any physical or mental health concerns with him. He said he did not know that Mr Fosu was on a "dirty protest" but that this would not necessarily be a concern or indicative of mental health issues. The GP said his visit to Mr Fosu that morning was fairly "routine". He recorded on Mr Fosu's medical record, "Detainee declined assessment by doctor, no medical issues."

82. At 11.15am, officers noted in the DISP daily check sheet that Mr Fosu was dressed and having a hot drink. At 11.25am, he declined the offer of time in the open air. At 11.45am, he threw faeces at the observation panel. Officers gave him lunch at 12.30pm.

83. UKBA (Home Office) staff are required to visit all detainees temporarily confined under Rule 42 every day. The deputy UKBA manager told us that this was to check on their welfare and to ensure that Elm Unit staff have offered them everything to which they are entitled. The UKBA representative should discuss the detainee's behaviour with a GEO manager and consider whether any extension to the Rule 42 authorisation is needed. They have access to the detainee's records and can speak to staff and the detainee themselves. The UKBA representative reports what they have observed to a senior UKBA manager, who makes the final decision about whether to authorise further temporary confinement under Rule 42.

84. The deputy UKBA manager said she first speaks to staff to establish whether it is appropriate to speak to the detainee. She said that if a detainee was naked she would not speak to them either in person or through the door as she believed this was inappropriate to protect their dignity. In her entry made following her visit to Mr Fosu on 25 October (the time is not recorded), she wrote: "During visit was naked in the room with food and faeces smeared around the room. Asked staff for a cup of tea during visit." The deputy UKBA manager said that as Mr Fosu was naked she asked a male officer to speak to him through the observation panel to ask whether he wanted to talk to UKBA.

85. The deputy UKBA manager said she is not medically trained so she would check that the doctor had visited Mr Fosu and would assume that there were no

concerns unless these had been documented. She can refer detainees to the mental health nurse or doctor but could not remember having any particular concerns for Mr Fosu. She reported her observations to a senior UKBA manager. The senior UKBA manager authorised a further 24 hours confinement on Rule 42.

86. At 7.49pm, a DCO recorded that he had completed a welfare visit but did not make a record of the outcome. There is no record of whether officers offered Mr Fosu his evening meal, or whether he accepted it. There is also no record of whether they offered Mr Fosu use of the telephone.

26 October

87. Officers recorded in the Rule 42 daily checklist that Mr Fosu declined breakfast, exercise and a shower on 26 October. An officer recorded that they did not offer Mr Fosu use of the telephone because he was "non-compliant".

88. At around 9.00am, a different GP to the previous day completed the Elm Unit medical checks. He was accompanied by a healthcare assistant whose name he did not know and which is not recorded in the medical record. The GP said that officers told him that Mr Fosu was on a dirty protest and that there had been no problems overnight. He told us that he did not have access to Mr Fosu's medical records so this was the only information he had. The GP said that an officer asked Mr Fosu through the observation panel if he wanted to see a doctor, to which Mr Fosu replied that he did not. The GP told us that he did not look through the observation panel himself but recalled that the healthcare assistant did. He recorded in the medical record that Mr Fosu had declined to see a doctor.

89. At 10.30am, the duty residential manager (the same duty manager as 25 October), reviewed Mr Fosu's support plan. He noted that Mr Fosu "continues to refuse to shower, remains smothered in his own faeces". Under the section entitled 'further actions' he recorded "detainee to be offered and have access to all facility and regime available on R42" and "encouraged to cease dirty protest and shower".

90. The duty manager visited Elm Unit a number of times that day. He told us that Mr Fosu had put faeces in his sink and was naked. Sometimes he was chanting or standing on top of the furniture in his room. He told us he was concerned about Mr Fosu because he was covered in his own faeces but, as healthcare staff had checked Mr Fosu, he assumed that these actions were the result of voluntary behaviour.

91. At 11.30am, a deputy UKBA visited Elm Unit to complete the UKBA check. (This was the only day that this deputy UKBA manager visited Mr Fosu. On all other days it was the deputy UKBA manager of 24 October who visited him.) She noted that Mr Fosu "continued with his dirty protest and walking around naked". She reported her observations to the senior UKBA manager, who authorised a further 24 hours temporary confinement under Rule 42.

92. Mr Fosu declined lunch at 12.45pm. He did not eat his evening meal and the officer who gave it to him recorded that Mr Fosu was aggressive towards him.

27 October

93. Mr Fosu did not eat his breakfast, lunch or evening meal on 27 October. He declined time in the fresh air fresh air and a shower. An officer recorded that they did not offer Mr Fosu a phone call because he was "non-responsive".

94. At around 10.45am, the same GP that had visited Elm Unit the previous day went to the unit to complete the daily doctor's check. Officers unlocked Mr Fosu's door at the same time to give him food. Mr Fosu was behind the door and the GP said he could not see him properly. Officers told him that Mr Fosu was naked but they had given him some clothes. An officer asked Mr Fosu if he wanted to see the doctor to which he replied "no".

95. The GP said he had no concerns about Mr Fosu at the time. The unit staff told him that Mr Fosu had not eaten, which the GP believed was part of a protest Mr Fosu was undertaking. He did not make an entry in the medical record.

96. The GP told us that if a detainee refuses food there would normally be a mental health assessment to determine his capacity to refuse. He said he did not know if Mr Fosu had been assessed by the mental health team as he did not have access to Mr Fosu's notes. The GP did not make a referral himself as he thought that anyone who is deemed to be on a food refusal protest was automatically referred. He said that nothing occurred at the time of his visits to raise any alarms.

97. The deputy UKBA manager visited Elm Unit at the same time as a GP, in order to complete the UKBA check. As Mr Fosu was naked she did not look into the room. Officers told her that he was sitting on the floor and that he would not move to the back of the room. She recorded that Mr Fosu's behaviour had "moderated", although she told us that she did not speak directly to him in any of her visits. She reported her observations to the senior UKBA manager, who authorised a further 24 hours temporary confinement.

98. A residential manager (whose signature is illegible) reviewed the DISP at 12.15pm. The manager recorded that Mr Fosu appeared to have stopped his dirty protest but he did not comply with requests or talk to staff. Mr Fosu was naked at the time and refused to dress. The further actions required were "continue to monitor and report on dirty protest situation" and "continue to encourage compliant behaviour and food and fluid intake".

99. The duty residential manager (the same duty manager who had seen Mr Fosu on previous days) said he visited Mr Fosu several times on 27 October. Once, when asked if he wanted to have a shower, Mr Fosu put faeces on his face.

100. On the same day, Mr Fosu moved to a clean room. Three officers with protective clothing and one with a shield moved Mr Fosu from one room to another. We watched the camcorder footage of this move. Mr Fosu was naked and walked between rooms of his own accord. Footage of his original room shows that it was very dirty covered in what looked like food and faeces.

28 October

101. On 28 October, Mr Fosu refused his breakfast, shower and lunch. Officers did not record whether he ate his evening meal. They offered him a phone call and time in the open air, and recorded that he refused both.

102. At 8.57am, a third GP signed the daily checklist to say he had visited Mr Fosu. However, when later interviewed by Primecare investigators he said that he had not actually assessed Mr Fosu or seen him. He said that he understood he only had to assess those detainees in Elm Unit who staff were concerned about. The GP subsequently moved from the UK and we have therefore not been able to interview him.

103. An IMB member visited Mr Fosu that morning. At the end of a visit, IMB staff are required to write a rota report which is sent to GEO and UKBA. The IMB member wrote the rota report on 30 October, after Mr Fosu's death. He recorded that Mr Fosu was on a dirty protest, uncommunicative and was slumped on the ground. He also recorded that officers told him that healthcare staff had visited Mr Fosu earlier that day and had decided against admitting him to the inpatient unit. (The only member of healthcare staff who had visited Mr Fosu was the GP.)

104. At 11.00am, the deputy UKBA manager visited the unit. She recorded that officers went to Mr Fosu's door and told her he was naked and covered in faeces. She recorded:

> "[Mr Fosu] still refuses to have a shower, clean his room or communicate with staff. He is regularly throwing meals around his room. A further 24 hours temporary confinement Rule 42 has been authorised [by a senior UKBA manager] to give Mr Fosu the chance to show compliance and cease his dirty protest."

105. At 6.00pm, the regimes manager and safer custody manager reviewed Mr Fosu's DISP. They recorded that Mr Fosu "continues to be non-compliant and remains on dirty protest". The further actions recorded were "detainee to be offered regimes and all facilities available on Rule 42" and "encourage to shower and to cease dirty protest". Officers did not offer Mr Fosu time out of his room during the day, or a telephone call. They offered him time out of his room in the evening and recorded that he refused.

29 October

106. On 29 October, Mr Fosu accepted but did not eat his breakfast. He declined his lunch and evening meal. Officers did not offer him time out of his room in the morning or afternoon, or a telephone call. They offered him time out of his room in the evening and recorded that he refused.

107. The DCO who spoke to us about the events of 24 October (see paragraph 77) returned to Elm Unit that morning after four days off work. (Officers generally work shifts of four days on and four days off.) The DCO told us that staff have access to a detainee's documentation and are expected to familiarise themselves with detainees on the unit when they return to work. She said that no one relayed any concerns to her about Mr Fosu. She recalled that he still did not

have a mattress or bedding, which she believed was because he was continuing a dirty protest.

108. During her checks that day, the DCO said that Mr Fosu displayed "very bizarre behaviour". She said he was naked, standing on the table, looking out the window, or shuffling around on his arms with his legs in the air. Mr Fosu did not speak to her at any of her checks that morning.

109. The DCO said that she was concerned about Mr Fosu's behaviour. However, she said she also had previous experience of detainees behaving in a similar manner and that their behaviour might suddenly improve. She said as an officer in Elm Unit she had become "acclimatised" to unusual behaviour. The DCO said she would have expected the daily doctor's assessment to identify any clinical issues.

110. A fourth GP completed the doctor's checks that morning. She told us she attended Elm Unit with a healthcare assistant who asked detainees whether they wanted to see a doctor. The GP said this was her usual practice, because the healthcare assistant generally knew the detainees better. She did not review any documentation about Mr Fosu but said the unit officers told her that he was on a dirty protest. The GP said that the healthcare assistant asked Mr Fosu through the observation panel if he wanted to see the doctor. He declined. The GP said she stood next to the healthcare assistant and did not see Mr Fosu, but heard him shouting that he did not wish to see the doctor. She thought he threw food at the door.

111. The GP said that she could not make a referral to the mental health team as Mr Fosu had refused treatment and she could not therefore force treatment on him. She said that she was not aware Mr Fosu was refusing food, not sleeping or exhibiting bizarre behaviour, only that he was on "dirty protest".

112. At 11.50am, the Head of Residence and two DCO's reviewed Mr Fosu's DISP. They noted that Mr Fosu continued to "behave in a bizarre way, not communicating and continuing dirty protest". The further actions were "to stop his dirty protest" and "to comply with rules and regulations of Elm R40/42". The Head of Residence said they tried to speak to Mr Fosu through the observation panel but he did not respond. He told us they did not know why Mr Fosu was protesting, but at the time he thought it may have been because he had removal directions.

113. The Head of residence told us he thought that a nurse (Harmondsworth's mental health nurse) had assessed Mr Fosu. This was not the case. He said he did not have concerns about Mr Fosu's mental health and saw Mr Fosu eating while sitting on the floor of his room on 29 October. He said he was not aware that Mr Fosu had refused food.

114. At 1.30pm, an IMB member visited Mr Fosu. Officers told her that they could not open the door as no manager was present. She therefore tried to speak to Mr Fosu through the observation panel. The IMB member told us that Mr Fosu did not speak to her but turned his head and looked at her when she spoke to him. She said there was a strong smell coming from his room. She recorded in the rota report (completed that day) that Mr Fosu was on a dirty protest and "looked

very vulnerable, crouching on floor, staring - has he had any MHA [Mental Health Assessment]?" She sent this to the centre manager just before 5.00pm that evening. The centre manager replied that no mental health assessment had been requested.

115. The IMB member told us that her impression was that Mr Fosu's behaviour might have been involuntary or due to illness rather than a form of protest. She explained that she thought this because she had seen people on dirty protest before and this felt different as there was no sense of defiance from Mr Fosu.

116. The deputy UKBA manager also visited Elm Unit on 29 October (she did not record the time). She noted that Mr Fosu was still naked, covered in faeces and had refused requests to have a shower. She reported her observations to the UKBA area manager, who authorised a further 24 hours temporary confinement.

117. At around 7.00pm, a residential manager went into Mr Fosu's room to remove his dinner tray, which he had thrown across the room. The residential manager told us this was the first time he had met Mr Fosu, and described his behaviour as "very bizarre". He said Mr Fosu was naked, shuffling along the floor in a crouched position, talking to himself and was on a dirty protest. He said that officers tried to talk to Mr Fosu but he did not respond. The residential manager said he thought the doctors would pick up any mental health issues during their daily visits and that information about Mr Fosu's health would be treated as 'medical in confidence' and not available to residential staff.

118. A DCO completed the checks on Mr Fosu between 7.00pm and 8.00pm. She told us that his behaviour was "bizarre" in that he was naked, covered in urine and faeces, crawling around his room or sitting on the floor or desk. She did not have any conversation with Mr Fosu.

119. The daily duty manager must collate information received from officers from all the units about detainees who have missed meals or not drunk any fluids. The Head of Residence said that the manager should telephone Elm Unit for this information. If a detainee does not eat for two days or more, he should be reviewed by healthcare staff each day and the details of these reviews added to the spreadsheet. Mr Fosu first appeared on this spreadsheet on 29 October. It was noted that he had not eaten for 24 hours as he had thrown his food on the floor.

30 October

120. Many of the 15-minute observations done over the night of 29 to 30 October noted Mr Fosu was lying or sitting on the floor, slapping the floor, clapping, awake, grinding his teeth or making strange noises. He only appeared asleep between 2.30am and 3.15am. The observations made on previous nights also indicated that Mr Fosu was not sleeping much and was often standing or crouching during the night.

121. A detainee was located in Elm Unit two rooms away from Mr Fosu. (The room between them was empty.) He told us that Mr Fosu banged on his window at night and sang songs during the day. He said he heard Mr Fosu banging very loudly on his window between 8.00am and 9.00am on 30 October. He did not

hear anything else from Mr Fosu's room. One of the DCOs working on Elm Unit that morning said she did not hear any banging from Mr Fosu's room and said there was another detainee in Elm Unit at the time who often banged on his windows.

122. Two DCO's completed the 15-minute observations on Mr Fosu that morning. One said they shared these observations between them, with whoever was free at the time carrying out the check. She said Mr Fosu was behaving similarly to the previous day.

123. One of the DCOs checked Mr Fosu at 8.45am and recorded that he was making strange noises. She told us that it sounded like a loud yawning noise. At 8.55am, the DCO offered Mr Fosu breakfast but he did not respond. Officers did not offer Mr Fosu time out of his room due to his "non-compliance".

124. At 10.00am, the other DCO recorded in the DISP that Mr Fosu was "still naked, crawling around the floor, remains still a lot of the time however moves his body i.e. shuffles around, looks up at the [observation panel] when spoken to". In the 15-minute observation log she recorded that he "began to move as I spoke but no verbal response".

125. At 10.15am, the first DCO recorded that Mr Fosu was "lying on floor by toilet, movement noted" and at 10.30am "lying down on the floor". The DCO said she could see Mr Fosu's entire body at these checks.

126. At around 10.35am, the residential manager (who had visited Mr Fosu the previous evening), and the Head of Residence went to Mr Fosu's room. They opened the door and the residential manager, put some clean clothes on the sink. The residential manager said that Mr Fosu was lying on his right side by the toilet. He said he could see from his feet to his shoulders and saw Mr Fosu move slightly. Mr Fosu did not respond to the residential manager. The Head of Residence remained outside the room and could only see Mr Fosu's legs and that he was lying on the floor. After this the second DCO who had been completing the observations said she asked Mr Fosu to put his clothes on several times through the observation panel but he ignored her.

127. At the 10.45am, 11.00am and 11.15am checks, the first DCO recorded that Mr Fosu was lying on the floor and that she had seen movement. She said she could only see the upper half of Mr Fosu's body. CCTV footage shows the DCO looked through the observation panel for around ten seconds at the 11.00am and 11.15am checks. The CCTV camera was pointing at a different room at 10.45am. (The CCTV camera moves and was not always fixed on Mr Fosu's room that morning. For most of the morning it was fixed on different rooms as the occupants of these rooms were confined under Rule 40 and were therefore unlocked to allow them to access facilities on the unit.)

128. At 11.15am, the residential manager, the deputy UKBA manager and a visiting colleague from DEPMU went to Mr Fosu's room. The residential manager looked through the observation panel door for approximately one minute. A minute later, at 11.17am, he returned to Mr Fosu's door, looked through the flap and put a facemask on. He opened the door, leant into the room but did not go in and closed the door shortly after. The deputy UKBA manager and her

colleague were nearby but did not look in or attempt to communicate with Mr Fosu. The deputy UKBA manager recorded that Mr Fosu was still naked, covered in faeces and refusing to have a shower. She also wrote that "GEO will make sure the doctor attempts to see him today".

129. The residential manager said that, when he looked through the observation panel, he could only see Mr Fosu's legs. He opened the door so he could see him properly. He said that Mr Fosu was lying on his back making regular clicking noises with his mouth. When he opened the door, he saw Mr Fosu lying on his back with his legs towards the door. He did not see Mr Fosu move. He said the clicking noises started when he opened the door and called Mr Fosu's name. They continued after he shut the door. The deputy UKBA manager also said she heard these noises.

130. The residential manager said he then went to speak to the Head of Residence. He wanted to encourage Mr Fosu to have a shower and move him to a clean room in the hope that this would encourage him to comply and stop the dirty protest. He also told us that he intended to ask the mental health nurse, to assess him later that day.

131. At 11.35am, the second DCO wrote under the Rule 42 observations: "lying on the floor by the toilet, clicking noise heard." This entry was crossed out and "voided" was written next to it. The DCO said that she crossed out this observation later that morning as she was unsure whether she had completed an observation or whether this was the 11.15am observation to which she was referring. (CCTV showed the DCO looked into Mr Fosu's room at 11.00am, but not 11.15am.) The DCO told us that she could not "honestly remember" whether she completed an observation at 11.35am. At 11.31am, the CCTV camera pointed away from Mr Fosu's room and towards the centre of the unit. No one walked across the unit towards Mr Fosu's room and it does not appear that anyone completed the required check at 11.30am. At 11.45am, the camera returned to Mr Fosu's room. No one completed the required check at 11.45am.

132. At 11.57am, the second DCO looked through Mr Fosu's observation panel. She saw him lying naked on his back. She thought this was at around 11.45am, although it is clear from CCTV coverage that it was at 11.57am. She called to Mr Fosu but he did not respond. The DCO said she could only see Mr Fosu's legs, which had also been the case during other observations that morning. However, she said she had previously seen his legs move but could not on this occasion. CCTV coverage shows that the DCO spent around a minute and a half outside Mr Fosu's room.

133. The DCO asked the first DCO if she could check on Mr Fosu. The first DCO also got no response. A third DCO was in the unit office and also went to Mr Fosu's room. He said he could only see the bottom half of Mr Fosu, up to his torso. He called a "code yellow 2" over the radio. This is an emergency call which means that a detainee is unresponsive. He also asked the response team to come to Elm Unit as they would be required to open Mr Fosu's door. The control room log shows that the DCO called code yellow 2 at 12.02pm.

134. At 12.03pm, the second DCO looked in Mr Fosu's room and walked away. In the next minute, the third DCO returned to Mr Fosu's door and kicked it. The duty operations manager arrived on the unit.

135. At 12.05pm, a unit manager, the duty operations manager and the third DCO went to Mr Fosu's door. At 12.07pm, another DCO, the first of the three-man response team, wearing protective clothing, arrived on the unit, along with a nurse and a GP. (The GP was the one who had visited Elm Unit on 28 October. The nurse was the one who saw him in Reception on 24 October.) Seconds later, another DCO arrived, also wearing protective clothing, and the duty operations manager opened the door. The two response team DCOs went into Mr Fosu's room. One of them said he shouted to Mr Fosu but he did not respond. He told us that he touched Mr Fosu and, finding he was very cold, he asked the nurse, who had followed him into the room, to examine him. The healthcare manager, said that the duty operations manager telephoned her to ask her to request an ambulance as a detainee had collapsed. She did this via a '999' call. The time of this call is not recorded.

136. The nurse said Mr Fosu was lying on his back with one arm upright at right angles to his body. On examination she found his body was cold and stiff. Mr Fosu's eyes did not move and he had no pulse. The nurse did not start cardiopulmonary resuscitation.

137. The GP noted that Mr Fosu did not appear to be breathing and, on examination, had no pulse in his wrist or neck. The GP confirmed that Mr Fosu had died. The nurse said that the GP told her when they left the room that he thought Mr Fosu had been dead "for hours". The clinical reviewer reviewed the camcorder footage and commented that there appeared to be evidence of rigor mortis.

Post-mortem report

138. The Home Office pathologist recorded that Mr Fosu's body was emaciated (he was 5 feet 6½ inches tall and weighed about 7½ stones) with extensive amounts of vomit on his face, chest and back. There were no external or internal injuries to suggest third-party assault or restraint.

139. The pathologist concluded that, on the balance of probabilities, Mr Fosu died as a result of cardiorespiratory collapse associated with sickle cell trait. (Sickle cell trait means that the person has inherited the sickle cell gene – a condition that affects red blood cells – from one parent but does not display the severe symptoms of sickle cell disease found in people who have inherited the gene from both parents.)

140. The pathologist noted that stress factors may precipitate a crisis in someone with the trait leading to hypoxia (low oxygen levels in body tissue) and sudden cardiac arrest. The pathologist considered that possible stressors in Mr Fosu's case might have included the behavioural disturbance that led to his arrest (possibly associated with psychiatric ill health), emotional distress caused by his detention, or dehydration.

141. Mr Fosu's family requested their own post-mortem examination which was conducted by a different pathologist. The family's pathologist also identified

sickle cell trait as a likely contributor to death and said it was possible (although not certain) that hypothermia, or acute exposure to cold, might have been the stressor that developed an acute sickle cell crisis.

Contact with Mr Fosu's family

142. Mr Fosu did not name a next of kin when he arrived at Harmondsworth but his family's contact details were available in his police records. Later on 30 October, a police family liaison officer visited Mr Fosu's brother in Milton Keynes and told him of the death. Mr Fosu's brother then telephoned their father in the Netherlands and told him that Mr Fosu had died. The police family liaison officer spoke to Mr Fosu's father later that day.

143. On 31 October, a Deputy Director at UKBA spoke to Mr Fosu's father on the telephone. She also offered the family assistance with repatriation or funeral expenses in line with national guidelines.

Support for detainees and staff

144. After Mr Fosu's death, the centre manager 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.

Findings

Management of Elm Unit

145. Mr Fosu moved to Elm Unit on 24 October 2012, just a few hours after he arrived at Harmondsworth. He remained there for the rest of his life. Mr Fosu was held on the unit under Rule 42 of the Detention Centre Rules 2001 which allows a detainee to be temporarily confined (segregated) if they have been refractory or violent. The Rules state that a detainee should not be confined as a punishment or after they have ceased to be refractory or violent.

146. Harmondsworth's 'Temporary Confinement Unit and Dirty Protest Procedure' (dated June 2009) and 'Rule 40/Rule 42 Procedures' (dated July 2012) set out the local operating protocols for Elm Unit that were in place in October 2012.

147. Mr Fosu moved to the unit and was temporarily confined after he assaulted an officer. We are satisfied that this violence meant that it was reasonable at the time to confine him under Rule 42. However, we are concerned about the operation of Elm Unit and particularly that several of the standard safeguards we would expect to see on such a unit – to identify and protect potentially vulnerable detainees and allow them to progress from the unit as quickly as possible – were either not in place or not supported by local operating protocols.

Assessment of medical suitability for temporary confinement

148. There was no provision in the Elm Unit protocols in October 2012 for anyone to assess whether a detainee was 'fit' for temporary confinement. Other than when a nurse very briefly checked his physical health, no one from healthcare saw Mr Fosu when he arrived on Elm Unit or assessed whether there were any health reasons not to confine him. This is a mandatory requirement when someone is segregated in a prison (an equivalent procedure to temporary confinement in an IRC), the aim being to provide a 'snapshot' of the prisoner's mental well-being at the time. The prison assessment is not intended to be a comprehensive mental health assessment but should immediately identify and exclude very mentally unwell prisoners from segregation in all but the most exceptional circumstances.

149. Detention Services Order (DSO) 02/2017, issued July 2017, provides current national guidance on managing detainees temporarily confined under Rule 42. It introduced the requirement for healthcare staff "to complete a risk/health screening" within two hours of relocation under Rule 42. DSO 02/2017 goes on to say that if healthcare staff assess continued detention under Rule 42 as "being injurious to the health of the detainee" they are obliged to bring this to the attention of the centre manager.

150. We cannot say whether a screening would have found health reasons not to temporarily confine Mr Fosu although, given his behaviour in the community, in police custody and in his first hours at Harmondsworth, this is a possibility. However, this represented one of many missed opportunities to refer Mr Fosu for a thorough mental health assessment and identify the additional healthcare needs he undoubtedly had.

Review of temporary confinement and reintegration planning

151. The Detention Centre Rules require that "an officer of the Secretary of State" (meaning a member of the Home Office rather than staff employed by the IRC contractor) must visit all detainees in temporary confinement at least once a day and must authorise any temporary confinement under Rule 42 that lasts for longer than 24 hours. The Rules state that this authorisation should be valid for no more than three days before review. In line with this, UKBA staff visited Elm Unit every day that Mr Fosu was confined, and a senior manager subsequently authorised further temporary confinement based on the information they provided.

152. The purpose of the daily visit and the 24-hour reviews by an officer of the Home Office is to ensure there is an independent review of the wellbeing of segregated detainees and of the need for continued segregation. We were, therefore, very concerned to find that the reviews lacked any effective independence and that the Home Office managers who visited Elm Unit each day from 25 to 30 October did not speak to or even see Mr Fosu before his continued segregation was authorised.

153. The deputy UKBA manager who carried out five of the six daily reviews told us that she would speak to staff in the unit first to establish whether it was appropriate for her to speak to a detainee, and that she asked a detainee custody officer to speak to Mr Fosu to see if he wanted to talk to someone from UKBA. Her records of her reviews contain only the information she was given by Elm Unit staff and in effect, therefore, the supposedly independent reviews of Mr Fosu's segregation amounted to nothing more than rubber stamping decisions taken by others. We are very concerned that the deputy UKBA interpreted her important role in this way.

154. The deputy UKBA manager told us that she did not receive any formal training for this role, and her only learning involved shadowing a more experienced colleague. We also appreciate that a more senior UKBA manager, rather than the deputy UKBA managers, ultimately authorised continuing confinement under Rule 42. Nevertheless, this authority was based on information obtained by the deputy UKBA managers in the course of their monitoring visits to Elm Unit. We consider that both deputy UKBA managers failed to exercise their responsibility to provide an independent review.

155. We appreciate that the deputy UKBA managers are not medically trained and might reasonably have assumed that the doctors who saw Mr Fosu would have flagged up any concerns about his mental or physical wellbeing. However, an IMB member, also not medically trained, saw Mr Fosu on the day before his death and attempted to speak to him. She questioned whether his behaviour was a deliberate dirty protest or the product of mental health problems and she was sufficiently concerned about him to write to the Centre Manager to ask if Mr Fosu had had a mental health assessment. If the deputy UKBA manager had seen Mr Fosu herself, she might also have been prompted to ask questions instead of simply relying on what she was told by unit staff. This is a particular concern as she had access to Mr Fosu's records, which included the circumstances of his arrest (running naked down the street) and the concerns expressed about his mental health while he was in police custody.

156. Harmondsworth's 'Rule 40/Rule 42 Procedures' state that the Residential Manager should conduct reviews on all detainees temporarily confined under Rule 42 "in consultation with UKBA and the Duty Manager" and with "input sought from the security department and unit staff". The procedure does not say how often these reviews should take place or what they should consider. There is also no suggestion of healthcare contribution to the reviews, to reassess whether there are healthcare reasons not to temporary confine the detainee. We consider this particularly important for detainees whose mental health might be affected by being kept apart from their peers.

157. Harmondsworth's 'Rule 40/Rule 42 procedures' also state that detainees placed on temporary confinement will be issued with a reintegration plan (known locally as a DISP) when they arrive on Elm Unit. The policy states that this will show the behaviour expected of the detainee, and that it should be specific, in order to manage his return to a standard residential unit. It does not say how frequently the reintegration plan should be reviewed or by whom.

158. The duty residential manager opened a DISP shortly after Mr Fosu arrived on Elm Unit. He noted two action points: that Mr Fosu have access to all facilities and regime available on Rule 42; and that he be encouraged to cease non-compliance. The DISP was subsequently reviewed twice, on 28 and 29 October, with similar action points recorded each time and the additional action point that Mr Fosu, with staff encouragement, cease his "dirty protest".

159. There is no evidence of any formal multidisciplinary review of Mr Fosu's suitability for temporary confinement. Other than brief conversations with unit staff, there is also no evidence of multidisciplinary input to the UKBA authorisations. The action points recorded in his DISP were unspecific and, in the absence of a multidisciplinary review, gave no consideration to the reasons for his behaviour or how to address them. We consider that these were further missed opportunities to properly consider the conditions that Mr Fosu was living in, and to identify his additional needs.

160. DSO 02/2017 has subsequently introduced national guidance that addresses these points. It states that, for each detainee managed under Rule 42, "a multidisciplinary team must be established" that includes the centre duty manager, representatives from healthcare, the Home Office Immigration Enforcement (HOIE, formerly part of UKBA) manager, and any other relevant party. It states that the team must meet daily to determine, amongst other principles, whether temporary confinement remains necessary, to determine the level of access to the regime, and to agree plans to return the detainee to association. DSO 02/2017 also states that healthcare staff "must assess the physical, emotional and mental wellbeing of the detainee and whether any apparent clinical reasons advise against the continuation of separation".

Use of unfurnished accommodation

161. The mattress and bedding were removed from Mr Fosu's room on his arrival on Elm Unit, and were not returned for the remainder of his life. The duty residential manager told us that this was because Mr Fosu might use them to block his observation panel, which would mean staff would have to enter the room and be at risk of assault. He said that if Mr Fosu had complied with staff they would

have returned the mattress and bedding but, as he did not, they were not returned at any stage.

162. There is no policy – either local or national – that governs the use of unfurnished accommodation in IRCs. (This means accommodation without one or more of furniture, bedding, or mattress.) Harmondsworth's 'Temporary Confinement and Dirty Protest Procedure' states that a "detainee on dirty protest" will be allowed to keep a mattress and bedding, neither of which Mr Fosu had for the duration of his time on Elm Unit.

163. Our view is that unfurnished accommodation should only be used for the shortest time possible and only to hold a very violent or refractory detainee in order to prevent them from injuring others or damaging property. We consider that any use of unfurnished accommodation should be authorised by managers at both the Home Office and the IRC and should be reviewed at least every 24 hours, and an appropriate member of healthcare staff must consider whether there are clinical reasons to advise against its use. We are not satisfied that Mr Fosu's conduct in Elm Unit, which was largely passive, justified the continued removal of his mattress and bedding, and we consider that to deprive him of these items was inhuman and degrading.

Dirty protest and engagement with regime

164. Harmondsworth's 'Temporary Confinement Unit and Dirty Protest Procedure' states that a "dirty protest" occurs when a detainee either defecates or urinates in his room without using the facilities provided. It states that the actions may be undertaken as a protest, but might also be as a result of mental health problems. The policy states that staff must make every effort to ascertain the reasons for the protest and the detainee must be encouraged to end the protest at least once a day. It also states that the detainee will be allowed access to regime activities such as exercise and telephone calls, provided they have showered and wear clean clothing.

165. Mr Fosu began to dirty his room shortly after he arrived on Elm Unit. He remained in such conditions for the rest of his life. Staff sometimes offered him regime activities to which he was entitled but he usually either did not answer or answered incoherently. Staff reported that he was lying on the floor of his room, or hiding under the bed, and not wearing any clothes. Sometimes it is not recorded whether staff offered Mr Fosu activities, and at other times they recorded that they did not do so because of his "non-compliance".

166. Many of the IRC staff we interviewed indicated that they had previous experience of working with detainees who were engaging in a 'dirty protest'. However, the staff we spoke to, and the records they made at the time, indicate that they had little insight into the reasons for Mr Fosu's 'dirty protest', food refusal, and other unusual behaviour. At various times they recorded that Mr Fosu was hiding under his bed, standing on furniture, putting faeces on his face, throwing faeces and food, talking to himself, chanting incoherently, slapping the floor, grinding his teeth, making strange noises and shuffling around on the floor with his legs in the air. They described such behaviour as "bizarre" or "very bizarre" and a residential manager recorded that it was difficult to know if Mr Fosu understood what was being said to him. In the absence of any meaningful healthcare input or

assessment (which we address later in this report), they appeared to assume that Mr Fosu understood what he was doing and was being purposefully disruptive.

167. While we cannot be certain why Mr Fosu behaved like he did, it is astonishing that no one appeared to ask any meaningful questions about the underlying reasons for this behaviour and whether it might be the result of mental or physical health problems. A DCO who described Mr Fosu's behaviour as "very bizarre", told us that she had become "acclimatised" to unusual behaviour while working in Elm Unit. We are very concerned that staff in the unit had apparently become de-sensitised to behaviour that appeared at the very least to suggest significant mental distress, and we consider that managers were responsible for a culture in which this could occur.

Temperature of room in Elm Unit

168. Mr Fosu's family were concerned that his room in Elm Unit was cold, and that this exacerbated the effects of him being naked and without bedding. The family's pathologist concluded that it was possible that hypothermia, or acute exposure to cold, might have been the stressor that developed an acute sickle cell trait crisis and led to Mr Fosu's death.

169. The room occupied by Mr Fosu in Elm Unit is heated and cooled by air blown into the room from a unit in the ceiling. The in-room temperature is computer-controlled across the Harmondsworth site and should fluctuate between 21 and 24 degrees Celsius. (Although detainees in most rooms can adjust their temperature from the standard setting by plus or minus three degrees, using an in-room control panel, this facility is not available on Elm Unit.) DSO 06/2018, on IRC accommodation standards, states that rooms must be maintained at a minimum temperature of 20˚C, plus or minus 1˚C.

170. We do not know what the temperature was in Mr Fosu's room over the six days he lived there. There is no evidence that the heating system was not working during this time. Mr Fosu spent much of his time lying on the floor naked, and this is likely to have affected his body temperature. As we have noted, these actions should have been identified and considered at a multidisciplinary review of his temporary confinement and are one of many reasons why a mental health referral should have been made.

171. We make the following recommendations:

The Director of Home Office Immigration Enforcement should:

- **ensure that Home Office staff employed in contracted out IRCs properly understand their role and the importance of acting independently, and are properly trained to carry out this function; and**

- **conduct an investigation into the way in which the deputy UKBA managers exercised their responsibilities in reviewing Mr Fosu's continued temporary confinement, with a view to taking disciplinary action if necessary, and inform the Ombudsman of the outcome;**

The Centre Manager and Head of Healthcare should ensure that staff manage detainees temporarily confined under Rule 42 in line with national guidelines, including that:

- **an appropriate member of healthcare staff completes a health screen within two hours of relocation under Rule 42, to assess whether there are any health reasons not to confine the detainee;**
- **a multidisciplinary team reviews the temporary confinement every 24 hours to consider whether the temporary confinement remains necessary, whether there are any health reasons to advise against continuing confinement, and to agree plans to end the temporary confinement and return the detainee to association;**
- **staff offer all activities and regime to which the detainee is entitled, record whether the detainee participates in the activity and any reasons, if given, why they do not; ensure that the multidisciplinary team are aware of any refusals; and make appropriate referrals; and**
- **detainees who are undertaking a dirty protest are provided with a mattress and bedding.**

The Director of Home Office Immigration Enforcement should issue national guidance on the circumstances in which a detainee can be held in unfurnished accommodation, including that:

- **unfurnished accommodation must only be used for the shortest possible time and only to hold very violent or refractory detainees;**
- **the use of unfurnished accommodation must be authorised by managers from HOIE and the IRC and must be reviewed at least every 24 hours; and**
- **an appropriate member of healthcare staff must assess whether there are any health reasons not to place the detainee in unfurnished accommodation; and**
- **a copy of the guidance is sent to the Ombudsman.**

Clinical care

172. Mr Fosu's police medical records highlighted the circumstances of his arrest, his behaviour in police custody and the mental health assessments completed during this time. These medical records were emailed to the Harmondsworth healthcare inbox on 23 October, the day before he arrived. It is also standard practice to attach the police medical record to the PER and, while we cannot be certain that the record travelled to Harmondsworth with Mr Fosu, a note on the PER indicated that the records had been attached.

173. Despite this, no one referred Mr Fosu to the mental health team at Harmondsworth on his arrival or at any other time. The Reception nurse said she was not given the police records, or any other information about Mr Fosu's history, in Reception. We do not know whether this is correct but we are satisfied

that there should have been sufficient information available to her and other staff to ensure a referral was made immediately.

174. We have already highlighted that there was no healthcare assessment to determine whether there were any clinical reasons not to temporarily confine Mr Fosu. Harmondsworth's 'Rule 40/42 Procedures', valid when Mr Fosu was confined in Elm Unit, also state that the medical officer (meaning an IRC doctor) should visit the detainee each day they are temporarily confined. (DSO 02/2017 also states that a daily visit from healthcare is required.)

175. IRC doctors visited Elm Unit each day that Mr Fosu was in the unit but a doctor only saw or spoke to him in person once on 25 October, and then only briefly. On other days they relied on IRC staff or a healthcare assistant to ask Mr Fosu if he wanted to see a doctor. As a result, the doctors told us that they were not aware of Mr Fosu's bizarre behaviour.

176. When Mr Fosu apparently said each time that he did not want to see the doctor, no further action was taken, and there was no consideration of his behaviour or the conditions he was living in and whether this warranted further assessment. The GP who visited Elm Unit on 29 October told us that she could not make a referral to the mental health team as Mr Fosu had refused treatment and she could not force treatment on him. However, like the other doctors, she had not seen Mr Fosu and was not therefore in a position to consider whether he had the mental capacity to refuse medical treatment.

177. Another doctor, who signed to say that he had visited Mr Fosu on 28 October, said that he had not actually assessed Mr Fosu or seen him and that he understood he only had to assess those detainees in Elm Unit who staff were concerned about.

178. We are extremely concerned that medical professionals who were employed to check on the wellbeing of detainees in Elm Unit (among the most vulnerable detainees at the IRC) did not consider that this required them to see and speak to detainees.

179. Despite the lack of any meaningful assessment or input from the doctors who visited Elm Unit, the IRC staff who worked on Elm Unit appear to have assumed that, as the doctors had not expressed any concerns, Mr Fosu was clinically well. While this is reasonable up to a point, staff and managers in the unit saw Mr Fosu 24 hours a day and we consider that they should have used their own common sense and raised concerns with the doctors themselves and should have considered making a mental health referral themselves.

180. The clinical reviewer found that healthcare staff should have satisfied themselves that Mr Fosu was in good physical and mental health and that his refusal to engage with assessments should not have been taken as evidence of wellbeing. We agree. We find it astonishing that professionals from a variety of disciplines – both healthcare and IRC staff – could have witnessed Mr Fosu's behaviour throughout his time at Harmondsworth and not considered it necessary to make a further referral or assessment to determine whether there was any mental illness or physical condition causing or contributing to this behaviour.

181. We make the following recommendations:

The Director of Home Office Immigration Enforcement Centre Manager should refer the three GP's to the General Medical Council for failing to see or speak to Mr Fosu or to assess his wellbeing.

The Centre Manager and Head of Healthcare should ensure that all staff are aware of the circumstances in which a mental health referral is appropriate.

The Centre Manager and Head of Healthcare should ensure that doctors working at the Centre:

- **have a full understanding of their role; and**
- **see and speak to detainees in Elm Unit in order to satisfy themselves that they are in good physical and mental health.**

Food and fluid refusal

182. DSO 7/2004 provided guidance to staff managing food and fluid refusal in IRCs in October 2012. (It has since been replaced by DSO 3/2017, although the principles referred to below remain in place unless stated.) It states that an IRC doctor must determine whether a detainee refusing food or fluids, or treatment related to this, has the capacity to do so. It also states that when a detainee is known to have refused food or fluid for 24 hours he should be offered a medical appointment to ensure that: (i) there is no undiagnosed mental illness causing the refusal, (ii) there is no physical illness causing the refusal, and (iii) the detainee understands the consequence of their action. (In the case of refusing food, this increases to 48 hours in DSO 3/2017.)

183. The first record that Mr Fosu had declined meals appears on 26 October, and he does not appear to have eaten any other meals for the remainder of his life. No one recorded whether he was drinking fluids and no one kept a formal food refusal log. (Information about whether he had accepted, eaten or refused his meals was sometimes, but not always, recorded in the Rule 42 daily records.) There is no record that anyone assessed his capacity to refuse food or to understand the consequences of this, and no one considered whether there was any mental or physical illness affecting his decision. In addition, no one noted that Mr Fosu was significantly underweight (his post-mortem report recorded that he was "emaciated") or considered whether this warranted additional healthcare input or assessment.

184. We make the following recommendation:

The Centre Manager and Head of Healthcare should ensure that detainees refusing food or fluids are managed in line with national guidelines.

Use of force on 24 October 2012

185. The Detention Centre Rules state:

> "A detainee custody officer dealing with a detained person shall not use force unnecessarily and, when the application of force to a detained person is necessary, no more force than is necessary shall be used."

186. The Detention Services Operating Standards manual sets out the circumstances in which force might be applied:

> "The Centre will ensure that force is used only when necessary to keep a detainee in custody, to prevent violence, to prevent destruction of property of the removal centre or of others and to prevent detainees from seeking to prevent their own removal physically or physically interfering with the lawful removal of another detainee."

187. The staff accounts of the events of 24 October are broadly consistent. They describe how Mr Fosu was shouting in his room and then assaulted a DCO when he tried to speak to him. (The detainee who witnessed the events in their shared room also corroborated this account.) We conclude that it was reasonable and necessary to use force on Mr Fosu, as his assault on the DCO constituted a violent act and a threat to the safety of staff and other detainees.

188. As Mr Fosu continued to struggle and resist attempts to take him to Elm Unit – ignoring attempts at de-escalation – we also conclude that it was reasonable and necessary to continue to use force to relocate him.

189. We note that the post-mortems found no evidence that Mr Fosu had been assaulted before his death.

Events of 30 October 2012

Rule 42 monitoring

190. Harmondsworth's 'Rule 40/Rule 42 Procedures' require all detainees temporarily confined under Rule 42 to be checked by staff every 15 minutes. (This is also a requirement of DSO 2/2017.) This is a basic welfare check and involves looking through the observation panel in the detainee's room to ensure he is well. Staff who complete the checks are required to record what they have seen in a log.

191. The first DCO completed every observation between 8.15am and 11.15am on 30 October, other than two (at 8.30am and 9.55am). These were completed by the second DCO. Each recorded observation was broadly similar, indicating that Mr Fosu was lying on the floor and the officers had seen him move. At least two observations, at 11.00am and 11.15am lasted no more than 10 seconds.

192. The second DCO initially recorded that she had observed Mr Fosu at 11.35am but later crossed out the entry and told us she was unsure whether she had completed the observation. In fact it is apparent, from both recorded evidence and from CCTV, that no one went to Mr Fosu's room between 11.17am and 11.57am, meaning that two welfare checks were omitted.

193. The nurse said that Mr Fosu's body was cold and stiff when she examined him at 12.07pm, and the clinical reviewer said that the camcorder footage appeared to show evidence of rigor mortis. The clinical reviewer added that the presence of rigor mortis would usually indicate that the patient had been dead for at least two to three hours. It is likely, therefore, that Mr Fosu was already dead at some of the earlier observations when staff recorded they saw him move, and almost certainly at the times of the missed observations.

194. The residential manager went into Mr Fosu's room at 10.35am and said he saw him move slightly. He opened the door to look at him again at 11.15am and said that, although he did not see him move, he heard him making clicking noises. The deputy UKBA manager who was nearby, said she also heard Mr Fosu making these noises at 11.15am. Again, it seems likely that Mr Fosu was already dead at 10.35am and almost certainly at 11.15am.

Emergency response

195. At 11.57am, Elm Unit staff spent five minutes looking into, but not entering, Mr Fosu's room. They could not see him move and, at 12.02pm, a DCO made a medical emergency radio call. No one went into Mr Fosu's room until the response team arrived at 12.07pm, some ten minutes after the staff first became concerned for Mr Fosu's health.

196. The second DCO told us that they did not go into the room before the response team arrived because Mr Fosu was confined under Rule 42 and therefore posed a high risk of violence. We recognise that it can be difficult for staff in such situations to make instant decisions but when there is a potentially life-threatening situation it is essential to act quickly. Mr Fosu appeared to be unresponsive on the floor of his room, and had been lying motionless, or virtually so, for nearly four hours. In these circumstances, we would normally expect staff to go into a room as soon as possible, in case there is a need to save someone's life.

197. However, we recognise that Mr Fosu's room was dirty, and the staff on Elm Unit did not have access to full protective equipment. Only the response team, who were the first into the room, had full protective equipment. We acknowledge that this made it more difficult for staff to enter the room quickly and treat Mr Fosu, as doing so might have put their own health and safety at risk.

198. Harmondsworth's 'Temporary Confinement and Dirty Protest Procedures' state that staff in Elm Unit must "carry out continuous assessment to identify the health and safety issues and develop strategies to reduce risk … [both to] persons who may come into contact with the detainee [and the] detainee on protest". (This guidance is repeated in the updated version of the policy, dated September 2017.) We have not seen any evidence that such an assessment or strategy was completed. We would expect it to include an emergency access plan, which should set out actions for staff to take in a medical emergency, including instructions for entering the room and provision for full protective equipment to be immediately available.

199. The procedure for requesting an emergency ambulance at Harmondsworth in October 2012 involved a member of staff on Elm Unit telephoning the healthcare manager and asking her to make a '999' call. This is inappropriate and far too time-consuming. DSO 9/2014, on Medical Emergency Response Codes, now instructs that if an emergency code is called over the radio, the control room must call an ambulance immediately and staff should ensure there are no delays in calling an ambulance. This has been incorporated into local policy at Heathrow IRC, most recently in Notice to Staff 94-2018.

200. We are not satisfied that Elm Unit staff acted appropriately on the morning of Mr Fosu's death. Some welfare checks were missed and those that were completed should have identified a medical emergency earlier, when Mr Fosu was lying unresponsive on the floor. Even when staff did identify a medical emergency, it took too long to go into Mr Fosu's room.

201. While we cannot be certain whether more thorough checks on Mr Fosu's wellbeing earlier in the morning would have affected the eventual outcome, it is possible they may have done. We make the following recommendations:

The Centre Manager should ensure that staff complete and record Rule 42 welfare checks in line with local and national policy, and satisfy themselves at each check that the detainee is breathing and does not need immediate medical assistance.

The Centre Manager should ensure that staff complete an emergency access plan for all detainees temporarily confined on Rule 42 who are undertaking a dirty protest.

The Centre Manager should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including that they enter rooms as quickly as possible in a life-threatening situation.

Breaking the news of Mr Fosu's death to his family

202. Mr Fosu's father asked why the news of his son's death was not broken to him directly, rather than to another family member first. DSO 2/2012, on Deaths in Detention, was valid in October 2012. It states that the Head of Operations (deputy director) in Home Office Detention Services should "ensure that the next of kin are informed". It says that, in most cases, the police should inform the next of kin.

203. DSO 8/2014 has subsequently replaced DSO 2/2012. It states that the police will always break the news of a death to the named next of kin, even when they are overseas. (DSO 2/2012 does not explicitly state what should happen if the next of kin is overseas.)

204. Mr Fosu did not name a next of kin when he arrived at Harmondsworth. In his police records, Harmondsworth staff found the contact details of Mr Fosu's brother in the United Kingdom. The police records also contained Mr Fosu's father's telephone number, in the Netherlands.

205. When a detainee does not name a next of kin, staff are faced with a judgement about who to notify of the death and how to do so. They have to balance the closeness of the relationship to the detainee with the most appropriate and sensitive means of breaking the news. Our view is that, all other things being equal, it is preferable to break the news in person rather than over the telephone whenever possible. In these circumstances, staff were faced with a difficult decision about who to contact. While we understand Mr Fosu's father's concerns, we do not think it was unreasonable to choose to break the news in person to Mr Fosu's brother first.

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