PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 10 February 2013 while a detainee at Harmondsworth Immigration Removal Centre

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who died of coronary heart disease on 10 February 2013, while a detainee of Harmondsworth Immigration Removal Centre (IRC). He was 84 years old. I offer my condolences to the man's family and friends.

A clinical reviewer was appointed to conduct a review of the man's clinical care whilst at Harmondsworth IRC. Harmondsworth cooperated fully with the investigation.

The man arrived at Gatwick on a flight from Canada on 23 January 2013. Immigration officers initially detained him at the airport because he seemed confused and could not give a clear account of his travel plans. The next morning, a doctor assessed him and was concerned about his health and sent him to hospital. At hospital, he suffered a heart attack but refused all medication and treatment and was discharged on 28 January. The man was then detained at Harmondsworth while arrangements were made to take him back to Canada. He continued to refuse to take any medication or have any medical treatment.

A GP, who assessed the man at Harmondsworth, considered that he was not fit to be detained. She reported this formally to the Home Office, which nevertheless decided that the man should continue to be detained for his own safety and because it was intended to return him to Canada imminently. Plans to send him back to Canada were arranged three times but thwarted; twice because he was not assessed as fit to travel and once because there was no medical escort available. Immigration staff attempted to find more suitable accommodation, but no one else was willing to take responsibility for him.

On 8 February, the man's health deteriorated and he was taken to hospital handcuffed to an escort officer. He refused any treatment and so he was returned to Harmondsworth. In the early hours of 10 February, he complained of chest pain three times. He initially resisted going to hospital, but eventually agreed to go. The man was handcuffed on the journey and then restrained by an escort chain in hospital. At 12.00pm, a nurse could not find a pulse and hospital staff began to attempt resuscitation, at which point the restraints were removed. Sadly, the man could not be resuscitated and, at 12.20pm, doctors certified his death.

The clinical reviewer was satisfied that the man received an equivalent standard of health care in detention to that he might have expected in the community, although we identify the need for Harmondsworth to draw up a protocol to manage chest pain. I also consider that, overall, Home Office immigration officials did what they could to manage the man humanely, within the constraints under which they operated, although there was scope for improvement in the handling reports about his fitness for detention.

Nonetheless, this is a particularly sad case in which no one considered that immigration detention was the appropriate setting for the man, but all attempts to find an alternative failed. It is a tragic indictment of the system, that such a frail and vulnerable man should have spent his final days in prison-like conditions of an immigration removal centre. It is particularly shameful that he should have spent his last hours chained to a custody officer without justification and the Home Office needs to ensure such a situation cannot reoccur.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2014**

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SUMMARY

1. The man arrived at Gatwick Airport on a flight from Canada on 23 January 2013. He was 84 years old and appeared confused with no firm onward travel plans and no luggage. He had no return ticket to Canada but had a lot of cash on him. He said he was going to see his daughter in Slovenia but was unable to give her address or telephone number and was unsure of her married name. He was adamant that he had no intention of returning to Canada. He was taken to an immigration holding room at the airport for his own safety pending a decision about whether to grant him leave to enter the country.

2. An immigration officer contacted the Canadian High Commission who indicated that they would not be able to help with accommodation as an alternative to detention, other than to find a hotel. An immigration officer contacted the local social services who were also unable to help so the man stayed in a holding room at the airport that night. The next morning, 24 January, it was decided that he should be refused entry to the UK. However, a doctor examined him and was concerned about his health, so sent him to East Surrey Hospital. He was temporarily admitted to the country and stayed at the hospital unescorted, until 28 January.

3. Enquiries the doctor made by calling the hospital and then a care home in Canada, indicated that the man had lived in a care home, but just two or three days earlier had been admitted to hospital for a mental health assessment after allegedly hitting a care worker. His care home thought he had suffered a mental breakdown. He was not detained in hospital and had chosen to leave of his own free will and bought a ticket to London. He wanted to see his daughter in Slovenia who he had recently established contact with after many years. He did not have her address or contact details but said he would be able to get these through friends, or his bank, once he got to Austria. The High Commission obtained and passed on his daughter's contact details to immigration staff, but they were never able to get an answer from the number provided.

4. While in hospital, the man suffered a heart attack, but refused all medical observations and treatment. A mental health assessment considered he had just sufficient capacity to make his own decisions about his treatment. The immigration authorities had originally planned to return him to Canada on 26 January, but this was not possible as he was in hospital at the time.

5. On 28 January, the hospital discharged him. He was detained, principally for his own safety and, in liaison with the Canadian High Commission in London, immigration officials organised a further planned removal to Canada for 30 January. In the meantime, the man was held at Harmondsworth Immigration Removal Centre (IRC). Because of his poor physical health, he stayed in the inpatient unit at Harmondsworth. The plan to take him back to Canada on 30 January did not go ahead because there was no medical escort available. It was rearranged for 6 February.

6. On Wednesday 30 January, a doctor examined the man and assessed him as unfit for detention, with likely Alzheimer's disease. The doctor completed a Rule 35 report. (Rule 35 of the Detention Centre Rules requires medical

practitioners to report on any detained person whose health is likely to be injuriously affected by continued detention. The responsible immigration caseworker must respond to such a report within two working days of receiving it with a written response giving reasons for any continued detention.) A mental health nurse assessed the man the next day and considered that he had situational distress and not Alzheimer's disease.

7. An immigration caseworker responded to the Rule 35 report on Monday 4 February, and decided that the man should remain detained for his own safety and because he was due to be returned to Canada two days later. On 5 February, another GP wrote in the records that the man was unfit for detention and at a high risk of death while at Harmondsworth because he refused any medical observations, interventions and medication. The GP did not submit a further Rule 35 report and noted he was due to be removed to Canada the next day.

8. The planned removal to Canada on 6 February did not take place because the man refused to cooperate with health checks and the medical escort was unable to assess him as fit to fly. Immigration staff spoke to Hillingdon social services in an attempt to find a more appropriate place to accommodate him. Social services said that they had no duty of care towards him because he was not a British citizen. A psychiatrist saw the man that evening and referred him for transfer to a psychiatric unit under section 48 of the Mental Health Act. On Friday 8 February, the psychiatric unit refused to take him as he did not meet their admission criteria. They gave information about alternative placements. As it was then the weekend, Harmondsworth intended to pursue these placements on the Monday. On the evening of Friday 8 February, the man became unwell and was taken to hospital handcuffed to a custody officer. At hospital, he refused any treatment and returned to Harmondsworth.

9. At 3.45am on Sunday 10 February, the man complained of severe chest pains but refused medical treatment or to go to hospital. At 5.00am he did the same. He complained again at 6.00am and a nurse called an ambulance. The man was taken to hospital handcuffed to an officer.

10. The man was admitted to hospital and was restrained by an escort chain. There was little evidence that the use of restraints was based on a fully considered risk assessment which took account of his health or vulnerability and it is difficult to understand the basis on which this decision was reached. In hospital his condition deteriorated and, at 12.00pm, a nurse was unable to find his pulse or any other signs of life. Hospital staff began to attempt resuscitation and at this point the escort chain was removed. Sadly, he could not be revived and shortly afterwards a hospital doctor confirmed that he had died. The Coroner gave the provisional cause of death as coronary heart disease.

11. The clinical reviewer concluded that overall the man's care was equivalent to community standards. We consider that the immigration staff who dealt with his case recognised his vulnerability and did their best to find alternatives to detaining him, but were unable to find a solution which would ensure his safety, resulting in him being detained at Harmondsworth IRC. The investigation also found that there was a delay in dealing with a doctor's

report about the man's fitness to be detained. While we are satisfied that, in the absence of alternative care provision, this did not affect the outcome for him, it is important that, because of their nature, such reports are dealt with as quickly as possible. There was no chest pain protocol at Harmondsworth which might have prompted staff to call an ambulance earlier on Sunday 10 February, when the man first reported pain. We are seriously concerned that he, an elderly, infirm and vulnerable man, who was no risk to the public, was restrained by handcuffs and an escort chain when he was taken to hospital. There is a need for the Home Office to ensure that immigration removal centres have appropriate up to date guidance about the use of restraints and follow it. We make four recommendations.

THE INVESTIGATION PROCESS

12. One of the Ombudsman's investigators issued notices to staff and detainees at Harmondsworth IRC informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of the man's detainee medical record and detainee record from Harmondsworth and what is now Home Office, Immigration Enforcement (formally the UK Border Agency.)

14. NHS England commissioned a doctor to review the clinical care the man received at Harmondsworth.

15. The police carried out a criminal investigation into the man's death. In line with our agreement with the police, the Ombudsman's investigation was suspended until the police investigation was completed. On 12 December 2013, the police confirmed their investigation was completed. We regret that this has led to a substantial delay before we could progress our investigation and issue this report.

16. We informed HM Coroner for Western London District of the investigation, who provided the preliminary cause of death on 25 February 2014. We have sent the Coroner a copy of this investigation report.

17. Another investigator took over the investigation after the suspension was lifted in December 2013. She visited Harmondsworth on 14 January 2014 and interviewed 11 members of staff there in February and March. She interviewed four further people by telephone.

18. One of the Ombudsman's family liaison officers, contacted the man's daughter on 14 May 2013, to explain the investigation. She did not have any specific issues for the investigation to consider, but asked to be kept informed.

19. The man's daughter received a copy of the draft report. She did not make any comments. The Home Office also received a copy of the report and commented on factual inaccuracies, this report has been amended accordingly. They gave assurances they would take all the recommendations forward.

HARMONDSWORTH IMMIGRATION REMOVAL CENTRE (IRC)

20. Harmondsworth is an immigration removal centre adjacent to Heathrow Airport. It holds just over 660 men detained by the Home Office Immigration Enforcement division (formerly UKBA) and has been run under contract by the GEO Group since 2009. Primecare were the healthcare provider during the man's time at Harmondsworth. (Med-Co took over in January 2014.) There is a medical centre providing 24 hour healthcare including a three ward inpatient unit.

HM Inspectorate of Prisons

21. The most recent inspection of Harmondsworth was in August 2013. The Inspectorate found that a lack of intelligent, individual risk assessments meant that most detainees were handcuffed when escorted. Inspectors drew particular attention to the cases of two elderly, vulnerable and incapacitated men, one of whom was the man, who were needlessly handcuffed up to the point of their deaths. There were significant gaps in healthcare although a new nurse manager was driving improvement. Management of chronic conditions was inadequate and medicines management was weak. Mental health services were limited but those available were good. The Inspectorate found there were delays in responding to Rule 35 reports by immigration caseworkers when doctors assessed detainees as unfit for detention.

Independent Monitoring Board

22. Each immigration removal centre has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that detainees are treated fairly and decently. In its most recently published report for the year to March 2013, the IMB commented that 9 out of 10 detainees who GPs assessed as unfit for detention, continued to be detained after a decision by immigration officials.

Previous deaths at IRC Harmondsworth

23. The man was the second death from natural causes at Harmondsworth since the beginning of 2012. There were no similarities with the previous death. We did not investigate the case of another elderly man who died after being taken to hospital from Harmondsworth in restraints in November 2012, as he had been bailed when he was in hospital and no longer in detention at the time of his death.

KEY EVENTS

23 January

24. The man arrived at Gatwick Airport from Vancouver on Wednesday 23 January 2013. He appeared to be in a confused state. He had a large amount of cash on him, but no luggage and no ticket for onward travel. At 2.00pm, an immigration officer interviewed the man. He told her that he did not want to return to Canada but planned to get the train to France and then go to Austria and from there to Slovenia to visit his daughter. He had been estranged from his daughter in Slovenia for many years, but had recently re-established contact. He did not know her address or contact number and said he would be able to get it through friends or the bank, once he got to Austria. He told the immigration officer that he had escaped from a mental hospital in Canada.

25. The man stayed in a holding room while attempts were made to get his daughter's contact details from the Canadian High Commission. An immigration officer spoke to a consular official at the Canadian High Commission and explained that it was likely the man would be refused entry to the UK and, to avoid the possibility of detention, asked the High Commission if they would be able to provide accommodation. A consular official from the Canadian High Commission said that the High Commission would only be able to help find a hotel.[1]

26. A Port Medical Inspector at Gatwick examined the man at 8.15pm. He assessed him as being confused and very vulnerable, making him unfit for travel and needing a place to be safe, with minimal supervision. An immigration officer contacted Crawley social services at 9.00pm to see if the man could be taken into a respite residential home either immediately or in the morning. A social services manager said nothing could be done that night, but asked the immigration officer to call back the next day when they would be able to say whether the ,man, as a Canadian citizen, would be eligible for care. (The next morning he was taken to hospital so this was not followed up.)

27. At 10.30pm, the Canadian High Commission provided his daughter's telephone number and address in Slovenia. An immigration officer was unable to obtain an answer when she called. (Further attempts to contact his daughter throughout the man's time in detention were not successful.) The immigration officer also began to see what immigration centres were able to house the man. The two nearby immigration removal centres were regarded as unsuitable; Tinsley House had experienced an outbreak of chicken pox so was only able to take adults in good health, and the level of security at Brook House was regarded as too high and inappropriate for him.

24 January – 28 January

[1] In response to the draft report, the Canadian High Commission commented that the Government of Canada could not take legal responsibility for the man (as per their mandate) but tried to accommodate him and offered to help him arrange hotel accommodation and offered consular assistance which he refused. The PPO did not see any documentation in relation to this.

28. At 12.55am on 24 January, immigration staff moved the man to a more comfortable room at Gatwick and continued to monitor him. Overnight, the Canadian authorities gave the immigration staff the contact details of the care home where he had lived in Canada. An immigration officer contacted them at 7.25am. A member of staff from the care home said the man was on a number of different medications which he took three times a day. He emailed the details of the medication. The staff member described him as confused, but said he would sometimes pretend to be more confused than he was. Two days earlier, the man had allegedly hit a carer at the home and had been taken to hospital for a mental health assessment, as his care home considered he had suffered a mental breakdown. He had then apparently disappeared from the hospital.

29. That morning, it was agreed that the man should formally be refused entry to the country. An immigration officer contacted the Canadian High Commission at 9.05am to inform them of the immigration decision. He recorded that a consular official, told him that the Canadian authorities did not have any facilities to provide social care. They suggested that if he was not a danger to himself or others then he should be detained and removed like any other passenger. If he was a danger, then he could be sectioned and detained in a mental health facility until he could be removed.

30. While he was at Gatwick, the man had refused all offers of food and drink. The staff were concerned about him and, at 7.45am, had called a doctor. At 9.30am, a doctor examined the man and said he needed medication and treatment in hospital as his health was deteriorating. His medication records from Canada indicated that he had heart failure, high blood pressure, angina, and acute coronary syndrome. He had also been prescribed an antipsychotic, possibly for schizophrenia. He had not taken any medication for at least two days. The doctor thought that the man was very vulnerable and unfit to travel and his plans were confused and unrealistic. Paramedics took the man to East Surrey Hospital. He was not accompanied by immigration escort staff and remained there for four days. While in hospital he was temporarily admitted to the UK.

31. An immigration officer, phoned East Surrey Hospital for an update at 4.15pm on 24 January. She gave a hospital doctor the details of the care home and hospital where the man had been treated in Canada. At 6.15pm, a hospital doctor told an immigration officer that the man had refused medication and treatment and therefore needed to be collected from the hospital. An immigration officer contacted Tascor (the company which provides escorts for immigration centres) to arrange an escort.

32. At 6.45pm, a hospital doctor called an immigration officer again to provide further details from the man's time in the hospital in Canada. He said that he had been the last resident in the care home which had now closed and that was how he had ended up in hospital. The Canadian police had found the man in the streets and had taken him to hospital for assessment. Doctors diagnosed him with dementia and referred him to social services, and the hospital then discharged him. It is unclear what happened after this, but a Canadian police officer, whose card had been found on the man, told an immigration officer who telephoned him that the police had no powers to

prevent him buying an air ticket and leaving Canada. It is clear that he had not been detained in any institution from which he had escaped.

33. Tascor could not arrange an escort that evening, so the man remained in hospital. On 25 January, he was due to be escorted to Harmondsworth IRC, before a planned move back to Canada the next day. Before leaving hospital, the man complained of chest pains so hospital doctors reviewed him. Tests indicated that he had suffered a heart attack, but he refused any treatment. He remained in hospital for observation. The hospital carried out a mental capacity assessment which stated the man had 'borderline capacity'. Doctors were unable to say how long he would remain in hospital, so the escort and transfer to Canada arranged for 26 January, were cancelled.

34. Immigration staff called the hospital each day for updates. The man was in the cardiac unit at the hospital but continued to refuse to comply with any medical observations and treatment. At 4.00pm on 28 January, he was considered fit for discharge and the hospital sent a letter listing fourteen medications he needed and noting his ongoing refusal of treatment. The medications were to treat acute coronary syndrome, diabetes, depression and anxiety. Doctors said that the man would be fit to fly in a few days if he had no further chest pains. Immigration detention was authorised on the basis that he was due to be returned to Canada two days later on 30 January and out of concern for his safety as there was no other suitable place for his care. Home Office immigration staff had continued to try and contact his daughter in Slovenia, without success.

35. The man was taken from hospital to Harmondsworth on the night of 28 January. A nurse saw the man at 11.10pm for an initial health assessment. The nurse noted his medications and his acute coronary syndrome. He recorded that he refused to have any observations taken. He noted that the man said he had been admitted to a mental health unit for depression in the past, but did not give details. Because of his age and medical conditions, he was admitted to the healthcare unit at Harmondsworth.

29 January – 10 February

36. On 29 January, a GP reviewed the man. He noted that he appeared to be mentally competent to make decisions about his care and understood the risk of not taking his medication. He offered to arrange a psychiatric assessment which the man refused. The GP noted that the possibility of release might need to be discussed with the immigration authorities.

37. Plans had been made to take the man back to Canada the next day. Because of his poor health it was then agreed that a medical escort should be provided. (This is an escort with an officer and a medically trained person, to ensure a detainee's health is monitored during the transfer.) A medical escort could not be arranged at such short notice and, therefore, the removal planned for 30 January was cancelled.

38. Healthcare staff noted that the man did not sleep during the night and wandered the corridors. He asked to use his GTN spray (a spray treatment for angina to help ease heart pain) but refused any observations and other medication. He ate occasionally.

39. A GP assessed the man at 3.30pm on 30 January. She stated he was frail and in her opinion had Alzheimer's disease and was unfit for detention. The GP completed a Rule 35 report which was sent to the Home Office immigration contact management team at Harmondsworth the same day by email. (Rule 35 requires medical practitioners to report on the case of any detained person whose health is likely to be injuriously affected by continued detention.) That night, staff noted that the man did not sleep and at 3.25am he asked for his GTN spray but refused any further intervention.

40. At 10.42am on 31 January, a consular official from the Canadian High Commission, wrote an email to an immigration officer, to confirm an earlier conversation. They said that the Canadian High Commission would be pleased to facilitate communication with individuals or organisations in Canada to assist with the man's return to Canada, but that the High Commission did not accept responsibility for the costs of removal and was not able to accommodate and care for a person pending their removal.

41. As a doctor had said that the man was unfit to be detained because he had Alzheimer's disease, Home Office immigration staff requested that a qualified psychiatrist should examine him quickly. Instead a mental health nurse at Harmondsworth assessed the man at 1.30pm on 31 January and recorded that he did not currently appear to fulfil the criteria for Alzheimer's disease but would continue to be monitored for his current distress which appeared largely situational. (There was no reference to the diagnosis of dementia in Canada or the discharge summary of 28 January from East Surrey Hospital which noted a secondary diagnosis of dementia.) The man denied having any ill health, including heart disease, although he used a GTN spray. The nurse said that he had seemed agitated and frustrated most of the morning, but he thought there was no aggression or perceived risk to others. He noted the man said that demons tormented him at night, but also said this was to describe distressing thoughts keeping him awake. He could also perform various cognitive tasks. He had some trouble eating. The nurse felt more concerned about the man's physical health and wrote a care plan for the GP to keep monitoring his physical health, ensure daily support from the mental health nurse and to provide a soft food diet.

42. Later that day, the Harmondsworth Centre Manager asked the head of healthcare if she considered that the man was fit for detention. As the mental health nurse had assessed him to have capacity and no significant mental health issues, she considered a short detention would be all right, although any longer than a week would concern her. The head of healthcare considered that the man would be a danger to himself if released with no suitable accommodation to go to.

43. At 9.30pm a GP was carrying out ward rounds in the healthcare inpatient unit and recorded that the mental health nurse had told her that the man had significant mental health issues and was unfit for detention. The mental health nurse told the investigator that he only recalls saying the man seemed distressed, as he did not think he had clear mental health issues. That night a healthcare assistant noted in the observation log that he had been distressed most of the day and did not sleep that night, saying "the evil spirits won't let me". During the night, the man went to the healthcare office and lay on the

floor demanding to be given his money. It took some time to convince him to sit on a chair.

44. On 1 February, the man continued to refuse any medical observations and medication. Further arrangements were made to return him on a flight to Canada on 6 February. A healthcare assistant again noted the man spent most of the night of 1 and 2 February pacing around. At 2.20am on 2 February, he spoke to the healthcare assistant, but appeared confused. She ascertained that he had chest pains and wanted his GTN spray which she gave him. She told him to tell a nurse if he felt more pain.

45. Early in the morning on 3 February, the man told nurses he felt unwell and had stomach pains but he refused any treatment. Later in the morning he felt better and went to sleep. At 9.15am a doctor examined him and took observations. (It is not clear from the records which doctor this was.) His blood pressure (129/75) and pulse (80) were normal. Healthcare staff continued to monitor him, but he still refused any treatment.

46. On Monday 4 February, the Home Office immigration case worker formally responded to the Rule 35 report submitted on Wednesday 30 January. The decision was that the man should remain detained because a removal flight had been arranged for 6 February, he had no contacts in the UK and doctors stated he was vulnerable and unable to care for himself. He continued to refuse medication and did not sleep again that night.

47. On 5 February, a GP recorded that during inpatient ward rounds he had tried to assess the man's capacity, as he continued to refuse any treatment, but he was not cooperative. He noted that the man had a degree of capacity but was unaware of the year and that there was a history of Alzheimer's in his records. The GP considered that he was not fit for detention and at a high risk of death because he was refusing all medication including for his heart conditions. He asked for a psychiatrist to review him for a formal mental capacity assessment but noted that the man might be deported before this could be done. (He was due to be removed from the UK the next day.) That night, a health care assistant noted he again seemed distressed. He was pacing the corridors crying and would not take any medication when it was offered.

48. On 6 February, the man was taken to Heathrow Airport for the flight back to Canada. He became very upset and refused to allow the medical escort to take any observations. He was therefore unable to be satisfied that the man was fit to fly and also noted that the man possibly had underlying mental health issues which made him unsuitable for detention. He was taken back to Harmondsworth and Home Office immigration officials began steps to investigate transferring him into the care of the Hillingdon social services.

49. At 4.30pm the same day, Hillingdon social services told an immigration officer that because the man was a non-British citizen they had no duty of care for him. Following the doctor's referral the day before, a psychiatrist saw the man at 9.30pm and assessed him as unfit for detention. The psychiatrist noted that the man had chronic confusion and needed to be transferred to a psychiatric ward urgently. The psychiatrist completed a Section 48 referral (section 48 of the Mental Health Act 1983 allows prisoners on remand and immigration detainees to be transferred to hospital for treatment). A nurse

faxed the referral to Hillingdon hospital the next morning, Thursday 7 February.

50. On 7 February, the man's temporary admission to the UK was authorised for when a suitable hospital bed was found for him. The same day, a doctor assessed the man and noted his refusal of medication would soon be life threatening.

51. On Friday 8 February, in response to the Section 48 referral, Colne Ward (a psychiatric unit in Hillingdon Hospital) said they were unable to take the man into their care as he did not meet their admission criteria. (They only took patients under 65, with clearly defined mental health issues.) They advised on possible alternative placements and the head of healthcare noted that this would be followed up on the Monday. At 6.45pm, on 8 February, the man's condition deteriorated and he was sent to hospital. A security officer assessed him as a risk of escape. He noted that although the man's age and "claimed medical condition"[2] indicated a low risk, he had escaped from a mental health hospital in Canada. The head of healthcare noted that there was no medical reason why handcuffs should not be applied.

52. The man was restrained by a single handcuff attached to an escort officer. Two officers escorted him to hospital. At hospital he refused treatment and was discharged back to Harmondsworth the same day. He spent the evening awake and pacing about the healthcare unit. Night staff noted he seemed calm but declined medication and observations.

10 February

53. At 3.45am on 10 February, the man was seen to be in bed crying. A nurse went to see him and he said he had chest pains. He refused to allow the nurse to take any observations and would not take any medication apart from his GTN spray. The nures asked if they could send him to hospital, but he refused. The nurse advised him to rest in bed but he got up and moved around the ward. He complained of chest pain again at 5.00am but refused to use his GTN spray or allow the nurse to take observations. At 6.00am he shouted out because of his chest pains. The nurse took observations. His pulse was normal (83), his oxygen was 98 percent and his blood sugar level was very high (23.5). The nurse requested an emergency ambulance.

54. A security risk assessment was completed for the man to be taken to hospital. The nurse indicated on the form that there was no reason why restraints could not be used. A security officer noted the man had a "claimed medical condition" and had previously escaped from a secure hospital in Canada, although he assessed him to be a low risk. The duty operations manager authorised a single cuff and two officer escort. While in hospital the man was restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the detainee and the other to an officer.)

55. The escort officers told the investigator that the man talked and was conscious for most of his time in hospital. Although he could speak English

[2] The official wording of 'Immigration Detainee – Movement Notification' and not the opinion of the security officer

well they said that he spoke only in a foreign language. A detention officer was attached to the man by the escort chain. She said that she had felt uncomfortable about this as he was elderly and frail. The escorting officers said they did not believe that the man needed to be restrained but they did not consider asking managers for permission to remove restraints because they regarded it as standard practice in such situations. The escort record shows that throughout the early part of the morning, the man was restless and refused to allow hospital staff to take medical observations. At 10.00am, he settled and at 11.30am was moved to the observation ward. At 12.00pm, a nurse could not find a pulse or other signs of life. Hospital staff began cardiopulmonary resuscitation and the officer removed the restraints, but at 12.20pm a doctor confirmed that he had died.

Support for staff and detainees

56. Notices were posted in Harmondsworth IRC informing detainees and staff of the man's death. The notices directed detainees and staff to support services if they needed them. No debrief was held for the staff closely involved in caring for him before his death to offer support and to discuss whether things could have been done differently.

Liaison with the man's family

57. After the man's death, Home Office immigration staff were still unable to establish contact with his daughter in Slovenia. The Canadian High Commission and the Slovenian Embassy were contacted on Monday 11 February and through their help, police in Slovenia informed his daughter of her father's death.

58. All agencies involved continued to have difficulties contacting family members and making appropriate arrangements. Home Office immigration officials were expecting to make funeral arrangements in liaison with the man's family but had understood that the man's body would not be released until after the final post-mortem report, which the Coroner did not release until April 2014. At that stage the Home Office learnt that the Coroner had arranged with Hillingdon Council for the man's body to be cremated in May 2013, without reference to the Home Office. We were assured that the Home Office would be discussing their responsibilities with the Coroner so that such a situation would not happen again.

59. At the time of this report the Home Office had not yet been able to return the man's money and property to his family.

ISSUES

The man's detention and location

60. When the man was refused entry to the UK at Gatwick Airport on 23 January, he was confused, had no clear onward travel plans, no luggage and a large amount of money in cash. He was refused entry and temporarily detained by immigration officers at the airport for these reasons, but principally out of concern for his own safety. Unsuccessful efforts were made to contact his daughter so she was not able to help. At the time, immigration officers were unaware of any other family who might be able to look after him. Efforts were made that first night to place him in the care of social services, but this was not possible. The Canadian High Commission were also approached but made it clear that they could do no more than help find a hotel for him. A medical officer assessed him the next morning and sent him to hospital. Plans to remove him to Canada on 26 January were cancelled as the man remained in hospital.

61. On 28 January, the man was discharged from hospital and UKBA staff placed him in Harmondsworth, where he was admitted to the inpatient unit because of his poor health. Originally it was planned that he would be returned to Canada shortly afterwards, on 30 January. This did not happen because there was no medical escort available.

62. On 30 January, a doctor said the man was unfit for detention as he had Alzheimer's disease and an appropriate Rule 35 form was completed (see below.) The next day a mental health nurse said she did not consider he had Alzheimer's disease. The head of healthcare told the centre manager that she considered it would be appropriate for him to remain in detention a short while longer as it would not be appropriate to release him with nowhere safe to go. The Canadian High Commission, as per its mandate, had reiterated that day that they were unable to help with accommodating him.

63. On 4 February, the immigration authorities decided to keep the man in detention because he was unable to care for himself and was again due to be returned to Canada, on 6 February. This planned removal did not take place because the medical escort was unable to assess him as fit to fly. Social services were contacted but they declined to accommodate him as he was not a British citizen. The same day a psychiatrist referred him for admission to a mental health unit under section 48 of the Mental Health Act. Temporary admission to the UK was agreed for when a suitable hospital bed was found. However, on Friday 8 February, the first mental health unit the man had been referred to said he did not meet their admission criteria. He died on Sunday 10 February before an alternative could be found.

64. The stated Home Office policy on immigration detention is that vulnerable people are unsuitable for detention and should be detained only exceptionally and when their care can be satisfactorily managed in detention. According to the policy guidance, elderly people should be treated as vulnerable. All those involved in making decisions about the man, and those who were responsible for his ongoing care, recognised his vulnerability and were aware that an immigration removal centre was not an appropriate place to meet his needs.

It is therefore something of an irony that the predominant reasons given for the man's continued detention was that very vulnerability and concern that he was unable to look after himself satisfactorily.

65. We recognise that in these circumstances immigration staff were faced with an almost impossible dilemma. As a vulnerable person, ideally the man should not have been detained. However, in the absence of any alternative provision it is difficult to see what else could have been done. He had no family and friends in the UK to support him, social services would not help and neither would the Canadian High Commission[3]. He had been discharged from his first hospital stay because he had refused treatment and, at the time of his death, a transfer to a mental health facility was being sought.

66. Although it is a major concern that such a vulnerable, elderly man should have been detained, we consider that immigration officials had little option in the circumstances. It would have been too risky to admit the man to the UK without being satisfied that he had appropriate care and support. We are satisfied that Home Office immigration staff and healthcare staff and others at Harmondsworth did what they could for him in difficult circumstances. Regrettably, this had the very sad consequence that a frail elderly man died in immigration detention before he was able to achieve his goal of being reunited with his daughter and other family in Slovenia.

Detention Centre Rule 35

67. On 30 January, a doctor considered the man unfit for detention and completed a Rule 35 report form which was emailed to the Home Office immigration management team at Harmondsworth the same day. The IRC manager also spoke to an immigration officer, about this on 31 January. The immigration officer emailed the IRC manager at 10.45 that morning to ask her to arrange a psychiatric assessment to see if the man might be transferred to hospital. In response, the IRC manager noted that they did not have immediate access to such services and that her experience was a transfer took some time. In the meantime, a mental health nurse assessed the man that day and did not consider that he had Alzheimer's disease as the Rule 35 report had indicated.

68. Immigration enforcement instructions and guidance states that the purpose of Rule 35 is to 'ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. The information in the report needs to be considered in deciding whether continued detention is appropriate in each case. The guidance says that Rule 35 reports 'must be considered and responded to as soon as possible, but no later than the end of the second working day after receipt.' The Rule 35 report was received on Wednesday 30 January and should have received a response on Friday 1 February. The Home Office immigration case owner did not respond until Monday 4 February, five days later.

[3] In response to the draft report, the Canadian High Commission stated that, as per its mandate, it does not have the facilities to house subjects and that it was in constant contact with local authorities to assist within its mandate. The PPO did not see any documentation in relation to this.

69. We asked the Home Office Immigration Enforcement Division why there was a delay. We were told that the Rule 35 form was received from the contact management team on 4 February by fax and replied to on the same day. They also said it was the responsibility of the contact management team at Harmondsworth to forward the Rule 35 report to the Gatwick Border Casework unit immediately it was received. Someone from the contact management team at Harmondsworth told us that at the time there were staff shortages that caused delays.

70. HM Inspectorate of Prisons raised the issue of the effective management of Rule 35 applications in their recent inspection, pointing out that a number of replies (from UKBA case owners) were late.

71. Detention Centre Rule 35 is designed to provide appropriate safeguarding for vulnerable people in detention. We recognise that the delay in the man's case amounted to just one working day as the period covered a weekend. It did not affect the outcome for him, as it was decided that his detention should be maintained. However, in other cases such a delay could result in a person not fit for detention remaining detained for several days longer than necessary, to the detriment of their health. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that all Rule 35 reports receive prompt responses within the expected timescales.

Restraints, security and escorts

72. When detainees have to travel outside an immigration removal centre, such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including whether any restraints should be used. The contract holder, in this case the GEO Group, has a duty to ensure detainees do not escape from detention and a responsibility to balance this by treating detainees with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on an individual risk assessment which considers the risk of escape and risk to the public. It should also take into account factors such as the detainee's health and mobility.

73. A judgement in the High Court in 2007 in relation the use of restraints on convicted prisoners made it clear that a distinction needs to be made between the risk of escape posed by someone in custody when fit and those risks posed by the same person when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the person's ability to escape must be considered as part of the restraints assessment process. As such tests are required for convicted criminals in prison then it is all the more important that they are rigorously applied to immigration detainees, like the man, who have not been convicted of any criminal offence. Unless risk is properly assessed and the use of restraints fully justified, particularly for elderly and infirm detainees, such use is likely to amount to inhuman and degrading treatment under Article 3 of the European Convention of Human Rights.

74. The escort risk assessments on 8 February and 10 February, did not take into account the man's actual risk. He had spent four days in hospital unescorted when he first arrived in the UK and had not tried to leave. He had never been convicted of any criminal offence and there was no evidence of any risk to the public. Some of the information included in the risk assessments was inaccurate, such as that the man had escaped from a secure hospital in Canada. This could easily have been checked. There was also insufficient information on the risk assessments from healthcare staff to make a properly informed judgement. In a proposal for the man to have an escorted removal to Canada dated 1 February, Home Office immigration officials agreed that 'given his age and vulnerability, restraints should not be used'. It is difficult to see why this did not apply when he was being taken to hospital.

75. He was a frail, elderly man and even the inadequate risk assessments that were completed judged him to be low risk. Despite this restraints were still used. It became clear during our investigation that, at the time the man was at Harmondsworth, detainees going to hospital were restrained almost by default. There was little attention given to individual risk assessment and limited medical opinion sought. Inspectors noted the same thing at their inspection of Harmondsworth in August 2013. We consider that, especially for civil detainees, the default position should be that restraints should not be used routinely unless there is a clearly assessed specific risk of escape or to the safety of the public or staff.

76. We note that immigration removal centres such as Harmondsworth are run by private companies under Home Office contracts which may encourage risk aversion in the use of restraints because of the financial penalties imposed should a detainee escape. It is therefore incumbent upon both the Home Office and centre managers to ensure that a proper balance is struck between security and humane treatment. This was not achieved in the man's case and we consider that the instruction to immigration removal centres in Detention Service Order 08/2008 about the use of handcuffs for escorts is inadequate to cover the legal position and the need to take into account the specific needs of elderly and frail detainees and those with serious medical conditions.

77. On 10 February, he remained restrained by an escort chain until he died. We consider it is wholly unacceptable for anyone to die in restraints, which is also distressing for escort staff. In the man's case, we believe that this is likely to have reached the threshold of inhuman and degrading treatment. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that appropriate and updated guidance is issued to all immigration removal centres to ensure that all staff undertaking risk assessments for detainees taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner and verified risks, and are based on the actual risk the prisoner presents at the time.

Clinical Care

78. The clinical reviewer concluded that the clinical care the man received during his time in immigration detention was at least equivalent to that he could have

expected to receive in the community. Despite his consistent refusal of treatment, his medication was offered and staff were at pains to ensure he was well looked after. The clinical reviewer states that he does not believe that the man's death would have been prevented by any additional actions by staff at Harmondsworth.

79. It is apparent from the medical records that various members of the clinical team at Harmondsworth saw the man frequently. There is also very clear documentation that he continued to refuse to take medication.

80. The clinical reviewer notes that the concerns of the staff involved led to an early mental health nurse assessment, a psychiatric evaluation about his mental capacity and a referral under Section 48 of the Mental Health Act for the man to be transferred to a hospital for assessment and treatment. Unfortunately it was not possible to secure a mental health bed before the man's death.

81. The clinical reviewer points out that, regardless of the question of mental capacity, it would have been extremely difficult to force the man to take the prescribed medication for his heart condition outside a mental health facility. It would have been inappropriate for staff at Harmondsworth to make any attempt to coerce him into taking the medication.

Responding to chest pain

82. Although the clinical reviewer was satisfied that the man received appropriate care, we were concerned that Harmondsworth did not have a protocol to advise staff how to respond to detainees reporting chest pain. On 10 February, he complained of chest pains at 3.45am and 5.00am. On both occasions he refused any treatment and said he would not go to hospital. He complained a third time at 6.00am and the nurse then asked for an ambulance.

83. The investigation found that there were no clear local procedures for healthcare staff at Harmondsworth. Some staff said they would call an ambulance immediately when a detainee reported chest pain even if they said they did not want to go to hospital and others said they would not. On 10 February, the nurse on duty did not call an ambulance the first two occasions when the man complained of chest pain, because he said he would not go to hospital. The third time he agreed, but still had to be persuaded to go to hospital when the paramedics arrived. We consider that as it had previously been identified that he had serious heart conditions and that his refusal to take medication was life threatening, it would have been prudent to call an ambulance earlier. However, we recognise that this would have been unlikely to change the outcome for him.

84. Nurses on the frontline need to be fully trained to recognise potentially serious conditions and know what to do, including when to refer to a doctor or the emergency services. The National Institute for Clinical Guidance (NICE) Clinical Guideline 95 provides information on recent onset chest pain. It advises clinicians to assess patients for signs of and risk factors for cardiovascular disease and indicates that a person with chest pain of

suspected cardiac origin should be referred to hospital for same day for urgent assessment and treatment. We consider that Harmondsworth should have a clear protocol about responding to and managing chest pain, including when to call an ambulance and what to do when someone is refusing treatment. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that the healthcare provider at Harmondsworth introduces a clear protocol for responding to sudden onset chest pain and that all healthcare staff are aware of current clinical guidance.

Support for staff and detainees

85. Staff from GEO and detainees were informed of the man's death through a notice displayed around the centre. The notices asked detainees to speak to their personal officer who would direct them to an appropriate person to speak to if they felt the need to talk to someone. The notice to staff directed them to their line manager, or a member of the staff support team. It also gave the number of the 24 hour employee assistance programme helpline.

86. The Detention Services Order 02/2012 states service providers' contingency plans are to include:

- communicating the death to other detainees/residents within the facility in an appropriate manner
- providing detainee/resident support where required

87. Despite notices being displayed, GEO staff told the investigator that they were not aware of where they could find assistance. Both healthcare and escort staff involved in the man's care at Harmondsworth, told us they were upset and affected his death, but were not debriefed. Escort staff who were with him when he died, said they were asked if they were okay but there was no substantive debrief about events to help identify whether things could have been done differently. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that staff are appropriately debriefed and offered support after a death or other serious incident in an immigration removal centre.

RECOMMENDATIONS

1. The Director General of Immigration Enforcement should ensure that all Rule 35 reports receive prompt responses within the expected timescales.

2. The Director General of Immigration Enforcement should ensure that appropriate and updated guidance is issued to all immigration removal centres to ensure that all staff undertaking risk assessments for detainees taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner and verified risks, and are based on the actual risk the prisoner presents at the time.

3. The Director General of Immigration Enforcement should ensure that the healthcare provider at Harmondsworth introduces a clear protocol for responding to sudden onset chest pain and that all healthcare staff are aware of current clinical guidance.

4. The Director General of Immigration Enforcement should ensure that staff are appropriately debriefed and offered support after a death or other serious incident in an immigration removal centre.