

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Amir Siman-Tov a detainee at Heathrow Immigration Removal Centre (Colnbrook) on 17 February 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Amir Siman-Tov was found unresponsive in his room at Colnbrook on 17 February 2016. A post-mortem concluded that the probable cause of death was morphine and codeine toxicity. Mr Siman-Tov was 41 years old. I offer my condolences to Mr Siman-Tov's family and friends.

Mr Siman-Tov had a long history of mental health issues and frequently expressed suicidal thoughts in connection with his deportation. He was placed under constant supervision in the Enhanced Care Unit under detention service suicide and self-harm monitoring procedures. He threatened several times to save his medication and take an overdose, which he apparently did on 16 February 2016. He was taken to hospital but was discharged back to Colnbrook the same day.

Despite some good mental health planning, the investigation found that overall the medical care Mr Siman-Tov received was inadequate. His death raises concerns over the supervision and administration of medication and it is of particular concern that there was no care management plan or direct clinical oversight following his discharge from hospital after apparently suffering an overdose. If Mr Siman-Tov's physical health had been adequately and safely monitored on his return from hospital, it might have changed the outcome.

There were also some deficiencies in the way staff operated suicide prevention procedures, in particular a lack of input from health care staff, and there were weaknesses in the emergency response. Taken together, these are serious failures from which the centre and its healthcare staff need to learn lessons.

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

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Summary

Events

1. Mr Amir Siman-Tov was granted asylum in the UK in 2001. Mr Siman-Tov was a psychiatric inpatient twice in 2002. He was arrested for fraud in 2010 and remanded in custody. His mental health deteriorated and he was transferred between prison and mental health units. On 25 November 2011, he was sentenced to six years and eleven months in prison. He was made aware he was liable for deportation on 20 December 2011. On 24 December 2013, immigration officials served him with reasons for deportation and a signed deportation order. Mr Siman-Tov was released on immigration bail on 26 November 2014.
2. On 21 January 2016, a Home Office caseworker reported Mr Siman-Tov had breached his bail by failing to report to them. He was detained on 25 January 2016, and tried to hang himself in a holding room with an electrical cable. He made a ligature from his boxer shorts in police custody and a police medical officer decided he should be constantly supervised.
3. On 28 January 2016, Mr Siman-Tov arrived at the Colnbrook site of Heathrow Immigration Removal Centre. He was immediately moved to the Enhanced Care Unit, where he was constantly supervised under detention service suicide and self-harm monitoring procedures (known as ACDT).
4. Mr Siman-Tov received a prompt mental health assessment, repeatedly said he wanted to kill himself and threatened to save his medication and take an overdose. He was put on a care plan which specified his medication should be strictly supervised.
5. On 16 February, a detention custody officer saw Mr Siman-Tov take a handful of tablets. Mr Siman-Tov was taken to hospital where he said he had taken an overdose of codeine and ibuprofen. He underwent blood tests and an electrocardiogram (ECG). The hospital tested him for aspirin and paracetamol but not for codeine or ibuprofen. Mr Siman-Tov's ECG showed an abnormal heart rhythm. The hospital discharged Mr Siman-Tov with an antacid and no clear discharge instructions.
6. Mr Siman-Tov was sick on three occasions between leaving the hospital and returning to his room. He went straight to sleep. At about 3.15am, detention staff found him unresponsive. They tried to resuscitate him and called an ambulance but paramedics pronounced he had died. A post-mortem concluded he had probably died from morphine and codeine toxicity.

Findings

7. The clinical reviewer criticised the lack of proper discharge information from the hospital which led to a poor handover of information to nurses. At Colnbrook, the lack of a care management plan and direct clinical oversight of Mr Siman-Tov meant that his physical health was not adequately or safely observed on his return from hospital. Had this happened, it might have changed the outcome. Accordingly, we consider that Mr Siman-Tov's healthcare at Colnbrook was not

equivalent to the clinical care he might have expected to receive in the community.

8. We found several weaknesses in ACDT procedures, most notably the lack of input from healthcare staff despite Mr Siman-Tov having obvious mental health issues.
9. We found that an emergency code was not used as it should have been. While this meant there was a short delay before an ambulance was called, it is unlikely to have changed the outcome for Mr Siman-Tov. In another emergency, such a delay might have been critical.

Recommendations

- **The Head of Healthcare should ensure there is a protocol in place with Hillingdon Hospital that covers the proper handover of discharge information and the results of tests undertaken on detainees in hospital.**
- **The Head of Healthcare should ensure that all detainees discharged from hospital have a care management plan in place on their return.**
- **The Head of Healthcare and the Centre Manager should clarify procedures to ensure that all nursing staff properly check detainees required to take medication under supervision, especially those monitored under ACDT procedures.**
- **The Centre Manager and Head of Healthcare should ensure that staff manage detainees identified as at risk of suicide and self-harm in line with national and local guidelines, including:**
 - **Holding multi-disciplinary case reviews attended by all relevant people involved in a detainee's care.**
 - **Communicating risk factors to all relevant departments involved in a detainee's care.**
 - **Reviewing detainees on constant supervision daily.**
 - **Managers make regular quality control checks.**
- **The Centre Manager and Head of Healthcare should ensure that all staff are made aware of and understand the emergency code system and that an ambulance should be called immediately.**

The Investigation Process

10. The investigator issued notices to staff and detainees at Colnbrook informing them of the investigation and asking anyone with relevant information to contact her. One detainee contacted her and was interviewed.
11. The investigator and an Assistant Ombudsman visited Colnbrook on 19 February 2016. They obtained copies of relevant extracts from Mr Siman-Tov's detention and medical records and CCTV recorded on 16 and 17 February 2016. They spoke to four detainees.
12. NHS England commissioned a clinical reviewer to review Mr Siman-Tov's clinical care at Colnbrook.
13. The investigator interviewed 12 members of staff at Colnbrook during 2016. The clinical reviewer joined her for five of the interviews. They also spoke to the Head of Primary Care and the Head of Mental Health for information about healthcare services and policies.
14. We informed HM Coroner for West London of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Siman-Tov's wife, to explain the investigation. Mr Siman-Tov's wife said she had no specific questions at that time but was taking legal advice.

Background Information

Heathrow Immigration Removal Centre (Colnbrook site)

16. Colnbrook is an immigration removal centre in West London and holds about 340 detainees. Mitie Care and Custody run the centre under contract from the Home Office. Central and North West London NHS Foundation Trust (CNWL) provide physical and mental health services. There is a six bed Enhanced Care Unit for detainees with mental health, substance misuse and social care needs. The unit is upstairs from the healthcare facility but is staffed by detention services officers.

HM Inspectorate of Prisons

17. The most recent inspection of Colnbrook was in February/March 2016. Inspectors reported some improvement since the previous inspection in 2013. However, there was much to do and healthcare was a particular concern. Chronic staffing shortages affected the continuity and consistency of care and restricted effective involvement in ACDT suicide and self-harm monitoring reviews. Care for those with severe mental health needs was generally good but inspectors were concerned that people with such severe illnesses were in detention. The Enhanced Care Unit offered a quiet environment but was not sufficiently therapeutic. The unit did not offer adequate formal care planning, sufficient multi-disciplinary reviews or a consistent officer staff group who had received specialist training.
18. Case reviews for detainees identified as at risk of suicide or self-harm were timely but input from health care professionals was rare, even where there were clear indications of a mental health issue. The number of detainees under constant observation was appropriately high.

Independent Monitoring Board

19. Each immigration removal centre has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to October 2015, the IMB reported that it was concerned that detainee custody officers with no healthcare background or training were responsible for staffing the Enhanced Care Unit. The IMB said detainees could be housed on the Enhanced Care Unit for long periods of time with significant mental health issues and considerable care needs which were not always well met.

Previous deaths at Colnbrook

20. We have investigated three previous deaths at Colnbrook since 2004, including two by natural causes in 2011. There were no similarities between those and Mr Siman-Tov's death.

Assessment, Care in Detention and Teamwork (ACDT)

21. ACDT is the Home Office care-planning system used to support detainees at risk of suicide or self-harm. The purpose of ACDT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the detainee.

22. After an initial assessment of the detainee's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the detainee anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the detainee. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACDT plan should not be closed until all the actions of the caremap have been completed.
23. All decisions made as part of the ACDT process and any relevant observations about the detainee should be written in the ACDT booklet, which accompanies the detainee as they move around the removal centre. Guidance on ACDT procedures is set out in Detention Service Order (DSO) 6/2008.

Key Events

Events leading to Mr Siman-Tov's detention

24. On 14 June 2001, Mr Amir Siman-Tov arrived in the UK illegally from Morocco. He claimed asylum and was allowed to stay in the UK. In 2002, he was twice admitted to an inpatient mental health centre, where he was diagnosed with post-traumatic stress disorder and prescribed antidepressants and antipsychotic medication.
25. On 8 June 2010, he was arrested for fraud and remanded into custody. His mental health deteriorated in HMP Wormwood Scrubs and he was transferred to a mental health centre. His mental health improved but he continued to hallucinate. In January 2011, a psychiatrist concluded that he was malingering and he was returned to Wormwood Scrubs, where his behaviour deteriorated again. In April 2011, Mr Siman-Tov was diagnosed with schizoaffective disorder (a severe psychotic illness characterised by delusions, hallucinations and depressive episodes). He was admitted to a secure psychiatric hospital for treatment and was returned to Wormwood Scrubs in November 2011.
26. On 25 November 2011, Mr Siman-Tov was sentenced to six years 11 months and served his sentence in several prisons. In December 2013, he was transferred to an immigration removal centre. Mr Siman-Tov was released on bail on 26 November 2014. In July 2015, the Home Office notified Mr Siman-Tov he would be deported. Shortly afterwards, he was admitted to a mental health centre after police arrested him while he was trying to harm himself. He was discharged to his local community mental health services.
27. On 21 January 2016, a Home Office caseworker reported Mr Siman-Tov had breached his bail by failing to report to them. On 25 January 2016, he was detained by a Home Office enforcement team. He tried to hang himself in a holding room with an electrical cord he had brought with him. Police took him to a police station, where Mr Siman-Tov tried to use his boxer shorts as a ligature. A police medical officer decided he should be constantly supervised.

Detention at Colnbrook

28. On 28 January, Mr Siman-Tov arrived at Colnbrook Immigration Removal Centre. He told a nurse at an initial health assessment that he had mental health issues, had recently tried to kill himself and felt suicidal. The nurse began ACDT suicide and self-harm monitoring. Mr Siman-Tov was placed under constant supervision in the Enhanced Care Unit (ECU).
29. On 29 January, one of the centre GPs assessed Mr Siman-Tov's physical health. He said Mr Siman-Tov was very articulate. He noted Mr Siman-Tov's right leg was shaking, which might have been a side effect of his anti-psychotic medication. He continued Mr Siman-Tov's regular prescription of mirtazepine (an antidepressant), risperidone (antipsychotic medication) and sodium valproate (anti-epileptic medication). The pharmacy team did not stock orphenadrine (which Mr Siman-Tov took to counteract the effects of the antipsychotic medication) so Mr Siman-Tov's family brought in his supply from home. The GP said Mr Siman-Tov did not have any physical health problems.

30. Mr Siman-Tov was also prescribed paracetamol (for back pain) and an antacid. He did not have any of his medication in possession. On the same day, an unknown agency mental health nurse saw Mr Siman-Tov and noted his personal and social history using a nurse's log in details. The record shows Mr Siman-Tov said his sleep was disturbed and he preferred to sleep on a chair rather than in bed. He was coherent and denied any thoughts of self-harm.
31. On 30 and 31 January, a GP visited Mr Siman-Tov. He said Mr Siman-Tov engaged well with him but appeared anxious and worried and told him that he wanted end his life.
32. On 1 February, a nurse took a detailed mental health history from Mr Siman-Tov. The nurse said Mr Siman-Tov had a very good memory of his past mental health interventions and the dates these had occurred. He did not think that Mr Siman-Tov showed psychotic symptoms. Mr Siman-Tov denied current suicidal thoughts or intention to harm himself but said he occasionally had fleeting thoughts of both. He said he had tried to kill himself with an electrical cord because he did not want to be detained. He said his sleep pattern was erratic with nightmares.
33. The nurse completed a care plan with action points to observe Mr Siman-Tov, contact Mr Siman-Tov's community mental health providers about his history and to discuss him at the mental health team's new referrals' meeting. The care plan said, "In view of his risk to self, his medications are to be supervised and not for IP [in possession] unless otherwise directed". (None of the detainees in the ECU had their medication in possession.)
34. On 2 February, Mr Siman-Tov told a consultant forensic psychiatrist that he would rather die than be deported to Morocco. She concluded that Mr Siman-Tov's mental state needed further examination, that he should remain in the ECU for observation, and that ACDT monitoring should continue because he had recently tried to kill himself. She said his attempted suicide was directly linked to his deportation.
35. On the same day, Mr Siman-Tov was discussed at the mental health team's new referrals' meeting. A care plan was agreed which included:
 - ACDT monitoring.
 - Remaining on the ECU under constant supervision.
 - Psychiatric review.
 - Medication to be given under strict supervision.
36. The psychiatrist spoke to another psychiatrist who had treated Mr Siman-Tov in a secure mental health facility. A nurse faxed Mr Siman-Tov's GP and the mental health centres he had previously been admitted to and his community treatment team for information. Mr Siman-Tov's mental state and risk of self-harm were reviewed daily to assess the level of observation needed.
37. On 7 February, Mr Siman-Tov declined to speak to a locum GP. The GP ordered baseline blood tests and an electrocardiogram (ECG). On 8 February, a nurse

took blood from Mr Siman-Tov, but there is no record of the results and no record that the ECG took place.

38. Mr Siman-Tov attended ACDT reviews daily between 29 January and 9 February (except for 31 January). At every review he said he was suicidal. He said he did not want to be in detention and did not want to be deported to Morocco. On 2, 3 and 4 February, Mr Siman-Tov said he had thought about concealing his medication for a few days and taking an overdose. A nurse identified only as "X" was present at the review on 4 February and this is the only time any healthcare staff attended a review. Mr Siman-Tov's risk was rated as 'high' at every review and he remained under constant supervision.
39. On 9 February, the mental health team discussed Mr Siman-Tov after they received information about Mr Siman-Tov from the community. They noted that Mr Siman-Tov's diagnosis had varied between schizoaffective disorder and no mental illness and decided to organise a comprehensive psychiatric assessment and continue monitoring. Mr Siman-Tov's blood pressure and pulse were raised but these tests were not repeated as they should have been.
40. On 10 February, a GP saw Mr Siman-Tov and replaced Mr Siman-Tov's paracetamol prescription with two tablets of Ibuprofen three times a day. (Mr Siman-Tov's medical record showed he was given paracetamol from 3 February but he refused to take it from lunchtime on 7 February onwards.)
41. Mr Siman-Tov was given his dose of ibuprofen twice on 10 February, three times on 11, 12 and 13 February, twice on 14 February and three times on 15 February (a total of 32 200mg tablets).
42. On 11 February, a consultant forensic psychiatrist concluded that Mr Siman-Tov had significant adjustment difficulties because of his immigration situation but was not psychotic. Mr Siman-Tov told him that theologically he was allowed to commit suicide to avoid slavery – which he equated with being returned to Morocco. He decided to discontinue Mr Siman-Tov's orphenadrine because he had no side effects from his anti-psychotic medication. He decided Mr Siman-Tov should continue to be monitored under ACDT procedures in the ECU but he supported a reduction in the frequency of observations.
43. Later the same day, Mr Siman-Tov told another locum GP that he wanted to harm himself and should be allowed to do so. He told an ACDT review team the same and that he wanted the constant supervision to stop so he could harm himself.
44. On 13 February, he told a GP that the ibuprofen was not relieving his back pain. The GP prescribed codeine (an opiate based painkiller) four times a day. He appeared to be stressed and fidgety at an ACDT review on the same day.
45. Mr Siman-Tov's medical record showed he was given codeine three times on 13 February and four times on 14 and 15 February (a total of 22 tablets). A nurse gave Mr Siman-Tov his medication twice on 15 February. While he said he had given Mr Siman-Tov his medication on several occasions, Mr Siman-Tov's medical records showed he previously gave him his medication on 3 February. He said Mr Siman-Tov was keen to take his medication on time and would often

demand it. He said he always watched Mr Siman-Tov take his medication and gave him water to make sure he swallowed it. He said, because he believed he was unable to ask Mr Siman-Tov to open his mouth, he would ask a question immediately afterwards to check that he had swallowed his tablets. He said he had not seen evidence that Mr Siman-Tov was hoarding his medication.

46. On 15 February, Mr Siman-Tov collapsed during a meeting with an immigration officer and complained of abdominal pain. A nurse helped him back to his room and Mr Siman-Tov said he felt better. His blood pressure, pulse, breathing rate and temperature were found to be normal. A GP visited Mr Siman-Tov later that day. Mr Siman-Tov asked to be referred to the psychiatrist to discuss his orphenadrine, which the GP did.

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47. At 00.46am, a nurse gave Mr Siman-Tov his night medication. He said Mr Siman-Tov was compliant but asked to replace his codeine phosphate with a different painkiller because he thought codeine phosphate should only be taken for a week. Mr Siman-Tov said he would prefer co-codamol, which he had taken before he was detained. He advised Mr Siman-Tov to continue taking his codeine phosphate and said he would tell the GP about his request.
48. A nurse gave Mr Siman-Tov his morning medication between 8.00am and 9.00am. Mr Siman-Tov refused to take his codeine phosphate and asked for co-codamol instead. He took his ibuprofen and his other medication. The nurse said it was his practice to get detainees to speak to him and open their mouths after he had given them their medication. He recorded that Mr Siman-Tov was compliant with his medication. Mr Siman-Tov asked to see the psychiatrist to discuss his orphenadrine and the nurse said he would pass on his request.
49. At 10.30am, a forensic psychiatrist assessed Mr Siman-Tov with a nurse. Mr Siman-Tov asked to restart his orphenadrine. Mr Siman-Tov told her he would have no life if he was returned to Morocco. Mr Siman-Tov said he felt suicidal and wanted to take an overdose. She said Mr Siman-Tov showed no signs of psychosis and she thought his symptoms did not justify the level of antipsychotic medication he was taking. He agreed to have his risperidone dose reduced. They agreed that Mr Siman-Tov should move to a standard unit and be discharged from the mental health team. Mr Siman-Tov returned to his room, escorted by a Detainee Custody Officer (DCO).
50. The DCO said Mr Siman-Tov said, "I told them I was going to kill myself", and swallowed a handful of tablets. The DCO pressed the personal alarm button on his radio for help. He said he was not allowed to try to remove anything from a detainee's mouth. He described the tablets as big - about an inch long.
51. A GP said he and the forensic psychiatrist were discussing her assessment of Mr Siman-Tov when a nurse told them they suspected Mr Siman-Tov had taken an overdose. He told the nurse to take Mr Siman-Tov's baseline observations and said he would review him in a couple of hours when he had finished his clinic. He said he changed his mind a few minutes later and asked the nurse to call an ambulance. He said his original decision had been influenced by the fact he knew Mr Siman-Tov had previously been suspected of malingering.

52. Mr Siman-Tov walked unaided to the ambulance. The DCO and a colleague accompanied Mr Siman-Tov to hospital. They said Mr Siman-Tov appeared his usual self throughout the journey, was cooperative and did not appear unwell.
53. According to the records from the hospital, Mr Siman-Tov told the triage nurse that at 11.40am, he had taken an overdose of ibuprofen and 15-16 codeine tablets. He denied taking paracetamol. Later, he told one of the casualty department doctors that, at 10.40am, he had taken four days' supply of ibuprofen and four days' supply of codeine, with the intention of killing himself. The record showed the doctor thought this equalled 12 ibuprofen tablets and 16 codeine tablets. Mr Siman-Tov told the doctor he had tried to kill himself by taking a mixture of his medication a few days before but it had not had any effect. He said he did not want to be deported and would try to kill himself again.
54. Mr Siman-Tov did not complain of any of the symptoms usually associated with an overdose. Mr Siman-Tov's blood pressure, temperature, breathing rate and oxygen saturation were normal. His pulse was raised. Blood tests showed normal haemoglobin and liver function. Mr Siman-Tov was tested for levels of paracetamol and aspirin (which were normal). He was not tested for ibuprofen and codeine. Both DCOs said Mr Siman-Tov kept dozing off in the hospital. One said he had seen Mr Siman-Tov like this before and it was not unusual for him.
55. Mr Siman-Tov was given an ECG which showed a fast pulse rate and a significantly abnormal heart rhythm (a raised interval between the Q and the T waves, which can be an indicator of sudden death). The clinical reviewer said this might have been caused by Mr Siman-Tov's risperidone.
56. At about 4.30pm, a DCO said an emergency medicine consultant decided Mr Siman-Tov could be discharged from hospital because his blood tests were normal and he was physically stable. Mr Siman-Tov said he had taken medication, had tried killing himself a few times and needed a psychiatric assessment. The hospital telephoned Colnbrook, who confirmed that Mr Siman-Tov was under the care of the forensic psychiatrist. As he left the cubicle, Mr Siman-Tov started shouting that he was going to kill himself and was dying. He then removed his clothes in protest.
57. Both DCOs managed to get Mr Siman-Tov back on his bed and covered him with his hospital gown. Mr Siman-Tov calmed down after his outburst. A DCO said he still appeared physically well.
58. A DCO telephoned Colnbrook and asked for more officers to help escort Mr Siman-Tov back to the centre. Two residential managers and a DCO arrived about 20 minutes later. As they left, a manager asked a nurse if there was anything he needed to know. She asked him if he had the medication prescribed by the doctor, which was a short course of lansoprazole (an antacid). A doctor told him that his colleague had spoken to Colnbrook and Mr Siman-Tov had been discharged.
59. The hospital gave the escorting staff a discharge letter, which was simply a pre-printed sheet confirming that Mr Siman-Tov had attended Accident and Emergency and had been treated and was fit for discharge. (The hospital faxed Mr Siman-Tov's blood test and ECG results to Colnbrook. This is standard

practice and was not intended for the attention of staff that night. Information about medical assessment, diagnosis and treatment should be contained in a formal discharge letter.)

60. The escorting staff wheeled Mr Siman-Tov out to the van in the hospital bed. Mr Siman-Tov appeared to doze off. Part way through the journey, he woke up abruptly and vomited several times. The escorting DCOs said they did not see any tablets in the vomit which appeared to be mostly liquid.
61. At 6.35pm, Mr Siman-Tov arrived back at Colnbrook and was escorted straight to the ECU. He did not have a reception screen or initial assessment by a health professional and was not searched. A manager said he decided that, because Mr Siman-Tov was not fully dressed and had just returned from hospital, he should go straight to the ECU. Mr Siman-Tov vomited twice on the stairs up to the ECU. All of the escorting staff said they did not see any tablets in Mr Siman-Tov's vomit. A manager said Mr Siman-Tov vomited once more into a polystyrene bowl in his room. He described it as a small amount of clear liquid.
62. A nurse said the orderly officer asked him to check Mr Siman-Tov. He thought this was a routine check because Mr Siman-Tov had not gone through reception on his return. Mr Siman-Tov did not appear dizzy or drowsy and was able to hold a conversation. Mr Siman-Tov told him the hospital had taken blood tests. The nurse did not see any discharge information from the hospital and said he was not sure exactly what they had done. He was aware Mr Siman-Tov had returned with lansoprazole and had vomited on the stairs. He checked the vomit on the stairs and said it was "yellowish" and he could not see any tablets in it. He was not aware Mr Siman-Tov had been sick in the van and again in his room.
63. The nurse gave a verbal handover to his colleague and left Colnbrook at about 7.20pm. He said his expectation was that his colleague would observe Mr Siman-Tov at two hourly intervals throughout the night and take his baseline observations again. He did not write this in the medical record and his colleague said he received no instructions to observe Mr Siman-Tov during the night. He said that he had received a handover from the previous nurse, who told him that Mr Siman-Tov had been taken to hospital after a suspected overdose but had been discharged with some lansoprazole.
64. Mr Siman-Tov's ACDT record for the rest of the day contains a series of observations indicating that Mr Siman-Tov was lying on his back snoring "loudly" and "extremely loudly".
65. At 9.13pm, a nurse went to give Mr Siman-Tov his night time medication of codeine and ibuprofen, but he was asleep. He decided not to wake him as he had just returned from hospital and he saw no point in giving him his medication.

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66. At 2.30am, DCO A took over from DCO B. It was her first experience of constant supervision. DCO B briefed her about Mr Siman-Tov's history and that he had taken an overdose during the day. DCO A said Mr Siman-Tov was asleep, snoring and she could see deep chest movements. His right leg was up and his left arm was out of the covers. He did not change position. After about 15

minutes, he stopped snoring and started breathing heavily. She said she could see his chest moving. She made entries in his record at 2.45am and 3.00am.

67. DCO A said at 3.15am, DCO B asked her if she wanted to be relieved. She said she was fine to carry on and DCO B went into Mr Siman-Tov's room. DCO B picked up Mr Siman-Tov's arm to check his pulse. DCO A said she could still see Mr Siman-Tov's chest rising and falling. DCO B said Mr Siman-Tov was not responding and DCO C joined her in his room.
68. DCO C said she came to the ECU at about 2.50am. DCO B was at the desk and DCO A was sitting outside Mr Siman-Tov's door. At about 3.15am, DCO B began her hourly check of the detainees on the ECU and DCO C accompanied her. When they got to Mr Siman-Tov's room, DCO B asked if he had moved position and then went into his room. DCO C said DCO B tried to wake Mr Siman-Tov by calling his name and then pinching his ear. He did not respond. DCO C said Mr Siman-Tov felt cold when she touched him. She radioed for an emergency response and DCO B started cardiopulmonary resuscitation.
69. Two nurses arrived very quickly with emergency equipment and took over resuscitation efforts. Mr Siman-Tov was cold, unresponsive and not breathing. They asked detention staff to call an emergency ambulance. Ambulance records showed the emergency call was made at 3.21am. Mr Siman-Tov was given oxygen and a defibrillator was attached. The defibrillator showed no heart activity and advised cardiopulmonary resuscitation should continue. A nurse gave Mr Siman-Tov adrenaline.
70. Paramedics arrived at 3.36am and took over resuscitation efforts. They gave Mr Siman-Tov six further shots of adrenaline and four of naloxone (an antidote to opiate overdose). The paramedics pronounced Mr Siman-Tov dead at 4.19am.

Contact with Mr Siman-Tov's family

71. An officer was appointed as the Home Office family liaison officer. He telephoned Mr Siman-Tov's wife on 17 February to break the news of his death and visited her the next day.

Support for detainees and staff

72. After Mr Siman-Tov died a senior 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.
73. Staff told the other detainees on the ECU of Mr Siman-Tov's death on 17 February and offered support.

Post-mortem report

74. A post mortem report concluded that the probable cause of death was morphine and codeine toxicity. The pathologist could find no natural disease that caused or contributed to Mr Siman-Tov's death. The toxicology analysis showed a high level of morphine and codeine and their combined effect "appear to be the probable cause of death". The neuropathology examination was consistent with the effect of an overdose of opiate drugs.

Findings

Medical care

75. The clinical reviewer concluded that the mental health care Mr Siman-Tov received at Colnbrook was appropriate given the uncertainty about his mental health diagnosis. Mr Siman-Tov had a thorough assessment and a coherent plan for his care. Psychiatrists saw him and good efforts were made to obtain information about his medical history. The decision to send Mr Siman-Tov to hospital on 16 February was also appropriate.
76. Although it is not within the remit of our investigation, we note the clinical reviewer's opinion that the hospital discharged Mr Siman-Tov without considering all his risk factors. As he was receiving risperidone and mirtazepine and had said he had taken codeine, it would have been best clinical practice to observe Mr Siman-Tov's vital signs overnight. We found it extremely surprising that the hospital did not test Mr Siman-Tov for either of the substances that he consistently said he had taken.
77. Mr Siman-Tov did not complete the routine reception process when he returned to Colnbrook, as he should have done. Instead, a nurse was asked to give him a routine health check. The nurse was told only that Mr Siman-Tov had become disruptive at hospital and had been sick once on the stairs on the way to his room. Information provided by the hospital on discharge offered no information to the healthcare staff at Colnbrook about his medical assessment, diagnosis and subsequent treatment, as it should have done. The handover to the nurse by detainee custody officers and the hospital was inaccurate and insufficient. The nurse assessed Mr Siman-Tov, with only Mr Siman-Tov's account of his blood results and other treatment at hospital. We recommend:

The Head of Healthcare should ensure there is a protocol in place with Hillingdon Hospital that covers the proper handover of discharge information and the results of tests undertaken on detainees in hospital.

78. The handover from the nurse to the two night nurses was also insufficient. None of the nurses were aware that Mr Siman-Tov had vomited three times since his discharge from hospital. The clinical reviewer concluded that this information should have made healthcare staff more vigilant that night.
79. Mr Siman-Tov's pulse was raised, as it had been at hospital. A nurse said he expected his colleague to repeat baseline observations every two hours. He did not write this in the medical record. His colleague, who had just come on duty and knew even less about the events of the day, did not check on Mr Siman-Tov, although Mr Siman-Tov said he had taken an overdose and had been sick three times since his discharge. The clinical reviewer concluded that it would have been best practice to obtain medical advice about how to treat Mr Siman-Tov. Although none of the nurses had a complete picture of what had happened, Mr Siman-Tov's raised pulse should have prompted further clinical observations.
80. A nurse found Mr Siman-Tov asleep when he went to give him his night time medication of codeine and ibuprofen. He decided not to wake him. The clinical reviewer concluded that this was a serious omission and a missed opportunity to

assess Mr Siman-Tov's wellbeing. We question whether staff should have considered whether a man who claimed to have taken an overdose of codeine and ibuprofen should have been offered both, especially without a plan in place to monitor his vital signs.

81. The clinical reviewer further concluded that the lack of care management plan and direct clinical oversight of Mr Siman-Tov meant that his physical health was not adequately or safely observed on his return from hospital. Mr Siman-Tov's healthcare at Colnbrook was not equivalent to the clinical care he might have expected to receive in the community.
82. Mr Siman-Tov's care plan included the instruction he should be strictly supervised when taking his medication. Nevertheless, it appears that he was able to hoard some of his tablets (although we cannot say for certain where he obtained them or how many he took). There appears to be some inconsistency in the nurses understanding of what is required of them when supervising medication. One nurse said he was not allowed to look in a detainee's mouth to check he or she had swallowed their tablets but another nurse said he always asked to look. We make the following recommendations:

The Head of Healthcare should ensure that all detainees discharged from hospital have a care management plan in place on their return.

The Head of Healthcare and the Centre Manager should clarify procedures to ensure that all nursing staff properly check detainees required to take medication under supervision, especially those monitored under ACDT procedures.

ACDT management

83. Guidance on ACDT monitoring is contained in DSO 6/2008 and requires all immigration removal centres to have local guidance in place. The Centre Manager and Head of Residence at Colnbrook issued considerable and regular guidance to detention staff on various aspects of care under ACDT procedures.
84. Notice to Staff 135/2015 gives local guidance that ACDT reviews should be multi-disciplinary, and at least two staff and the detainee must contribute to the detainee's care. Notice to Staff 136/2015 made it mandatory that staff invited to attend ACDT reviews should attend in person. It specifies that constant supervision should be actioned for the shortest time possible. Notice to Staff 214/2015 says that detainees on constant supervision should have their ACDTs reviewed daily.
85. A nurse was only present at one (on 4 February) out of 14 case reviews. The case manager sought verbal updates for 11 of the reviews from the healthcare team for but two took place with no involvement from healthcare staff.
86. It is not good practice to ask nurses for verbal updates about a patient they have not seen or without consulting his records. Mr Siman-Tov was under the care of the mental health team, receiving a significant amount of medication and frequently expressed a wish to kill himself. At his reviews between 2 and 4 February, he said that he had considered saving his medication and taking an overdose. We consider that mental health staff should have been present at all

Mr Siman-Tov's ACDT reviews. The nurse who attended the ACDT review on 4 February is only identified as 'X' but does not appear to have been otherwise involved in Mr Siman-Tov's care. We have not seen evidence that mental healthcare staff in the ECU were aware of Mr Siman-Tov's threat to divert his tablets and take an overdose.

87. Given Mr Siman-Tov's frequently expressed desire to kill himself, we do not take issue with the fact that he was constantly supervised for an extended period. Although there was a local instruction to review detainees on constant supervision daily, Mr Siman-Tov did not have reviews on 31 January or 15 February. The required number of management checks as quality control did not take place. We make the following recommendation:

The Centre Manager and Head of Healthcare should ensure that staff manage detainees identified as at risk of suicide and self-harm in line with national and local guidelines, including:

- **Holding multi-disciplinary case reviews attended by all relevant people involved in a detainee's care;**
- **Communicating risk factors to all relevant departments involved in a detainee's care;**
- **Reviewing detainees on constant supervision daily;**
- **Managers make regular quality control checks.**

Emergency response

88. Detention Service Order (DSO) 9/2014 requires immigration removal centres to have a medical emergency response code protocol which ensures that an ambulance is called automatically in a life-threatening medical emergency. The guidance in DSO 09/2014 was repeated in notices to staff issued on 16 June and 3 November 2015. DCO C did not use a medical emergency code when she first radioed for help. An ambulance was only called when the emergency response nurses confirmed one was needed. We recognise that the delay was short and was unlikely to have affected the outcome for Mr Siman-Tov. Paramedics arrived 12 minutes after they were called which is within the Ambulance Service's target for responding to an emergency. Despite this, in cases where a person is not breathing, every second is critical. We note that a nurse thought that it was routine practice for staff to wait for the nurses before calling an ambulance, which is not the case. We make the following recommendation:

The Centre Manager and Head of Healthcare should ensure that all staff are made aware of and understand the emergency code system and that an ambulance should be called immediately.

**Prisons &
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