REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] wife of the deceased** **2. Mitie Care and Custody;** **3. Home Office;** **4. Central and North West London NHS Trust;** **5. Hillingdon Hospital NHS Trust;** **6. [redacted];** **7. [redacted] Langley Health Centre Common Road Langley SL3 8LE**
1	**CORONER** **I am Dr Séan Cummings, Assistant Coroner for the Western District, London**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 28th February 2016 an investigation was opened into the death of Amir Siman-Tov. The investigation was concluded by way of Inquest over the period 13th May 2019 to 30th May 2019.
4	**CIRCUMSTANCES OF THE DEATH** Mr Siman-Tov was detained on the 25th January 2016 under immigration regulations at The Beckett House Reporting Centre. He had had previous involvement with police, custodial services and also the Home Office over a number of years and there were a number of documented suicide attempts. He had had a diagnosis of paranoid schizophrenia, depression and epilepsy and was treated for all three. At Beckett House Mr Siman-Tov asks to use the toilet. Sometime later a choking sound is heard coming from the toilet and officers enter to discover that he had attempted to strangle himself with an electrical wire that was in his pocket at the time of his arrest. The ligature was around his neck. Following this, Mr Siman-Tov was moved to the Walworth Road Police Station. At around 1750 on the 25th January 2016 at Walworth Police Station Mr Siman-Tov is subject to a forced search. His clothing is removed and he is placed in his cell in his underpants. He removes his underpants and attempts to make a ligature of them. His underpants are removed from his cell and he is then under constant supervision/watch

	whilst at the police station. While at Walworth Police Station and partly because of (1) the attempt to strangle himself at Beckett House and (2) the attempt to strangle himself with his underpants at the police station he is deemed to require constant supervision. On the 27th January 2016 Mr Siman-Tov was moved from the Walworth Road Police station to Colnbrook Immigration Removal Centre. Tascor, a private secure transport firm collected Mr Siman-Tov at 0055 from Walworth police Station and removed him to Colnbrook Immigration Removal Centre (IRC), Heathrow, arriving at 0230 hrs on the 28th January 2016. On arrival Mr Siman-Tov was placed on an ACDT. An ACDT is an Assessment Care in Detention and Teamwork (ACDT) self harm reduction strategy. It provides a holistic approach to suicide prevention (with a move away from simple awareness to prevention), within the broader context of decency, safety, and the concept of a healthy centre, but also brings existing policy in line with similar changes implemented by the Ministry of Justice. In short it is a process designed to avoid at risk individuals taking their own lives. To be effective it needs participation in by all staff involved in caring for a detainee. Mr Siman-Tov remained on an ACDT constant watch from his arrival at Colnbrook IRC to his death on the 17th February 2016. During his stay at Colnbrook IRC he repeatedly expressed suicidal thoughts and articulated that he would save his medication and take as an overdose. At about 1042 on the 16th February 2016, Mr Siman-Tov was suspected of taking an overdose of medication. He was taken to the Hillingdon Hospital and assessed. After assessment he was discharged from the Hillingdon Hospital at 1710. The “discharge” note sent by Hillingdon Hospital staff contained no clinical information or advice. He was returned to Colnbrook. At 0419 the next morning he was found to have died. The medical cause of death is recorded as 1a Codeine Toxicity. Mr Siman-Tov had a genetic variant which meant that his metabolism of codeine into morphine was faster than in people without the variant.
5	**<u>CORONER’S CONCERNS</u>** During the course of the Inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. A GP who had seen Mr Siman-Tov during his stay at Colnbrook IRC told the jury that he never seen and was not aware of the content of ACDT documents and regarded the document as a custody officer process. He told the Court that it was not customary for healthcare staff to attend or participate in the ACDT process. This puts detainees at risk. 2. The nurses who gave evidence similarly were uncertain of their role with respect to the ACDT process and had variable accounts of their involvement in the ACDT process. This puts detainees at risk. 3. The Consultant Forensic psychiatrist did not read the ACDT documents. This puts detainees at risk. 4. The Centre Manager gave evidence that he recognised the importance of the

	ACDT process in keeping detainee's safe and he actively encouraged as wide participation in the process as possible. He stated that he was only able to direct the custody staff and it was not in his power to direct that healthcare staff participated. 5. Mr Siman-Tov expressed that he might save his medication and take as an overdose. There was conflicting evidence as to the rigour of the checks to ensure detainees had swallowed issued medicine at the time of dispensing and the nurses who gave evidence described different practices of observation. Mr Siman-Tov was able to collect sufficient codeine ultimately to be able to end his life. This lack of consistency of checks puts detainee's at risk. 6. Mr Siman-Tov was taken to the Hillingdon Hospital in the late morning following his overdose on the 16th February 2016. At the Hillingdon Hospital an assessment, examination and blood tests were taken. The blood tests indicated renal impairment. An information system TOXBASE is used in emergency departments to provide assistance to clinicians. Toxbase indicates that in renal impairment greater care must be taken in cases of codeine overdose. This was missed. 7. The hospital clinicians gave evidence which suggested that they were not fully aware of the level of medical monitoring and supervision available at Colnbrook IRC. Mr Siman-Tov had taken an overdose whilst supervised within that facility and a decision was made to return him to that environment. 8. On discharge Mr Siman-Tov in the early evening of the 16th February 2016 was returned to Colnbrook IRC with no accompanying clinical information at all and no advice or directions to the clinical staff at the Colnbrook IRC from the hospital. The only information provided was that one of the hospital doctors had spoken to one of the Colnbrook IRC on the telephone and that Mr Siman-Tov was "good to go". Failure to provide detailed written information puts patients at risk. 9. During the journey back to the Colnbrook IRC Mr Siman-Tov vomited several times. He vomited on his return to the healthcare unit. The nurse on duty was not told by the escorting custody staff and did not ask about any vomiting in the returning minibus. In oral evidence the nurse said that had he known of the vomiting then he would have returned Mr Siman-Tov to the hospital for further assessment. He did not know because he did not ask and was not told. 10. Mr Siman-Tov's care was then handed over to night staff. No explicit direction or handover was given. The explanation for this was that the observations should be second nature and did not need elaboration. 11. The night nurse on duty at around 2100 noted that Mr Siman-Tov was sleeping and snoring. He made no attempt to wake him, check him or take his vital signs. This put Mr Siman-Tov at risk. 12. At approximately 3.10 on the 17th February 2016 Mr Siman-Tov was found to be unresponsive by custody officers. Medical assistance was called for but the required "code blue" for summoning an immediate emergency ambulance was not used. 13. Nursing and other staff arrived. A custody officer asked the nurse if Mr Siman-Tov should be moved to the floor for resuscitation. The nurse replied no. Dr Harris, an expert in Emergency Medicine said that he should have been moved to the floor for effective resuscitation. This puts detainees at risk. 14. An emergency bag was brought containing adrenaline autoinjector and also naloxone which Dr Harris said was a temporary antidote to opiates. A nurse gave an injection of adrenaline into the thigh "because he thought it might help". Naloxone was not given, even though [redacted] had required emergency admission the day prior because of an opiate overdose. This puts detainees at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd October 2019. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. [redacted] wife of the deceased 2. Mitie Care and Custody; 3. Home Office; 4. Central and North West London NHS Trust; 5. Hillingdon Hospital NHS Trust; 6. [redacted] 7. [redacted] GP Langley Health Centre Common Road Langley SL3 8LE I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**28 /08/ 2019 Dr Séan Cummings**