Amir Siman-Tov – jury concludes several missed opportunities contributed to death of vulnerable immigration detainee

By Jed Pennington of Bhatt Murphy

Name of deceased:
Amir Siman-Tov

Place of death:
Colnbrook Immigration Removal Centre

Date of death:
17 February 2016

Date of inquest:
13 - 30 May 2019

Coroner:
HM Assistant Coroner Dr Sean Cummings

Solicitor:
Jed Pennington, Bhatt Murphy

Counsel:
Nick Brown, Doughty Street Chambers

Other interested persons represented:
The Home Office, Mitie Care and Custody, The Central and North West London NHS Foundation Trust, Hillingdon Hospital NHS Foundation Trust

Conclusion:
Death caused by codeine toxicity as a result of misadventure; critical jury narrative

Background and evidence

Amir Siman-Tov was 41 years old when he died at Colnbrook IRC on 17 February 2016. He was originally from Morocco and had converted to Judaism. He is survived by his wife, three year old son (born after his death), parents, siblings and other family members who have made the UK their home. He had a history of trauma and severe mental illness, having spent periods held in mental health detention and had been treated on a long-term basis by community mental health services.

Mr Siman-Tov was convicted of fraud and received a lengthy prison sentence. This led the Home Office attempting to deport him. In response, Mr Siman-Tov claimed asylum, fearing he would be ill-treated or killed if deported to Morocco. He was detained under immigration powers for nearly one year. In November 2014 the Home Office released him on stringent bail conditions due to the poor prospects of deporting him. He mostly complied with his bail conditions before he was taken back to immigration detention on 25 January 2016. At the time, Mr Siman-Tov had legal challenges against deportation outstanding and his wife was pregnant.

Mr Siman-Tov was initially detained in a police station where, after expressing an intention to self-harm, he was placed on constant supervision. He also attempted self-harm by making a ligature out of his trousers. On 28 January 2016 he was transferred to Colnbrook IRC where the Assessment Care in Detention and Teamwork process (ACDT – the process for managing detainees at risk of self-harm in IRCs) was immediately commenced. Mr Siman-Tov was constantly supervised throughout the time he was detained at Colnbrook.

At a number of ACDT review meetings, Mr Siman-Tov expressed a plan to store up his prescription medication and take an overdose. ACDT reviews are intended to be multi-agency, but no member of Colnbrook's healthcare team attended any of the review meetings. At the inquest hearing, doctors and nurses stated that it was not their practice to attend ACDT reviews; they regarded ACDT as a custodial process and in Mr Siman-Tov's case did not read the ACDT documentation that accompanied him. They were in consequence not aware of his plans.

Mr Siman-Tov either had to attend healthcare at a designated time to receive doses of his prescription medication from a nurse, or a nurse would attend the unit he was held on (the care and separation unit) and dispense the medication to him. When dispensing medication, the nurses were supposed to ensure that detainees swallowed their medication. One of the detention custody officers (DCO) who gave evidence stated that in his experience the nurses would simply hand over the medication and move on without checking that the detainee had swallowed it. There was no evidence that Mr Siman-Tov was able to obtain prescription medication or illicit drugs from elsewhere and the jury concluded that Mr Siman-Tov managed to hoard his prescription codeine. There were also no records documenting a search of Mr Siman-Tov's person or his room, including after he repeatedly threatened to hoard his prescription medication.

On the morning of 16 February 2016, Mr Siman-Tov was seen by the DCO responsible for his constant supervision to swallow a handful of tablets with a large amount of water. This was reported to a GP, who was initially sceptical about whether he had taken an overdose, before changing his mind and directing that an emergency ambulance be called to take him to hospital.

At Hillingdon Hospital, Mr Siman-Tov had his observations taken and blood tests were done,

which were mostly within normal parameters (save, in particular, for creatinine levels which indicated renal impairment). The Accident and Emergency (A&E) doctor gave evidence that he received a telephone call from a psychiatrist at Colnbrook who was sceptical as to whether Mr Siman-Tov had overdosed, suggesting that he may have taken "tic-tacs". The doctor did not note down the psychiatrist's name and both psychiatrists working at Colnbrook at the time denied having the conversation described by him. At approximately 4pm, the doctor reviewed Mr Siman-Tov with the on duty consultant; together they decided that in view of the fact that Mr Siman-Tov was not showing signs of opiate toxicity, he could be discharged back to Colnbrook. They expected him to be reviewed by a psychiatrist on return and observed for signs of deterioration, but the discharge note that followed him to Colnbrook provided no details of investigations undertaken or the care plan that should be implemented on return; it simply said he had attended A&E and was fit for discharge.

Mr Siman-Tov was taken back to Colnbrook by a team of four custody officers. During the journey back, there were at least two episodes of vomiting in the van, at least two further episodes on stairs at the detention centre, and a brief episode after entering his room. This was clear evidence of deterioration in his condition. One of the escorting DCOs stated that he had wanted to return him to hospital but was overruled by a manager. Mr Siman-Tov was reviewed by a nurse, who was only aware of one episode of vomiting on the journey back; the custody officers failed to accurately communicate what had happened, and the nurse failed to ask further questions of the officers or Mr Siman-Tov. The nurse stated that it was his expectation that nurses on duty that night would carry out regular vital sign observations, but there was no evidence of a care plan and the night nurses gave evidence that they were not aware of any requirement to carry out observations. The nurse stated that if he had known about the repeated episodes of vomiting, this would have been a "red flag" and he would have returned him to hospital. The night nurses carried out no vital sign observations that night and he was eventually found unresponsive by DCOs at 3.15am.

The post-mortem examination was unremarkable; the neuropathologist stated his findings were consistent with either an overdose or sudden unexplained death in epilepsy. The toxicological analysis showed high (though not at the level usually found in lethal dose cases) levels of codeine and morphine. The pathologist concluded that likely cause of death was morphine or codeine toxicity. Mr Siman-Tov had an extremely unusual reaction to the overdose as he did not present with severe symptoms of toxicity at Hillingdon Hospital. At the request of the family, genetic testing was undertaken which determined that Mr Siman-Tov was an ultra-rapid metaboliser of codeine into morphine. According to toxicology evidence, notwithstanding that it was still a highly unusual reaction, this together with the evidence that Mr Siman-Tov's kidney function was impaired, provided a credible explanation for the delayed onset of symptoms.

An expert in A&E medicine gave expert evidence that if Mr Siman-Tov had either not been discharged and instead kept in for observation, or if he had had vital sign observations taken regularly at Colnbrook, the deterioration in his condition probably would have been identified; and the toxic effects of his overdose probably could have been reversed such that he would have survived.

Inquest conclusion

The jury agreed with the family's view that the overdose was a "cry for help" rather than a desire to deliberately end his life. The jury returned a short-form verdict of misadventure. In a ruling that was difficult to reconcile with the evidence heard (in particular, the nurses' failure to formulate a care plan and carry out regular vital sign observations), the coroner declined to allow the jury to consider neglect. They did however return a critical narrative verdict, concluding that "inadequate information sharing" resulted in "several missed opportunities to prevent the hoarding and ingestion of prescribed medication, despite Mr Siman-Tov repeatedly stating his intention to do so". In addition, there was a "failure to provide a discharge summary, inadequate communication at handover and a failure to establish an adequate care plan on return". Shortly after the hearing, the coroner announced that he would prepare Rule 43 reports in relation to the ACDT process (specifically, the lack of healthcare involvement) and delays on the part of Central and North West London NHS Foundation Trust (CNWL) and Hillingdon Hospital to implement recommendations from various investigation reports.

Comment

The case was beset by delays by West London coroner's court with evidence preparation and inquest hearings repeatedly delayed. The coroner and West London coroner's court referred to resources and caseload demands (according to the 2017-2018 Chief Coroner's report as of 30 April 2018 there were some 355 cases that were over 12 months old). In addition, despite the requirement for Prevention of Future Deaths reports to be sent within 10 working days of the end of the inquest hearing , as of 20 August 2019 reports had still not been prepared and sent.