Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Alfred Dosku, a detained person at Brook House Immigration Removal Centre, on 17 November 2023

## A report by the Prisons and Probation Ombudsman

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## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE

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 detained persons in immigration centres.

If my office is to best assist the Home Office in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Alfred Dosku died in hospital on 17 November 2023, eight days after he was found hanging in his room at Brook House Immigration Removal Centre (IRC). He was 37 years old. I offer my condolences to Mr Dosku's family and friends.

Mr Dosku had been at Brook House for fewer than two weeks when he was found hanging. He had no known history of self-harm and gave no indication to staff that he was at risk of suicide or self-harm in the lead up to his death.

I make no recommendations.

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

**Adrian Usher**
**Prisons and Probation Ombudsman** **September 2024**

# Contents

# Summary

## Events

1. On 1 November 2023, Mr Alfred Dosku was detained at Brook House Immigration Removal Centre (IRC) pending removal to Albania. He reported no immediate concerns.

2. On 5 November, a nurse saw Mr Dosku as he said he had a sharp burning pain in his stomach. The nurse gave him medication for indigestion.

3. Later that evening, Mr Dosku's fiancée visited him. During the visit Mr Dosku was emotional and said he would rather take his own life than go back to Albania. Staff were not aware of his comment.

4. On the evening of 9 November, Mr Dosku and his fiancée argued over the telephone. Mr Dosku was crying and said that he wanted to kill himself.

5. At 10.13pm, a detention custody officer (DCO) let Mr Dosku's roommate out of their room for cleaning duties. The DCO saw Mr Dosku lying on his bed.

6. At 10.56pm, the DCO let Mr Dosku's roommate back into the room and he found Mr Dosku hanging behind the door. He alerted the DCO, who called out to two detention operational managers (DOMs) who were close by. Staff cut the ligature and started CPR. A DOM radioed a medical emergency code and staff called for an ambulance.

7. At 11.06pm, ambulance paramedics arrived and continued CPR. Paramedics regained a pulse and took Mr Dosku to hospital where he was placed in an induced coma.

8. Mr Dosku did not regain consciousness and died in hospital on 17 November.

9. After Mr Dosku died, a detained person at Brook House told us that Mr Dosku had said to him and others that he wanted to take his own life. They said that they told a female member of healthcare staff but were unable to provide any further details.

## Findings

10. Mr Dosku gave no indication to staff that he was at risk of suicide or self-harm during his time at Brook House. There is nothing in any of the records to indicate that other residents of Brook House reported that Mr Dosku had expressed thoughts of suicide. We are satisfied that staff could not have foreseen his actions.

11. We make no recommendations.

# The Investigation Process

12. The Home Office notified us of Mr Dosku's death on 17 November 2023.

13. The investigator issued notices to staff and detained persons at Brook House IRC informing them of the investigation and asking anyone with relevant information to contact him. Four detained persons contacted the investigator as a result.

14. The investigator visited Brook House on 23 November. He obtained copies of relevant extracts from Mr Dosku's detention and medical records, CCTV and body worn video camera (BWVC) footage. He also obtained Serco custodial documents and Ambulance Service records.

15. The investigator interviewed five members of staff and four detained persons in person on 23 November, via telephone on 21 November and 1 December, and by video call on 16, 23 and 26 February 2024.

16. NHS England commissioned an independent clinical reviewer to review Mr Dosku's clinical care at Brook House. The investigator and clinical reviewer conducted joint interviews with three healthcare staff by video call on 15 February 2024.

17. We informed HM Coroner for West Sussex of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Dosku's fiancée to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Dosku's fiancée asked us how Mr Dosku had used the bedsheets to hang himself, how long he was hanging before he was found, whether his roommate made a statement, and whether Mr Dosku was on suicide and self-harm monitoring. She also asked if Mr Dosku received adequate medical care. These questions are answered in this report.

19. The Ombudsman's office also tried to contact Mr Dosku's brother but was unsuccessful.

20. We shared our initial report with the Home Office. They pointed out a factual inaccuracy which has been amended in this report.

21. We sent a copy of our initial report to Mr Dosku's brother and fiancée. They did not notify us of any factual inaccuracies.

# Background Information

## Brook House IRC

22. Brook House Immigration Removal Centre (IRC) is situated next to Gatwick Airport in Crawley, West Sussex. Serco group run the centre under contract from the Home Office. Practice Plus Group provides physical and mental health services. The centre has five wings, including an induction wing (B Wing), and a smaller unit (E Wing) used to manage detained persons with complex needs and those who are separated from the rest of the population.

## HM Inspectorate of Prisons

23. The most recent inspection of Brook House was in June 2022. Inspectors reported that the identification and management of risks on arrival was not good enough. Not all detained persons were offered a private interview on arrival and staff did not always spend enough time enquiring into their risks. The standard of health screening was variable.

24. Inspectors were concerned that the emergency protocols were not consistent and not all staff used the centre's method of summoning emergency assistance.

## Independent Monitoring Board

25. Each IRC has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that detained persons are treated fairly and decently. In its latest annual report for Gatwick IRC (Brook House and Tinsley House) for the year to 31 December 2022, the IMB reported that Brook House provided a generally safe environment for detained persons.

26. The Board observed mainly positive interactions between Serco and detainees, with several instances of custody officers showing real concern for men and engaging with them in a positive way.

27. The Board noted that reception at Brook House was generally stable and well-managed, but they were concerned about the poor communication from the Home Office about arrivals. They were also concerned with the use of interpretation, where access to 'Big Word' (interpretation service) was frequently frustrated by long waiting times. Although custody officers with language skills often stepped in to help, this was not a solution as they were not specially trained or independent.

## Previous deaths at Brook House

28. Mr Dosku was the first detained person to die at Brook House.

# Key Events

29. On 1 November 2023, Mr Alfred Dosku (an Albanian national) was arrested for alleged domestic abuse (but was not charged with any offences). When police identified that he had entered the UK illegally, they referred him to Immigration Enforcement who detained him under immigration powers. He was taken to Brook House Immigration Removal Centre (IRC) pending removal to Albania.

30. Mr Dosku arrived at Brook House very late at night and was not processed in reception until the early hours of 2 November. The reception nurse recorded that Mr Dosku understood basic English and that, because of the lateness, she used a fellow detained person as an interpreter with Mr Dosku's consent. The nurse recorded that Mr Dosku was well-kempt and maintained good eye contact but was tearful and said he did not want to return to Albania. Mr Dosku said that he had no thoughts of suicide or self-harm.

31. New detained persons are usually placed on the induction wing (B Wing), where staff can better observe them and identify any vulnerabilities. However, there were no bed spaces on B Wing, so Mr Dosku was moved to a standard wing (C Wing).

32. On 2 November, Mr Dosku did not attend a scheduled GP appointment. (It is standard practice for a GP to see new arrivals.)

33. The same day, there is an entry in Mr Dosku's medical record from a member of the psychosocial team to say that she had given Mr Dosku induction and harm minimisation advice (in relation to illicit drug use). She made an identical entry on 3 November. When the investigator asked her about this, she said that she thought she would have visited Mr Dosku only once and that the second entry must have been an error. She said that her entry suggested that she did not see Mr Dosku and that she put leaflets under his door.

34. On 3 November, a detention operations manager (DOM) helped Mr Dosku complete an immigration request form. In the form, Mr Dosku asked for an update on his case. He said his fiancée was three months pregnant and was stressed. Mr Dosku said that he feared his fiancée would have a miscarriage due to the situation, and that she had been going to the 'emergency' (believed to mean hospital) because of how stressed she was.

35. On 4 November, a member of the Detention Engagement Team (DET) spoke to Mr Dosku over the telephone (with the aid of an interpreter). Mr Dosku told the DET staff member that he did not attend his GP appointment two days earlier as he thought he had no need to see a doctor, but later said he sometimes experienced stomach pain. Mr Dosku said that he had debts in Albania and was worried about returning there.

36. On 5 November, a nurse saw Mr Dosku (with another detained person who acted as interpreter). Mr Dosku was clutching his abdomen and said he had a sharp burning pain in his upper abdomen that would come and go. After examining Mr Dosku, she diagnosed suspected indigestion. She gave him Gaviscon (a medication used to treat heartburn and indigestion). Over the next four days, healthcare staff administered Gaviscon to Mr Dosku on a further five occasions.

37. Later that evening, Mr Dosku's fiancée visited him. She told us that Mr Dosku was emotional during the visit and said he would prefer to take his life rather than go back to Albania. At the time, Mr Dosku's fiancée was around ten weeks' pregnant with their child. A detained person told the investigator that Mr Dosku was upset that day and did not speak with anyone. He said a DCO spoke to Mr Dosku for five minutes, but Mr Dosku just said he was fine. Staff recorded no concerns about Mr Dosku (and if Mr Dosku spoke to a DCO it was not logged in his records).

38. On 7 November, a solicitor met with Mr Dosku. The solicitor was in the process of gaining instructions from Mr Dosku regarding seeking asylum.

## Events of 9 November

39. On the evening of 9 November, between 6.30pm and 9.00pm, Mr Dosku and his fiancée argued over the telephone (detained persons have access to their mobile phones and so staff were unaware of the call). She told us that Mr Dosku was crying and said that he wanted to kill himself. (Mr Dosku's roommate told the investigator that Mr Dosku had been arguing with his fiancée over the telephone for two days.)

40. CCTV footage shows that at 10.13pm, a DCO unlocked Mr Dosku's room to let his roommate out to do his wing cleaner duties. She told the investigator that she saw Mr Dosku lying on his bed. She said Mr Dosku did not show any signs of distress and appeared to be watching television.

41. The DCO told the investigator that later, while he was cleaning, the roommate told her that he could hear someone calling Mr Dosku's mobile telephone, but Mr Dosku was not answering.

42. At 10.56pm, the DCO let the roommate back into Mr Dosku's room. The roommate told the investigator that when he entered the room, he could not see Mr Dosku. He said he called out to ask if Mr Dosku was in the toilet, but there was no response. When he closed the door, he found Mr Dosku hanging behind the door.

43. The DCO told the investigator that she heard the roommate say, "Oh my god", and then he indicated to her to look behind the door. She then entered the room and saw Mr Dosku hanging. Mr Dosku had a ligature made from a bedsheet around his neck, which he had tied to a wooden television bracket that was above the top right hand of the door.

44. The DCO quickly ran out of the room and shouted to alert DOM A (Oscar 1, the senior officer in charge), who was in the wing office nearby. The DCO, DOM A and DOM B (Oscar 2, the second most senior officer on duty) then ran into Mr Dosku's room. DOM A and the DCO cut the ligature around Mr Dosku's neck.

45. At 10.57pm, DOM A radioed a code blue (a medical emergency code used when a detainee is unconscious or having breathing difficulties which alerts healthcare staff and tells the control room to call an ambulance). At 10.59pm, the control room called an ambulance. (We have used BWVC timings - there is a discrepancy of around a minute between CCTV and BWVC footage.)

46. DOM A started chest compressions, while the DCO administered respiratory breaths. More detention staff responded.

47. Shortly after, two nurses arrived at Mr Dosku's room. One nurse applied an Automated External Defibrillator. (AED - a portable device that can be used to treat a person whose heart has suddenly stopped working.) The AED stated that no shock was advised on three occasions and staff continued CPR.

48. At 11.06pm, an ambulance crew arrived at Mr Dosku's room and continued CPR. Paramedics regained a pulse and took Mr Dosku to hospital where he was placed in an induced coma on a ventilator.

49. Detention staff at Brook House began suicide and self-harm monitoring procedures (known as ACDT) for Mr Dosku. Detention staff remained with him in hospital.

50. On 13 November, the Home Office assessed that Mr Dosku was no longer well enough to be detained and released him on bail. They closed Mr Dosku's ACDT plan, and detention staff left the hospital.

51. Mr Dosku died in hospital on 17 November.

## Information received after Mr Dosku's death

52. A detained person told us that Mr Dosku had said in front of a group of other Albanians that he wanted to take his own life. The detained person said they told a female member of healthcare staff about this. The detained person was unable to tell the investigator the name of the staff member, what they looked like, or when or where they told the staff member. There was no information in Mr Dosku's medical record to indicate that healthcare staff had been approached, or that they had any concerns about Mr Dosku's mental state or risk to self.

## Contact with Mr Dosku's family

53. Initially, Home Office staff thought that hospital staff would liaise with Mr Dosku's family. When, on 10 November, it became clear that this was not happening, the Home Office appointed a family liaison officer (FLO). That afternoon, the FLO contacted Mr Dosku's fiancée and told her that Mr Dosku was in hospital.

54. The FLO made further enquiries regarding Mr Dosku's other next of kin. On 12 November, she contacted Mr Dosku's brother and informed him of the situation. The following day she contacted Mr Dosku's cousin.

55. After Mr Dosku's death, the FLO kept in contact with Mr Dosku's family. Over the following weeks, she continued to offer support and advice.

56. The Home Office assisted in the arrangements and financial cost of repatriating Mr Dosku to Albania for his funeral.

## Support for prisoners and staff

57. After Mr Dosku's death, IRC managers 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.

58. The IRC posted notices informing other detained persons of Mr Dosku's death and offering support. Staff reviewed all detained persons assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Dosku's death.

59. Immediately after Mr Dosku was found, a DCO took his roommate aside and spoke to him. He was later moved to a different unit. He said that he was offered mental health support.

60. IRC staff also held meetings with Albanian residents, to support them and attempt to address their questions and concerns.

## Post-mortem report

61. The post-mortem report concluded that Mr Dosku died from hypoxic brain injury (lack of oxygen to the brain) caused by hanging. The toxicology report showed no illicit substances in Mr Dosku's system at the time of his death.

# Findings

## Assessment of Mr Dosku's risk

62. Mr Dosku had been at Brook House for less than two weeks when he was found hanging in his room. He gave no indication to staff when he arrived at Brook House that he was at risk of suicide or self-harm. A detained person told us that Mr Dosku later said in front of a group of Albanians that he wanted to take his own life and they told a female member of healthcare staff. The detained person was unable to provide any details about the staff member, or when or where this happened. We have been unable to corroborate this account. There are no custody or medical records that indicate IRC staff were made aware that Mr Dosku had expressed thoughts of suicide.

63. Mr Dosku expressed thoughts of suicide to his fiancée during her visit and during telephone calls. However, IRC staff were not aware of these conversations.

64. We are satisfied that Mr Dosku gave no indication to staff that he was at risk of suicide and that they could not have foreseen his actions.

## Emergency response

65. Detention Service Order (DSO) 09/2014 on Medical Emergency Response Codes says that all IRCs should have local operating procedures in place based on a two-code system for medical emergencies (code red for bleeding/burns and code blue for collapse/breathing difficulties). This should ensure that healthcare staff attend promptly with the correct equipment and that an ambulance is called immediately.

66. When the DCO found Mr Dosku hanging, she did not call a code blue as she should have done. Instead, she called for help from the DOMs who were nearby. They responded quickly, cut down Mr Dosku and started CPR. One of the DOMs then radioed a code blue. This all happened in under a minute.

67. The DCO told us that she knew that a DOM was in the office close by and thought it would be quicker to physically get support. She said if the DOM had not been close, she would have radioed a code blue. While the correct procedure was not followed, staff started CPR quickly and there was a minimal delay in calling the code blue. We therefore make no recommendation.

68. There was a short delay in the control room calling for an ambulance when the code blue was called. The control room seemed unsure that they were supposed to call an ambulance immediately in response to a code blue and a DOM had to specifically ask for an ambulance to be called twice. We bring this to the Director's attention.

## Clinical care

69. The clinical reviewer concluded that the care Mr Dosku received at Brook House was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

70. She made one recommendation, which the Head of Healthcare will wish to address. She also noted concerns about using other detained persons as interpreters for clinical assessments.

## Inquest

71. At the inquest, held on 21 July 2025, the jury concluded that Mr Dosku died by suicide.

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