Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohamed Izem, on 20 February 2024, following his release from Harmondsworth IRC

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

Summary

1. 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.

2. 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.

3. Mr Mohamed Izem, a foreign national from Algeria, died from MDMA toxicity on 20 February 2024 following his release from Harmondsworth Immigration Removal Centre (IRC) the previous day. (MDMA is a class A, synthetic drug, commonly known as 'ecstasy'.) He was 22 years old. I offer my condolences to those who knew him.

4. The Home Office's Electronic Monitoring (EM) Team did not inform Harmondsworth IRC that Mr Izem was to be released until the day of his release. This could not have been prevented and we make no recommendation about this.

5. Mr Izem was not referred to the psychosocial substance misuse service following his reception screening because he did not disclose a history of drug use. A GP saw Mr Izem a day later and he disclosed previous drug use, however as he had already been referred to the integrated mental health team (which the substance misuse service was part of at the time) the GP assumed that they would have picked this up and did not make a further referral. The Head of Healthcare told us that the services had been separated since Mr Izem's death, therefore we do not make a recommendation about this.

Head of Healthcare to note

6. Although Mr Izem needed a follow-up mental health appointment, the healthcare team did not contact the Home Office to arrange the appropriate multidisciplinary team meeting to discuss Mr Izem. However, as this was not related to the cause of Mr Izem's death and the relevant guidance has since been updated, we do not make a recommendation.

The Investigation Process

7. The Home Office notified us of Mr Izem's death on 23 February 2024.

8. The PPO investigator obtained copies of relevant extracts from Mr Izem's prison and probation records.

9. We informed HM Coroner for Camden of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman office contacted Mr Izem's next of kin, his partner, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for a copy of the report.

11. Mr Izem's next of kin received a copy of the draft report. They did not make any comments.

12. The initial report was shared with the Home Office and Practice Plus Group. Practice Plus Group pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

Harmondsworth IRC

13. Harmondsworth is an immigration removal centre for adult male detainees. It is managed by Mitie Group and its healthcare provider is Practice Plus Group.

Probation Service

14. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

15. The most recent inspection of Harmondsworth IRC was in February 2024. Inspectors reported that the standard had fallen further since their previous inspection in 2017 and the score for safety and respect had declined from not sufficiently good to poor.

16. Inspectors found that drug use had become an increasingly serious problem and outcomes for detainees were not sufficiently good for preparation for removal and release. HMIP specifically referred to Mr Izem's case and noted that a multidisciplinary team meeting was not convened to make sure appropriate arrangements were made for his safe release.

Key Events

17. On 11 August 2021, Mr Mohamed Izem, a foreign national from Algeria, was charged with robbery and remanded to HMP Thameside.

18. On 23 March 2022, Mr Izem was convicted of robbery and sentenced to seven years and six months in prison. His sentence was later reduced by the Court of Appeal to five years and five months.

19. Mr Izem had a history of substance misuse, epilepsy, anxiety and depression.

Pre-release planning

20. On 29 June 2022, Mr Izem was transferred to HMP Feltham. During his reception screen with Nurse C, he reported that he had no problems with drugs and alcohol.

21. On 30 June, Mr Izem saw Nurse A. He disclosed a history of cannabis use but said he had no history of using class A drugs. He declined a referral to the substance misuse service. An assistant psychologist referred Mr Izem to the mental health team, following discussion at a multidisciplinary team (MDT) meeting. Mr Izem remained under the care of the mental health team whilst he was at Feltham.

Harmondsworth IRC

22. On 12 January 2024, Mr Izem was released from Feltham and admitted to Harmondsworth IRC, as he was a Foreign National Offender (offender identified as being of interest to Home Office Immigration Enforcement and is therefore liable for deportation.) Nurse B completed his initial health screen in reception, and he reported a history of epilepsy. Mr Izem also reported that he had stress and anxiety. The Nurse B referred him to the integrated mental health team, which consisted of the mental health team, the clinical and psychosocial substance misuse service and psychology. Mr Izem said that he had not previously used drugs. Head of Healthcare told us that at the time, the substance misuse service was part of the integrated mental health team and meetings regularly took place to discuss onward referrals.

23. On 13 January, a clinical practitioner saw Mr Izem as part of an assessment to determine whether he was vulnerable (to assist with decisions about whether continued detention is appropriate and to manage risk). Mr Izem disclosed that he had misused drugs in the past. The Head of Healthcare told us that as a clinical practitioner noted that Mr Izem had been referred to the integrated mental health team, a further referral to the psychosocial substance misuse team was not completed.

24. On 15 January, Mr Izem was referred to the National Referral Mechanism (NRM which identifies and refers potential victims of modern slavery for support).

25. On 18 January, Nurse D, a mental health nurse, saw Mr Izem for a mental health inreach review and noted that Mr Izem was taking antipsychotic medication. The integrated mental health team met to discuss onward referrals for Mr Izem and he was added to the mental health caseload and psychology waiting list to support his

PTSD. As these referrals were based on what had been raised during the reception screening, he was not added to the psychosocial substance misuse waiting list.

26. On 19 January, an immigration judge granted Mr Izem bail on the condition that he lived at an address approved by the probation service and that he wore an electronic tagging device. (His bail was not to start until an address had been approved.)

27. The pharmacy team tried to phone Mr Izem about not complying with his medication but he did not answer. They therefore sent him a message to remind him about his medication.

28. On 22 January, Mr Izem's Community Offender Manager contacted Mr Izem. He told him that he had been granted bail and had 28 days to find accommodation or he would have to re-apply. Mr Izem's Community Offender Manager told Mr Izem that it would be difficult to find accommodation but all avenues would be explored. Mr Izem's solicitor told Mr Izem's Community Offender Manager that they had submitted an application to the Home Office for accommodation for asylum seekers which the Probation Service needed to assess. They said that the Home Office should contact Mr Izem's Community Offender Manager once they had found suitable accommodation.

29. On 29 January, Mr Izem phoned Mr Izem's Community Offender Manager and told him that his partner had found an address and would fund the accommodation. Mr Izem's Community Offender Manager told Mr Izem that the Probation Service needed first to assess the address.

30. On 9 February, a public order disqualification was served on Mr Izem. (This meant that Mr Izem was deemed a threat to public order which disqualified him from NRM support.) A clinical practitioner submitted a report to the Home Office that Mr Izem might have been a victim of torture and was therefore vulnerable.

31. On 10 February, MH Nurse E saw Mr Izem for a mental health assessment. He told her he had a history of using illicit substances. MH Nurse E referred him to the substance misuse service. MH Nurse E told us that she did not have any significant concerns about Mr Izem and he was looking forward to being released.

32. On 12 February, an Adults at Risk assessment took place in response to a clinical practitioner's report. It concluded that Mr Izem's risk was assessed as Level 3. This meant that there was evidence that he was at risk of harm if he were to remain in detention. As an immigration judge had already granted Mr Izem conditional bail, no further action was taken.

33. On 13 February, Mr Izem's Community Offender Manager phoned Mr Izem's partner to discuss the address she had found for him. She said she had told the landlord that Mr Izem was under probation supervision. She said that there would be difficulties funding the accommodation and asked if the Probation Service could support him. Mr Izem's Community Offender Manager told her that this was difficult because of Mr Izem's immigration status but that support would be given, where possible.

34. On 14 February, Mr Izem's Community Offender Manager asked for police checks to be completed on the address provided by Mr Izem's partner.

35. On 15 February, Mr Izem did not attend his psychiatric appointment with Dr B, despite him ringing several times. Dr B noted concerns that Mr Izem was not always compliant with his medication which put him at risk of seizures. A principal pharmacist told us that Mr Izem did not take his medications as regularly as prescribed, but healthcare staff always intervened when medications were missed and made doctors aware. The principal pharmacist said that Mr Izem was often contacted, and would agree to attend for his medication but did not always do so.

36. On 16 February, Mr Izem collected his medication from the healthcare unit. The judge removed the requirement for accommodation to be provided from Mr Izem's bail. This meant that Mr Izem had to be released from the IRC within 72 hours.

37. At 3.49pm, Mr Izem's case was referred to the electronic monitoring (EM) team to arrange his release. The Operation Lead for the EM team, told us that due to the lateness of the referral, the case was not picked up until the next working day, 19 February.

Post-release

38. On 19 February, the EM team notified Mr Izem's Community Offender Manager, the Detention Engagement Team (DET) and the healthcare team that Mr Izem would be released that day. Mr Izem's Community Offender Manager tried to call Mr Izem but he did not answer. The Head of Healthcare told us that an MDT meeting was not necessary to discuss Mr Izem's release as he did not pose a risk to himself or others. The Area Manager for the DET told us that they had no significant concerns about Mr Izem's release so did not arrange an MDT meeting.

39. MH Nurse E called Mr Izem to ask him to attend a pre-release review so that she could advise him where he could get mental health support in the community. He told her that he would visit the healthcare unit, but he did not attend before he was released. MH Nurse E tried to call him again to advise him to register with a GP, but his phone went to voicemail.

40. The substance misuse team called Mr Izem to discuss their services. He told them that he was interested in accessing their support but said he was waiting for the Home Office to contact him and asked if they could call him back. The medical records noted that the team had no concerns and that Mr Izem had presented in good spirits. The Team Manager for Forward Trust (a substance misuse charity) told us that they usually try to see people within five days of a referral being made. However, this was not always possible due to resource issues, and at the time, the team only consisted of three staff members.

41. The Salvation Army contacted Mr Izem and told him that they had secured a safe house for him. He told them that he was being released to his cousin's address. Arrangements were made for the Modern Slavery Team to contact Mr Izem the following day to discuss if he wanted to live at the safe house or at his cousin's address. Mr Izem was bailed out of the IRC later that evening, and his cousin picked him up from the IRC. He was given his medication, his medical notes, some money and a travel warrant before his release.

42. On 20 February, MH Nurse E tried to call Mr Izem but his phone went to voicemail. Therefore, she wrote to him to advise him to register with a GP so he could be referred to community mental health services. The substance misuse team at the IRC tried to call Mr Izem to refer him to community substance misuse service but were informed that he had been released the previous day. The referral was therefore closed. (The Team Manager for Forward Trust told us that they could only have referred Mr Izem to a community substance misuse service if he had completed an assessment with Forward Trust and signed the consent forms.)

43. Mr Izem's Community Offender Manager tried to contact Mr Izem through his partner's phone number. His partner told Mr Izem's Community Offender Manager that she had not spoken to him for a few days and was unaware that he had been released. Senior Probation Officer A told us that there was no evidence that a probation induction had been arranged for Mr Izem and it is likely that this was due to the last-minute release and not being able to contact Mr Izem.

Circumstances of Mr Izem's death

44. On 20 February, Mr Izem's cousin and friend told the police that they had gone to a hotel with Mr Izem the previous evening and had woken up at around 10.00am on 20 February. They said they heard Mr Izem murmur and put a blanket on him before they left the hotel. At around 3.00pm, they returned to the hotel room and found Mr Izem in bed. They tried to wake him but realised his face was purple, he was cold to touch and had no pulse. They immediately alerted the front desk to call for emergency services. Paramedics pronounced life extinct at 3.41pm.

45. On 21 February, the Home Office contacted Mr Izem's Community Offender Manager to say that they had heard that Mr Izem had died. Mr Izem's Community Offender Manager contacted Mr Izem's partner who confirmed that Mr Izem had died.

Post-mortem report

46. The post-mortem report concluded that Mr Izem died of MDMA toxicity. The post-mortem report stated that alcohol, caffeine, nicotine, clonazepam, cannabis and morphine were also present but were unlikely to have contributed to Mr Izem's death.

47. The toxicology results could not determine whether Mr Izem's seizure activity was under control at the time of death, but the post-mortem report noted that the absence of epilepsy medication in his system could be consistent with non-compliance. The neuropathological, histological and macroscopic examination showed no other significant abnormality to suggest an alternative cause of death.

Inquest

48. At an inquest held on 21 August 2025, the Coroner concluded that Mr Izem's death was drug related.

Findings

Substance misuse

49. During his reception screening, Mr Izem was referred to the integrated mental health service, consisting off the mental health team, the clinical and psychosocial substance misuse service and psychology. Mr Izem reported that he had not previously used drugs. The following day during his appointment with a clinical practitioner, he reported a history of drug use. The Head of Healthcare told us that he was not referred to the psychosocial substance misuse service at this point as he was awaiting review from the integrated mental health team.

50. The integrated mental health team met on 18 January, and Mr Izem was added the mental health caseload and psychology waiting list. He was not referred to the psychosocial substance misuse service as the referrals were based on the concerns that had been raised during his reception screening.

51. When MH Nurse E saw Mr Izem on 10 February, he reported a history of drug use, and she referred him to the psychosocial substance misuse service. Unfortunately, the team were unable to see Mr Izem before his release from Harmondsworth.

52. The Head of Healthcare told us that since Mr Izem's death, the services have been separated, and referrals are completed to the mental health team and the substance misuse service separately. He said that as soon as somebody is referred to these services, they are added to a specific caseload. This would have avoided the assumption that A clinical practitioner made that Mr Izem was going to be referred to the substance misuse service following the integrated mental health team meeting. In light of this change, we do not make a recommendation.

Release planning

53. Harmondsworth IRC was not informed that Mr Izem was to be released until the day of his release. This meant that the substance misuse team was unable to see him and refer him to the community service before his release. When the substance misuse team phoned Mr Izem on 19 February to discuss their services, they were not aware that he was going to be released later that day. They did not therefore offer him naloxone or harm reduction advice during this phone call. When the substance misuse team called him the following day, they found out he had been released.

54. Mr Izem's Community Offender Manager was also not informed of Mr Izem's release until 19 February. This meant that a probation induction appointment was not arranged before Mr Izem's release which would have given him a further opportunity to discuss his substance misuse and be referred to a community service.

55. Mr Izem was released before the Salvation Army was able to offer him accommodation (but was bailed to his cousin's address). The Salvation Army contacted him on 19 February once they had found him accommodation and he confirmed he was at his cousin's address. He was told a safe house was available and was given until 10.00am the following day to decide whether he wanted to stay

at his cousin's address or the proposed safe house. The Salvation Army tried to contact him the following day but by then, Mr Izem had died.

56. Mr Izem's case was not referred to the EM team until 3.49pm on 16 February. The EM team reasonably picked up the referral on the next working day, 19 February, the day of Mr Izem's release. An immigration bail officer told us that immigration bail cases have a 72-hour window to arrange release. He said that it can often be difficult to arrange release for people bailed on a Friday as there are no staff available at the weekend, even though weekend hours count towards the 72-hour window. In light of this, we do not make a recommendation.

Head of Healthcare to note

57. At the time of Mr Izem's death, Detention Services Order (DSO): Managing Adults at Risk in Detention 08/2018 stated that in cases where IRC or healthcare staff have significant concerns about planned releases who are considered at risk - for example, if the detained individual requires a mental health follow-up appointment – the local DET must arrange an MDT meeting to agree a safe release plan.

58. Our investigation highlighted a gap in communication for an MDT meeting to be arranged. The Home Office told us that the usual process was for the healthcare team to communicate concerns about a detainee's vulnerability/risk to the DET so that an MDT discussion can be arranged. The DET told us that the healthcare team had not highlighted to them any concerns about Mr Izem. However, the Head of Healthcare told us that it would be good practice – rather than standard procedure - to notify the DET if they had concerns about a release.

59. While the Head of Healthcare told us that an MDT meeting was not necessary for Mr Izem as he did not pose a known risk to himself or others, he was prescribed antipsychotic medication and would therefore have needed a mental health follow-up appointment and a referral to the community mental health team. The Home Office said they would have expected healthcare staff to raise this with them.

60. We note that the mental health team tried to contact Mr Izem to attend a pre-release review and organise support for him in the community but he did not attend. As Mr Izem's death was drug-related, it is unlikely that an MDT meeting would have affected the outcome.

61. The Home Office told us that since Mr Izem's death, they have updated DSO 08/2018. It now states that in cases where staff (anybody working in the centre, including healthcare staff) have significant concerns about planned releases who are considered at risk - for example, if the detained individual requires a mental health follow-up appointment - the DETs must be informed at the earliest possible opportunity so that they can arrange an MDT meeting to agree a plan to release the individual safely. This change provides clarity about responsibilities when arranging MDT meetings ahead of release.

62. The Home Office said that they planned to roll out awareness sessions about this DSO to ensure that all staff understood the changes to the published guidance, including the circumstances when an MDT meeting is needed. In light of the above, we do not make a recommendation.

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Prisons and Probation Ombudsman **July 2025**

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