The lonesome death of Prince Fosu
Nick Armstrong and Kate Maynard

They saw him but they did not see him.

Prince Kwabena Fosu was a 31 year old Ghanian who dealt in used car parts. He had a wife, and a one year old daughter. “A quiet guy”, his father said. He had never been out of Ghana before. But an opportunity to buy parts came up and so he sought and obtained a business visitor visa. He arrived in the UK on 8 April 2012.

At port, however, he made a mistake about the name of the person he was meeting. He was refused leave to enter. Prince did not understand; he was here to do what he said he was here to do. He sought advice. That advice was to appeal. So he did.

That took five months, and the appeal was dismissed. It is not clear why because the Tribunal determination could not be found. Prince, however, found the process very stressful. His mental health suffered. Shortly after his appeal was dismissed he missed a reporting appointment. Less than three weeks after that, on 21 October 2012, he was encountered by the police, running naked down the streets of Kettering.

It is now obvious that Prince was suffering the sudden onset of psychosis, and probably mania. However a Mental Health Act assessment conducted in police custody concluded that he did not, at least at that time, require admission to hospital. On 24 October 2012, therefore, he was transferred to Harmondsworth. When the escorts arrived for him they found him still naked, with his breakfast in his hair, and smelling strongly of urine. The police had not called back the doctors, because that is how he had been throughout and so far as they were concerned, he had been declared fit for detention.

The urine meant that Prince had also now been labelled a dirty protestor by the Home Office. That label would stick, and would have profound consequences. From now on there was no enquiry about Prince’s mental health. It was assumed that he was on a protest. This was despite no-one ever asking him what he was protesting about. When asked later, staff said that immigration detainees often protested about being removed. However that was not Prince. When still able to communicate Prince had told the police, and the Home Office, that he wanted to return to Ghana. His father had told them the same thing. He had a valid ticket and passport. One of the many tragedies of this case is that his father, who had travelled from Amsterdam to see his son in police custody, asked why he could not just take him back to the airport himself. He was told that was not how things worked.

On arrival at Harmondsworth the searching officer thought Prince was obviously unwell, to the extent that he did not have the capacity to submit to the searching process. That officer alerted the reception nurse. However in an assessment that started at 11:30 am and concluded at 11:35 the nurse also passed Prince as fit. She saw no need for a mental health referral. Although the nurse ticked a box to confirm that she had seen medical records, she later said she had not.

Those medical records had come from the police, and so referred to the mental health assessment which had been conducted there. They had been sent to the centre in at least two different ways. They had been faxed to the Home Office staff in the centre, who had sent them on to ensure Prince was managed appropriately. They had also been sent with the person escort record. Witnesses would later say that clinical record keeping at Harmondsworth was “chaotic”.

Around four hours after the nurse finished her reception assessment, Prince was found ranting into a mirror in his room on the induction wing. The search officer happened to be one of those called, and because he had already met him, he now volunteered to try to speak to him. Prince responded by punching him. Prince was now taken to the ground. A control and restraint team removed him, by force, to the segregation unit.

That control and restraint carried a requirement that he be assessed again by a nurse. The nurse called was the same reception nurse. Although there was evidence that she later expressed concern to her manager about Prince's apparently sudden change in demeanour since she had initially seen him, neither she nor her manager took any steps to investigate. Still no mental health referral took place. No entry was made in the clinical records. No search of the system was made (which might have turned up the police medical records). This time the nursing assessment had taken just 15 seconds.

On arrival in segregation, Prince's bedding was removed. That included his duvet, his pillow, and his mattress. There was no written authority for such action, and the centre manager later told the inquest that it "absolutely should not have happened". Other officers, however, said that the same centre manager had been responsible for that policy. The rationale for it appears to have been that Prince was a dirty protestor. As has been seen, however, Prince was not dirty protesting, in any real sense. He had previously taken off his clothes, and smelled of urine. That was all. Still less had he expressed anything approaching a protest. Nevertheless the result was that Prince had nothing soft to sit or lie on. That remained the position for the next six days. No-one seems to have wondered why, or carried out any kind of review.

Harmondsworth was then operated by a security contractor called GEO. It was GEO policy to check someone in segregation every 15 minutes. Save for right at the end, those checks were recorded. Segregation is authorised by Rule 42 of the Detention Centre Rules 2001, and staff completed two key documents: a Rule 42 daily routine checklist, and a record of actions and observations. Those documents would come to plot Prince's death, in slow motion, and in plain sight, every 15 minutes for nearly a week.

The checks revealed that Prince had stripped naked again, just a few hours after arriving in segregation. They recorded that he had stopped communicating with anyone. He began smearing his faeces and urine. He was offered food, but there was no sign that he ate or drank anything, save for a little tea on 25 October. The records also showed that Prince did not sleep, at all, save for about 45 minutes a few hours before he died.

Yet no-one did anything. During his time at Harmondsworth Prince was seen by four GPs, two nurses, at least two Home Office monitors including the one who had passed on the police mental health records in the first place (and so knew the background), three members of the Independent Monitoring Board (IMB), and countless detention custody officers (DCOs) and DCO managers. The most that happened was one member of the IMB, on the very last night of Prince's life, sent an e-mail asking about a mental health assessment. That IMB member began to see Prince. But she only began, and by then it was too late.

All these individuals, all of whom were seized of the need to monitor Prince's welfare, either saw him directly (usually through the wicket in the door) or at least wrote on the documents that recorded his deterioration. It was one of the IMB members who use the phrase "he died in plain sight". He used it in a tone of sadness, bewilderment and defeat. Not all were quite so candid.

The pathology evidence was that Prince died as a result of a cardiovascular collapse brought about by psychosis, malnutrition, dehydration, and hypothermia. The hypothermia was despite evidence that the cell was averagely warm. Prince, however, was naked, wet, and lying on a concrete floor. That is how he was found, around midday on 30 October 2012, almost exactly

six days after he had arrived. Again, he was seen by the same reception nurse. She had previously worked as an oncology nurse. She was familiar with death. She said Prince was clearly dead. His body was cold and stiff.

The pathology evidence was also that Prince now weighed less than 47kg. The reception nurse had weighed him at 55kg, just six days earlier. He had therefore lost more than 1 kg of weight a day. A senior Home Office manager who later saw the body said he was obviously emaciated.

The inquest was delayed because the CPS originally decided to bring criminal proceedings, only to abandon them four years later. The inquest jury returned a conclusion which found gross failures across all agencies. The General Medical Council is reviewing three of the four doctors. Nothing else is happening. The two nurses face no action, and are still working. The Home Office decided to take no action against its staff because it felt the problems were systemic, and its staff had not been put in a position properly to discharge their duties. No action has been taken in respect of the discipline staff.

The Prison and Probation Ombudsman concluded that Prince's treatment had been inhuman and degrading. It therefore expressly used the language of Article 3 of the ECHR. It is thought that this is the first time the Ombudsman has expressed itself in such terms.

Arguably, however, even that language is not enough. Prince's death was shocking. It raises profound questions about the immigration detention system and the way it operates. Some of those are questions of detail. They include questions about information sharing, and about how doctors are trained to work in the immigration detention environment. The inquest heard that none of the doctors had read the Detention Centre Rules. None knew that Rule 42 imposed an obligation to conduct, directly, a welfare check on Prince. None knew that they, as GPs, were the only individuals who could conduct those checks, nor that the Rules imposed other key obligations on them, and only on them. Two of the GPs had heard about Rule 35, which imposes very specific reporting obligations, and those two knew something about that. Even then, however, their knowledge was limited, they had not seen the Rule itself, and their knowledge had been obtained some months after starting at the centre.

There were, in other words, long periods of time when the GPs in Harmondsworth, who were the only people capable of operating fundamental safeguards against unlawful and inappropriate detention, did not know they were supposed to be operating those safeguards. It is an open question how long that had gone on, but it seems to have spanned a period from an earlier death in mid 2011, where a locum GP was found to be in the same position, to at least past Prince's death. It may or may not be the case now.

There are however more fundamental questions still. The most important is why there was such a profound failure of professional responsibility. As the independent GP expert put it, there was no "professional curiosity". However that failure extended well beyond the GPs. All the people, from all the different disciplines, walked away. Prince's presentation was obviously a mental health presentation. He was a naked, uncommunicative man, ranting at mirrors, talking to his food, smearing his faeces and at times lying under the shelf which served as a bed. All in an empty, hard-surfaced cell.

The only explanation ever attempted for how this could have occurred was found in unguarded responses in some of the early interviews. Some of those interviews recorded staff suggesting that the behaviour might look bizarre to an outsider, but that is what "they" did. A GEO manager put it this way, when asked whether Prince's behaviour had concerned him. This was on the first day, when Prince had been found ranting into the mirror:

> "[F]rom what I have seen from being in this job the chanting and things like that I've seen it before. Obviously it's concerning and it's not your normal day at work but we do see that quite a bit and especially certain nationals will take to chanting whether it be when they're in that situation because that's how they release their tension. So the chanting didn't necessarily flag up any concerns and again I go back to we've been advised it's behavioural".

The racial connotations of this statement will be obvious. However it goes further, and to the heart of the matter. When staff say that this is what "they" do, and so the staff are less concerned than they might otherwise be, those staff are saying that immigration detainees should not be judged by the same standards that apply to others. They are saying that immigration detainees are different, and somehow less, than anyone else.

That, we suggest, is what really happened here. Bury the rag deep in your face, for now is the time for your tears: Prince Fosu was seen but not seen because he was seen as less. That is the matter which further investigations, including the Brook House inquiry, must examine.

It may also be noted that the manager quoted above still works in immigration detention.

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