The death in immigration detention of a man

Haslar Removal Centre – 1 May 2004

Report by the Prisons and Probation Ombudsman for England and Wales

January 2005

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Foreword

This report concerns the death of a man at Haslar Removal Centre on 1 May 2004.

All deaths in immigration detention accommodation are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service in the case of Haslar, but has now been passed to the Prisons and Probation Ombudsman to bring greater independence and consistency to the task.

In this case the investigation has been carried out by my Deputy Ombudsman.

We would like to extend our condolences to the man's family and friends for their sad loss. We would also like to thank the Centre Manager at Haslar, and the other staff members and detainees who assisted us in our enquiries. We found everyone very helpful and co-operative.

I personally visited Haslar early on in this investigation and am aware that there were concerns that the man's death was in some way suspicious, or related to the circumstances of his arrest and detention. The post mortem conducted by the Home Office pathologist failed to reveal any evidence of natural disease, intoxication or injury sufficient to account for death. It may simply and tragically be that the man died as a result of taking strenuous exercise shortly after a meal.

In light of the pathologist's findings, we have limited the scale of our investigation. However, I trust that this report presents as full an account as is possible of the circumstances surrounding the man's death. He died unexpectedly and at a young age, many thousands of miles from his home country.

In the anonymised version of this report, the names of those involved have been removed, and some very minor amendments made to the text of the report. Otherwise, the report is as I first produced it in January 2005.

STEPHEN SHAW CBE
Prisons and Probation Ombudsman

Summary

The man who was the subject of this investigation was a 34 year old national of the Democratic Republic of Congo who arrived in England in February 2004. He had made an application for asylum, but was detained under the Immigration Act at the beginning of March when it became clear that he had made a previous asylum claim in France.

On the afternoon of 1 May 2004, the man attended the gym at Haslar to take part in some cardiovascular exercise. This was not the first time he had attended the gym and he had participated in a full induction process.

The man subsequently collapsed whilst on the running machine and despite the exceptional efforts of Haslar staff and the paramedic team, he could not be revived.

Following the sad death of this young man, the manager and staff at Haslar acted in a thoroughly professional and sympathetic manner.

Haslar Removal Centre

1. Haslar is situated in Gosport, Hampshire and is managed under Detention Centre Rules (2001) by HM Prison Service on behalf of the Immigration and Nationality Department of the Home Office.

2. The Centre stands on the sea front over looking Spithead and the Isle of Wight. Haslar was originally built in 1864 as an army barracks, providing accommodation for soldiers who guarded the Haslar Naval Hospital. It remained in such use until 1953.

3. The Prison Commissioners acquired the property in 1960 and opened Haslar as a Senior Detention Centre in 1962. In 1988, it became a Young Offenders Institution and then in 1989 a so-called Holding Centre for detainees. Its current designation as a Removal Centre derives from s.66 of the Nationality, Immigration and Asylum Act 2002.

4. Up to160 detainees are located in five single storey dormitories with privacy screens. There is no cellular accommodation.

5. On 1 May, 112 detainees were in residence.

6. The man's death was the first at Haslar since the self-inflicted death of a Ukrainian detainee in January 2003.

Background

7. So far as can be ascertained, the man was born on January 1970 in the Democratic Republic of Congo. (That country says it cannot accept anyone as one of their nationals without an identity card or other paper evidence.)

8. He claimed asylum on 23 February 2004 in Liverpool, however it was discovered that he had previously claimed asylum in France. The Immigration Service therefore began enquiries with the French authorities to establish who was responsible for dealing with his claim under the terms of the Dublin Convention.

9. On 2 March 2004, the man was detained under the Immigration Act 1971. It appears that he resisted arrest and the police used CS gas. Either then or subsequently, he punched out a section of safety glass that resulted in an injury to his right hand.

10. The man remained in policy custody at St Anne's Police Station, Liverpool until 4 March 2004. During his time in police custody, he was noted to have been at risk of self-harm.

11. On 4 March 2004, the Immigration Escort Services collected the man from St Anne's Police Station, in order to transfer him to Haslar in Gosport, Hampshire. Due to the distances involved, they stopped at Harmondsworth Remand Centre on the night of 4 March 2004 before continuing their journey south. They arrived at Haslar mid afternoon on 5 March 2004.

12. On arrival at Haslar, the man was seen by reception staff and then subsequently by the healthcare team. Due to the language difficulties experienced by many of the detainees, the healthcare team have arranged for the reception screening form to be translated into 22 different languages. This helps them to obtain an accurate medical history from detainees whose first language is not English.

13. The man told the healthcare team that he was stressed and did not know the whereabouts of his family back in the Congo. He also reported that, since his arrest, he could not see well in his left eye and had trouble hearing with his left ear. It was also noted that the knuckles of his right hand were swollen, consistent with the earlier incident when he allegedly smashed a pane of safety glass.

14. In accordance with local policy, the man was seen by the visiting GP. The GP examined him fully and referred him to the local opticians for a further eye examination.

15. The man was accompanied to the appointment at SpecSavers on 18 March 2004. He did not require glasses and was advised to see a GP if the problem persisted.

16. The man had no further direct contact with healthcare until his collapse on 1 May 2004.

17. The man's solicitors contacted healthcare on 28 April 2004 enquiring if a mental health assessment had been done. They spoke to a Staff Nurse who advised that the medical team did not feel one was necessary. The Staff Nurse provided details of a local psychiatrist who could provide an independent assessment. The Staff Nurse also advised that, if the solicitors wished to commission an assessment, Haslar would be happy to facilitate the appointment.

18. A note on the man's core file reads:

> *"Pushed out window in police custody. IS91 [immigration form] states intent of self-harm, not supported during reception interview and not noted on reception self harm document."*

This was following his arrest as an illegal person to whom section 10 of the Immigration and Asylum Act 1999 applied.

19. After arriving at Haslar, the man was noted by staff and detainees to be cheerful. His English was limited and his spoken languages were recorded as Lingala, French and Kikango. He was a short man (1.68m) and weighed 72 kg.

20. The man had made friends with other Democratic Republic of Congo nationals and was in fact with them in the gym at the time of his sudden collapse.

21. He had undergone the gym induction process whilst at the Haslar and had used the gym on at least six previous occasions.

Events leading up to the death

22. On Saturday 1 May 2004, the man went to the dining hall at about 1pm for lunch.

23. Some half an hour later, he arrived at the gym for the afternoon session. However, he had forgotten his identity card and therefore had to return to his dormitory to collect it before being admitted to the gym. He arrived back at the gym shortly after 2pm. He was one of about 20 detainees in the gym at the time.

24. A hole is punched in the centre of the identity card when a detainee has completed the gym induction process. This allows quick and easy identification by gym staff when detainees arrive for a physical activity session. The man signed on 6 March that he had completed gym induction.

25. The man began using the running machine and had been running at a good pace for about 20 minutes before he slowed the machine down to walking pace.

26. At about 2.50pm, the man collapsed on the machine and staff and detainees immediately ran to provide assistance. One detainee pressed the emergency button to stop the machine whilst staff and detainees promptly placed the man into the recovery position as he appeared to be having a 'fit'.

27. Medical help was summoned using the agreed code system and a Staff Nurse attended immediately. (The nurse station is located virtually next to the gymnasium.) The Staff Nurse requested an ambulance at 2.54pm following assessment of the situation. The Control Room log notes the ambulance was immediately requested at 2.55pm.

28. The duty governor also attended. Three detainees were allowed to remain but the rest were instructed to leave the gym.

29. Shortly after the Staff Nurse’s arrival at the scene, the man arrested and Cardio Pulmonary Resuscitation (CPR) was commenced by the Staff Nurse and a PE Senior Officer. (The PE Senior Officer is himself a first aid and resuscitation instructor.) When CPR was started, Ambulance Control was contacted and updated of the situation.

30. Whilst undertaking the resuscitation, the Staff Nurse and PE Senior Officer had on a number of occasions to clear the man’s airway of vomit to enable them to continue resuscitation.

31. The ambulance arrived at 3:12pm and was immediately directed to the gymnasium. The attending paramedics took over CPR. The paramedics attached a cardiac monitor and attempted to intubate the man. This was unsuccessful due to the amount he had vomited. A collective decision was taken to stop the CPR at 3:35pm.

32. At 3.45pm, the on-call medical officer attended Haslar and certified the death of the man.

33. I am aware that at least one member of staff closely involved in the attempt to revive the man had himself suffered family bereavements shortly beforehand.

Post incident

34. Immediately post incident, the appropriate contingency plans were activated and two local police officers attended.

35. Whilst the police were carrying out their enquiries, the Staff Nurse spoke to the detainees who had been in the gym at the time of the man's collapse (including those who had remained during the incident) to explain what had happened.

36. A large number of detainees were upset and distressed about the news that was filtering through the centre. There was a refusal to go inside for the roll-check and only one detainee came down for his tea. A small number of detainees began to encourage others to participate in a passive protest.

37. The protest presented a significant threat to good order and Prison Service contingency plans were followed with the opening of the Gold Command Suite at Headquarters and the marshalling of external support through Operation Tornado. Additional staff were also called in and the Independent Monitoring Board (IMB) were present throughout.

38. During this tense situation, the duty Principal Officer and a member of the IMB met a deputation of detainees. The detainees' main demand was that a doctor should be permanently on duty at the centre. I have to say I do not think this is realistic. At the weekends, in particular, Haslar has only a small number of staff on duty: duty governor, Principal Officer, one or two Senior Officers, seven Officers, and a nurse.

39. The nurse and the PE Senior Officer were the subject of foul and extremely hurtful verbal abuse from some detainees.

40. In the event, by 10pm, all detainees had returned to their dormitories and bedrooms without the need for external intervention or use of force.

41. On Thursday 6 May 2004, the chaplaincy arranged a service in memory of the man, which was well attended by staff and detainees. The chaplain had known the man, who was a Christian. Detainees contributed to the service with readings and prayers in which they thanked all those (detainees, nurses and uniformed staff) who had tried to save the man. The readings for the service were available in various languages to ensure as many detainees as possible could actively participate in the celebration of the man's life.

42. The man had not listed a next-of-kin, as he did not know where his mother was, a fact that had distressed him when he arrived at Haslar. A number of attempts were made to track next-of-kin by the Coroner's Officer and my office's Family Liaison Officer, but to no avail. There are some suggestions that he had a wife and children, although his asylum claim in France was as a single man.

43. My Family Liaison Officer did make contact with a friend of the man, and had visited him at Haslar. The friend advised that the man had a brother in Marseille

who did not speak English. The friend said that he had informed the brother of the man's death.

44. The Haslar Visitors Group contacted me and said that some of the detainees had concerns about the length of time it took for the ambulance to respond (widely believed by them to be 45 minutes). However, the Control Room incident log shows the ambulance was requested at 2:55pm and arrived at the gate at 3:12pm. This matches the log of the Hampshire Ambulance Service, which has been verified by Hampshire Strategic Authority. I conclude that this is authoritative and that there was no undue delay.

45. During our investigation, the Staff Nurse spoke to two of the detainees who were present during the entire incident and were still at Haslar. They did not want to speak to my Deputy Ombudsman. Through the Staff Nurse, they advised that they were happy for me to rely on their police statements and had no complaints about the care that the man had received. A third detainee, who had been transferred to Harmondsworth, was contacted through an interpreter. Once again, he had no complaints about the care the man received and commended the prompt action of the nurse and gym officer.

46. Subsequent to the man's death, I gather that France had accepted jurisdiction for his asylum claim. He would, therefore, have been transferred out of Haslar and removed to France some weeks later.

Post Mortem Report

47. A Home Office Pathologist, carried out a post mortem on Wednesday 5 May 2004.

48. The detailed autopsy examination, in conjunction with a wide range of tests and detailed analysis, failed to reveal any evidence of “natural disease, intoxication or injury sufficient to account for death”.

49. The pathologist also noted in his report: -

> *“In special circumstances described in the history supplied, it appears that [the man] was exercising after a meal, and it may be that pooling of blood around the gut coupled with the demand from the voluntary muscles starved his brain and heart of blood for long enough to trigger a fatal defect in heart rhythm or to set off a fatal fit.”*

Findings and conclusions

50. The man was considered to be cheerful and popular at Haslar. He had not presented disciplinary problems for staff nor had he sought help for any medical reasons, save for the problem with his eye.

51. The events of the 1 May 2004 could not have been foreseen. At the time of the incident, staff and detainees acted in a prompt and timely manner in their attempts to resuscitate the man. Despite their best efforts, the man could not be revived.

52. Staff and prisoners had access to good support networks post incident. Those who wished to were able to participate in a celebration of the man's life.

53. On arrival at Haslar, I was presented with a comprehensive dossier including all the incident reports and other paperwork. This was very good practice and I am very grateful to the Centre Manager and her colleague for it.

54. The way in which the chaplaincy sensitively handled the celebration of the man's life, with translations of the readings and the active encouragement of detainees to participate, was commendable.

55. The attempts to revive the man were carried out in distressing circumstances. Should she not already have done so, the Centre Manager should send letters of commendation to the staff concerned.

Recommendations

56. The Staff Nurse and PE Senior Officer should be commended for the way in which they managed the situation and administered first aid until the arrival of the paramedics.

57. The use of translated reception screening forms is an example of good practice that should be shared with other removal centres.