Investigation into the circumstances surrounding the death of a former immigration detainee at Addenbrooke's Hospital on 14 March 2005.

A report by the Prisons and Probation Ombudsman for England and Wales

August 2005

A man died in Addenbrooke's Hospital, Cambridge on 14 March 2005 of an AIDS related illness. He had presented to the Asylum Screening Unit in Liverpool on 22 February. He was taken directly into detention and held for two nights at Manchester Short Term Holding Facility (STHF). From there he was transferred to Oakington immigration reception centre, where he spent just one night, before being taken to hospital the next morning.

During the course of my investigation, one of my Deputy Ombudsmen and an Assistant Ombudsman visited the STHF at Manchester. They were generally impressed with the cleanliness and brightness of the unit and with the staff, who appeared engaged and caring. They noted, however, that the unit was claustrophobic (having no windows) and that the health care facilities were extremely poor. The nurse's assessment room was no more than a cupboard – in fact it doubled as a storage area for detainees' property. They were also told by one of the regular nurses that insufficient hours were allocated to the unit for the amount of work they had to do. Many of my recommendations in this case, therefore, relate to health care screening facilities and environmental issues.

Not unexpectedly, those staff who came into contact with the man who died have been concerned for their own health and that of their families. Clearly, there are many reasons for getting health care provision right and for getting it right at the very start of the process. This is in the best interests of the detainees themselves, of the staff and other detainees with whom they come into contact and ultimately for the population at large. The Immigration Service must take action urgently to set its house in order.

I am grateful to Securicor staff at Manchester for their hospitality and openness during the investigation. I am grateful too for the assistance I received from the Immigration and Nationality Directorate.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN August 2005

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Summary

This is my report on the death, from natural causes, of a Cameroon national. He died of AIDS related illnesses following a three-week stay at Addenbrooke's Hospital in Cambridge. He had been referred there by Oakington Immigration Reception Centre on 26 February, having been received by them the previous night from Manchester Short Term Holding Facility.

In the first section, I describe what little was known about the man. He was 33 and from a large family, with four children himself. He claimed asylum on 22 February 2005, saying that he had been tortured whilst in prison in the Cameroon.

I also describe the two facilities in which the man was held. As its name suggests, Manchester Short Term Holding Facility is used for holding detainees in the short term before they are removed or transferred elsewhere. The unit is small and claustrophobic but bright and clean. Staff are caring and engaged. Oakington deals, amongst other things, with fast track asylum cases. It has 24 hour medical cover but no in-patient healthcare provision.

Section 2 sets out details of the investigation, including a review of the available papers, a visit to the STHF and an interview with the nurse responsible there for the man's care.

Section 3 describes how the man presented at Reliance House Asylum Screening Unit in Liverpool. He was seen by a number of staff, some of whom recorded that he had stomach and chest problems. His health did not give undue cause for concern, however. The man was transferred later the same day to the STHF.

He was seen the following day by a nurse who made a detailed note of his symptoms and referred to the on-call doctor for advice. He was given paracetamol and throat lozenges.

The man was not transferred later that day as planned, and the same nurse saw him the next day. Again, he referred to the doctor, who instructed the man be given amoxil. The man was considered to be fit for travel and left the STHF at 7:40pm on 25 February, arriving at Oakington at 1am. He was seen by a nurse on arrival and referred to the doctor the next morning. The doctor immediately referred him to hospital and he was admitted later that day. He died on 14 March. I record that there was significant concern amongst GSL staff who had come into contact with him.

The next section gives details of the post mortem. This found that the man died of natural causes owing to AIDS related illnesses.

I then look more closely in section 5 at healthcare at Manchester. I note that nurses are contracted to attend for just three hours per day and that this is considered to be inadequate. Healthcare staff looked out for the possibility of

TB but detainees were not routinely screened for it. I refer to the unhelpful conditions at the facility and the lack of a joined up approach to healthcare across the detention estate. Finally, I record the nurse's comments on occupational health provision for GSL staff.

In my assessment of the issues in section 6, I note some ambiguity on immigration screening forms in relation to healthcare and consider the fact that there is no healthcare provision at Reliance House, even though detainees might spend several hours there. I am critical of both healthcare provision (in terms of hours allocated) and facilities at Manchester STHF, and the fact that an unwell detainee who is not moved as expected can easily be overlooked by healthcare staff. I note concerns about the apparent poor ventilation of the facility and lack of opportunities for exercise in the fresh air, despite the possibility that detainees might be held there for seven days. I criticise the timing of the man's journey to Oakington. I also note that he was placed in normal accommodation, albeit in a single room. Finally, I consider the concerns of all those staff who came into contact with the man who died, in relation to their own health and that of their families. I make recommendation about all of these matters.

At annex A is the clinical review of this case carried out by my Deputy Ombudsman, Ms Emma Bradley, a trained healthcare professional. Her review contains further recommendations.

1. Background

The man

The man who died was a 33 year old Cameroonian national. He had formerly worked off-shore for a petrol company. He was one of 12 children and was himself married with four children, all aged under 8 years. The only family of which the Immigration Service had details were still in the Cameroon. However, one man claiming to be the dead man's brother apparently appeared at the Coroner's office after the man's death, asking to see the body and take photographs. He was allowed to do so. My office has dealt only with a woman who told the Coroner she was acting on behalf of the family.

The man presented himself at the Asylum Screening Unit at Reliance House on 23 February, having apparently arrived in the country, via Heathrow, the day before. He said his entry to the country had been facilitated by an agent, whom he met through his brother. (I understand, however, that during the course of this inquiry, someone from the Cameroon claiming to represent the wife of the man who died, told the Coroner's officer that he had by this time been in this country for 10 months.) The man said the agent had left him at the bus station in Liverpool the night before. He had no money with him and just one small bag and had apparently waited outside the building on the street all night. He was French speaking and spoke no English. The man gave as his reason for coming to the UK, "I'm running from the government, I fear for my life."

During a medical interview at Oakington, the man told the nurse that he had been held in prison in the Cameroon and subjected to torture. He said he had been given two injections in his arm and told that these would cause him to die slowly. The man said he was held in inhuman and insanitary conditions, beaten constantly, including on the soles of his feet, and immersed in water in chains every night for long periods.

The Immigration Removal estate

The Immigration Act 1971 makes provision for the detention of asylum seekers and illegal immigrants who are awaiting imminent removal, deemed to be easily removable, considered to be likely to abscond if released into the country or whose identities are in question.

IND's Operational Enforcement Manual says:

> "There is a presumption in favour of temporary admission or temporary release. There must be strong grounds for believing that a person will not comply with conditions of temporary admission or temporary release for detention to be justified. All reasonable alternatives to detention must be considered before detention is authorised. Once detention has been authorised, it must be kept under close review to ensure that it continues to be justified."

Those suffering from mental illness or who have been subject to torture are "normally considered suitable for detention in only very exceptional circumstances, whether in dedicated IS detention accommodation or elsewhere".

There are nine removal centres in England, and one in Scotland. There is no centre in England further north than Lindholme Removal Centre in South Yorkshire. However, there are almost 30 holding rooms (see below) nationwide.

Manchester STHF

The STHF is located airside (so in a restricted area) at Manchester Airport, in Terminal 2. At the time of the man's stay, it was managed under contract by Global Solutions Limited (GSL). (Group 4 Securicor (G4S) took over the contract on 1 May.)

The facility holds people detained by the Immigration Service on arrival in the country until they are released, removed or transferred to a longer term immigration removal centre. It also accommodates those due to return to their country of origin on the next available flight and other removals following detention elsewhere. Finally, it is used as a holding area for those in transit between different immigration facilities.

The unit is self-contained and can hold 16 detainees for up to five days pending transfer or release, or seven days to effect removal from the country. It takes both men and women, but not children. The unit comprises a single corridor. There are four bedrooms, each capable of sleeping four. There is a communal television area (where smoking is allowed), a kitchen/dining room, two single showers and toilets. The healthcare screening/treatment room is also on this corridor.

My investigators visited the STFH. They were impressed by the brightness of the facility (the walls are painted an attractive yellow) and by its cleanliness. Floors were spotless and all rooms were tidy. However, the facility has no windows and is stuffy. This is especially pronounced in the communal TV room, where smoking is allowed. The atmosphere was quite unpleasant.

The staff were engaged and appeared to enjoy positive, easy relationships with the detainees. Only a television, some board games and a small amount of reading material (donated by the staff themselves) was available by way of occupation or entertainment.

The room in which healthcare staff worked was little more than a cupboard. In fact, the room was also used as a storage room for detainee property, further reducing the small amount of working space available. There was no sink. The nurse told my investigators that, when he need to carry out tests, he had to walk samples down the length of the corridor in order to have access to a sink (which was for communal use). There was no phone either.

Oakington

Situated in Cambridgeshire, the centre has a certified accommodation capacity of 440 and an operational capacity of 360. It consists of five discrete residential units (including a fenced-off female block), with accommodation on two floors in each block. A family accommodation block is located outside the secure compound.

The centre was originally intended as a reception centre holding detainees for a maximum of 10 days, while initial fast-track decisions were made on their cases.

Oakington has 24-hour healthcare cover (due to the fact it can receive detainees at any time of day or night), but has no in-patient facility.

2. Investigation

The investigation into the man's death was conducted by one of my Assistant Ombudsmen, Miss Ali McMurray. In addition, my Deputy Ombudsman who leads on the fatal incidents team, Ms Emma Bradley, took a close interest in the case as part of a wider review of healthcare issues in the immigration detention estate. She also conducted a formal clinical review of the man's care.

During the course of the investigation, Miss McMurray reviewed paperwork generated by both the Immigration Service and GSL in relation to the man who died and spoke to the centre manager at Oakington. She also obtained further information from screening officers at Reliance House and spoke to the Coroner's officer. She and Ms Bradley visited the Manchester STHF and interviewed the nurse responsible for the man's care there. Finally, Miss McMurray spoke and wrote to a woman who claimed to be the family's representative in this country, inviting her to engage in the investigative process and submit any questions she or the family might have. (She did not respond to the letter.)

3. The man's period in detention

The man who died presented himself to the asylum screening unit (ASU) at Reliance House on the morning of 23 February. He told staff he had spent the previous night outside the building.

An Immigration Service file minute noted that the man was a walk-in applicant, speaking French and from the Cameroon. He had a birth certificate, but no other documents and claimed to have arrived in the country at Heathrow the previous day. The man reported that he had chest and stomach problems, had never claimed asylum, never been finger-printed and never applied for a visa before.

A fast-track form recorded that he was fit and well and had no special needs. He was described as "Country without leave".

A Detention Review form said:

> "The subject is an illegal immigrant, who admits to have entered the United Kingdom at Heathrow airport and has claimed that with the aid of an alleged agent who provided a forged passport, allowing subject to enter the United Kingdom without leave of an Immigration Officer [sic].
>
> The subject has therefore committed an offence under 24(1)(a) and in breach of 3(1)(a) of the 1971 I.A.
>
> Subject does not have any close family in the United Kingdom. Subject is in good health. Subject has been accepted for the Oakington fast track process."

A section for 24-hour review bears a stamp mark stating, "Meets Oakington criteria. Further detention authorised". It is signed by a Chief Immigration Officer and dated 24 February.

The man was apparently screened in the presence of an interpreter. The Screening Interview notes said under "Are you in good general health?" "No. Chest and stomach problems." A further section asking if the applicant had any medical problems was marked "no".

Another form relating to mitigating circumstances notes that the man was single, with no dependants and with no close ties in the United Kingdom. It is ticked to show he was in good health. "N/A" has been written under, "There are no known or compelling compassionate circumstances."

The screening officer provided a statement to the Immigration Service shortly after the man's death. This read:

> "I first noticed applicant … when I first entered the front entrance of Reliance House. He was standing outside the doors of Reliance House, just wearing a T-shirt and trousers and was shivering. When ASU opened, I was asked to call the first ticket up to my screen to see what the applicant had come for and if it was to claim asylum, to get his file created and to take his basic details. It was the applicant who I had seen outside and he was still shivering and was also coughing loudly. I asked applicant why he had come to ASU and he said to claim asylum. He was still coughing and I asked applicant if he was OK and if he had any medical problems. Applicant said that he had "chest and stomach problems" and that he had spent the night outside the building. I offered to get the applicant a glass of water and went and handed it to him. Applicant had several glasses of water and was continuing to cough away. I recorded in my notes … about what applicant had said about his medical condition and where he had spent the night."

Another screening officer submitted a statement that said:

> "I level one screened [the] Cameroon applicant … on 23/2/2005, as it is over 3 weeks since that screening and having conducted numerous interviews since I found it difficult to recall. Having now looked at the applicant's photograph and screening interview I can remember the applicant complaining he had chest and stomach problems, I recorded this down but thought no more of it as the applicant had also stated he slept outside that night and I thought his symptoms were a result of this."

The screening officer told Miss McMurray that she remembered that the man said he did not feel well and about him coughing and spluttering, but said this was based more on her colleague's comments than on what she actually saw. On a scale of 1 – 10 for poorliness, she placed him at 5. She did not think he was "really, really sick". She described him as a bit slow – she thought at first he was deliberately trying to confuse her, but subsequently realised this was not the case.

My investigator spoke to a manager at the Asylum Screening Unit. He said that there was no healthcare provision at Reliance House. Some staff were trained first aiders, but if anybody presented with symptoms beyond what first aiders could cope with, staff were instructed to refer to a Chief Immigration Officer (CIO) or Higher Executive Officer (HEO). They would then decide whether to call an ambulance.

The manager said that the decision to detain was made by the Immigration Officer, and endorsed by either an HM Inspector of Immigration (HMI) (men or women) or a CIO (men). Unless the prospective detainee's condition was so serious as to warrant calling an ambulance, the health of the applicant would not impact on the decision to detain. If there were medical concerns, however, the HMI or the CIO would contact the detention centre to which the person had been allocated to alert them to these. This might sometimes result in the centre declining to take them, due to inadequate healthcare facilities.

The man who died was put down for the 2pm bus, but in the event did not leave Reliance House until 6:35pm. He apparently spent most of his time there sleeping. The escort record shows that he had no special needs. He coughed occasionally during the journey, and arrived at Manchester STHF at 7:45pm. There seems to have been a considerable amount of movement at the facility whilst the man was there.

The Manchester STHF reception report noted that the man spoke no English and had no special needs. He was not medically examined. He was allocated to a room with three other detainees and took an evening meal at about 8:15pm.

The following day, the man took breakfast at 7:45am. He was examined at 10:45am by a nurse. He recorded:

> "Asked to see by DC staff.

No English spoken. Can't read.
Apyrexial at 36.5°c (repeated and apyrexial)
Resps 32/min
Pulse = 100 BPM
Severe productive cough with thin mucopurulent sputum/clearing to white and 1 X slight blood streaking noted.
No to asthma disclosed. C/o burning anterior chest pain – bilaterally
History ? 2 months coughing – sputum – blood stained. No medical help sought. Often vomits during coughing episodes. No headache.
Will d/w G.P. and commence paracetamol and cough lozenge.
C/o torture in prison in CMR. Describes various injections and ? plunging into water. Displayed lesions to thigh and penis 2 wart like.
Very reluctant to display and became very distressed.
Nil else disclosed.
D/w doctor. Continue with paracetamol and strepsil. Refer to Oakington H.C."

The nurse also recorded that the man vomited part digested food as a result of coughing. He also noted, "Unable to assess further."

The nurse checked on the man again at 12:30pm and noted that he was settled with less coughing. He had had his lunch and returned to bed. Later that day he accepted an evening meal.

The man was due to transfer to Oakington the following day, but the transfer was cancelled. No reason is recorded.

He did not get up for breakfast on 25 February, but did accept lunch. The nurse saw him again at 3:20pm. The medical record says:

"Temp 38.7°c, perspiring, feels hot.
Resps 32 min. P = 100 BPM. B.P = 110/70
Sputum tenacious – clear with purulent elements. No blood seen. Copious amounts. Wheezy cough. Appetite poor. Not drinking much according to DCO staff.
Paracetamol 1g given. Oral fluids encouraged.
Will d/w G.P. Supervisor informed.
For amoxil 250mg T.D.S and if deteriorates G.P to see. Can continue transfer arrangements.
Commenced amoxil 250mg T.D.S as instructed.
Approx 600 mils H_2O taken orally.
Paracetamol given.
Review temp in 1 hour.
Supervisor aware."

Later, the nurse noted that he had discussed the man with healthcare at Oakington, who were aware of his condition. He saw the man again at 5:10pm. At this time, his temperature was 36.6°c, respiration 26/minute, pressure was 96 BPM. The nurse noted that the man was now up and

watching television. He was rested and “improved somewhat on earlier today”.

Ms Bradley and Miss McMurray spoke to the nurse about the man who died and about healthcare provision generally. Of the man who died, the nurse said that he had been placed in a four-man room and had mixed openly with other detainees in the facility - for example, when he had his evening meal. The nurse noted that a couple of paracetamol had perked the man up considerably, and at this time he was up and about.

He said he did not initially suspect TB – the man had an unusual BCG scar high on the top of his shoulder. His attention had been drawn, however, by the man’s reported weight loss. He said the man’s sputum was clear but not frothy. He had been concerned and therefore consulted a doctor (the doctor provides 24 cover for the facility), as he felt the man needed to be seen by a GP. The doctor did not feel there was a need, however. He thought that TB was likely and sought to contain the symptoms with paracetamol and lozenges. He had not wanted the man to be given antibiotics. The nurse said he had not been at all sure about this, but the paracetamol did seem to help. He noted that he would not have expected TB to be improved by paracetamol, but that the man had gone from pyrexial to apyrexial on just 1g of paracetamol.

The nurse had not expected to see the man during his rounds the next day and no-one had pointed him out – he noted he was still there from the occupancy board. He said that the man was de-hydrated and responded well to cold water. He had consulted the doctor once again, who considered the man fit for transfer. The nurse thought the man needed somewhere with better facilities. He had spoken to the nurse at Oakington and explained the background to the case, as he wanted to ensure the man was assessed on arrival. He felt the man had had a rough time because of his alleged torture and abuse in his country of origin and “the unbelievable distress and suffering this must have caused him”. He expressly told the Oakington nurse that the man should not be placed in the general population on arrival. The nurse noted that the man had been transferred at night, not arriving at Oakington until after midnight. He said he understood the man had had a bit of a rough time and queried why these moves had to take place at night.

The man who died had dinner at 5:30pm and was collected for transfer to Oakington at 7:40pm. They arrived at Oakington at 1am the following morning. There is nothing on the escort record to indicate that the man was offered or took any food or drink or that they stopped for any comfort breaks.

The GSL reception report noted that the man was coughing and vomiting upon arrival. He was seen by a nurse at 1:10am. She noted that he complained of coughing, had been seen by medical staff at Manchester and prescribed amoxil. She noted that no chest X-ray had been taken and that he was apyrexial on arrival at Oakington. His temperature was 36.2°c. He was given bronchial pastilles to ease the coughing. She noted that he was to see the doctor that day for review.

The man was allocated to a single room in one of the normal male accommodation blocks.

At 9:20am the following morning, he was seen by the doctor with a French speaking nurse present. The doctor noted that the man had been coughing all day long for two months and that the sputum was blood stained. He also suffered night sweats, had lost weight, had no appetite, was vomiting and feeling weak. He had not had any problems before with breathing. The doctor referred the man to Addenbrooke's Hospital, noting that "TB is a possibility and he may be HIV +". The nurse also noted that the man might have scabies which they had had not had an opportunity to treat.

A nurse recorded on an Allegation of Torture form the details the man had given about his treatment in prison in the Cameroon. She noted that he had multiple lesions over his body. She wrote down the same details on his medical record. She also recorded that the man had become upset when asked about possible HIV status and requested a test and that he complained that, since the injections he was given in the Cameroon, he could no longer read or write although there was no problem with his vision.

The man was taken to hospital at 11:55am on 26 February. A note written at 10:30pm the same evening said that he was still having tests and there was no diagnosis as yet. He was subsequently moved to the intensive care unit. The man was initially guarded by staff from Oakington, but granted temporary release on 27 February. At this time, the bed watch was removed.

There is no paperwork to suggest any further contact with the man or the hospital until, at 10:40am on 14 March, a doctor from Addenbrookes contacted the Chief Immigration Officer at Oakington to ask for next of kin details and any details relating to the man's alleged torture. The doctor advised that the man was in a very bad way and might die shortly. The Chief Immigration Officer spoke to healthcare staff at the centre half an hour later, having obtained the port file. During that meeting, the healthcare manager phoned the hospital and learned that the man had died at 11am.

During my separate inquiry into the BBC programme Detention Undercover: The Real Story, a number of staff spoke about their concerns over the man's death. Miss McMurray was told that those who had been deployed to escort him to hospital or carry out the bed watch were especially concerned, because of their prolonged contact with him. It was pointed out that it was not just a question of their own health, but that of their families. They needed to be able to make informed decisions about whether it was safe for them to come into contact with others.

My investigator took this up with the centre manager. He told her that a note was put out to staff immediately following the man's death. This was based on information from the hospital and advised that the man had not died of any communicable diseases (although the post mortem results were not available at this time, extensive tests for communicable diseases had been carried out

on the man whilst he was still alive) and had not been isolated at the hospital. A further note was issued once the post mortem results were known emphasising that staff had nothing about which to be concerned. The centre manager said the notes were supplemented by briefing.

More generally, the centre manager explained that staff were given guidance about a wide range of communicable diseases. They were advised to treat all detainees as though they had HIV – this enabled them to protect themselves while avoiding breaching patient confidentiality. Staff were also supported in obtaining occupational health care from their own GPs. In addition, the centre has access to an occupational health adviser (OCCHIA) and to ICAS, a body that provides counselling support. The centre also has good links with the Communicable Diseases Directorate in Cambridge. People from the directorate visited the centre from time to time and ran seminars on communicable diseases and gave regular advice.

4. Post Mortem report

The post mortem was carried out the day after the man died, but no report was submitted until 4 May. The pathologist noted that the man's condition had "rapidly deteriorated, requiring inotropic support and ventilation. Despite this he developed respiratory, renal and cardiac failure of unknown cause." His conclusion was:

> "There was no external or internal evidence of trauma and no convincing evidence to confirm the history of torture. The cause of death was severe intrapulmonary haemorrhage due to extensive involvement of the lung by Kaposi's sarcoma, due to HHV-8 infection consequent on immunodeficiency due to HIV infection, which also predisposed to the mycrobacterial infection present. In my opinion, death was due to natural causes."

Cause of death was:

I a. Intrapulmonary haemorrhage
b. Kaposi's sarcoma
c. Immune deficiency due to retroviral disease (HIV infection)

II. Mycrobacterium avium infection.

The inquest has already taken place. Only the pathologist was called to give evidence. The Coroner apparently enquired at length into the man's claim that he had been tortured, but found no evidence to support it. He determined that death was due to natural causes and that no Immigration Service, GSL or healthcare staff were in any way responsible for the man's death.

5. Healthcare provision at Manchester

My Investigators learned that seven day healthcare cover is provided at Manchester STHF by Saxonbrook. Saxonbrook is a GP clinic based in

Crawley, which also provides healthcare services to Tinsley House. It is run by two GPs. One of three nurses attends each day for a three-hour shift. However, the nurse to whom my investigators spoke said it was frequently not possible to do what needed to be done during this time. It could take up to six hours to do the work properly.

A local GP provides 24 hour healthcare cover for the holding facility. The nurses refer to him as necessary, though they can – and did – send detainees to hospital via paramedics. (The nurse told the investigators that the man who died did not warrant paramedic transfer at the time.)

The nurse said that detainees were not routinely screened for TB, but each one was asked about TB, all BCG scars were noted and any possible symptoms recorded. The GP and TB specialist nurse could then be informed if necessary. Facilities militated against a comprehensive screening assessment, however.

The nurse suggested that, ideally, all detainees should receive a comprehensive 'service', similar to the well man or well woman clinics. They should undergo a thorough health interview and assessment, during which both TB and HIV could be properly explored and appropriate treatment offered. Other issues, such as weight loss could be explored at the same time, as could mental health problems. These were not dealt with at all well – there was only a very limited reference to psychological mental health issues (although two of the nurses who attended at the facility were mental health trained nurses). However, referrals were made to local services – e.g. sexual health clinics, antenatal services etc as appropriate and contact was often made with the previous healthcare provider e.g. GP, hospital etc.

The nurse noted that the environment at the holding facility was not conducive to medical care. The ventilation was poor, it was smoky and the air was heavy. However, detainees were closely supervised and monitored by detention staff, who spent much time in their company throughout the day, recording what they ate, ensuring they ordered meals, reporting any concerns etc. The supervisor could liaise with the GP and the nursing staff reviewed them daily.

Detainees were not allowed medication in possession, although they could retain Ventolin inhalers or GTN spray for example. Some minor medication, such as E45 cream, could also be retained, so long as it was in plastic containers. Much depended on which supervisor was on duty, however. Medication was held by the supervisor for the detainee, who had to request it when he wanted it. A note was made when any medication was handed out.

If staff had any concerns about a detainee after the nurse had left, they could either call the paramedics if it was an emergency or they could refer to the doctor who provided 24-hour cover. He would then decide how to deal with the matter.

The nurse told my investigators that there was a requirement to see everyone within 24 hours. He noted, however, that some detainees were in and out before they could be seen.

The nurse referred to the difficulties caused by the many 'islands' of healthcare services. Much of what he knew about what went on elsewhere he had picked up through gossip. He was not specifically given information about what the various removal centres had to offer or how they operated.

The investigators learned that, although medical records were sent with detainees who left Manchester STHF, records did not routinely travel from other centres with the detainees. Some went astray completely. The nurse also suggested that a single, standardised medical record would be beneficial, as they varied a lot.

No bespoke rooms were available if a detainee needed to be isolated for any reason. Instead, one of the four four-man occupancy rooms was set aside for the purpose (i.e. with its occupancy reduced to one).

The nurse thought there had not been any screening of staff following the man's stay at the holding facility and his subsequent death. Staff routinely received Hepatitis B jabs, but he noted that there were very poor systems for dealing with staff health issues and that this was a cause for concern amongst staff. There was an occupational health advisor, but generally speaking staff were inadequately informed about health care issues. The nurse said he felt there appeared to be a problem surrounding this case and the lack of information concerning his diagnosis, which seemed to have caused some staff concerns. (He added that he did not know until interviewed by my investigators what the cause of death had been, and assumed that other staff did not know either.)

6. Examination of the issues

The man who died was coughing when he presented to Reliance House in Liverpool. Some staff noted this on Immigration Service documentation, but others recorded that he was in good health and fit and well. I assume the latter assessment was based on the fact that he was recorded as having no medical problems. I am not entirely clear as to what distinction is intended in the two questions on the Interview Screening form, "Are you in good general health?" and "Do you have a current medical condition?" but consider they are liable to create confusion and to mislead – especially where someone is scanning the form very quickly.

I recommend that the Interview Screening form be revised to combine the two healthcare questions in one.

I am also concerned that there is no healthcare provision at Reliance House. Immigration Service detention centre standards stipulate that detainees must be seen by a healthcare professional within two hours of arrival. Given that many people are arriving from countries where highly infectious and life-

threatening diseases are prevalent, I consider this to be a sensible and appropriate standard, since it means that serious health issues should be identified before the person comes into contact with too many other people, be they staff or other detainees. In the case of the man who died, however, he arrived at the ASU first thing in the morning and remained there until 18:35pm. He was therefore on site, mixing with others for some 9½ hours, without having been seen by a healthcare professional. I understand that staff can call for medical intervention in emergency cases, but the man did not fall into this category – one of the screening staff said she did not consider him "really, really ill" and not unreasonably ascribed his coughing to having spent a February night out of doors.

I recommend that a healthcare presence be maintained at all screening and reception centres and that the two-hour requirement is rigorously enforced.

In the event, the man was not even seen within two hours of arriving at Manchester STHF. Healthcare provision there is for a nurse to attend just three hours per day. While a GP provides 24-hour cover, this is not for the purposes of screening all new arrivals and it is clear that, despite the man's coughing, he was not considered to be in imminent danger. Clearly, the two-hour requirement is rarely capable of being met at Manchester.

I am also concerned by the nurse's assertion that insufficient time is allowed to provide appropriate medical screening and ongoing care. Even though the medical provider is apparently now better at paying for additional time taken, healthcare professionals should not be required regularly to work more hours than they are contracted for – many will have other responsibilities which short working hours are intended to accommodate.

I recommend that healthcare provision at all short-term holding facilities be reviewed.

I understand that the healthcare facilities also leave much to be desired. It is one thing having to work at speed and with people who present with a variety of problems but who speak little or no English. It is quite another to expect healthcare professionals to carry out their work in what amounts to little more than a cupboard, with little space and no proper facilities.

I recommend that the Immigration Service urgently reviews the healthcare facilities at Manchester and all other short term holding facilities.

There is no standardised medical record or health screening form in use across the immigration estate. This does not lend itself readily to good communication between different healthcare professionals. It also leads to inconsistencies in type and quality of assessment carried out.

I recommend that consideration is given to the introduction of a standardised, transferable medical record and standard reception screening assessment forms.

Despite the inadequacy of healthcare provision and facilities, my Deputy Ombudsman, herself a healthcare professional, was impressed by the caring and diligent attitude of the nurse. He clearly worked in very difficult conditions, but had been thorough in his dealings with the man who died, keeping detailed notes. He also acted properly in referring the case to the GP.

It was only through the nurse's vigilance that he became aware that the man had not been transferred on 24 February as planned, as he saw his name on the occupancy list. Nobody alerted him to the fact that the man remained on site. He could easily have been overlooked. Given the number of movements that are cancelled or postponed for various reasons, this is a matter of some concern, especially since the same nurse may not attend on consecutive days and the name of a particular detainee would not mean anything unless he or she had been specifically referred by their colleague.

I recommend that Saxonbrook work with G4S to establish a system that ensures that detainees whose health is a cause of concern are routinely brought forward for a further appointment (to be determined by the healthcare professional) unless the detainee is actually transferred in the interim.

Generally speaking, my investigators were impressed with the brightness and cleanliness of the STHF. However, they spent time in the communal area talking to staff and noted that the atmosphere was close and smoky. In fact, the atmosphere throughout the facility felt stale and lacking in air. As the nurse noted, this is not conducive to patient care. Nor is it acceptable more generally.

I recommend that the ventilation in the STHF be improved.

I also note that the facility has no windows. Detainees (and indeed staff) are shut away from natural light for hours on end. The facility is small and there is not much chance of detainees being able to stretch their legs. My investigators learned that staff occasionally accompany detainees to the airport shop, but this is not a routine activity. A television is provided, along with a small amount of reading material (which is donated by the staff) and some games, but there is little to occupy detainees. This is unacceptable, given that they might be held at the facility for seven days. The lack of possibility of exercise in the fresh air is of special concern in relation to detainees who are ill.

I recommend that the Immigration Service explores with G4S the possibility for providing an opportunity for daily exercise outside the facility.

The man who died was collected from Manchester STHF at 7:40pm. He then had to endure a journey of over five hours to reach Oakington almost an hour after midnight. Some movements have to be effected either very late at night or during the very early hours because of the need to make flights etc. In this case, however, the movement was routine and the sole driver determining when the man was moved was when he could be fitted in. I do not underestimate the logistical difficulties inherent in the escorting business (there are 8 or 9,000 movements every month), but the timing in this case (and indeed in many others) was simply not decent. It is hard to imagine what must have been going through the mind of a man who spoke no English and who was clearly suffering as he travelled in darkness for hours. It can have done little to improve his state of health.

I recommend that the Immigration Service considers with G4S how to ensure that, wherever possible, routine movements are completed no later than 10pm.

I note that, on arrival at Oakington, the man was seen promptly by a nurse, (appropriately) placed in a single room and noted for review by the doctor the next morning. In fact, the doctor saw the man at 9:20am and immediately referred him to the hospital. I have no criticisms of Oakington staff with regard to the man's care (though they might have maintained contact whilst he was in hospital). I am concerned, however (as I know some staff at the centre are), that the man was placed in a normal accommodation block, presumably sharing washing and toilet facilities with others. If he had had TB, a single room would have done little to prevent the spread of infection. I appreciate, however, that there was no alternative, given that Oakington does not have an in-patient facility. I also appreciate that, in the event, the man did not have any communicable diseases. This might not have been the case, however.

I recommend in my report into the BBC programme Detention Undercover: The Real Story that separate provision be made within Oakington for those at risk of self-harm. I recommend that, at the same time, the Immigration Service and GSL consider how they might effectively isolate detainees considered likely to have infectious or contagious diseases.

Finally, I am conscious of the concern amongst staff at both Manchester and Oakington over the man's stay and subsequent death. My investigation has revealed that staff at Oakington were given appropriate and timely reassurances and that provision of occupational health was reasonably comprehensive. It seems, however, that staff at Manchester were overlooked.

I recommend that, following a death from natural causes, staff at all places where the detainee has been held are given early information about the cause of death and advised of any action they should take.

7. Conclusions

I am satisfied from my own investigation into the man's death that Immigration Service, GSL and healthcare staff all acted entirely properly in the level of care they provided for him. This view is endorsed by the Coroner's finding at the inquest.

Nevertheless, I have discovered some worrying facts about healthcare provision around the margins of immigration detention. There is no-one on site at Reliance House to deal with healthcare issues beyond normal first aid needs, and no routine screening of potential immigrants and detainees is carried out at that stage. Those who are not taken into detention will simply be returned to the community at large, with no account having been taken of their state of health.

At Manchester STHF, a healthcare provider has been engaged to screen detainees and attend to their immediate medical needs. But the facilities there are poor and the number of hours allocated to the task may be inadequate.

I do not believe that either of these circumstances was in any way responsible for the death that is the subject of this report. They do, nevertheless, raise serious, wider concerns for the individual detainee, for staff and other detainees with whom they come into contact, and for the community at large. Healthcare provision across the whole range of Immigration Service activity is in need of urgent review.

I recommend that the Immigration Service reviews healthcare provision across the entire range of its activity.

Recommendations

1. I recommend that the Interview Screening form be revised to combine the two healthcare questions in one.

2. I recommend that a healthcare presence be maintained at all screening and reception centres and that the two-hour requirement is rigorously enforced.

3. I recommend that healthcare provision at all short-term holding facilities be reviewed.

4. I recommend that the Immigration Service urgently reviews the healthcare facilities at Manchester and all other short term holding facilities.

5. I recommend that consideration is given to the introduction of a standardised, transferable medical record and standard reception screening assessment forms.

6. I recommend that Saxonbrook work with G4S to establish a system that ensures that detainees whose health is a cause of concern are routinely brought forward for a further appointment (to be determined by the healthcare professional) unless the detainee is actually transferred in the interim.

7. I recommend that the ventilation in the STHF be improved.

8. I recommend that the Immigration Service explores with G4S the possibility for providing an opportunity for daily exercise outside the facility.

9. I recommend that the Immigration Service considers with G4S how to ensure that, wherever possible, routine movements are completed no later than 10pm.

10. I recommend in my report into the BBC programme Detention Undercover: The Real Story, that separate provision be made within Oakington for those at risk of self-harm. I recommend that, at the same time, the Immigration Service and GSL consider how they might effectively isolate detainees considered likely to have infectious or contagious diseases.

11. I recommend that, following a death from natural causes, staff at all places where the detainee has been held are given early information about the cause of death and advised of any action they should take.

12. I recommend that the Immigration Service reviews healthcare provision across the entire range of its activity.

Annex A

CLINICAL REVIEW OF THE CARE AFFORDED TO THE MAN WHO DIED

Emma Bradley MSt (Cantab) BSc RGN
Deputy Ombudsman

Clinical review into the care afforded to the man who died

Summary

1. The man arrived in the UK on 22 February 2005. He was initially seen by immigration officers in Liverpool on 23 February, and taken later that day to the Short Term Holding Facility at Manchester Airport. He was then seen by healthcare and a physical and mental health review was undertaken.

2. The man was quickly identified as requiring an increased level of healthcare and so arrangements were made to transfer him to Oakington. Within nine hours of his arrival, the man had been referred to Addenbrooke's Hospital.

3. He was admitted to Addenbrooke's on 26 February with a chest problem of unknown origin. The man's condition deteriorated and he was transferred to Intensive Care. He died on 14 March 2005 from HIV related complications.

4. The man was cared for in a timely and sensitive manner by all healthcare professionals. This report makes three recommendations for improving health services in the immigration estate.

Clinical events

5. The man arrived in the UK on 22 February 2005 from Cameroon and claimed asylum in Liverpool. He was taken into detention on 23 February and transferred from Liverpool to the Short Term Holding Facility at Manchester Airport. On arrival, he was seen by a nurse.

6. The nurse obtained a medical history from the man, including his mental state. He noted that the man was feeling tense or stressed. The man went on to describe alleged torture whilst in prison in Cameroon. He became very tearful during this discussion. The nurse also obtained a baseline set of observations and noted the man had a BCG scar on his right shoulder.

7. Later the same morning, the detention centre staff asked the nurse to see the man again, due to a severe productive cough, that was causing him to vomit and giving burning anterior chest pain. The nurse examined the man and noted he was apyrexial. The nurse decided to commence the man on paracetamol and cough lozenges.

8. The nurse contacted the duty medical officer, a local GP. The GP's practice provides 24-hour medical cover for the facility. He advised to continue with the paracetamol and throat lozenges and refer the man to the health centre at Oakington.

9. The nurse saw the man again before he went off duty. The man appeared to have settled, had eaten some lunch and taken himself back to bed.

10. On the afternoon of 25 February, the nurse reviewed the man again. He had spiked at temperature of 38.7^{oc} at this stage and was hot to touch. The custody officers advised the nurse that the man was not eating much and his fluid intake was limited. The nurse appropriately gave the man 1 gram of paracetamol to reduce his temperature. He again contacted the GP, who recommended the man commence anti-biotic treatment. Amoxycillin 250 mgs three times daily was duly started. Arrangements also continued to transfer him to Oakington.

11. The nurse then contacted Oakington and briefed them about the man's condition. The nurse saw the man at 5:10 pm and noted he was more settled and his temperature had returned to normal.

12. The man transferred to Oakington Immigration Removal Centre, arriving at 1:10 am on the morning of 26 February. On arrival at Oakington, he was seen by the healthcare nurse before being located in a single room. He was listed to see the medical officer later that morning.

13. At 9:20 am on 26 February, a doctor saw the man with a French speaking nurse for translation purposes. The man gave a two month history of coughing, with blood stained sputum. The doctor immediately referred him to Addenbrooke's Hospital, querying TB or HIV.

14. The man was also seen by a nurse. He alleged that he had been kept in inhumane and insanitary conditions, had been injected on two occasions – being told they would cause him to die slowly - beaten constantly and immersed in water every night. An Allegation of Torture form was completed and the man consented to disclosure of this information to the authorities.

15. The man was taken to Addenbrooke's Hospital. At 6 pm, healthcare staff were advised that he was being admitted to the Medical Assessment Unit. He was due to be moved to ward D10 when a bed became available. However, he was later moved to Intensive Care. He remained in intensive care until his death on 14 March 2005 at 11 am.

16. A post mortem was carried out at Addenbrooke's Hospital at the request of the South and West Cambridgeshire Coroner. The cause of death was given as:

    Ia. Intrapulmonary haemorhage
    b. Kaposi's sarcoma
    c. Immune deficiency due to retroviral disease

II Mycrobacterium

17. The pathologist noted that there was no convincing evidence to confirm the history of torture and that the death was due to natural causes.

Findings and conclusions

18. The man was treated promptly and sensitively by all healthcare professionals. He was provided with care commensurate with that in the wider community. His clinical condition was not compromised by being in detention.

19. The facilities available for health screening at the Short Term Holding Facility in Manchester are little more than a store cupboard. Whilst it is clean and brightly painted, the room is small, airless and has no running water.

    Arrangements should be made to provide an appropriately equipped clinical room for use by healthcare professionals.

20. Detention Centre Standards require that all admissions are seen by healthcare staff within two hours of admission and by a General Practitioner within 24 hours. The arrangements at Manchester only detail nurses on duty for three hours per day. Manchester receives and discharges detainees 24 hours a day. There are arrangements in place for 24 hour emergency medical cover, which custody officers can readily access.

    Consideration should be given to reviewing the healthcare staffing arrangements to provide greater on site cover.

21. There is no standardised medical record or health screening form in use across the immigration estate. The type and quality of assessments is variable. The use of a standardised medical record and health screening forms would ensure that comprehensive physical and mental health assessments are undertaken. Furthermore, it would prevent the duplication of work each time the detainee transfers. A recent investigation at IRC Haslar identified as good practice their reception screening document which is translated into 22 different languages.

    Consideration should be given to the introduction of a standardised, transferable medical record and standard reception screening assessment forms.

22. The nurse at Manchester STHF kept contemporaneous, concise clinical records, giving a clear picture of the care and treatment afforded to the man who died. The nurse contacted Oakington prior to the man's transfer to fully brief them of the situation. On his arrival at

Oakington a further health assessment was carried out and the findings clearly and concisely documented.

The nurse at Manchester STHF, the reception nurse at Oakington and the nurse who noted the man's allegation of torture should be commended for their standards of record keeping.

Recommendations

1. **Arrangements should be made to provide an appropriately equipped clinical room for use by healthcare professionals.**

2. **Consideration should be given to reviewing the healthcare staffing arrangements to provide greater on site cover.**

3. **Consideration should be given to the introduction of a standardised transferable medical record and standard reception screening assessment forms.**

4. **The nurse at Manchester STHF, the reception nurse at Oakington and the nurse who noted the man's allegation of torture should be commended for their standards of record keeping.**