Circumstances surrounding the death of a detainee in Yarl's Wood Removal Centre on 15 September 2005

Report by the Prisons and Probation Ombudsman for England and Wales

January 2006

A man brought his family to England from Angola during October 2001. He claimed asylum immediately, but it was almost three years before a decision was made. By that time, the man, his wife and two sons had settled in Leeds, becoming fully engaged with the local community.

The man's asylum application was refused in June 2004, and a subsequent appeal (the outcome of which was announced in November 2004) was unsuccessful. The man said he was not informed of the result of his appeal. Ten months later, on 13 September 2005, he was visited by two Immigration Officers. The next day, he and his 13 year old son awoke to find an immigration officer and a police officer in their bedroom. They were told to dress and pack and that they would be removed from the country the next day.

The man was found hanging in a stairwell at Yarl's Wood Immigration Removal Centre at around 1:00 am the next morning (15 September 2005). His son was still asleep in their shared room and had to be woken to be told about his father's death. The man left a note saying that he did not want his son to go to Angola and that he hoped he would continue his studies in England.

Whatever the rights and wrongs of immigration control, this is an immensely sad and moving story. My heartfelt sympathies go out to the man's son. There are few worse things than to lose your father at such a young age and in such shocking circumstances.

Staff of the Immigration Service, the escort contractor (G4S) and of the Yarl's Wood contractor (GSL), have all been shaken by the man's death. It has prompted much soul-searching as they have tried to identify whether they missed an opportunity to save the man's life. Each has concluded that they did not. I agree. I doubt, however, that this will give them much comfort. I am grateful to them all for their help and co-operation. My colleague who conducted this investigation, Miss Ali McMurray, met with unfailing willingness from all concerned.

This final version of my report reflects comments made at draft stage both by the Home Office and, in particular, by the solicitors representing the man's son.

Stephen Shaw
Prisons and Probation Ombudsman **January 2006**

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Summary

This is the report of my investigation into the death by hanging of a man in a stairwell at Yarl's Wood Immigration Removal Centre on 15 September 2005.

The report starts by providing some information about the man, a 35 year old Angolan man with a wife and two sons. It describes his account of being held in prison without trial in Angola as a result of his political activities, and of the night when the authorities came and murdered his parents and sister. He escaped and arrived in England with his family in October 2001. He claimed asylum immediately, but his case was not determined for almost three years. An appeal was unsuccessful, but the man said he never received notification of the result. The man had lived in Leeds since his arrival in 2001 and had established close links with the local church community. I quote at length from a 'Declaration' written by the man in April 2005, in which he complains that he has not heard about his appeal despite chasing the matter up, and that he had "no life for live" (sic). He mentions killing himself.

The report then provides some background information about Yarl's Wood Immigration Removal Centre. It describes how it was purpose-built to hold 900 detainees, but was partly destroyed during a disturbance in February 2002. It has been run since its opening by the company now known as GSL (formerly Group 4). At the time of the man's death, it held just over half its operational capacity. The rooms are clean, if somewhat spartan, and there is a range of facilities on offer.

The next section, 'Investigation', describes the form my investigation took. The Investigator, Miss Ali McMurray, viewed video footage of the man's death and the subsequent efforts to revive him. She interviewed a number of staff at Yarl's Wood and reviewed papers relating to the man's custody as well as statements by staff. She spoke to immigration staff, read reports relating to the man's arrest, and reviewed the man's immigration case file. She also liaised with a solicitor engaged by the man's son to ensure his (the son's) needs were met by my investigation.

A section entitled 'The man's arrest' describes how a vicar, also a family friend, wrote to the Immigration Service in August 2005 to inform them that the man's wife had been arrested on her return to Angola the previous October. Miss McMurray learned that the information was considered by an Executive Officer who judged that a document referring to the arrest was not authentic.

I go on to describe a so-called 'pastoral visit' conducted by two Immigration Officers on 13 September. The purpose of the visit was to enable them to prepare for the man's arrest the next day. They had found the man to be relaxed and hospitable, but he said he had not received the result of his appeal. An Immigration Officer undertook to check on this. Miss McMurray learned that he did so on his return to the office, and was satisfied that a notice had been sent out to the correct address.

A total of eight police and immigration officers went to the man's house just after 6:00 am the next morning. (Miss McMurray was told that this size of team was about normal for this type of arrest. It was necessary to be prepared for all eventualities.) They broke the lock on the door and found the man and his son in bed. They allowed them to dress and pack and then took them to the Leeds/Bradford Reporting Centre at Waterside Court. The man had asked and been allowed to take his morning medication (for depression), but was not allowed to take his evening medication. The man was apparently calm and compliant throughout.

I then describe how Miss McMurray contacted The Court Service to find out if a copy of the appeal decision had been sent to the man. Staff inferred from their records that one had, but they could not say for certain.

I also set out details of a letter from the vicar. In this, he describes his acquaintance with the man, the progress of the man's asylum application, and the actions he took following the man's arrest. He said that, when he spoke to the man that evening, the man complained that the Immigration Service had not listened to him and that he had been injured when he had been pushed. I describe the actions Miss McMurray took to investigate this last point.

'The journey to Yarl's Wood' describes an uneventful journey under escort to the removal centre. The only event of note was that escort staff confiscated from the man a coiled washing line. They said he gave them no cause for concern during the journey.

'At Yarl's Wood' sets out the reception process. The man was interviewed by two officers, who found him compliant and chatty. They shared a joke with him and explained that he could not keep his medication with him. They had also told him he could not have the washing line. He accepted both decisions without question. The immigration forms that accompanied the man did not indicate any risk of self-harm and the officers did not detect anything to give cause for concern.

The man was then seen with his son by a nurse. She too found him pleasant and easy to understand. He did not express any concerns to her about his situation although he did mention that he was depressed. She told Miss McMurray that it was not her custom to ask a direct question about self-harm, and that it was a difficult subject to broach with the man's son present. The screening form she used did not refer specifically to mental health and self-harm issues. The nurse said it was apparent from the man's medication that he had not been consistent about taking it. She also had concerns that some of it contra-indicated. The nurse explained to the man that he would need to collect his evening medication from healthcare at 6:30 pm. In the event, he did not do so.

The officer who escorted the man and his son to the family unit said there was nothing remarkable about them. The son had been quiet and kept his head down, but the man had been responsive. He had subsequently found the man on the phone and noted that he had a long list of numbers.

During the afternoon, the man put in a request to see an immigration officer about his case. This had been faxed to the Immigration Service.

Another officer had come across the man and his son on several occasions. She had helped the man phone his solicitor and had subsequently, at the man's request, arranged for the vicar in Leeds to phone him. She said that, at about 9:00 pm, the man had asked if he could collect his medication. She had contacted healthcare, but was told he could not collect it as he had missed his allotted time. The officer described the man and his son as really nice people, who were polite and courteous. They had not mentioned to her their impending return and gave her no cause for concern.

Miss McMurray asked the nurse about her decision not to allow the man to collect his medication. She said she had concerns that it contra-indicated and wanted him to see a doctor before any medication was given to him.

'The man's death' describes CCTV footage of the man emerging from his room, going to the stairwell and hanging himself from a banister. It then describes the actions of a number of staff in trying to resuscitate him. CPR was administered immediately and continuously until paramedics arrived. Additional equipment had to be brought from the healthcare centre. The man was taken to hospital but pronounced dead on arrival at 2:05 am.

I then quote from notes found in the man's room after his death. In these, the man assumes responsibility for his family's situation and says he cannot return to Angola. He says he does not want his son to go to Angola either, but hopes he will continue his studies in England.

'After the death' describes actions taken after the man's death. The chaplain, a member of the Independent Monitoring Board (IMB) and the contract monitor all arrived very quickly. A hot debrief was carried out and staff were supported by the centre's own Care Team.

The son was left to sleep but woken up at 4:50 am to be told the news. He was then cared for in healthcare until Social Services found foster carers for him.

'Post mortem report' sets out the principal findings from the post mortem. These were that the man died from hanging.

'The man's family' describes action taken by the Immigration Service in trying to notify the man's wife of her husband's death. It also describes the son's engagement, via his solicitor, with this investigation. I report that the areas his solicitor particularly asked to be investigated related to Immigration Service handling of the man's asylum application and the availability of publicly funded immigration solicitors, the man's arrest and transportation to Yarl's Wood, and his care there. I note that my investigation covers all these issues but I consider that Government policy on legal advice for asylum applicants is not a

matter properly within my remit. I record the solicitor's concerns on the matter and draw this to the attention of the relevant authorities.

In 'Examination of the issues', I identify and consider a number of matters arising from my investigation. I am critical of the delays in progressing the man's asylum application and suggest that The Court Service should develop a system of sending out notification of appeal decisions that would enable delivery to be confirmed. I am also critical of the speed with which the man's removal was to be effected, and the number of people who carried out the arrest on 14 September. I consider specifically the vicar's report that the man said the Immigration Service would not listen to him and that he was injured during his arrest. I find the first allegation probably to be true but find no evidence to support the suggestion that he was pushed and injured. Although risk indicator forms were properly completed by Immigration Service staff, I recommend that they should be required to mark all risk boxes either 'yes' or 'no' to show they have considered each point. I consider whether any risk indicators were missed in relation to the man's wish to take his evening medication in the morning and in his wanting to take with him a washing line. I conclude that they were not.

I also examine the healthcare screening process. I recommend that all adults should be screened on their own, and suggest that it might be better to ask a direct question about suicide ideation. I also recommend that staff use a form that refers specifically to mental health and self-harm, and that they be reminded to be especially careful when assessing those who are newly arrested and due for immediate removal. I question whether proper consideration was given to the man's request to collect his evening medication and suggest both that all decisions should be made on a clinical basis and that they should be properly recorded.

I note that one member of staff responded to First Response when she should not have done so. While not intending to undermine her contribution in trying to save the man, I recommend that GSL reminds its staff to observe established protocols at all times. The agency nurse did not carry keys. This slowed progress as the two nurses responded to the alert. I recommend that all healthcare staff working in the centre should be key trained and issued with keys. I also recommend that GSL considers placing emergency medical equipment on each unit and looks at the benefits and costs of having more defibrillators and oxygen bottles round the centre. I record my concern that only healthcare staff may ask for paramedics to be called. I suggest that this should be automatic for a Code 1 alert.

I review the lack of contingency planning specific to the needs of children following the death of a parent whilst in detention. I recommend that this should be rectified. Finally, I am very critical of confusion over who should notify the next of kin and suggest that this should always be done by someone at the removal centre itself.

In ‘Conclusion’, I write that all staff acted professionally and that the man’s death could not reasonably have been predicted or prevented. I commend staff for their efforts to revive him.

1. Background

The man in question

The man was a 35 year old Angolan national. He was married and had two sons, who are currently 8 and 14 years old. Before coming to the United Kingdom, he had lived in the Bie province of Angola all his life and described himself as a successful self-employed farmer. He had also helped his father with his farm. The man said in a statement for the Immigration Service that he had had plenty of land and lived a very comfortable lifestyle.

He told Immigration Service officials that his father had founded a political party, the Associcao dos Jovens Democraticos (AJD), of which he, the man, became first secretary. The party's objective was to "demonstrate about government policy, the lack of food and medicine, the corruption and so on and campaign for democracy in Bie" (statement to Immigration Service dated 31 October 2001). He said he and his father were harassed by the Angolan Government and that, on 31 December 2000, he and his father had been arrested and detained without charge for almost six months. The man said they were subjected to inhumane treatment while in prison.

Following their release in June 2001, the man said the party carried on its work clandestinely, but on 28 August they held a demonstration. During the early hours of 29 August, the army came to their farm. The man said he escaped through an underground tunnel, but that his father was killed and his mother and sister were raped and killed. He man said he subsequently hid out in the jungle until a friend arranged his escape. He apparently met up with his family en route and arrived in the United Kingdom with them on 17 October 2001. He claimed asylum the same day.

The man and his family settled in Leeds, where they worshipped at Christ Church, Armley, an Anglican Church, and were supported by the church community.

The man's asylum application was refused in June 2004, on the grounds that he had not "established a well-founded fear of persecution and … did not qualify for asylum." It seems the caseworker judged that the man's account simply did not add up. The man's solicitors lodged an appeal on 15 July.

Before the appeal was heard, however, the man's wife and younger son returned to Angola in October 2004 to look after a relative who had been orphaned.

The appeal was heard on 8 October 2004. The Adjudicator noted that the man said his solicitor was no longer prepared to represent him because there was no funding. The man had no private funds and "agrees to rep self". The Adjudicator also recorded that the man was satisfied with the Portuguese interpreter. The determination was promulgated on 23 November. The adjudicator concluded that, so far as the man's claim under the Refugee Convention was concerned, the man was "not credible in his account taken as

a whole and has failed to show, to the low standard of proof which is upon him, that there is a real risk of ill-treatment or torture on his return to Angola." He therefore dismissed this part of his appeal. As far as his appeal under the Human Rights Convention was concerned, the adjudicator noted:

> "I have already concluded that the Appellant is not credible in his account and the authorities before me indicate and confirm my view of the objective evidence produced to the Court by the Home Office and the Appellant that the humanitarian situation at present in Angola is not such that it crosses the high threshold required to engage Article 3 and, therefore, Articles 2 and 3 are not engaged by this claim."

The decision was apparently sent to the man's address, although he was to say that he did not receive it.

After his death, a note was found with the man's property headed "Declaration". It had apparently been written on 15 April 2005. In it, the man recorded that he had heard nothing about his appeal despite having phoned and written to The Court Service, Immigration Appellate Authority. He said they had not answered his letter. He went on (I have used his words exactly as they were written):

> "I don't have any representative, because I don't have the money for pay the solicitor.
>
> This situation is very distressful for me, because I don't have life for live, I can't work, I can't do nothing in my life is not too easy for my live in this manner, have to take tablet during the day and nights for sleep, I feel sick and so frustrate in my life.
>
> The reason that I'm writing this document, I want to die or kill self. Because I don't have choice, is too sad for me. I can't return to my country, because is not safety for my son [name] and me.
>
> If I return to my country we can be tortured the point being died for the authority of government Angolan.
>
> So that this not happen to me and my son in my country, I prefer to kill myself hire in England and I would like to be embedded hire in England."

The man appears to have reported regularly to the Immigration Service, as he was required to do, but heard nothing more from them until he received a letter dated 19 August 2005 advising that his NASS support could be withdrawn. On 13 September, he was visited by two Immigration Officers.

He and his son were then taken into Immigration Service custody on the morning of 14 September, in readiness for his removal from the country the next day.

The Immigration Removal Estate

The Immigration Act 1971 makes provision for the detention of failed 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.

There are nine removal centres in England, and one in Scotland. Most are run by private contractors on behalf of the Immigration Service.

Yarl's Wood Immigration Removal Centre

Yarl's Wood is situated just outside the town of Bedford. It was a purpose-built immigration removal centre, designed to hold 900 detainees. It has been run since its opening in November 2001 by the company now called GSL. It originally held men, single women and families.

In February 2002, one half of the building was destroyed by fire following a major disturbance. The other half of the centre re-opened during September 2003, taking just single women. It now takes families too and has an operational capacity of 405. At the time of the man's death, the roll was 232. Operational capacity in the family ('Crane') unit is 123, but the number on the unit at the time of the man's death was considerably less than this.

The accommodation consists of four units in a large, two-storey H block and is built around six internal courtyards. Family units are double rooms with en suite facilities. They are spartan but clean and reasonably spacious. Each unit has a multi-faith room, library, association areas and laundry facilities. Detainees are not locked in their rooms at night, though they are expected to observe a quiet period between 11 pm and 7 am.

All detainees are given an induction, although a shortened version is given to those expected only to stay overnight.

2. Investigation

Miss Ali McMurray, an Assistant Ombudsman, investigated the man's death on my behalf. Ms Lucy Phelan was the Family Liaison Officer.

Miss McMurray visited Yarl's Wood the day after the man's death. She spoke to the deputy centre manager, who was in charge of the centre during the centre manager's absence on annual leave, and visited the unit where the man died. She also spoke to the contract monitor and the member of the Independent Monitoring Board (IMB) who had attended immediately following discovery of the man's death. Miss McMurray collected a bundle of documents relating to the man's stay at the centre as well as a number of policy documents. She also arranged to be sent a video recording of CCTV coverage of the man's death and the attempts by staff to resuscitate him, which she reviewed in due course.

Miss McMurray arranged for notices to both staff and detainees to be put up around the centre, inviting them to contact her if they wished to provide any information to the investigation. She visited the centre on a further four occasions to interview members of staff who had been involved on the night or who had come into contact with the man and his son during the day. She was not able to interview the officer who first discovered the man's death, due to his absence on sick leave.

Miss McMurray also obtained the Immigration Service caseworking file for the man. This provided details of his asylum application and its consideration by the Immigration Service, his appeal and the determination of the adjudicator. She spoke to and corresponded with The Court Service Immigration Appellate Authority about notification to the man that his appeal had failed, and to an Executive Officer who considered a letter from a Leeds vicar, also a friend and supporter of the man and his family, suggesting that the man's wife had been arrested on her return to Angola and could not be traced. She also invited the vicar to contribute in whatever way he chose to the investigation.

Miss McMurray obtained copies of reports from staff involved in arresting the man and interviewed some of those involved either in the pastoral visit or the subsequent arrest. She also reviewed statements by officers who escorted the man and his son from Leeds to Yarl's Wood, and reviewed extracts from CCTV coverage of the journey.

Finally, Miss McMurray obtained a copy of the post mortem report.

Miss McMurray liaised with a solicitor who had been retained by the man's son to represent him in relation to his father's death. She furnished him with copies of a range of documents relating to the man's asylum application, his arrest by the Immigration Service, transport to Bedfordshire and his stay at Yarl's Wood. She also disclosed to him (and to IND and GSL) a working draft of this report.

Miss McMurray considered whether it would be appropriate to interview the son, given that he was a witness to all that happened on the day of the man's death. She decided on balance, that, given his youth (he was just 13 years old), it would not be appropriate. His solicitor concurred. However, Miss McMurray spoke to the senior investigating police officer, and received from him some notes taken of an interview with the man's son.

It is normally my practice to commission a separate clinical review as part of my investigation into a death in custody, and the son's solicitor suggested that this would be appropriate in this instance also. (The purpose of commissioning a clinical review is to look into issues outside my area of expertise where clinical knowledge and judgment is required – such as diagnoses, appropriateness of medication, likely effects of medication etc.) I was conscious that the man was in detention for only a matter of hours, and that his health gave no cause for concern. But I have sought independent clinical advice on what I have judged to be the single clinical issue arising – that the man did not take his medication during the evening before his death.

This advice was provided by my colleague, Ms Emma Bradley MSt (Cantab) BSc RGN, who is a registered clinician in addition to her duties as Deputy Ombudsman.

I have also carefully considered the actions and decisions taken by healthcare staff – and make several observations about the screening that was carried out to determine risk of self-harm. (I judge that these are matters on which I myself, as a non-clinician, am equally qualified to comment.)

3. The man's arrest

The man was designated All Appeal Rights Exhausted (ARE) on 10 December 2004, after he failed to exercise a final right of appeal to the Tribunal following the failure of his asylum application and subsequent appeal. He therefore became removable from the country at that point. However, there appears to have been no further action on his case until 19 August 2005, when the man was warned that NASS support could be removed. On 23 August, a checklist was prepared for his removal.

Miss McMurray found out that the file was forwarded to Leeds RCT (the caseworking arm of the North East Region) by the Presenting Officers Unit on 20 December 2004. A caseworker at Leeds sent the file to the work in progress store. This was in line with their policy because Angolan nationals were categorised as 'amber' cases at that time – that is, not readily removable as they required Emergency Travel Documents to progress with removal. The man and his son were subsequently identified as a removable family and the file returned to Leeds RCT on 4 April 2005. As a result of pressure of work and lack of caseworkers, the file was processed only when it came to the top of the queue to be dealt with. The checksheet was completed on 23 August and the file was forwarded to the family team on 25 August. The family team then started the planning on 8 September for the detention and removal on 14 September.

On 26 August, the Immigration and Nationality Directorate (IND) received a letter from Christ Church, Upper Armley, Leeds. This constituted a letter of support from the vicar and included a copy of the Appeal Notice of Hearing. A fax was attached, apparently from a cleric friend of the man's in Luanda, stating that the man's wife had been arrested. There was also a copy of an Amnesty International document, signed by the man, giving authority for Amnesty International to use photographs to assist in locating the man and their younger son.

An Executive Officer replied to the letter from the vicar on 14 September. She advised that the Immigration Service did not engage in correspondence with third parties about individual cases. However, she wrote separately to the solicitors shown on the record as representing the man to inform them of receipt of the documents and to advise that she did not judge the "Red Cross document" (sic) to be authentic. Arrangements for the man's removal would therefore continue.

Miss McMurray spoke to the Executive Officer. She said she had discussed the vicar's letter with her manager, as it was impossible to know what was true and what was not. She said the document apparently from the pastor did not look much and there was no way of telling from whence it came – but that did not of itself mean it was not authentic. The Executive Officer said that, having spoken to her manager, her judgement was that, given that the man's wife had volunteered to return to Angola she clearly felt safe to do so. This suggested that it would be unlikely that she would be arrested. The Executive Officer readily acknowledged that this judgement might have been wide of the mark, but it was a judgement call made in circumstances where the information was not verifiable.

On 13 September, two Immigration Officers conducted a 'pastoral' visit to the man's home on the outskirts of Leeds. Miss McMurray was told that the purpose of such visits was to assess the mental and physical health of the family to be removed and to ascertain that they know how far their immigration case has got – that is, that they were now liable to removal. It was also an opportunity to view the family as a unit. They would also check who else lived at the location and whether there had been any additions to the family. Generally speaking, the purpose was to check whether there were any possible barriers to removal. (I have to say that in light of the avowed purpose of the visits, I find the term 'pastoral visit' misleading and offensive.)

Miss McMurray was told that no appointment is made and the person is not warned beforehand that the visit is to take place. Immigration Officers simply turn up at the address, usually a couple of days before the date set for removal. (The Executive Officer advised that, where it was considered such a visit would cause the person or family to flee, no 'pastoral visit' was carried out.)

A report of the 'pastoral visit' shows that it took place at approximately 8:40 am. The man apparently granted the officers entry and offered them a seat. He confirmed that only he and his son lived at the address and that his son was at school. The man stated that he was on medication for depression and showed the officers what this was – mirtazapine, 30mg to be taken at night and fluoxetine, 20mg to be taken in the morning. He also said that he had instructed a new solicitor to look at his case at his own expense, as he did not qualify for legal aid. He then apparently offered the officers a cup of coffee. The man explained that he had represented himself at his appeal hearing as he could not obtain legal aid, but claimed that he had not received the determination and did not know what it was. One of the Immigration Officers said he would look into this. (The Immigration Officer told Miss McMurray that he had checked the file when he got back to the office and found a copy of the determination, sent on 23 November 2004. The correct address was on it.) The man also confirmed that he was still on benefits.

He then explained to the officers that his wife had returned to Angola the previous year with his other son. He said he had subsequently contacted the Red Cross, Amnesty International and the US Defense Department to seek help with locating them, as he had not heard from them. As a result, he had

learned that they were both in Namibia. The officers left the address at 8:55 am.

The detention visit was carried out at 6:10 am on 14 September by three Immigration Officers and four police officers. A Chief Immigration Officer (CIO) (the Family Unit team leader) went to observe. A report of the visit says it was highlighted during the briefing that the man suffered from depression and was on medication.

The report says that the party found all the curtains at the property closed. Officers attempted to gain entry by consent by repeatedly knocking at the door. After about five minutes, however, there had still been no response and a key provided by the housing consortium was tried. Either the wrong key had been supplied or the locks had been changed, as the key did not work. After discussion with the police and with the authority of the CIO, it was decided to use the "Method of Entry" kit. One of the Immigration Officers described this to Miss McMurray as a large heavy baton with a handle on either end. She said that the locks flew off the door after it was struck.

The report says that one Immigration officer and two police officers then went upstairs to the attic where the man and his son were in bed. The son was awake, but his father had to be roused. When he was asked why he had not heard the knocking, the man apparently indicated the tablets and said they made him tired.

The report said that, once the man was dressed and in the lounge area with his son, an Immigration Officer explained "in great detail" to the man that his asylum claim was now at an end and that he would be taken into Leeds for onward transfer to London. He and his son would be arrested under paragraph 17(1) of Schedule 2 of the Immigration Act 1971. The man was told that he and his son would have an opportunity to collect their belongings.

Miss McMurray spoke to the Executive Officer about why it was considered necessary to detain and remove the man and his son without notice. The Executive Officer said that this was standard policy. They tried to detain people for as short a time as possible, and did not give notice of impending detention and removal in case the person went into hiding. This policy applied regardless of any previous history of compliance with Immigration Service conditions. The only exceptions were for "operational reasons" or where the Immigration Service knew that the person wanted to return.

The report says that, at this point, the man said he was not aware of the decision in relation to his appeal as he had not received it. The Immigration Officer showed him a copy and explained that the original had been posted to the address at which they now were. The man said he wanted to make a phonecall and was told he would be able to do so once they got into Leeds.

The man then said he needed his medication. On the grounds that he was asleep when the Immigration officers arrived, a decision was taken to allow this since he would not have had an earlier opportunity to take it. The man

said he wanted the other medication (intended to be taken at night) also, but this was denied him. Miss McMurray asked if anything could be read into the man's wish to take both lots of medication, but the Immigration Officer was certain there was nothing untoward about it. He thought the man might simply have been confused as a result of being awoken in the way he was.

Father and son then collected their possessions before being escorted from the premises.

Once in the Leeds/Bradford Reporting Centre at Waterside Court, the man and his son were placed in a holding room. The man took a couple of glasses of water when offered, but his son declined. The man said he wanted to make a phonecall, but was told he could do so once the G4S (escort) officers arrived. G4S officers took over custody of the man and his son at around 8:40 am. The report says that the man's new solicitors were informed of the man's detention and removal directions.

The report adds that the man had been open and friendly during the pastoral visit and remained calm and compliant during the detention process. It says that, at no time, did he display any signs that he might be suicidal. Nor did he do so in the holding room.

The Immigration Officers reiterated this to Miss McMurray when she spoke to them. Another Immigration Officer said it had been an absolutely routine pick-up. The man had packed and was compliant in all respects. The officer said she had been involved in quite a number of family detentions and, even with the benefit of hindsight, there was nothing out of the ordinary. She said the man had not said a word on the way to the holding rooms but appeared to be okay.

The male Immigration Officer described it as one of the better visits he had done. The man remained quite calm throughout. He too had had a lot of experience in family detention and was really shocked by the man's death.

The female Immigration Officer told Miss McMurray that it was routine for police to be present. Only a small number of Immigration Officers were PACE trained and so able to carry out arrests. No-one on the Family Unit had had the training. She noted that family pick-ups could be very emotional and lead to public order/safety issues. In addition, it was not possible to predict what might happen. Sometimes there were more or different people in the house than expected. It was therefore normal for the police to be present. Four police officers was normal also. The Immigration Officer said one police officer might remain outside in case of trouble.

The male Immigration Officer said it was he who took the decision on the numbers to carry out the arrest. He said he was influenced by the area in which the pick up was to take place and by the possibility of public disorder. The number of people engaged on this occasion was not unusual. He said that, notwithstanding the pastoral visits, they still sometimes found more people in the house than they expected. He added that the majority of the

personnel remained downstairs. In this instance, he and one police officer had entered the man's bedroom while the other police officer had waited outside. The others were all downstairs.

Miss McMurray looked into the suggestion that the man had not received notification of the Adjudicator's decision. A member of staff at the Official Correspondence Section at the Tribunals Support Centre advised that the procedure adopted when sending out appeal decisions was that:

> "the determination is posted by first class mail together with a notice of promulgation endorsed by the Clerk to the Adjudicator. This indicates the date of postage and the addresses of the recipients … In accordance with the relevant Procedure Rules, the determination is deemed to have been received two working days after the date of postage. If a determination is returned to the AIT, records are updated to indicate the date of receipt and the reason for return … I can confirm that neither [the man] nor his solicitor's copies of the determination were returned to the AIT."

The writer enclosed a copy of the notice of promulgation. The same address as the one at which he was arrested was given for the man, while his solicitor's details accorded with information on the man's immigration file. The notice is annotated to show both letters were sent out by first class mail.

In light of what the man said in his Declaration of April 2005 about contacting The Court Service about not having received the determination and hearing nothing in response, Miss McMurray rang The Court Service Customer Services Department. The member of staff to whom she spoke advised that it would be an extremely protracted process to check whether the man had called the Service as calls were not routinely logged on the computer and only a proportion were recorded. However, he was able to confirm that they had received a letter from the man on 16 December 2004 and that, as a result, the file had been called up. The system did not show whether a copy of the letter had been sent out, but the person to whom Miss McMurray spoke said he assumed it had, given that the file had been requested.

Miss McMurray pursued this matter further with the Asylum and Immigration Tribunal (AIT) and asked for the man's file to be reviewed. She was advised that the man's solicitor's details had been removed on 16 December 2004 as requested by the man in his letter of 13 December, but that the writer was "unable to confirm conclusively that a duplicate copy of the determination was sent". (The Immigration Service Executive Officer observed at draft report stage that, "In my experience as a removals caseworker it is almost impossible to obtain a copy of an appeal determination from The Court Service, so it is highly likely that [the man] did not receive his determination.")

The writer added that the man "indicated" (presumably in his letter to AIT) that he had spoken to AIT Customer Service Centre staff on 13 December 2004 regarding the result of his appeal. She continued:

> "The AIT database was updated to show the outcome of his appeal when it was promulgated on 23 November. [The man] called after the date of deemed service, and in these circumstances the standard practice for Customer Service Centre staff is to inform the customer of the Immigration Judge's decision."

In a letter to me received on 7 October 2005, the Leeds vicar told me that his church ran an organisation that provided friendship and support to asylum seekers and refugees. The man's family became regular members of the vicar's congregation and also personal friends. The vicar said it was apparent that the man had been "greatly affected" by his experiences in Angola and became deeply depressed. He had represented himself at his appeal because his solicitor did not turn up. The vicar thought the man foundered badly whilst representing himself. He said the man was not notified of the decision of the court.

The vicar said the man learned during November 2004 that his wife had been arrested on her return to Angola. He informed the Immigration Service but got no response. The man subsequently heard that his wife had been released from prison and was now in Namibia.

The vicar said that, when he learned of the letter about withdrawal of NASS support, he (the vicar) wrote to the Home Office and rang the 'deportation administrators'. He said the person to whom he spoke apologised profusely and said the letter should not have been sent.

The vicar said the man phoned him following the pastoral visit, and they agreed he should obtain legal representation. The following morning, the vicar heard from neighbours that the man had been arrested. The vicar's wife then made a series of phonecalls to find out what was happening and to try to secure the man's release. Later that evening, the vicar and his wife both phoned the man. The man said he was to be flown out the next day. He seemed very down. The vicar said the man said he was not okay, that Immigration would not listen to him when they came to the house, and that he had been hurt when they pushed him.

Miss McMurray pursued some of these issues. There was no correspondence from either the man or the vicar on the immigration files until the vicar's letter of 23 August 2005. A reply was sent to him on 14 September. Miss McMurray discovered that there is no system for recording incoming mail in the Immigration Service. Any correspondence, whether received in Leeds or Croydon, would simply be forwarded for the caseworker's attention. There is therefore no way of knowing what happened to any letters sent by the man or the vicar.

Miss McMurray also investigated the suggestion that the Immigration Service would not listen and that the man was injured when they pushed him. The Chief Immigration Officer (CIO), Family Unit in Leeds, advised that a copy of the adjudication determination was given to the man on the day of his arrest. She surmised, however, that, if the man had not previously seen the

judgment, he might have felt he should not be detained. She thought this might have given rise to him feeling that he was not listened to.

The CIO added that the situation was fully explained to the man, but that he sought to extend the conversation. She noted that it was "usually unwise to engage in lengthy discussion about such things". She said the police are not allowed for legal reasons to engage in detailed discussion following arrest, and that the Immigration Service give an explanation initially but that it is important that they then proceed with packing and leaving the address as quickly as possible. This was for health and safety reasons. The CIO added that experience had shown that one could become embroiled in lengthy discussions, "which detract from the job in hand and achieve nothing but delay, with the subject not in an ideal situation to take on board what is being said." The police apparently refer to this as 'disorientation'.

The CIO said that, during the detention visit, the man was keen to locate some papers that he held so that they could be forwarded to a neighbour. It took some time to locate these. He was adamant that they were in a bedside table in a bedroom. The police went to look, but could not find them after quite an extensive search. The CIO also searched through papers located on a table in the lounge, but to no avail. She said the man was clearly not happy that the papers were not where he thought they should be, and kept repeating himself about their whereabouts. He was told a number of times that they were not there, and eventually the man was allowed exceptionally to go back upstairs to the bedroom (accompanied by police) to see for himself. They were subsequently located in the wallet of papers that he already had with him. These papers were passed, at his request, to a neighbour. The CIO said it took some time to get details of the neighbours whom he wanted to receive the papers as his first choice were not at home and he took some time to identify an alternative.

With regard to the suggestion that the man was pushed and injured, the CIO said the man was not restrained during the visit. He was escorted to the van from his address (a matter of about 10 yards). In practice, this meant the police putting a restraining hand on him in a recognised manner. This was for his own health and safety and to prevent him absconding. The CIO refuted the possibility that the man would have been pushed in any way. He remained compliant throughout and the requests that he made with regard to disposal of his papers (and pet fish) were adhered to. She said he was not apparently suffering any injury when they arrived back at Waterside Court and certainly did not make any complaint.

IS91 is the form that authorises detention. On the reverse it has a section entitled risk factors, which is designed to alert those responsible for the detainee's care of any special monitoring or supervision required. Nothing is marked next to "Suicide/Self Harm Risk, but "Other Medical Concerns" is marked. In "Comments", is written "1 Fluoxetine tablet administered at the address. Mirtazapine x 1 at night, Fluoxetine x 1 in the morning: depression."

The Immigration Service Operation Enforcement Manual says that, “Once it has been identified that the person is one who should be detained, consideration should be given as to what, if any level of risk that person may present whilst in detention. IOs should undertake the checks detailed on form IS91RA part A ‘Risk Factors’ (in advance, as far as possible, in a planned operation/visit when it is anticipated detention will be required).” (I understand that all those joining the Immigration Service are given a full session on suicide awareness as part of their training.) The IS91RA completed for the man has neither yes nor no indicated alongside any of the various risks, with the exception of “Medical problems/concerns”, which has been marked “yes”. Comments are “Suffers from depression” with details of the man’s medication, including the information that he had taken one tablet that morning.

4. The journey to Yarl’s Wood

The Detainee Escort Record shows that the man and his son were collected from Waterside Court at 10:30 am and delivered to Yarl’s Wood at 12:55 pm. One of the escort officers reported that both detainees were in the holding room when the escort arrived. He said he asked them if they were okay and both of them said that they were. He searched them and gave them a drink. The escort officer said the man and his son were calm and talkative throughout the journey and that they encountered no problems.

The other escort officer recorded that both the man and his son seemed fine when they arrived. She said the man asked whether some money had been given to a neighbour. When the man’s bags were brought out for checking, a washing line was found amongst his property. When asked, the man said he had it for protection. The washing line was removed and bagged separately with the paperwork. The man was content with this. The escort officer advised staff at Yarl’s Wood about the line when they arrived at the centre. She too reported that the man and his son were fine - calm and compliant - that there were no problems, and that they chatted throughout the journey.
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5. At Yarl’s Wood

As noted, the man and his son arrived at Yarl’s Wood in the early afternoon. A reception officer recalled that they arrived on a van by themselves and that there was no-one else in reception at the time – although it had been a busy day.

The reception officer explained to Miss McMurray that information from the Immigration Service forms is entered on to the computer system, producing a reception report. A copy of this report is passed to the nurse while the original is placed in the detainee’s file to accompany him/her throughout the centre. Although the computer system highlights ‘special needs’ (including risk of self-harm), this is not flagged on the reception report print out. The officer said that, where the Immigration Service form had not been completed fully or where he identified a risk where none was mentioned on the form, he would record his observations on a First Night in Custody form. This was passed to the nurse and then forwarded to the unit.

No risk indicators were shown on the Immigration Service forms accompanying the man, but one form recorded that the man suffered from depression and was on medication for this reason. It provided details of the medication and a manuscript note has been added to show that the man had taken one of the tablets that morning. The reception officers did not independently identify any signs that either the man or his son might harm themselves.

On the contrary, both reception officers who dealt with the man said that he was pleasant and very polite. He had been quite chatty and smiling. The officers had established a rapport with him and they had joked about the Leeds United bag he had with him. The man had smiled. The officers said he was completely compliant and calm and seemed very confident. He did not mention his impending removal or his arrest earlier in the day. One of the reception officers thought the man might have asked about the time of his flight, but nothing more. The officers agreed that he did not appear to have any worries – one described the man as one of the calmest detainees he had dealt with in a long time.

The man had not wanted to take much property with him – just some overnight things and a change of clothing for him and his son.

The officers had explained to the man that he would not be allowed to take his medication with him, but that it would be given to the nurse. He did not have a problem with this and did not ask to be allowed to retain it.

During the reception process, one of the escort officers produced a new washing line, still coiled up and fastened with plastic. They said they had taken it off the man and that he said he had it as a weapon for protection. He also said he no longer wanted it. The washing line was therefore retained in reception and subsequently discarded. The man was relaxed about this. One reception officer said that, following the man's death, he had wondered whether he should have flagged up the incident with the washing line. However, they had not allowed the man to keep the line and there were no indicators of risk, so he concluded they had not been remiss. (I agree.)

The man and his son were then seen by a nurse. She thought that healthcare staff generally spent about 10 minutes on average with each detainee. This might be less where detainees were known to be leaving the next day, as there would be no need to obtain GP details etc. In the case of the man in question, however, she thought the screening had still taken about 10 minutes. She had seen the man and his son together, as they are not allowed to see minors by themselves.

(Another nurse said a questionnaire had been produced in all the most common languages encountered at the centre to enable healthcare staff to assess detainees whose English was poor. Where communication difficulties were insuperable, the practice is to take the vital observations and then refer the case to the doctor, who might use Language Line. Detainees must see

the doctor within 24 hours. (The man had no difficulty communicating, however.))

The reception nurse said it was not generally her practice to ask a detainee directly if he was thinking about killing himself or about self-harming. She tried to broach the subject in a more oblique way, by asking about the detainee's mental health for example. (Another nurse told Miss McMurray that she took the same indirect approach, asking the detainee if they felt low, rather than asking them outright if they felt suicidal. She said she did not want to put the thought in their heads.) The reception nurse noted that it was sometimes difficult to talk about suicide and self-harm with the detainee's child present. She added, however, that there was nothing about the man to give her any cause for concern that he might harm himself.

The nurse said that the man had been quite chatty, had maintained appropriate eye contact and had interacted well. The son was a bit quieter. She said that the screening was a mix of direct questions and engaging the detainee in conversation. The man had not said anything about his impending return to Angola. He had, however, told her about his depression (which she noted on his screening form). The nurse said he had with him three types of anti-depressant medication. One was dated January and others March/April, so it seemed likely he had not been consistent about taking it. She was rather surprised that he had the three types, as they did not work well together. Apart from the anti-depressant medication, the man had quite an assortment of other medication for run of the mill complaints such as constipation etc. They were the sort of items one might find in a bathroom cabinet.

The nurse said it was normal practice to take medication away from detainees until they had seen the doctor (which happened within 24 hours). She had therefore taken the man's medication and explained that the doctor would review it with him the next morning. (She knew he was due to leave the next day, but said she usually tried to avoid referring to the detainee's removal in case they were not already aware of it.) She also explained to the man that he would need to go to healthcare at 6:30 pm for his evening medication. (In the event, he did not attend.) The medical record shows that he was to see the doctor and receive a full screening the next day.

The screening form filled in for the man has sections for health problems and allergies, blood pressure, height, pulse, weight and medication. There is no reference to suicidal ideation or mental health.

An officer escorted the man and his son to Crane unit. The walk took about 4/5 minutes. The officer said the man's son had been really quiet the whole time and the officer had tried to engage him in conversation by asking if he played football. The officer said the man did not say much - he certainly did not mention his impending return to Angola - but was smiling and pleasant, and more attentive than his son. He seemed not to have any worries. They were both very polite. The officer had explained to the man that, once they got to the unit, they would be able to wander round freely – they would not be

locked up. He also explained a little about the facilities they would find there – the library etc. He said that the man and his son did not talk amongst themselves at all.

The officer took them to their room and showed them what there was and explained about things such as the hygiene pack. He told them that, if they needed anything at all, they should ask at the unit office which was open 24 hours a day.

When he looked for them shortly afterwards to give them their ID cards, the officer found them in the phone room. The man was at the phone, though the officer was not sure whether he was actually talking or just dialling. The officer noticed that the man had a piece of paper with lots of numbers on it. The man's son stood a little apart and was sullen and quiet. The officer recalled that, every time he saw him, the boy was staring down at the floor.

A First Night in Custody form completed by an officer on Crane Unit noted that:

> "Both lads appear polite. They have concerns about leaving but are making necessary arrangements by talking to solicitors and contacting Immigration."

Miss McMurray was told that this entry was based on what the officer overheard of a telephone conversation the man had with his solicitor when the man used a phone in the unit office. The officer heard the man say that he did not want to leave the United Kingdom. However, when asked, the officer said the man was no more anxious than any other detainee who had just arrived at the centre.

Another officer who was on Information Officer duties on the day of the man's arrival, said she came across them several times. She had gone upstairs on patrol and found them at the phone. The man wanted to contact his solicitor, but could not work out how to use the phone. The officer showed them what to do and got them connected with their solicitor. Subsequently, the man's son had gone to the information office asking for a toothbrush. She went back to their room with him to check what was there, as detainees are provided with a basic hygiene kit on arrival. She found they had only been given one, so gave them another. Later on, both the man and his son went to the office as they had run out of phone credit and wanted to phone a religious friend to let him know where they were. Another officer had phoned the number for them and asked the vicar to phone the man back. Finally, the officer saw both father and son at dinner time when she was marking detainees off on the board.

The officer described them as really nice people who were polite and courteous. She particularly noticed what a good relationship father and son seemed to have. They were both nicely spoken and had no problem understanding or making themselves understood. The officer said she did not have any conversation with them as such, and neither had said anything to

her about their impending removal or any other concerns. The officer said she did not see any signs of distress or unease. She said they did not seem to engage with other detainees – but that that in itself was not unusual. They had only just arrived at the centre. People usually took a little time to find their way round and find out who was there to speak to.

At 3:30 pm, the centre was notified that the man's removal had been cancelled. This information was not apparently relayed to him. (In the event, the removal order was re-instated. Annex 21 sets out the history of the removal process.)

At 3:35 pm, the man submitted a "Request for Interview with Immigration Officer" form. On this he stated:

> "I have been to court last year and had no reply (Oct). Could you please tell me what's going on."

This was faxed to the Immigration Service.

The officer in charge of Crane unit office said she had seen the man's son playing outside at one point. In addition, the man had come to the office because he wanted to go to healthcare for his medication. She could not say what time this was, but it was quite late. She had phoned healthcare to see if he could be squeezed in and had asked the man to come back in half an hour. Healthcare said he was too late (different units are allocated different times for attending), so the man did not get his medication. The officer added, however, that he had not come back to the office as asked and that she had not therefore been able to explain the position to him. She said she had found him "really pleasant", though he had not been chatty. His English was not good, but he was understandable.

The man's medical record says:

> "Contacted at approximately 21:00 by manager [name] to inform that detainee escorted to Healthcare. Reason? (Myself /colleague at detainee reception advised by DCO "Charlie 1" that [deleted] stated he had been informed by member of nursing staff to present for medication. Advised Charlie 1 that he had been instructed by member of staff to present between 18:30 – 19:00 hrs (designated medication time)."

Miss McMurray pursued this point with healthcare staff. She was told that, at about 9:00 pm, a message was relayed to the night nurses (who were both in reception) by Control. The nurses were told that somebody (no name was given) from Crane wanted to come up to healthcare for his medication. One of the nurses said she was unaware that anybody was expected and would contact Crane on her return to healthcare. She did this at about 10:00 pm (having been busy in reception in the interim) and found out who the detainee in question was. She declined to give any medication, as the tablets he had were contra-indicated and it was not clear which he was taking at that time.

There was also some concern about the dates on the bottles. She therefore advised him to attend his doctor's appointment the next day.

The man's son told the police that his father had told him not to worry and that they would be treated okay at the detention centre. His father had said that, if they returned to Angola, the army might kill him. He told his son that, if anything happened, he wanted his son to be brave and stay in England. The boy said his father "tried everything to stay in the country" the day before he died and had been in touch with solicitors. Finally, however, he had said there was no hope and they were being deported. He told the boy to be strong and do his studies. He did not tell him that he intended to take his own life.

The man's son told the police that he had gone to bed at 10:30 pm, and that, before he did so, his father told him to be strong and not blame him.

6. The man's death

Much of Yarl's Wood is covered by closed circuit television and CCTV cameras at the centre filmed the man killing himself. The tape shows the man emerging from his room at 12:42 am with something wrapped loosely round his neck. He walked straight to the stairwell (no more than a few yards from his room) and went though the door. He appeared briefly to check that there was no-one in the corridor before closing the door. The man then walked straight to the banister, unwrapped a length of cloth from round his neck, leaving one end attached, and climbed over. He braced himself with one foot against the landing and the other on the staircase while he tied the other end of the sheet to the upright of the banister. The man then lowered himself down as far as he could before dropping. At that point, he disappeared from sight of the camera. The ligature would not have been apparent on a cursory glance at the screen.

Twelve minutes later, the tape showed a male officer coming in through the downstairs door underneath the stairs. The officer saw the man hanging and immediately went to support the body, before cutting him down. He then went to the door before returning to the body.

This officer was off work for an extended period following the man's death. I understand that he was extremely upset. Given that his initial reaction was caught on film and that other staff who arrived within seconds have been able to provide detailed accounts of what happened next, Miss McMurray judged that she could conclude her investigation without interviewing him.

A female officer said she had been over to Bunting unit to collect some paperwork and was on her way back to the office. She heard her colleague call her name in a panicky sort of way. She looked round but could not see him. She guessed where the shout had come from, however, and went to the stairwell. She said another female officer had just come over for her break and followed her, a couple of seconds behind.

The female officer said that, on entering the stairwell, she saw the man on the floor and the male officer bending over him. She assumed from his position that the man had fallen down the stairs as he was in a heap in the corner. The male officer told her that his radio batteries were dead, so she used her radio while he checked the man's vital signs. She said she called a Code 1 which was a healthcare code for the most serious type of incident. It meant that someone was unconscious and/or was not breathing.

The female officer explained that staff generally took the radio of the person from whom they were taking over. That person would tell them if they had changed the batteries within the last hour or whatever. She said that the radios gave out a couple of beeps when the battery went dead. It was still possible to hear what was going on, but you could no longer send messages.

The female officer then checked the man's vital signs herself. She saw the SASH (suicide prevention) knife and a piece of sheet on the floor. She then saw the ligature. As soon as she realised the man had hanged himself as opposed to having fallen down the stairs, she and the male officer moved him into a better position for CPR to be administered (she had not wanted to move him immediately for fear of causing further damage). The male officer had already removed the ligature from around the man's neck. He gave mouth to mouth whilst the female officer administered chest compressions.

The second female officer said she and the first female officer had just left the office to go for a cigarette and were explaining to a new colleague where they were going. They were therefore in the doorway. The male officer had called out the female's officer's first name and she had gone in the direction from which he had shouted. The second female officer followed a couple of seconds behind.

She said that, when she arrived, the man was on the floor with the male officer standing beside him. He said his battery was dead, so her female colleague called First Response on her radio. The second female officer said she tapped her on the shoulder to tell her to call a Code 1 also. This would indicate to healthcare staff to bring everything (1 was the most serious, 2 meant bleeding and 3 was for fainting or similar).

The second female officer said she and the male officer got on the floor near the man's head. She said his arms were above his head because of the way he had been cut down. The first female officer was on his right hand side. The second female officer said she felt for a pulse, but could not feel anything. She asked her female colleague to double check in case she had been feeling in the wrong place. Her colleague could not find a pulse either.

They then moved the man's body to give them more room to carry out CPR. At that point, a third female officer arrived and took over from the male officer on mouth to mouth. The first female officer was giving chest compressions. The third female officer asked the male officer to step aside which he did. The second female officer confirmed that the male officer had already

removed the ligature from around the man's neck and that the SASH knife was lying by his side.

The third female officer to arrive was First Response for Avocet and Crane units. She said she heard over the radio that First Response was required in Crane. It was a Code 1, which meant that the person was unconscious or not breathing. She said she thought she probably had to go through about six doors to reach the Crane stairwell. The distance was about 100 feet. She thought it had probably taken no more than a couple of minutes for her to get there.

When she arrived, a female officer was holding the door open. She was extremely pale and the newly arrived officer feared the worst. The male officer was checking on the man's breathing whilst the first female officer to have arrived was administering chest compressions. The First Response officer said she just took over. The male officer told her he could not detect a pulse or any breathing, so she checked for herself. She also checked that the man's mouth was clear, and noticed that his jaw was quite tight. She did not get her mask out but just started giving mouth to mouth straightaway. Someone subsequently offered her a mask but she continued as she was. The officer said the signs were not good – the man's eyes were staring and bloodshot, as well as his jaw tightening.

The officer, a first aid trainer, explained that the correct procedure was to give fifteen chest compressions and then two breaths. She said the first female officer to have arrived had the procedure exactly right. The First Response officer extended the man's airway and gave some good breaths.

A fourth female officer was working on Dove unit. She was not First Response for Crane, but was aware that they were short-staffed and that there had been an incident with an aggressive detainee the evening before. She therefore responded to the First Response call because she thought an officer might be in trouble.

When she arrived at the lower stairwell, she saw the man on the floor. Two female officers were administering CPR. The Dove unit officer had looked up and seen a green and white length of sheet hanging from the banister. It was only then that she realised what had happened. She offered to take over with the CPR but both officers declined. She therefore went to hold the door back. Other officers upstairs were making sure that no-one came down. She said it felt like a lifetime whilst they waited for healthcare assistance, but in reality it was probably a few minutes.

A nurse said she had been working in reception with an agency colleague when she heard a Code 1 call on the radio. This indicated a medical emergency and that the victim/patient was unconscious and possibly not breathing. No further details were given out, so she did not know the precise nature of the emergency until she arrived at the Crane stairwell.

The nurse thought it took a minimum of three minutes to get from reception to the scene. She did not know how long it took, but it seemed a long time. She explained that there were between 10 and 12 doors and that she had to unlock and lock each one (the other nurse did not carry keys so they had to stay together). Some of the doors were difficult to open and different keys were required for different doors. In addition, she was initially carrying the emergency bag, and this had to be put down and picked up at each door.

She had taken the emergency bag from reception. This contained general medical equipment such as bandages, an airway, a BP cuff etc.

As they arrived at the gates, they had been met by the duty manager who told them that someone had hanged himself. When they got there, they found a man on the floor between the bottom step and the door. The nurse could not recall whether staff were trying to resuscitate the man when she arrived. She had been told subsequently that the first man to discover the apparent death had attempted resuscitation. The man was flat out on his back and there was enough room to enable them to work effectively.

The first female officer to arrive said that, as soon as she was relieved from administering chest compressions, she went to check that the man's son was unharmed. He was still asleep. She had subsequently checked on him once more.

The nurse had checked the man's vital signs and found no sign of life. She administered chest compressions and asked the duty manager for an ambulance. She noted that, wherever CPR was necessary, it would be appropriate to call an ambulance. She then commenced CPR. There had been no ambu-bag with the emergency bag (the ambu-bag was normally attached to the outside of the emergency bag, as it was too cumbersome to go inside. It could become detached when the bag was picked up in a hurry.) She also needed a defibrillator. (Neither oxygen nor a defibrillator was kept in Detainee Reception, so it had not been possible to bring these items with her.) She had physically administered mouth to nose (mouth to mouth was not possible) while they waited for staff to bring it.

The agency nurse could not go for the defibrillator as she had no keys. The First Response officer went, therefore, as she knew what she was looking for. The fourth female officer to have arrived took her place in administering CPR. The First Response took the male officer with her just to get him away and for help with opening and closing doors quickly. She thought they had taken about five minutes. The officer explained that there were no healthcare staff in healthcare to bring the equipment. This was why someone had to go and fetch it (the Crane stairwell was in the middle between Detainee Reception and healthcare – the two nurses had not therefore been able to collect what they needed on the way.) The male officer had picked up a second emergency bag just in case it was needed.

The First Response officer then took over mouth to mouth from hr colleague, as she looked as though she was not coping well emotionally. They did not

disrupt the procedure. She said the agency nurse had asked a couple of times if they wanted any help but both had declined. They were anxious to avoid a gap in the CPR.

The agency nurse said she and the nurse had tried to put in an airway, but were unsuccessful as the man was biting his tongue. They then found that they needed the oxygen, so the agency nurse went with an officer to fetch it from the healthcare centre. Progress was slowed by the number of doors and the need for the two of them to lock and unlock each time, rather than one person unlocking and the other following behind to lock. She thought they might have taken 4/5/6 minutes to bring the oxygen back to the stairwell. The agency nurse said she was very frustrated at all the rushing backwards and forwards to get equipment.

The nurse said that officers applied the ambu-bag as soon as it arrived. She was not sure who did what when – staff were constantly changing over, due to the tiring nature of resuscitation – but she and the agency nurse had carried out the chest compressions whilst two members of GSL staff had operated the ambu-bag. The nurse was happy with their technique.

She thought that it took about 20-25 minutes for the paramedics to arrive. This was broadly in line with the time it had taken on other occasions. She noted both the distance they had to come and the delays inherent in passing through gates etc. She had continued to help with the resuscitation attempt after the arrival of the paramedics.

The man's medical record says:

> "Paramedics applied ECG monitor to [the man]; monitor: ASYSTOLE; attempted cannulation by paramedics in L arm and neck: UNSUCCESSFUL. Intubated by emergency personnel; adrenaline administered by above personnel on two occasions, via endotracheal tube."

The man was taken to hospital, but pronounced dead on arrival at 2:05 am.

Two notes were found in the man's room (one of them was in the bin). One note was in two parts. The first part said:

> "[Son's name]
>
> I am really sorry. I don't you come to Angola to suffer.
>
> To: This centre crew
>
> Is not fault for anybody just my decision.
>
> Sorry
>
> [His first name]

14.09.05”

The second part was headed “Declaration” and said:

> “[The man’s first name], 35 years old from Angola. I am writing this declaration to UK Immigration.
>
> I am the person the responsible to put through my family in this situation.
>
> I put a lot of pressure in my wife when she live with me to agree for everything that I’ve said here in the UK.
>
> Also I tried to kill, because she don’t agree with me in all situation and immigration and everything.
>
> I kill my self, because I don’t have life for live any more.
>
> My son [name] stay here in UK to continue his studying. When he grow up, he [illegible] your decision.
>
> I really sorry because I can’t return to Angola.
>
> [The man’s first name]
> 14.09.05”

The note found in the bin was also headed “Declaration” and was virtually identical to the other note.

7. After the death

After the ambulance had left, staff were assembled in the library. Some members of staff in other parts of the centre were Care Team members and were made available to help those involved straightaway. Two or three other members of the Care Team were also brought in, and additional staff were called in to replace those who had been most closely involved in the attempt to resuscitate the man.

The centre chaplain and an IMB member both arrived at the centre at 1:50 am. The contract monitor arrived just after 2:00 am. Staff were given a hot debrief at 2:00 am.

The chaplain told Miss McMurray he asked how staff knew the man’s son was asleep and they told him they had looked in and had seen him breathing. As time went by, however, his anxiety about the boy increased. He was concerned that there might have been some form of collusion between father and son and that the boy might in fact be unconscious. He thought staff should be taking account of the family aspect of the case and the possibility that a family suicide had been intended. He raised these concerns with a

senior manager who, while agreeing that this was an issue, was reluctant to take any action until a senior police officer gave the go-ahead.

During all this time, the man's son was apparently still 'asleep', but no-one was willing to make a decision to wake him. There was uncertainty about how to proceed. One manager thought the boy should be told as soon as possible, in case he awoke and found his father's bed empty. Another wanted to wait to give him the news until they had moved on operationally.

The chaplain said that, even after the police arrived, there did not appear to be any urgency to establish the boy's well-being or how the news should be disclosed to him. He said he had spoken to the police about his concern about the boy's health, but they wanted to wait for their Detective Chief Inspector to arrive – hence there was a further hiatus while they waited for him. There was also uncertainty over who should tell the man's son. No-one was willing or thought they had the authority to do it. In the event, the chaplain said he would tell the boy.

The chaplain and a Detective Sergeant had gone to wake the boy at about 4:50 am. They found him asleep in his clothes (the chaplain surmised that this was perhaps because he knew he was leaving early the next morning). He said the boy was immediately awake and alert. His intuition was that the boy already knew something had happened to his father.

He said he did not tell the boy on the spot what had happened. He simply asked him to go with him to the healthcare centre so that he could speak to him. The chaplain noted the number of doors that had to be unlocked and re-locked. He said officer presence was kept to a minimum, but speculated even so on what the man's son must have been thinking.

The boy was cared for in healthcare for the remainder of the day before Social Services arranged local foster care for him.

The chaplain contacted the Leeds vicar to inform him of the man's death. The chaplain said that when he explained who he was, the vicar's first question was to ask if he was phoning about the Angolan man. His second was whether the man had hung himself. The vicar and another family friend attended the centre later during the day.

The man's sonhas now been placed in foster care in Leeds.

The chaplain said that the duty manager had been absolutely clear that he wanted everyone to be told at the same time about the man's death. Operational instructions covered the simultaneous debriefing/briefing of staff going off shift and coming on respectively, but they had to decide how best to communicate the news to the other detainees. There was clearly a need to do this in a controlled way so that they did not cause tension. They therefore agreed that all detainees throughout the centre should be given a letter setting out what had happened.

GSL brought in ICAS to provide counselling for staff. The first six on scene were told that they must go to see the counsellor, even if it was only to say they did not want counselling. One officer said she went to let the counsellor know she did not require counselling and spent some considerable time there. Another member of staff said she had not realised she had any symptoms of stress until she spoke to the counsellor. A notice was issued to all staff to inform them of the man's death and offering the opportunity to speak either to the chaplain or the counsellor. Nearly all the staff interviewed said they felt very well supported after the man's death. Immigration Service staff had, naturally, also been very shocked by the death. They too reported that they were well supported afterwards. This is to be commended.

8. Post mortem report

A post mortem was carried out on 15 September. It found nothing unusual and concluded that the cause of death was hanging. A toxicology report noted "a negative screen" apart from minimal amounts of Mirtazapine.

9. The man's family

The man's wife returned to Angola in 2004. The man said he had lost contact with her and did not know where she and his other son were. Shortly after the man's death, someone who said they were a friend of the family phoned the centre to say that the man's wife was in Portugal. He gave a mobile phone number for her.

There was some delay before any attempt to contact the man's wife was made. Indeed, no-one seemed sure about whose responsibility it was to do so. The Family Team leader was asked to do it, but did not consider it appropriate for her to do so (I agree). Eventually, an Immigration Service Assistant Director in Leeds took responsibility for contacting the man's wife, as "someone had to do it." I understand that he left a message on the mobile phone but, at the time of writing, nothing has been heard from her.

The man's next of kin in this country is his son. (He says his father's wife is not his natural mother.) My normal practice would be to appoint a family liaison officer to explain to the next of kin my role and to engage them as far as they wish to be engaged in my investigation. The Investigator did not consider it appropriate to contact the man's son directly, however, and no-one from this office has spoken to him (although the Investigator advised the boy's solicitor that she would be happy to meet the man's son if he wanted to do so).

The Investigator has dealt instead with the boy's solicitor. The solicitor suggested that the issues my investigation needed to deal with were:

- "The lack of availability of competent publicly funded immigration solicitors to assist [the man] with his immigration case.
- The apparent failure to notify [the man] of his immigration appeal decision.

- The failure to deal adequately or at all with queries from [the man] and [the Leeds vicar] relating to [the man's] immigration appeal.
- The failure to deal adequately or at all with the fresh evidence giving rise to a fresh claim for asylum for [the man] in relation to his wife's arrest and detention on her return to Angola.
- The 'dawn raid', albeit that this may be regarded by the police and immigration as 'routine' this practice as you will appreciate has been described by the Commission for Children in Scotland as 'terrorising' families of asylum seekers.
- [The man's] transportation from Leeds to Yarl's Wood.
- The screening of [the man] for medical issues and risk of self harm at Yarl's Wood.
- The supervision of [the man] during his period of custody at Yarl's Wood."

(The solicitor also asked Miss McMurray to investigate the non-return of two SIM cards that had apparently been removed from the man's mobile phones at Yarl's Wood. The cards could not be found, however, and there was no evidence that staff had removed them – it was apparently not usual practice to do so. Miss McMurray suggested the solicitor pursue the matter directly with the centre manager.)

I have covered each of these points in my investigation, but I do not think that Government policy on the question of publicly funded legal advisors for asylum applicants falls within my remit. I am, however, happy to record the solicitor's concern on this matter. This report will of course be considered widely within the Immigration Service and I draw the solicitor's comments to their attention.

10. Examination of the issues

Handling of the man's asylum application

The man arrived in this country in October 2001. It was almost three years before there was any progress on his asylum application. No reason for the delay is apparent from the files. I assume it was due simply to the large backlog of work in the Immigration Service. In the interim, the man and his family had put down roots and settled in this country. The rejection of his asylum application must have been an extremely heavy and traumatic blow. Thereafter, the man and his son were allowed to remain in the country for almost a year before the unexpected 'pastoral' visit from the Immigration Service on 13 September 2005. Such treatment may not be unusual but it does not reflect well upon the Immigration Service. Indeed, in its impact upon children in particular, a long period of inaction followed by the robust exercise of state power, is frankly cruel and lacking in humanity. While it is beyond my remit specifically to address the point, I hope the Immigration Service is doing all it can to reduce delays in the consideration of asylum claims.

The man alleged that he had not received the adjudicator's determination of his appeal despite having chased it up. The Immigration Officer who arrested him said he checked on the file and saw that the letter had been sent on 23 November 2004. The indications from The Court Service are that the documents were correctly sent out, although there is nothing to show conclusively that a copy was sent at the man's request in December 2004. An Executive Officer in the Immigration Service has suggested that, in her experience, it was unlikely that they would have been. However, policy is to tell customers the result of their appeals if they phone, and the man's details had been properly updated on the system when he phoned on 13 December. On balance, I conclude that the man was properly notified of the decision. Whether he was able to understand it or its implications is, however, a different matter.

The procedures followed by The Court Service in promulgating asylum appeal decisions appear akin to those followed by other courts (although it is not clear whether the clerk who signs the notice of promulgation physically posts the documents himself). This system does not allow for letters that simply go astray. Given the importance and implications of asylum decisions, it seems to me that a more fool-proof method of proving service – such as the Royal Mail's "signed-for" service – should be sought.

I am also concerned that the decision itself is a lengthy document that may not be very accessible to those whose command of English is limited. Where an appellant is not legally represented and relies on the services of an interpreter during the proceedings, consideration should perhaps be given to providing a copy of the decision in the appellant's own language.

I recommend that a copy of this report is forwarded to The Court Service so that it can consider further both a more fool-proof method of proving service of decisions and the feasibility of providing decision letters in the appellant's own language.

The arrest

I am also very concerned by the manner of the man's removal, although again the circumstances are by no means unique. The shock of waking from a deep sleep to find two men in your bedroom and six other strangers in your house must have been immense. The effect this shock might have had on a 13 year old boy or someone suffering from depression can only be guessed at. I understand that it is 'normal' for eight people to carry out an arrest such as that of this man. I accept that arrests have to take place very early in the morning to ensure all personnel are at home. I also accept that, despite the 'pastoral' visit, it is possible that arresting officers might be unpleasantly surprised on finding additional people at home or encountering hostility on the day. And it goes without saying that Immigration Service must have adequate protection as they carry out their lawful work. But if arrests are to be conducted as humanely as possible (in circumstances that are always going to be traumatic), the approach taken must be proportionate. Each situation must be carefully risk assessed and the approach tailored appropriately.

Given the report of the pastoral visit, I am puzzled that it should have been felt necessary to deploy a total of eight people to arrest the man and his 13 year old son.

I recommend that the Immigration Service reviews how it conducts risk assessments to ensure that its approach to each arrest is proportionate.

I have examined the Leeds vicar's statement that the man told him that Immigration staff would not listen and that he had been injured when he was pushed. From the CIO's account, I think it quite likely that, after a point, the Immigration Service staff did cease to listen. Certainly, it is likely that the man would consider they had not listened. However, I cannot be overly critical on this point. The Immigration Service staff report that they explained the situation fully to the man, but then moved swiftly on to avoid letting the situation get out of hand. I do not see what choice they had.

As for the allegation that the man was injured when he was pushed, I have found no evidence to support it.

I have also considered the speed with which the man and his son were to be removed from the country. The Immigration Service has advised that this is normal practice (though there is apparently no written policy on effecting removals). A Chief Immigration Officer from the Leeds Family Team explained:

> "We would not give notice of the actual removal directions until the family were placed in detention. Experience has shown that if families were given notice prior to detention – then there is a high risk of them absconding. The decision to detain a family to effect removal is not lightly taken. If we can avoid detention then we will do so and we would set removal directions and advise the family that they should attend the airport for removal themselves. They would be given adequate notice of RDs (would probably be a couple of weeks) in order to allow them to make arrangements. This is clearly more cost effective and preserves a level of dignity. Unfortunately, the very fact that someone remains in the UK after they have exhausted all appeal rights indicates that they are unwilling to comply with removal themselves – hence the decision to detain. They would be advised of the removal directions when they had been detained. We always seek to keep detention to a minimum and hence notice of RDs can vary depending when the RDs have been scheduled in relation to the flight. For operational reasons we sometimes detain a few days before the flight and this may explain why notice varies."

I accept that the Immigration Service's approach is driven by experience and that it is likely that some people, given notice of their impending removal, will disappear. However, I dislike the blanket approach and the assumption that everyone would react in the same way. The man had consistently complied with the reporting conditions imposed on him, even after (as far as the Immigration Service was concerned) he knew he had exhausted all his rights.

They had no reason to suppose he would not comply with any instruction to leave the country.

I recommend that the Immigration Service reviews its policy on the execution of removal directions and issues appropriate guidance.

Risk indicators

I have considered whether there was any particular significance in the man wanting to take his evening medication with his morning medication on 14 September. Immigration staff, who inevitably have scrutinised the whole arrest very carefully to ascertain whether they might have missed anything, assured Miss McMurray that there was nothing about the man's manner when asking for the medication to arouse any suspicions. They concluded simply that he was confused having been awoken from a deep sleep.

I have also considered the significance of the man taking a washing line with him. It is hard to see what purpose he might have intended it for. Should either escort or reception staff have read anything sinister into this? I do not believe so. In the first place, detainees not uncommonly bring with them unusual items of property. In the second, there was nothing to suggest that the man might harm himself. Lastly, he did not argue or seek to retain the rope when it was taken from it. Staff said he was quite relaxed about letting it go.

On balance, therefore I do not consider that any obvious risk indicators were missed.

Neither the IS91 nor the IS91RA forms indicated that the man presented a risk of suicide or self-harm (although both mentioned his depression). In light of everything I have learned about the man's demeanour and behaviour during both the 'pastoral visit' and the arrest, I do not consider this was an unreasonable assessment. However, I am concerned that not all the risk indicators are marked one way or the other. There is nothing to show therefore whether each of them has been considered. Whilst I understand that anyone would be reluctant actually to state that there was "no risk", I consider best practice would be to enter an assessment alongside each factor (this would show, not that there was or was not any risk, but that there was or was not an indication of such risk).

I recommend that Immigration Officers be instructed to annotate each of the factors on the risk assessment sections of the IS91 and IS91RA forms.

Screening

The nurse who carried out the healthcare screening interview with the man said she saw him and his son together, as it is unlawful for them to interview a minor without a responsible adult present. She said that this could sometimes inhibit the sorts of questions they could ask detainees, as it was not

appropriate to ask a parent in front of its child if he/she had self-harmed or was thinking of suicide, or even about more general anxieties about leaving the country. Healthcare staff might be the first people to whom new detainees feel they can open up to. Everybody else is likely to be perceived as somehow hostile to the detainee. It is therefore vital that the healthcare interview is carried out in optimum conditions, where the detainee feels able to confide in staff. In this case, I see no reason why the man and his son could not be seen together and then the man by himself.

I recommend that all adult detainees are screened on their own by healthcare staff.

I also note that it is not the practice of healthcare staff at Yarl's Wood to address the question of suicide ideation directly. It was suggested that this was for fear of putting the thought into detainees' minds. Received wisdom on this matter is that asking the question will not make someone more likely to self-harm if they were not previously considering suicide, and that it is most effective to ask specific questions.

I recommend that GSL reviews with Veritas (the healthcare provider at Yarl's Wood) the approach taken by healthcare staff to assessing suicide ideation.

I also note that the screening form attached to the man's medical record does not refer specifically to suicide or self harm. It is important both that there is a prompt to staff to assess detainees for risk of self-harm and also that there is a record of that assessment.

I recommend that a screening form that requires healthcare staff specifically to address issues of mental health, self-harm etc be used for all new receptions.

Nursing staff said that the healthcare screening carried out in relation to those whose stay would be 24 hours or less was often shorter than that for longer term detainees. This is apparently because less information - for example, GP name and address - needs to be obtained. It is important, however, that screening for risk of self-harm is at least equally rigorous as for other detainees. Imminent removal may be a trigger and this may be exacerbated by the shock of being arrested in the early hours and not being given the opportunity to prepare for departure.

I recommend that healthcare staff be reminded to take special care in assessing newly arrested, short term stayers for risk of self-harm.

Issue of medication

According to the man's medical record, he was not allowed to go to healthcare to collect his medication because he had missed his allotted time. This tallies an officer's recollection of her conversation with the nurse. When asked about this, however, the nurse said she made the decision on the

grounds that the medicines contra-indicated and there was some doubt about what the man was actually taking. She therefore wanted him to see a doctor first. If this was the case, it was a sensible decision. However, in light of the written record and the officer's recollection of the conversation, I am inclined to believe that the fact the man had missed his allotted time was a factor. Any request by a detainee to collect medication should be treated on its medical merits and not purely on the basis that he should have collected it at the proper time.

I recommend that nursing staff be reminded individually to consider any requests by detainees for medication and, where there are medical grounds, allow deviations from established routine.

I also recommend that the precise reasons for any decisions taken be recorded in the medical record.

In this instance, Ms Emma Bradley MSt (Cantab) BSc RGN advised me that the man not taking his evening medication would not have had any repercussions for his mental health in the short timespan that obtained.

Radios

I note that the male officer who discovered the man's death was not able to transmit on his radio because the batteries were dead. In other circumstances, this might have caused critical loss of time before help arrived (in this case, he was able to call for assistance from staff who were a matter of feet away). I understand that the radios bleep when the battery runs out.

I recommend that GSL reminds its staff to change the radio batteries as soon as they hear the bleep.

Staff in attendance

I note that one of the staff who responded to the First Response call was not designated to attend, but did so thinking a colleague might be in difficulty. I understand the intention, but it is important that only those staff designated to attend any given response call do so. Otherwise, there is a danger of additional people getting in the way and leaving other parts of the establishment under-staffed. (This is not intended to undermine the officer's contribution on the evening.) Given the potential for unrest after a death in custody, this is to be avoided.

I recommend that GSL reminds staff that the correct protocol for responding to incidents must be observed at all times.

Keys

The agency nurse told Miss McMurray that she did not carry keys on the night and in fact had never been issued with any. This was because she came from an agency, rather than being employed by either GSL or Veritas. She

said that not carrying keys could make life very difficult – especially at night. She noted that there could be particular problems if two detainees needed medical attention at the same time.

On the night of the man's death, the speed with which the nurses were able to respond to the Code 1 was impeded by two factors. First, the number of doors through which they had to pass, and second by the fact that the same person had both to unlock and then lock each door, rather than racing ahead and leaving her colleague to lock up behind her. The same situation arose when the agency nurse went to fetch the oxygen. Given the length of time the man had been hanging before he was discovered, I do not consider this delay mattered on the night. In other circumstances, however, the delay could be fatal.

I recommend that all healthcare staff working in the centre be key-trained and issued with keys.

Accessibility of equipment

I was struck by the amount of to-ing and fro-ing there was to collect what might have been life saving equipment. The agency nurse told Miss McMurray that she found it very frustrating. I also note that the ambu-bag, which is normally attached to the emergency bag, became detached. Because the bag was brought from Detainee Reception, it was not easy to retrieve.

I recommend that GSL considers placing emergency medical bags on each unit.

I also recommend that they review the benefits and costs of providing additional defibrillators and oxygen bottles around the centre.

Summoning paramedics

A Code 1 was called by staff. This meant that someone was unconscious and possibly not breathing. Nevertheless, no ambulance was called until the nurse had arrived and carried out an initial assessment. Inevitably, this was some minutes after the man's apparent death was first discovered. The delay might in other circumstances have proved costly. I understand that only a member of healthcare staff can request that an ambulance be called. While I appreciate that detainees sometimes feign injury or illness, I do not consider risks should be taken where someone is apparently unconscious.

I recommend that, wherever a Code 1 is called, paramedics be summoned immediately.

Contingency plans for families

In describing to Miss McMurray the decisions and actions taken in relation to the man's son following his father's death, the chaplain was critical that there

was no guidance to follow and no specialist resource on whom to call. He said managers and staff were unsure what to do and who should do it. This meant both that the man's son was potentially not as well served as he might have been and that staff were put through additional stress. The chaplain also pointed out that it was fortunate that the boy spoke English and that he and the chaplain had religion in common (both belonged to the Anglican Church). The chaplain said it might have been very different if the boy had been a Muslim or a non-English Ethiopian child of 10. Finally, he said he was very conscious that the man's son had no advocate on hand to care for his rights and needs. The Social Worker had not been able to attend at the centre until late afternoon.

I recommend that all centres holding families review their contingency plans to ensure they deal specifically with actions to be taken with regard to family members following a death.

I also recommend that centres holding children arrange with Social Services for a child-care specialist to be on-call in case of emergencies.

The chaplain was also critical that it was some time before the man's son was told about his own immigration status following his father's death. For many hours after he heard the news, he must have assumed he was to return to Angola alone. An Immigration Service manager readily agreed to talk to the boy, but no-one thought about this for some significant time.

I recommend that the Immigration Service's Operating Standards for Immigration Removal Centres be amended to ensure the family of the deceased are promptly informed about what will happen to them. The standard should also give clear guidance on who pays for the funeral.

Notifying next of kin

The delay in locating the man's wife could not be helped – indeed it is by no means certain that the information that she was in Portugal was in fact correct. I am concerned, however, about the apparent confusion over whose responsibility it was to inform her.

It is clearly not appropriate for Immigration Service staff involved in the detainee's case work or arrest to convey the news, as they are liable to be subjected to considerable hostility (for being 'responsible' in the first place for the detainee's detention) and will not be able to tell the family what they need to know.

The Detention Services Order on Deaths in Custody states that either the senior immigration official at the centre or the on-call senior manager is responsible for contacting the next of kin. (Since the on site senior immigration official is now the contract monitor (a post currently graded at HEO), I have said in a previous report that I do not consider this is appropriate.) Given the clarity of this instruction, I am not sure why there was so much confusion over who should contact the man's wife.

It is clear to me that notification must come from someone sufficiently senior or appropriately trained/experienced at the removal centre, as the family will almost certainly want to know details of the death and events leading to it and will also want to make arrangements for visiting the centre.

I recommend that, regardless of the length of stay, the next of kin should be informed of a death by a senior manager at the removal centre or someone else at the centre suitably experienced in conveying bad news.

11. Conclusions

The circumstances surrounding the death of this man are especially sad. However, I am satisfied that everyone who came into contact with the man on 14 September acted professionally. I have found no indication that staff overlooked any signs that he might kill himself. On the contrary, given what Miss McMurray was told about his clearly close relationship with his son, little can have been further from their thoughts.

The man did not want to return to his own country and had been picked up from his home in hugely stressful circumstances that morning. But in this, he was no different from many other detainees. If he had already made up his mind to kill himself (a possibility suggested by the 'Declaration' he wrote in April), it is perhaps unlikely that he would have given staff any clue.

Following discovery of the man's body, a number of staff worked extremely hard to try to revive him. They could not have known at that time how long he had been hanging, but a number have reported that it was immediately very clear that he was beyond saving. It is enormously to their credit that staff persevered as they did until the paramedics arrived.

There are of course ethical questions of decency and respect about whether it is right to try to resuscitate someone who is clearly dead, but that is not a question for this report. I have the greatest respect for those who carry out the physically and emotionally draining demands of CPR. All those staff involved in trying to resuscitate this man are to be commended.

Recommendations

1. **I recommend that a copy of this report is forwarded to The Court Service so that it can consider further both a more fool-proof method of proving service of decisions and the feasibility of providing decision letters in the appellant's own language.**

2. **I recommend that the Immigration Service reviews how it conducts risk assessments to ensure that its approach to each arrest is proportionate.**

3. **I recommend that the Immigration Service reviews its policy on the execution of removal directions and issues appropriate guidance.**

4. **I recommend that Immigration Officers be instructed to annotate each of the factors on the risk assessment sections of the IS91 and IS91RA forms.**

5. **I recommend that all adult detainees are screened on their own by healthcare staff.**

6. **I recommend that GSL reviews with Veritas (the healthcare provider at Yarl's Wood) the approach taken by healthcare staff to assessing suicide ideation.**

7. **I recommend that a screening form that requires healthcare staff specifically to address issues of mental health, self-harm etc be used for all new receptions.**

8. **I recommend that healthcare staff be reminded to take special care in assessing newly arrested, short term stayers for risk of self-harm.**

9. **I recommend that nursing staff be reminded individually to consider any requests by detainees for medication and, where there are medical grounds, allow deviations from established routine.**

10. **I also recommend that the precise reasons for any decisions taken be recorded in the medical record.**

11. **I recommend that GSL reminds its staff to change the radio batteries as soon as they hear the bleep.**

12. **I recommend that GSL reminds staff that the correct protocol for responding to incidents must be observed at all times.**

13. **I recommend that all healthcare staff working in the centre be key-trained and issued with keys.**

14. **I recommend that GSL considers placing emergency medical bags on each unit.**

15. **I also recommend that they review the benefits and costs of providing additional defibrillators and oxygen bottles around the centre.**

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18. **I also recommend that centres holding children arrange with Social Services for a child-care specialist to be on-call in case of emergencies.**

19. **I recommend that the Immigration Service's Operating Standards for Immigration Removal Centres be amended to ensure the family of the deceased are promptly informed about what will happen to them. The standard should also give clear guidance on who pays for the funeral.**

20. **I recommend that, regardless of the length of stay, the next of kin should be informed of a death by a senior manager at the removal centre or someone else at the centre suitably experienced in conveying bad news.**