Circumstances surrounding the death of a man in Campsfield House Immigration Removal Centre on 27 June 2005

Report by the Prisons and Probation Ombudsman for England and Wales

November 2005

A man died at Campsfield House Immigration Removal Centre on 27 June 2005 after apparently hanging himself from the bracket at the top of the door. He was just 18 years old.

I offer my sincere condolences to his family and friends for their loss.

This was the first death to have occurred at Campsfield House. Even so, the staff who were on duty – some of whom were little more than the dead man's age themselves – responded quickly and extremely professionally, carrying out resuscitation even though it seemed hopeless. The contingency plans were properly executed and the paramedics arrived within ten minutes of the man's body being discovered. The Independent Monitoring Board (IMB) also responded effectively and in accordance with their own contingency plans.

The man's family were contacted promptly and invited to visit the centre. Subsequently, the Campsfield House staff were offered comprehensive support. Overall, this very sad event appears to have been handled well. All those directly involved are to be commended.

I am grateful to the centre manager, for facilitating my investigation and to his staff for their help and openness. I am also grateful to colleagues in the Immigration Service for quickly furnishing me with papers and advice.

Although I have concluded that the man's death could not have been predicted or prevented, and that staff acquitted themselves well, my investigation has identified a number of areas which IND and the contractor should address. I have made some 21 recommendations to help prevent further deaths at Campsfield House and throughout the immigration detention estate.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **November 2005**

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Summary

This is the report of my investigation into the death at Campsfield House Immigration Removal Centre of an 18 year old Turkish Kurd. All the evidence suggests that he hanged himself.

Section 1 provides some personal information about the man. It describes how he entered the country in the back of a lorry on 12 February, having run away from home to come to England. He was taken first to Oakington Immigration Reception Centre and then to Campsfield House on 18 February.

The section also sets out the criteria for detention and provides some information about Campsfield House. It was built as a military barracks, comprises a number of residential units and has a capacity of 184. The average length of stay is 14 – 15 days.

I draw attention to the report by HM Chief Inspector of Prisons, Ms Anne Owers, on her most recent inspection of Campsfield House. Ms Owers noted that staff-detainee relationships remained good, and that there had been some improvements at the centre since her previous inspection - most notably in the care of vulnerable detainees. However, the Chief Inspector also recorded that detention reviews were not sufficiently rigorous.

I also draw upon the views of Campsfield House's Independent Monitoring Board.

Finally, I note that, although it has been agreed that Campsfield House should have 24-hour medical cover, this will not be implemented until the inception of a new contract in April 2006.

Section 2 describes the form my investigation took. I visited Campsfield House myself on 29 June, but the investigation was conducted on my behalf by Miss Ali McMurray, an Assistant Ombudsman. She visited the centre and carried out a number of interviews. She also reviewed a large body of documentation generated by GSL (Global Solutions Ltd - the contractor that runs the centre), and by the Immigration Service, and viewed CCTV coverage of the period before and after the discovery of the man's body. Miss McMurray and one of my Family Liaison Officers, Ms Lucy Phelan, also visited the man's next of kin. Finally, Miss McMurray commissioned Ms Jean May to carry out a clinical review of the healthcare afforded to the man.

Section 3 describes the man's period in detention and the management of his case by the Immigration Service. He was transferred to Campsfield House after it was discovered that he had previously applied for asylum in Italy. He was seen by a member of the healthcare team on arrival at Campsfield House, but, in accordance with normal procedures there, was not assessed for risk of self-harm or suicide.

The Immigration Service wrote to the Italian authorities on 9 March to ask them to take responsibility for processing the man's asylum application. On

23 March, they gave the Italians a further week to reply before a decision was taken, on 5 April, to remove the man to Italy. In the interim, the man's solicitors had lodged an application for him to be considered under the European Community Association Agreement (ECAA), a scheme enabling foreign nationals to set up businesses in the United Kingdom. The Immigration Service rejected the application on 20 April and set removal directions for 10 May. On 3 May, the solicitors lodged an application for judicial review. The Treasury Solicitor advised the Immigration Service, however, that its letter rejecting the ECAA application was inadequate. The Immigration Service then agreed with the man's solicitors on 14 June that they would re-consider the application if the solicitors withdrew the application for judicial review.

The man was given monthly updates on his case. The letters were mostly identical with a few small changes to reflect recent developments. The wording of the reasons for his continued detention stayed exactly the same throughout.

This section of my report reveals that there were some (slight) delays in processing the man's case, but that the Immigration Service was subsequently unable to pinpoint the reasons with any certainty.

The man was in regular phone contact with his family throughout this period and received a number of visits. He put in a succession of applications for an update on his case, but no-one with whom he came into contact – family, detainees or staff – perceived him to be unduly depressed or frustrated. However, one detainee told the police that, four weeks before his death, the man had spoken to him about cutting himself. The man was due a visit from his cousin on the day he died.

Section 4 describes the discovery of the man's body and the action taken by staff to try to revive him. The man had spoken at length to an Afghan detainee late into the night. He was worried about being sent back to either Turkey or Italy and said he wanted to cut his hand or hang himself. The Afghan detainee tried to talk him out of it and pointed out that suicide was against his religion. The man said he was only joking.

The Afghan detainee went to the man's room at about 3:30 am to wake him for early morning prayers. He was unable to open the door and, with another detainee, went to fetch a detention custody officer (DCO). The officer forced the door open and discovered the man hanging behind it, suspended from the restraining hinge. The officer and the two detainees lifted the man down. Two other officers arrived almost instantly and commenced resuscitation. A third subsequently took over from one of them. The paramedics arrived less than ten minutes after the man had been found but they too were unable to revive him.

Section 5 covers action taken after the death. It describes how a relative was identified from the man's list of visitors and contacted by the Sheikh by phone. I discovered that the Operating Standards for Immigration Service Removal

Centres on Deaths in Custody specifies that the local Immigration Service manager [the contract monitor] or on-call senior manager should inform the next of kin. The contract monitor did not consider this was appropriate.

Following the death, a care team was mobilised and an ICAS[1] counsellor was brought in to support staff. Staff spoke highly of the support offered to them.

Section 6 reports that the family had no criticisms of the way they were treated after the death. However, they did question why their relative was allowed to retain belts, shoelaces bedding etc with which he could hang himself. They were also angry about the length of time for which he was detained.

Section 7 sets out the findings of the post mortem. These were that a fabric belt had been used as a ligature and that the man died as a result of compression of the neck. There were no injuries to indicate that he had been assaulted. The cause of death was given as hanging.

In Section 8, I consider the various issues arising as a result of my investigation. I am critical that there is no routine healthcare screening for self-harm and suicide at Campsfield House and note that plans to increase medical cover to 24-hours have been delayed. I consider the length of time the man was held in detention and query whether the matter was substantively reviewed. I also look at the way in which bail applications were handled.

I consider whether it is appropriate to accommodate detainees in single rooms, but conclude that it is – provided that certain safeguards are in place. I also find that it was not unreasonable for the man to be allowed to retain items that could be used as ligatures. I consider the fact that there is no means for detainees to raise the alarm and that staff do not routinely carry equipment with which to cut through ligatures.

I am critical of the requirement that the contract monitor should contact the next of kin. I also suggest that detainees should be encouraged (I understand they are already asked) to give details of next of kin on arrival at a removal centre.

Finally, I commend the response of the IMB and staff to the man's death.

I make recommendations on all these points.

[1] Independent Counselling and Advisory Service.

1. Background

The man

The man was an 18 year old Turkish Kurd. Before leaving Turkey, he worked as a tailor. His father owned two companies in Turkey. He had an older sister and a younger brother and sister. He also had two step sisters. His mother died when he was 8 or 9 years old. He appears to have been close to his family and stayed in regular contact with them whilst he was at Campsfield House.

The man arrived in England at Teesdock, Middlesborough, on 12 February 2005 in the back of a lorry. He was with 18 other Turkish nationals. They were caught running across the dock towards the perimeter fence by Teesport Harbour police. The man later told another detainee at Campsfield House that he was sent to the UK because his life was not safe in Turkey. He said that he had a problem there but did not say what it was. Whilst he was at Oakington Reception Centre, he told a nurse that he had been detained in Turkey three times, the last of which was on 21 March 2004. He said he had been beaten with truncheons, kicked and had his head pushed against a wall. He also said he had been beaten on the genitals by Turkish police.

During an initial screening interview, the man told the Immigration Officer that a cousin had paid 5,000 Euros for him to be brought to the United Kingdom. He told the detainee at Campsfield House that his father had borrowed £20,000 in order to get him to the UK. However, the man's next of kin told my investigators that the man's father had not wanted him to come, so he had run away from home. He thought the man wanted to come to the UK because he had a large number of relatives here.

After being detained, the man was taken first to Oakington Immigration Reception Centre. He moved to Campsfield House on 18 February.

Everybody to whom I and my colleagues spoke described the young man as likeable and bubbly. He was apparently quite young for his age, always had something to say and could be quite cheeky. He got on well with everyone – staff and other detainees alike. He loved music and played a lot of sport.

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.

IND's Operational Enforcement Manual says:

> "There is a presumption in favour of temporary admission or temporary release. There must be strong grounds for believing that a person will not comply with conditions of temporary admission or temporary

> release for detention to be justified. All reasonable alternatives to detention must be considered before detention is authorised. Once detention has been authorised, it must be kept under close review to ensure that it continues to be justified."

There are nine removal centres in England, and one in Scotland.

Campsfield House Immigration Removal Centre

Campsfield House is situated near Kidlington in Oxfordshire. Built originally as a military barracks, it has also served as a hospital and a young offender institution. It became an immigration centre in 1993 and has been run throughout the life of the contract by the company now known as Global Solutions Ltd (GSL).

Almost immediately after opening as an immigration centre, Campsfield House experienced a serious disturbance that caused significant damage. This resulted in bars being added to windows and razor wire being added to the fences. Other disturbances followed in 1994, 1997 and 2001. Campaigners against immigration detention regularly protest at the centre.

At one time, Campsfield House held up to 199 detainees, including some women. However, since 1997 it has only held men (in a slightly reduced capacity of 184) following the conversion of some rooms into a healthcare centre. At the time of the man's death, the average stay of detainees was 14 – 15 days, but one or two detainees had been at the centre for more than five months (that is, even longer than the four months that the man was there). The centre had about 150 detainees (just the previous week, the population had been down to around 60). Campsfield House is used as a feeder centre for Prison Service-run removal centres, which do not operate a 24-hour reception. There can, therefore, be a very large number of daily movements in and out.

The centre has three residential units – pink, yellow and blue blocks. Accommodation is a mixture of single, double and some multiple occupancy rooms. Single rooms are reserved for those detainees who have been at the centre for some time and whose behaviour warrants the 'privilege'. Facilities at the centre are limited, although it does have a sports hall and fitness room.

HM Chief Inspector of Prisons, Ms Anne Owers, last inspected Campsfield House during 2004. This was an unannounced inspection to follow up on one carried out two years previously. Ms Owers noted that there had been "some improvements" in the interim and many of her recommendations had been implemented. Staff-detainee relationships remained good and staff supervision of detainees had improved. The Chief Inspector also noted that the centre had made progress in providing support for vulnerable and anxious detainees – there was a dedicated group of reception staff and a 16-strong welfare support team, trained by the Samaritans. In addition, on-site immigration officers were more ready to discuss cases with detainees.

Ms Owers said:

> "There were regular suicide prevention meetings and the strategy was generally well managed. The isolation unit held those at serious risk of self-harm, abscond or who had been disruptive. It was clean and well supervised but there were no observation panels which, when the doors were closed, made monitoring vulnerable people impossible. This was unacceptable."
>
> "Staff-detainee relationships were positive and helpful, and there was a positive emphasis on diversity. Primary healthcare was good …"
>
> "There were in total insufficient activities for the population."

An induction video, available in 17 languages, was used as part of the first day induction procedure.

In relation to an earlier recommendation that "It should be a priority to progress the casework of those held in detention", Ms Owers said:

> "Information in on-site files was very limited, patchy and concerned processes rather than substance. For example, entries showed officers' diligence in reminding caseworkers to issue monthly reviews of detention but they generally contained little evidence that careful consideration had been given to maintaining detention."

On-site immigration officers had not been trained in suicide awareness, as per a previous recommendation. However:

> "An active suicide prevention committee met every month and the minutes showed wide representation, including the IMB [Independent Monitoring Board], chaplaincy, Samaritans and the race relations liaison officer. There were indications in the minutes that positive action had been taken in relation to issues that are particularly relevant to detainees."

On the other hand, a recommendation that staff should receive training to help them understand the backgrounds of people in their care and the impact of detention in a foreign country had been only partially achieved. Staff now received a substantial amount of cultural awareness training, "but it did not include material specific to the impact of detention".

When I visited Campsfield House after the man's death, I spoke to the chair and a member of the IMB. They told me that staff could sometimes be a bit 'sharp' with detainees – what they termed a 'muscular approach' – but relationships between staff and detainees were generally good.

The IMB's most recent annual report had flagged up the need for reinforced cultural awareness training for staff and for staff to watch how they talked.

The IMB also told me that a lot of shifts were undermanned. (I note from a roster I was given that the shift on duty at the time of the man's death was carrying six vacancies.)

Campsfield House does not currently enjoy 24-hour on site medical cover (although a nurse is on-call during the night-time and Primecare - the medical services provider - also provides out of hours cover.) I learned from the IMB that 24-hour medical cover had been agreed, but that its implementation had been delayed. The contract monitor told me that round the clock cover would be introduced with the inception of a new contract to run Campsfield House from May 2006.

2. Investigation

The man's death was investigated on my behalf by my colleague, Miss Ali McMurray. One of my family liaison officers, Ms Lucy Phelan, was the principal contact with his family.

Given the man's age and the fact that his was the first death to have occurred at Campsfield since it opened as an immigration detention centre, I myself visited the establishment two days after he died. I spoke at length to the centre manager, the chair and a member of the Independent Monitoring Board, and to the contract monitor. I also collected a bundle of documents relating to the man's stay at the centre, the management of his case by immigration staff and his medical records. In addition, I met with some of the police officers investigating the death and inspected the room in which the man had died.

Miss McMurray also visited the centre, walked the distance between the induction unit and the man's room, and viewed the room itself with the officer who discovered the man's death. She spoke to the centre manager and the contract monitor and interviewed four members of staff who were involved either in the discovery of the man's body or in trying to resuscitate him. She obtained additional documentation, including a number of policy documents and minutes of meetings of the welfare group and the suicide awareness group. She also viewed CCTV coverage of the corridor outside the man's room. This showed the comings and goings of staff as they responded to the discovery of the man's body. The CCTV recordings also showed that no-one entered the corridor until an Afghan detainee went to wake the man for early morning prayers at about 3:30 am.

Miss McMurray and Ms Phelan visited the man's next of kin in this country to explain my role and the nature of my investigation, establish the questions the family wanted answered, and learn more about the man himself. Ms Phelan also wrote a letter of condolence in Turkish to the man's father in Turkey, inviting him to engage with the investigation.

Miss McMurray obtained the Immigration Service caseworking file for the man. This set out clearly the various developments in the consideration of his case. She also spoke to the senior investigating police officer, and received from him some additional statements and a copy of the post mortem report.

Finally, she commissioned Ms Jean May to carry out a clinical review of the man's care. (This is attached at annex 1.)

3. The man's period in detention

The man arrived at Teesport, Middlesborough, in the back of a lorry on 12 February 2005. He was in the company of 18 other Turks (many of whom were even younger than he was) and was caught trying to flee the area and taken to Redcar police station. He was interviewed by an Immigration Officer the same day and claimed asylum.

The man had no documents to establish either his nationality or his identity. He was served with illegal entry papers and his detention was authorised. He was collected from the police station at 10:15 am on 14 February and taken to Oakington Reception Centre as a fast track case. He arrived there at 2 am on 15 February. There was no record with the Campsfield House papers of any screening at Oakington for suicide or self-harm.

During the screening process, the man had his fingerprints taken. Checks showed that he had claimed asylum in Italy on 24 November 2004. As a result, he was designated a third country case[2] and transferred to Campsfield House on 18 February.

GSL's detainee information system record states that the man had a good understanding of English and lists his languages as Turkish and English. However, his Immigration Service induction form states that he spoke no English. A fellow detainee was used as an interpreter.

A member of the healthcare team at Campsfield House saw the man on 19 February. The interview was carried out with the assistance of a medical phrase book. Most of the screening was unremarkable. However, the man complained of pain in his left groin and said he had been put on medication for it at Oakington. He said he still felt unwell. The nurse gave him some advice about his medication and told him that if he did not feel better in five days, he should see a doctor. The man duly saw the doctor on 23 February (further details of his medical care and a clinical assessment are attached at Annex 1). He claimed at this interview that his date of birth was 5 May 1989. (His next of kin confirmed, however, that he was in fact 18.)

The medical screening form did not include any reference to suicide or self-harm and there was no separate bespoke form with the papers. Miss McMurray pursued this with Campsfield House. She was advised that non-medical staff assess detainees during reception and induction for self-harm and suicide and to ascertain any welfare needs. Where concerns are raised, they open an H2052SH booklet[3]. If the concern is not so serious as to

[2] Asylum seekers in the European Union are required to seek asylum in the first safe country in which they arrive. Where they subsequently go on to another country to claim asylum, they are returned to the original country for their application to be considered.

[3] This form, in use throughout the detention estate and based on a Prison Service model, can be raised by any member of staff who is concerned about a detainee. Once the form has been opened, a case conference is convened to determine how best to manage the detainee. An action plan is drawn up and the position monitored by the case conference until such time as the detainee is no longer considered to be at risk of self-harm.

warrant raising a form, other staff are made aware of the detainee, so that they can keep an eye on him and try to encourage him to talk. Miss McMurray was told that medical staff would also be notified. However, none of this was documented anywhere.

The chair of the suicide awareness committee acknowledged that the Operating Standards for Immigration Service Removal Centres required detainees to be screened for self-harm and suicide within two hours of arrival at a detention centre. This was not possible at Campsfield House, however, because medical cover was not 24-hour. The chair had recommended that self-harm and suicide screening should be incorporated in the medical screening and that the centre should apply for an exemption to the two-hour requirement.

The man was first of all allocated to room 14B. He changed rooms a number of times during his time at the centre - sometimes for medical reasons but also at his own request, because he did not get on with his room mate or because there was too much noise at night. The response to a room move application dated 15 April suggests that the man had been pressing for a single room (he did not qualify at that stage). He was finally allocated a single room at his own request one week before his death.

The man's case was passed to the Immigration Service's Third Country Unit (TCU) on 17 February for a formal request to be made to Italy to take on responsibility. A first detention review was missed on 22 February, but one was carried out on 3 March and the need to make a formal request to Italy was clearly noted in the minutes. However, nothing was done to progress the case until 9 March. After the man's death, the Immigration Service conducted a review of the case to establish the reasons for delays at "one or two stages". However, the officer tasked with the job was unable to ascertain why this delay occurred. He surmised that it was probably due to a combination of factors – the fact that the first detention review was missed, a possible delay due to backlog of work or perhaps the plastic wallet (made up in the absence of the file, which did not arrive in the TCU office until 30 March) might have been misplaced.

On 9 March, a formal request was sent to Italy asking the authorities to accept responsibility for determining the man's asylum application, in accordance with Article 16(1) of the Dublin Convention.[4] The Italians were asked to respond by 23 March.

On 15 March - that is, 30 days after he was first detained – the man's continued detention was reviewed. The review noted that the man had claimed that he travelled directly to the United Kingdom, had never had his fingerprints taken and had never claimed asylum anywhere else. The review concluded:

[4] The Dublin Convention has two main aims: to establish a common framework for determining which country in the European Union decides an asylum seeker's application and to ensure that only one member state processes each asylum application.

> "The subject is an adult, single male with no UK contacts and no dependants. He has no document with which to establish his nationality and identity and he knowingly entered the UK illegally. He has no known medical conditions and he claims to be in good health. He is not a suitable candidate for temporary release, therefore, detention should be maintained."

The man was sent his first monthly progress report on 18 March. This explained that, because he had claimed asylum in Italy before claiming asylum in the United Kingdom, enquiries were ongoing with the Italian authorities to establish who was responsible for dealing with his claim. The letter also said:

> "Your case has been reviewed. It has been decided that you will remain in detention because:
>
> - There is reason to believe that you will fail to comply with any conditions attached to the grant of temporary admission or release.
>
> This decision has been reached on the basis of the following factors:
>
> - You have failed to observe the United Kingdom immigration laws by entering the United Kingdom by clandestine means
>
> - You have not produced satisfactory evidence of your identity, nationality or lawful basis to remain in the United Kingdom."

On 22 March, the man's legal advisers submitted an application for leave for him to remain under the provisions of the Turkish European Community Association Agreement (the Turkish ECAA).[5] Included with the submission was a business case for a proposed cleaning business. The proposal was to provide cleaning services for family and friends to begin with. Only a very small amount of start up capital was necessary, as the man was to use customers' own equipment and cleaning materials. The solicitors also asked at this time that the man be temporarily released, "without further delay as a decision is not likely to be made soon".

On 24 March, the Immigration Service sent a chaser to the Italian authorities, asking for a response within a week.

One week later, the Chief Immigration Officer wrote to the solicitors to advise that the man would not be released. The reasons given were that:

[5] The Turkish ECAA was set up under the Ankara Agreement, signed on 12 September 1963. Under the terms of this agreement, Turkish nationals may come to the EU to set up their own business. They must prove that they have sufficient capital to start up the business and to support themselves while it is getting established.

- “Your client has presented no document to satisfactorily establish his nationality or identity
- He has sought to enter the UK illegally
- He has failed to give satisfactory or reliable answers to an Immigration Officer’s enquiries
- He is likely to abscond if released.

> “I am not satisfied that he would comply with any conditions of TR [temporary release] imposed upon him. I am sorry not to be able to give you a more welcome reply. You do, of course, have the option to apply for consideration of Bail.”

By 5 April, no response had been received from Italy. Since they had failed to respond within relevant Dublin Convention timescales, they were considered to have accepted the man by default. A decision was therefore taken to enforce removal to Italy under Article 20(1) of the Convention.

However, no action was taken immediately. The delay appears to have been caused by the need to consider the application for the man to be considered under the Turkish ECAA. On 9 April, a letter was sent to the solicitors advising that:

> “In March 2003 the consideration of applications from Romanian and Bulgarian nationals under the European Community Association Agreements was suspended. Following an internal inquiry the Sutton report was published and recommendation 15 of this report was that guidance for handling in country applications from Turkish nationals under this agreement should be reviewed and revised procedures and guidance put in place.
>
> “Turkish ECAA applications have been held during this time. Revised guidance has now been produced for handling in country Turkish cases.”

On 15 April, the man attended Churchill Hospital in connection with his testicular problem. He was diagnosed with a large left hydrocoele.[6]

On 18 April, another monthly progress report was sent to the man. This was virtually identical to the previous one, but also referred to his application under the Turkish ECAA, to which he was currently awaiting an outcome.

A file minute dated 19 April set out the consideration of the man’s application. It noted that projected profits for his business in 2005 were £2,960, rising to £10,384.85 in 2007. The caseworker noted:

> “No evidence of own funds. No potential customers, no tenancy agreement or utility bills. Dependant upon uncle accommodation, food, clothes and other basic necessities (money?).

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[6] An extra-testicular serous fluid collection.

> "Application has been considered under current rules HC395 [current Immigration Rules] (para 205) and does not meet the requirements, therefore falls for refusal.
>
> "ALSO, if it could be considered under the 1973 rules (which he has waived his right to as he is an illegal entrant) it would be refused as he does not meet the requirements of para 32 in that there is no evidence that he is bringing sufficient funds into the country."

On 20 April, the Immigration Service advised the solicitors that the application had failed. The letter stated that:

> "The requirements to be met by a person seeking leave to enter the United Kingdom to establish himself in business are that he holds a valid United Kingdom clearance for entry in this capacity. The Secretary of State is not satisfied that you hold such entry clearance and is therefore not prepared to exercise his discretion in your favour.
>
> "The Secretary of State has also considered your application under the Immigration Rules in force as at 1 January 1973 and under paragraph 32 of HC509 [the on-entry Immigration Rules in force in 1973] and he is not satisfied that you would be able to establish yourself as a self-employed person under these rules …
>
> "There is no right of appeal against this decision."

Removal directions were duly set the following day for the man's removal to Italy on 10 May.

A bail hearing was set for 22 April. Two people had offered surety of £2,000 and £1,000 respectively. The Chief Immigration Officer in the TCU opposed bail for the following reasons:

- "He has not provided any documentation satisfactorily establishing his identity or nationality
- His removal from the UK to Italy, where he made a claim for asylum in November 2004, is set for 10/05/05
- The subject has no incentive to comply with any conditions of bail imposed on him
- The surety lodged is not sufficient to ensure control of the subject
- No details had been given of the relationship to the subject of the sureties
- No details of the immigration status of the sureties have been given
- No details have been given of the financial standing of either surety, nor of their employment
- No details have been given of any other residents at the proposed bail address."

In the event, the man's solicitors withdrew the application before the hearing took place.

The Immigration Service file at Campsfield House shows that the man was seen by an officer on 25 April. The notes say, "Explained to subject twice, with different interpreters, that he has to go to Italy on 10 May. He has health concerns – sent him to health care."

On 3 May, the man's solicitors lodged an application for Judicial Review (JR). They argued that the fact that the man had unlawfully entered the country was not a relevant consideration. TCU received notification of the JR application on 4 May and duly cancelled the removal directions.

A file note says that:

> "Following re-examination of this and another similar case, Treasury Solicitors advised that our ECAA refusal letter was inadequate and needed to be re-written and re-issued if the decision was to stand up to the scrutiny of the Court. The related case was referred to Sheffield as a 'test case' on 24/25 May and they produced a revised refusal notice. In light of this, and following further discussion with Treasury Solicitors, we suggested doing the same with Mr K's case, provided that [the solicitors] first withdrew the JR application."

There followed further consultation with Managed Migration Directorate (part of the Immigration and Nationality Directorate) and Treasury Solicitors in relation to the ECAA.

On 5 May, the man attended the John Radcliffe Hospital in Oxford in connection with a skin problem. The escort risk assessment shows that there were no Incident Reports or Security Information Reports about him. Nevertheless, the boxes for Likely to abscond, Harm to public, detainees or staff, Likely damage to property, Preventing their own movement from UK, and Preventing movement of another detainee, are all marked in the affirmative. The man was duly handcuffed to an officer (although the handcuffs were apparently removed during the consultation).

The man saw a nurse at Campsfield House the next day. His medical notes said that he remained concerned about the swelling on his testicle and wanted to know what was likely to happen in the future.

On 10 May, the doctor wrote to the specialist to say that the problem was causing the man increasing distress and pain. He asked if the specialist would consider excision.

On 14 May, the man was found in his room in some pain. He could not stretch his leg and said he was bleeding. The nurse attended. She apparently told an officer that the man was prescribed medication for the problem with his testicle but had not collected his medicine the previous Friday. She also said she had offered him medication, but he had refused to

take it. His medical notes state that he did not think the medication was helping and was upset at the time the hospital referral was taking. The nurse has noted that they discussed his situation via an interpreter.

The man saw a nurse later the same day and again insisted the referral was taking too long – he wanted the operation immediately. The nurse noted that she advised and reassured him about the policy and that he apologised and re-commenced his medication.

The re-scheduled bail hearing took place in Birmingham on 18 May. Bail was refused. Discussion about the ECAA was ongoing at this time.

An Afghan detainee to whom the man spoke on the night of his death said that, about four weeks previously, the man had showed him a razor and said he had thought about cutting himself. The detainee told him that his mother and father were waiting for him and that, "This was not good." The man had apparently said okay and thrown the razor in the bin. After that, he was happy and laughing until about five days before his death when another Turkish national had tried to cut himself. The Afghan detainee speculated that this reminded the man about committing suicide.

On 2 June, the man reported to healthcare saying that he felt nauseous and had vomited after breakfast. He wanted to discuss surgery with the doctor once again. On 4 June, he presented again, this time complaining of chest pains. He enquired once again about progress with his referral. The nurse commented, "Is becoming unpleasant about the whole situation. He feels we are not doing enough for him."

On 14 June, the man's solicitors agreed to withdraw the JR application provided that the Immigration Service also withdrew and re-considered its decision to refuse the man's ECAA application. The solicitors also requested that the man be given temporary admission or, failing that, CIO bail. The latter was considered by the CIO the following day, and refused on the grounds that the CIO was not satisfied the man would comply with any conditions of release. He added:

> "I am led to believe that his case will be resolved speedily, and that his continued detention is proportionate, lawful and appropriate.
>
> "You do have the option of applying for Bail in front of an Immigration Judge (Adjudicator's Bail). I would remind you that your previous application was not successful."

The man's next of kin told Miss McMurray and Ms Phelan that the solicitor was not a family friend but the interpreter who acted as intermediary was. The next of kin considered that the solicitors had done their best for his relative. He also said that his relative was fully aware of, and in agreement with, everything that was being done on his behalf and discussed it frequently with his family. The man was apparently due another bail hearing shortly after his death. The next of kin said that the man had said that, if the application

was again unsuccessful, he would return voluntarily to Turkey. The next of kin also said that at no time had his relation presented as being particularly depressed. However, as a young man who had committed no crime, he was naturally fed up with being detained.

On 15 June, the man attended healthcare complaining of pain in his right ear. Two days later he complained of feeling listless.

The IND official tasked with the review of the man's case reported:

> "I have also had a look at file to establish what has happened since 15/06, when [named officer] responded to the sols request for CIO bail. The file went to an IO on 16/06 to complete a detention review and was tracked to [named officer] the following day (although as [the second named officer] does not work on Fridays she did not see the file until Monday 20/06). [The second named officer] was unable to deal with the case immediately and therefore sent the file to yourself and [third named officer] to sign off the latest detention review on 21/06. The file was not tracked after this but it was returned to [the second named officer's] desk on either 22/06 or 23/06."

The final monthly progress report, dated 19 June, was identical to previous ones except that it referred to the refusal of the ECAA application, the setting and cancelling of the removal directions and the lodging of the Judicial Review application. The letter advised, "As you have withdrawn the Judicial Review application on 14 June 2005 your removal from the UK can be re-arranged." (This does not seem to be in keeping with the agreement with the solicitors that the Immigration Service would re-consider the application.)

On 20 June, the man again presented to healthcare. He complained that his skin complaint was not getting any better and that he had been feeling dizzy for some time. He was seen again on 24 June. His medical record says, "indigestion/headache/insomnia – all stress related".

During his five months of detention, the man put in numerous applications to be updated on progress with his case. These were dated 22 (x2), 23, 24 and 25 April, 3, 9, 14, 19, 23, 26 and 30 May, 2, 4, 11, 17 and 22 June. Most of the responses said that there was nothing new to report or referred him to his solicitor.

The man's next of kin told my investigators that a relation spoke to the man every couple of days. He and other family members made sure that the man always had sufficient money to enable him to make telephone calls. As a result, he was able to keep in regular contact with family here and in Turkey. He had last spoken to his father on the Sunday (26 June, the day before his death). In addition, he received a total of 11 visits and knew he was due a visit by the relation on the day he died. The man's family could not understand why he had killed himself, knowing that he was to receive a visit that day. The relation confirmed that the man never seemed particularly down, stressed or depressed. The next of kin's father (who owns two

businesses in London) was prepared to stand bail for the man and he was aware of this. However, everything seemed to move very slowly and the man found this frustrating and all the delays hard to understand. He was not worried about his impending operation, however. On the contrary, he was looking forward to it as the problem was causing him considerable discomfort.

4. The man's death

A detainee told the police that he had noticed during Sunday 26 June that the man was not smiling in his usual way – "He did smile but it was not a true happy smile." He said the last time he saw him was at about 9:30 – 9:45 pm in the prayer room. He said the man appeared to be deep in thought and was staring and had a blank look on his face.

During the evening of 26 June, the man was given a ticking off by staff for kicking over some chess pieces. It was perceived to be nothing more serious than the behaviour of a typical teenager and the ticking off was apparently quite mild. The shift manager told him that if he misbehaved again he would be put in the seven-man dormitory. At lock down, the man had asked whether he should move to his new room. The shift manager advised him that he had only been joking and that he could stay where he was as long as he behaved. The incident was not considered serious.

An Afghan detainee also provided a statement to the police. He explained that rooms at Campsfield House were not locked, so that detainees could visit each other whenever they liked. He said that, at about 12:30am on 27 June, the man went to his (the Afghan detainee's) room and sat on his bed. He said he had been at the centre for 4 months and 15 days. The detainee said the man sounded very sad, although he was not crying. He apparently said that he did not know what to do. The detainee said he tried to reason with the man and to tell him that he was young and had his whole future to look forward to. The man had then told the detainee that his father had borrowed £20,000 and that he was sent to the United Kingdom because his life was not safe at home. He did not expand on this. The man also said that if he was sent back to Turkey he would have to serve two years National Service and "if he was still alive" would then have to find £20,000 to repay his father's debt and £4,000 to pay for a solicitor. The detainee tried to tell the man that everything would be all right, but the man was not persuaded.

At around 1:30 am, the detainee told the man that he would have to go back to his own room as he (the Afghan detainee) wanted to get three hours sleep before getting up for prayers. The man was reluctant to go, however. They chatted about sleeping tablets and the man also revealed that he was due to have an operation on 17 July. He said Immigration had told him that he would have to go back to Italy after that (there is no record of this in the Immigration Service files). The detainee said that the man was also worried that, if he was sent to Italy, he would be used in sex movies, adding that he was not gay. The detainee said the man did not say whether this had happened to him previously or whether it was just something he had heard about.

The detainee said the man said he wanted to cut his hand or hang himself. He said he thought he was joking, but nevertheless he told him that he would go to hell forever if he killed himself and that he must never do it. The man had apparently smiled and said he was only joking, finally leaving the Afghan detainee's room at 1:30 am, asking him to call him for early morning prayers.

He said twice that, if he did not wake up, the Afghan detainee should put cold water on his leg.

The Afghan detainee was awoken between 3:15 and 3:30 am by a friend. He went to the man's room and tried to open the door, but could only move it about an inch. He could see the light was on and that the man was not in his bed. He thought this was strange and went to fetch his friend. The friend also tried the door, but again could not move it. He said they would have to leave it for staff to sort out in the morning.

The Afghan detainee was not happy, however, and went to fetch a third detainee. He too tried the door without success. They thought about using the white phone on the passage wall, but decided to find an officer. They knew there would be two on the induction block. (In fact, the emergency phones have never been used in this way. In addition, there is no equivalent to the Prison Service cell-bell system for raising the alarm in an emergency.)

A Detention Custody Officer (DCO) answered the door to the induction block (it is locked off from the residential area). The detainees told him what had happened and he made a phonecall. (The DCO told my investigator that he was ascertaining whether the man was still located in the same room.)

The DCO then accompanied the two detainees up to the man's room. (Miss McMurray later walked the distance with the DCO. The walk went along a couple of corridors and one set of stairs. Walking at normal pace, it took no longer than a couple of minutes.) The DCO said he tried the door himself but could not open it. The shift supervisor had arrived by this time and gave him permission to force it. He therefore applied his shoulder to the door and forced it, breaking the restraining hinge away from the doorframe. He said that he did not at first see anything and that detainees sometimes played jokes by hiding. However, when he looked behind the door he found the man hanging by a belt from the restraining hinge. He asked the shift supervisor to call for back-up. Her call was timed at 3:35 am.

The Afghan detainee and the DCO got hold of the man's legs to support his weight. The DCO told the other detainee to untie the knot. The detainee untied the knot around the door hinge and they lifted the man down on to the bed. The second detainee said that the man's joints were still flexible and his flesh was still slightly warm.

Once she had called for both back-up and an ambulance, the shift supervisor detailed a member of staff to wait for the ambulance. She then left the area to liaise with the duty shift manager, whom she met in the crew room corridor. He asked her to contact healthcare, Broadway (GSL's headquarters) and the Chaplain, which she did. The shift supervisor told Miss McMurray that no other staff had arrived at the man's room when she left to find the duty shift manager.

The DCO told my investigator that he tried to find a pulse but his hands were shaking badly and he could not tell for certain if there was one. While he was

trying, another DCO arrived followed shortly afterwards by a third. Miss McMurray asked the first DCO about the speed of the response. He explained that staff in the control room had watched on the CCTV screens as he walked to the room. As soon as they saw him trying to force the door they raised the alarm.

Miss McMurray also asked the first DCO if he would have commenced resuscitation had the others not arrived. He said his first aid certificate had expired the previous day. He had been on leave when his refresher training was due to take place.

The second DCO to arrive said he had been in the gymnasium when he heard the call over the radio for general assistance. He said the transmission had been broken and that he had therefore telephoned to find out what was going on. He was told it was a general medical emergency.

He said he then sprinted from the gymnasium, overtaking the shift manager on the way. He said he arrived just as the man was being placed on the bed. He saw someone removing the belt from around the man's neck, but could not recall who had done this. He said he could see marks on the neck where the ligature had been. The man's eyes were wide open.

The DCO described how he had fumbled with the bag on his belt containing the mouthpiece for giving artificial respiration. He thought in the event he had borrowed the third DCO's, but found on checking that his own was missing, meaning that he must have managed to get it out. He said he checked that the airway was clear and then he gave mouth to mouth while the third DCO administered CPR. The DCO said he gave a few really deep breaths. He could hear a gargling noise coming from the man's chest and thought he must have fluid on the lungs. He asked the others what they could do about that. The first DCO pointed out that the bed was not firm enough to enable effective resuscitation. They therefore moved the man to the floor.

The second DCO said that when he re-commenced giving mouth to mouth, he caught his own mouth on the man's tooth. He had given some more really deep breaths but nothing was happening. He said he simply could not do any more – from smell and touch, the man was clearly dead. Catching his mouth was the final straw. He made way for others to continue. He thought it was about two minutes later that the ambulance had arrived. The DCO said he waited outside until death was confirmed. He added that it was the first time he had had to administer first aid. He said, however, that he responded instinctively in light of the training he had had. He was certain that they had done all they could do – it was clear before they began that the man was dead.

The third DCO told Miss McMurray that, at about 3:00 am, he went to the control room to see a friend. They spent perhaps 15 minutes chatting. The DCO had worked in the control room and was therefore familiar with the cameras. He had looked at one and seen the first DCO and the supervisor walking along a corridor with two detainees. He had a gut feeling that

something was not right and that he needed to be ready. He started running as soon as he saw the DCO apply his arm to the door. Whilst he was running, he radioed for general assistance.

When he got to the room, the man was already on the bed. He moved a blue chair out of the way, as it was a single room and there was not much space. The first DCO had tried to find a pulse but could not do so. The third DCO then tried. He said he felt for a pulse in the neck as that would be the last one to go. He found nothing.

The DCO said that the room was boiling hot and that the man felt clammy to the touch. He soon became quite cold, however.

At the second DCO's instigation, they then commenced resuscitation on the bed, but subsequently moved the man onto the floor. After a while, the second DCO stopped – the third DCO said he was having difficulty in the small room because of his size – and the third DCO took over mouth to mouth. A fourth DCO took over from him on CPR. The DCO said there was no break while the changeover took place and that they continued with resuscitation for about five, six or seven minutes. There were no signs of life.

The shift manager said in a statement that he responded to the call for assistance and arrived at the man's room to find the third DCO trying to locate a pulse. He was told what had happened and immediately called for an ambulance. He also told the officers present to clear the corridor and lock off both ends. He was aware that staff had begun resuscitation, so told others present to stay on the block in case other detainees became aroused. He then left the area to carry out his responsibilities as laid down in the Contingency Plans.

The fourth DCO told Miss McMurray that she had been in the crew room when she heard the call for general assistance. No details about the nature of the emergency were given. She had immediately run towards the man's room, and as she did so, more information was given over the radio. She said everyone had been a bit confused, but that her initial thought was that the man had cut himself, as she heard someone talking about his neck. The first DCO had been coming out of the room as she arrived.

The third DCO arrived just after she did and went past her into the room. She said he and the second DCO tried to resuscitate the man on the bed. The mattress had not been firm enough, however, and they had moved him to the floor. She said that she stood in the doorway whilst this was going on. The supervisor had gone to fetch the shift manager.

At this stage, officers had locked off the gates to prevent other detainees seeing what was going on.

The fourth DCO said that the third DCO administered CPR while the second DCO gave mouth to mouth. He had given some deep breaths but it was not working. She said he became upset. She therefore told the third DCO to

move up and relieved him on CPR while he took over mouth to mouth. She thought they had continued for about seven or eight minutes before the paramedics arrived. When they did so, she vacated the room and stayed in the corridor. However, the third DCO was trapped in a corner. Several other officers were present, but the shift supervisor and shift manager had gone to do other things.

The fourth DCO said that the paramedics seemed to know what to expect when they arrived, although the male paramedic had run back to the ambulance at one point to get some additional equipment. However, they seemed to have most of what they needed in the bag they brought with them.

Miss McMurray asked the DCO whether the response to incidents was always so quick at Campsfield House. She said it was, although in this case the fact that the control room had seen on camera what was going on had speeded things up.

The shift manager said that he returned to the room when the paramedics arrived. He then asked officers to remove the detainees from the rooms on either side of the man's room.

Logs from Campsfield House show that an ambulance was called at 3:36 am by an officer who also broadcast a call for general assistance to all available call signs. The ambulance arrived at the main gate at 3:40 am and paramedics were at the man's room by 3:44 am. They emerged at 4:04 am having declared the man dead.

Other personnel arrived equally promptly. The duty manager arrived at 4:12 am, the police at 4:40 am, the centre manager at 4:42 am, the nursing manager at 5:02 am, the IMB member at 5:14 am and the contract monitor at 6:10 am.

5. After the death

Following the man's death, both detainees involved in discovering him were placed on suicide and self-harm watch. (Miss McMurray noted that photographs of those on SASH were displayed with relevant information on a noticeboard in the shift manager's office.) One of the detainees was subsequently removed from special supervision, but the Afghan detainee was still on SASH watch when he was removed from this country on 5 July. Miss McMurray met him very briefly before his removal. He was clearly (visibly) extremely shocked and upset. The centre manager had arranged for external agencies to visit Campsfield House to support the two detainees.

The centre manager told me that there was no requirement for detainees to provide the name of their next of kin. They had therefore to sift through their records to identify someone. Third Country Unit in Croydon was also contacted for details of any family information on file. In the event, they discovered the name of a relative from Leamington Spa on the man's visits list. The Sheikh had contacted him by phone and four relatives had attended the centre within ten hours of the death being discovered. They did not take any property with them at this stage, though I gather one relation has since attended the centre to collect it. (The family was concerned when Miss McMurray and Ms Phelan spoke to them that the man had promised to let them have a photo of himself. Sadly, this had not been amongst his property.)

I spoke to the contract monitor about the arrangements for informing next of kin of a death in immigration detention. She told me that the Operating Standards for Immigration Removal Centres on Deaths in Custody states that either the contract monitor or on-call senior manager should inform the next of kin. (Worryingly, the contract monitor had tried to ring the senior on-call manager as soon as she was informed of the death at about 3:50 am. She could not get a reply and therefore rang another senior manager.) The contract monitor told me that she was very uncomfortable with this and did not consider it was appropriate. She also noted that there was nothing in the contract monitor training to prepare for this eventuality. She said that, in the event, they had decided to ask the police to inform the next of kin. However, Warwickshire police said they were dealing with 27 incidents and could not guarantee a time. In the end, the Imam rang the man's uncle with the news.

Campsfield House has a care team, which mobilised after the man's death. In addition, the centre manager arranged for ICAS counsellors to attend on the Thursday (30 June) to support staff. He also put the entire management team at the disposal of staff "at any time of night or day". The staff whom Miss McMurray interviewed spoke warmly of the support they had received.

Both the contract monitor and the IMB told me they were impressed with the way the centre manager had responded. The IMB commented particularly on the briefing he had given to staff and said that detainees had been "beautifully handled". They said that there was a low profile but high presence of staff

and that they had used good interpersonal skills. They were also impressed by the Sheikh's "quiet dignity".

However, the IMB told me they considered the contract monitor had not been offered adequate support. They thought a senior manager from headquarters should have attended the centre. In the event, the IMB chair had rung the Deputy Director of Detention Services to say that the contract monitor needed support.

Whilst she expressed some concern herself to me on this score at the time, however, the contract monitor has since said she considered the level of support given to her was fine.

I was told that the IMB planned to visit Campsfield House every day during the week following the man's death. I was also given a copy of the IMB's own Contingency Plans. These set out clearly what is required of a member attending the centre during or immediately after a serious incident. It also gives some practical tips.

6. The man's family

When Miss McMurray and Ms Phelan spoke to them, the man's family had no criticisms of the way they were informed about his death or of their treatment when they visited the centre.

They had two principal concerns:

- Why the man was allowed to retain belt, sheets, laces etc. They said the centre had a duty to look after him. As a young man who had been detained for five months, he was always likely to be vulnerable;
- That a young man had been detained for five months. They were quite bitter about the role of the Immigration Service leading up to the man's death.

7. Post mortem

The pathologist concluded that a fabric belt had been used as a ligature and that the man died as a result of compression of the neck. There were no injuries to indicate that he had been the victim of a violent assault immediately prior to his death and no defensive or restraint injuries were seen.

The cause of death was given as hanging.

8. Examination of the issues

My investigation has revealed that healthcare staff at Campsfield House do not conduct suicide and self-harm assessments on newly arrived detainees. This is a cause for concern. Although I was told that staff carry out their own assessment, this is not the same as a formal process conducted in privacy with a trained healthcare professional. Given that the man had been at the centre for between four and five months before he died and had given no cause for concern, I do not judge that this omission was related in any way to his death. However, it is something that should be rectified as soon as possible.

I recommend that routine screening by healthcare professionals for suicide and self-harm risk is introduced immediately.

I also note that Campsfield House is currently unable to meet the Operating Standards for Immigration Service Removal Centres requiring detainees to be seen by a healthcare professional within two hours of arrival, because the centre does not enjoy round the clock medical cover. Such cover has been agreed in principle, but its introduction has been delayed pending inception of a new contract in April next year.

I recommend that 24-hour medical cover be provided immediately.

The man had a number of healthcare problems and was referred to outside specialists on various occasions. I was concerned to note that a risk assessment completed before one visit to a hospital suggested that he was likely to abscond, harm the public, detainees or staff, damage property, and so on. I can find no justification for this assessment. (I note that HM Chief Inspector of Prisons recorded in her latest report that her recommendation that there should be a presumption against the use of restraints for detainees attending outside hospitals had not been achieved.)

I recommend that GSL instructs its staff to conduct individualised risk assessments based on objective evidence when determining whether to handcuff detainees.

I recommend that the contract monitor conducts regular reviews of the use of handcuffs.

Whereas prisoners are statistically less likely to kill themselves as they move through their sentence, the opposite may be true for detainees. The fact of detention itself, and the very real prospect of being returned somewhere they do not wish to go, are inherently stressful. In the man in question’s case, these strains may have manifested themselves in a range of physical symptoms. It is important, therefore, that the question of self-harm and suicide risk be kept under review throughout the period of detention.

I recommend that healthcare staff be required to carry out risk assessments for suicide and self-harm at no more than monthly intervals.

The man apparently spoke to a fellow detainee about his fears for the future on the night he died. He specifically spoke about killing himself, although he subsequently said he was joking. Nevertheless, the detainee was concerned enough by what he had said to be worried when he could not open the man's door. This was not the first time that he had talked about harming himself. On neither occasion, however, did the detainee to whom he spoke mention their conversation to staff. Steps need to be taken at removal centres to raise detainee awareness of the possibility of self-harm or suicide, to be on the watch for any indications of risk and to report them to staff.

I recommend that a self-harm and suicide awareness session be included in all detainee induction programmes and that awareness be further raised by posters around each centre. Detainees should be encouraged to raise any concerns with a member of staff.

I share the concern of the man's family about the length of his detention. The law governing immigration detention makes clear that temporary release should be the norm and that detention should only be used where no other measures appear adequate for managing the applicant. It also says that the matter should be kept under review.

In the man in question's case, I cannot say that the original decision to take him into detention was wrong. He had been caught clearly trying to evade immigration controls and had no documentation to prove his nationality or his identity. On the face of it, his case appeared to be capable of early resolution and he was therefore allocated to the fast track process at Oakington.

It subsequently transpired, however, that he had already applied for asylum in Italy and was therefore a third country case. At this point, his case might still have been susceptible to swift resolution, but his solicitors then lodged an application under the Turkish EC Association Agreement. Given that no decisions were being taken in relation to Turkish nationals at that time, it might be argued that the man should have been released at this point, since no-one could say how long the process might take. Temporary release might also have been considered once the application for JR was submitted, as this was likely to delay a final determination for some time.

Concern over his lack of documentation and his clandestine entry into the country appear to have remained the overriding concerns. I understand that the man's circumstances did not change in this respect, but I have seen nothing to suggest that the strength of these concerns was ever re-assessed in light of the delays in progressing his case. In fact, I am not persuaded that the matter was reviewed in any meaningful sense and view with concern the fact that it was not reviewed at all between 15 March and 17 June. I also note that HMCIP expressed concerns on this matter in her most recent inspection report.

I recommend that caseworking officers be reminded of the need to carry out meaningful reviews of detention that re-assess the weight to be afforded to earlier considerations in light of progress on the case.

In addition, I am not persuaded that a decision whether or not to continue to detain can properly be made on the basis of papers alone. There is much circumstantial evidence that indefinite detention can lead to a deterioration in either mental or physical health or both. These factors should be taken carefully into consideration, in consultation with those who deal with the detainee on a day to day basis.

I recommend that Immigration Officers be required to consult residential and healthcare staff when reviewing continued detention.

In his reasons for opposing bail, the CIO set out a number of factors relating to the probity of the sureties. In a nutshell, he had insufficient information about them to be certain that they would be effective in guaranteeing the man's compliance. I do not know if these same considerations applied when the man's application for bail was turned down in May. However, it is a matter for concern that a court's time could potentially be wasted due to inadequacy of information and that a detainee's legitimate right to be considered for bail should be curtailed because someone had not provided the proper paperwork. I fully accept that detainees and their legal representatives have responsibilities in this matter. But it must also be remembered that detainees are at a real disadvantage through ignorance and communication problems.

I recommend that Immigration Officers are instructed to take a more proactive role in ensuring that all relevant information is to hand for bail hearings to enable a proper consideration of the application.

Turning to the man's care at Campsfield House, it was clear that he was well known to staff and that they engaged with him on a regular basis. Many played sport or games with him. All were shocked by his death and said there had been absolutely no indication that he was down or depressed. They also thought it unlikely that he was bullied, partly because he got on well with everyone and partly because his relationship with staff was such that they were sure he would have mentioned it to them. I have found nothing to suggest that residential staff missed any indications of what was to come.

Much of the accommodation at Campsfield House is shared. On the night of his death, however, the man was in a single room. This was at his own request and was a reward for his good behaviour. It was also granted in recognition of his long stay at the centre. The shift manager told Miss McMurray that he considered that the use of single rooms was a major point of vulnerability at the centre. He noted that detainees tended to become more stressed over time and, for this reason, the risk of them self-harming increased. He suggested that this made the granting of single accommodation to long term detainees inappropriate.

I acknowledge the point the shift manager makes. However, I am also mindful of the fact that many detainees could safely be allocated single rooms and that this would be considered by them to be something eminently desirable. The availability of single rooms can therefore be a worthwhile part of any earned privilege scheme. There is also a much more basic question of humanity. The stresses of being detained in a foreign country where you do not understand the language and do not know what the future holds must be difficult to cope with. To have to do so when you are constantly in the company of others would be an additional trial for many. Finally, some measure of privacy, where this is possible, is something to which all detainees should be entitled. I do not agree, therefore, that Campsfield House should abolish its single rooms.

However, I do consider that allocation could be more safely managed and that detainees should be risk assessed by medical staff and others before they are allocated a single room. This should entail an interview with the detainee to ascertain his current state of mind.

I recommend that all detainees are risk assessed before being allocated single rooms.

I was also concerned to note during my own visit to Campsfield that the restraining hinge on the door lent itself so readily as a ligature point. There were, however, a number of other points that could have been used. Ideally, all rooms should be 'safer rooms' – that is, as far as possible they should be free from features that can facilitate a suicide attempt – but the need is particularly great in a single room where there is no-one to watch over the occupant.

I recommend that the single rooms at Campsfield House be modified to make them safer.

More generally, I have considered the family's concern that the man was allowed to retain in his possession items such as a belt, shoelaces and bedding, all of which could be employed as ligatures. In removal centres, as indeed in prisons, there is a need to strike a proper balance between the duty of care to persons detained and ensuring they are treated humanely and decently. The man was well known to staff and was not considered by any of them to be likely to attempt self-harm. In light of this, it would simply not have been appropriate to deny him the basic dignity of allowing him to retain his belts and shoelaces and proper, comfortable bedding. On the contrary, denying him these things would have been likely to lower his sense of self worth, increase his frustration and any depression and make him more likely to try to harm himself. I cannot criticise Campsfield House in this respect.

The police statements by the two detainees indicate that they chose to go to fetch a member of staff when they could not open the man's door. But I discovered that in fact there was no other means of summoning help. There is no system analogous to the Prison Service cell bell arrangements. I have no reason to believe that the outcome would have been any different had the

first DCO reached the room minutes earlier, but in other cases, the loss of minutes or even seconds might be crucial.

I recommend that a system for summoning staff in an emergency that is quickly accessible to all detainees be introduced at Campsfield House.

The priority when someone is found to have hanged themselves is to remove the ligature from around the neck and administer first aid. Ideally, two people are required for this – one to support the body and the other to release the ligature and then one to administer mouth to mouth resuscitation and one to give CPR. However, the shift supervisor left the area before any other staff arrived, leaving the DCO and two detainees to deal with the situation. This was not appropriate.

I recommend that the centre manager reminds staff that their first priority on discovering someone hanging must be resuscitation.

In this context, it is worth noting that, following the discovery of an apparent suicide at Harmondsworth Immigration Removal Centre in July 2004, detainees rioted causing significant damage. Detainees at Campsfield House are not locked in their rooms at night and could well have reacted in a similar manner. For this reason also, the shift supervisor should have stayed at the man's room until other staff arrived.

One DCO told Miss McMurray that staff used to carry knives for cutting through ligatures but that they stopped doing so. In this case, they were able to untie the ligature because two men were able to support the body whilst the third untied the knot. This would not have been possible had the DCO been on his own. Speed in releasing a ligature can be crucial in saving lives.

I recommend that front line staff be required to carry so-called fish knives[7] at all times.

It is also a matter of concern that the first DCO's first aid certification had expired. I assume that he would nevertheless have begun resuscitation if the others had not arrived when they did, but it is crucial that all those staff likely to discover someone in a life-threatening situation are properly trained to deal with it. This is especially the case where there is not 24-hour medical cover.

I recommend that GSL takes steps to ensure that no DCO's first aid certification is allowed to lapse.

Miss McMurray was told that the call that was put out following discovery of the man's death was non-specific. Staff responded not knowing whether they were going to a riot, a fight, a barricade or a suicide. I consider it would be helpful if they had a few extra moments in which to prepare mentally for

[7] Fish knives are so called because they look like a fish. The blade is not on an outward facing edge and so cannot be used as a conventional knife and is less prone to accidental cutting.

whatever they will face and that information about the type of emergency should therefore be provided.

I recommend that GSL develops code signals for different types of emergency.

The IMB raised with me their concern that the contract monitor was inadequately supported from Immigration Service headquarters. I agree. Contract monitors are relatively junior grades and it is not appropriate that they should be advised at arm's length by their managers following a death in custody. A senior manager from IND should have attended the centre on the day of the man's death to support the contract monitor and ensure that all necessary action was taken by both the contractor and the Immigration Service.

I recommend that IND reviews its policy for handling serious incidents.

I am also concerned that the contract monitor was unable to raise the on-call senior manager. This can only have added to the pressure on her.

I recommend that IND inquires into the failure of the on-call manager to respond and takes action to ensure the situation is not repeated.

I understand that there is no requirement for detainees to give the name of a next of kin on arrival at a removal centre, although they are asked for them. Staff identified one of the man's relatives from his visits record, but there was considerable confusion about whom should properly be regarded as next of kin. The police finally decided on one individual as the appropriate representative, and I have taken their lead. The position would have been much clearer, however, if the man had been asked to give details for next of kin on arrival. The ready availability of such information would also ensure that delays in contacting the next of kin in the event of a fatality are kept to a minimum.

I recommend that detainees be encouraged to give next of kin details on arrival at a removal centre.

I consider the requirement that it should be the contract monitor who contacts the next of kin to be wholly inappropriate.

I recommend that the Immigration Service reviews the provision for contacting next of kin.

I end on two notes of praise. I was impressed to note that the Campsfield House IMB has a Contingency Plan for dealing with serious incidents. It is detailed and offers sensible and appropriate advice on what an IMB member should do if he or she is called to the centre as the result of a serious incident.

I recommend that all IMBs draw up contingency plans for dealing with serious incidents.

I was also pleased to note that the IMB planned to visit the centre every day following the man's death. This too is good practice and to be commended.

Finally, I should record my admiration for the way staff at Campsfield House responded to the man's death. Their response was extraordinarily quick. All three officers involved in trying to resuscitate the man were young and this must have been a harrowing experience for them. It is greatly to their credit that they reacted with such professionalism. They are to be commended.

9. Conclusion

This man's death is the fourth self-inflicted death in an immigration removal centre that I have investigated since I took over this area of work. In two cases - this and another - the death came without any warning and after the detainee had been detained for some time. Both spoke almost no English. Although the amount of engagement between staff and the detainee differed considerably, it is possible that changes in both detainees' state of mind went unnoticed by staff because of communication barriers, relating to both language and cultural behaviour.

This is a particularly tough challenge for those charged with the care of immigration detainees. They must use all the resources at their disposal to meet it. This means effective engagement between detainees and staff. It means raising awareness of self-harm and suicide amongst detainees and those making detention decisions. And it means building systems for ongoing healthcare assessments of risk.

Recommendations

1. I recommend that routine screening by healthcare professionals for suicide and self-harm risk is introduced immediately.

2. I recommend that 24-hour medical cover be provided immediately.

3. I recommend that GSL instructs its staff to conduct individualised risk assessments based on objective evidence when determining whether to handcuff detainees.

4. I recommend that the contract monitor conducts regular reviews of the use of handcuffs.

5. I recommend that healthcare staff be required to carry out risk assessments for suicide and self-harm at no more than monthly intervals.

6. I recommend that a self-harm and suicide awareness session be included in all detainee induction programmes and that awareness be further raised by posters around each centre. Detainees should be encouraged to raise any concerns with a member of staff.

7. I recommend that caseworking officers be reminded of the need to carry out meaningful reviews of detention that re-assess the weight to be afforded to earlier considerations in light of progress on the case.

8. I recommend that Immigration Officers be required to consult residential and healthcare staff when reviewing continued detention.

9. I recommend that Immigration Officers are instructed to take a more proactive role in ensuring that all relevant information is to hand for bail hearings to enable a proper consideration of the application.

10. I recommend that all detainees are risk assessed before being allocated single rooms.

11. I recommend that the single rooms at Campsfield House be modified to make them safe.

12. I recommend that a system for summoning staff in an emergency that is quickly accessible to all detainees be introduced at Campsfield House.

13. I recommend that the centre manager reminds staff that their first priority on discovering someone hanging must be resuscitation.

14. I recommend that front line staff be required to carry so-called fish knives at all times.

15. I recommend that GSL takes steps to ensure that no DCO's first aid certification is allowed to lapse.

16. I recommend that GSL develops code signals for different types of emergency.

17. I recommend that IND reviews its policy for handling serious incidents.

18. I recommend that IND inquires into the failure of the on-call manager to respond and takes action to ensure the situation is not repeated.

19. I recommend that detainees be encouraged to give next of kin details on arrival at a removal centre.

20. I recommend that the Immigration Service reviews the provision for contacting next of kin.

21. I recommend that all IMBs draw up contingency plans for dealing with serious incidents.