

**Investigation into the circumstances surrounding the
death of a man
at Campsfield House in August 2011**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

October 2012

This is the report of an investigation into the circumstances of the death of a man at Campsfield House Immigration Removal Centre in August 2011. He was a 31 year old Moldovan national, arrived at Campsfield House in July and was found hanging in the shower room two days later.

I offer my condolences to the man's family and friends for their loss. The investigation was carried out by an investigator and a clinical reviewer completed a review of his clinical care. I apologise for the delay in issuing this report.

The man was arrested on 29 July 2011 by Dyfed-Powys police immediately on release from a four month prison sentence at HMP Wandsworth. After being taken to a Police Station and questioned, he was bailed. In an apparent error, he was served with immigration detention papers and transferred to Campsfield House Immigration Removal Centre.

The United Kingdom Border Agency decided that there were no grounds to detain him, as he could not at that time be removed from the UK because of the outstanding police enquiries. Arrangements were made to release him from Campsfield House the next day. Northamptonshire Police then contacted Campsfield House to arrange to arrest him in connection with a serious charge. The following morning, before he was released, he hanged himself. Nurses attempted to resuscitate him but he was pronounced dead by paramedics at 12.08pm.

Although there is a technical question over whether the man should have been in Campsfield House at the time of his death, his detention was lawful; it was because he was facing further police questioning and could not yet be removed from the country that it was decided he should be released. Campsfield House did not inform him that the police were coming to arrest him but he knew from talking to his solicitor the day before that the police intended to question him about an alleged offence of rape.

It would have been difficult for Campsfield House to have foreseen the man's actions and prevent his death. Nevertheless, this investigation has exposed some serious deficiencies in emergency response procedures. In particular, it is essential for there to be sufficient trained healthcare and other staff on duty at all times who are competent to administer emergency first aid. It is also disappointing that a recommendation for the introduction of emergency codes to expedite and improve emergency responses, which we made after a previous death at Campsfield, had not been implemented. Other areas for learning were also identified, including the need for a more comprehensive health and risk screen for new arrivals, the scope for improved communication between UKBA and the police, and – again repeating a previous recommendation – the need for better procedures to obtain and record the details of next of kin. I trust that, in light of his death, all our recommendations will be accepted and implemented expeditiously.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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SUMMARY

1. The man, a Moldovan, first came to the UK in October 2002 and made an unsuccessful claim for asylum. He remained in the country and, on 29 May 2011, he was arrested for using a false identity document and sentenced to four months in HMP Wandsworth. While he was in custody, two police forces expressed an interest in interviewing him about other offences. On 29 July, he was arrested by Dyfed-Powys Police immediately on release from Wandsworth and taken to Aberystwyth for questioning. (This is known as gate arrest.)
2. Dyfed-Powys police bailed him until 11 August but apparently erroneously served him with immigration detention documents. Instead of being released from police custody he transferred to Campsfield House Immigration Removal Centre.
3. The man arrived at Campsfield House at 1.06pm on 31 July and went through the reception process. A Detention Custody Officer (DCO) spoke with him about his history of depression but he said he was fine. He was also seen by a nurse who did not have any concerns about him. He spent his first night on the Short Stay Unit (SSU).
4. The next day, 1 August, he attended induction and had a routine welfare check. Again, no concerns were recorded, although staff described him as very quiet. At midday, he telephoned his solicitor, who told him that Northamptonshire Police wanted to interview him about an alleged offence of rape and she would get back to him once she knew when they intended to interview him.
5. The man's brother visited that afternoon and recalled that he was very distressed and confused. Later that day, UKBA staff told him that he was being temporarily released as there was no immediate prospect of him being removed from the UK because of the outstanding police enquiries. Northamptonshire Police later arranged with UKBA staff at Campsfield House that they would arrest him on his release from immigration detention.
6. Campsfield House staff say they did not tell the man of the impending arrest, but the next morning his brother said he had phoned him and said that the police were coming to collect him. When the police arrived staff went to get him but were unable to find him. They called his mobile phone which they heard ringing in the shower. After getting no response they unlocked the door and found him hanging from a ligature made of shoelaces. No pulse could be found. Two nurses arrived and began a resuscitation effort. He was pronounced dead by paramedics at 12.08pm.
7. We make six recommendations as a result of our investigation, two of which relate to the resuscitation and the need for more comprehensive training. A further recommendation relates to the need for a code system to communicate the nature of an emergency. We also recommend the development of a more robust reception health screen. One recommendation

concerns communication between UKBA and the police. The final recommendation relates to obtaining detainees' next of kin details.

THE INVESTIGATION PROCESS

8. The investigator visited Campsfield House Immigration Removal Centre on 9 August 2011 to open the investigation and collect documents relating to the man. She met two members of staff from MITIE, the company which runs Campsfield House, the centre manager and the Bid Director for Care and Custody. She also met the Deputy UKBA Manager.
9. The investigator visited the short stay unit where the man died and the rest of the centre. Notices of the investigation inviting staff and detainees to contact the investigator with relevant information were posted. Nobody came forward in response. Ten members of staff were interviewed by the investigator on 24 August and 16 September. She was given a statement made by an Independent Monitoring Board (IMB) member who was present when the man was found.
10. A clinical reviewer was commissioned to provide an independent review of the man's clinical care at Campsfield House. He was provided with a copy of all documents, including interview transcripts and CCTV coverage of the resuscitation effort.
11. The delay in issuing this report is regretted. In part, it was caused by the absence of staff because of ill health and leave, and because of the need for additional enquiries to clarify the man's immigration position.
12. MITIE carried out its own internal investigation into the death of the man and the author shared his report with the investigator and discussed his findings over the telephone. As part of the author's investigation, an internal review of the clinical care given to the man was provided by the Clinical Lead for Secure Health for The Practice plc (who deliver healthcare at Campsfield House). The investigator discussed concerns about the quality of the medical response with the centre manager, who provided updates about training and feedback from the Clinical Lead.
13. HMP Wandsworth, forwarded the man's prison records to the investigator. A DI from Thames Valley Police, who carried out an investigation on behalf of the Coroner provided copies of police statements, including one from the man's solicitor.
14. The DI who carried out the professional standards report for Dyfed-Powys police provided a copy of their report. The investigator also spoke to a DC from Northamptonshire police.
15. On 2 November 2011 and 8 February 2012, the investigator and another colleague interviewed three members of staff from the UKBA office in Croydon.
16. One of the Ombudsman's family liaison officers spoke to the man's brother by telephone on 30 August 2011. He said that his brother's death came as a complete shock to him and the family. He questioned the actions of the police

but it was explained that this was outside the Ombudsman's remit and it was suggested that he could contact the Independent Police Complaints Commission. He did not have any particular questions or issues for the investigation but just wanted to know how his brother's death had happened.

17. The investigator and a family liaison officer met with the man's brother after he had received and read the draft report. He had no comments to add to the report.

18. A copy of the draft report was sent to the UK Border Agency.

CAMPSFIELD HOUSE IMMIGRATION REMOVAL CENTRE

19. Campsfield House Immigration Removal Centre holds up to 216 adult male detainees on behalf of the UK Border Agency (UKBA). From 2006 until May 2011 it was run by GEO Group Ltd. and after which the contract was awarded to a different private provider, MITIE. Healthcare is provided by The Practice plc. Two nurses are on duty from 9.00am until 5.00pm and one works overnight. A doctor comes to the centre for an hour a day on weekdays and is on-call at weekends.
20. The centre has three residential units; short-stay unit (26 beds), and Yellow (57 beds) and Blue (133 beds) blocks. The rooms are either single, double or multiple occupancy. Some UKBA caseworkers are based there. In 2009, there were 13 incidents of self-harm.
21. Campsfield House was most recently inspected by HM Inspectorate of Prisons in May 2011. This was a short follow-up inspection following an announced inspection in October 2009. Relationships between staff and detainees were described as satisfactory but inspectors noted significant weaknesses in health care services. In particular, the inspection reported that there was a lack of clinical supervision, and inspectors had received a number of complaints about disrespectful behaviour on the part of some nurses.
22. In 2005, a detainee was found hanging at Campsfield House. On that occasion, the Ombudsman made 21 recommendations, although we found that the death could not have been prevented or predicted. At that time, 24 hour healthcare was not provided. Two of the recommendations made after the death in 2005 are repeated in this report. Firstly, that detainees should be encouraged to give next of kin details at reception, and secondly that a code system should be used to communicate the nature of an emergency.

KEY FINDINGS

23. The man was born in 1979 in Moldova. He arrived in the UK in October 2002 and claimed asylum in December 2002. This was turned down in February 2003. He appealed against the decision but, in July 2003, the appeal was dismissed. In January 2004, he exhausted his appeal rights. In June 2005, an emergency travel document (ETD, issued by the individual's native country for a single journey to enable one of their nationals to return home) was issued for his removal from the UK. He disappeared from the view of the authorities and there was no further contact with the UK Border Agency (UKBA) until November 2010, when his legal representative wrote to UKBA requesting consideration of his immigration status.
24. On 29 May 2011, the man was arrested at St Pancras Station trying to leave for Paris with false identification. The police indicated that he was very remorseful during his interview and was crying. The British Transport Police (BTP) risk assessment identified that he said he was suffering from stress but there was no other issue of concern. He was remanded into custody, pleaded guilty to using false documents and was sentenced to four months custody on 8 June, which he served at HMP Wandsworth.
25. The clinical record from Wandsworth shows that the only time the man saw a nurse was when the first reception health screen was completed. The only comment of note was:
- ‘... [the man] stated that he gets very anxious when in a stressful situation. Feels he needs sleeping pills. Requested to speak to someone about his feelings.’
26. There is nothing further to indicate that he was referred to the mental health team.
27. In a statement to the police, the man's solicitor said she was contacted by Northamptonshire Police on 22 June about their interest in him in relation to a rape allegation. They also wanted to interview him about a fraud case on behalf of another police force. The police officer booked an appointment for 30 June to interview him at Wandsworth with the solicitor present. The solicitor wrote to him on 23 June to explain that Northamptonshire Police wanted to interview him. She wrote “He has explained that he intends to interview you about matters from 2009 in the Northampton area together with two fraud matters which arise from Wales”. The solicitor did not mention the nature of the allegation.
28. The man's solicitor wrote again on 28 June to say that the police had had to cancel the appointment for 30 June and had rebooked it for 4 July. The rearranged appointment was also cancelled and a further appointment booked for 28 July, which again did not happen.
29. At 11.25am on 29 July, he was arrested as he was being released from Wandsworth by Dyfed-Powys Police in relation to the alleged fraud offences.

He was taken to Aberystwyth Police Station by two officers and arrived there at 5.30pm. His solicitors were told that he had been gate arrested and taken to Wales, but were unable to provide anyone to represent him at that time.

30. At 6.22pm that evening, a custody officer carried out a risk assessment and the man indicated that he had suffered from depression for which he had taken medication. He said that he had never tried to harm himself and was not dependent on drugs or alcohol. The officer wrote: 'DP [detained person] gives no cause for concern'.

31. An officer of the Wandsworth, Merton and Sutton local immigration team, who was working as the acting Chief Immigration Officer (A/CIO), spoke to Aberystwyth Police that evening and completed a computer entry at 6.32pm. There is no corresponding record in the police detention log. She wrote:

'T/C [telephone call] from Officer 1010 stating that they had arrested subject as he left HMP Wandsworth today (see minutes dated today) and they were in possession of sub's IS96 however subject is due to be i/v [interviewed] regarding fraud offences (ATM machines) committed in April 2010 Aberystwyth Police & December 2009, Northampton Police. [IS96 refers to release document]

'It is unlikely that the subject will be attending our office on the 1 August 2011 as stated on his IS96.

'If subject is not charged then IS91 & IS 91R to be issued as mentioned in notes. [IS91 & IS91R refer to documents giving the authority to detain someone for immigration reasons]

'The police will call us back with outcome.'

32. She made a further note at 7.29pm that evening:

'Telephone call from the SGT [sergeant] @Aberystwyth Police, just wanted clarification on what would happen if the case NFA [no further action]. Have informed the sarg that we will fax over IS91 & IS91R for subject not to be released.'

33. She told the investigators that this was not the same officer she had spoken to earlier that evening. She discussed with the officer what was meant by 'NFA' and understood that they might not charge the man with a criminal offence. In the circumstances, she told the officer that if the police were not going to take any further action, then he would be placed into UKBA detention pending his removal from the UK. Later that evening, she faxed the IS91 and IS91R documents to the police station.

34. In interview, she said that the question of him being bailed by the police was not mentioned during the conversation. She explained that if someone is bailed, then UKBA would not issue the IS91 document as they would not be

able to detain an individual with a view to removal because he or she would need to remain for ongoing police investigation.

35. The IS91 form stated that the man was being detained as 'an illegal entrant or a person to whom section 10 of the Immigration and Asylum Act 1999 applies'. The IS91R informed him that he would be detained because his 'removal from the UK was imminent' and his 'release is not considered conducive to the public good'.
36. The A/CIO explained during interview that, if the police had said they were going to bail him, she would have made a note in the casework record, and would not have issued any detention paperwork as UKBA could not have detained him for immigration reasons.
37. The police custody log shows he was arrested at 8.40pm that evening for a further offence of fraud committed in the North Wales area in 2009. At 9.26pm, the police started to interview him with the duty solicitor present.
38. None of the conversations which officers had with the A/CIO are recorded in the police custody log. The only relevant entry is at 3.51am:

'[The man] was released on bail at 3.44am on July 30 and due back at Aberystwyth Police Station on 11 August. Gave an address in Northampton. UK Border Agency have communicated with Aberystwyth police and forwarded papers to be served on DP to be detained under powers contained in the Immigration Act 1971 or the Nationality Immigration and Asylum Act 2002. The UK Border Agency has decided that DP should remain in detention because his removal from the UK is imminent and release is not considered conducive to the public order'. DP served with **IS91R** papers.'
39. The police wrote in the custody record that they were still waiting for transport from UKBA. On Sunday 31 July, the man was taken to Campsfield House and arrived there at 1.06pm. A Person Escort Record (PER) form was completed and no risk factors identified. A Detention Custody Officer (DCO) booked him in at reception and completed an assessment of risk for sharing a room. No risk was identified.
40. The DCO told the investigator that when he saw the information on the UKBA document about the man suffering from depression he asked him about this to try to establish whether he was a risk but he said he was 'okay'. As he had told him he was fine, the DCO did not record any concerns, although he said he thought that he was very quiet. The section in the Detainee Transferable Document about next of kin was not completed and he did not sign it.
41. At 2.25pm the same day, 31 July, a nurse completed a Detainee Full Health Review with the man. She asked him about self-harm and suicide and wrote "no, anxious about immigration issue. Denies any [suicidal] thoughts". When she spoke to the investigator, the nurse recalled that he asked about whether he would be put on a plane. He also asked general questions about

procedures at Campsfield House. The nurse told him that after the health assessment he would go through the induction process with officers who would be able to explain what was going to happen. During interview, she recalled that he was relaxed and settled and did not come across as agitated. She took his blood pressure and pulse and both were fine. He said he did not need to see a doctor.

42. The nurse completed a healthcare risk assessment form about the man sharing a room and did not record any concerns. He spent his first night on the SSU. A member of the chaplaincy staff spoke to him as part of the induction process and he did not raise any concerns.
43. The next morning, 1 August, DCO 1 carried out the group induction for all new arrivals. He recalled that nobody in the group asked any questions and the man did not raise any concerns. DCO 2 carried out a brief, routine welfare check with him. This check involves questions about solicitors, family or friends in the UK, property issues and any queries the detainee may have. The DCO's impression of him was that he was quiet. She said he had said he wanted to go home to Moldova. She said he was not forthcoming but he did not stand out. After induction, he moved into room 29 in the yellow block in the main part of the centre.
44. The man's brother visited him that afternoon at about 2.15pm. Both DCOs were on visits duty and said the man and his brother sat in the garden. DCO 2 told the investigator, 'they were both quiet and did not share much emotion and he wasn't there for a particularly long time'. She remembered that she and the other DCO commented on him briefly as they had both had something to do with him previously. They agreed that he was 'a bit strange' but that there was nothing to cause them concern. DCO 1 recalled that the man and his brother had both taken off their shoes and socks and he thought that this was quite unusual.
45. Although DCO 2 said she did not believe the visit was particularly long, the man's brother told our family liaison officer (FLO) that the visit lasted for three hours. He said his brother had been uncharacteristically tearful and distressed during the visit. The man had telephoned his solicitor at about midday and been told that he faced a serious charge in relation to an incident in Northampton. He told his brother he was not guilty of this offence. The man's brother told our FLO that by nature his brother was a strong person but had become depressed following his arrest and time in Wandsworth. He said that his brother had been very distressed about what had happened in Wales and that he had been confused about why he had been arrested and what he described as aggressive questioning by the police.
46. In the man's solicitor's statement, she stated that when he telephoned her that day, he was anxious to know what was happening with the outstanding police investigation. She explained that Northamptonshire Police wanted to interview him in relation to an alleged rape said to have occurred a few years previously for which they now had DNA evidence. She said that she had not previously mentioned the nature of the offence in her correspondence with

him because she had been worried that the information would be disclosed to others. She told him that she would contact the police to let them know where he was and get back to him to confirm the proposed date of interview. He said he would call back with a contact telephone number. This was the only time his solicitor had direct contact with him. According to the man's brother, he called his solicitor back during their visit but he was unable to get through.

47. In the meantime, a UKBA Casework Officer had spoken to an Acting HMI about the man's detention. As there was no prospect of him being removed from the UK because of the outstanding police matters, the HMI authorised his release from detention that same day.
48. A UKBA contact manager based at Campsfield House was contacted by fax and asked to obtain a suitable release address from the man. He saw him briefly and obtained an address. The manager told the investigator that he had informed the man his caseworkers were considering his temporary release and he did not ask any questions about the process. The manager told him that his release would either be that day or the next, once the paperwork had come through from the casework office. The manager told the investigator that there was nothing about the man's manner that worried him.
49. The manager said that the release documentation was faxed through, but unexpectedly, at about 7.00pm, he received a phone call from Northamptonshire police to say that they were coming to gate arrest the man.

Events leading up to the incident

50. The following morning the manager telephoned reception and explained to DCO A that the man was going to be released and then gate arrested, but that staff would need to wait for the police to arrive before going through the release papers with him. The police had telephoned to say that they were going to arrive at about 11.00am.
51. The man's brother telephoned him early on Tuesday morning to see how he was. He told our FLO that his brother told him that he had been given some tablets and had slept well. His prescription chart shows that he was given Nytol at 8.00pm the night before. He telephoned his brother back some time between 9.00am and 10.00am and told him that the police were coming for him. He also telephoned his younger brother in Moldova, told him about the police coming and asked him to look after their parents.
52. At about 10.00am, DCO A telephoned DCO B and instructed that the man should pack his belongings and be brought down to reception. During this conversation, he told DCO B that the man was going to be arrested at the gate following his release but told the DCO not to tell him.
53. DCO B found the man in the garden with a group of detainees. The DCO explained that he needed to collect his belongings as he was being released. A couple of the detainees cheered but the officer noted that he just stood up, without expression and followed him inside without saying goodbye to the

group. The DCO recalled thinking this was an unusual reaction from someone who was being released. After he collected his belongings, they walked to the reception area in silence and he handed him over to DCO A.

54. The man was asked to wait in the day room in the SSU while his documents were prepared for release. DCO A also noticed that he was unresponsive and his mood was unusual for someone who had been told that he was about to be released. After he took him to the day room, he spoke to DCO C (also on duty in the SSU) about his imminent release and arrest. They spoke in the office and as they came out, the man was making himself a cup of tea directly outside the door. Asked during interview if there was any chance that he could have overheard any of their conversation about him, the DCOs thought it unlikely but not impossible.
55. The manager went to the reception area to go through the discharge papers with the man and asked the DCOs to bring him as the police had arrived at the gate. He recalled that the time was about 11.10am. The reception staff telephoned their colleagues in the SSU for him to be brought to reception.
56. DCO D was working in the SSU from about 10.00am that morning. Nobody had mentioned the man to her before DCO E arrived from the reception area at about 11.20am asking for him. She did not recall seeing him while she had been in the SSU and wondered if he might have been allowed into the main centre by mistake.
57. Neither DCOs were able to find him. DCO E returned to the reception area and DCO D went to look for him in the main centre but returned without him. The DCOs decided to telephone his mobile phone. As DCO E was searching the SSU, he heard the mobile phone ringing in one of the shower rooms.
58. DCO E unlocked the shower room and found the man hanging from a towel hook with a ligature made from shoelaces. He shouted to DCO D to call the first response team (three officers and a manager) and the medical response team. CCTV footage showed the DCOs going into the shower and seconds later they bring him out of the shower into the corridor and call for assistance. The call for medical assistance was logged at 11.45am.
59. DCO E supported the man's body while DCO D removed the shoelaces from around his neck. The ligature did not need cutting from the towel hook. They then placed him on his back outside in the corridor. (There is a CCTV camera outside the door and he can be seen on the footage from the chest down.)
60. DCO D recalled that the man's eyes were open and fully dilated. She then began to try and get a response from him by striking his chest.
61. DCO E checked the man's airway. The DCO then put his ear to the man's mouth to check for breathing. He said that he was just preparing to start CPR when the nurses arrived. He said he felt relieved that medical staff were there to take over.

62. Two nurses were both in the staff room when the call for an emergency medical response came over the radio. Nurse A picked up emergency equipment (contained in a red bag) and the nurses went to the SSU. The SSU is very near the healthcare centre so this took only a few seconds. Nurse A told the investigator that she saw that the man's skin was blue and cold to the touch. She believed him to be dead. She felt for a pulse but could not find one. Nurse B returned to the healthcare department to bring some oxygen. Nurse A asked for him to be placed in the recovery position. The investigator asked her why she did this when she thought that he was dead. She replied:

“Because when you find a person like that you still hope that you could do something and help, you don't just leave like that. That's why I did that. Maybe I was wrong, I don't know, but I thought that's what I should do”.

63. DCO E recalled Nurse A saying that the staff should turn the man on his side. He said the nurse tried to put the oxygen mask on him but was not able to do so. DCO B was one of the first response officers. When he arrived, he checked for a pulse and noted that the man was very cold to the touch. He told the investigator that the nurses arrived and 'panicked a bit'. He also attempted to attach the oxygen mask. The nurses tried to insert a breathing tube but were unable to do so. One of the nurses tried to move the man so that he was lying on his back again.

64. DCO C told the investigator that he had presumed the nurses would start CPR, but this did not happen. He asked a nurse for a mouthpiece so he could start giving breaths. He said that the nurse did not respond and it was as if she had 'frozen'. A member of the IMB attended the SSU following the emergency call. She recorded her concern that the nurses did not seem to know how to use the oxygen.

65. The shift manager responded to the call for first response and arrived at about the same time as the nurses. He used his radio to ask for an ambulance to be called at 11.45am. The gate log recorded that the ambulance was requested at 11.47am. The ambulance service rang back for more information and asked if Campsfield House had a defibrillator on site. He asked one of the nurses to go and get it. One of the nurses then went to collect the defibrillator and prepared to attach it to the man when she returned.

66. After the defibrillator was fitted, the CCTV footage shows both nurses standing up and demonstrating how to perform chest compressions but neither performed them on him. The paramedics arrived seconds later, at 11.51am and took over. The ambulance report says that there was 'no CPR in progress....no CPR carried out immediately'. The paramedics pronounced him dead at 12.08pm.

67. There were no next of kin details on file. It is not known whether the man declined to give any details or was even asked to provide them. According to Detention Service Order 05/2011, contact with families following a death in an

immigration removal centre is the responsibility of the UKBA Area Manager rather than the organisation running the centre and UKBA asked Thames Valley Police to contact his brother. They tried the address he gave when he visited Campsfield House but this was unsuccessful. The police then contacted the landlord of the release address he had given. The landlord confirmed that he had previously lived there, contacted the brother and gave the police his brother's mobile number.

68. The man's brother was very distressed and did not want a visit from the police. He was given the telephone number of Campsfield House. He asked a friend to act on his behalf, and the friend spoke to the deputy UKBA manager. He did not want to visit the centre. Financial assistance with the funeral and the repatriation of the man's body were offered.
69. Following the man's death, detainees were told the news in small groups. Detainees in the SSU were offered the opportunity to move to other available rooms in the centre, although they were all prepared to remain there. All detainees subject to special monitoring were reviewed. Staff involved were supported and allowed to go home. It was arranged for the Samaritans to visit and the chaplaincy team and welfare team were available to support detainees and staff.

ISSUES

The Emergency Response

70. A clinical reviewer completed a review of the man's clinical care at Campsfield House. He has serious concerns about the actions taken by the nursing staff to attempt to resuscitate the man and identifies a serious failing in their understanding of when it is appropriate to commence CPR. He describes what would be expected when discovering an emergency situation:

- the airway should be checked
- staff should ascertain if the patient is breathing
- if a pulse is present, staff should make an assessment of the patient's cardiopulmonary status
- In the absence of breathing and a pulse, the patient should be placed on their back and CPR commenced

In this case, the man was placed in the recovery position and the nurses tried to give him oxygen. The clinical reviewer concludes:

'It is possible that CPR would not have been successful in reviving the man. However in such a circumstance CPR should still be administered to maximise every opportunity to revive the patient. From reviewing the DVD evidence it would appear that such a course of action was taken by paramedic staff upon their arrival at the scene. The DVD did not capture a full picture. However following the arrival of paramedic staff I noted that he was placed in a supine position and a subsequent rhythmic movement of his feet for approximately 15 minutes would indicate a lengthy period of delivering chest compressions. Thus I conclude that they made every attempt to revive him.

'...the actions taken by nursing staff to resuscitate him were seriously outside reasonable and acceptable practice. To have competencies that are equivalent to those possessed by wider NHS staff all healthcare staff should undergo initial induction training in the basics of CPR and undergo annual refresher training to ensure their skills remain up to date.'

71. The internal investigation of the incident carried out by another reviewer differs from that of the independent reviewer. The reviewer concluded that, 'MITIE [who run Campsfield House] and staff should be commended for the professional way that they managed this very unfortunate incident, and the care and attention that was evident during the attempts at resuscitation'.

72. The reviewer wrote that the nurses had brought appropriate equipment for an emergency response. This is despite the fact that one of the nurses had to return twice to the healthcare centre to collect equipment. In their policy for dealing with medical emergencies and resuscitation, the healthcare provider requires:

“In the event of a medical emergency callout the attending nurse will be escorted by a member of the security staff to the location. The red emergency bag and oxygen will also be taken.”

When healthcare staff responded to the emergency call, they took the red bag, but failed to take the oxygen with them in contravention of their own policy.

73. An emergency code system is a useful way to convey information quickly about the nature of an incident, who should attend and what they should bring. Such a system is used in most custodial establishments. When the man was discovered by DCOs, nurses were alerted over the radio. No code system was used to communicate the nature of the emergency so nurses did not know what they were attending. Nurses told the investigator that an emergency code would have been helpful. In the PPO's investigation into the death in 2005, we recommended that Campsfield House introduced an emergency code system. There is still no code system in use at the IRC. We repeat the recommendation for the attention of UKBA:

UKBA should ensure that an emergency code system is introduced to notify responding staff about the nature of an emergency.

74. Despite the reviewer's internal investigation for the healthcare provider, the internal investigation for MITIE makes four recommendations about resuscitation, although he does conclude that the response of the 'nursing staff was prompt, professional and compassionate'.

75. The investigator immediately fed back her concerns about the quality of the nurses' actions and the findings of both internal reviews to the Healthcare Manager and the Centre Manager. When it became available, she also forwarded the clinical reviewer's review. The Centre Manager responded:

“In terms of CPR training and the reviewer's conclusion – yes I do acknowledge there is disparity between the two separate investigation reports on this specific issue. It seems the HC Manager has followed up the recommendation to the healthcare provider requiring all nurses carry out CPR in such circumstances. This formal training took place last week which I believe (from a non clinical viewpoint) to be the correct course of action”.

76. The reviewer commented further that healthcare staff responded promptly to the emergency call. He suggested that nurses did not immediately start CPR because of the risk that the man had broken his neck and, as they were not trained to stabilise airway fractures, it was his view that they could have worsened his condition. He also said that nurses could not physically administer oxygen because of the severity of the neck injury, which made it difficult to insert an airway. Despite his rationale for the nurses' actions that day, he outlined the following actions which have been taken following the investigator's feedback:

'We have now instructed our nursing staff to attempt CPR, in its classical form, in all cases of collapse, where no pulse is obtainable and will be providing a 'table top' training session to support the nursing team further.

"We have also requested two further oxygen cylinders to be placed throughout the centre to aid the nursing team during emergency responses. We are also in the process of re-writing the emergency response protocol which will dictate that the defibrillator must be taken with the nurse along with the emergency red bag. This protocol will be shared with MITIE upon implementation."

77. According to the training records, Nurse A received Basic Life Support training in June 2010 and Nurse B in July 2009. The healthcare provider's own policy says that 'immediate first aid, including CPR in line with current resuscitation council guidelines, will always be given'.

78. During interview, neither nurse was able to accurately recall what the correct current guidelines are for breaths and chest compressions in resuscitation. Both nurses had over twenty years of experience each but only one had ever dealt with an emergency situation and then only once. The interviews with the nurses do not support the perceptions of the reviewer, who found that a clear assessment was made and acted upon. We do not believe the nurses, who no longer work at Campsfield House, should be unduly criticised, as both gave honest accounts of feeling daunted and lacking experience of such situations.

79. There is a difference of view between the independent clinical reviewer and the healthcare provider about the resuscitation effort, but we prefer the independent opinion. CPR is only carried out when there is no pulse and the person is not breathing. In such circumstances the restoration of vital signs should take priority over concerns about other injuries. We make the following recommendations:

UKBA should ensure that there are sufficient trained healthcare and other staff on duty at Campsfield House at all times who are competent to administer CPR.

UKBA should ensure that the healthcare provider at Campsfield House adequately trains staff to respond to emergency situations.

Assessment of Risk

80. The clinical reviewer's second area of concern relates to the initial assessment undertaken by healthcare staff during the reception process:

"Regarding initial assessment, the Don Grubin assessment is now commonplace in many parts of the national secure environments estate, particularly remand prisons. This is a comprehensive

assessment of both mental health (including substance misuse) and physical health issues. It provides for wider questioning and therefore more comprehensive assessment of mental health status than the *Campsfield House IRC detainee full health review* screening tool which was administered to the man. It is possible that a more comprehensive screening tool such as the Don Grubin assessment would have highlighted indicators of a mental health condition which could have been managed accordingly”.

81. On occasion, the man described suffering from depression and anxiety. The nurse who completed the detainee health screening saw the documents referring to this and asked him how he was feeling. However, as the clinical reviewer comments, it is possible that a more detailed assessment in line with other custodial settings could have elicited more information about his state of mind which may have resulted in a follow up assessment. We make the following recommendation:

UKBA should develop with the healthcare provider at Campsfield House a more comprehensive initial healthcare screening assessment tool to allow for quick follow up referrals where necessary.

The man’s continued detention in immigration accommodation

80. Shortly before the man was due to be released from Wandsworth, Dyfed-Powys Police contacted UKBA staff and arranged to arrest him when he was released on 28 July. He was taken to Aberystwyth Police Station for questioning.
81. Later that evening, a custody sergeant spoke to the Acting Chief Immigration Officer (A/CIO) to ask what UKBA wanted to do should the police decide not to press charges. The A/CIO said that, were this the case, UKBA would wish to detain him, and she faxed a set of detention papers to Aberystwyth Police Station.
82. In the event, the man was released on police bail until the following Friday. This decision meant that he was still under investigation by the police and therefore could not be removed from the country by UKBA. However, the police served the detention papers that had been faxed earlier and he was detained under the Immigration Act.
83. When his file was reviewed by the casework officer on 1 August, she noticed that he had been detained even though there were still outstanding police matters. She referred the file to an A/HMI, who agreed that detention should not be continued. She contacted staff at Campsfield House to obtain a release address for the man. On 2 August, she was contacted by Northamptonshire Police, who also wanted to speak to him. They agreed to go to Campsfield House to arrest him after he had been released from UKBA detention.

84. The decision of Dyfed-Powys Police to bail the man on 29 July is relevant to the events leading to his death. As the A/HMII decided on 1 August, he should not have been detained following the decision to bail him as at that stage he could not have been removed from the country. In the normal course of events, he would have been released from police custody and therefore would not have been at Campsfield House at the time of his death.
85. UKBA's Enforcement Instructions (section 55.3.A) gives a list of relevant factors to be taken into consideration when detaining someone. The first of these is "What is the likelihood of the person being removed, and in what timescale?" However, other considerations include whether the person has failed to comply with conditions of entry, or has a history of "complying with the requirements of the immigration control". In this case, the man had previously not complied and was arrested trying to leave the UK using a false document. Therefore, his detention was legal, as there was a possibility that he might not comply with the conditions of any release. However, as recognised by the A/HMI on 1 August, he was not likely to be removed and his detention, while legal, should therefore not have been maintained.
86. The A/CIO recalled that the custody sergeant in Aberystwyth had asked only what the UKBA wished to do if they took no further action against the man. He did not mention that there was a possibility that he might be bailed and there does not appear to have been any discussion about what would happen in that event. She said she faxed the detention paperwork to Aberystwyth Police Station in case it was needed, but at that stage was not sure of the outcome of the police investigation. The police made no record of the conversation in his custody record.
87. Not all police custody sergeants will have a lot of experience in dealing with immigration cases, and of serving paperwork on behalf of the UKBA. When UKBA officers ask police to serve papers on their behalf there is a need to make it explicit in what circumstances they should be used in order to avoid people being detained inappropriately when there is no immediate prospect of them being removed. We make the following recommendation:

UKBA should ensure that all staff who fax detention forms to be served in police stations explicitly state on the cover sheet the circumstances in which they should be served.

Next of kin

88. The man's documents did not contain next of kin details and, following his death, it was difficult to contact his brother. The Detainee Admissions Operational Instruction 2011, which outlines the admissions process, does not make any mention of obtaining next of kin details. In the report of our investigation into the death of a detainee at Campsfield House in 2005, one of the recommendations was 'that detainees be encouraged to give next of kin details on arrival at the removal centre'. We repeat this recommendation:

UKBA should ensure that detainees are encouraged to give next of kin details on arrival at a removal centre and that the Detainee Admissions Operational Instruction is update to reflect this guidance.

CONCLUSION

89. Although there were technical questions about the man's detention at Campsfield House, the detention was lawful. We cannot know the reasons he appears to have taken his own life but he knew he was wanted for questioning by the police in connection with a serious charge and this may have preyed on his mind.
90. Although we found that improvements could be made in mental health risk assessment during the admissions process at Campsfield House, other than his reported history of depression, there was little to indicate that he was a risk of suicide and self harm.
91. Emergency procedures were poorly managed when he was found hanging but, in the circumstances, it seems most unlikely that anything could have been done to revive him at the time he was found. Nevertheless, there is a need for Campsfield House to make improvements so that lessons can be learnt from his death.

RECOMMENDATIONS

1. UKBA should ensure that an emergency code system is introduced to notify responding staff about the nature of an emergency.

Accepted by UKBA.

2. UKBA should ensure that there are sufficient trained healthcare and other staff on duty at Campsfield House at all times who are competent to administer CPR.

Accepted by UKBA.

3. UKBA should ensure that the healthcare provider at Campsfield House adequately trains staff to respond to emergency situations.

Accepted by UKBA.

4. UKBA should develop with the healthcare provider at Campsfield House a more comprehensive initial healthcare screening assessment tool to allow for quick follow up referrals where necessary.

Accepted by UKBA.

5. UKBA should ensure that all staff who fax detention forms to be served in police stations explicitly state on the cover sheet the circumstances in which they should be served.

Accepted by UKBA.

6. UKBA should ensure that detainees are encouraged to give next of kin details on arrival at a removal centre and that the Detainee Admissions Operational Instruction is update to reflect this guidance.

Accepted by UKBA. UKBA added “that details are requested on three separate occasions, at reception, during the initial health screening and during UKBA induction, but unfortunately many detainees have concerns about giving such details, for example, when their next of kin is living in the UK illegally. We are however working on how we try to improve the process so that detainees will be more willing to share this important information”.