Circumstances surrounding the death of a man at Harmondsworth Immigration Removal Centre on 19 January 2006

Report by the Prisons and Probation Ombudsman for England and Wales

April 2006

On the afternoon of 19 January 2006, a man was discovered by another detainee, hanging in the shower in the room they shared at Harmondsworth Immigration Removal Centre. Attempts to resuscitate him were unsuccessful. The man was just 26 years of age and was an Eritrean national.

Almost nothing personal is known about the man beyond the basic details he provided to the Immigration Service following his arrest.

Staff and detainees at Dover and Harmondsworth could tell my investigator almost nothing about him, other than that he was quiet man who kept himself to himself. In this respect, he was no different from hundreds of other people who pass through the removal estate. The population is transient and there is little time for even the best and most committed staff to build up relationships with individual detainees. This poses particular challenges in relation to identifying risk of self harm and suicide and to its prevention. Not surprisingly, given how little is known of the man, my investigation has not found any missed opportunities for preventing his death. Instead, it focuses on systemic issues in the hope that, by addressing them, further deaths will be less likely.

I am grateful to all those who have helped with this investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2006**

CONTENTS **Page**

		Page
Summary		4
1.	Investigation	7
2.	Background	7
	Tha man	7
	The Immigration removal estate	8
	Harmondsworth Immigration Removal Centre	9
3.	Dover (20 October – 12 December 2005)	10
4.	Self harm or fit on 12 December	11
5.	Harmondsworth	15
	Reception	15
	F2052SH	16
	15 December 2005 – 19 January 2006	17
6.	Perceptions of the man	23
	Staff	23
	Detainees	24
7.	Discovery of the man hanging	26
8.	After the death	30
	Support for staff	30
	The man's next of kin	30
9.	Examination of the issues	31
	Communication	31
	Safer suite	32
	Detainee Profile Report	32
	Reception response to open F2052SH	33
	Triggers	33
	Case reviews	34
	Completion of F2052SH documentation	34
	Supervision of detainees at risk	35
	Follow up to F2052SH	35
	Staff equipment	36
	Staff training	36

ACCT 36
Suicide Prevention Committee 37
Engagement of other detainees 37
Immigration Service correspondence 38

10. Conclusion 38

11. Recommendations 39

Annex A - Clinical review

Summary

This is the report of my investigation into the death by hanging of a man in the shower recess in his room at Harmondsworth Immigration Removal Centre on 19 January 2006.

The report starts by setting out some of what the man told Immigration staff about himself when he was first arrested. He was a 26 year old Eritrean national who came to the United Kingdom, he said, for religious reasons. He said he had been detained for his religion in 2000.

The man was taken to Dover Immigration Removal Centre to await his removal to Italy, where he had apparently claimed asylum before coming to the United Kingdom. He kept himself to himself and nobody could offer much information about him, except that he had asked repeatedly for a single room. On 12 December, shortly after moving to a single room, the man, a known epileptic, was found on the floor of his room covered in vomit. Staff also found a ligature attached to the window bars. He was taken first to a safe cell in the healthcare centre and then admitted to hospital later the same day. The following day, he was transferred to Harmondsworth Immigration Removal Centre.

On arrival at Harmondsworth, the man did not appear to present any risk of suicide, but the healthcare manager opened a F2052SH form in light of the fact that he had arrived on constant watch. He was admitted to the healthcare centre but discharged to normal location the next day. The F2052SH was closed on 16 December.

On 21 December, the man was informed that he was to be returned to Italy. On 24 December, he asked if he could be released pending arrangements being made, but was advised that this was not possible. On 27 December, Removal Directions were issued. The man's solicitors appealed against removal on 5 January 2006, on the grounds that the man's asylum claim would not be properly considered by the Italians. Nevertheless, he was seen by Immigration staff on 6 January, and issued with the Removal Directions (for 9 January). The Directions were subsequently cancelled, however, and the man was invited to submit grounds for his appeal. A letter dated 19 January advised the man that his detention had been reviewed and it had been decided the detention should continue. It is not clear whether he received this letter before his death (though it was not found with other papers in his room).

(Nobody interviewed during the course of my investigation was able to tell the investigator much about the man. He was a quiet man with a small circle of acquaintances. No-one considered him to be depressed or suicidal.)

On returning to the room he shared with the man and another detainee at about 4:35 pm, a detainee found the man hanging in the shower recess. He ran to get staff from the unit office. Several staff attended and tried at length to resuscitate the man. An ambulance arrived within 10 minutes of being

summoned. Paramedics took over the resuscitation attempt and then took the man to hospital at 5:17 pm. He was pronounced dead on arrival at the hospital at 5:32 pm.

Examination of the issues

In my examination of the issues, I note that, generally speaking, communication between Immigration Service officials with regard to the man's possible suicide ideation was good. I note my concern, however, that some staff took at face value a doctor's finding that the man was not suicidal, despite his being found collapsed in his room with a ligature attached to the window. I commend an advance warning sent to Harmondsworth by escort staff, but note that any such communication should incorporate as much background detail as possible. I am also critical of the failure to give due prominence in the records to the man's admission that he had tried to kill himself.

I recommend that use of so-called Safer Suites should be avoided wherever possible.

I note that no information about the incident at Dover was incorporated in the Detainee Profile Report generated at Harmondsworth and recommend changes to the form itself. I also recommend that staff should be instructed to refer to all available documentation when inputting information.

I record that, despite numerous discussions at Suicide Prevention Committee meetings about reception staff not dealing appropriately with open F2052s, no action was taken on the man's arrival at Harmondsworth, until he was seen by healthcare staff some 30 minutes later.

I also recommend that, in assessing detainees for risk of suicide, staff should try to elicit information about what prompted any previous episodes of self harm. (This did not happen in the man's case.)

I review the conduct of F2052SH reviews and am critical of both the inconsistency of review team membership and the fact that it is not unusual for staff to review detainees about whom they personally know nothing. I am also critical of the standard of form completion, again noting that the Suicide Prevention Committee had discussed this point many times.

I record that observations carried out on the man appear to have been timely and properly recorded, but that there is little evidence of interaction during the observations.

I express my concerns that, once a detainee ceases specifically to be observed by staff, he is not observed at all. I suggest that a named officer be made responsible for maintaining regular contact after the F2052SH is closed.

I note concerns about availability of equipment for dealing with a suicide attempt and about staff training in self harm and suicide. I also record that

Harmondsworth had made little progress in implementing ACCT [Assessment, Care in Custody and Teamwork] and recommend that IND publishes a timetable for the roll-out of ACCT throughout the removal estate.

I am critical of a lack of robustness by the Suicide Prevention Committee, in that several issues were discussed at meeting after meeting without being addressed or resolved. I am also critical that there is no detainee membership on the committee (although I welcome information provided to detainees advising them to tell a member of staff if they have concerns about a fellow detainee).

Finally, I am critical (as I have been in other reports) of Immigration Service letters to detainees, which are couched in language that many detainees must find impenetrable.

I conclude that I do not consider staff missed any opportunities for preventing the man's death, but suggest that my comments on systemic matters may help tighten up care of detainees. I end by noting the huge challenges faced by Removal Centres in dealing with those who are desperate, but about whom they know next to nothing.

I make 23 recommendations.

1. Investigation

Miss Ali McMurray, an Assistant Ombudsman, investigated the man's death on my behalf.

She visited Dover Immigration Removal Centre and spoke to staff and detainees on the wing where the man was last located before transferring to Harmondsworth, and to healthcare staff. She also obtained copies of documents relating to an incident on 12 December 2005 when the man was found on the floor of his room, and other Immigration Service papers.

Miss McMurray visited Harmondsworth Removal Centre on a number of occasions. On her first visit, she spoke at length to the centre manager and the contract monitor and visited the room where the man died. She also arranged for notices to be put up round the centre inviting staff and detainees to submit evidence to the investigation (in the event, just one detainee responded[1]), and obtained copies of various policy documents and staff statements. On subsequent occasions, Miss McMurray interviewed the detainee who discovered the man's death, and a number of staff who were involved in trying to resuscitate him or who had been involved in some way in the man's management at the centre. She also spoke to detainees with whom the man was said to have associated.

Late in the preparation of this report, Miss McMurray met Mrs Margaret Johnson and Mr Khalid Pritchard of the Independent Monitoring Board.

She also obtained and reviewed Immigration Service files on the man and spoke to his solicitor.

Finally, she commissioned Ms Jean May, RN, to carry out a clinical review of the healthcare provided to the man during his detention.

2. Background

The man

The man who died was a 26 year old Eritrean national. (There was some early confusion over his nationality, as he told the police when he was arrested that he was from Sudan.) He was single with no dependants and said his mother, father and four brothers and four sisters both older and younger than him were living in his home town of Asmara Akrea.

The man told the Immigration Service that he was born in Asmara, Eritrea. He served in the military from 1999 – 2005 and had been injured in the war. He left to travel to the United Kingdom.

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[1] The detainee alleged, amongst other things, that detainees who protested about conditions at the centre following the man's death were assaulted by staff. I referred the letter to IND for investigation.

The man was apparently very vague with the details, but said he travelled to Khartoum by foot and stayed with his aunt, before meeting an agent to whom he paid 3,000 US dollars to get him to the United Kingdom. He said that, if he had stayed at home, he would have been kidnapped by Government forces. The man said he left Khartoum by aeroplane on 15 October using a passport not in his name supplied by the agent. He told the Immigration Officer who interviewed him that he did not know where he landed and said that the agent had taken the passport from him. He had been put in a car and entered the United Kingdom in it on 20 October 2005. He said he did not know at which port in the United Kingdom he had arrived, nor whether he had travelled by rail or ferry. He said he did not pass any officials. The man said he was dropped off along the M25, where the police arrested him.

He was reported to be wearing several layers of clothing and was "dirty and unwashed". He had £100.10 and 493.08 Euros in his possession. (He was arrested with another man who said he was Sudanese. The other man was granted temporary admission.)

The man who died stated that he came to the United Kingdom for religious reasons and that he had been detained for his religion in 2000. (His religion is recorded variously as Christian and Muslim.) He said he was not a member of a political party, but that the political environment affected him. He said his problems began in 1999 when he approached the authorities and was beaten up by them. As a result, he suffered a shoulder injury which hurt when he slept. (He said on another occasion that his shoulders were prone to dislocate after he injured them in a fall following a fit.) He said he faced death if he was sent back. The man said he did not leave immediately after being detained in 2000, as "it was impossible for me to leave, tight security. I escaped 7 July 2005."

The Immigration Service discovered from his fingerprints that he had previously claimed asylum in Italy. The man told the Immigration Officer, however, that he had only been fingerprinted on arrival in the United Kingdom that day and denied having been fingerprinted in any other country or in Italy on 21 September. He said he had not claimed asylum in any other country before and was claiming asylum in the United Kingdom, as it was "good for human rights".

The Immigration removal estate

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

The Immigration and Nationality Directorate's (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."

Each removal centre has a cadre of Immigration Service staff, but they do not get involved with caseworking. Their role is simply to liaise between the particular caseworking unit and the detainee.

Harmondsworth Immigration Removal Centre

An 8-year contract to build and manage Harmondsworth Immigration Removal Centre (IRC), near Heathrow airport, was awarded by IND to the company UKDS in October 2000. The centre opened in September 2001 and provides accommodation, healthcare, education and recreational activity for 500 people detained by the Immigration Service and awaiting removal from the UK.

The centre holds those detained by the Immigration Service as overstayers, illegal entrants or failed asylum seekers prior to their removal from the country. It also holds a smaller proportion of detainees whose cases have not yet been determined, but who are considered to be at risk of absconding or whose identity is being established.

It was originally assumed that each detainee would stay for between 2/3 months and that there would be around 15 movements in and out of the centre per day. The picture changed very quickly, however. While some detainees remained at the centre for several weeks, many spent barely a day there, simply passing through on their way to the airport. The number of movements in a single day has been as high as 150. At the time of the man's death, the centre was almost at capacity, having been relatively quiet over the Christmas period.

Harmondsworth is a purpose built centre on three floors. Bedrooms are mostly shared, although there are some single rooms. Generally, the rooms are fitted with a wardrobe and storage facilities, a television with video and a telephone for incoming calls. Accommodation is on long, narrow corridors with no natural light. Currently, some rooms designed to hold families (and therefore with en suite toilet and shower facilities) are used to hold male detainees. The man was located in one of these.

Detainees are restricted from going to and from other residential units, but are not locked in their rooms at any time and have free access to showers, toilets, drinks, snacks and meals within their residential block.

HM Chief Inspector of Prisons conducted an unannounced inspection of Harmondsworth in February 2005. The inspection concluded that the centre was in general a safer environment than at the last inspection (September 2002). It found that, "Self harm and suicide procedures had improved, but

arrangements for supporting and monitoring vulnerable non-English-speaking detainees were inadequate". The Chief Inspector had "significant concerns about whether vulnerable detainees who spoke little or no English were being identified and given support." However, the Inspectorate team also observed "generally respectful relationships between detainees and staff … an improvement from the last inspection." The Chief Inspector concluded:

> "Overall, this report records progress in what has been a troubled removal centre. But Harmondsworth will continue to be a difficult environment to manage safely: holding a large and transient population, some with little to lose or much to fear."

There has been one previous self-inflicted death at the current centre since its opening. Another man was found hanging in a shower room on 19 July 2004. I investigated his death and my report of that investigation is also on this website.

Between July 2005 and January 2006, there were 30 recorded instances of self harm at Harmondsworth. Fourteen of these were strangulation or hanging, with the rest being cutting, banging the head, swallowing/poisoning/overdose and one burning. Three of these (including the subject of this report) required hospital treatment or the attendance of the emergency services.

3. Dover (20 October – 12 December 2005)

Detention was authorised for the man who died on 20 October because there was "insufficient reliable information to decide whether to grant you temporary admission or release" and he had "not produced satisfactory evidence of [his] identify, nationality or lawful basis to be in the UK." The box showing that he had had the terms of the notice of detention explained to him was not completed, other than the date.

An Immigration Service file note dated 23 October 2005 recorded that, when interviewed the previous day, the man was fit and well, happy to be interviewed in Tigrinya and could understand the interpreter. The Immigration Officer recorded that the man had said he suffered from epilepsy. He was not taking any medication, but asked for some Tegratol tablets which he used to take twice a day. He said he last took the medication on 28 July and last fitted about two months before his arrival in the United Kingdom. A separate note on the Caseworking file said that the man stated that, without the medication, he could expect to suffer fits more frequently.

A PMI[2] referral form was raised, but it has been annotated, "[The doctor] will not attend" and "Details will be referred to Health Authority for a GP to be allocated. Monitor subject and if he has a fit call an ambulance."

[2] A private medical company.

The man was detained by the Dover police, pending his transfer to Dover Immigration Removal Centre on 25 October. An induction interview was conducted by immigration staff at the centre on 26 October and the Third Country process was explained to the man.[3]

On 31 October, the man was informed in writing that his case was deemed to fall within the Dublin II Regulation. He was advised that he would be notified if another country was responsible for deciding his asylum application, in which case arrangements for his transfer to that country would normally be made within six months of the date of the determination of responsibility (which itself would be within two months of writing).

A file note dated 5 December recorded that the case had been over-looked and not reviewed on 28 November as it should have been. A chaser was sent. On the same date, the Immigration Service asked the Italian authorities to confirm that they were willing to accept responsibility for the man.

On 10 December (a Saturday), the man was seen at his own request by a member of the Immigration Service. He was informed of the delay in hearing from the Italian authorities and advised that it was likely that an enforced removal would take place if the Italians did not reply. He was advised to put in a further application for the following Wednesday.

On 12 December 2005, the Immigration Service again wrote to the Italian authorities to advise that it had now been more than one month since they made a formal request for Italy to take charge of the man. The letter asked the Italian authorities to confirm without delay that they acknowledged Italy's responsibility for the man, due to their failure to reply within the time limits. Failing that, transfer arrangements would be made within one week to return the man to Italy.

4. Self harm or fit on 12 December

The man had originally been placed in shared accommodation at the centre (the vast majority of the rooms at Dover hold multiple occupants). However, in early December he was given a single room at his own request. Staff commented to Miss McMurray that it was not unusual for detainees to ask for single rooms immediately upon their arrival, but they usually warmed to the idea of sharing after a while (possibly in light of the fact they are locked in their rooms from mid-evening). The man was apparently adamant that he wanted a single room, saying that he wanted peace and quiet and his own space. Healthcare staff were routinely consulted and approved the move.

[3] The Dublin II Regulation determines which of the participating states is responsible for considering an asylum claim made in their territories. It may apply when individuals travel between countries without seeking asylum in the first participating country, have already asked for asylum in other participating countries or have been issued a visa or residence permit by one participating country before seeking asylum in another. In such cases, the first participating country through which the claimant passed, claimed asylum or was granted a visa will be invited to accept responsibility for assessing his claim. If no response is received within a specified timeframe, the claimant can be removed to that country.

About one week after his move to a room on his own, the man was found collapsed in it. An entry on the Hastings Unit Staff Observation book noted that, "On doing a roll count (am) found [the man] laying on the floor covered in his own vomit. HCC phoned. [A nurse] said he should go to outside hospital but would wait for doctor to confirm."

An officer said in an incident report that, at about 7:28 am, another officer came to the office and asked him to go to the man's room with him, as the detainee was lying on the floor and not responding verbally. On arriving at the room, they called for healthcare to attend and asked the duty officer for permission to enter the room. Inside, they found the man semi-conscious, covered in vomit and still lying on the floor. They moved him on to the bed in the recovery position. While they were waiting for healthcare, the officer who first found the man removed a holdall strap from the window bars. Healthcare staff arrived and carried out checks. The report writer said the healthcare staff told them that they had twice called the man the previous day to collect his medication, but he did not turn up. The healthcare staff said the man would need to go to hospital, but that would have to be the doctor's decision. A senior officer remained outside the room to observe the man until the doctor arrived 10 – 15 minutes later. The report writer said that, when the Principal Officer (PO) heard what had happened, he instructed that the man should be placed in the anti-ligature suite. The man was then taken to healthcare in a wheelchair.

The PO said in his statement that the officer who found the man thought he (the man) should be located in healthcare, but a nurse said they could not look after him as she was on her own. The PO then phoned the nurse to advise that he had "enough corroborating evidence" to suggest the man had attempted suicide and that he was going to locate him in the anti-ligature suite. He said the nurse replied that her boss would not be happy and that he should not be located there. The PO said he asked the nurse if she had examined the man for evidence of ligature marks, but she said she had not. He said that, when the nurse arrived at Hastings House (the unit on which the man was located), she repeated that they could not have the man in the anti ligature suite and that her boss would not allow it.

The nurse said in her incident report that, on arriving for duty, she had been informed that the man had been found on the floor during unlock. She said she found him on his bed in the foetal position. On examination, she found that he had been vomiting repeatedly, his responses were slow, his comprehension poor and his pupils were equal and reactive to light. She noted that previous medical history indicated that he was epileptic and on daily medication. He had failed to collect this for three days, despite being paged several times to attend healthcare.

The nurse said she and her colleague cleaned up the man and re-made his bed. She added that, during this time, there was some 'cross communication' between the officers which did not directly involve her and her colleague until the issue of location and immediate care was discussed. The nurse said she

was not happy that the man should remain in a single room alone, in case he had another fit. (She added that she and her colleague both considered that this was what had occurred.) She was anxious that the doctor should assess him as soon as possible. One of the officers suggested re-locating the man in the anti-ligature room, but the nurse objected for two reasons:

- The anti-ligature suite was suitable only for potential or actual self harmers and not for patients requiring in-patient facilities and continual care; and
- She felt the patient needed ongoing attention, which he could not receive locked up in a cell.

The debate was gone through once again when the Principal Officer arrived. The nurse said that, at that stage, she was still unaware of any attempt at self harm and her priority was the immediate and future management of her patient and his medical condition. She said one of the officers offered to remain with the man while she went to healthcare to call the doctor.

The nurse said that, on her return, she received a call from the PO informing her that the man was to be re-located to healthcare. She said she repeated her objections, but the PO insisted that the man had made a noose with the intention of killing himself. The nurse said she asked if anyone had asked him if this had been his intention. The PO said they had not, but insisted that the existence of the noose provided sufficient evidence. The nurse said she asked if an F2052SH[4] had been initiated, and the PO confirmed that this was in the process of being done. The nurse said that, after the man had been relocated, she asked him whether he had tried to kill himself and he confirmed that he had intended to do so.

After the event, the healthcare manager advised the Governor that she considered the lack of clear communication had been the problem. She had now informed both nurses that, if there was an attempted suicide or self harm, the safer suites should be used and there must not be a problem with detainees being located in them. Lack of staff was not an issue, as officers would have to be provided if necessary to monitor the detainee in the safer suite. The healthcare manager said she would advise all her nurses of this at her team meetings and try to ensure the confusion did not arise again.

An F2052SH was raised at 9:00 am. This recorded that the man had been found lying on the floor covered with his own vomit with a noose hanging from the bars. It said he had not said anything about his situation, as he was not properly conscious.

It was also recorded that the man had been placed in the anti-ligature room after being strip-searched, and safe clothing had been issued. He had been sick. The medical officer visited at 9:35 am. Observation was satisfactory and the man had been given further sips of water.

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[4] A suicide and self harm monitoring form.

The PO completed the Record of Case Review at 12:20 pm. He noted that the man was to be seen by the community psychiatric nurse (CPN) at 2:00 pm and that, depending on his decisions, the doctor would be contacted with regard to assessing fitness for travel to Harmondsworth. The man was to remain in the anti-ligature suite until the outcome was known, and transferred to Harmondsworth as soon as possible. Consideration of his medical condition was to be taken into account and the buddy suite on Sandwich Unit was to be made available (with a named detainee acting as buddy). The support plan was that the man should remain in the anti-ligature suite, see a CPN, be transferred to Harmondsworth as soon as possible, be located in the buddy suite in the afternoon and checked on five times per hour. Named staff were given responsibility for each part of the plan.

Accordingly, the man was observed regularly and frequently by staff. He slept for much of the day, but was given water several times, most of which he vomited.

A CPN has recorded in the F2052SH that she tried to assess the man's health care at 2:15 pm and that he stated that he had attempted self harm that morning. She noted that the story became vague after that point.

At 6:15 pm, the Samaritans attended. They asked the man if he wished to speak to them, but he declined. He was removed to hospital at 8:20 pm.

The Chief Immigration Officer (CIO) at Dover advised Detention Escort and Population Management Unit (DEPMU) that:

> "The subject was found unconscious on the floor of his room this morning covered in vomit and with a self-made noose. It is unclear whether he had attempted to hang himself or had had an epileptic fit or both. He has stated that he has not taken his epilepsy medication for two days. His medication and physical and mental health need close monitoring and a transfer to a Centre with 24 hour medical facilities would seem appropriate therefore. However, he is not yet fit enough to travel by normal vehicle to Harmondsworth and requires to be taken to hospital for assessment and treatment until he is."

The following day, the CIO e-mailed various other colleagues with the same information, adding, "The hospital advises this morning that he should be fit for discharge later today and DEPMU will be asked to arrange for his transfer to Harmondsworth thereafter."

An undated file note recorded that the Case Information Database had not been updated following notification that the man had been found unconscious and taken to hospital on 12 December. The Immigration Officer noted that he had attempted to contact Harmondsworth on several occasions but had not got an answer. He said that, after checking the Detainee Escort Management System (DEMS), it was apparent that the man had been taken from Dover Removal Centre to the William Harvey Hospital. He noted that the man had been discharged the next morning and taken to Harmondsworth. The

Immigration Officer recorded that the man had been assessed by a doctor and deemed not to be a suicidal risk.

A note on the caseworking file recorded that the man had been found unconscious and with a self-made noose, and that he had stated that had not taken his epilepsy medication.

5. Harmondsworth

Reception

At 10:21 am on 13 December, the escort service G4S faxed reception staff at Harmondsworth to notify them that the man would be arriving from the William Harvey Hospital at about 11:30 am. They advised that he had been on 'Bedwatch' but had since been discharged as fit to travel and fit to detain. The fax added, "Apparently the sub is not a suicidal risk, hence his discharge. Our control will be contacting DEPMU direct to arrange completion of a IS97RA Part C which will hopefully be forwarded to you."

A PER – Part A (Prisoner Escort Record) form in the Harmondsworth reception file dated 12 December relating to the man's transfer to outside hospital had a ticked box for 'medical condition', but nothing marked alongside 'Suicide/self harm'. However, under further information about risk is the entry "?attempted suicide this am. Open 2052SH in progress." No additional PER – Part A appears to have been completed for the man's onward transfer to Harmondsworth.

Two Movement Notifications were completed. The first recorded that the man had special needs – "MEDICAL (see dems); SUICIDE RISK". The second advised, "*Amended* Doctor @ hospital has adv subj is NOT a suicidal risk." Special needs were recorded solely as 'medical'.

At Harmondsworth, it was noted on the man's Detainee Profile report that his English was poor. (A medical record entry for 25 October on the other hand said, "speaks quite good English also able to read some English.") Under 'Warnings (IS91)' was noted 'medical'. (The IS91 form was dated 20 October and therefore pre-dated the incident on 12 December.)

There is a note to show that the man asked for 'destitute clothing' (that is, clothing lent to detainees who have none or insufficient of their own). He accepted hot food and said he wished to see World Faith. The officer completing the form has commented that there were "No problems".

F2052SH

The healthcare manager raised an F2052SH form at 11:45 am. (This was 30 minutes after the man's arrival at the centre. There is nothing to show that he had been watched constantly in the interim.) He recorded that the reason for his concern was that the man had arrived on constant watch and that a noose had been found in his room. He noted that the man stated that he was angry

at the time but was now feeling calmer. He suggested that the man should be given staff support and encouraged to attend activities and World Faith. The healthcare manager also completed the Healthcare Assessment. He noted, “As initial assessment, good eye contact, eating and drinking.” He advised that the man should be located in normal accommodation on normal location and placed on 30 minute watch.

The Duty Officer reviewed the case five minutes later. He endorsed the proposals for support, but referred the man to healthcare with the F2052SH and instructed that the man should be placed on 30 minute observations and reviewed the next day.

Miss McMurray spoke to the healthcare manager. He said he carried out the healthcare reception screening on the man and that the man had arrived on an open F2052SH and was on constant watch. He said that he came across as relaxed and fine. The healthcare manager said that, had it not been for the open F2052SH, he would not have considered him a risk. Because one was already open, however, and the watch was ‘constant’, he decided to keep the form open to be on the safe side.

The healthcare manager read his contemporaneous notes from the computer. These were that the man was not feeling suicidal, had been angry previously and that was why he tried to self harm, but he was feeling good now and was not going to harm himself. The healthcare manager therefore reduced the watch to half hourly. As a result, the man was located on the healthcare centre (all high frequency watches are placed on the healthcare centre, because freedom of movement elsewhere makes it impossible to maintain regular observations). The healthcare manager had not made a note of what the man had been angry about and could not recall what it was.

The watches were carried out almost without exception within 30 minute periods of each other. The man appears to have spent much of the time asleep.

A Case Review was duly carried out at 10:10 am on 14 December by two Senior (residential) Detention Custody Officers (SDCOs). (The instructions on the form state that the reviews should “involve other departments as much as possible”.) One of the SDCOs recorded:

> “… has been told by Immigration that he will return to Italy. Asked if he wanted to die. Has replied that he did before but doesn’t know now.
>
> “Good eye contact. Has no thoughts of dying /self harm. [This appears at odds with the man’s stated ambivalence on the matter.]
>
> “Will be placed on normal location when discharged by the doctor.”

The support plan was as before. Staff responsible for implementing it were World Faith Ministers, DCOs and Regimes.

At the top of the form has been written “Hourly Obs” with the date of either 15 or 16 December (the figure has been over-written and is not clear). (A Daily Supervision and Support record entry suggests this was the decision of the two SDCOs on 14 December and that, within an hour of the review, the man had transferred to A wing.)

Miss McMurray spoke to one of the SDCOs who conducted the review. The SDCO said that, as part of her residential SDCO duties, she was regularly involved in F2052SH reviews. She had been involved in seven the previous day.

The SDCO said she had no recollection at all of having been involved in an F2052SH review for the man in question. She remembered him slightly as a very, very quiet man who kept himself to himself and that he occasionally attended education.

The SDCO said that the selection of staff to conduct the F2052SHs was fairly random. It depended on who was available on the day. Residential staff brought to bear their knowledge of the detainee’s behaviour and demeanour on the wing. However, a member of healthcare had to be present for an F2052SH to be closed. In addition, everybody had to be in agreement.

The SDCO said that the detainee himself was always involved and that reviews were kept as informal as possible. She said the frequency of the watch (i.e. 15 minutes, 30 minutes etc) determined the frequency of the review. Those on hourly watch would be reviewed every three days. Those on more frequent watch would be reviewed daily.

An officer noted at 10:50 am that the man “appears withdrawn but asked if any other Eritreans on level 3”. He subsequently commented at 11:45 am that he was sitting up in bed, asking about his property at Dover. The officer recorded, “No problems.” At 12:00 pm, the same officer wrote, “On level two using phone. Appears to have cheered up somewhat and chatting to other detainees.” The man ate lunch in the dining hall and at different times asked about his pager, the centre phone number and again about his property. (An officer filled in a general application form for him with regard to the latter.) He was observed a few times on the phone or in the association room during the afternoon and then ate dinner. Regular observations continued through the evening and night.

The following morning, the man told officers he was okay. He ate breakfast and then at 11:16 am was seen talking in another detainee’s room. The officer noted that they seemed to be quite friendly. He spent some time in the association room with other detainees, and in the afternoon attended education where he played games with other detainees or watched pool. In the evening, he was taken to reception to collect his property. (It is clear from the record that the F2052SH accompanied the man around the centre.) It was noted that he was restless during the night, but said he was okay. The following morning, he ate breakfast and was subsequently seen in the laundry

room. The officer spoke to the man and noted that he seemed okay. The last entry noted that the man went to the office at 11:00 am to go to medication.

A further Case Review was conducted on 16 December. Present were two residential SDCOs, the healthcare manager and an assistant nurse. Under summary of review was recorded, “Good eye contact; is on medication. Book closed.” It is signed only by one of the residential SDCOs. The separate Discharge Report page has not been completed at all.

When Miss McMurray spoke to her, one of the residential SDCOs involved in the review told her that she had no recollection at all of having carried out the F2052SH review on the man. She identified the handwriting as her own, but noted that there was not as much detail on the form as she would normally include. She also noted that the healthcare representative had not signed the form. She wondered if she/they had been called away.

More generally, the SDCO said she had been doing the job for 8/9 years. She had been involved in many F2052SH reviews (in fact, there were 11 on the day Miss McMurray spoke to her) and was quite comfortable with the role. She had not received special training for it, but had a wealth of experience to bring to bear.

She said the detainee was always present during the reviews and their responses and demeanour helped to inform the decisions taken. The reviews were kept quite informal.

The SDCO said who attended the reviews depended largely on availability, although there was always someone from healthcare present. Trying to ensure the same people were involved at each review was not possible because of the shift system. This sometimes meant that staff were required to conduct reviews on detainees they did not know or had not even seen before. She said that, in those circumstances, she would always elect to keep the F2052SH open.

When Miss McMurray spoke to him, the healthcare manager also had no recollection of the review at which it was decided to close the F2052SH. He noted that he had not signed the form, but could not explain why this was. He said it was not uncommon for him to take part in such reviews, but the nurses usually did them. As a rule, he only became involved in the problem cases.

The healthcare manager explained that the procedure was to sit with the detainee in a quiet room somewhere away from the healthcare centre (the aim was to de-medicalise the process). They would engage the detainee in conversation about how he was feeling and any problems, but would then discuss his care amongst themselves. The healthcare manager explained that it was sometimes difficult to hold such discussions in front of the detainee – especially for example, if they thought there was no real risk. He said that the key point was to approach the reviews with a completely open mind. It was wrong to go into them thinking that they would close the F2052SH, for example. The group must be guided entirely by what transpired during the

review. He said that residential staff were able to bring relevant information to bear about how the detainee was behaving on the wing, the extent to which he mixed with others etc. He said World Faith sometimes took part in reviews, but this was not common.

The healthcare manager said he occasionally took detainees aside for a one to one after an F2052SH had been closed, but had not done this in the case of the subject of this report. However, he had seen him in the corridor not long before his death when the man attended healthcare to collect his medication. The healthcare manager said he was smiling and happy and had chatted briefly.

15 December 2005 – 19 January 2006

There were just five entries on the man's residential Record of Events. On 15 December, it was noted that he had been to education that afternoon and seemed okay when spoken to. Another entry of the same date by a different officer commented that the man had been seen on the wing. There were no problems and he was very polite. A third officer wrote on 29 December, "Spoken to on several occasions. No issues." A fourth officer wrote on 5 January 2006, "Seen on several occasions. Seems OK." A fifth wrote on 12 January, "No problems. Seen about on wing on a couple of occasions. Seems OK." (The phrase 'seems OK' may be inescapable, but I note the frequency of its use and its inexactitude.)

On 18 December, the Dover E&R Casework office faxed Harmondsworth asking for the outcome of the man's hospital attendance on 12 December, and in particular whether he had attempted suicide or whether an epileptic fit was confirmed. They asked for a full update on the man's medical condition. In the meantime, the officer contacted immigration staff at Harmondsworth. They advised that the man arrived at Harmondsworth on 13 December and was on hourly watch until 16 December, when he was taken off it. He was currently under normal detention conditions. Immigration staff at Harmondsworth advised that any further detail would have to be obtained from healthcare – all the officer knew was that the man had been found unconscious on the floor at Dover, and that it was "unclear whether it was a suicide attempt although there has been mentions of possible epilepsy".

The reply from UKDS dated 19 December referred to an attachment from healthcare advising that the man had suffered an epileptic fit and was on medication, but was non-compliant. The note from healthcare read, "Discharged from hospital, hospital stated <u>not suicidal</u>. [Emphasis in original.] It would appear to have been an epileptic fit. He is on medication but currently non-compliant."

On a fax dated 19 June 2005 (but probably 19 December), the Chief Immigration Officer at HM Immigration – Dover noted the man's "possible epileptic fit and their refusal to take medication, together with the fact that the hospital has stated that the above subject is not suicidal" and asked the Duty Immigration Officer (presumably at Harmondsworth) to "continue maintaining

a close watch on the subject, in view of the refusal of medication and inform this office should there be any further developments or deterioration in the subject's medical condition." (A copy of this fax was on the Harmondsworth Immigration file, but there is nothing on the file to show any engagement with the man beyond the basic requirements of managing his his asylum application.)

The Immigration Service sent the man a monthly progress report on 20 December. It rehearsed the details of his arrival in the United Kingdom and said that he had claimed asylum on 25 October, but had already done so in Italy. It said enquiries were therefore ongoing with the Italian authorities to establish who was responsible for dealing with his claim. The letter said that the man's case had been reviewed, and that it had been decided he would stay in detention because there was reason to believe he would fail to comply with any conditions attached to the grant of temporary admission or release and in order to effect his removal. The reasons given for this decision were that he had failed to observe UK immigration laws by entering by actual clandestine means, had not produced satisfactory evidence of his identity, nationality or lawful basis to remain, and did not have enough close ties to make it likely he would stay in one place. Finally, the letter advised that his case would continue to be reviewed on a regular basis and that a further letter would be sent in one month if his case had not been resolved by then.

On 21 December, the Immigration Service again wrote to the man. The letter advised that, although he had applied for asylum on the grounds of a well-founded fear of persecution in the Sudan, this was not the only country to which he could be removed and he was returnable to Italy, which had accepted responsibility for examining his application for asylum. The letter explained that the Secretary of State would normally decline to examine the asylum application substantively if there was a safe third country to which the applicant could be sent. There were no grounds for departing from that practice in the man's case. The man was therefore formally notified of the intention to remove him to Italy and provided with information relating to his rights of appeal.

A note on the caseworking file dated 21 December recorded that there had been a "possible suicide attempt" which meant escorts would be required for the man's removal.

An IS91RA Part A form dated 24 December, noted that there was "a history or threat of" self harm/attempted suicide/food refusal/fluid refusals" and also "medical problems/concerns". The officer completing the form explained, "Sub was found unconscious on the floor of his room covered in vomit and with a self-made noose. It is unclear whether he had attempted to hang himself or had had an epileptic fit or both."

The man submitted a request for information from an Immigration Officer form on 24 December. He attached a letter to the form, responding to the letter sent him by Immigration on 20 December. This noted that he had been detained for one month and 10 days at Dover and 12 days at Harmondsworth,

totalling 65 days. He said he did not understand two things in the letter. These were the charge that he had failed to observe immigration laws by entering by actual clandestine means and that he did not have enough close ties to make it likely he would stay in one place. He asked, if possible, to be allowed to stay outside the detention centre until they 'arranged everything' in his case. He suggested that he could report to an Immigration office or police station on a regular basis. The man added that he had some medical problems and also had friends on the outside with whom he could stay.

An Immigration Officer replied the same day. He advised:

> "I am afraid it will not be possible to release you for the reasons set out in the letter to you dated 20/12. You apparently entered the UK hidden away and did not seek to see an Immigration Officer. One of the things we must be sure of when considering release is that you will stay at the address to which you are sent. We are not sure that you will do this."

A file note dated 26 December – CIO Review – noted that removal directions were to be set on 27 December. The writer asked for it to be checked prior to removal that the man was fit to fly "as a medical report was submitted. RDs to be set with medical escorts."

Removal Directions (RDs) were duly set on 27 December for 9 January 2006. The man was to fly to Rome.

A Notification of Second Port Removal form addressed to the Immigration Office at Heathrow advised that the man was to be accompanied by two escorts and one medical escort, as he suffered from epilepsy. There was no mention of the possibility that he might have attempted self harm at Dover.

However, a Request for Escorts form noted that escorts were necessary for both suicide risk and medical reasons, explaining, "Sub suffers from epilepsy and was found unconscious on the floor of his room, covered in vomit and with a self-made noose."

The Removal Directions were received by Immigration staff at Harmondsworth on 29 December. An appointment was made to see the man at 10:10 am on 6 January 2006.

On 5 January 2006, the Immigration Service received representations from the man's solicitor citing Article 3 of the European Convention on Human Rights and threatening judicial review if no response was received that day. The solicitors advised that they acted on behalf of six Eritrean nationals and one Ethiopian whom the Immigration Service proposed to remove to Italy. They said they had "grave concerns" regarding Italy's treatment of these people, and asked that removal proceedings be halted pending clarification of points raised in their letter. They said their clients had complained about the attitude of the Italian authorities to their claims for International Protection. The solicitors asked that removals to Italy be suspended until the Italian authorities had satisfied the Immigration Service that the Council Directive

laying down minimum standards for the reception of asylum seekers was being met. They attached a lengthy report from Amnesty International.

With regard specifically to the subject of this report, the solicitors advised that he entered Italy in September 2005, lodged an application for asylum and was placed in a refugee camp at Crotona. They said he was not asked for any details of his asylum application. On learning from others of the difficulties in finding work following grant of temporary admission, their client apparently left the camp to try to make arrangements for work. The solicitors said that, on returning to the camp, their client was given notice to leave Italy within five days or face imprisonment. This was apparently due to a requirement that he should not leave the camp. The solicitors said their client complained that he had not been informed of this and had in fact walked out of the camp past security guards. They said their client alleged that "he risks refoulment to Italy [sic] if returned to the Italian authorities, as they will not consider his asylum application".

Despite this letter, the appointment between the man and an Immigration Officer at Harmondsworth went ahead on 6 January, and the man was served with Removal Directions for 9 January. A form confirming service of Removal Directions asks whether the detainee responded by threatening self harm or suicide, by stating they would refuse to go, or by accepting the Removal Directions. The last box has been ticked for the subject of this report. There is no other record of his response.

However, following confirmation of receipt of the notification from the solicitors by the Third Country Unit, the Removal Directions were cancelled. The man and his solicitor were both informed on 7 January. An officer confirmed that the man had to submit grounds within 7 – 10 days and that the situation would then be reviewed. She noted that the process could take up to two months.

A file note dated 16 January, recorded that the Third Country Unit would respond to the solicitors within the next 5 – 7 days and would seek to have the case expedited. A note was made to check progress in two weeks time.

A note on the Home Office file recorded that arrangements had been made to make enquiries of the Italians into the allegations the man made about his treatment/experience in Italy.

A monthly progress report was sent to the man on 19 January 2006. This summarised the history of his asylum application to date. It advised that his case had been reviewed and it had been decided that he should remain in detention because there was reason to believe that he would fail to comply with any conditions attached to the grant of temporary admission or release. (The reference in the previous update to effecting removal was omitted.) However, the basis of the decision to maintain detention was identical to that provided previously. The caseworker advised that the man's case would continue to be reviewed on a regular basis and that a further letter would be sent in one month if it had not been resolved by then.

It is not clear whether the man received this letter before his death (it was not found amongst his other papers following his death).

6. Perceptions of the man

Staff

Few members of staff to whom Miss McMurray spoke could tell her anything about the man. However, the SDCO on A wing said he knew him. He said they regularly exchanged greetings and shared a joke with one another. He said the man did not appear to be someone who would kill himself. The SDCO said the man was depressed at first and was placed on an F2052SH. He did not leave his room very much to begin with, but had then started to mix with other detainees. Staff had offered the man lots of advice about solicitors etc, but he had not been interested at first. Subsequently, he had been active in progressing his case, and had also attended the gym and World Faith.

The SDCO said he had had some conversation with the man during his time at the centre. The man seemed not to know where his parents were or if they were alive. He said the man was doing everything 'normal' detainees would – he was eating his food, sending faxes to his solicitor, attending the gym etc. The SDCO said that, if the man had seemed at all withdrawn, he would have checked on him.

The SDCO said he was on a late shift on 19 January. He had seen the man in the dining room. The man had greeted him with "Hello, officer" and they had joked together. He said the man was bubbly, playing and mixing with others. The SDCO said that, with hindsight, it might have been the case that the man had found a solution to his 'problem' and was in good spirits as a result.[5]

A Detention Custody Officer (DCO) on A wing on the day of the man's death said officers talked all the time to detainees – that was their job. He said that relations between staff and detainees were quite relaxed and they were comfortable with one another. He said he knew the man only slightly, exchanging "Good mornings" with him. The man was quite quiet and they did not engage in conversation. He said he seemed normal in all respects, though he was perhaps not out and about the centre as much as some.

Miss McMurray also spoke to the man's solicitor. He knew very little about his client, but said he was shocked by his death – he said he had not seemed the sort of person to kill himself.

Detainees

One of the man's room-mates said there was "nothing wrong" with the centre - staff were very good and always talked and listened to detainees. He described them as "fine people".

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[5] This is a phenomenon noted in the research literature on suicide.

He said that the man was very quiet when he arrived – he kept himself close to himself. However, a week or 10 days before his death, he and the man had started to have jokes with each other, as far as their language barrier allowed. The room-mate had received his 'ticket' to return to Turkey and the man had told him he should not go because of the bird flu.

The room-mate said the man was upset that the Immigration Service had traced his fingerprints to Italy. He was also down about his 'ticket' (that is, Removal Directions) being issued. The room-mate confirmed that the man knew that his 'ticket' was subsequently cancelled and that he had been happy about that.

The room-mate said the man did not say very much about anything – there was a language barrier between them (the room-mate speaks no English). He said he had one or two friends from his own country and that the man spoke to them. He spent time during the day talking to these friends, but returned to their shared room at night to sleep.

The room-mate said they sometimes talked to each other in their room, the man watched films on the TV in the room. Sometimes he watched the TV in the association room.

The room-mate was not aware that the man was depressed. He had said nothing about killing himself or about feeling very bad for the future. The room-mate repeated that they had joked together. There was nothing different about him on the night before he died.

The following morning, the man was still in bed asleep when the room-mate left the room (at about 7:50 am). The room-mate said there was nothing unusual in this, as the man did not usually go to breakfast. He subsequently saw him at lunchtime, but only across the dining room – he did not speak to him.

Miss McMurray spoke to four other detainees whom she was told were friends with the man. Two said they did not know him at all and spoke no English. One only knew the man very slightly. He said he had come across him once in education, but had nothing to report. The fourth said he knew the man and was very surprised at what he had done – he did not think he was the type. The man was troubled about his case, but not unduly so. He did not talk about his situation, but was in close and regular contact with his solicitor. However, the detainee said that, for about four days before his death, the man complained of feeling 'homesick'. The detainee described him as being mostly to be found squatted against a wall in the TV association room. He said lots of detainees spoke to him. Even so, he did not consider the man to be depressed or especially unhappy.

Another detainee wrote to Miss McMurray. He said:

> "I remember being with him in the education centre, the day before he dies, he looks so depressed an distraught, but no one there to help him out, the way he sat very quiet, I approached him and asked him, is everything alright? He said yes, but he did not look it. What I have notice is, if some thing has not been done to change the way the staff are treating us here, multiple of that will happen, as we saw one was about to happen last week. Because the staff are just there for a detainee to do a list mistake for them to sent him to the torturing unit [sic]."

The detainee also complained that, "the problem is clear in this centre, with the way the staff are treating us mentally and physically bad. They made it clear to us that, once we are detainees we have got no right, even those in the Guantanamo Bay are having better treatment than we do." He said the quilts were not changed after different detainees used them and they smelled as a result, and that people with communicable diseases were located in the mainstream. The detainee also said the medication offered was inadequate. He said, "they make life very tough for us", did not give detainees the chance to explain their cases to their solicitors and made it known "that who ever is brought here us bound to be sent to his country no matter how strong his case is." Education staff did not help as they were supposed to do and "that is what is leading people to commit suicide, because they do feel nothing more they can do to get them out of this terrible frustration but to kill them selves." The detainee suggested that staff were poorly qualified to help them and explained that, "most detainees were being separated from their loved ones, businesses and all they have, and we are going to send them to their countries empty handed, moreover they have not got a clue how the future is going to hold for them …" [sic].

The detainee complained that, "the worst of all is this Harmondsworth detention centre, the staffs are abusive …" and said he had heard that conditions in prisons were better. He said, "I have witness several torturing been carried out by these ill-educated staffs by swearing and insulting old people twice their age"[6].

7. Discovery of the man hanging

CCTV footage shows the man entering his room at about 1:30 pm on 19 January. This was the last sighting of him alive.

The room-mate said he went back to his room at about 4:35 pm because he had a phonecall. He explained that an Indian detainee (since released) had moved into the room the previous night. The Indian man was on his bed when the room-mate returned. The room-mate turned to the toilet door, but it was closed. The other detainee looked at him and the room-mate asked who

[6] I judged it right to include this detainee's comments in this report, rather than appear to suppress them, but should stress that I have not investigated his allegations. I should add that HM Chief Inspector of Prisons' comment about a generally respectful relationship between detainees and staff was borne out by Miss McMurray's own observations whilst at the centre.

was in the toilet. The Indian detainee said the man's name and pointed to his bed. The room-mate said he knocked on the door, but got no answer. He waited one or two minutes, but still there was nothing. He said the Indian detainee had a 'key', and they unlocked the door from the outside. He turned towards the sink and then saw the man hanging in the shower area.

The room-mate said he ran to fetch officers from the office (this is about 20 yards down one corridor and then the same again down another) on the same level. Because he could not speak English, he gesticulated to show someone hanging. He persuaded the officers to follow him and they ran back down the corridors. Once they reached the room, the room-mate said the officers asked all the detainees to leave. Afterwards, he saw the doctor arrive but otherwise had no further part.

(One of the DCOs explained to Miss McMurray that detainees could raise an alarm via the intercoms in the rooms. The alarm would be routed via the Comms Office to the relevant wing office. They would be directed to the room where the alarm had been raised, but would know nothing about the nature of the emergency. The DCO thought that it was probably quicker for the room-mate to have run to the office himself. He said he had never known an intercom used as an alarm.)

The A wing SDCO said he received a comms call and went to the office. He was on the terminal when someone came running down the corridor. He said an officer was going to tell off whoever it was, as running was not allowed. However, when the detainee arrived at the door, he was gesturing to indicate self harm and wanted the officers to go with him. The SDCO said the officer and another immediately "shot out" after the detainee. The SDCO knew they would need additional staff if there had been a self harm and that there were some officers in the courtyard just outside. He therefore summoned them, before returning to lock the office. This took only about 20 seconds, but as a result he was the last one to reach room A104.

A DCO told Miss McMurray that he had been standing in the staff base. Another officer and the SDCO were also present. The officer said he heard a detainee running down the corridor and stepped out to meet him. The detainee did not speak much English but gestured with his hands across his throat. He and the other officer then ran with the detainee to room 104. He said he was aware of someone already in the room when he got there but did not take much notice. They went into the bathroom and found the man facing the shower wall. The officer thought his feet were probably resting on the ground with his knees bent. (The ligature was a plaited shoe-lace.) The two officers lifted the man's body and the first officer tried to raise the alarm with his radio. He was obstructed by the man's body and the tightness of the space.

The second officer told Miss McMurray he was sitting in the office with the other officer when a detainee ran up the corridor, gesturing frantically. He said he and the other officer followed him to his room and went into the shower where they found the subject of this report. He said he and the other

officer tried to support the man's weight and that the other officer tried to send a radio message but it was awkward and the water was running (he thought they might have turned it on accidentally when they supported the man).

A third DCO said that he was standing in the courtyard on 19 January when the SDCO came through the door from A wing. He asked another officer, who was also there, to go with him. The officer said it was clear that something was wrong and that the SDCO was trying to keep calm. They went to room 104 and someone called "In here". He and two other officers all went into the shower and found two officers trying to hold up the man. He helped them to support the weight in order to relax the tension on the ligature. He said they had not specifically been taught to do this – it was just common sense.

The DCO said he could not reach the shower head, but his colleague had done so, pulling off the ligature. An officer then took the man's weight and they pulled him away from the shower and placed him in a half-sitting position on the floor, with his head towards the toilet. They had not been able to open the door.

Miss McMurray asked the officer whether there had been too many officers in the bathroom. He said they needed that number in order simultaneously to support the body and release the ligature. He thought they had enough room to manoeuvre and had not been slowed down by the numbers. He could not think of anything that might have been done differently.

The SDCO said that, on arriving at the detainee's room, the five other officers had all squeezed into the en suite bathroom. The SDCO leaned round the door to see what had happened in order to make the correct code call for assistance. He saw the man at the shower end, being supported by officers. He said the man's face was ashen. The SDCO said he then made a code call on his radio and healthcare staff came running. He passed his ligature knife to an officer, having first unfastened it from his chain (only SDCOs carry ligature knives). By the time the officers brought the man out of the bathroom, healthcare staff had arrived. The healthcare manager asked for additional equipment to be brought and, because he knew what was required, SDCO ran off to fetch it. (He explained that he did not send a radio message for it, as there was a lot of radio traffic as a result of the Code 2. In the event, it was quicker simply to go in person. He thought it took less than two minutes in total.) A nurse followed him back from healthcare.

Once there, the SDCO set about clearing the adjacent three rooms of detainees and secured the area. He also called for additional staff from other parts of the centre, in case there was any reaction to the death by detainees. He wanted to ensure they maintained a high, visible presence.

The healthcare manager explained that a Code Yellow was primarily directed at Hotel 5 (the healthcare first response in a medical emergency) but that everybody heard the call. He said Yellow 1 or 2 indicated the nature of the emergency and therefore what needed to be taken. He said he was not the

emergency response nurse, but had “shot off” even so on hearing the code call. He said he would always do this if he was in the main part of the centre.

The healthcare manager said he reached the room ahead of the emergency response nurse. When he got there, the en suite door was open and officers were trying to bring out the man. The healthcare manager said the ligature had already been removed by this point and there was a deep ligature mark on the right hand side of the man’s neck. The two officers who brought him out made to place him on the bed, but the healthcare officer instructed them to place him on the floor as this was firmer. The manager said that, as the officers were putting the man on the floor, he called for healthcare assistance and equipment and for the doctor to be brought. He also asked for an ambulance to be called, instructing that staff report that “he’s suspended”, so that the paramedics would know what to expect. The emergency response nurse had gone to fetch the doctor.

The healthcare manager said the man was not breathing and he checked his pulse. He said he could not be absolutely certain that there was no pulse, but he was 98 per cent certain that the man was dead and had been so for some time. Nevertheless, he started resuscitation (Harmondsworth’s suicide and self harm strategy states that resuscitation should be attempted unless “rigor mortis has clearly set in”). He cut off the man’s shirt and pre-cordial thumped him. He then administered mouth to mouth and was satisfied air was getting through, as the man’s chest was rising.

A healthcare assistant told Miss McMurray that she had just completed her handover to the agency nurse and was going down the stair well, when she heard a Code Yellow over the radio. She knew that the emergency equipment would be needed and immediately went to the station on the next floor down to get it. She said she heard a call for the equipment over her radio as she ran. She collected the oxygen and the defibrillator and then ran to room A104. She said the equipment was cumbersome and she had to negotiate three doors, but it did not take her long to get there.

A nurse said she had not come across the man before. She said she was Hotel 5 for 19 January and had received a Code Yellow over the radio. She said this meant someone was hanging. She said she went straight to the Nurse Base to collect the emergency bag. This included airways and an oxygen meter. She said the room was not usually locked when staff were around as detainees did not have access to this part of the corridor.

The nurse said that, when she arrived at room 104, the healthcare manager was already there carrying out mouth to mouth. She assisted with chest compressions.

The nurse said that, once the healthcare assistant arrived, she went to fetch the doctor. She explained that the doctor only attended the centre once a week and did not carry keys. He therefore needed to be fetched. She thought it probably took her about two and a half minutes. When she returned, she and other healthcare staff alternated on cardiac compressions.

The healthcare assistant said she set up the defibrillator (she had been trained in its use) and the healthcare manager attached the pads. She then took over from the nurse on administering chest compressions. She said everything appeared to be under control and there was no sense of panic.

The healthcare manager said that, when they attached the defibrillator to identify whether there was any shockable rhythm, there was none. Instead, it advised them to “Check pulse and do CPR (cardio pulmonary resuscitation)”.

(The doctor completed a Medical Report. Details are included in the clinical review at annex A.)

The healthcare manager thought it took the ambulance about 10 minutes to arrive (in fact the Comms Log shows it took just eight minutes from an ambulance being requested to the first one arriving. In total, three ambulances responded.) This was quicker than it had sometimes been. Centre staff continued to treat the man and the doctor asked for full resuscitation. The paramedics intubated the man and the nurse administered the cannula at their request. The healthcare manager and healthcare assistant swapped positions and the nurse carried out chest compressions for a while.

The healthcare manager said that two officers remained in the room throughout and were very helpful either in assisting with the resuscitation attempt or in documenting what was going on. He said he had written to the centre manager to commend them, but had also written directly himself to all those involved.

At 5:17 pm, the man was taken by ambulance to Hillingdon Hospital. He was pronounced dead at 5:32 pm.

8. After the death

Support for staff

Miss McMurray asked the staff involved in trying to save the man about the support they had received afterwards. One officer said the Post Incident Care Team (PICT) had offered support immediately whilst they were writing their reports. The team had also contacted the staff involved a couple of days later to remind them of the support available. He had also received a letter of thanks. Another DCO said he had been happy with the support offered him by the PICT. A third DCO said staff had been offered support and the PICT had been available. He said they also received letters of thanks and recognition for their efforts from the centre manager. The A wing SDCO and the healthcare manager said they had been offered support by the PICT but had not felt the need to accept. (The SDCO said he was quite badly shaken and had taken the following day off. Management had suggested he take the next day off also, but he went into work.)

The healthcare assistant said she had received a letter from the PICT offering support, but that nobody (other than the healthcare manager) had come to sit down with her or asked her how she was. However, she noted that the healthcare manager had sent letters to all the staff involved and that the centre manager had also done so. She thought that someone should speak to staff involved in such incidents on a one to one basis, as it might be difficult for some to admit they needed support. She thought in particular that the SDCO had been quite shaken up. Finally, the healthcare assistant said she was not sure that PICT staff had any special training – she had been a member for a while and had not received any training herself. She thought it was simply a case of those with an interest offering to take get involved.

The man's next of kin

No details of next of kin were recorded for the man.

Various notes on the caseworking file following the man's death relate to efforts to track down the man's next of kin. One officer noted that there were no specific details on file, but that the screening interview gave details of the man's family in Asmara Akrea. The Harmondsworth contract monitor subsequently asked the caseworkers if they could check whether Italy had any next of kin details. Unfortunately, the Italian authorities had no details of next of kin, other than that there were family members in Asmara.

I understand, however, that the Eritrean embassy has succeeded in finding his family to let them know of his death. (No details of the family's whereabouts were released to the Immigration Service or me.) The family did not make contact with the Immigration Service, but the man's body was flown home.

9. Examination of the issues

Communication

My investigation has revealed several instances of good practice. Generally speaking, the communication between Immigration Service officials was good, with the various parties being quickly alerted to the incident on 12 December when the man was found on the floor of his room. There was also evidence of sustained follow-up by the Immigration Service and of their taking account of the man's possible vulnerability in their further planning. This is to be commended.

However, I am concerned that in some respects the conclusion by the doctor at William Harvey Hospital was taken at face value. While Immigration Service staff continued to refer to the man's epilepsy, some did not refer to the possibility of self harm. I appreciate that there was ambiguity around the incident on 12 December, and that the doctor had said the man was not a suicide risk, but the fact remains that a noose had been found attached to the window bars in his room.

I recommend that Immigration Service staff are reminded that, wherever a detainee has attempted to harm him or herself, all documentation should refer to that fact.

I was impressed by the faxed message to reception staff at Harmondsworth by G4S staff alerting them to the man's situation and impending arrival. This is good practice and to be commended. However, I note that the form referred to the man not being a suicide risk without any explanation for the comment. I would have preferred the message to have briefly set out the background to the man's hospital admission before adding the doctor's assessment. As it was, Harmondsworth staff received the conflicting messages of the man arriving on constant watch on an open F2052SH with an 'all-clear' from the doctor.

I recommend that the G4S staff be commended for sending the advance warning but advised to incorporate as much background detail as possible to ensure no relevant details are over-looked. (It follows from this that the Immigration Service must ensure that escort staff are fully briefed.)

If both escort and Immigration Service staff overlooked or discounted the possibility of suicide risk, this may be down to a failure to communicate a vital piece of information – the man's own assertion that he had intended to kill himself. The CPN recorded this in the F2052SH, but the remark is almost hidden in that document. The only other mention was in the nurse's incident report (which remained at Dover). The man's admission put an entirely different complexion on the incident on 12 December. While the finding of the noose was rightly a matter for concern, the level of risk was much higher than might otherwise have been supposed.

I recommend that all centre managers remind staff and others responsible for detainees' care to highlight significant pieces of information in a prominent position on the F2052SH.

It was clear from the observations recorded, that the man's F2052SH accompanied him to whatever part of Harmondsworth he was in. This too was good practice.

Safer suite

There was an unseemly dispute at Dover following the discovery of the man on the floor of his room, when staff argued over the correct location for him. I consider this came about as the result of a genuine breakdown in communication and am satisfied that steps have been taken to ensure that any detainee going through a suicidal crisis will be admitted to the Safer Suite.

Having said that, I have real concerns about the use of such accommodation – especially when the centre apparently has a buddy suite and detainees prepared to act as buddies. It must be better for a suicidal detainee to retain his own clothing and be located *with proper support* on normal location, than to be searched, put in special clothing, isolated from other detainees and left to his own thoughts in a Safer Suite.

I recommend that use of the Safer Suite at Dover be restricted to those occasions when no buddy is available to support the detainee.

Detainee Profile Report

The documentation passed to reception staff at Harmondsworth was contradictory in relation to suicide risk. There were clear signs that suicide risk was a consideration only a day earlier, but documents advised that the doctor had said the man was not a suicide risk. However, the man arrived at Harmondsworth with an open 2052SH. It is a matter for concern, therefore, that the Detainee Profile Report made no reference to self harm. (Indeed, it is a concern that there is no requirement to record risk of self harm on the form.) This may be because the form refers specifically to warnings on the IS91. In this case, the IS91 dated from October 2005 and so was not up to date.

I recommend that the Detainee Profile Report is amended to include a field specifically for history or risk of self harm. (Staff should be required to specify which.)

I recommend that reception staff are reminded to draw upon all documentation when completing the detainee profile.

I recommend that the IS91 is automatically updated and re-issued after any significant event.

Reception response to open F2052SH

The Harmondsworth Suicide and Self Harm strategy says:

> "At reception of detainees where there is an existing form opened by another organisation the screening process will still take place to hear what the detainee says about their situation; UKDS staff will then open a new form with any existing documentation appended to it."

The minutes of the Suicide Prevention Committee (SPC) meeting on 19 July 2005 recorded that the healthcare manager had expressed concern that reception staff were "not dealing with open 2052SHs and leaving them for the nurses. There could be a 20 minute gap between a detainee arriving and being seen by a nurse." On 18 October, it was noted that there were still problems, that training was required, and that there was a need to refine reception procedures as detainees were sometimes arriving on an open F2052SH and not being monitored during the reception process. On 15 November, reception procedures for those on open F2052SHs were yet to be defined, and on 5 January 2006 it was recorded that there was still confusion over the procedure for dealing with detainees who arrived with open F2052SHs from another location. The minutes said that "in all cases reception staff must open a 2052 using UKDS paperwork."

I note that the man arrived on an open F2052SH, but that the UKDS document was not opened by reception staff but by the healthcare manager during the healthcare screening. This was 30 minutes after the man's arrival and there is no evidence that he was on constant watch during this period.

I recommend that the centre manager ensures that reception procedures for those arriving on open F2052SHs are reviewed and clear practice set out. This must be completed and communicated to staff as a matter of urgency.

Triggers

The healthcare manager quite properly carried out his own assessment of the man's state of mind at Harmondsworth. He elicited some information about the incident on 12 December, but did not make a note of what precisely had prompted the man to try to harm himself, noting only that the man was angry at the time. Information about what triggered a previous episode of self harm can be vital in preventing a recurrence. If staff know what caused an earlier episode of self harm, they can be on the look out for the same triggers in the future.

I recommend that staff are reminded of the importance of finding out and recording what triggered any previous attempts at self harm.

Case reviews

The instructions on the Harmondsworth F2052SH forms state that staff from a variety of disciplines should take part in case reviews. The man's first case review was carried out by two residential staff, despite the fact that he had until that point been located in healthcare. I am also concerned that it is not unusual for staff not to know the detainee on whom they are conducting a case review, and that the question of who conducts each review is quite arbitrary. Some knowledge of the detainee is surely essential in determining whether the level of risk presented is higher or lower than it was previously.

I recommend that in all instances case reviews be carried out by staff with personal knowledge of the detainee.

I recommend that, wherever possible, membership of the group conducting the case reviews for a particular detainee must be consistent for the duration of the period of risk.

I recommend that the selection of staff carrying out case reviews is regularly audited.

Completion of F2052SH documentation

The minutes of the Suicide Prevention Committee meeting on 21 June 2005 noted a shortage of F2052SH booklets in the centre and that "entries made in open booklets still contain insufficient information". The minutes of the SPC meeting on 20 September again noted a shortage of F2052SH forms and that, "Entries are not up to standard e.g. wrong ink colour used, or insufficient information." The minutes of the SPC meeting on 15 November noted, "Entries in 2052SH books are still lacking in information, and some are illegible. Staff are to be reminded of the importance during briefings." Finally, the minutes of the SPC meeting on 5 January 2006, noted that, "Entries made by staff in the 2052SH booklets are still lacking in information, and this is being addressed on a one to one basis."

It is clear that the Suicide Prevention Committee was aware of a problem with form completion but failed effectively to remedy it. It is worrying that, six months after the issue was highlighted, it continued to be a concern. Indeed, the entry in the subject of this report's F2052SH recording that the form was to be closed is very sparse and the discharge report itself was not completed at all. Neither of the officers concerned could account for the paucity of detail, although both acknowledged that it was unacceptable.

One SDCO told Miss McMurray that part of her duties as a F2052SH co-ordinator was to audit the equipment, but it was planned that her role would be extended to incorporate audits of the F2052SH paperwork to ensure entries were comprehensive, appropriate and signed and dated. I welcome the introduction of regular audits of the forms, but believe additional training and close management oversight is needed to bring about the necessary change.

I recommend that further training be given to staff on completion of the F2052SH paperwork.

I also recommend that senior managers regularly scrutinise the F2052SHs and provide immediate feedback to staff.

Supervision of detainees at risk

For the most part, observations were carried out in a timely manner and properly recorded. But there was little evidence from the Daily Supervision and Support forms of engagement by staff with the man. The actual contact and moral support provided by those staff charged with watching a detainee is as important as the checking to make sure he or she is safe. Such contact can also provide more information about the detainee's developing state of mind.

I recommend that staff charged with carrying out special watches be instructed to speak to the detainee as often as possible, except where this is clearly not welcomed or not appropriate. They should record details of any relevant conversations.

Follow up to F2052SH

The healthcare manager told Miss McMurray that he did not consider the man presented a risk of self harm, but that he opened an F2052SH purely to err on the side of caution. He acted entirely properly and I consider it was sensible to keep the man under review whilst he settled at Harmondsworth.

I have some concerns about the recording of the decision to close the F2052SH but have no reason to suppose the decision itself was wrong. The healthcare manager spoke in detail about the need to approach reviews with an open mind, both the staff carrying out the review were very experienced, and the Supervision and Support forms did not indicate ongoing risk.

The critical point – and I fear it may apply in all the removal centres – is that a detainee who is not specifically watched ceases to be watched at all unless he does something to bring himself to the attention of staff. To all intents and purposes, the subject of this report simply vanished once he was taken off the F2052SH. This all or nothing approach leaves no margin for error in the decision making of those carrying out F2052SH reviews – in itself a very inexact science. It also places unrealistic demands on staff to pick up signs that a detainee may be at risk. I consider that there should be some form of follow up to the F2052SH process to ensure the detainee does not simply 'disappear'.

I recommend that, where a F2052SH is closed, a named officer be appointed to keep in contact with the detainee for the duration of his stay.

Staff equipment

I note that the doctor at Harmondsworth does not carry keys, that not all front-line staff carry fish knives, and that emergency equipment is not available on all the units. Although none of these matters was a factor in the man's death, they could be crucial on a future occasion.

I recommend that the centre manager reviews staff equipment in light of my comments in this report.

Staff training

All those staff to whom Miss McMurray spoke said they had received training on suicide and self harm – and were satisfied that the training was adequate. However, it is a matter for concern that a large number of staff are shown as having a due date for their next suicide/self harm training of 2005 or much earlier. I hope this is computer error.

I recommend that the centre manager ascertains whether refresher training on suicide prevention is up to date and, if it is not, takes urgent steps to remedy the situation.

ACCT

The minutes of the June SPC meeting recorded that the healthcare manager had reviewed the ACCT [Assessment, Care in Custody and Teamwork][7] document and believed that it would entail a lot of work. He and the Chair were to visit HMP Peterborough for advice. The Chair reported to the next meeting that the prison had not yet implemented the ACCT procedure due to the amount of work involved. He explained that, "A caseworker has to be present when review is done – in our environment this [would] mean there would need to be 3 to 4 caseworkers for each detainee. Additionally, there would need to be 12 to 15 assessors. Peterborough was visited as is similar to Harmondsworth." The September meeting noted that implementing ACCT would be a 'big job' and that no other detention centres were running it. It was agreed, however, that the procedure represented best practice and should be followed.

ACCT represents current best suicide prevention practice in a custodial environment and should be implemented by all removal centres as soon as possible. I understand that it is intended to roll out the ACCT process to all removal centres, something I very much welcome.

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[7] During the next two years, the F2052SH (the Prison Service system for managing risk of self harm and suicide) is to be replaced with a new system to help identify and care for prisoners at risk of suicide or self harm. The replacement is known as the ACCT Plan (Assessment, Care in Custody and Teamwork). This was successfully piloted at five establishments in 2004. ACCT encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis, or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

I recommend that IND publishes a timetable for the roll-out of ACCT throughout the removal estate.[8]

Suicide Prevention Committee

More generally, I am disappointed by what appears to be a lack of robustness and effective intervention by the Suicide Prevention Committee. The issues of both form completion and reception procedures came up month after month. There is little point having a Suicide Prevention Committee if it cannot rectify shortcomings and bring about improvements in practice.

I recommend that the centre manager reviews the make up of the Suicide Prevention Committee to satisfy himself that it has sufficient authority to bring about change.

I recommend that, where issues are raised at the SPC, a clear plan of action is formulated and recorded and a named individual charged with implementing it within a given timescale.

Finally, I note that the suicide and self harm prevention strategy does not include a requirement for a detainee to sit on the Suicide Prevention Committee. I appreciate the difficulties this poses with such a transient population, but there is no reason why the same detainee would have to attend all meetings. Capturing detainees' perspectives of the centre, its staff and what might make a difference to a vulnerable detainee is potentially an extremely valuable tool in managing risk of suicide and self harm.

I recommend that a detainee representative be sought for each SPC meeting.

Engagement of other detainees

One of the recommendations I made in relation to the previous death at Harmondsworth was that detainees should be encouraged to speak to staff if they were worried about another detainee. I am pleased to note, therefore, that the draft 'Rough Guide to Harmondsworth' advises:

> "If you have concerns about your own situation or about other detainees in the centre not feeling well or are particularly upset then please come and talk to an officer about it. If you are feeling anxious or worried about something and need to talk, need advice or need assistance then do not be wary of discussing this with the officers working on your wing."

In addition, (but pre-dating my recommendation), the Suicide and Self Harm Procedure published on 31 January 2005, says that,

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[8] I understand that it is planned to roll out the ACCT procedures in May 2007.

> “All staff having contact with detainees will observe and assess behaviours, setting the example to detainees who will be encouraged to identify and report concerns to staff so that appropriate support can be offered ...
>
> “Notices, printed in a variety of languages, will be displayed to social and official visitors which details actions to take if they have concerns about any detainee. Notices will also be displayed in detainee areas detailing actions to take if they have concerns regarding other detainees.”

Given the nature of the population, staff simply are not in a position readily to identify risk of self harm before it happens. Other detainees are an invaluable source of information in this respect.

Immigration Service correspondence

This is the eighth death of an immigration detainee I have investigated since becoming responsible for such investigations in April 2004. In reviewing the Immigration Service files, I was struck once again by how impenetrable much of its correspondence must be for detainees whose command of English is limited. Indeed, the terms of the letters setting out Third Country policy would test many native English speakers. I accept that the Immigration Service must set out the legal position in a precise way, but there is a need too to ensure the detainee understands what is being said. There is enough uncertainty around detention and removal without burdening detainees with letters they cannot understand.

I recommend that the Immigration Service reviews all its standard letters to ensure they are as simply and clearly written as possible.

10. Conclusion

It is simultaneously a consolation and a cause for concern that I have not been able to identify something that could have been done, or something that should not have been done, in order to prevent this man’s death. On the one hand, staff may be reassured that they were not responsible for his death. On the other, the absence of specific lessons to be learned leaves open the very real possibility of further tragedies.

For this reason, my examination of the issues has focussed on a number of policies and procedures that I consider would benefit from review and further thought. I hope that, by addressing these, the number of gaps through which detainees might fall will be reduced.

It may be true that these gaps cannot be completely eliminated in an environment where people have already lost much and still have much they might lose; where they face uncertainty about their future and the length of their incarceration; where they are isolated from their families; and where the transience of the population means that individuals are largely invisible.

However, this is the challenge to which all Immigration Removal Centres must rise.

11. Recommendations

- **I recommend that Immigration Service staff are reminded that, wherever a detainee has attempted to harm him or herself, all documentation should refer to that fact.**

- **I recommend that the G4S staff be commended for sending the advance warning but advised to incorporate as much background detail as possible to ensure no relevant details are over-looked. (It follows from this that the Immigration Service must ensure that escort staff are fully briefed.)**

- **I recommend that all centre managers remind staff and others responsible for detainees' care to highlight significant pieces of information in a prominent position on the F2052SH.**

- **I recommend that use of the Safer Suite at Dover be restricted to those occasions when no buddy is available to support the detainee.**

- **I recommend that the Detainee Profile Report is amended to include a field specifically for history or risk of self harm. (Staff should be required to specify which.)**

- **I recommend that reception staff are instructed to draw upon all documentation when completing the detainee profile.**

- **I recommend that the IS91 is automatically updated and re-issued after any significant event.**

- **I recommend that the centre manager ensures that reception procedures for those arriving on open F2052SHs are reviewed and clear practice set out. This must be completed and communicated to staff as a matter of urgency.**

- **I recommend that staff are reminded of the importance of finding out and recording what triggered any previous attempts at self harm.**

- **I recommend that in all instances case reviews be carried out by staff with personal knowledge of the detainee.**

- **I recommend that, wherever possible, membership of the group conducting the case reviews for a particular detainee must be consistent for the duration of the period of risk.**

- **I recommend that the selection of staff carrying out case reviews is regularly audited.**

- **I recommend that further training be given to staff on completion of the F2052SH paperwork.**

- **I also recommend that senior managers regularly scrutinise the 2052s and provide immediate feedback to staff.**

- **I recommend that staff charged with carrying out special watches be instructed to speak to the detainee as often as possible, except where this is clearly not welcomed or not appropriate. They should record details of any relevant conversations.**

- **I recommend that, where an F2052SH is closed, a named officer be appointed to keep in contact with the detainee for the duration of his stay.**

- **I recommend that the centre manager reviews staff equipment in light of my comments in this report.**

- **I recommend that the centre manager ascertains whether refresher training on suicide prevention is up to date and, if it is not, takes urgent steps to remedy the situation.**

- **I recommend that IND publishes a timetable for the roll-out of ACCT throughout the removal estate.**

- **I recommend that the centre manager reviews the make up of the Suicide Prevention Committee to satisfy himself that it has sufficient authority to bring about change.**

- **I recommend that where issues are raised at the SPC, a clear plan of action is formulated and recorded and a named individual charged with implementing it within a given timescale.**

- **I recommend that a detainee representative be sought for each SPC meeting.**

- **I recommend that the Immigration Service reviews all its standard letters to ensure they are as simply and clearly written as possible.**