

**Investigation into the circumstances surrounding the  
death of a man in December 2011 at hospital while in the  
custody of Harmondsworth Immigration Removal Centre**

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

**August 2013**

This is the report of an investigation into the death of a man who died in December 2011 at hospital aged 40. A post mortem report gave the cause of death as massive haemoptysis (coughing up of blood) and disseminated tuberculosis infection (widely dispersed within his lungs). I extend my condolences to his family and all who have been affected by his death.

The investigation was carried out by an investigator. An independent clinical review of the healthcare the man received while in custody was carried out by a clinical reviewer. I apologise for the delay in producing this report.

The man, a French national, was homeless when he was arrested and detained at Harmondsworth Immigration Removal Centre (IRC) on 12 November. He was taken to hospital on 16 November and diagnosed with tuberculosis the next day. He remained in hospital until 28 November when he was discharged back to Harmondsworth. He returned to hospital on 2 December after his condition deteriorated. He died a few days later after a prolonged bout of coughing and severe internal bleeding.

The clinical reviewer was critical of the three-day delay in recording observations when the man first arrived at Harmondsworth, given that his physical condition and history of sleeping on the streets suggested possible tuberculosis. He concluded, however, that the delay was unlikely to have been particularly detrimental as he was likely to have lived with his condition for some weeks.

The man's family in France learned of his death through the French judicial authorities. The investigation is critical of the United Kingdom Border Agency (UKBA) and Harmondsworth's failure to find his next of kin details, offer condolences, explain how he died, return his belongings or offer financial assistance for the repatriation of his body. It is disappointing that even when these shortcomings were pointed out during the investigation, Harmondsworth maintained that its response had been "reasonable and proportionate". Clearly, it was not.

Accordingly, the report makes a total of seven recommendations regarding the appropriate assessment of risk factors in relation to tuberculosis and ensuring that lessons are learned regarding the weaknesses identified in the management of family liaison and staff support, and in information sharing within UKBA and between UKBA and the contractors.

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

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## SUMMARY

1. The man was a French national who was homeless and living on the streets. On 22 July 2011, he was questioned about his immigration status during a patrol of Central London by the United Kingdom Border Agency (UKBA). He was warned by UKBA that he was liable to be removed from the United Kingdom, even though he was an EU citizen, because he was not in employment or education and did not have a stable home address in the UK. He was asked to report to the UKBA for interview on three occasions but did not turn up.
2. The man sought advice from the French Consulate and agreed in principle to return to France in October but changed his mind. He was arrested and detained on 11 December by a joint patrol of police and UKBA officials and taken to Harmondsworth Immigration Removal Centre on 12 November pending removal to France. Harmondsworth is operated by the contractor GEO Group on behalf of UKBA.
3. When asked for his next of kin by a nurse during a health screen on reception to Harmondsworth, the man gave the names of his parents and their telephone number, this was written in his clinical record. He was coughing and had body lice so after a wash and change of clothes he was given a single room in the induction centre that night before being taken to the Healthcare Centre the next morning.
4. The man was given an isolation room in the Healthcare Centre. Arrangements were made by UKBA for him to return to France on 16 November but his flight was cancelled on 15 November when he was found to be short of breath and had a chest infection. His health deteriorated and after his persistent cough did not improve following medical treatment, he was taken to hospital for further tests. He was diagnosed with pulmonary tuberculosis. He spent 13 days in hospital escorted by detainee custody officers.
5. The man was discharged from hospital on 28 November and treated with the appropriate medication on his return to Harmondsworth. However, his previous symptoms returned and, on 2 December, he was taken back to hospital. A few days later, after a prolonged bout of coughing, he began to haemorrhage blood. Hospital staff were unable to stem the bleeding and he died. A post mortem examination report gave his cause of death as massive haemoptysis (coughing up blood) and disseminated tuberculosis infection.
6. A clinical reviewer carried out a review of the clinical care the man received while in custody. He did not believe that his death could have been prevented. However, he concluded that had an early warning risk score been considered as part of the reception assessment process he could have been admitted earlier to hospital as staff would have been alerted to deterioration in his clinical state.

7. The man's body was repatriated to his family in France with the assistance of the French Consulate. For several months, neither Harmondsworth nor UKBA contacted the family to express their condolences, offer an explanation of how he died, return his belongings or offer financial assistance to his family in line with its own policies.
8. We have made a number of recommendations about the importance of effective family liaison, support for staff, improved clinical care such as the use of an early warning risk score to alert staff to a patients deterioration, communication between Harmondsworth's GEO Group Centre Manager and UKBA's Harmondsworth office and communication between UKBA Harmondsworth and its Local Immigration Team in Central London.

## THE INVESTIGATION PROCESS

9. The Ombudsman's office was informed of the man's death on 6 December 2011. The investigator issued notices to staff and immigration detainees asking anyone with any information to come forward. The investigator received a letter from a detainee. Unfortunately, the letter was not seen until 9 January and we were unable to interview him before he was removed to India on 17 January 2012.
10. Another investigator visited Harmondsworth IRC on 13 December on behalf of the original investigator and was given access to the man's records held at Harmondsworth. He met UKBA manager, Harmondsworth's GEO group Centre Manager and the then Healthcare Manager.
11. The local PCT appointed a clinical reviewer to undertake a review of the clinical care the man received at Harmondsworth. He received copies of the relevant medical documentation.
12. There were a number of difficulties in receiving all the relevant documentation from UKBA and the lack of a UKBA single contact point meant that communication was hampered. The UKBA North Central London Local Immigration Team port (casework) file was not provided to the investigator until May 2012. In addition, despite the requirement for UKBA to obtain contact details for the man's family and provide them to Harmondsworth and Prisons and Probation Ombudsman's office (PPO), this was not done. These actions were not in keeping with the Memorandum of Understanding between PPO and UKBA. The investigator eventually sought assistance from the French Consulate, who provided her with the relevant details.
13. On 15 May, the investigator met a representative from the Independent Monitoring Board (IMB) (independent and unpaid members of the community who are appointed to each immigration removal centre to ensure that detainees are being cared for humanely). The IMB were concerned that they had not been kept informed of arrangements for the man's funeral nor efforts to trace his next of kin.
14. On 15 May, the investigator also conducted interviews with staff who had contact with the man, the acting Healthcare Manager and the Centre Manager. These interviews had been delayed due to sick absences, annual leave and the lack of documentation required for the investigation. This contributed to the delay in this report being published. The day after visiting Harmondsworth, the investigator provided UKBA and the Centre Manager with feedback.
15. The investigator contacted HM Coroner for West London to inform her of the investigation and to request a copy of the post mortem report. The inquest hearing into the man's death took place on 4 – 5 October 2012. It concluded that he died of natural causes.

16. Our Family Liaison Officers contacted the man's family to explain the investigation process and to give them the opportunity to raise any concerns or issues. They did not raise any issues at the time. The draft report was also shared with his family. A Family Liaison Officer approached UKBA and GEO group's Centre Manager to seek agreement as to which organisation would take responsibility for offering the family the cost of his repatriation to France and returning his belongings.
17. The man's family were contacted by a chaplain from UKBA, on 1 September 2012. He spoke to the man's father, who asked the following questions:  
  
Why had his son been detained?  
What was his cause of death?  
What help is available for repatriation and funeral costs?
18. The chaplain had answered these questions to the best of his ability; however we hope that this report goes some way to help the family understand the circumstances surrounding his death.

## **HARMONDSWORTH IMMIGRATION REMOVAL CENTRE (IRC)**

19. Harmondsworth IRC is a purpose-built secure detention centre on the outskirts of London, near Heathrow Airport. It holds up to 615 male detainees whom the United Kingdom Border Agency (UKBA) has deemed to have no legal right to remain in the UK, but have refused to leave voluntarily.
20. The centre is run by the GEO group, an American company which runs other custodial institutions internationally, including an IRC in Scotland. They have the contract to run the centre on behalf of UKBA until 2014.
21. Harmondsworth was opened in 2001 and expanded significantly between 2006 and 2009. Harmondsworth has the appearance of a prison, however, the detainees are not locked in their rooms during the day and some have their movement only restricted at night. Newly arrived detainees are taken to Fir unit for induction and assessment of their risk to others and to themselves. Lower risk detainees are moved to Dove and Cedar units, described by the Independent Monitoring Board as 'hostel-style'. Ash, Beech and Gorse units are built to prison standard and house higher risk detainees.

### **Healthcare at Harmondsworth**

22. GEO commission the healthcare at Harmondsworth. Since 2011 the provider has been Primecare, the fourth private provider since the centre opened. Due to staff departures, there was no permanent Healthcare Manager from August 2011 to February 2012. The healthcare centre, which is staffed by nurses and healthcare support workers 24 hours a day, has two wards which can each accommodate six detainees; there are some single rooms and two isolation rooms. General practitioners are provided by a local practice, which also provides on-call cover outside of normal working hours.
23. Healthcare complaints made by detainees go to the UKBA Customer Service Centre to be logged before being allocated to the healthcare manager to be answered.

### **HM Inspectorate of Prisons (HMIP)**

24. Her Majesty's Inspectorate of Prisons (HMIP) also inspects immigration removal centres as part of its remit. HMIP carried out a full inspection of Harmondsworth in January 2010 and a follow up inspection in November 2011. In the 2010 inspection, the Chief Inspector commented that healthcare was unacceptably poor in terms of the approach of healthcare staff and the quality and quantity of provision. Detainees said they found it difficult to access healthcare. Overall, the Inspectorate considered that healthcare provision required urgent attention and made 60 recommendations for its improvement including the introduction of a policy for the clinical management of tuberculosis.

25. The 2011 follow up inspection report confirms there are still issues:
- “A major area for ongoing concern was healthcare which remained a source of considerable complaint from detainees. Mental health needs were under-identified and the inpatients department was described by staff themselves as a ‘forgotten world’. The poor service we witnessed the last time we visited was still evident in many respects, but we also saw renewed efforts from managers and improvements were beginning to be seen.”
26. A recommendation of the 2010 inspection report that there should be a policy for the clinical management of tuberculosis had been achieved and there were good links with the local National Health Service tuberculosis service. Another recommendation that healthcare complaints should be reviewed by and responded to by a senior member of health services staff had also been achieved and complaints were answered by the healthcare manager.

### **Independent Monitoring Board (IMB)**

27. Each prison or immigration removal centre has an Independent Monitoring Board (IMB) made up of unpaid members of the public appointed by the Secretary of State for Justice. Their role is to monitor all aspects of a detainee’s life to ensure that proper standards of care and decency are maintained.
28. In their last annual report for 2011 (published in March 2012), Harmondsworth’s IMB highlighted that the quality of healthcare continued to be ‘of very serious concern’ but noted some signs of improvement during the year such as the appointment of several new staff, a reduction in healthcare complaints and a ‘more caring and friendly atmosphere within the healthcare department’.
29. The IMB report highlighted the lack of specific welfare officers to resolve practical problems of detainees such as belongings not arriving at Harmondsworth. It comments that GEO’s policy of tasking all detention custody officers with handling such issues means there is a lack of continuity in seeing such matters through to completion. It also means that no single member of staff carries the responsibility for ensuring that specific issues are resolved.

## **Previous deaths at Harmondsworth**

30. There have been two previous deaths at Harmondsworth which have been investigated by PPO. While the recommendations in both reports have no direct bearing on the investigation into the man's death, it is notable that in one case, the Immigration Service (forerunner to UKBA) did not obtain next of kin details and assumed that the relevant embassy had informed the family of the detainee's death.
  
31. In July 2011, two detainees at Colnbrook IRC, which is next door to Harmondsworth, died. Both had been in Harmondsworth until three and four days respectively before their deaths. Our investigations into their deaths identified similar issues to those in this report. These included the need for better immigration casework handling, liaison with consular staff, the complaints process and the recording of medical and next of kin information at Harmondsworth.

## KEY EVENTS

32. The man was born in April 1971 and was 40 at the time of his death. He was a French national who was homeless and living on the streets in the Marble Arch area of Central London. He was registered on CHAIN, the cross London database of rough sleepers and homeless people. Little is known about how he came to be living in the United Kingdom. As a citizen of the European Economic Area (EEA -European Union countries plus Iceland, Liechtenstein, Norway and Switzerland) he was entitled to travel between EU countries as he had a valid French passport.
33. A member of a charity working with the homeless told our investigator that he became the man's caseworker in March 2011. The man spent six months sitting in the same spot in Marble Arch in spite of inclement weather. He wore the same clothes for six months and covered himself with a blanket but told the caseworker that he did not see it as a problem.
34. According to United Kingdom Border Agency's (UKBA) case notes, the man was questioned about his immigration status during a UKBA patrol on 22 July 2011. He was issued with a 'Minded to Remove' (MTR) letter. This meant that as an EEA national, although he had the right to enter the UK, his right to residence was subject to certain limitations under regulation 6 of the Immigration (EEA) Regulations 2006. In practice this means that, after living in the UK for at least three months but less than five years, EEA nationals can be administratively removed if they are not exercising what UKBA terms 'treaty rights'. This means the individual should either be a jobseeker (actively looking for work), a worker, self employed, a student, a person of self sufficient means or a family member of an EEA national who fits one of these criteria. As he did not appear to be exercising his treaty rights, he was given a MTR letter which asked him to report to Charing Cross Police Station on 22 August for an interview. The purpose of the interview would have been for him to provide further details of his personal circumstances so an immigration officer could make a decision about his status. He did not attend.
35. When the caseworker visited the man on the street near Marble Arch on 2 September, he had a cold and looked run down. As the caseworker believed that he had mental health problems and was not in a position to care for himself, he referred him to the Joint Homeless Team which is part of Central and North West London NHS Trust. He described this as a mental health service aimed at rough sleepers in the London Borough of Westminster. The man, however, was reluctant to engage with the team. Eventually on 12 September, he agreed to see a doctor but when he realised that the doctor was a psychiatrist rather than a General Practitioner, he became angry and refused to talk or engage further.
36. On 15 September, the man was questioned by UKBA again and given another MTR letter asking him to report to Charing Cross Police Station on 25 September. He did not attend the appointment.

37. The homeless charity held a case conference concerning the man a few days afterwards (the caseworker could not recall the exact date). They suggested to him that, as his claim for welfare benefits had been turned down, they could help him return to France as they had contacts within UKBA to help people in similar circumstances. He agreed. The caseworker put him in touch with a member of the social welfare department of the French Consulate, helping French nationals who are destitute and at risk of removal from the UK. She told our investigator that he agreed to return to France but at the last minute he changed his mind.
38. An immigration officer from North Central London Local Immigration Team went to Marble Arch on 28 September and spoke to the man. According to his case file, he did not give him a reason for not attending the interview and told him that the French Consulate would call him to account for his actions. The minute sheet states "Subject further refused to provide any evidence to suggest he was exercising his treaty rights in the UK". He was served with a notice of removal to France "on or around 27 October 2011" and an appeal form (IAFT-1) which gave him 10 working days to appeal.
39. The immigration officer checked the Home Office database but there were no records on the man. A check on the Department for Work and Pensions database showed that he had previously applied for Job Seekers Allowance but it had been refused. He referred the case to a UKBA Inspector, who authorised form IS151A to be served on him. This informed him that he ceased to have the right to reside in the UK as he did not comply with the requirement to exercise his treaty rights.
40. The man was served with notification (form IS96) to report to a UKBA office in Central London on 5 October, 19 and 26 October. He did not turn up on any of the dates requested.
41. On 10 November, the immigration officer contacted a member of the homeless charity by email to say that UKBA would be detaining the man that night. In the early hours of 11 November, the Metropolitan Police Homeless unit conducted a joint operation with UKBA. They found him in Marble Arch. The police custody records show he was arrested at 1.15am as an "immigration overstayer" and arrived at a Police Station at 1.50am.
42. As UKBA regarded the man as an immigration offender, he was served in the police station with immigration form IS91R 'Notice to Detainee, Reasons for Detention and Bail Rights' dated 10 November. This form explained that he would be detained under powers contained in the Immigration Act 1971 or the Nationality, Immigration and Asylum Act 2002 because:

'You are likely to abscond, if given temporary admission or release ...Your removal from the United Kingdom is imminent' and the decision had been reached because 'you do not have enough close ties (e.g. family or friends) to make it likely you will stay in one place, you have previously failed to comply with conditions of your stay, temporary admission or release, you have absconded or escaped.'

43. The immigration officer questioned the man as to his personal circumstances. He told him that he was single, he had no family in the UK, his parents lived in Paris and he had last seen them in January 2011. He said he was not in receipt of any benefits, was 'fit and well' and not prescribed any medication. The immigration officer noted in his case file that he could be 'removed' (returned to France) as soon as possible using the passport in his casework file. He emailed a member of the French Consulate to ask whether any arrangements could be made to support the man when he got to France.
44. A 24 hour review into the decision to detain the man was conducted by a UKBA Inspector. He wrote 'subject is an EEA national failing to exercise his treaty rights; he is also a rough sleeper. Subject has failed to leave UK when required to do [therefore] detention remains appropriate to affect removal'. He spent the rest of the day and most of 12 November in a police station before being taken by immigration escort staff to Harmondsworth at 6.40pm.

### **The man's initial stay at Harmondsworth**

45. The man arrived at Harmondsworth at 9.25pm on 12 November. On arrival, he was seen by a nurse, who conducted a reception screen at 11.15pm. He named his parents as his next of kin and gave their telephone number in France, which was recorded on the Nursing Reception Assessment in his Detainee Healthcare Record (clinical record). He was recorded as homeless. His spoken language was given as English but he could read French. His blood pressure, pulse, temperature, height and weight were not recorded on the assessment. He indicated that he did not have any health issues.
46. The nurse noted that the man had "attended hospital due to bronchitis ... 3 weeks ago – still coughing. Was covered in body lice and all his belongings. To see Dr [doctor]...'
47. The man said he had no previous contact with mental health services and had no mental health issues. He did not have thoughts of self harm. Asked about his vaccination history, the nurse noted "claims completed childhood vaccinations" and indicated that he had been tested for or immunised against HIV, hepatitis B and hepatitis C. He replied that he had not had tuberculosis and the nurse noted that he did not have a visible TB immunisation scar.
48. The man said he had friends in the UK but no family support here as his parents lived in France. He was not expecting anyone to visit him. He was offered and took the opportunity to have a wash and given a change of clothing (as the clothes he was wearing were infested with lice) and then taken to the induction unit for newly-arrived detainees. He was monitored periodically by the night nursing staff – it was noted in his clinical record that he appeared to be sleeping and coughing.
49. At 7.15am, the man was taken to the Healthcare Centre. A nurse opened a barrier nursing care plan for him. Barrier nursing is a method to protect nursing staff from the risk of infection from a patient by setting out instructions

for washing hands, wearing protective clothing and the disposal of bed linen and clinical waste. He was allocated a single room with integral washing and toilet facilities.

50. At 9.10am on 13 November, the man had an appointment with a prison doctor. The doctor did not complete the assessment form in his clinical record but made notes that he had “head and body lice from poor personal hygiene and chest cold – mild, moist, non-productive, lung clear, no wheeze observed”. A healthcare assistant wrote in his clinical record that the doctor had given him cream and lotion for the treatment of lice. She updated the records at 3.45pm to say that he had not eaten or had anything to drink and had declined lunch. Notes by the night staff describe him as feeling well, in a good mood, lying on his bed and coughing.
51. On 14 November, prison doctor explained to the man how to use the cream and lotion he had been given and that he needed to shave off his body hair, which he did.
52. The man saw a prison doctor about his cough at about 9.00am on 15 November. His temperature was recorded as 38.8 degrees (normal range is between 35 and 38.4), his pulse was 116 (normal rate is between 51-100), he had a respiratory rate of 25 (normally 16-18), oxygen saturation of 92% (normally 96-100%) and his blood pressure was 140/100 (most adults have blood pressure readings in the range from 120/80 to 140/90). This was the first time since his arrival at Harmondsworth that these readings had been recorded. His prescription chart shows that 500mg of amoxicillin (antibiotic) three times a day was prescribed for a chest infection. There is no entry in his clinical notes that any further examination was carried out.
53. At about 11.15am, a nurse (unnamed) noted that the man seemed short of breath and his respiratory rate had increased to 26. The nurse discussed his case with a doctor (unnamed in the records) who advised that he should be given two puffs of an asthma pump.
54. UKBA records show that the man’s passport was sent by courier to Heathrow Airport on 15 November and arrangements were made by UKBA’s North Central London Local Immigration Team for him to return on a flight to Paris on 16 November. However at 12.36pm, a member of the UKBA team based at Harmondsworth faxed the Immigration Team to say that he was too unwell to be interviewed and was awaiting a doctor. She asked whether the removal could be deferred. At 1.00pm, a member of the Immigration Team informed Harmondsworth that the removal directions to send him to Paris had been cancelled.
55. At 7.45am on 16 November, a Healthcare Assistant (HCA) recorded that the man was complaining of feeling cold. At 10.15am, she recorded his temperature as 37.4 degrees, his blood pressure was 142/98 and his pulse was 116. She also noted that he was seen by a doctor; however, his medical record does not show whether this occurred.

56. At 3.15 pm the HCA recorded the man's temperature as 39.8 degrees, blood pressure 134/84 and pulse 129 and that he was "sitting on his bed with quilt wrapped around him". She recorded that the doctor had been informed and advised that he should be given paracetamol and ibuprofen.
57. A prison doctor and a senior nurse saw the man shortly after 3.15pm and decided that he should go to hospital for further investigation of his medical condition.
58. Harmondsworth prepared a risk assessment which examined security and health risks in taking the man to hospital. The healthcare centre did not identify any risks. The security department did not have any security information that he posed any particular risk. The Duty Operations Manager decided that the risk was unknown as he had not left Harmondsworth before by escort and that two Detention Custody Officers should accompany him in the ambulance to hospital. The Duty Manager decided that he should be handcuffed to an officer via an escort chain (a chain of approximately 6 feet long with a cuff at either end). He gave the escort specific instructions that if medical staff asked for the escort chain to be removed, approval should be sought from the Duty Manager at Harmondsworth.

#### **The man's first hospital stay 16- 28 November**

59. The man left Harmondsworth by ambulance at 5.25pm and arrived at hospital at 5.40pm on 16 November. After having blood tests and X-rays, he was admitted as an in-patient to the Emergency Admissions Unit and nursed in a side room. Nursing staff told the escorting officers that he would be treated using barrier nursing, so masks would need to be worn.
60. According to the observation record kept by escort staff, at 10.15am on 17 November a doctor asked a Detention Custody Officer (DCO) to remove the handcuffs as he was very weak and attached to a drip. The DCO's entry in the record said that he contacted the Duty Manager (unnamed), who said that that they could be removed on condition that, should an officer or the man need to leave his room, the handcuffs would be placed back on.
61. The doctor advised the DCOs that they should be outside the man's room as his condition was "quite advanced" and that the risk of infection was high. Harmondsworth agreed to this, provided that the escorting officers could see him at all times (there was a glass observation window in the door).
62. On 18 November, Harmondsworth's Healthcare Co-ordinator faxed the UKBA's Detainee Escorting and Population Management Unit (DEPMU) to say that the man had been admitted to hospital with an air borne virus. The next (unsigned) entry in the UKBA file on 21 November said that a decision would be made regarding his removal following diagnosis of his medical condition.

63. On 21 November, the man was moved from the Emergency Admissions Unit to a side room in the hospital. His condition improved and was being monitored through daily blood tests.
64. Entries in UKBA Harmondsworth's file by a manager said that when she attended the morning briefing meeting (between key UKBA and GEO group staff) on 21 November, the man was discussed. Her minute reads "No diagnosis has been made yet, however, if it is he could remain in hospital for a further 6-8 weeks. GEO/H/c [healthcare] has asked if resident could be released. I advised GEO/H/c that I will speak to the c/w [casework team] and see." She further noted that she spoke to a Senior Executive Officer (SEO) at the North London casework unit to ask whether his release could be considered. He replied that the casework team could make a decision once a diagnosis had been made. The immigration officer made a note in the Case Information Database saying:
- "When decision is taken with regards to release, please note that the only place the subject will go is Marble Arch where he has been observed by myself and police and colleagues sitting on a wall next to the Arch. His only covering is two blankets in which he wraps himself and, as far as I am aware, he does not sit under cover. This will need to be taken into account as I am not sure whether sitting all day and night will be conducive to his health. It will be beneficial to liaise with the French Consulate to assist in removal as the subject is known to them."
65. The manager emailed Harmondsworth's interim Healthcare Manager, who replied that the man had been diagnosed with active tuberculosis. She faxed the SEO (UKBA North London) on 22 November asking him to consider release.
66. On 23 November, a member of the UKBA's Local Immigration Team emailed Harmondsworth's Healthcare Manager asking for an update on the man's health. There are no further entries in his immigration record concerning why he was not released at that time.
67. The clinical reviewer has established from hospital records that the man was seen by a doctor on 24 November, who suggested that he be discharged and followed up early as an outpatient. This plan was discussed with another hospital doctor. However, moxifloxacin, (an antibiotic used to treat more resistant infections) was added to his treatment that day and the planned discharge did not take place. The TB Clinical Nurse Specialist reviewed his case on 28 November and planned to see him the following day.

### **Return to Harmondsworth 28 November - 2 December**

68. The man was discharged from hospital on 28 November by a doctor. The hospital provided a discharge summary which said that he had been admitted with the presumed diagnosis of tuberculosis, which was confirmed after a sputum (mucus coughed up from lower airways) sample tested positive. He was started on quadruple therapy (a combination of four drugs used to treat

tuberculosis – pyrazinamide (antibacterial), pyridoxine (vitamin B6), rifinah (combined antibiotic), ethambutol (antibiotic) and prednisolone (a drug to reduce inflammation). He was tested for HIV with his consent and the result was negative. He was treated with moxifloxacin as his breathing was abnormally fast and he was coughing up sputum containing pus, caused by bacterial infection. The hospital referred him to the outpatient's clinic and planned to see him in two weeks. The report summarised that he had been diagnosed with pulmonary TB and iron deficiency and recommended that liver function tests were carried out weekly. He continued to be prescribed the quadruple therapy and other medications when he returned to Harmondsworth, although his clinical record does not show whether the liver function tests were carried out.

69. The hospital's tuberculosis team referred the man to the 'Find and Treat Project' who provide specialist community tuberculosis services, particularly to hard to reach groups and have a role in linking tuberculosis services to prisons and detention centres. Find and Treat are funded by the NHS and come under the umbrella of University College Hospitals NHS Foundation Trust. On 29 November, a TB Specialist Nurse contacted a member of the UKBA Local Immigration Team to find out whether the hospital was going to discharge him back to Harmondsworth. She told him that the man should remain in hospital and not be discharged and she would advise the TB Clinical Nurse Specialist at Hillingdon. He said that as he had not yet received a discharge summary from the hospital, he assumed that the man was still in hospital.
70. The TB Specialist Nurse faxed Harmondsworth's Healthcare Centre on 30 November asking for someone to contact her regarding managing the man's tuberculosis. There is no record that Harmondsworth replied. The Clinical Lead and Manager for Find and Treat told our investigator that they were concerned that the hospital wanted to discharge him back to Harmondsworth, and if Harmondsworth subsequently released him, he would go back to living on the streets and the opportunity would be lost to treat him.
71. The man arrived back at Harmondsworth at 6.30pm on 28 November. His clinical notes covering 28 and 29 November are minimal with no clinical observations recorded, although the appropriate medication appears to have been prescribed and administered. He remained feverish and coughed regularly but appeared settled. At 8.45am on 30 November, his temperature was recorded as 38.7 degrees. On 1 December, it had risen to 39.8 degrees. A prison doctor saw him on 2 December after he became short of breath and his condition appeared to deteriorate. The doctor discussed his condition with a doctor's team at Hillingdon and it was decided that he should return to hospital.
72. A UKBA deputy manager at Harmondsworth updated the UKBA Case Information Database (CID) on 2 December to say that she had attended the daily morning meeting between UKBA and GEO group. She wrote that the Healthcare Manager advised that they would be designating the man as unfit for detention as they felt he had other health issues as well as TB. She

telephoned an officer in the casework unit (UKBA Local Immigration Unit) to let him know.

73. Harmondsworth prepared an escort risk assessment based on the man's risk of escape, as he would be outside the removal centre. A healthcare assessment completed by a nurse said there was an identifiable risk to staff and they should wear masks. The security department assessment was completed by a DCO, who said that there were no relevant security information or reports on him and he had previously been on an escort where handcuffs were used. A Duty Manager wrote specific escort instructions "Single cuff throughout escort, escort chain can be applied in treatment area to assist. Any changes or requests V2 [duty manager] to be informed. Cuffs only to be removed outside of this remit for life threatening emergencies. Staff to be vigilant." The risk of infection to staff flagged up by the healthcare assessment did not appear to have been taken into account.

### **The man's second stay in hospital 2 - 6 December**

74. The man was admitted to a ward at hospital at 4.45pm on 2 December. Following a request from medical staff, the Duty Manager authorised that his handcuffs could be removed and staff posted at the door of his room.
75. The man was observed, his medical treatment was continued and he was given paracetamol to control his fever and oxygen for his shortness of breath.
76. An officer of the UKBA Local Immigration Team also wrote in the CID on 2 December
- "It is clear that this sub [the man] has ongoing health issues and we seem to have a situation where the hospital does not want him under their care, but that our healthcare (at Harmondsworth) may have to deem him unfit for detention. My viewpoint is that if he is too unwell to detain then he should be in a hospital and not in IS [Immigration Service] detention. If he is well enough for IS then we should be proceeding with his removal. I have sent an email to Healthcare (healthcare manager) to ask for a fit to fly. If all OK, his RDs [removal directions] will be set ASAP. Sub has currently been temp discharged back to a hospital and I am awaiting information as to why."
77. Later, an officer from UKBA, Harmondsworth wrote that the Healthcare Manager said "she had been having a re-think as the TB clinic had asked her not to make him unfit to detain as he would become homeless again and then his TB etc would be more difficult to treat".
78. In the event, the man remained in hospital, still in the custody of Harmondsworth and two Detention Custody Officers (DCOs) remained outside the door of his room, using masks when they spoke to him. A doctor recorded in the hospital notes her impression that he had "TB pneumonia" and advised that he remained in hospital until he improved.

### **The events leading up to the man's death**

79. In December, two DCOs took over the escort of the man at about 8.45am. DCO A told the investigator that she introduced herself to him from the room door when a nurse went into his room, and asked him if he needed anything. He replied 'No Miss, I'm fine, I'm fine'. DCO B said he looked at him through the observation window in the room door periodically and saw him was lying on his bed and coughing throughout the day.
80. A hospital doctor saw the man at 10.00am and suggested that his continuing high pulse was likely due to dehydration. On a ward round later in the day, the doctor's team recorded that he "feels improved compared with last week." Further blood tests were recommended due to his continuing anaemia despite him taking iron supplements to the condition.
81. Both DCOs recounted the man's last moments. They were both visibly distressed at interview. They said that at about 6.10pm, his coughing was getting louder and prolonged. They looked through the observation window and saw him sitting "keeled over" on the end of his bed. He coughed and a large volume of blood gushed out of his mouth and on to the bed. DCO B shouted to a passing nurse to get some assistance. When he looked back into the room again, he had fallen to the floor and was bleeding copiously. A resuscitation team rushed to his room and tried to administer Cardio Pulmonary Resuscitation (CPR - a combination of rescue breaths and chest compressions carried out to ensure oxygen and blood continue to circulate around the body). The hospital team were unable to save him due to the volume of blood and blood clots present in his airways. After establishing that there were no signs of life, he was pronounced dead at 6.30pm.

## Events following the man's death

### Support for Staff

82. DCO A telephoned Harmondsworth and informed them of the man's death. In total, the officers say they made five or six calls to Harmondsworth over the next hour and a half to ask to be collected.
83. A manager at Harmondsworth wrote in his incident report that the Duty Operations Manager informed him at 7.00pm that the man had died. He said he asked him if he wanted himself to go to the hospital to support the staff. He agreed, so he went to the hospital with DCO C. He stayed to liaise with the hospital concerning the man's death while DCO C took both DCOs back to Harmondsworth.
84. On their return to Harmondsworth just before 8.00pm, the officers went into the security department and were offered refreshments and asked to complete an incident report. DCO B completed his at 8.00pm and DCO A's was done at 8.20pm. DCO B recalled that two senior managers were there as well as a member of the Independent Monitoring Board. He was angry and explained how he felt he and DCO A had been treated once Harmondsworth had been told of the man's death. He said he could not understand why they had been left at the hospital for an hour and a half, especially as they were in public, as there was no designated rest room for them to use. (However hospital nursing staff did allow them to use their tea room to make a drink and to make telephone calls).
85. Both DCOs were given a lift home. Both were eventually given the number for Oakdale, an organisation that provides telephone counselling for GEO employees.
86. DCO B was off work for two days. He told our investigator that on his return to work no mention was ever made to him about the man's death, how he felt or whether he needed any further support. He described his interview with our investigator as the first conversation he had with anyone on the subject since the man died.
87. DCO A said the day after the man's death a manager telephoned her at home and gave her the telephone number for Oakdale, an organisation which provides telephone counselling. He telephoned her a few days later but she did not have any other personal contact from managers at Harmondsworth. After raising the matter with her trade union representative, she received a letter from the Centre Manager in mid-December asking if there was anything she could do to help, but no-one visited her or spoke to her in person. The traumatic manner of the man's death affected her deeply and she was unable to return to work for several weeks. On her return she was supported by a manager and allowed a gradual, phased return to full duties.

### Informing staff and detainees about the man's death

88. Harmondsworth did not inform staff or detainees of the man's death until our investigator sent the Prisons and Probation Ombudsman's (PPO) notices of investigation. At this time the Centre Manager issued separate notices to staff and detainees which prefaced those of the PPO. Both notices drew attention to the PPO notices but did not mention his death or local sources where staff or detainees could seek support.

### Contacting the man's family

89. On 7 December, the Immigration Officer telephoned a member of the French Consulate to inform them of the man's death. He asked her to find out whether he had any family in France who should be notified and with whom arrangements for his burial should be made. In addition a member of the UKBA Local Immigration Team emailed her to ask whether they were able to inform his family of his death. She responded on 8 December that the family had been contacted and they wanted his body to be returned to France. The subsequent entries on the UKBA database from 18 December onwards are concerned with UKBA returning his passport to the French Consulate.
90. A Chief Immigration Officer (CIO) added the final entry to UKBA's Case Information Database on 6 January to say that a DC from the Metropolitan Police had reported that the man's body had been returned to France, but his family said that it was not him. The CIO noted that on each date UKBA spoke to the man before he was detained, he gave a false name. He had his French passport with him and although he had lost weight and changed his hairstyle, the CIO said that the UKBA photograph of him on file and his passport did match although his appearance had changed. The DC had confirmed that his fingerprints and DNA matched those contained in police records when they came into contact with him in 2004. The DC telephoned later in the day to say that the Coroner had investigated the matter and confirmed that the correct body had been returned to France.
91. Our investigator contacted a Detective Sergeant (DS) of the Metropolitan police to try to clarify how the man's family came to learn of his death. He said that after the man died, Harmondsworth contacted the police in line with their contingency plans. The police concluded there were no suspicious circumstances and contacted the French Consulate in order to establish his identity. Through the French Consulate, the Metropolitan police were put in touch with France's Office for Judicial Affairs who confirmed that he was French, with a French identity card and had no family in the United Kingdom.
92. Our investigator spoke to an official of the French Consulate on 25 January. She explained that when she had telephoned the man's father who lived in a town on the outskirts of Paris, he was already aware of his son's death from the police in France. She had not made a note of when the conversation took place and she did not know whether the news had been delivered in person or by telephone. He asked her to delay the repatriation until after Christmas and the New Year, so it was arranged for 3 January 2012. He did not raise

specific concerns but asked how his son had died. She said that as far as she was aware, the family had paid for the repatriation themselves.

93. A spokesperson from the funeral director that repatriated the man, told our investigator that UKBA had not contacted her company. She said that repatriation costs of around £2,200 had been paid for by the man's family. In addition, the family had paid a French funeral director to collect his body when it arrived in Paris and to conduct a funeral in his home town.

#### Post mortem report

94. A post mortem examination was conducted on 12 December. The examination was limited due to the high risk of disseminated TB. The man's right coronary artery was completely blocked by atheroma (accumulated fatty deposits). There was evidence in his respiratory and gastro-intestinal systems of caseous necrosis (dead cell tissue consistent with tuberculosis infection) and blood clots. No tissue samples were taken for toxicological analysis. The pathologist commented that massive haemoptysis (coughing up blood) is a recognised cause of sudden death in TB. He gave the cause of death as massive haemoptysis and disseminated tuberculosis infection.

## ISSUES

### Clinical Care

95. A review of the man's medical care was carried out by a clinical reviewer. He considered the man's clinical records, examined hospital records from the hospital and undertook a review of the good practice in the diagnosis and management of tuberculosis in a custodial setting.
96. The man's first reception health screen recorded that he gave no history of serious health problems and he had received childhood vaccinations but this may not have included TB. He had attended another hospital with what he called 'bronchitis' but his cough had persisted despite being prescribed medication. It was noted that he had body lice and he was admitted to an isolation room in the healthcare centre pending examination by the GP.

### Establishing a diagnosis

97. The clinical reviewer commented that the man underwent reception screening on 12 November by a nurse soon after arriving at Harmondsworth. The nurse noted his lice infestation and cough but did not record any observations. On 13 November, a prison doctor did not complete the doctor's assessment form (using instead the continuous medical record sheets). He did not record basic observations such as temperature or pulse, but he listened to the man's chest and diagnosed a "chest cold". The clinical reviewer continued:

"It was not until the third day of his detention that any observations were recorded on the man. By then he had seen three doctors and several nurses. Given the history of rough sleeping, the finding of body lice suggesting a lack of self-care and the history of cough over several weeks pointing towards possible TB, this is poor."
98. On 15 November, the man's temperature, pulse, respiratory rate, oxygen saturation and blood pressure were recorded for the first time. Part of the doctor's record of the consultation was "coughing ++". Although no further examination was recorded, the doctor decided to prescribe 500mg of amoxicillin (antibiotic) three times a day for seven days. Two hours later a nurse, who was concerned that he was short of breath, discussed his case with an unnamed GP who advised that he should have two puffs of salbutamol (an asthma treatment), even though his symptoms pointed to an infection rather than asthma.
99. A doctor sent the man to hospital by ambulance on 16 November for further investigation of an "atypical chest infection". The clinical reviewer comments that: "had observations been recorded between 13-15 November with an appropriate early warning risk score, his admission could have been arranged up to three days earlier". He suggests in his report that, if an early warning score (such as the Modified Early Warning Score - MEWs) had been used on

15 November, his score would have indicated the need for an urgent hospital admission. However, he considers that: “with retrospect, it seems likely that the man had been suffering from TB ... as long ago as October 2011”.

100. The clinical reviewer states that, in his opinion, it is unlikely that the three day delay in diagnosis contributed directly to the man’s death as he had probably been suffering from tuberculosis for several weeks already and he had responded to treatment following his first admission to hospital.
101. The clinical reviewer concluded that the man’s death could not have been prevented by any additional actions by staff at Harmondsworth. However, he was concerned that basic observations were not carried out regularly and that his history of rough sleeping, the finding of body lice (suggesting a lack of self-care) and the history of a cough over several weeks did not alert staff to possible tuberculosis. He made specific recommendations relating to this, which we reframe as follows:

**The Healthcare Manager should ensure that staff are vigilant in identifying risk factors for tuberculosis, especially during reception health screening. An early warning risk score (such as MEWs) should be used as part of the assessment of detainees who appear acutely unwell.**

#### **Use of restraints**

102. Any use of restraints to prevent escape should be based on an assessment on the actual risk the detainee poses at that time. On both occasions when the man was taken to hospital, the risk assessments in his Detainee Escort Records concluded that he should be restrained. On 16 November, the first time he went to hospital, the assessment noted that little was known about him and it appears restraints were used as a default position. He did have a chest infection and symptoms that needed further investigation, but was also mobile. We are satisfied that, given the lack of information and his mobility that restraints were applied appropriately on this occasion.
103. On 2 December, the second time the man was taken to hospital, it was known that he had active tuberculosis and that he had been to hospital before and been well behaved and had made no attempt to escape. In addition, the risk of infection to staff was flagged up by the healthcare assessment. We are surprised therefore to note that restraints were still imposed. However, Harmondsworth did remove the restraints after a hospital doctor spoke about the risk of infection to the escorting staff. We are concerned that he was restrained on this second occasion, there was little attempt to assess the risks that he actually posed at that time, and apparently no consideration was given to the infection risk to staff.

**The Centre Manager should ensure that risk assessments regarding the use restraints carried out before a detainee is taken to outside hospital are based on the actual risks the detainee poses at that time and balance security with the health of the detainee.**

## Contact with the man's family

104. The 2005 Detention Services Operating Standards covering the handling of a death in detention stipulate that the Immigration Removal Centre must make arrangements for the transfer of the body to the next of kin.
105. In June 2009, the GEO Group, which manages Harmondsworth on behalf of UKBA, drew up a contingency plan on how to handle deaths of detainees in detention. It states in its introduction (in bold type) 'the prime responsibility for dealing with a death in custody lies with The GEO Group UK'. Annex A sets out a table of liaison between GEO, UKBA, the Coroner and family. Under the heading 'Action by Harmondsworth' it said:

"Detention Services will now offer to meet the cost of a funeral or cremation within the UK (up to £3,000). Provide a set amount (approximately the same as UK funeral costs) towards the cost of repatriating the body or cremated remains to the country of origin."
106. Under the heading 'Action by Centre Manager' with the timescale of "immediately" it says "check that UKBA have arranged for next of kin to be notified". The Centre Manager is responsible for contacting the bereaved family by telephone or letter of condolence and arranging a follow-up visit to family within two to three days. The Centre Manager also has responsibility for arranging a follow-up visit or detailed letter with further contact as appropriate.
107. At a monthly meeting between UKBA, GEO and the Independent Monitoring Board (IMB) on 12 December, the IMB were told that the man's 'case owner' was trying to contact his next of kin in France. According to the notes of the follow up meeting on 11 January attended by the UKBA Manager at Harmondsworth and the Centre Manager for GEO, the UKBA Manager said that the police had informed Harmondsworth that the man's family "that had seen the deceased body have confirmed that he is not their family member. It could be assumed that he was travelling on false documentation." It was agreed that UKBA would speak to the case owner and provide the IMB Chairman with more information. No further information was forthcoming. This is despite the police informing UKBA on 6 January that the man had been correctly identified and that his family had received the right body.
108. However, a copy of relevant pages from the man's passport was in his UKBA Local Immigration Team casework file. The passport contained the address of his parents in France. In addition, he gave the names of his parents and their telephone number when he arrived at Harmondsworth on 12 November and this was noted in his clinical record. Neither of these sources seems to have been considered by either UKBA or Harmondsworth.
109. After the man's death in December, it is clear from the documentation provided by UKBA that they were aware by 8 December that the French Consulate had made contact with his family. Neither UKBA nor

Harmondsworth asked the French Consulate for the family's address or telephone number. It does not appear that either UKBA or the Centre Manager at Harmondsworth regarded contact with the family as their responsibility.

110. Once the French Consulate started to make arrangements for the man's repatriation, staff at UKBA appeared to concentrate on where his passport should be sent, not the needs of the bereaved family. Neither UKBA nor Harmondsworth offered the family any significant support. No contact was made, no condolence letter sent and the man's belongings were not returned as soon as practicable. Indeed, his property remained in Harmondsworth and it was not until our investigator asked about it that any effort was made to return it to the family. Finally, no offer of support was made with the costs of repatriating the body or the funeral, as required with the Detention Services Order on deaths in detention.
111. On 6 September 2012, this office was told that a member of the chaplaincy team from Harmondsworth had telephoned the man's father (we understand this was Harmondsworth's first contact with them). The man's father raised a number of matters including whether there was any financial assistance available to them. We are concerned that he was advised that a letter would follow, setting out "how to ask the UK authorities for such assistance". The family should not be expected to ask for assistance, it should be offered.
112. The Centre Manager told our investigator that Harmondsworth's response was "reasonable and proportionate". We disagree, and believe the man's case demonstrated a lack of recognition of the importance of timely and meaningful interaction with a bereaved family.

**The Director of UKBA Detention Services should ensure that when a detainee dies in custody next of kin details are gathered immediately and the detainee's family personally informed and appropriately supported, including being offered financial assistance for repatriation of the body and funeral in line with guidance.**

### **Family Liaison Arrangements**

113. The investigation has demonstrated clear weaknesses in family liaison in this case. Matters might have been improved if a trained Family Liaison Officer had been appointed who could have acted as a central point of contact and pursued matters for Harmondsworth and the man's family.
114. Harmondsworth's Centre Manager suggested to the investigator that there was no need for a designated family liaison officer, as all managers had the skills to deal with families. This view is hard to accept given the facts of the case. While staff may have been sympathetic towards the bereaved family, little or no support was offered. This also underestimates the specialist skills that may be required for this sensitive role.

115. The number of deaths of detainees that occur in Immigration Removal Centres is, thankfully, small. The last death that occurred at Harmondsworth was in 2006. This may suggest that the need for Family Liaison Officers (FLO) may be different from other custodial institutions. However, apart from deaths, detainees do attempt to harm themselves or end up in situations where staff contact with a family member may be necessary or desirable. We believe it is important for there to be appropriately trained staff available for this task.

**The Centre Manager of Harmondsworth should ensure that there are suitably trained staff to enable the appointment of a named Family Liaison Officer whenever the death of a detainee occurs.**

### **Staff support**

116. Both DCOs were both still clearly distressed when interviewed some five months after witnessing the man's sudden and traumatic death. Indeed, DCO B said that our interview was the first opportunity he had been given to talk about the events in December. DCO A described his death as an extremely shocking experience. They had remained outside the hospital room but as the door had been half-open they were aware of the efforts to resuscitate him and could see the extent of blood on his bedding and on the floor. She summed up the effect the experience had on her:

“I sat at home for weeks and weeks thinking about that man. I have children myself and in my mind I kept thinking ‘this is someone’s son’. Does anyone know this guy is dead? Does he have any friends? Does he have any family? Does he have anyone? All these things pestered me for weeks and weeks and weeks ...”

117. DCO A found the telephone counselling useful but was told by Harmondsworth's Human Resources department that they did not offer a face-to-face service and she should contact her own doctor to ask to be placed on her local waiting list. At the time of interview, she had been waiting for counselling for five months. She said that she had worked at Harmondsworth for almost 12 years and there had previously been a Post Incident Care Team (PICT) for staff but this no longer existed.
118. We discussed the lack of face-to-face counselling with the Centre Manager and were told that Harmondsworth had a contract with Oakdale Employee Support Service to provide to GEO employees and their immediate families “unlimited access to a 24-hour counselling helpline, structured telephone counselling with the same counsellor, face to face counselling with prior approval from HR [and] management consultation service”. It is clear both officers were not aware that face to face counselling was available.
119. We are concerned that there is no staff care team at Harmondsworth to enable staff to support each other when a traumatic event has occurred. Both officers shared a distressing experience and they wanted to talk to someone about it and receive some support. DCO B commented that he wanted to talk

to a colleague who was familiar with his work environment, not a stranger on the end of a telephone. Telephone support can be successful but it should complement a staff care team not replace it. Both officers commented that until our investigator interviewed them, no-one had asked them how they were coping since the immediate aftermath of the man's death.

**The Centre Manager of Harmondsworth should ensure that there are effective peer support arrangements to meet the needs of staff who have experienced a traumatic event at work.**

120. When a detainee dies, it can be distressing for detainees and staff who had contact with or got to know the individual. We are surprised and disappointed that Harmondsworth did not appear to consider the effect that news of the man's death may have had on staff or detainees. They did not issue notices to staff or detainees until PPO sent notices announcing the purpose of our investigation. One of the purposes of issuing an informative notice to staff and prisoners is to give clear basic facts about what happened and provide information about sources of support. It also helps to dispel misunderstandings and set out what is to happen next.

**The Centre Manager should always issue notices to staff and detainees confirming the death of a detainee and details of the support mechanisms available to them.**

#### **Poor communication**

121. The investigation has exposed some weaknesses in communication between UKBA Local Immigration Team (LIT), UKBA Harmondsworth and the GEO Centre Manager. UKBA Harmondsworth and UKBA LIT did not appear to keep each other up to date, not helped by the misplacing of the man's Harmondsworth file. There was also poor information sharing between UKBA Harmondsworth and the GEO Centre Manager. For example, his case files show that there was enough information for UKBA staff and GEO Group staff to have contacted his family and provided them and the Independent Monitoring Board with meaningful information. Instead, meetings between the Centre Manager and UKBA Harmondsworth staff relied on information on him that was out of date.

**The Director of UKBA Detention Services should ensure that crucial information on the death of a detainee is shared effectively within UKBA and between UKBA and the Centre Manager.**

## CONCLUSION

122. The man was a French national who came to UKBA attention as he was homeless in the UK and living on the streets in Central London. After being detained, he was diagnosed with pulmonary tuberculosis and spent almost two weeks in hospital before being discharged. His health deteriorated and he returned to hospital but died there four days later.
123. The clinical reviewer states that the man's death probably could not have been prevented, but highlights that key observations were not taken for three days and an appropriate early warning risk score was not used.
124. The man was restrained both times he went to hospital until medical staff asked for the restraints to be removed. We accept that the first time his risks were not known and therefore the decision to restrain was appropriate. However, we are not satisfied that the risk assessment on the second occasion took into account the actual risk of escape at the time or balanced this with his medical condition, including the risk to staff from the infectious nature of his TB.
125. UKBA reported the man's death to the police, but made no attempt to contact his family as it believed it did not have their contact details. However, his clinical record contained his parent's names and telephone number and his UKBA case file contained a photocopy of his passport taken in November 2011 with the address of his parents on it. Likewise the GEO Centre Manager at Harmondsworth did not make any attempt to contact his family or attempt to obtain contact details from UKBA.
126. We are concerned about the lack of understanding of the importance of family liaison at Harmondsworth. We are concerned that when shortcomings in family liaison were raised with Harmondsworth, it considered its response to be reasonable and proportionate.
127. We are also concerned that support for the staff who were with the man when he died had been patchy and that they had spent the months since trying to come to terms with the traumatic manner of his death.

## RECOMMENDATIONS

**The Service's response is noted in italics below each recommendation:**

1. The Healthcare Manager should ensure that staff are vigilant in identifying risk factors for tuberculosis, especially during reception health screening. An early warning risk score (such as MEWs) should be used as part of the assessment of detainees who appear acutely unwell.

*Room Sharing Risk Assessment and Healthcare screening complies with recommendation.*

2. The Centre Manager should ensure that risk assessments regarding the use restraints carried out before a detainee is taken to outside hospital are based on the actual risks the detainee poses at that time and balance security with the health of the detainee.

*Risk assessments are completed and recorded in advance on all detainees subject to escort in accordance with DSO 08/2008. Risk assessments take proper account of security information, offending history, ability to abscond, clinical advice/concerns and the medical condition of the detainee. The risk assessment document includes input from the security department, healthcare and the Duty Manager as a minimum. The decision on whether to use handcuffs or not will be based on the individual risk assessment and the reasons for the decision will be clearly recorded. Escort risk assessment paperwork has been updated in October 2012 to ensure consistency of decisions on cuffing.*

3. The Director of UKBA Detention Services should ensure that when a detainee dies in custody next of kin details are gathered immediately and the detainee's family personally informed and appropriately supported, including being offered financial assistance for repatriation of the body and funeral in line with guidance.

*UKBA and Service provider staff are required to obtain this information upon detainee arrival into the IRC. UKBA staff seek this information at induction stage and Service provider staff seek this information upon arrival during the Reception process. The current DSO on Deaths in Detention provides clear instructions on ensuring the detainee's family is informed and the process for offering financial assistance.*

4. The Centre Manager of Harmondsworth should ensure that there are suitably trained staff to enable the appointment of a named Family Liaison Officer whenever the death of a detainee occurs.

*Following on from the incident, the Centre's contingency plans for Death in Custody have been reviewed to include the delegation of a family liaison officer, typically a member of the chaplaincy or welfare team whom possess the skills to undertake this role.*

5. The Centre Manager of Harmondsworth should ensure that there are effective peer support arrangements to meet the needs of staff who have experienced a traumatic event at work.

*The Manager of Religious Affairs (MRA) has taken the lead on the establishment of a Staff Support Group (SSG) made up of Centre staff who are able and willing to be available to other staff who are experiencing personal difficulties (either work related or from outside work) and that may be affecting their work. Eight individuals from diverse backgrounds have volunteered and the MRA is currently drafting a brief set of guidelines for these SSG members. The SSG will provide a listening ear, be confidential (unless there is an overriding reason not to be) and seek to offer simple practical advice. Once established, the existence of the SSG will be communicated appropriately to all staff.*

6. The Centre Manager should always issue notices to staff and detainees confirming the death of a detainee and details of the support mechanisms available to them.

*This will be issued as promptly as is practicable following any future death in detention.*

7. The Director of UKBA Detention Services should ensure that crucial information on the death of a detainee is shared effectively within UKBA and between UKBA and the Centre Manager.

*This will be addressed going forward by the DSO on Deaths in Detention.*