Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bai Bai Ahmed Kabia a detainee at Morton Hall IRC on 6 December 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Bai Bai Ahmed Kabia died in hospital on 6 December 2016 of a brain haemorrhage, having been detained at Morton Hall Immigration Removal Centre. Mr Kabia was 49 years old. I offer my condolences to Mr Kabia's family and friends.

We consider that the clinical care Mr Kabia received at Morton Hall was equivalent to that he would have received in the community. However, we are concerned that the correct emergency response procedures were not used. It is also troubling that an emergency responder was delayed in gaining access to Morton Hall.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **October 2017**

Contents

Summary

Events

1. On 18 September 2014, Mr Bai Bai Ahmed Kabia was made the subject of a deportation order after serving a prison sentence for fraud. On 27 November 2014, he was sent to Morton Hall Immigration Removal Centre to await deportation. Mr Kabia had no relevant medical concerns while at Morton Hall.

2. On 5 December 2016, Mr Kabia complained of a headache. Healthcare staff saw him and noted that his observations were normal and that he did not require any further intervention. Mr Kabia subsequently returned to his room.

3. At 4.24pm, Mr Kabia alerted officers, complaining about a headache and asked to see a nurse. At 4.29pm, he called for help again, and an officer stated that he was now more distressed. As Mr Kabia was not known to seek medical help without cause, the officer went in person to fetch healthcare staff and returned with a nurse and a healthcare assistant at 4.35pm.

4. The nurse observed that Mr Kabia was able to communicate in full sentences and his observations were normal. He suddenly began to vomit, dropping back onto his bed, and slurring his words. The nurse immediately asked an officer to call an ambulance. The officer left Mr Kabia's room and went in person to pass on the request for an ambulance to the duty custodial manager. The custodial manager made and logged this call at 4.49pm, and instructed the gate staff to let the ambulance straight in. She did not use an emergency code but turned her radio to the security network for easier communication with the ambulance crew.

5. The nurse noted that Mr Kabia was struggling to breathe, was unresponsive, and had dilated pupils. At one point his pulse dropped. Together with another nurse, he began cardiopulmonary resuscitation (CPR) and monitored Mr Kabia's pulse. Mr Kabia's pulse returned so the nurse continued assisting him to breathe, and monitored him until the ambulance arrived.

6. At 5.09pm, a further (emergency) ambulance was requested. At 5.10pm, a volunteer clinical professional arrived at the gate house of Morton Hall, but was denied entry while security checks were performed. An ambulance arrived at Morton Hall shortly afterwards and was allowed straight through security, reaching Mr Kabia at 5.13pm. The volunteer was also then allowed entry. A second ambulance arrived at 5.27pm. Mr Kabia was taken to hospital at 6pm.

7. Mr Kabia was given a CT scan that evening which indicated he was brain stem dead. Hospital staff confirmed that brain stem tests were required to confirm this and these were performed the following day.

8. Mr Kabia was pronounced dead at 7pm on 6 December.

Findings

Clinical care

9. We agree with the clinical reviewer that the clinical care Mr Kabia received at Morton Hall was equivalent to that which he could have expected in the

community. We also agree that Mr Kabia's death could not have been predicted or prevented.

Emergency response

10. Mr Kabia did not initially appear to require urgent assistance, and we find that officers behaved appropriately. When officers returned to Mr Kabia at 4.29pm, his condition had deteriorated and an officer stated that she thought the matter was serious. Despite this, the officer went in person to collect healthcare staff rather than making an emergency call on her radio. This led to a delay of approximately five minutes. While this is unlikely to have saved Mr Kabia, it was an unnecessary delay.

11. When Mr Kabia deteriorated rapidly and became unresponsive, the nurse asked an officer to call an ambulance. The officer went in person to the control room a second time and asked her manager to call an ambulance. We are, again, concerned that the officer did not radio an emergency code.

12. After calling for an ambulance, the custodial manager instructed the gate staff to allow the ambulance straight in. A volunteer medical professional arrived first, but was denied entry on security grounds. The ambulance arrived shortly afterwards and gained immediate entry, at which point the volunteer was also allowed entry. We accept that there was minimal delay, and that the ambulance gained immediate entry, but we are concerned that the volunteer was delayed despite the gate staff being informed there was an emergency.

13. Before the first ambulance arrived, it became clear to the ambulance operators that an emergency ambulance would also be needed. This call was logged at 5.13pm, and the ambulance arrived at 5.27pm. We are concerned that the failure to use an emergency code may have prevented an emergency ambulance being requested in the first place. We are also concerned that the request from the nurse for an emergency ambulance was not clearly understood or conveyed.

Support for staff

14. Morton Hall posted notices for staff informing them of Mr Kabia's death, and offering support, but we are concerned that they failed to hold a hot debrief.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. All staff should use an emergency code immediately there are serious concerns about the health of a detainee to alert control room staff to call an ambulance automatically.
- The Governor should ensure that the Centre Instruction is amended to clarify situations relating to emergency access, or develop local protocols to cover all situations regarding emergency response.
- The Governor should ensure that a debrief is held promptly after the death of a detainee and that all of the staff involved are offered effective support.

The Investigation Process

15. The investigator issued notices to staff and detainees at Morton Hall Immigration Removal Centre informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator visited Morton Hall on 12 December 2016. He obtained copies of relevant extracts from Mr Kabia's detention records and medical records. He interviewed three members of staff at Morton Hall on 12 December 2016

17. NHS England commissioned a clinical reviewer to review Mr Kabia's clinical care at Morton Hall. The investigator and clinical reviewer interviewed two members of staff and one detainee on 9 January 2017.

18. The Prisons and Probation Ombudsman has a duty to investigate any death which occurs while a detainee is in the custody of an Immigration Removal Centre, and the discretion to investigate a death which occurs after a detainee has been released from detention. On 26 January 2017, the investigation into the death of Mr Kabia was stopped when it came to light that he had been released from his detention prior to his death at the hospital. On 10 May, following correspondence with solicitors representing Mr Kabia's family, the Prisons and Probation Ombudsman decided to exercise their discretion and restart the investigation following submissions from the family of Mr Kabia.

19. We informed HM Coroner for Central Lincolnshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

20. The investigator wrote to Mr Kabia's friend and nephew to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They did not respond directly, but appointed solicitors who liaised with one of the Ombudsman's family liaison officers. They did not specify any particular issues for the investigation to consider.

21. Mr Kabia's family received a copy of the initial report. The solicitor representing Mr Kabia wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

Morton Hall Immigration Removal Centre

23. Morton Hall Immigration Removal Centre, near Lincoln, was previously a prison and is run by the Prison Service on behalf of the Home Office. It holds up to 392 adult men in single rooms in six residential units. Nottingham Healthcare NHS Trust provides 24 hour healthcare cover at Morton Hall. Mr Kabia was located in Fry residential unit.

24. A Home Office team of contact management officers are based at Morton Hall, and are responsible for liaising between the detainees and their Home Office caseworkers. The Home Office caseworkers are responsible for managing the immigration case of detainees, and have the authority to make decisions administratively relating to their detention and external escorts.

HM Inspectorate of Prisons

25. The last inspection of Morton Hall was conducted in November 2016. Overall, inspectors found the IRC was generally well run. The reception area remained cramped and too small for purpose but screening of new arrivals was thorough. Many detainees reported feeling depressed or suicidal on arrival. There had been a three-fold increase in incidents of self-harm since the previous inspection in 2013.

Independent Monitoring Board

26. The Independent Monitoring Board (IMB) consists of unpaid volunteers from the local community who help ensure that detainees are treated fairly and decently. In its most recent annual report for the year ending December 2016 the IMB noted that Morton Hall is a very well-run establishment and provides a safe and secure environment for the detainees being held there. However, they observed that there had been increasing levels of verbal abuse, aggression and violence directed to staff, often as a consequence of drug abuse. The board was impressed with developments in healthcare provisions, in particular the increased staffing levels for mental health and the reinstatement of an appointment system for GP consultations.

Previous deaths at Morton Hall Immigration Removal Centre

27. Mr Kabia was the first natural cause death at Morton Hall since it became an immigration removal centre in 2011.

Key Events

28. Mr Bai Bai Ahmed Kabia was sentenced to 15 months imprisonment for fraud on 9 May 2013. He was made the subject of a deportation order on 18 September 2014, while in prison at HMP Moorland. On 14 November, he was released from prison, but remained detained at Moorland due to the order.

29. On 27 November 2014, Mr Kabia was transferred to Morton Hall Immigration Removal Centre (IRC). He had a reception health screen on his arrival, and had no medical concerns at that time.

30. On 11 May 2015, healthcare staff saw Mr Kabia after it was reported by staff on his unit that he might have had had a seizure. Mr Kabia's behaviour was recorded as being strange, but he denied taking any illicit substances. Healthcare staff saw Mr Kabia, and recorded his clinical observations as normal. He was monitored by healthcare staff, and his behaviour returned to normal after a few hours. The following morning, Mr Kabia saw a nurse in clinic complaining of dental pain. Other than this occasion, Mr Kabia did not have any significant or relevant health concerns during his time at Morton Hall

31. On 18 September 2015, Mr Kabia spent a short time in another IRC, before returning to Morton Hall on three days later. He had a reception health screen on his arrival back at Morton Hall, but no medical concerns were raised.

Events during the afternoon on 5 December 2016

32. During the afternoon of 5 December 2016, Mr Kabia was visited by two charity volunteers. One of the volunteers reported that Mr Kabia complained of a terrible headache and held his head in pain, saying that he had never had such a bad headache. The volunteer gave Mr Kabia some water, and asked an officer to contact medical staff urgently. Mr Kabia drank the water but did not seem to improve. The volunteer followed up with the same officer and was told that medical staff were aware and would attend as soon as they were free. The volunteer recalled that it seemed to take over 15 minutes for them to arrive.

33. At about 3.30pm, a nurse and a healthcare assistant attended to Mr Kabia in the visiting hall. Mr Kabia told the nurse that this had happened previously when his blood pressure fell and his neck tightened. Mr Kabia also said that he had not drunk enough, but felt better once he had drunk some water. The nurse noted that Mr Kabia's observations were all normal, but advised him to continue taking fluids and to attend the nurse clinic in the morning to have his blood pressure checked. Mr Kabia continued with the visit and the volunteer said that he appeared better but was still clearly suffering. The visit ended at about 4.15pm.

Emergency response

34. At 4.22pm, Mr Kabia arrived back at his room on Fry Unit. At 4.24pm, he pressed his call bell and two officers went straight to his room. Officer A said in interview that Mr Kabia was holding his head and was asking to see a nurse, so she went to the Fry Unit office to telephone for a nurse. There was no answer at the healthcare unit, so she left a message at Johnson Unit, another residential block, where they were dealing with another incident.

35. At 4.29pm, Mr Kabia pressed his call bell again and Officer A attended immediately, accompanied by another officer, who had been on duty earlier in the visiting hall. Officer A said in interview that Mr Kabia seemed to be more distressed than earlier. She said she took the matter seriously because he did not usually seek medical attention without justification. She returned to the Fry Unit office, but left at 4.34pm to fetch healthcare staff from Johnson Unit.

36. At 4.35pm, Officer A returned to Mr Kabia's room with two nurses. Mr Kabia told Nurse A that his head was very painful and confirmed that it was similar to the headaches he had experienced before. She confirmed that at this stage Mr Kabia was groaning in pain, but able to speak in full sentences. He denied having taken any illicit substances. She took Mr Kabia's blood pressure and other observations, which were all within normal limits. She reported that as he was finishing these observations, Mr Kabia said he was going to be sick. He sat upright and began to vomit. He then rolled back onto his bed and his speech became slurred. She confirmed in interview that he could no longer elicit any response from Mr Kabia. He placed him in the recovery position and asked an officer to call for an ambulance. In interview, she confirmed that this request was for an emergency ambulance.

37. Officer A went to the Fry Unit office, and told a Custodial Manager (CM) that an ambulance was required. The communications log at Morton Hall stated that at 4.48pm, the CM requested an ambulance "straight away". She returned with the officer to Mr Kabia's room, and switched the radio onto the security network to enable direct contact with the control room for relaying information to and from the ambulance crew. She also instructed the gate staff to let the ambulance in as soon as it arrived.

38. Nurse A stated that he performed a full 'head to toe' assessment on Mr Kabia while waiting for the ambulance, and quickly realised that Mr Kabia's breathing was laboured. Mr Kabia was not responding and his eyes were fixed and dilated. His pulse quickly started to drop and he was struggling to breathe, so she rolled him onto his back and began to assist him using a breathing mask.

39. When the Head of Healthcare arrived, she and Nurse A decided to start CPR on Mr Kabia after his pulse dropped significantly. The nurse administered rescue breaths while the Head of Healthcare performed chest compressions. Another nurse attached a defibrillator, but it advised against giving a shock. After three cycles of CPR, Mr Kabia's pulse and oxygen levels recovered, so the chest compressions were stopped, although Nurse A continued to provide rescue breaths. She said that after about 20 minutes paramedics arrived, but asked her to carry on assisting Mr Kabia to breathe.

40. At about 6pm, Mr Kabia was taken by ambulance to hospital. He was accompanied by two officers but was not restrained.

Ambulance response

41. East Midland Ambulance Service (EMAS) confirmed that they received the first call for an ambulance at 16.49pm. EMAS dispatched an ambulance crew and a community first responder from the Lincolnshire Voluntary Emergency Service -

LIVES. (This is a charity which provides qualified medical professionals from the community to attend emergencies.)

42. The LIVES volunteer arrived at Morton Hall at 5.10pm, and was first to arrive at the centre. He said he was delayed at the gate to Morton Hall due to security checks. He further stated that while these checks were going on, the ambulance crew arrived and gained immediate entry. He told the operators he was going to leave but was told that a cardiac arrest was suspected, so he returned to the gate and gained entry straight away.

43. The EMAS log recorded that the first ambulance arrived at 5.10pm, and the LIVES volunteer arrived shortly afterwards.

44. EMAS confirmed that a request was made for a paramedic first responder (an emergency ambulance) at 5.09pm, seemingly in response to the dialogue between the control room at Morton Hall and the ambulance crew. This second ambulance arrived at 5.27pm and was with Mr Kabia by 5.35pm.

45. Both ambulances left Morton Hall at 6pm, and arrived at the hospital at 6.25pm.

Mr Kabia's time in hospital

46. At about 7pm, an officer emailed the Home Office Immigration Manager at Morton Hall to inform her that Mr Kabia had been taken by ambulance to hospital with a suspected stroke.

47. The escort officer noted that Mr Kabia was taken for a CT scan at 7.05pm. At 8.10pm, he recorded that the CT scan indicated that Mr Kabia was brain stem dead.

48. At 8.12pm, a senior officer at the Home Office called a manager enquiring about the situation in respect of restraints for Mr Kabia. She contacted the Orderly Officer to confirm that Mr Kabia had not been restrained.

49. At 8.45pm, a nurse spoke to a staff nurse at the hospital and was told that Mr Kabia was in a critical condition and that they planned to perform brain stem tests later that day or the following morning. She informed the manager and staff at Morton Hall.

50. At 10am on 6 December, the manager called Mr Kabia's case worker at the Home Office to enquire whether his release from detention was being considered. She called again to ask whether this process could be speeded up. At 10.34am, Mr Kabia's *IS106 (Authority to Release*) paperwork was emailed to Morton Hall. This was sent to staff at reception at 11.47am, and to the Governor and Deputy Governor at Morton Hall at 11.59am.

51. At 12.10pm, the Head of Healthcare called staff at the hospital and noted that Mr Kabia was having treatment to correct abnormal blood results before brain stem tests could be carried out. At 4.02pm, she noted that the first brain stem test had been completed, and the second one would happen later that day. Hospital staff said they could not disclose the result of this first test at that time. At 5.47pm, she noted that the second brain stem test was underway.

52. Mr Kabia was pronounced dead at 7pm on 6 December.

Contact with Kabia's family

53. A manager was appointed as the family liaison officer upon Mr Kabia's admission to hospital. Mr Kabia's friend was listed as his next of kin.

54. The manager called Mr Kabia's friend at 7.50pm on 5 December, to inform her of his condition. She also asked whether Mr Kabia had any blood relations in the country, and Mr Kabia's friend said that there was a distant relative who was "like a brother", whom she would inform. Mr Kabia's friend said she would not be able to visit Mr Kabia, but would appreciate receiving updates from her.

55. The blood relation that Mr Kabia's friend was referring to was his nephew. At 9pm, his nephew called the manager. He said that he had already spoken to staff at the hospital and did not require updates from her as he was happy to deal directly with the hospital.

56. On 6 December at 12.30pm, Mr Kabia's friend called the manager because she had heard that Mr Kabia had died. She told her that Mr Kabia was still alive, but that he remained in a critical condition. At 10.33pm, a nurse called the manager to tell her that Mr Kabia had died at 7pm, and that his next of kin had been informed. The following morning, the manager called Mr Kabia's nephew.

57. The manager remained in regular contact with Mr Kabia's nephew and provided him with support. She called him on 12 December to tell him that a memorial service had been held for Mr Kabia the day before, and that a book of condolence had been opened and would be sent to the family.

58. On 23 February, Mr Kabia's body was repatriated to Sierra Leone, with all the costs being covered by the Home Office. They also paid for Mr Kabia's nephew to accompany the body, and for the funeral costs, including the church service.

Support for detainees and staff

59. Morton Hall posted notices informing staff about Mr Kabia's death. The staff care team also offered support. There was no record of a hot debrief with staff members following Mr Kabia's death.

60. Morton Hall posted notices informing other detainees of Mr Kabia's death, and offering support. Staff reviewed all detainees assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Kabia's death.

Post-mortem report

61. The post-mortem recorded that Mr Kabia's immediate cause of death was an intra-cerebellar haemorrhage (a type of stroke caused by bleeding within the brain tissue). The pathologist stated that further examinations revealed that this was caused by arteriovenous malformation (a naturally occurring abnormality of blood vessels which are prone to rupturing).

Findings

Clinical care

62. We agree with the clinical reviewer that the clinical care Mr Kabia received at Morton Hall was equivalent to that he would have expected to have received in the community. We also agree that given Mr Kabia's cause of death, this could not have been predicted or prevented.

63. When in May 2015, staff reported that Mr Kabia might have had a seizure, or taken something illicit, Mr Kabia denied taking any drugs, and his clinical observations were all normal on examination. He was kept under review, and his behaviour returned to normal a few hours later. It is good practice for anyone suffering from a first seizure to be assessed by a GP, and we agree with the clinical reviewer that it may have been prudent for a GP appointment to have been offered. We note, though, that Mr Kabia did not seek further medical attention himself following this incident, and did not mention it when he saw a nurse the following morning. Mr Kabia did not mention this when he had a further health screen on his return to Morton Hall in September that year, and did not report any other significant medical concerns during his remaining 18 months in detention there.

Emergency response

64. DSO 09/2014, *Emergency Medical Response Codes,* requires IRCs to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. It states that all IRC staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The DSO makes it clear that there should be no delay in admitting and discharging an ambulance in a medical emergency.

65. Morton Hall had a Centre Manager's Order (*Emergency response No. 023.16*) in place at the time of Mr Kabia's death. This contained mandatory instructions for detention staff to use in the event of an emergency response and stated they must:

> "Call the Comms room by radio or telephone immediately. The term 'Code One' should be used for chest pain, difficulty in breathing, being unconscious, fitting or concussed, severe allergic reaction or suspected stroke. The term 'Code Two' should be used for serious loss of blood, severe burns or scalds or suspected fracture."

The instruction added that Comms staff must call for an ambulance immediately on receiving a code one or code two call, and request healthcare staff to attend immediately to deal with the patient. It also stated that the Comms room should inform gate staff to ensure they facilitate the swift entry and exit of emergency vehicles. The instruction also stated that if staff had concerns about the medical welfare of residents but did not think it was serious enough to be life threatening, healthcare staff and Oscar 1 (the senior officer on duty) should be contacted immediately. However, if the situation developed into an emergency situation, the emergency procedure should be implemented immediately.

66. We accept that when Mr Kabia was first seen in his room at 4.25pm, he did not appear to require urgent assistance, so we accept that officers took appropriate steps in trying to locate a nurse. However, when Mr Kabia was seen at 4.29pm, he was in far greater distress and Officer A confirmed in interview that she took the situation seriously. She did not use an emergency code, or her radio, but went in person to find healthcare staff. While it did not take long for her to leave the unit and return with healthcare staff, we would have expected her to have used their radio in these circumstances, to ensure a more timely response.

67. When Nurse A requested an ambulance, Officer A went in person to the Fry Unit office, and it was the CM who contacted Comms to request an ambulance. We would have expected an officer to have used an emergency code immediately in these circumstances, and find this to be a missed opportunity to ensure a prompt emergency response at a time when any delay could be critical.

68. The CM returned with the officer to Mr Kabia's room, with her radio switched to the security network. There is no record of an emergency code being given at any time, but an emergency ambulance was requested at 5.09pm. We are concerned that an emergency ambulance was not requested in the first place, and find that this was in part due to the initial failure to use an emergency code, and that the request from the nurse for an emergency ambulance was not clearly understood. We consider that there were several missed opportunities for healthcare staff to have seen Mr Kabia sooner. These included a failure to request an emergency ambulance earlier, using the appropriate emergency code, and the apparent failure to understand the urgency of the request for an emergency ambulance at all. We make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. Staff should use an emergency code immediately there are serious concerns about the health of a detainee to alert control room staff to call an ambulance automatically.

69. When the LIVES volunteer arrived at Morton Hall, he was delayed due to security checks at the gate. The Centre Instruction clearly states that staff on the gate should ensure the swift entry of emergency vehicles, but is unclear as to the situation where an emergency responder arrives effectively on foot. We accept that this did not cause a significant delay in this case, but nevertheless make the following recommendation:

    The Governor should ensure that the Centre Instruction is amended to clarify situations relating to emergency access, or develop local protocols to cover all situations regarding emergency response.

Restraints

70. The IRC are responsible for decisions relating to restraints and escort risk assessments for IRC detainees. The Home Office Manager liaised with Home Office officials and confirmed with IRC staff that restraints were not required for Mr Kabia. He was never restrained during his escort to hospital or at any time

while he was there. We are satisfied that Morton Hall and the Home Office acted appropriately in not restraining Mr Kabia.

Detention release

71. Home Office officials are solely responsible for decisions relating to the detention of individuals awaiting deportation. These decisions are taken administratively under the delegated authority of the Secretary of State for the Home Office.

72. Once Mr Kabia became unconscious and posed no flight risk, a manager referred his case to a case worker at the Home Office to initiate a review of his detention. She proactively chased a decision in relation to this, and his release from detention was confirmed during the morning on 6 December, and communicated to all relevant people by 11.59am that day.

73. We are satisfied that Home Office staff at Morton Hall acted appropriately in ensuring Mr Kabia was released from his detention in a timely manner.

Contact with Mr Kabia's next of kin

74. The Home Office are responsible for family liaison contact for detainees in an IRC. The manager was appointed as the family liaison officer for Mr Kabia on his admission to hospital.

75. Mr Kabia's next of kin was listed as his friend. The manager rang Mr Kabia's friend promptly following Mr Kabia's admission to hospital. During this phone call, she established that Mr Kabia had a nephew in the country, so continued to liaise with him as well.

76. Mr Kabia's nephew was informed of Mr Kabia's death by the hospital, but the manager continued to liaise with him to assist in issues relating to the repatriation of Mr Kabia's body to Sierra Leone. She also arranged for all the costs to be paid, including the cost of Mr Kabia's nephew's accompanying his body.

77. We consider that Home Office staff at Morton Hall acted appropriately in their dealings with Mr Kabia's family, and make no recommendation.

Support for staff

78. Morton Hall posted notices for staff informing them of Mr Kabia's death, and offering support, but they failed to hold a hot debrief. We would have expected this to have happened in the circumstances, and make the following recommendation:

The Governor should ensure that a debrief is held promptly after the death of a detainee and that all of the staff involved are offered effective support.

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