Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shazad Aziz a detainee at Morton Hall Immigration Removal Centre on 19 November 2017

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*

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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.

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

Mr Shazad Aziz was found hanged in his room at Morton Hall Immigration Removal Centre (IRC) on 19 November 2017. He was 27 years old. I offer my condolences to Mr Aziz's family and friends.

Mr Aziz was an Iraqi Kurdish national who was facing deportation from the UK after serving a prison sentence. He was considered at risk of suicide and self-harm for several periods while serving his sentence and was monitored under HM Prison and Probation Service suicide and self-harm prevention procedures.

Mr Aziz remained in prison under immigration detention for 16 months after his sentence ended. Due to his declining mental health and bizarre behaviour, he spent four months in a psychiatric hospital under assessment where he was diagnosed with an untreatable personality disorder. He was transferred to the immigration detention system in January 2017 where he stayed a further 10 months. He had spent almost four months at Morton Hall when he was found hanged.

Although there was little to indicate Mr Aziz was at imminent risk of suicide before his death, I am concerned that custodial staff at Morton Hall were insufficiently aware of his risks and personal history. They did not obtain most of his previous suicide and self-harm records or make sufficient use of those they had. Had they done so they would have had a better understanding of the risks he posed to himself.

I am particularly concerned that the underlying reasons for Mr Aziz's "Adult at Risk" status were not at the forefront of some staff's consideration of his welfare.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **July 2019**

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Summary

Events

1. On 10 May 2014, Mr Shazad Aziz, an Iraqi national, was remanded into prison on charges of assault against his former partner. On 11 December, he was sentenced to two years imprisonment and was recommended for deportation to Iraq once his sentence was served.

2. During his time in prison – at HMP Elmley and later at HMP Maidstone - staff started suicide and self-harm monitoring known as ACCT on several occasions after Mr Aziz harmed himself or expressed thoughts of suicide.

3. On 8 May 2015, Mr Aziz completed his custodial sentence but he remained at Maidstone pending decisions by immigration officials on his future. In August 2015, he withdrew his application for asylum and was transferred to HMP Lewes after he said he would hang himself if he was not moved out of Maidstone. He was unable to secure bail due to lack of a suitable address and public protection issues.

4. Over the next six months staff started ACCT procedures on several occasions after Mr Aziz's risk to himself escalated and he harmed himself, expressed thoughts of suicide and attempted to hang himself.

5. In October 2015, he said he wanted to leave the UK voluntarily and the Home Office referred his case to the Iraqi Consulate. In March 2016, the Iraqi Consulate told the Home Office it could not give a timescale for providing travel documents.

6. In April 2016, Home Office officials assessed that Mr Aziz was not suitable for detention in an Immigration Removal Centre (IRC) due his history of self-harm and unstable mental health. He remained at Lewes.

7. In September 2016, after a marked decline in his psychological wellbeing and an increase in disturbed behaviour, Mr Aziz was admitted to a psychiatric hospital for assessment. In December, a consultant psychiatrist concluded that Mr Aziz did not show clear evidence of suffering from a treatable mental illness, and that he was fit to be detained, preferably in an IRC as his self-harming behaviour was likely to resurface in a prison environment.

8. On 28 November, Mr Aziz's continued detention was authorised by a senior Home Office official. On 23 December, Home Office staff designated Mr Aziz an 'Adult at Risk' due to his mental health issues (meaning there was a presumption that he should not be detained unless immigration control factors outweighed his risk factors).

9. On 23 January 2017, he was transferred to Colnbrook IRC where he was monitored under suicide and self-harm procedures known as ACDT for six weeks. He was later moved to Harmondsworth IRC and then, at his own request, to Brook House IRC.

10. In April 2017, the Iraqi Consulate agreed to provide travel documents and Mr Aziz's removal to Iraq was set for 4 June 2017, but had to be put on hold when he applied for a Judicial Review.

11. On 27 July, a consultant psychiatrist saw Mr Aziz at Brook House and diagnosed him with schizophrenia.

12. On 30 July, Mr Aziz was transferred to Morton Hall IRC at his own request. Mr Aziz declined involvement with the Mental Health Team, although they continued to monitor him and offer support. His mental health appeared largely stable although there were occasions when he neglected his room and his personal care, and appeared to use psychoactive substances.

13. On 16 October, Mr Aziz's application for Judicial Review was refused. On 19 October, the Home Office decided that there were no further bars to his removal and his case was referred to the Returns Team so they could arrange a date for his deportation.

14. On 28 October, Mr Aziz set fire to a towel and left it in his empty room. The next day, his access to facilities was reduced under the Incentives Privileges Scheme (IPS) and he was moved to a residential unit where detainees were locked in their rooms at night.

15. On 15 November, Morton Hall sent Mr Aziz an update on his immigration status through the internal mail, which was prepared on 10 November. It is not clear whether he received it.

16. On 19 November, an officer completing an early morning roll check saw Mr Aziz hanging from the window in his room. The officer raised the alarm at 6.14am, went into Mr Aziz's room, cut the ligature and started cardiopulmonary resuscitation (CPR). Healthcare staff continued with resuscitation attempts until a paramedic arrived. The paramedic pronounced Mr Aziz dead at 6.39am.

Findings

17. There was little to indicate that Mr Aziz was at imminent risk of suicide at the time of his death. He was relatively stable mentally and had not self-harmed for more than 18 months.

18. However, the investigation found that Mr Aziz's risk factors had not been sufficiently highlighted. Although healthcare staff at Morton Hall knew of Mr Aziz's complex mental health history and risk of suicide and self-harm, HM Prisons and Probation Service (HMPPS) did not obtain previous risk information that was available to them. Residential unit staff were largely unaware of his history of vulnerability. NOMIS (the HMPPS case notes system) lacked much of the information contained in the separate Home Office casework database, and few staff had access to both computerised systems.

19. The planning for Mr Aziz's transfer from Brook House to Morton Hall focused on transport arrangements. The healthcare team at Brook House were unaware that Mr Aziz had been transferred to a different IRC until he had already left. As a result, there was no healthcare handover between the two IRCs despite there being a 'healthcare to healthcare process' for best practice transfers between

IRCs. This was particularly important for Mr Aziz as he had been diagnosed with possible schizophrenia three days before the transfer.

20. This lack of coordination and information-sharing is worrying, but particularly so as Mr Aziz had been designated as an ‘Adult at Risk’ by the Home Office in December 2016. There is no evidence that this generated sufficient action to assess or monitor his risk to himself after he set fire to a towel in his room.

21. We note that Mr Aziz spent 30 months in detention under immigration powers, which was longer than the time he served in prison.

Recommendations

- The Centre Manager at Morton Hall IRC should ensure that IRC staff manage detainees at risk of suicide or self-harm and Adults at Risk in line with DSO 6/2008 and DSO 08/2016. In particular staff should:
    - Review the effectiveness of the First Night Assessment questionnaire.
    - Consider and record all the known risk factors of newly arrived detainees when determining their risk of suicide or self-harm, including information from person escort records, previous ACCTs/ACDTs, medical records and Home Office databases.
    - Use all sources of information when conducting a Room Sharing Risk Assessment review.

- The Centre Manager and Head of Healthcare at Brook House IRC should carry out a root cause analysis to understand why a ‘healthcare to healthcare’ handover did not take place before Mr Aziz was transferred to Morton Hall.
- The Home Office Director General for Immigration Enforcement should ensure that Adult at Risk status is taken into account by IRC staff when assessing a detainee’s risk to themselves and the way in which that risk should be managed.

The Investigation Process

22. The investigator issued notices to staff and residents at Morton Hall IRC informing them of the investigation and asking anyone with relevant information to contact her. One resident contacted the Ombudsman's office expressing concerns about the condition of the IRC and the risk of further deaths, but no one provided specific information about Mr Aziz's death.

23. The investigator obtained copies of relevant extracts from Mr Aziz's custodial, detention and medical records from the IRC. She also met Mr Aziz's case owner at the Home Office's Criminal Casework Team and obtained copies of relevant paperwork relating to Mr Aziz's detention.

24. NHS England commissioned an independent clinical reviewer to review Mr Aziz's clinical care at the IRC.

25. The investigator and clinical reviewer jointly interviewed four members of staff at Morton Hall IRC. The investigator separately spoke to four residents about life at Morton Hall, though none wished to be identified out of concern that it would affect their detention adversely. The interviews took place between November 2017 and May 2018.

26. We informed HM Coroner for Central Lincolnshire of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

27. One of the Ombudsman's family liaison officers contacted Mr Aziz's uncle to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He raised a number of questions including:

    - Why was Mr Aziz detained for so long after his custodial sentence had finished?
    - Why he was not returned to Iraq?
    - Why was he moved to Morton Hall when he had mental health problems?
    - Why did staff not enquire more into his missed appointments?

28. Mr Aziz's uncle received a copy of the initial report but did not raise any further issues. Immigration Enforcement received a copy of the initial report. Its Detention and Escorting Services group pointed out some factual inaccuracies which have been amended in this final report. HMPPS' Centre Manager wrote to the Deputy Ombudsman with her concerns about the initial report. We have responded by way of separate correspondence.

Background Information

Morton Hall Immigration Removal Centre (IRC)

29. Morton Hall is a rural low-rise IRC near Lincoln. It is the only IRC managed by HM Prisons and Probation Service (HMPPS) on behalf of the Home Office. It holds up to 392 men. The residential accommodation comprises six units with single rooms. Two of the units, Windsor and Fry, are regarded as more secure and detainees who are seen as higher risk are housed there. HMPPS staff run the residential units and are responsible for the physical safety and security of the site. A small team of Home Office staff provide liaison between detainees, case workers in other Home Office locations and the wider operational network of immigration enforcement. Healthcare services are run by Nottinghamshire NHS Foundation Trust.

HM Inspectorate of Prisons

30. The most recent inspection of Morton Hall was in November 2016. Inspectors said the centre looked and felt like a prison and this was a major issue for detainees who experienced very high levels of frustration fuelled by lengthy periods in detention without a clear pathway to release. There had been a significant decline in safety since their last inspection in 2013. They found that levels of violence, anti-social behaviour and self-harm had risen and there did not appear to be a clear understanding of why this had happened.

31. Nearly half of detainees said they had problems with feeling depressed or suicidal on arrival. Detainees at risk of self-harm who were monitored under ACDT were reasonably well supported. Inspectors saw many examples of positive interactions between staff and detainees and relationships were generally strong, despite the anger and frustration detainees felt. The bleak physical condition of some of the residential buildings, particularly Windsor and Fry which were very dirty in places, and the austere conditions contributed to a tense atmosphere. The incentives and privileges scheme penalised poor behaviour while doing little to encourage good behaviour. (It was discontinued in December 2017 and replaced by the Behaviour Management Strategy which is tailored to increase or decrease access to the facilities that each resident participates in.)

Independent Monitoring Board

32. Each IRC has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that detainees are treated fairly and decently. In its annual report for the year to 31 December 2017 they found Morton Hall was well managed and the quality of care offered to detainees appeared to be good. The IMB expressed concern about the number of former prisoners who had completed their sentences but were still in detention, and about the levels of verbal abuse, aggression and violence. Many residents complained to them about the frustration they felt at the length of time they had spent in detention and that Morton Hall was like a prison. The IMB was impressed with the healthcare services, particularly mental health, but questioned the suitability of the centre for residents with serious mental health conditions.

Previous deaths at Morton Hall IRC

33. Mr Aziz was the second detainee to apparently take his life at Morton Hall IRC in 2017. The investigation into the death of the other detainee also identified concerns about staff identifying and recording all known information about risk and self-harm.

Assessment, Care in Detention and Teamwork (ACDT)

34. ACDT is the Home Office care-planning system used to support detainees at risk of suicide or self-harm. HM Prisons and Probation Service operates a similar system (ACCT). The purpose of ACDT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the detainee. After an initial assessment of the detainee's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary review meetings involving the detainee. As part of the process, a care map (a plan of care, support and intervention) is put in place. The ACDT plan should not be closed until all the actions of the care map have been completed. All decisions made as part of the ACDT process and any relevant observations about the detainee should be written in the ACDT booklet, which accompanies the detainee as they move around the centre. Guidance on ACDT procedures is set out in Detention Services Order (DSO) 6/2008.

Safer Detention Meetings

35. Safer Detention meetings involve healthcare, security, safer custody, custodial and immigration staff and take place weekly at Morton Hall. Residents who are on an ACDT plan are discussed. Since 13 October 2017, detainees who are Level 2 or 3 Adults at Risk who would need additional support on release are listed in the minutes and any action points are noted.

Enforced Departures from the UK

36. There are three main categories of state enforced departures: deportations, administrative removals, and voluntary departures. Deportations apply to people whose removal from the country the Secretary of State deems to be 'conducive to the public good'. A court can also recommend a deportation in connection with conviction of a criminal offence that carries a prison term. Administrative removals involve the enforced removal of non-British citizens who have either entered the country illegally or deceptively, stayed in the country longer than their visa permitted, or otherwise violated the conditions of their leave to remain. Voluntary departures involve people against whom enforced removal has been initiated. Some people depart by official Assisted Voluntary Return schemes, others make their own travel arrangements and tell the authorities, and some people leave without notifying the government.

Adults at Risk

37. In 2015, Mr Stephen Shaw, a former Prisons and Probation Ombudsman, conducted a review of the welfare of vulnerable people in immigration detention. His report led to the publication in December 2016 of Home Office guidance *'Adults at Risk in Immigration Detention'* with the aim of striking the right

balance between protecting the vulnerable and maintaining legitimate immigration control. The guidance requires that an evidence-based assessment should be carried out to ascertain whether an individual is at risk, what level risk of harm they face (on a three-tier scale) and whether immigration considerations outweigh risk factors.

38. In February 2017, the Home Office published Detention Services Order 08/2016, *Management of Adults at Risk in Immigration Detention*, which sets out operational guidance for all staff working in IRCs on the care and management of adults in detention who are identified as being at risk. While the presumption is that a person considered an Adult at Risk should not be detained, there are circumstances, determined on a case by case basis, when at risk persons will be detained.

Key Events

39. Mr Aziz arrived in England from Iraq in 2007 and was granted discretionary leave to remain in 2011. On 10 May 2014, he was remanded to prison custody on charges of assault against his former partner and was sent to HMP Elmley. It was his first time in prison custody.

40. Mr Aziz arrived at Elmley with a suicide warning form completed by court staff who had placed him on continuous observation for banging his head repeatedly against the court cell walls. A nurse carrying out a standard health check asked him about his mood and whether he had harmed himself before. He told the nurse that he suffered from depression and psychosis and had tried to hang himself in 2012. On 13 May, Mr Aziz was seen by a psychiatrist who did not find any evidence of clinical depression or psychosis.

41. Mr Aziz had regular appointments with the mental health team at Elmley who monitored his progress. On 8 October, he told a mental health team worker that he had thoughts and plans to take his life as it was not worth living if he was not able to see his children. Staff started ACCT procedures to monitor and support him while he was at risk of self-harm.

42. On 11 December 2014, Mr Aziz was sentenced to two years imprisonment for assault against his partner and a two-year restraining order was imposed. Mr Aziz told a nurse he considered the sentence fair and said he could cope until his release date in April 2015

43. On 19 December, a deportation notice was served on Mr Aziz. He responded on 20 January 2015, by claiming asylum.

44. On 3 February, Mr Aziz was transferred to HMP Maidstone. He was seen by a member of the mental health team. He said he did not have active plans to take his life but felt low in mood. He was told on 20 March that he was being discharged from the mental health team's caseload, due to his non-attendance and his refusal of medication. He said that he only had 15 days left in custody so he was 'okay'.

Detention under immigration powers

45. On 8 May 2015, the custodial part of Mr Aziz's sentence ended but he continued to be held at Maidstone under immigration powers. He was interviewed in connection with his asylum claim on 25 June, but he withdrew his application on 4 August.

46. On 15 August, Mr Aziz cut his chest superficially and ACCT procedures were re-opened. Mr Aziz had asked to leave Maidstone and on 25 August he was told he would be transferred to HMP Lewes the next day.

47. On 26 August, Mr Aziz was transferred to HMP Lewes. Staff started suicide and self-harm monitoring (ACCT) on several occasions over the next six months after Mr Aziz's risk to himself escalated and he harmed himself, expressed thoughts of suicide and attempted to hang himself.

48. On 10 October, Mr Aziz submitted representations on his deportation but on 16 October, he withdrew them and said he wanted to return to Iraq voluntarily. The Home Office referred his case to the Iraqi Consulate. His application for bail in the UK while his case was being considered was refused on 22 October

49. On 18 February 2016, Mr Aziz applied for a facilitated return to Iraq but it was rejected on 15 March. On 16 March, the Iraqi Consulate confirmed to the Home Office that it was seeking authorisation of Mr Aziz's travel documents but they could not give a timescale. Mr Aziz applied for bail again on 19 April but was refused.

Transfer to hospital under the Mental Health Act

50. On 29 April 2016, Mr Aziz tried to hang himself but he was brought to safety by other prisoners. Mr Aziz remained in the healthcare centre at Lewes. His clinical record noted his flat mood and lack of engagement. His behaviour became increasing disturbed and bizarre and he distanced himself from others. Clinical staff were very concerned and worked with Woking mental health services to find an in-patient bed in a mental health unit.

51. On 7 September, Mr Aziz was seen by a psychiatrist who completed the documentation for transferring him to hospital for assessment under the Mental Health Act. By this time, Mr Aziz was not taking care of himself.

52. On 19 September, Mr Aziz was transferred to Thornford Park Hospital, Kent for a mental health assessment under PSI 50/2007 (*Transfers of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act 1983*). Under the PSI, prisoners detained under the Immigration Act 1971 are treated as unsentenced prisoners and, once ready for discharge, they can be detained in an IRC. Mr Aziz's detention under immigration powers remained in place.

53. On 16 November, a Consultant Forensic Psychiatrist at Thornford Park Hospital contacted Central and North-West London NHS Foundation Trust (CNWL provide healthcare to Heathrow IRC) and Mr Aziz's Home Office case owner of the Mentally Disordered Offenders Team about the conclusions of the assessment.

54. The psychiatrist said that Mr Aziz's mental health had rapidly improved, that there was no clear evidence that he was suffering from a treatable mental health condition, and that consideration should be given to releasing him from detention. The psychiatrist added that he was concerned about the significant risk Mr Aziz posed to his former partner, prospective future partners and children if released into the community as Mr Aziz was likely to seek contact and the restraining order imposed on sentencing was due to expire shortly. Mr Aziz's behaviour had improved and he wanted to move to a removal centre 'urgently'. The psychiatrist said he supported Mr Aziz's prospective move but needed confirmation from a named removal centre that they would be happy to take him.

55. On 25 November, the Home Office case owner referred Mr Aziz's case to the Home Office Detention Gatekeeper Team to consider whether Mr Aziz should be considered an 'Adult at Risk' for who detention would be harmful, and

released from the hospital with a robust plan for managing him in the community as his sentence had already expired, or released because there was no prospect of him being removed within a reasonable timescale. The Home Office Detention Gatekeeper Team confirmed that Mr Aziz was an Adult at Risk, and that without a clear route to removal, immigration detention was not an option.

56. On 1 December, the Home Office case owner replied to the psychiatrist and said the issue of Mr Aziz's detention had been reviewed under the Home Office policy introduced in September 2016, where there was a presumption that detainees considered Adults at Risk could only be detained to effect removal from the country. He said as Mr Aziz had not cooperated with the processes to obtain an Iraqi travel document and as his ongoing detention would appear to run counter to the policy, the decision to release him would be made at a senior level within the Home Office.

57. On 8 December, a Care Programme Approach meeting was held at the hospital. The psychiatrist diagnosed Mr Aziz as having possible dissocial and emotionally unstable personality traits. The view of the clinical team was that a return to prison would be likely to lead to a re-emergence of his previous symptoms.

Transfer to the immigration detention estate

58. On 23 January 2017, Mr Aziz was transferred to Colnbrook IRC. On 15 February, Mr Aziz's legal representatives made an application for Judicial Review in relation to his continued detention which was not processed due to an administrative error.

59. On 22 February, Mr Aziz was transferred to Harmondsworth IRC. It is unclear why he was transferred. On 3 March, he was transferred back to Colnbrook.

60. On 23 March, Mr Aziz's case was referred again to the Iraqi Consulate but he refused to see their representative on 5 April for a face-to-face interview.

61. On 16 April, Mr Aziz saw a GP. He said he wanted to return to Thornford Park Hospital as he felt it was a much better place for him than Colnbrook. The GP told Mr Aziz that he did not have an acute mental illness so the hospital was not an appropriate place for him.

62. On 17 April, Mr Aziz became upset that no mail had been delivered - it was a Bank Holiday - and punched a detainee custody officer (DCO) in the head. He was restrained and taken to the Care and Separation Unit (CSU). An hour later, he set fire to his mattress. The GP recorded in his clinical record that although there was a significant amount of smoke in the room, Mr Aziz appeared calm and was breathing normally. He would not discuss with the GP why he had started the fire. The GP referred Mr Aziz for a psychiatric assessment.

63. The next day, a consultant psychiatrist saw Mr Aziz in the CSU. Mr Aziz did not reply to specific questions about the mattress fire but showed no clinical evidence of mood disorder. The psychiatrist wrote that Mr Aziz should continue to be managed under ACDT and he should remain in the care of the mental health team (MHT).

64. On 24 April, the Iraqi Consulate confirmed that they would issue Mr Aziz with a temporary travel document, and the Home Office arranged a deportation date for 4 June. On 1 May, Mr Aziz was transferred to Brook House IRC, Gatwick at his own request.

65. On 11 May, Mr Aziz's judicial review application was reinstated. The Home Office cancelled his proposed deportation date in view of the pending hearing, at a date to be fixed.

66. On 19 July, Mr Aziz asked to be moved to Morton Hall IRC. On 20 July, he refused to eat any food and was monitored by a nurse from the mental health team, although he would not engage with her.

67. On 27 July, a consultant psychiatrist saw Mr Aziz. He wrote in his clinical record that Mr Aziz did not have insight into his mental health problems and her diagnosis was schizophrenia. He explained to Aziz that he was experiencing delusional beliefs and offered him anti-psychotic medication, which he refused.

68. Mr Aziz repeated his request to move to Morton Hall IRC as he had relatives living nearby. His request was agreed and he was transferred there on 30 July.

Mr Aziz's transfer to Morton Hall IRC

69. Brook House healthcare staff did not contact Morton Hall prior to his arrival for a handover. Mr Aziz was seen in Morton Hall reception by a nurse for a standard health check. Mr Aziz declined contact with the mental health team but the nurse made the referral nevertheless, as she was concerned about the entries about his mental health in his clinical record and that he had not engaged with mental health teams in the past. Mr Aziz would not allow the nurse to check his blood pressure or pulse and he refused to sign a medications and fitness for work/gym compact.

70. A Supervising Officer (SO) carried out a First Night Assessment, which is designed to highlight any immediate issues or concerns. Mr Aziz told her that he had no family or friends and would not give her a next of kin contact name or address. He said he did not feel suicidal or have thoughts about harming himself. She noted, in error, that he had not previously been managed under ACDT procedures. Mr Aziz was taken to Seacole Unit, the first night centre and induction unit for newly received residents.

71. On 31 July, Mr Aziz was discussed at the mental health in-reach team (MHIRT) meeting. The MHIRT manager noted that there had been no handover from Brook House healthcare team despite the psychiatrist's observations that Mr Aziz was presenting with delusional beliefs. He spoke with a detainee custody officer on Seacole Unit who said that Mr Aziz had collected his meals and was relating appropriately with staff and other residents.

72. The MHIRT manager telephoned Brook House and spoke to a mental health nurse, who apologised for the lack of a handover but did not explain why it had not taken place. He said that it had been difficult to engage Mr Aziz.

73. The investigator contacted Brook House's Head of Healthcare, who said that Mr Aziz's transfer had been arranged by a Home Office unit who did not inform the

healthcare team that he was moving. She only realised Mr Aziz was no longer at Brook House after he had already left when Morton Hall queried why there was no handover.

74. The MHIRT manager asked Mr Aziz to attend the healthcare centre on 1 August for a mental health appointment but he did not attend. She contacted Seacole Unit but he could not be found, so she made another appointment for 3 August. Mr Aziz moved from Seacole induction unit to Sharman Unit on 3 August. The MHIRT manager went to see him on the unit. He was reluctant to engage but appeared relaxed and stable in mood and she did not see evidence of psychosis.

75. A consultant psychiatrist and the MHIRT manager visited Mr Aziz in his room on 10 August. He said he was fine and did not want to talk to them. When they asked him about the conversation he had with another psychiatrist, he laughed and said he 'no longer thought such things'. There was a smell of psychoactive substances (PS) in his room, which was overpowering, and they left after 10 minutes. They recorded there was no evidence that he was acutely mentally unwell or that he posed a risk to himself or others. They suspected that he was using PS, which might have explained why he had presented in the past as acutely psychotic, but that the MHIRT should continue contact with him and attempt psycho-education on PS. Mr Aziz's residential case notes make no mention of possible issues with the use of PS.

76. On 10 August, a DCO recorded that he spoke to Mr Aziz about moving rooms three times in a week and told him that he would have to settle down and accept that his living conditions were not ideal. Mr Aziz made a transfer request on 17 August to move to Dungavel IRC in Scotland where he said he had friends. His application was rejected on 26 August.

77. The MHIRT manager scheduled a mental health review on 1 September but was unable to visit Mr Aziz on his unit. She noted in his clinical record that no issues had been raised by unit staff about him and that she would arrange for a nurse to follow up. The nurse visited Mr Aziz on his unit as he did not turn up at the healthcare centre. The nurse tried to engage him in conversation and Mr Aziz said he did not have any thoughts of self-harm and his mood seemed settled.

78. On 29 September, the MHIRT manager discussed Mr Aziz with a DCO, who was working in the Sharman Unit. He told her Mr Aziz did not engage with other residents or staff unless he needed something, so his contact with them was minimal. The MHIRT manager went to see Mr Aziz in his room, which was dirty and neglected. He was lying in bed under the covers. Mr Aziz was dismissive of her attempts to emphasise the importance of a clean environment and he said he did not want to talk. He would not sign a care plan, although he said he would get up later and clean his room. Mr Aziz denied using illicit substances and there was no indication he was doing so.

79. The DCO told the MHIRT manager he had encouraged Mr Aziz to clean his room. She noted in his clinical record that she would consider a Vulnerable Adult Care Plan if Mr Aziz remained in a state of self-neglect as she was concerned about his social isolation, but that she had not seen any other risk

factors. The MHIRT manager reported her concerns to the Duty Manager, who said he would ask officers to deal with it and ask a unit cleaner to help. She checked with the DCO on 30 September who said that he had done this.

80. On 4 October, the MHIRT manager saw Mr Aziz in his room. She noted that his room appeared tidier and cleaner, he looked well-groomed and he said that he had taken a shower recently and was taking his meals in the dining hall. He told her had asked for a move to Colnbrook as he thought the move would be better for him. Mr Aziz's manner was relaxed, there was no evidence of recent illicit substance use or acute illness. After talking to Mr Aziz, the MHIRT manager saw him speaking with another resident and the DCO on duty said that he had a small group of peers. He said that Mr Aziz's mood fluctuated and his room could be clean for a time then appear neglected.

81. The MHIRT manager contacted a Home Office contact manager based at Morton Hall, about a possible transfer to Colnbrook. The Home Office manager said there were no plans to transfer Mr Aziz there and that his continued detention had been authorised because his Judicial Review was a barrier to his removal.

82. On 14 October, Mr Aziz's uncle, who lived in Lincoln, visited him at Morton Hall. Mr Aziz told the visits officer that he was not expecting a visit and did not seem pleased. He went to the visits hall but did not engage with his visitor and eventually returned to his room.

83. On 16 October, Mr Aziz's application for Judicial Review of his immigration status was refused. On 19 October, the Home Office decided that there were no more bars to his removal and his case was referred to the Returns Team so they could arrange a date for his deportation.

Fire setting incident

84. During lunch time on 28 October, when Sharman Unit was unstaffed, Mr Aziz put a towel on top of his cupboard in his room and set fire to it. He left the room with the towel still alight and crouched down at the far end of the corridor. A resident told staff that he saw smoke escaping from under the room door so he went in, pulled the towel off the cupboard and put the fire out by stamping on it. The smoke detectors did not sound automatically so another resident pressed the fire alarm. A DCO responded to the fire alarm and put the towel, which was hot to the touch, in the wash basin with some cold water and he noticed burn marks.

85. A custodial manager (CM) questioned Mr Aziz about what had happened. Mr Aziz told him that he had set fire to the towel with an incense stick but could not explain why he had done so. The CM's incident report said that he explained to Mr Aziz that he could have put other detainees lives in danger and that arson was a criminal offence which could attract a long prison sentence. Mr Aziz then said that it had been an accident. A watch manager for Lincolnshire Fire Brigade inspected Mr Aziz's room at 1.10pm and was content that the fire had been started deliberately.

86. The CM initiated a Room Sharing Risk Assessment (RSRA) review. He raised Mr Aziz's RSRA to high, recording that Mr Aziz's actions in setting fire while not in the room showed a heightened risk of potential harm to other residents. He did not indicate which sources of information he had used in reaching his decision nor did he consider opening an ACDT.

87. Morton Hall's security department reviewed the incident reports about the fire and decided that Mr Aziz posed a raised risk to others. Mr Aziz was moved from Sharman Unit, a lower security unit where residents were not locked in their rooms at night, to Windsor Unit where residents were locked in their rooms from 7.45pm to 7.45am. A DCO spoke to Mr Aziz on 29 October about his behaviour and what was expected on Windsor. He told the investigator that Mr Aziz had asked to move back to Sharman but he had explained to him why that was not possible.

88. On 30 October, an Incentives and Privileges Scheme (IPS) board was convened to consider Mr Aziz's behaviour. IPS was a two-tier scheme based on access to facilities in order to encourage positive behaviour. Mr Aziz was downgraded to Standard for a minimum of 21 days. This meant a blanket restriction on access to activities.

89. On 31 October, the MHIRT manager visited Mr Aziz with a nurse. He seemed irritable in mood and dismissed their attempts to engage with him. She noted that his room was very tidy and that she did not find any evidence of thought disorder. She decided that he should remain on her caseload to identify whether setting fire to his towel was an early marker of mental health relapse.

90. On 10 November, a Home Office Director authorised Mr Aziz's detention for a further 28 days. A progress report on his immigration status was sent to him on 15 November through Morton Hall's internal mail but it is unclear whether he received it as he was not obliged to sign for it.

Events of 19 November

91. On 18/19 November, a DCO was on night duty on Windsor Unit. At about 11.00pm, he checked all the detainees were in their rooms and were alright. He did not specifically recall seeing Mr Aziz.

92. At about 6.00am on 19 November, the DCO started a welfare check on all the detainees. At about 6.13am he looked through the observation panel of Mr Aziz's room and saw Mr Aziz at his window looking at him. He then noticed that Mr Aziz was hanging from the window with a ligature made from a bed sheet around his neck. The DCO radioed a code blue (an emergency code for someone with serious breathing difficulties or who is unconscious) and used his emergency key pouch to unlock the room door and he went in. He cut the ligature with his ligature-cutting tool, lowered Mr Aziz to the floor and began cardiopulmonary resuscitation (CPR) with the assistance of a DCO who had responded to the emergency code.

93. A nurse and healthcare assistant arrived two minutes later, took over CPR, gave Mr Aziz oxygen and attached a defibrillator (a device that monitors heart rhythms and administers an electric shock if required). An ambulance was

called at 6.14am and a paramedic arrived in Mr Aziz's room at 6.39am and pronounced him dead.

Contact with Mr Aziz's family

94. Mr Aziz's uncle was listed as his next of kin. At 7.28am, a Home Office family liaison officer (FLO) was notified of Mr Aziz's death by a senior on-call manager for Detention and Escorting Services. Lincolnshire police were asked to notify Mr Aziz's uncle of his death, as required by Detention Services Order 08/2014 on dealing with deaths in detention. However, they had not done so by 9.00am and so the FLO contacted the senior on-call manager and was given the authority to telephone him herself. Mr Aziz's uncle asked why the police had not visited him in person and the FLO explained she had acted in accordance with the Home Office's guidelines.

95. In line with national instructions, the Home Office contributed to the cost of the repatriation of Mr Aziz's body to Iraq.

Support for detainees and staff

96. Staff involved in the emergency response were debriefed individually by a duty manager and offered support by the staff care team and by other colleagues.

97. The Centre Manager posted a notice for detainees informing them of Mr Aziz's death and offering support. Staff reviewed all detainees assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Aziz's death.

Post-mortem report

98. A post-mortem examination concluded that Mr Aziz's death was caused by hanging. An external examination identified a large number of historical self-inflicted injuries, but there were no fresh self-inflicted injuries other than the ligature mark. Toxicology tests were undertaken and no traces of alcohol or illicit drugs were detected.

Findings

Identifying and managing risk of suicide and self-harm

99. Mr Aziz was identified as an Adult at Risk under Detention Services Order 08/2016, Management of Adults at Risk in Immigration Detention. As part of the reception process at Morton Hall an individual health and welfare risk assessment should have been drawn up. However, the information gathered from his First Night immediate needs assessment and induction did not feed into a wider consideration of his day-to-day life in detention. It is hard to see what purpose the designation served beyond an administrative label. There is little evidence that it generated any protective steps to address his acknowledged vulnerability beyond healthcare monitoring. We were told that Mr Aziz was discussed at the Safer Detention meetings for 13, 20, 27 October, 3 and 10 November but only action points rather than minutes of the meetings were recorded. There were no action points relating to Mr Aziz after his cell fire and he was not discussed at the meeting on 17 November. His residential case notes did not reflect awareness that he was a subject of such meetings.

100. Mr Aziz had a number of known risk factors for suicide and self-harm. He was a foreign national who had been served with a deportation order. He had a history of violence, had experienced family breakdown after being imprisoned for offences against a family member and was restricted by a court order from contacting his children. He had spent an extended period in detention after serving his sentence and had been transferred to different establishments. He had a history of self-harm and had attempted to hang himself while in prison. He had a complex mental health history and had been hospitalised. While there was debate amongst the mental healthcare professionals as to whether he was suffering from psychosis or any other treatable condition, his behaviour was undoubtedly bizarre and disturbed for periods of time.

101. Paragraph 13 of DSO 08/2016 states that a detainee's prison files and any other records should accompany them on transfers between IRCs and be kept updated following detention. While Mr Aziz's self-harm had not been recent, the accumulation of risk factors meant that custodial staff should have carried out a more thorough analysis of his risk by obtaining previous risk information. Not doing so, was a lost opportunity to make a full assessment of Mr Aziz's risk to himself. Morton Hall should have been able to use established links with Safer Prisons Teams and should have had access to NOMIS, the HMPPS case notes system.

102. Mr Aziz's first night assessment completed at Morton Hall said that he had not been subject to an ACDT document before, when in fact the most recent one had only been closed three months before his arrival the IRC. Mr Aziz's clinical records documented his self-harm but these were only available to healthcare staff and not to detention custody staff.

103. Residential staff were not aware of Mr Aziz's self-harm history or that he was considered an Adult at Risk by the Home Office. While he had appeared stable and was not on an open ACDT, they did not consider initiating one when he set fire to his towel, and instead dealt with the incident punitively. In their view,

there were no indications that he should be viewed any differently than any other detainee. He had not cut himself or, apart from periods of lack of self-care, showed any behaviour that suggested he was at risk. His fire-setting was considered by healthcare as possibly the start of a period of vulnerability but viewed by custodial staff as reckless and poor behaviour and his IPS level was reduced as a result. The Centre Manager in correspondence with us did not accept that the fire was an indication of potential self-harm.

104. We make the following recommendations:

The Centre Manager at Morton Hall IRC should ensure that IRC staff manage detainees at risk of suicide or self-harm and Adults at Risk in line with DSO 6/2008 and DSO 08/2016. In particular staff should:

- **Review the effectiveness of the First Night Assessment questionnaire.**
- **Consider and record all the known risk factors of newly arrived detainees when determining their risk of suicide or self-harm, including information from person escort records, previous ACCTs/ACDTs, medical records and Home Office databases.**
- **Use all sources of information when conducting a Room Sharing Risk Assessment review.**

The Home Office Director General for Immigration Enforcement should ensure that Adult at Risk status is taken into account by IRC staff when assessing a detainee's risk to themselves and the way in which that risk should be managed.

Mr Aziz's move from Brook House to Morton Hall and his clinical care

105. Mr Aziz asked to move to Morton Hall as he felt it was more 'open' and he said had relatives who lived in the area. His request was approved but the Home Office made the arrangements for his transfer focused on logistical issues of when his move and transport could be facilitated. Although he was designated an Adult at Risk, there is no evidence that healthcare arrangements and wellbeing were considered. As a result, Brook House healthcare staff did not know Mr Aziz had left and Morton Hall healthcare department was unaware of his arrival. His transfer should have been discussed between both healthcare departments and planned so that both healthcare and custodial staff could prepare for his arrival. This is especially relevant as only four days prior to his move, a psychiatrist had diagnosed him with schizophrenia.

106. The clinical reviewer found that there was a failure to transfer information between Brook House and Morton Hall despite there being a 'healthcare to healthcare process' for best practice transfers between IRCs. This would have ensured that Morton Hall was fully briefed about known physical or mental health concerns. Brook House acknowledged that the 'healthcare to healthcare process' had not taken place and that they were unaware that Mr Aziz had gone

until they were contacted by Morton Hall. We make the following recommendation:

The Centre Manager and Head of Healthcare at Brook House IRC should carry out a root cause analysis to understand why a healthcare to healthcare handover did not take place when Mr Aziz was transferred to Morton Hall.

107. There was, however, some good practice: the Mental Health In-Reach Team manager at Morton Hall provided a good standard of assessment, follow up and documentation. She visited Mr Aziz in his residential unit or his room when he did not attend arranged appointments in the healthcare centre, devised a care plan and kept him on the mental health caseload due to his past medical history. She reviewed him every three to four weeks and he was due for review at the time of his death. She fully assessed and documented Mr Aziz's risk factors and vulnerabilities and noted that Mr Aziz might have used PS and tried to engage him in harm minimisation and awareness.

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