

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

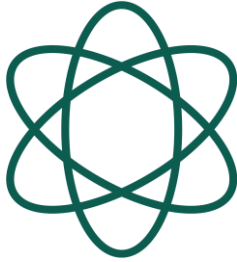
# **Independent investigation into the death of Mr Miroslav Lavicka, a prisoner at Morton Hall IRC, on 19 February 2021**

**A report by the Prisons and Probation Ombudsman**



## 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

**OGL**

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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, detainees of approved premises and detainees in immigration centres.

My 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 Miroslav Lavicka was found hanged in his room at Morton Hall Immigration Removal Centre (IRC) on 19 February 2021. He was 46 years old. I offer my condolences to Mr Lavicka's family and friends.

Mr Lavicka arrived at Morton Hall from HMP Leeds the day before he died. We are satisfied that he did not give staff at Leeds or Morton Hall reason to believe that he was at imminent risk of suicide.

However, we are concerned that staff did not use telephone interpreting services during Mr Lavicka's brief time at Morton Hall to ensure that he fully understood what was happening to him, as he spoke very little English. We consider that the failure to do so, particularly during Mr Lavicka's reception screen and first night assessment on 18 February, was a missed opportunity to understand Mr Lavicka's concerns.

We are also concerned that there was a short delay in allowing the emergency ambulance into the IRC on 19 February.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**November 2021**

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# Summary

## Events

1. On 21 April 2020, Mr Lavicka, a Czech national, was convicted of threatening behaviour and taken to HMP Leeds. Mr Lavicka had a history of mental health and substance misuse problems. His English was poor.
2. Mr Lavicka was eligible for release from prison on 19 January 2021 but was detained past this date when the Home Office notified him that they were considering deporting him to the Czech Republic.
3. On 18 February, Mr Lavicka was transferred from Leeds to Morton Hall Immigration Removal Centre (IRC), pending his potential removal from the UK.
4. Shortly before 1.00pm on 18 February, during his initial health screen, Mr Lavicka told the nurse that he had no thoughts of suicide or self-harm. Mr Lavicka had several interactions with staff at reception, none of whom raised any concerns. No one used the telephone interpreting service to speak to Mr Lavicka.
5. At about 9.45pm that evening, a nurse administered Mr Lavicka's prescribed dose of olanzapine (an anti-psychotic medication) and raised no concerns about him. The night patrol officer completed a welfare check on Mr Lavicka at around 2.00am and again raised no concerns.
6. At 4.00am, while conducting his next welfare check, the night patrol officer could not see Mr Lavicka in his cell so asked his colleague for help. The two officers went into Mr Lavicka's cell together and found him hanging. One of the officers radioed a medical emergency 'code blue' at 4.08am, indicating a life-threatening situation. Officers and nurses arrived quickly, but due to an issue with keys there was a two to three-minute delay getting the ambulance vehicles through the gates of the centre. At 5.04am, paramedics confirmed Mr Lavicka had died.

## Findings

### Management of risk of suicide and self-harm

7. We consider that Mr Lavicka gave IRC staff no reason to consider that he was at imminent risk of suicide or self-harm in the hours leading up to his death. We conclude that his death was not foreseeable.

### Clinical care

8. The clinical reviewer concluded that Mr Lavicka's healthcare at Morton Hall was of a reasonable standard and was equivalent to that which would have been received in the community.

## **Use of approved interpreters / translation services**

9. We consider that Morton Hall staff should have used translation services during Mr Lavicka's reception screen and first night assessment on 18 February 2021. We consider that this was a missed opportunity to fully discuss and explore any concerns which Mr Lavicka may have had at that time.

## **Emergency response**

10. We are concerned that the third vehicle gate leading into the centre compound still had the double lock on it when the emergency response vehicles arrived and staff at the gate could not open it. Although the issue was resolved quickly, it still resulted in a two to three-minute delay. We are unable to say whether earlier intervention from ambulance staff could have prevented Mr Lavicka's death, but any delay may be crucial in future medical emergencies.

## **Recommendations**

- The Centre Manager and Head of Healthcare at Morton Hall IRC should encourage the use of interpreting services in all instances where a detainee is not a fluent English speaker.
- The Centre Manager at Morton Hall IRC should ensure that staff are aware of the procedures for allowing timely access to the establishment for emergency vehicles during the night.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at Morton Hall IRC informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Lavicka's prison, immigration and medical records.
13. The investigator interviewed eight members of staff and one detainee at Morton Hall, two members at staff at HMP Leeds, and one member of staff from the Home Office. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic.
14. NHS England commissioned a clinical reviewer to review Mr Lavicka's clinical care at the IRC. The majority of the interviews were conducted jointly by the clinical reviewer and the investigator.
15. We informed HM Coroner for Central and West Lincolnshire of the investigation and have sent the coroner a copy of this report.
16. We asked the Czech Embassy for Mr Lavicka's family's contact details. His family did not consent to their details being passed to us, so we have not contacted them directly about this investigation.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified some factual inaccuracies, which we have addressed in this report.

## Background Information

### Morton Hall IRC

18. Morton Hall Immigration Removal Centre (IRC) near Lincoln is the only IRC managed by HM Prisons and Probation Service (HMPPS) on behalf of the Home Office. It holds up to 392 men, although current numbers are not near capacity. 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

19. The most recent full inspection of Morton Hall IRC was in October and November 2019. Inspectors reported that the centre had improved, becoming safer and more respectful for detainees since its previous inspection in 2016. They found that the number of detainees held for over a year had reduced to five compared with nearly 30 at the previous inspection, and two-thirds of the population left the centre within a month.
20. However, inspectors noted that uncertainty about detainees' immigration status and the potential for long-term detention continued to cause frustration. Nearly a quarter of the population arrived after serving prison sentences, during which inspectors considered that their cases should have been resolved.
21. Inspectors found that levels of self-harm were high, and that over 40 detainees had been subject to constant supervision in the previous six months because they were assessed to be at risk of imminent suicide or self-harm. Despite this, they reported that care for detainees at risk of self-harm was generally of a good standard.
22. Inspectors reported that although the accommodation was in adequate condition, the centre still looked and felt too much like the prison it was before it was designated an IRC. They also noted that the welfare service provided by the third sector organisation 'Lincolnshire Action Trust' was a considerable strength, which detainees valued highly. The report said that well-qualified workers gave good support on arrival and before discharge.

### Independent Monitoring Board

23. 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 latest annual report, for the year 2019, the IMB commended the professional focus of staff on the safety, dignity and welfare of detainees, particularly those considered vulnerable or who exhibited challenging behaviour. The report also praised the reduction in the number of people detained at the centre, which was down from an average of 293 in 2018 to 247 in 2019. They highlighted the beneficial impact on life in the centre as a result.

24. However, the IMB also raised concerns about the number of incidents of self-harm. These were down from 7% from 217 in 2018 to 202 in 2019, but the IMB stressed that this was still high and was less than the 16% decrease in the centre population.

## **Previous deaths at Morton Hall IRC**

25. Mr Lavicka was the first detainee to take his own life at Morton Hall since 2017.

## **Assessment, Care in Detention and teamwork (ACDT)**

26. 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.
27. 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.
28. 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.

## **Adults at risk**

29. In 2015, 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.
30. 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

## Background

31. On 30 November 2011, Mr Miroslav Lavicka, a Czech national, was convicted of attempted robbery in Prague and given a five-year prison sentence, suspended until 24 June 2022. Mr Lavicka said that he first came to the UK in 2015, as a citizen of the European Union, and he had a history of mental health and substance misuse problems. (Mr Lavicka was not known to community health services in the UK.)
32. On 21 April 2020, Mr Lavicka was convicted and sentenced to two months' imprisonment. He was taken to HMP Leeds later that day. Mr Lavicka was also awaiting trial at Leeds Crown Court for other more serious offences and was remanded in custody until his trial date.

## HMP Leeds

33. Mr Lavicka was assessed as being at risk of suicide or self-harm because he had behaved strangely at court and tied a shoelace around his neck. Staff began monitoring him under HMPPS suicide prevention measures, known as ACCT. The ACCT was closed two days later, on 23 April.
34. A psychiatrist began assessing Mr Lavicka weekly from 23 April, but initially struggled to do so due to his erratic behaviour. The psychiatrist could not determine whether Mr Lavicka's disturbed behaviour was due to previous substance misuse or the effects of a major mental health disorder. The psychiatrist recorded on Mr Lavicka's medical record that he prescribed him promethazine (a sedative). Mr Lavicka's mental health appointments at Leeds were conducted with the help of 'Language Line', a telephone interpretation service, where appropriate.
35. Staff monitored Mr Lavicka under ACCT procedures from 24 April after he continually pressed his cell bell, smashed his furniture and television, and posted parts of the television through his observation panel. Following the incident, Mr Lavicka was moved to the segregation unit under restraint. Staff closed the ACCT on 6 May after his behaviour improved.
36. The substance misuse team assessed Mr Lavicka on 24 April, but no further appointment was offered as Mr Lavicka's urine analysis was negative when tested.
37. From 28 April, Mr Lavicka was subject to Challenge Support and Intervention Planning (CSIP) procedures due to his aggressive behaviour. (CSIP is a multi-disciplinary approach which focuses on those who pose a raised risk of being violent and works to change their behaviour.)
38. On 27 May, the psychiatrist recorded on SystmOne that Mr Lavicka may have a major mental disorder and started him on a course of olanzapine, an antipsychotic. In interview, the psychiatrist told us that he believed Mr Lavicka had suffered a hypomanic episode and diagnosed him with bipolar affective disorder. The psychiatrist said that Mr Lavicka responded well to treatment with olanzapine.
39. During a video link appearance at Leeds Crown Court on 19 June, Mr Lavicka gestured to the judge that he would kill himself. Staff started ACCT monitoring. At

an ACCT review the next day, he told staff he was angry about being in custody and felt his imprisonment was unfair. He also said he made the gesture as a joke to get attention from court and prison staff. On 27 June, staff closed Mr Lavicka's ACCT after he said he did not want to hurt himself or take his own life. (Mr Lavicka was not managed under the ACCT process again.)

40. On 4 August, staff stopped Mr Lavicka's CSIP monitoring after he showed a positive response to his olanzapine medication.
41. An officer was Mr Lavicka's key worker. In interview, the key worker told us that Mr Lavicka's level of English was "very poor, next to none". She spoke to him in Polish and he spoke to her in Czech and she said they could understand each other because the languages are similar. She recorded conversations with Mr Lavicka at least monthly, often more frequently, and she documented her efforts to support him in prison.
42. On 3 December 2020, Mr Lavicka was convicted at Leeds Crown Court of two counts of Possession of a Knife/Sharp Pointed Article in a Public Place and two counts of Assault by Beating of an Emergency Worker. He received a total of 18 months' imprisonment but was eligible for release the following month due to time already served.
43. On 29 December, Home Office Immigration Enforcement (HOIE) served Mr Lavicka with a 'Stage 1' letter, stating their intention to deport him.

## 2021

44. On 11 January 2021, HOIE served Mr Lavicka with an 'IS91' document, informing him that he would be detained under immigration powers following the completion of his prison sentence on 19 January. His cellmate helped him to understand the IS91 document. The key worker said she gave Mr Lavicka contact details for the charity, 'Bail for Immigration Detainees', to help him translate his immigration paperwork. She was also in the process of arranging further help with translation from another prisoner, but Mr Lavicka left Leeds before this could take place.
45. On 19 January, HOIE received Mr Lavicka's response to the Stage 1 letter. Mr Lavicka told HOIE that he had been living and working in the UK for four to five years and wanted to remain here because no one in the Czech Republic could help him. (HOIE referred Mr Lavicka's case to their decision-making team on 16 February, however he died before a decision about his deportation could be made.)
46. The psychiatrist saw Mr Lavicka on 8 February, and on 15 February, a mental health nurse, saw him. The language barrier was an issue at the appointment on 8 February, so Language Line was used on 15 February (for the final time) to ensure that Mr Lavicka fully understood all the questions he was being asked. On both occasions Mr Lavicka said he did not have any thoughts of suicide or self-harm. On 15 February, Mr Lavicka told the nurse that he did not know what was happening about his immigration status and he did not have legal representation. He told the nurse he was not overly worried about this.
47. On 18 February, Mr Lavicka was transferred from Leeds to Morton Hall IRC, pending his potential removal from the UK.

## Arrival at Morton Hall IRC (18 February)

48. Mr Lavicka arrived at Morton Hall at around 12.30pm. His Person Escort Record (PER) did not indicate that he was at risk of suicide or self-harm. When he arrived, Mr Lavicka tested negative for COVID-19 and was booked into the centre by the reception officer. Reception staff issued Mr Lavicka with a mobile phone with some credit, a phone charger and a smoker's pack.
49. During an initial health screen, shortly before 1.00pm, a nurse recorded on SystmOne that Mr Lavicka appeared calm, with good levels of eye contact and engagement. Mr Lavicka told the nurse that he had no thoughts of suicide or self-harm and no history of it. Although Mr Lavicka presented well, the nurse referred him to the mental health team because she saw on SystmOne that he was taking olanzapine. (The nurse told us in interview that Mr Lavicka's olanzapine and promethazine medication had not arrived with him, despite SystmOne stating that it had been sent with him. The nurse said she immediately spoke to the pharmacist to continue Mr Lavicka's medication.)
50. After the health screen, a trainee welfare officer for the Lincolnshire Action Trust (LAT), completed Mr Lavicka's welfare assessment. (In interview, she told us that LAT complete these assessments with all new detainees as standard practice.) Although Mr Lavicka said he could speak a bit of English, she used the 'Big Word' interpretation service to arrange a Czech interpreter for the meeting, who joined them by telephone.
51. Mr Lavicka told her that he understood why he was at Morton Hall and said he knew the Home Office were attempting to deport him. She completed a welfare induction assessment with Mr Lavicka, explaining the support available to him, and asked if there were any friends or family he would like to contact, to which he replied there was no one.
52. The trainee welfare officer arranged an appointment for Mr Lavicka with the duty immigration solicitor for 22 February. She explained that it was a free consultation, and if the solicitor decided they could represent Mr Lavicka (and he was happy for them to do so), it would be covered by legal aid funded by the Government. She asked Mr Lavicka if he needed any paperwork translating while the interpreter was on the phone, but he said he did not. She booked a Czech interpreter for the meeting on 22 February.
53. The trainee welfare officer discussed Deportation Orders and Removal Directions with Mr Lavicka, to make sure that if he was issued with any further paperwork about his removal from the UK, he understood what needed to be done with it and how to appeal if necessary. She told us in interview that she had no concerns about Mr Lavicka's presentation during the assessment. She remembered that he was smiling, nodding and laughing at points.
54. After the LAT's assessment, a Supervising Officer (SO) carried out Mr Lavicka's 'First Night Assessment' interview. In interview, the SO told us that he asked Mr Lavicka whether he needed a Czech interpreter and Mr Lavicka shrugged in response and said he spoke some English. The SO therefore went ahead without an interpreter and said Mr Lavicka responded appropriately to the questions asked, indicating that he understood.

55. The SO noted from Mr Lavicka's movement order that he was an 'Adult at Risk Level 1', the lowest risk level, due to medical issues. In interview, the SO said he did not know the specific medical issue due to confidentiality. (It was self-stated depression.) The SO noted on Mr Lavicka's core record that he had previously been on ACCTs, so he asked Mr Lavicka about this and also asked how he was currently feeling. Mr Lavicka replied that he had no thoughts of suicide or self-harm and felt good. The SO told Mr Lavicka that, as a result of the COVID-19 pandemic, he would be located in a single cell on the Reverse Cohorting Unit (RCU) for the next 14 days.
56. Fifteen minutes later, Mr Lavicka went outside for a cigarette and spoke to other detainees, including a detainee 'peer supporter'. In interview, the detainee 'peer supporter' told us that Mr Lavicka said he was going to be deported back to his home country and was not happy with the way his life was going. However, he also told us that Mr Lavicka seemed happy, that they shared jokes and there was nothing about Mr Lavicka's presentation or behaviour that gave him any cause for concern.
57. At 4.15pm, Mr Lavicka's mobile phone records show that he telephoned a number in the Czech Republic, but the call was not answered.
58. At around 4.45pm, officers checked all detainees on the RCU and raised no concerns. Staff observed Mr Lavicka eating his evening meal with other detainees at around 5.00pm.
59. At 6.02pm, Mr Lavicka telephoned the same number in the Czech Republic and again the call was not answered.
60. At around 7.30pm, a member of staff completed Mr Lavicka's chaplaincy induction, and he confirmed he was Christian. He did not record any concerns.
61. At around 8.30pm, officers again checked all detainees on Mr Lavicka's unit and raised no concerns. All detainees, including Mr Lavicka, were then locked in their rooms.
62. At around 9.30pm, a nurse attended Mr Lavicka's room and issued him his prescribed medication of 15mg olanzapine and 25mg promethazine.
63. At around 11.00pm, an officer conducted a welfare check on Mr Lavicka and raised no concerns.

## **19 February**

64. Shortly after 2.00am, an officer checked Mr Lavicka and raised no concerns. (Local policy at Morton Hall states that additional first night checks on new detainees must be completed at approximately 2.00am and 4.00am.)
65. At 2.20am, Mr Lavicka telephoned the same number as before in the Czech Republic and again, the call was not answered.
66. At around 3.40am, an officer walked past Mr Lavicka's room on his way to check a resident on a Vulnerable Adult Care Plan (VACP). In interview, the officer told us that he did not see or hear anything from Mr Lavicka's room that gave him any cause for concern.

67. At around 4.00am, the officer went to conduct the next welfare check on the new detainees, including Mr Lavicka. Using a torch, the officer saw that the bathroom door in Mr Lavicka's room was slightly ajar and he could not see Mr Lavicka. The officer knocked on the door but there was no response. In interview, the officer told us that at this point there were no signs that anything was wrong. The officer checked on the other detainees before going back downstairs to the office to fetch another officer. In interview, an officer told us: "It's not particularly uncommon [for residents to not be sighted during a welfare check], there's a bathroom in the room, so there was no sense of urgency at this time."
68. Both officers went back to Mr Lavicka's room and looked closely through the observation panel using a torch. They noticed that Mr Lavicka's head was slumped forward. An officer immediately broke the seal on the pouch for the key for the door, and the two officers went into Mr Lavicka's room at 4.06am. An officer radioed a medical emergency code blue, indicating a life-threatening situation. An officer cut the ligature from the bathroom door (which was made from a bed sheet), removed it and checked Mr Lavicka for signs of breathing. When he could not find any, he began chest compressions
69. As soon as she heard the code blue, the control room officer called an ambulance.
70. A nurse responded quickly to the code blue, arriving at Mr Lavicka's room at around 4.10am, alongside another officer who had helped her carry medical equipment. The nurse took over cardio-pulmonary resuscitation (CPR) from Officers turns doing chest compressions. Other officers also responded quickly to the code blue, including a Custodial Manager (CM).
71. At about 4.09am, the ambulance service told the prison that it might take between 8 to 18 minutes for an ambulance to reach the prison. The ambulance arrived at the centre's first vehicle gate at around 4.28am and staff opened the gate to let it through. At about 4.30am, the CM was told by the control room over the radio that the third vehicle gate still had the double lock on it (due to night state security procedures) and staff at the gate could not open it. The CM immediately sent a SO to retrieve the key to unlock the gate. The SO ran to get the key and then unlocked the gate to allow the emergency vehicles to enter the centre. This resulted in a delay of around three minutes.
72. Paramedics got to Mr Lavicka's room at around 4.40am, carrying emergency medical equipment, and started treatment. At 5.04am, they confirmed that Mr Lavicka had died.

### **Contact with Mr Lavicka's family**

73. Mr Lavicka did not have any relatives in the UK and had not nominated a next of kin. The Home Office's family liaison officer (FLO), informed Mr Lavicka's sister and nephew of his death, with the assistance of the Czech Embassy in Manchester.
74. In line with national instructions, the Home Office offered to contribute to the costs of Mr Lavicka's cremation and the FLO flew to Prague to meet Mr Lavicka's family and give them his ashes.

## **Support for prisoners and staff**

75. The HMPPS Deputy Centre Manager, held a debrief with the staff involved in the emergency response. All staff and detainees were offered the support of the centre's care team.
76. The centre posted notices informing other detainees of Mr Lavicka'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 Lavicka's death.

## **Post-mortem report**

77. A post-mortem examination identified Mr Lavicka's cause of death as hanging. Post-mortem toxicology tests found no evidence to suggest that alcohol or any drugs, within the scope of analysis, contributed to Mr Lavicka's death.

# Findings

## Assessing the risk of suicide and self-harm

78. We have considered whether staff at HMP Leeds and Morton Hall IRC should have identified Mr Lavicka as being at risk of suicide or self-harm and begun suicide and self-harm monitoring procedures to support him.
79. Detention Services Order (DSO) 08/2016, *Management of adults at risk in immigration detention*, sets out factors that can increase an individual's risk of suicide or self-harm. Mr Lavicka had some risk factors. As set out in this report, he had a history of mental health problems and had previously used illicit substances. However, despite Mr Lavicka's troubled history, he had not been on an ACCT since June 2020, around eight months before he transferred to Morton Hall. During Mr Lavicka's period of ACCT monitoring, his erratic behaviour appears to have been due to a combination of drug-induced psychosis and mental health issues, which greatly improved once he began taking olanzapine.
80. It is acknowledged that there is a trigger for self-harm and suicide for Foreign National Prisoners, who are, or are about to be held on an IS91 and those close to deportation. Prison Service Instruction (PSI) 2011/52, *Immigration, Repatriation and Removal Services*, says:
- “Foreign national prisoners can often experience isolation in prison due to language and cultural difficulties and lack of family visits and support. Prison staff should be aware of the heightened risk of self-harm in these cases and particular care should be taken when serving documentation relating to deportation which could cause distress.”
81. However, if Mr Lavicka was feeling anxious about his potential removal from the UK, he did not express this to staff at Leeds or Morton Hall despite having several opportunities to do so. The Home Office were unable to confirm to us whether Mr Lavicka would have faced imprisonment on his return to the Czech Republic (or whether he believed he was going to face imprisonment), so it is not possible to know what impact this would have had on Mr Lavicka's state of mind before his death.
82. In the period leading up to Mr Lavicka's death, he presented well, appeared settled and did not express any thoughts of suicide or self-harm during his contact with prison or IRC staff or other detainees.
83. At interview, staff and detainees told us of their shock and surprise at Mr Lavicka's death. His key worker at HMP Leeds, with whom he had a close relationship, said he seemed his normal self in the weeks leading up to his death. Similarly, when Mr Lavicka arrived at Morton Hall on 18 February, he did not give staff any cause for concern.
84. We are satisfied that there was little to indicate that Mr Lavicka was at heightened or imminent risk of suicide or self-harm in the period before his death. It would have been difficult given these circumstances for staff to have foreseen or prevented his actions on 19 February 2021. We therefore consider that Mr Lavicka's death was not foreseeable.

## Clinical care

85. The clinical reviewer concluded that Mr Lavicka's healthcare at Morton Hall was of a reasonable standard and was equivalent to that which would have been received in the community. She was concerned that Mr Lavicka's medication was not transferred to Morton Hall but she did not consider that this contributed to his death, especially as it was addressed promptly at the IRC.

## Use of approved interpreters / translation services

86. For non-healthcare matters, staff at Morton Hall used a translation service called 'The Big Word'. The trainee welfare officer of the Lincolnshire Action Trust (LAT) spoke to Mr Lavicka with the help of a Czech translator from the Big Word, as she went through immigration procedures. We are satisfied that she acted appropriately and professionally.
87. SO A is an experienced supervising officer who routinely carried out first night assessments. He told the investigator that he asked Mr Lavicka about his English and they agreed to see how the assessment went and use translation services if they needed to. The SO said that he uses the telephone interpretation service every day but felt that Mr Lavicka understood sufficient English to complete the first night assessment.
88. While we understand that Mr Lavicka could answer the SO's questions, we consider that communicating via a translator would have provided an opportunity to speak to him in depth and discover and record any further immediate needs and risks, and any other information about him that may have been relevant.
89. DSO 06/2013, *Reception, Induction and Discharge Checklist and Supplementary Guidance*, says, "It is important that all service providers utilise professional interpreting facilities where a language barrier is identified and the information being interpreted is detainee specific." Given the limitations of Mr Lavicka's English, we consider that an interpreter should have been arranged for him.
90. Public Health England guidance (*Language interpreting and translating: Migrant Health Guide* [June 2017]) states that, wherever possible, clinical staff should attempt to ensure effective communication with patients and in cases where an interpreter is required, a professional interpreter, should always be offered.
91. Language Line was not used during Mr Lavicka's reception health screen at Morton Hall on 18 February 2021. At interview, the reception nurse told us that she felt an interpreter was not required as Mr Lavicka spoke some English. We consider that this was another missed opportunity to fully discuss and explore any concerns which Mr Lavicka may have had at that time.

**The Centre Manager and Head of Healthcare at Morton Hall IRC should encourage the use of interpretation services in all instances where a detainee is not a fluent English speaker.**

## Emergency response

92. We are concerned that the third vehicle gate leading into the centre compound still had the double lock on it when the emergency response vehicles arrived and staff at the gate could not open it.
93. We are unable to say whether earlier intervention from ambulance staff could have prevented Mr Lavicka's death, but any delay may be crucial in future medical emergencies.
94. We recommend:

**The Centre Manager at Morton Hall IRC should ensure that staff are aware of the procedures for allowing timely access to the establishment for emergency vehicles during the night.**

## Inquest

95. On 16 January 2023, the inquest into Mr Lavicka's death took place. The inquest concluded that Mr Lavicka's cause of death was suicide.

**Sue McAllister CB  
Prisons and Probation Ombudsman**

**November 2021**

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