

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the circumstances surrounding the
death of a woman in March 2014 at Yarl's Wood
Immigration Removal Centre**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a woman at Yarl's Wood Immigration Removal Centre (IRC) on 30 March 2014. A post-mortem showed that the woman died from a pulmonary embolism. She was 40 years old. I offer my condolences to the woman's family and friends.

The investigation was carried out by an investigator. A professor reviewed the woman's clinical care at the IRC. Yarl's Wood cooperated with the investigation.

The woman arrived in the United Kingdom from Jamaica in December 2000, but did not comply with the terms of her temporary admission and went missing. She did not contact the Home Office again until 2010, after which she made a number of applications to stay in the country permanently. On 20 March 2014, the immigration authorities detained the woman at Yarl's Wood after refusing her last application to stay. Staff recorded no significant health concerns at her reception health screen. On 30 March, the woman collapsed in her room and quickly became unresponsive. Centre staff and paramedics attempted resuscitation but the woman did not recover. An air ambulance doctor declared her dead.

The clinical reviewer considers that the care the woman received at Yarl's Wood was equivalent to that she could have expected to receive in the community and I am satisfied that staff at Yarl's Wood could not have predicted or prevented her death. While it does not appear that this would have changed the outcome for the woman, the investigation identified a need to improve emergency response procedures. There is also a need to provide appropriate support for staff and residents affected by the death of a detainee.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

October 2014

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SUMMARY

1. The woman arrived in the United Kingdom in December 2000 from Jamaica and was granted temporary admission. However, she did not report to an immigration officer the next day and the Home Office considered that she had absconded. The woman did not contact the immigration authorities again until 2010. The woman submitted three unsuccessful applications to remain in the UK. The Home Office refused the last of these applications on 17 March 2014. She had no right of appeal.
2. On 19 March, immigration officers detained the woman and sent her to Yarl's Wood Immigration Removal Centre. When she arrived in the early hours of 20 March, a nurse carried out an initial health screen and a doctor saw her later that morning. They recorded no significant health concerns.
3. After a short period on the induction wing, the woman moved to one of the main residential areas on 26 March. A detainee wrote in a statement for the Coroner that the woman had told her that she had felt unwell with stomach problems on 27 March and again on 29 March. Another detainee told the investigator that, on 28 or 29 March, the woman had told a nurse that she had chest pains and he had told her to get paracetamol from officers in the unit office. CCTV footage shows the woman collecting paracetamol on 28 March.
4. On 30 March, just before 8.00am, the woman's room mate was woken by the woman screaming. The woman collapsed and her room mate rang the emergency bell. Officers attended and contacted a nurse who arrived at 8.04am. Control room staff called an ambulance at 8.13am, after the nurse requested one. Nurses and officers administered cardiopulmonary resuscitation and the first paramedics arrived at the woman's room at 8.34am. Paramedics and staff continued to attempt resuscitation but, at 8.57am, an air ambulance doctor confirmed that the woman had died.
5. A Yarl's Wood chaplain told detainees the news of the woman's death that morning at a church service. It does not appear that detainees received much structured support after that. Some officers and nurses involved in the emergency response told the investigator that they remained on duty for many hours afterwards and were not given the option of going home, although they had been distressed. They said that they had received little support after the woman's death.
6. The woman had not given any family contact details and it took some time to trace her relatives. The police informed them of her death that evening.
7. We agree with the clinical reviewer that the woman's care was equivalent to that she could have expected in the community and that her death was not foreseeable or preventable. While it is unlikely to have made a difference to the outcome for the woman, the investigation identified a need for improvements in emergency response procedures and for better support for detainees and staff after a death. We make two recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and detainees at Yarl's Wood IRC informing them of the investigation and inviting anyone with relevant information to contact her. No one responded. The investigator offered detainees the opportunity to meet as a group to discuss the events and any information they wanted to share about the woman's death.
9. The investigator obtained copies of the woman's detainee medical record and relevant extracts from her detainee record from Yarl's Wood and the Home Office. She visited Yarl's Wood on 7 April 2014, and spoke to the Director, the head of healthcare, the woman's room mate and the family liaison officer. She met a group of residents.
10. The investigator interviewed 15 officers, the head of healthcare and three nurses at Yarl's Wood in May. She interviewed another nurse by telephone in June and obtained a statement from a doctor who was unavailable for interview.
11. NHS England commissioned a professor to review the woman's clinical care at Yarl's Wood.
12. We informed HM Coroner for Bedfordshire and Luton of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
13. One of the Ombudsman's family liaison officers tried to contact the woman's sister by telephone and letter to explain the investigation, but did not receive a reply. A solicitor representing the woman's family contacted the investigator later.
14. The woman's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
15. The Director of 'Returns Immigration Enforcement' considered our draft report and accepted the recommendations. She raised one factual inaccuracy regarding Yarl's Wood's capacity and we have amended the report. She raised one other issue which we have addressed through separate correspondence. The Director has not yet provided a formal action plan to address the recommendations.
16. Approximately forty residents attended the group the investigator held on 7 April. A number of detainees said they were concerned about staff attitudes towards the woman and other women at Yarl's Wood. Most of the matters raised were outside the remit of this investigation or were claims we were unable to substantiate. We have therefore not included them in this report, but have passed them to HM Inspectorate of Prisons to consider when they next visit.

YARL'S WOOD IMMIGRATION REMOVAL CENTRE

17. Yarl's Wood is an immigration removal centre in Bedfordshire. It holds 410 detainees, mostly adult women, but the centre also holds a number of adult families including some men.
18. Health services are commissioned by the Home Office and provided by Serco Health. GPs run clinics every day on weekdays and there is one clinic at the weekend. There are four nurses on duty during the day on weekdays and three at weekends. There are two nurses on duty at night.

HM Inspectorate of Prisons

19. The most recent inspection of Yarl's Wood was in September 2013. A survey of detainees indicated that they were mostly satisfied with access to health services and the level of care provided. Inspectors found that emergency resuscitation equipment was well maintained and three automated external defibrillators were positioned across the estate. All custody staff had attended first-aid training, which included how to use defibrillators.

Independent Monitoring Board

20. Each immigration removal centre has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that detainees are treated fairly and decently. In its most recently published report for the year to March 2013, the IMB commented that the healthcare department was relatively settled. However, the report also noted that the number of complaints about healthcare had increased.

Previous deaths at Yarl's Wood

21. The woman's was the first death at Yarl's Wood since 2005. There were no similarities with the previous case.

KEY EVENTS

22. The woman arrived in the United Kingdom on 3 December 2000 from Jamaica and was granted temporary admission. The next day, she did not report to an immigration officer, as required, and was regarded as an absconder as she had breached the condition of her temporary admission and her whereabouts were unknown. The woman did not contact the Home Office again until 2010.
23. On 12 August 2010, the woman submitted an application to stay in the UK. The Home Office refused this application, with a right of appeal, on 15 September 2010. The woman submitted a reconsideration request on 15 November 2010. The Home Office did not formally refuse this request until 17 January 2014. On 27 February 2014, the woman applied again for leave to remain. The Home Office refused this on 17 March 2014. There was no right of appeal.
24. On 19 March 2014, the woman reported to Immigration Enforcement at Lunar House in Croydon which she was required to do every fortnight as part of the conditions of her temporary admission agreement. Immigration staff then detained her because her application had been refused. Security staff took her to Yarl's Wood Immigration Removal Centre.
25. The woman arrived at Yarl's Wood at 12.35am on 20 March 2014. The nurse saw her at approximately 2.35am for a reception health screen. He recorded that the woman's blood pressure was slightly raised at the time. He noted that she was taking an antidepressant (citalopram, 20mg daily) and that she was obese. (She weighed 125.9 kgs, almost 20 stone).
26. At 9.50am, the doctor and nurse saw the woman for the second part of her health screen. The doctor noted that the woman had had an operation to remove a fibroid in 2002 and a further operation in 2013 to remove a benign breast lump. He also recorded that she was obese and her blood pressure was now normal. The doctor re-prescribed citalopram.
27. The woman was assigned to a shared room in Crane Unit, the induction unit. On 21 March, the woman went to the healthcare unit to collect her medication. Later that afternoon, the woman told the nurse that she wanted to see a doctor about stress. He told her that there were no more appointments that day and she should come back the next morning.
28. Records show that on 22 March, the woman did not attend the healthcare unit to see the nurse to make a doctor's appointment or to collect her medication. The nurse told us that he had seen the woman in the reception area on 23 March and had reminded her about making a doctor's appointment. She promised she would do this the next day, but did not. She did not collect her medication on 23 March.
29. On 24 March, the Home Office received a claim for asylum from the woman and a request for temporary admission. The Home Office rejected the request for temporary admission and records show they were planning to

schedule a screening interview to consider her request for asylum. Although the screening interview took place on 25 March, the rest of the consideration process had not taken place by the time the woman died.

30. On 24 March, the woman collected her medication from the acting head of healthcare. He told the investigator that it is likely that he would have asked the woman about why she had not collected her medication for the previous two days and reminded her of the importance of taking it. However, there is no note of this in her medical record.
31. The woman did not collect her medication again on 25 and 26 March. On 26 March, she moved to a shared room in the Avocet Unit. She did not collect her medication again on 27 March. According to a statement made by a detainee for the Coroner, the woman had said that she felt unwell that day.
32. On 28 March, the acting head of healthcare noted in the woman's medical record that she had been to collect her medication and he had discussed with her the importance of collecting it regularly.
33. Another detainee told us that, on either 28 or 29 March, she had been in the queue to see healthcare staff at the same time as the woman and that the woman had told the nurse that she was having chest pains. The detainee said that the nurse told the woman it was probably wind and that she should go to the unit office for some paracetamol. The nurse told the investigator that he did not recall this conversation. There was nothing in the records to show that the woman had been to the healthcare unit, other than to collect medication, on either of these days or that she had complained of chest pain.
34. The paracetamol log book, which is kept in Avocet Unit office, shows that at 2.20pm on 28 March, a detention officer gave the woman some paracetamol. The detention officer could not remember why the woman asked for paracetamol and there is no space to record this information in the log book.
35. CCTV footage shows that the woman went to the office at 2.02pm and spent approximately twenty minutes talking to officers, standing outside the office and at one point taking some tablets. At 2.17pm, the woman touched her head repeatedly and moved her arm in an agitated fashion. The woman left the office at 2.23pm.
36. On 29 March, a nurse gave the woman her medication in the healthcare unit. The nurse told us that she had asked the woman how she was and she had said she was okay.
37. In a statement for the Coroner, a detainee said that, while braiding the woman's hair for her on 29 March, the woman told her she did not feel well and had been given some paracetamol. She told the other detainee that she was waiting for a doctor's appointment and said that she had previously had problems with her stomach.

38. The woman's room mate told us that, on 28 and 29 March, the woman had seemed very tired and needed to lie down before dinner one night. She could not remember which evening this was. The investigator saw CCTV footage of the woman walking normally to her room before roll count on the evening of 29 March at approximately 9.42pm and she did not appear to be unwell.

Events of 30 March

39. Three officers began the roll count of Avocet Unit at approximately 7.30am on 30 March. One officer checked the woman's room between 7.35am and 7.40am. He told us that he knocked on the door and when no one responded he opened the door. He said he could see the heads of both women in bed and closed the door again. After all the officers had completed the counts, they went back to the Avocet Unit office to phone through the numbers to staff in the control room.
40. The woman's room mate told us that, when she woke on 30 March, she heard the woman screaming. The woman was coming out of the bathroom and said that she had passed out. The room mate went to get help from other detainees. The woman continued to scream and her room mate rang the alarm bell in their room to summon officers. The alarm bell records show this was at 7.59am.
41. The CCTV footage shows that, at 8.00am, the three officers went to the woman's room. The officers stood outside the door and spoke to the women inside. They told us that they were discouraged from entering women's rooms unless specifically invited to or unless somebody was obviously seriously ill. The woman was conscious, moaning and sitting on the floor leaning against a bed with her room mate near her. At the time they did not consider that she was seriously ill.
42. At 8.02am, an officer asked for a nurse to attend. Two officers left to continue with their normal duties. One officer said that, while he was waiting for the nurse to arrive, the woman said that she had a pain in her heart.
43. At 8.04am, the nurse attended with an emergency bag but this did not contain a defibrillator or oxygen. The woman was lying on the floor and told the nurse that she had been to the toilet and passed out on her way back into the room. The nurse asked her to get up on the bed so she could assess her. The woman said that she could not move.
44. The woman managed to sit up against the bed. The nurse tried to take her blood pressure, but the woman kept moving. After the nurse removed the blood pressure monitoring cuff, she noticed that the woman's breathing changed and her eyes were rolling. She said the woman looked as if she was having a seizure.
45. At 8.09am, the nurse asked the woman's room mate to get the officer, who had left the room and she radioed for officer assistance and for other healthcare staff to attend. The officer arrived at 8.11am and the nurse moved

the woman into the recovery position. She could not find a pulse and moved the woman onto her back. She began cardiopulmonary resuscitation (CPR) and asked the officer to call an ambulance.

46. The officer radioed the control room for an ambulance which was requested at 8.13am. The officer and nurse arrived and another nurse requested some oxygen and the woman's medical records. A few minutes later, a nurse arrived with oxygen and the woman's medical records and handed these to a nurse. At about 8.16am, an officer arrived and a nurse requested a defibrillator. The officer brought this at 8.18am. The two nurses assisted the nurse with the resuscitation attempt and inserted an airway. The nurse said the woman was unconscious and unresponsive.
47. At 8.20am, a member of the control room staff contacted emergency services to find out where the ambulance was and was told it was on its way. The nurses and officers continued with resuscitation. A nurse asked the officer to bring another defibrillator as she was concerned that the one she was using had detected no heart rhythm and was advising no shock. She wanted to be sure it was functioning properly. The officer arrived with another defibrillator just before 8.29am. The nurse attached the second defibrillator and it also advised no shock.
48. At 8.34am, first response paramedics arrived and continued with cardiopulmonary resuscitation. At 8.41am, an air ambulance arrived in the grounds and the crew, including a doctor, got to the woman's room two minutes later. The resuscitation attempt continued until 8.57am when the doctor declared that the woman had died.

Contacting the woman's family

49. The Director of Yarl's Wood arrived at the centre at approximately 8.25am and went straight to the control room to speak to staff. The woman had not given any family contact details when she arrived at Yarl's Wood. (We were told that detainees often refuse to give this information because they fear their families will also be detained.) The director spoke to Home Office staff on site to see if they had any contact details or information about the woman's family. They only had a previous address for her sister.
50. The IRC and the police worked together to try and trace the woman's relatives. The police then managed to contact the woman's brother and told him that the woman had died. The woman's brother rang the Director of Yarl's Wood at 8.00pm. He invited the woman's family to visit Yarl's Wood the next day, which they did. (Although we would usually expect centre staff to break the news of a death in person to the family, we are satisfied that in the circumstances, this approach was appropriate.)
51. In line with national policy, the Home Office made a contribution towards the funeral costs. There was a memorial service for the woman at Yarl's Wood on 6 April and her funeral was held on 6 June.

Informing staff and detainees

52. Yarl's Wood's chaplain told detainees that the woman had died at that morning's church service. The centre manager also put up a notice to inform detainees. The woman's room mate missed the church service and told us that no one ever spoke to her formally about what had happened to the woman. She told the investigator that she had been unable to return to her room because the area had been sealed off. She was then moved twice and was unable to rest properly. She was offered a move back to the induction unit, but said she preferred to stay on Avocet Unit.
53. A centre manager's notice informed staff of the woman's death that day. Most of those who had been involved in the emergency response were invited to a debrief which took place later that day and details of the support available were provided. However, not all the staff involved were able to attend the meeting. Some, who had been involved in the resuscitation attempt, said that managers did not give them the opportunity to go home, although they were clearly upset and they remained on duty until the evening.

Post-mortem report

54. The post-mortem report concluded that the immediate cause of the woman's death was a pulmonary embolism.

ISSUES

Clinical Care

55. The clinical reviewer found that the care the woman received at Yarl's Wood was equivalent to that she could have expected in the community. Her death was as a result of a catastrophic and sudden pulmonary embolism, which was not foreseeable or preventable.
56. The investigator tried to establish whether the woman complained to a nurse that she had chest pain in the days leading up to her death as one detainee claimed. There is no record of this in her medical notes and the nurse could not recall her doing so. The detainee who said that the woman had complained was not specific enough about the time and date to enable the investigator to identify relevant CCTV footage. In any event, the CCTV footage does not have sound, so any conversation would not have been heard. We know that the woman visited the healthcare unit on the dates the other detainee mentioned, to collect her medication, but there is nothing in the records to indicate she complained of chest pain.
57. Although the woman did not collect her antidepressant medication on several occasions, the clinical reviewer notes that this would not have impacted on her death in any way.
58. The woman requested some paracetamol from the unit office, on 28 March, and the CCTV suggests that she was in some discomfort. The officer who gave the woman the paracetamol could not remember why the woman asked for it. The clinical reviewer examined the footage, but said it is not possible to say whether her apparent agitation was in any way connected to the cause of her death. He considered that the staff could not have been expected to predict or prevent it.

The Emergency Response

59. The clinical reviewer was satisfied that all staff who attended the emergency response did everything they could to try and save the woman's life. He noted that the nurse asked for a second defibrillator, which was unnecessary as, unless there are other signs the device had malfunctioned, it is most likely that the patient cannot be saved.
60. At Yarl's Wood, when staff find a detainee in a critical condition they radio for a 'First Response'. This prompts an assigned member of healthcare staff to attend the scene, without knowing any detail. Three officers designated as first responders for that day would also attend with the duty officer. The 'First Response' procedure was not used during this incident and there is no system to prompt an ambulance to be called automatically in an emergency.
61. When staff find a detainee in what they consider a non-critical condition but in need of healthcare assessment, they make a non-urgent request for

healthcare to attend. When the officer asked for a nurse to attend at 8.02pm this was a non-urgent request. He and the nurse, when she first arrived two minutes later, did not initially consider that the woman was in a critical condition. Some minutes later, the nurse asked for additional healthcare assistance and, when she became unresponsive, the nurse requested an ambulance. The control room called one at 8.13am. This was fourteen minutes after the original alarm was raised and four minutes after the nurse realised that she needed additional healthcare support.

62. We recognise that, at first, the staff did not originally consider there was a life-threatening situation and the clinical reviewer said that the delay in calling an ambulance and the initial lack of equipment were unlikely to have made a difference to the outcome for the woman. However, we are concerned that there is no clear procedure to call an ambulance, as soon as there are serious concerns about the health of a detainee. An NHS guide for use in the community, advises that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking, fitting or concussion, severe allergic reaction or a suspected stroke. This should also be the case with detainees. It is better to act with caution and request an ambulance that can be cancelled later if it is assessed as not required.
63. There is no national emergency code system for immigration removal centres, as there is with prisons. We have raised this issue with the Home Office in previous investigations and in a Learning Lessons Bulletin issued in March 2014. An emergency code system should identify the type of emergency (for example breathing difficulties/collapses or blood loss) to help healthcare staff decide which emergency equipment to bring and should lead to an ambulance being called immediately a code is used. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that each Immigration Removal Centre has a medical emergency response code system which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Support for staff and detainees

64. Both staff and detainees told us that they did not feel well supported after the woman's death. Some managers gave staff appropriate support, but this was not consistent. Although there was a debrief for staff, not all those involved were able to attend, and there appears to have been an expectation that they would continue working without sufficient discussion with each individual member of staff about whether they felt able to do so. One officer, who had

been involved in the resuscitation attempt, told us that he was asked to accompany another detainee with chest pain to hospital the same day, which he felt showed a lack of sensitivity.

65. Although a care plan was initiated for the woman's room mate she told the investigator that she did not feel well supported after the woman's death. When the investigator spoke to the woman's room mate she was concerned enough about her psychological welfare to report it to the Director.
66. The Detention Services Order 02/2012 states that service providers' contingency plans are to include:
 - communicating the death to other detainees/residents within the facility in an appropriate manner
 - providing detainee/resident support where required
67. A death in custody can be a traumatic event for staff and detainees. It is important that there are effective processes in place to ensure all those affected are offered support if required. We made a recommendation about this issue in another recent investigation into a death at an immigration removal centre and we make the following recommendation:

The Director General of Immigration Enforcement should ensure that all relevant staff are involved in a debrief and that staff and detainees receive appropriate support after a death or other serious incident in an immigration removal centre.

RECOMMENDATIONS

1. The Director General of Immigration Enforcement should ensure that a national Medical Emergency Response Code protocol is developed which:
 - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
 - Ensures staff called to the scene bring the relevant equipment; and
 - Ensures there are no delays in calling, directing or discharging ambulances.

2. The Director General of Immigration Enforcement should ensure that all relevant staff are involved in a debrief and that staff and detainees receive appropriate support after a death or other serious incident in an immigration removal centre.