Investigation into the circumstances surrounding the death of a man at Oakington Immigration Removal Centre

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of an investigation into the death of a man in April 2010 at Oakington Immigration Removal Centre. He was 39 years old. He was a Kenyan national who had been in detention for just under a month.

The man appeared well during the day before he died, but had asked for some paracetamol at around 11.15pm. He had been given it several times before but was refused on this occasion as it was during the night. The man woke during the early hours of the following morning and collapsed shortly afterwards. Unfortunately, attempts to resuscitate him were unsuccessful. The verdict of the inquest held on 7 October 2010 was that he died of natural causes.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by my Senior Family Liaison Officer.

The investigation was undertaken by my colleague. I would like to thank the manager of Oakington and the Director of Detention Services for United Kingdom Border Agency (UKBA) for their assistance during the investigation. I am also grateful to the two people who made the arrangements during the investigation.

A clinical review into the man's medical care at Oakington was commissioned by my office. A clinical reviewer conducted the review and I am grateful to him for his report. He concludes that the man's clinical care was comparable to what could be expected in the community. I apologise for the delay in issuing the report, which was caused by late receipt of the post mortem report.

Although attempts were made by UKBA to contact the man's family in Kenya, his family in the United Kingdom found out about his death via the internet. Therefore, I make a recommendation about the recording of next of kin information when detainees arrived in detention. I also comment on the safeguards to be considered when giving out stock medication. Although, for unrelated reasons, Oakington is to close in November 2010, I hope that my recommendations will be implemented across the rest of the immigration and removal estate.

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

Jane Webb
Acting Prisons and Probation Ombudsman **July 2011**

CONTENTS

Summary

The investigation process

Oakington IRC

Key events

Issues

Conclusion

Recommendations

SUMMARY

Born in 1970, this gentleman was 39 years old when he died in April 2010 at Oakington Immigration Removal Centre (IRC). He died of natural causes as a consequence of an irregular heartbeat.

The man arrived in the United Kingdom in 2002 from Kenya on a six month visit visa. On 19 March 2010, the man was detained by the United Kingdom Border Agency (UKBA) after they carried out a search of premises in London. As he was in the country illegally, he was initially held at Colnbrook IRC before being taken to Oakington on 20 March. He was allocated a bed on the first floor of Block 19. During the man's first reception health screening interviews, it was recorded that he had history of asthma.

During his stay in detention the man seemed in good health. However, at his own request, he was given soluble paracetamol for headaches on five occasions. He was not seen by a doctor and I comment on the safeguards regarding giving stock medicines, such as paracetamol, on so many occasions without seeking a doctor's advice.

At around 11.15pm on the night preceding the man's death, he asked discipline staff on Block 19 for more paracetamol. His request was refused as, at the time, officers had been instructed that it could only be issued during the working day. He accepted the refusal but asked other detainees whether they could give him any pain relief medication.

During the early hours of the day the man died (at around 2.40am), the staff on Block 19 were asked by a detainee to follow him to his dormitory. The officers followed the detainee and discovered the man collapsed on the floor of Dormitory 5. He was lying on his back, breathing but unconscious. The staff requested assistance from the duty nurse who came to the block.

The nurse assessed the man and asked for an ambulance to be called. About ten minutes later (at 3.10am) the man stopped breathing and cardio pulmonary resuscitation (CPR) began. The nurse asked the officers to inform the Ambulance Service of the change in the man's condition and to upgrade their response. An ambulance staffed with technicians arrived at the houseblock at 3.25am. They were joined by a paramedic crew, at around 3.30am, who continued the resuscitation attempts. The paramedics were unsuccessful in their attempts and resuscitation was stopped. The man's death was pronounced at 3.52am.

The clinical review considered the care provided for the man. In the clinical reviewer's view, the quality of care given to the man was equivalent to that he could have expected in the community.

I make two recommendations relating to recording next of kin information when detainees are received at removal centres and administering stock (or non-prescribed) medicines. After receipt of the draft report, the solicitors representing the man's family have suggested further recommendations which I included in the final report for consideration by UKBA.

THE INVESTIGATION PROCESS

1. The investigation was opened on the day of the man's death by one of the Ombudsman's investigators. He issued notices announcing the investigation to staff and detainees. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. In the event no one came forward. However, through interviews with staff, my investigator was able to identify the man's friends whom he interviewed.

2. My investigator also studied all the relevant records relating to the man. They included his detention records, immigration history and his medical records. He was also given copies of the police witness statements.

3. The Ombudsman's office commissioned a review of the care provided for the man during his time in detention. A clinical reviewer was appointed to lead the clinical review, and I am grateful for his report which was received on 18 October.

4. My investigator visited Oakington on 21 April, including the healthcare centre and Block 19, and spoke to the Centre Manager as well as other staff involved in the man's care. He returned to Oakington on 26 April, 7 and 27 May and 22 June. My investigator interviewed the Security Manager, three Detention Custody Officers (DCOs), a Nurse Sister, a Nurse and the Chair of the Independent Monitoring Board. My investigator carried out a telephone interview with a further Detention Custody Officer (DCO).

5. My investigator also interviewed seven detainees.

6. My investigator also wrote to four released detainees from Dormitory 5 to ask for their assistance. None of them responded. However, except for one released detainee, they had all previously been interviewed by the police following the man's death.

7. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death. My investigator attended a pre-inquest meeting with the Coroner on 23 June to discuss his investigation and findings at that stage. The inquest for the man's death was held on 7 October 2010 and the finding was that he died because of natural causes.

8. My Senior Family Liaison Officer contacted the man's family. They discussed the purpose of the investigation and the concerns and questions which they wanted to be addressed. My Senior Family Liaison Officer and investigator met the family to discuss their concerns which included the following:

    - Whether an ambulance had been called and then turned away on the day before the man's death?
    - Clarify on the policy regarding the administration and issue of medication between 9.00pm and 5.00am.

- Why the man had asked for paracetamol and whether this was his first request?
- The sequence of events from when the man collapsed.
- Whether there was any closed circuit television coverage within Oakington?
- Confirmation of the time of death.

9. The family were also concerned about how they had been notified of the man's death and the lack of information following the death. They will have the opportunity to receive my report and comment on the findings. I hope that my report helps them better understand the events leading to his death. The solicitors representing the man's family received a copy of my draft report and commented on it. They expressed concerns relating to the timing of events and the emergency response following the man's collapse. They have also suggested the following additional recommendations:

- Immigration removal centres should employ a coding system for medical emergencies to ensure that these are communicated with the correct level of urgency.
- All immigration removal centres are equipped with at least one defibrillation machine for use of trained staff
- All healthcare providers within the immigration estate are subject to training on medical emergencies including resuscitation and the use of a defibrillator equipment on an annual basis.

OAKINGTON IMMIGRATION REMOVAL CENTRE

10. Oakington is an immigration removal centre managed by Group 4 Securicor (G4S) on behalf of the United Kingdom Border Agency (UKBA). The centre opened just over ten years ago as a reception centre where quick decisions could be made about those subject to the asylum process. All services, including immigration and legal advice, are provided on site. Detainees, including women and children, spent a very short period there and were usually released pending appeals against negative decisions.

11. The function and population of the centre has changed considerably in the past five years. It now holds only men, some staying for long periods, and all facing the possibility of imminent removal.

12. There are five houseblocks (19, 20, 26, 30 and 39) which have dormitories holding up to 12 detainees and some single rooms. The man slept in one of the dormitories. All the houseblocks are equipped with showers, laundry facilities and a large association area. The regime at Oakington includes education, training, organised sports and paid work opportunities. There is no closed circuit television coverage inside Oakington.

13. Healthcare for Oakington is contracted out to Primecare Forensic Medical Services Ltd who employ four doctors and 11 nurses. The healthcare centre is a 24 hour operation, with healthcare staff on duty between 8.00am to 6.00pm on a rotational shift pattern. Between 6.00pm and 8.00am there is one nurse on duty on a rota shift pattern. All the detainees are seen by a nurse on admission to the centre prior to their transfer to their houseblock. Those needing to see a doctor following their admission can do so within 24 hours. In addition to this detainees can request to see a doctor at other times and this is arranged as soon as practicable via an appointment system.

Issuing soluble paracetamol

14. Detainees cannot buy their own paracetamol on site. All houseblocks at Oakington have a supply of soluble paracetamol, and a book to record relevant detainee information. Should a detainee require paracetamol, they will make the request to staff on the block. The officer will then telephone healthcare and liaise with a member of the nursing team to request soluble paracetamol. The nurse will refer to the detainee's medical records to ascertain their allergy status, current medication and whether they have pain relief medication already in possession.

15. Before approving the request, the nurse ensures that the detainee is present with the requesting officer and the reason for the request (for example, headache, backache etc). If it is appropriate, the detainee will be asked to collect a cup of water and the soluble paracetamol will be placed into the water by the officer. The detainee will remain in sight of the officer until the tablets have dissolved and been ingested. The officer records the detainee's name, the date and time of administration, the name of the nurse authorising the paracetamol, the number of tablets issued and the name of the officer issuing

the medication. The nurse will record in the detainee's medical records that the paracetamol has been dispensed and the date and time of issuing.

16. If a detainee requests more than two doses of paracetamol in one day, then an appointment will be booked for them to see a doctor as soon as possible to ascertain the nature of the problem and assess appropriate treatment. In February 2010 an instruction was issued that paracetamol would not be available for detainees between 9.00pm and 5.00am. Detainees had to make any request for paracetamol before 9.00pm or wait until after 5.00am for their request to be actioned. A revised instruction was issued in May 2010 which enabled detainees to have access to paracetamol during the night.

Her Majesty's Chief Inspector of Prisons' Report

17. The former HM Chief Inspector of Prisons made a full announced inspection of Oakington in June 2008 (there was an unannounced short follow-up inspection in August 2010, but the report of that inspection was published after the draft report was issued). In the report of the 2008 inspection, the Chief Inspector noted that most detainees arrived at night and she recommended that this should be avoided whenever possible. Regarding reception arrangements, the Chief Inspector wrote:

> "The reception was open 24 hours a day, seven days a week, and more than two-thirds of new arrivals were received during the late shift, between 7pm and 7am, of which more than half arrived between midnight and 5am. As detainees came from all over the country, some had been travelling for many hours before they arrived. Not all reported a comfort break. In the vehicles we checked, a comfort break had been offered on journeys of more than two-and-a half hours, usually when staff stopped to pick up a new passenger."

18. A high number of detainees are still received during the night at Oakington. My investigator was informed that requests have been made by G4S to UKBA for additional nursing resources to accommodate the healthcare screen process during the night but these were not forthcoming. However, on the night the man collapsed the nurse who was carrying out the health screening interviews finished seeing detainees around 1.30am, over an hour before the man collapsed.

19. With regard to the inspectors' observations during the visit, she wrote:

> "Detainees spoke negatively about healthcare, both in our groups and in interviews. Access to the service was hindered by the location of the centre [it has since moved], and detainees were concerned about the length of time it would take for nurses to reach them in an emergency, although the one medical emergency we observed was well managed."

20. Following the inspection in 2008 the healthcare centre moved to inside the compound at Oakington. This has made it easier for detainees to access services. The new facility has a small waiting area, several consultations

rooms and two treatment rooms. My investigator observed the appointment system which is in place and the facilities offered to detainees. He was also informed that the shortfall in the resources for detainees with mental health needs was being met by the Healthcare Manager whilst waiting for staff security clearance checks to be completed.

Independent Monitoring Board (IMB) Report

21. Each Immigration Removal Centre has an Independent Monitoring Board (IMB). IMB members are voluntary, independent and unpaid. The Board monitors day-to-day life in their establishment and ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB at Oakington covers the period from January 2009 to December 2009. The report drew attention to the difficulty recruiting and retaining healthcare staff due to the uncertainty about the centre's future.

22. The report also said:

> "… funding is still not forthcoming for a second nurse at night in spite of concerns over workload of multiple admission of detainees at night as well being available for medical emergencies."

23. Disturbances by detainees followed the man's death. The IMB commented that:

> "These have been dealt with and managed by the officers within the centre in a well controlled manner resulting in all finishing peacefully. The Board feel that this is largely due to the good relationship the staff has with the detainees allowing the situation to be talked down. UKBA and G4S have held talks with detainees after these instances to ascertain the concerns of the detainees."

24. There have been no previous deaths at Oakington. It was announced in August 2010 that Oakington would close on 12 November 2010 for reasons unrelated to the man's death.

KEY EVENTS

25. The man was born in 1970 in Kenya. He came to the United Kingdom in 2002 but his wife and two children remained in Kenya. The man had seven brothers (once of whom is deceased) and four sisters.

26. On 24 February 2010, the United Kingdom Border Agency (UKBA) made an application to a Magistrates' Court for the issue of a warrant to enter and search premises (a supermarket) in Harlesden. This was to search for any persons in the United Kingdom unlawfully and followed information which suggested that people might be working illegally.

27. At around 8.30am on 19 March, a UKBA operational team gained entry to the premises and served the warrant. They encountered 13 persons of various nationalities there and five were arrested, including the man who is the subject of this report. Following questioning and immigration checks, it was discovered that the man had been issued with a six month visit visa in Kenya, valid from 23 July 2002 until 23 January 2003. There was no trace of any other applications to the Home Office to indicate that he had tried to regularise his stay since then. He was identified as having committed an offence under Section 24(1)(b)(i) of the Immigration Act 1971 in that he had stayed in the UK after his visa expired.

28. After being detained, the man admitted to having worked at the supermarket for over two years, five days a week and ten hours a day. The arresting officer recorded that the man was asthmatic and had three salbutamol inhalers in his possession. This information was documented and relayed to the detention and escorting population management unit (DEPMU) so they could notify the appropriate detention centre. He was taken to Colnbrook IRC at around 5.15pm later that day. The following day, 20 March, he moved to Oakington.

29. At the man's first reception health screen interviews at both Colnbrook and Oakington, it was recorded that he had asthma. He was prescribed a salbutamol inhaler which he kept in his possession. When the man saw a doctor on 20 March his asthma was said to be well controlled and his chest was clear.

30. The first night in detention form completed when the man moved to Oakington contained basic details such as his mood, whether there was any cause for concern and whether he could share accommodation. The form does not, however, ask for next of kin information.

31. The new arrival induction log has a section where family contact is mentioned but no information was recorded when he first arrived in detention and the form was not completed by staff when he moved to Oakington.

32. The man's removal to Kenya was initially arranged for 26 March, but was subsequently re-scheduled for 30 March as removals to Kenya have to be arranged on weekdays. The Local Immigration Team for Brent, Hammersmith & Fulham and Royal Borough of Kensington and Chelsea assumed

responsibility for the man's case as his address was within the borough of Brent.

33. On 22 March, the man was seen by a nurse as he had a pain in his right ear which appeared to be blocked. He was prescribed sodium bicarbonate ear drops. On the same day, the man made an application for bail.

34. When the man complained of headaches on 24, 26 and 27 March he was given soluble paracetamol.

35. His bail application was refused at a hearing at Taylor House on 29 March which the man attended. On the afternoon of 30 March, the date of the man's intended removal to Kenya, a fax was received from his solicitors advising that he wished to make an asylum application. The man's removal directions were therefore deferred and he returned to Oakington during the early hours of the following day (at around 1.45am). He was asked whether he wanted to see the doctor and he declined.

36. In his immigration screening interview with UKBA on 1 April, the man provided his wife's contact details in Kenya. He did not give the contact details of his brother, who resides in the United Kingdom, saying that he did not know where his brother was living. When he was interviewed on 7 April by UKBA staff, he was asked whether he had any family in the United Kingdom and he replied, "No, I don't. My family are back home."

37. The man was given more soluble paracetamol after complaining of headaches on 9 and 12 April.

38. During the investigation into the man's death members of the general public wrote to the investigator and suggested that an ambulance had been called the day before the man's death but had been turned away. My investigator found no evidence to suggest that this had happened. From interviews conducted by my investigator with staff and detainees, it appears that the man appeared to be well and in good spirits during the day before his death. He seemed quite pleased to have completed his gym induction during the day. At around 10.00pm during roll check (this is a check to confirm that all the detainees are accounted for and have not absconded from the IRC) he engaged in some banter with one of the Detention Custody Officers (DCO) about showing his identification.

39. At around 11.15pm, the man approached the houseblock officer and asked a DCO (who shall be referred to as DCO1 in this report) for paracetamol. DCO1 confirmed, in her interview with my investigator, that this was the first time that she recalled dealing with the man. He was not given the medication. DCO1 was not allowed to issue paracetamol to the man following an instruction issued on 10 February stating that:

> "… paracetamol will not be available for detainees between 2100 and 0500 hours. Detainees will have to make any request for paracetamol prior to 2100, or wait until after 0500 for their request to be actioned."

He was told that there was an instruction issued by healthcare (on 10 February 2010) stating that paracetamol would not be issued between 9.00pm and 5.00am.

40. DCO1 told the investigator that:

> "He (the man) came to the office door and there were a number of people at the office door asking for, you know, different things and right at this minute I just can't remember what the other guys were after, but it was the man that caught my eye. I asked him what he wanted … he walked in and said 'Paracetamol, Miss'. …. I told him I was sorry that I couldn't issue any paracetamol because after 9 o'clock we're not allowed to contact PFMS (Primecare Forensic Medical Services who provide healthcare at Oakington) regarding paracetamol."

41. The man did not return to the staff again. At interview, the other staff on duty on Block 19 during the night preceding the man's death confirmed that the man did not approach them to ask for paracetamol. He complained to another detainee that he had been refused paracetamol. The man asked the detainee and other fellow detainees whether they had any paracetamol or pain relief medication.

.

42. When interviewed for this investigation, the detainee confirmed that around 11.15pm on the night preceding the man's death, he had asked him for paracetamol. The detainee said:

> "… if you need any medicine, paracetamol, you have to go downstairs to see the officer. So he went to see officer, he asked them for paracetamol and they didn't give him. It was too late to give him paracetamol and he has to wait until tomorrow morning to get it. So he came up around looking for paracetamol and I met him outside my dormitory. And he asked me 'do you have any paracetamol'; I said 'no, I don't have any paracetamol'. I said if he needed one (paracetamol) he should go downstairs to see officer. And he said he went there but nobody [was] going to give him paracetamol."

43. At around 2.40am on the day of his death, the man got out of his bed and was walking towards the door of his dormitory when he collapsed to the floor, banging his head. He landed between beds 19/5K and 19/5L (occupied by two detainees). Two DCOs (DCO1 and DCO2) immediately responded when told by one of the detainees who came down to the staff office to raise the alarm. The officers followed him up the stairs to Dormitory 5 and they discovered the man lying on his back on the floor. As he did not respond, they immediately asked for medical assistance via the radio network.

44. In her interview, DCO1 confirmed that when they arrived in Dormitory 5 the man was on the floor on his back. She checked that he was breathing and found he had a pulse which "seemed strong enough". DCO1 then asked DCO2 to request medical assistance. After DCO2 left the dormitory DCO1 was

informed by one of the detainees that the man had banged his head when he collapsed. She then checked the man's head and neck for signs of any injuries but found nothing untoward.

45. Two Detention Custody Supervisors (DCS) arrived shortly afterwards, one male, one female. DCO1 informed the male DSO that she had not put the man into the recovery position as she afraid to cause any further injury. The female DSO confirmed that the man was breathing. They were joined soon afterwards by a nurse and DCO1 updated her about what had happened. In their response to the draft report, the solicitors representing the man's family felt that the timeline of events was not precise enough. They stated that the man probably collapsed prior to 2.37am and then staff were alerted by detainees. Medical assistance was sought by staff at 2.42am and the solicitors estimated that the nurse would have arrived at the dormitory block between 2.49am and 2.50am. When interviewed, the nurse said she was delayed in her attendance for a number of reasons. She was in reception when she received the call, had to attend the medical centre to collect the man's records and then had to walk to the dormitory. I am content to include this revised information in the report. In response to the concerns raised by the solicitors, the clinical reviewer wrote:

> "It is my understanding that [the man] stopped breathing at around 3.10am. Therefore there would have been no clinical indication to start CPR before this point. Therefore discussions of the precise arrival of the nurse on the scene are academic as she was in attendance at the point [the man] stopped breathing and CPR was immediately started at this point."

46. After the nurse assessed the man's condition, she requested that an ambulance be called. The ambulance was called at 3.00am, which was 20 minutes after the man collapsed. The nurse inserted an airway into the man's throat and also asked one of the officers to collect a canister of oxygen from the healthcare centre. The other detainees were asked to leave the dormitory and they were taken downstairs to the television room before being moved to another block. In their response to the draft report, the solicitors representing the man's family drew attention to the evidence presented at the inquest into his death in relation to the lack of an emergency coding system at Oakington. I would concur that a clear indication of what type of emergency situation had occurred would have assisted the nurse in her response to the man's collapse.

47. When interviewed as part of this investigation, the nurse said that when she assessed the man:

> "He was unresponsive; he didn't answer to any verbal communications… I then got a pulse and there was an officer at his head and she said 'yes, he's breathing'. I looked at his pupil to see if they were reacting, they were reacting but sluggish, not as quick as a normal ... I then took a blood pressure, I was able to get a blood pressure; it was low but it was attainable. Then I tried to do a blood glucose. I attempted three times to do a blood sugar on him because sometimes if a person has collapsed it's because maybe their blood

sugar has gone low and they need some glucose. But in this incident I wasn't able to get any blood because his fingers were cool, the light was quite poor because all the detainees in the room, there were about nine in the room. They'd got their side lights on but the main lights in the room weren't on. So then I thought well this is really not a very good situation, so I spoke to G4S and asked them to clear the room because it was, I didn't want an audience, and also I asked for an ambulance as well, which was approximately 3 o'clock."

48. The man stopped breathing at around 3.10am and cardio pulmonary resuscitation (CPR) was started by the nurse with assistance from the Detention Custody Supervisors. The nurse also asked DCO2 to inform ambulance control that CPR had been started and "to upgrade the situation and their response".

49. An ambulance with technicians arrived at around 3.25am and they took over CPR. Another ambulance with paramedics arrived at around 3.30am. The paramedics continued with attempts to resuscitate the man but were unsuccessful. They pronounced that he had died at 3.52am. In response to the draft report, the solicitors representing the man's family felt the response to the emergency by the ambulance was not prompt and they also asked for copies of the records for both of the ambulances. In response to the concerns raised by the solicitors, the clinical reviewer said: "My understanding is that [the man] stopped breathing at 3.10am and an ambulance arrived at 3.25am. I do not consider this to be an excessive delay." The East of England Ambulance Service also confirmed that only one record was completed for the two ambulances. The paperwork commenced by the first ambulance crew was continued and used by the second ambulance crew.

50. After the man died, Oakington activated its death in custody contingency plan. The police visited Oakington and found no suspicious circumstances.

51. UKBA took responsibility for informing the family of the death. As mentioned above, at that time it appeared that the man's family were all in Kenya. Contact was made with the Kenyan High Commission, via the Foreign and Commonwealth Office (FCO), and they insisted that they facilitate informing the family. It was later discovered that (although there was no record of their contact details) the man had family living in the United Kingdom who unfortunately found out about the death via the internet. In their response to the draft report, UBKA said that their decision to not take further steps to try and identify other next of kin was at the request of the Kenyan High Commission, who requested that they be allowed to trace family and to break the news themselves.

52. With assistance from the Kenyan High Commission, the family were able to visit Oakington soon after the death. A memorial service was held at Oakington on 22 April which was attended by both staff and detainees.

53. UKBA appointed an Area Manager as their family liaison officer. She maintained contact with the family and assisted with the funeral arrangements.

UKBA also offered financial assistance with the costs of the repatriation of the man’s body and his funeral.

54. The detainees were told of the man’s death after they were unlocked on the day of his death.. Disturbances followed and no injuries to detainees were reported on that day or the day after.

55. The man’s funeral took place on 17 July in Kenya.

56. The post mortem conducted after the man’s death was inconclusive. Subsequent toxicology and histology tests failed to give a clear indication of cause of death. A Home Office Pathologist could find no certain cause of the man’s death, but believed it to be sudden arrhythmic death syndrome (a disorder of the electrical system of the heart that can lead to the death of apparently healthy people without any warning). The inquest into the man’s death was held on 7 October. The finding of the inquest was the cause of death was natural causes probably caused by an irregular heartbeat. The Coroner said:

> “It seems to me, and I find as a matter of fact for the record, that I consider the response by staff engaged at Oakington to have been timely and appropriate. I feel there was no gross negligence from any party in the tragic death of [the man].”

ISSUES

Clinical care

57. As noted, a review of the man's medical care was undertaken by a clinical reviewer. He noted that when the man was resident at Oakington he asked for paracetamol outside of normal working hours and this request was refused. He finds this practice reasonable and acceptable community primary care practice. However, he states that it is unlikely that such a failing contributed to the death of the man.

58. The clinical reviewer was unable to find any failing on the part of clinicians in the provision of healthcare to the man. He finds that the treatment appeared reasonable and acceptable and within the boundaries of equivalent community primary care practice. The clinical reviewer concludes:

> "I could not find any evidence that the overall standard of care offered to [the man] fell below what could reasonably be expected to be provided in community health services. It would appear from the post mortem report that [the man's] sudden and unexpected death was from natural causes. It would appear that the healthcare service have now developed a protocol for out of hours requests for paracetamol. This appears to be equivalent with community practice."

Administering stock (or non-prescribed) medication

59. As mentioned previously, each houseblock has a stock of soluble paracetamol which can be issued to detainees. Detention Custody Officers liaise with the healthcare department who check the detainee's allergy status, their current medication and whether they have pain relief already in possession. If there are no concerns permission is given by healthcare and the paracetamol is issued to the detainee. All dispensed medication is recorded in the detainee's clinical record and if they ask for paracetamol on more than two occasions in a day then a referral is made to the doctor. This is to ascertain the underlying reason for the need for the pain relief and appropriate treatment.

60. My investigator met the Chair of the Independent Monitoring Board (IMB) at Oakington as part of the investigation. She said a detainee had told her that the man had been fine during the evening but complained later and asked for paracetamol but his request was refused.

61. The Chair of the IMB confirmed that complaints to the IMB about the non-issue of paracetamol overnight started in February 2010 after the overnight arrangements were changed and continued into April. She said the IMB had been told that the decision was made because of the workload of the sole night duty nurse, who could at times be dealing with 30 to 40 new detainees arriving at Oakington each night. She said that G4S were trying to restrict the number of detainees sent to Oakington overnight, as UKBA had refused to fund another night duty nurse. She had challenged this at Board meetings as the IMB found it unacceptable for the medication to be unavailable from 9.00pm until 5.00am.

The IMB was told that this was being trialled for a month. At the next meeting in March, the IMB raised the matter again as the trial period had been extended.

62. After the disturbances that followed the man's death, the IMB were told that requests for paracetamol overnight would be made to the shift manager and be at his discretion. There was a great deal of discussion about this and also about logging requests for paracetamol, which was not happening prior to the incident. The Chair of the Independent Monitoring Board confirmed that a new staff instruction regarding paracetamol has since then been issued, ensuring it is available through the night. The new instruction (issued on 10 May 2010) said:

> "Up to and including 2200 hours daily, any request for paracetamol should be made in the normal manner, i.e. contact with PFMS to ensure that the detainee can have paracetamol, and then issue as appropriate. Between 2200 hours and 0030 hours, any request for paracetamol should be communicated to detainee reception, who will log the details of the detainee, and pass them onto the duty nurse who will deal with as and when they are able. Between 0030 and 0500 hours paracetamol request from be made through your Shift Manager to PFMS."

63. As mentioned above, the man requested and received paracetamol on five occasions whilst he in detention (24, 26 and 27 March and 9 and 12 April). As the man did not receive more than two doses of paracetamol in one day, an appointment was not booked for him to see a doctor to ascertain the nature of the problem and decide upon appropriate treatment.

64. I suggest that where a detainee presents for repeat requests of paracetamol nursing staff should undertake an assessment and carry out baseline observations (pulse, blood pressure and temperature). Additionally I suggest that a check should be introduced with a limitation of four single doses of paracetamol in seven days before referral to a doctor with symptoms also being a consideration.

    The United Kingdom Border Agency Director of Detention Services should work with the healthcare provider to ensure that there are appropriate safeguards in place when stock medicines are given to detainees.

65. On the evening before his death the man asked for paracetamol but was refused as his request was made after 9.00pm. Subsequently the policy for issuing medication has been revised in May (2010) and paracetamol can now be issued after 9.00pm.

Notification of next of kin

66. As mentioned previously, the man's family in the United Kingdom found out about his death via the internet. This was very distressing for them. In the

Detention Service Operating Standards manual for Immigration Removal Centres[1], it is made very clear that assistance should be sought from the relevant mission (high Commission or Embassy) to enable relatives living abroad to be informed about the death. The standards also state that the mission should not be informed if the detainee was claiming asylum. I appreciate that in this man's case, UKBA approached the Kenyan High Commission as it was not clear from their records that he had family in the United Kingdom. UKBA therefore decided to ask, via the Foreign and Commonwealth Office, for assistance from the Kenyan High Commission to notify his family of the death.

67. The first night in detention form was completed when the man moved to Oakington but does not ask for next of kin information.

68. In the new arrival induction log for the man, when he first arrived at Oakington, there was no information recorded in the section where family contact is mentioned. When he returned to Oakington, during the early hours of 31 March, the form was not completed by staff.

69. In his correspondence to my investigator dated 14 May, the Director of UKBA Detention Services wrote:

> "As you have perhaps already identified, there was an oversight by UKBA to inform [the man's] solicitor and his family immediately of the death. In the immediate hours following [the man's] death, the information provided to DS (Detention Services) HQ by both Oakington and the case owner, was that he did not have any known family in the UK, rather he had a wife and two children in Kenya. The High Commission was notified promptly, and they asked to take responsibility for tracing and notifying family members rather than UKBA. That said, that was based on an assumption that his family were overseas. Whilst we continued to liaise with the FCO throughout the morning, our immediate attention then switched to dealing with the incident at Oakington and ensuring the Centre remained safe and secure. This is in no way seeking to make an excuse for the fact that all of UKBA records were not checked sufficiently well, but it seeks to explain how this occurred. As soon as [the man's] solicitor contacted us on the Monday morning with [the man's] brother in his office, my deputy spoke with them and offered our deepest sympathy and apologies if indeed we as an agency had known about the existence of family in the UK. This was followed up with a letter to [the man's solicitor] and an offer of further contact if we could be of further assistance."

70. It is important that, whenever someone is held in the custody of the state, details of their next of kin are accurately recorded. This can be of vital importance not only when someone dies in custody, but also should they fall ill.

---

[1] The Operating Standards cover a wide range of areas including: accommodation, handling a death in custody and healthcare.

71. While, of course, there may be many reasons why an individual chooses not to disclose the details of their next of kin living in the United Kingdom, they should at least be given the opportunity to give the information, and for it to be recorded in a uniform way when they are first received into UKBA accommodation. I recommend that the initial reception/induction paperwork completed when a detainee arrives at an Immigration Removal Centre should include full contact details for their next of kin.

The United Kingdom Border Agency Director of Detention Services should ensure that when someone is detained in UKBA detention accommodation, their full next of kin details are recorded.

CONCLUSION

72. The man arrived at Oakington IRC on 31 March 2010. During the evening preceding his death he asked for paracetamol and his request was refused due to the medication procedures in place at that time. During the early hours of the following morning, the man awoke and collapsed soon afterwards. He died just over an hour later after attempts to resuscitate him were unsuccessful.

73. The cause of the man's death was not clear at the post mortem. The cause of death at inquest was suggested as an irregular heart beat, unrelated to the refusal of paracetamol on the night that he died. The Coroner also said at inquest that there was no "gross failure" by the authorities at Oakington who acted in a "timely and appropriate" manner.

74. In the light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was generally appropriate. The clinical reviewer in his review has concluded that the medical care the man received whilst he was detained was comparable to what is available in the general community. However I am concerned that stock medicines, such as paracetamol, were given to the man on so many occasions without any suggestion of a referral to a doctor. I recommend that UKBA works with their healthcare provider to review these arrangements.

75. The man's relatives in the United Kingdom found out about his death via the internet. Unfortunately, the records held by both staff at Oakington and UKBA did not have the contact details for the family in the United Kingdom. Therefore, attempts were made to contact the man's family in Kenya. I make a recommendation about recording next of kin information when detainees arrive at a removal centre. After receipt of the draft report, the solicitors representing the man's family suggested the following additional recommendations which I have included for the consideration of UKBA.

- Immigration removal centres should employ a coding system for medical emergencies to ensure that these are communicated with the correct level of urgency.
- All immigration removal centres are equipped with at least one defibrillation machine for use of trained staff
- All healthcare providers within the immigration estate are subject to training on medical emergencies including resuscitation and the use of a defibrillator equipment on an annual basis.

RECOMMENDATIONS

1. The United Kingdom Border Agency Director of Detention Services should work with the healthcare provider to ensure that there are appropriate safeguards in place when stock medicines are given to detainees.

   Recommendation accepted – Units will be asked to keep a log of tablets handed out which the nurses will review daily. They will then use their clinical judgement whether to arrange for a clinical appointment with the doctor.

2. The United Kingdom Border Agency Director of Detention Services should ensure that when someone is detained in UKBA detention accommodation, their full next of kin details are recorded.

   Recommendation accepted - We have updated our induction form which requires officers to ask where a detainee does not provide information regarding next of kin and to seek an explanation.