

A man died as a result of trying to hang himself from the second floor landing railings at the newly opened Colnbrook Removal Centre. This is the third self-inflicted death in the Immigration Removal estate that I have investigated since taking on responsibility for investigating deaths in custody in April 2004. There have been two other deaths from natural causes.

Many features of this case reflect an establishment newly set up with procedures not as yet clearly established. There was a lack of understanding by healthcare staff of the centre as a whole, failures in systems of psychiatric referrals and shortcomings in the communication between centre staff and the Immigration Service. Of particular concern was the decision to place the man, a known suicide risk, on a unit with a reduced regime.

Support for staff after the man's death was also somewhat patchy. The nurse who administered first aid on the scene said she received adequate support, but the nurse involved in managing his suicide risk was not specifically offered any. The Chair of the Independent Monitoring Board (IMB) – who, coincidentally, arrived on the scene immediately after the man's fall – received no contact from the IMB Secretariat. She was, however, phoned the Head of Detention Services in IND.

As with the other four immigration deaths, this investigation was conducted directly by members of my office. Along with them, I personally visited Colnbrook at the beginning of the investigation.

I am grateful to Premier Detention Services who run Colnbrook for both their generous hospitality and their openness and responsiveness in co-operating with my investigation. It was particularly helpful to be able to view CCTV coverage of the incident.

I am also grateful to the staff of both Premier and the Immigration Service who spoke to my investigators. Finally, I am grateful to the police senior investigating officer for providing a copy of his report and supporting documents.

There is no comfort to be drawn from the death of this detainee, a sad and vulnerable man, whose exact identity and life-history can only be guessed at. My colleagues and I hope our long list of recommendations will assist IND and Premier to reduce the likelihood of a recurrence of the unhappy circumstances described in the report.

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PRISONS AND PROBATION OMBUDSMAN

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Contents	
Summary	4
Glossary of Terms	5
Background	6
The man	6
The Immigration Removal Estate	7
Colnbrook Removal Centre	7
Investigation	8
The Man's Detention at Colnbrook	9
Reception	9
Ongoing Care	10
19 October 2004	16
Period in hospital	18
Post Mortem report	19
Examination of the Issues	19
Medical care	19
Communication/Role of Immigration Service	20
Management of Detainees at Risk of Self Harm	21
Placement on Delta Unit	23
Single room	23
Sheet/towel	24
Safety net	24
Conclusions	26
Recommendations	26

Summary

This is the report of my investigation into the death at his own hand of a man following an incident at Colnbrook Immigration Removal Centre on 19 October 2004.

The report starts by explaining how the man came to be at Colnbrook. He arrived in this country in October 2003 and applied for asylum. His application was refused and his subsequent appeal was unsuccessful. He was deemed to have exhausted the process in April 2004. The man was given temporary release during this time, but reported only sporadically. He was brought into detention in July 2004, but granted temporary release once again. He was finally taken into detention at Colnbrook in September.

The report describes the purpose of the removal estate and IND's guidance on determining who should be detained. This makes it clear that the presumption is that most asylum seekers and illegal immigrants will not be detained while their cases are decided or they are awaiting removal.

I then describe Colnbrook Immigration Removal Centre. It was built to a high security classification and looks and feels like a category B prison. It provides a range of facilities and activities for detainees, but their access to these is tightly regulated. Detainees are locked in their rooms overnight.

In 'Investigation' I explain how the investigation was carried out. It involved visiting the centre and speaking to a variety of staff, some of whom were formally interviewed. We also watched CCTV footage of the incident that led to the man's death. We obtained copies of both the police and the Premier investigation reports and reviewed a range of documentation pertaining to the man's care while at the centre. Finally, we commissioned an independent clinical review of the medical care provided to the man during his detention at Colnbrook.

'The man's detention at Colnbrook' looks in detail at the reception process. I find that the man was properly assessed by a nurse on arrival, but that he was not seen by a doctor the following day. In fact, he was not seen by a doctor until 11 days later, when he reported to healthcare complaining of stomach pains. Through all this time he had been without his anti-depressant medication.

The man was identified at this stage as being at risk of suicide or self-harm and the centre's procedures were invoked. Nevertheless, he attempted suicide by hanging himself from a second floor landing railing. I track the care afforded to the man over the ensuing days, leading to a decision to return him from healthcare to the wing and reduce his level of supervision.

I then describe events on 19 October leading to the man being taken to hospital with head injuries. The man tried to hang himself from the second floor landing railings, hit his head and fell off the edge of the safety netting to the floor. The report also sets out the response by staff to the incident.

'Period in hospital' gives brief details of the man's stay in hospital leading to his death. He was first taken to Hillingdon hospital, but subsequently transferred to the Intensive Care Unit at Charing Cross hospital. It was there that he died.

'Post Mortem Report' sets out the findings of the post mortem. This was that death was the result of multi organ failure, pneumonia and severe head injury.

I then consider the various decisions arising in this case. Based on my own observations and the conclusions of the clinical review, I am critical of the medical care given to the man. I refer to the failure to refer the man to a psychologist and to obtain the results from a urine test. I also refer to poor systems and breakdowns in communication. I report that I accept the recommendations arising from the clinical review.

I am critical of the failure to keep the Immigration Service properly apprised of the man's condition and of a lack of sensitivity by them in their communications with him.

Although generally speaking I find the care afforded to the man adequate while he was considered at risk of suicide, I express serious reservations about the number of people involved in his care and the lack of consistency. I consider how this might have impacted on decision making in his case.

In 'Placement on Delta Unit', I consider the appropriateness of placing the man on a unit with a reduced regime with others whose behaviour has been deemed to fall below the required standard. Although I balance this with evidence from a DCO (Detention Custody Officer) that detainees actually preferred the unit for a variety of reasons, I think the use of the Unit should be reviewed.

I question the wisdom of placing the man in a room by himself with no-one in the adjacent rooms and at the far end of the unit from the DCO's office. I also consider whether it was appropriate for the man to have been in possession of a sheet and towel (he used the sheet to form the ligature).

Finally, I examine the design of the safety net. I refer to the conclusions reached by the Premier and police investigators in relation to the net – both of whom make recommendations for improving safety. I also cite advice received from Prison Service Property Services Group, which suggests that the design of the safety netting differed in important ways from that used by the Prison Service.

I conclude that, while I have serious misgivings about the quality of medical care provided to the man, the management of his suicide risk was generally adequate and that staff responded well to the incident on 19 July.

I make 12 recommendations.

Glossary of Terms

BID	-	Bail for Immigration Detainees
CIO	-	Chief Immigration Officer
DCO	-	Detention Custody Officer
DCM	-	Detention Custody Manager
ETD	-	Emergency Travel Documents
ICU	-	Intensive Care Unit
IMB	-	Independent Monitoring Board
IND	-	Immigration and Nationality Directorate
IRC	-	Immigration Removal Centre
MODCU	-	Management of Detained Cases Unit
NASS	-	National Asylum Support Service
RGN	-	Registered General Nurse
RMN	-	Registered Mental Nurse
SHARF	-	Record of management of those at risk of self harm

Background

The man

The Immigration Service has a date of birth for the man of 8 June 1980. However, he was also by another name and with a birth date of 22 August 1963. He told Immigration Service officials that he had not seen his mother for 13/14 years and that she was dead. He said he was born in Liberia but moved to Gabon and then to Nigeria at a young age, subsequently living on the streets. None of this has been verified – one of the barriers to his removal was uncertainty over his true identity and nationality.

While he was at Colnbrook, the man apparently told an RMN that he had been a member of a secret religious cult in Nigeria where he operated as an assassin. He had decided that he no longer wanted to be involved with that sort of work and left them. He feared reprisals as a result.

The man arrived in Gent, Belgium in October 2003 on a merchant ship with four other stowaways. He was arrested by Immigration officials and taken to the Nigerian High Commission in Brussels, who had offered to issue the stowaways with Emergency Travel Documents (ETDs) to allow them to be repatriated. However, the shipping company refused to wait in port whilst the flights were booked to return them home. The subject of this report and the others were therefore put back on the boat, arriving in Liverpool on 26 October 2003. When Immigration officials tried to seize them, they barricaded themselves in the ship and threatened self-harm. The subject of this report apparently cut himself during this time with some cutlery. The stowaways were forcibly removed from the ship and taken into custody.

The man claimed asylum on 4 November and was referred to Oakington Reception Centre. His asylum claim was refused on 24 November. He was released from Oakington the following day while his appeal was outstanding. He was granted Temporary Release to a NASS hostel in Norwich and placed on reporting restrictions. He only reported sporadically. All his appeal rights expired on 22 April 2004. Lack of documentation was the only barrier to his removal.

On 26 May, the Immigration Service discovered that the man had left the hostel. He was subsequently reported as an abscond.

The man surfaced again when the Immigration Service visited an address in Ipswich. He originally stated that he was a Liberian national who had entered the country legally about eight months ago, but was identified and detained with a view to obtaining documentation.

Whilst in detention at Harwich, the man refused food and drink and complained of “problems with his brain”. He said his GP was at St Clements Hospital, Ipswich, a psychiatric hospital. The interview scheme for Nigerians at Harmondsworth had been suspended because of the serious disturbance there on 19 July, there was no supporting evidence to allow the application for repatriation to be put through as a paper application and the man would not co-operate in the process. Because there was little prospect of early resolution, therefore, he was again granted Temporary Release on 26 July and placed on weekly reporting. In summarising the case, the Immigration Service noted, “The prospect of obtaining any documentation looked slim, as there was no supporting evidence and the subject was unco-operative.”

The man was picked up a further time during routine van stops on 28 September. He was detained once again to try to progress his case. The man said at this stage that he was a Liberian national, and had recently been released from psychiatric hospital. He was apparently “disruptive and banging his head against the wall”. He was seen by the police doctor, who stated that he had two weeks worth of medication with him. The Immigration Service note that the police doctor had also said that he believed the man was “play acting”. The doctor actually wrote:

“A somewhat confused man but he was wily enough to ask for a solicitor – appears to have mental health issues but responded well at times – I wonder how much is acting.”

The doctor noted that the man was fit to be detained and was a standard risk of self-harm.

The Immigration Removal Estate

The Immigration Act 1971 makes provision for the detention of asylum seekers and illegal immigrants who are awaiting imminent removal, deemed to be easily removable, considered to be likely to abscond or released into the country or whose identities are in question.

IND’s Operational Enforcement Manual says:

“There is a presumption in favour of temporary admission or temporary release. There must be strong grounds for believing that a person will not comply with conditions of temporary admission or temporary release for detention to be justified. All reasonable alternatives to detention must be considered before detention is authorised. Once detention has been authorised, it must be kept under close review to ensure that it continues to be justified.”

Those suffering from mental illness or who have been subject to torture are “normally considered suitable for detention in only very exceptional circumstances, whether in dedicated IS detention accommodation or elsewhere.” In this connection, the Detention Centre Rules require that:

“The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.”

He or she should also report incidence of suicidal ideation.

Each Removal Centre has a cadre of Immigration Service staff, but they do not get involved with caseworking. Their role is simply to liaise between the particular caseworking unit and the detainee.

Colnbrook Removal Centre

Colnbrook Immigration Removal Centre near Heathrow is the newest of nine removal centres in the United Kingdom (the Immigration centre at Oakington is designated a “reception centre”). It opened officially on 15 September 2004. It is run by Premier Detention Services and started receiving its first detainees in small numbers at the end of August. It provides 316 bed spaces for single males, 20 of which are for use by Customs and Excise. It has not reached capacity to date and at the time the

man's death was running at about 153 with a further 9 in the short term holding facility, though staffing provision at the time was as for full occupancy.

The centre was built to much more secure specifications than any of its predecessors. This was due at least in part to the destruction of half the Yarl's Wood Removal Centre in February 2002. Consequently, it has the look and feel of a category B prison. I was struck as I walked round by how austere the centre felt. There had been no attempt to mitigate the stark white walls with any pictures or notices, for example.

The centre's mainstream accommodation comprises four accommodation units, each capable of holding 66 detainees on three floors in twin rooms. (At the time of the man's death, each room housed just one detainee.) Each room has en suite toilet and shower facilities and a television and video. There is also a laundry on each unit. Detainees are locked in their rooms at 9:45pm and unlocked again at 7:30am. Each unit has its own servery and detainees either take their food back to their rooms or eat it in a shared area on the unit.

In addition, there is a central spine on which are located classrooms for art, IT and English, a multi-faith centre and a shop and hairdressing facilities. There is also a two level healthcare centre. The centre also has a gym. Each unit takes it in turn on a rota basis to access the central spine to take part in activities.

Under Detention Centre Rules, detainees may be temporarily confined or removed from association where their conduct warrants it. In either case, the decision must be authorised by the Secretary of State. In addition, the IMB must be informed and are expected to monitor use of both the secure and temporary confinement units. Just short of either of these formal measures, Colnbrook uses its Delta unit to accommodate those whose conduct falls below what is expected. Detainees housed on Delta unit are not allowed off the unit to attend education, gym, the shop etc. Instead, instructors visit the unit to conduct classes there. Any items detainees require from the shop are delivered to them. The level of staffing on the unit is, however, broadly the same as that on the other units.

Investigation

The man's death was investigated on my behalf by Miss Ali McMurray (Assistant Ombudsman) and Mrs Eileen Mannion (Fatal Incident Investigator). As noted, I accompanied them on their first visit to Colnbrook following the man's death.

We received a very helpful overview from the Independent Monitoring Board (IMB). We also spoke to the Duty Centre Manager. During the course of the visit, we visited the reception area, healthcare and the unit on which the man was located at the time of his death. We received in depth briefing from staff at each of these locations.

We spoke to the police senior investigating officer and agreed with him that he would let us have a copy of his report and of the post mortem report. We also viewed CCTV coverage of the man walking to the top landing, securing the ligature and then jumping.

We spoke to the nurse who was first on the scene and took possession of Premier's own investigation reports on the man's death. Premier also provided us with all their records relating to the man's period in detention. This included his Medical Record and his Self Harm at Risk Forms (SHARFs). We also obtained copies of various policies and operating procedures for the centre and details of the technical

specification for the safety net. Finally, we obtained a copy of the Immigration Service's case notes for the man.

The Investigators formally interviewed three members of staff – the nurse who carried out the initial screening on reception and was involved with the man's care while he was on SHARF procedures, the centre medical officer and one of the members of the case conference who returned him to normal location following a period under close observation in the healthcare centre. They also spoke to the Chief Immigration Officer and the Contract Monitor.

We issued a notice to staff and detainees (appropriately translated) inviting anyone with information relating to the man's death to make themselves known to the inquiry. In the event, no-one contacted us.

Finally, we commissioned Ms Tracey Campbell, RN ONC, to conduct a clinical audit of the man's care whilst in detention. Her findings are attached at Annex A. We also invited the Director of Clinical Services, Charing Cross Hospital to make a contribution to the investigation in relation to the man's care whilst in hospital.

The Man's Detention at Colnbrook

Reception

The man arrived at Colnbrook at 6:45pm on 28 September. He was seen by a Registered General Nurse (RGN) at 8:15pm. He apparently told her he suffered from mental illness and that he had self-harmed the previous year but could not remember when. The nurse originally recorded that he had current thoughts of self-harm and/or suicide but amended this to show that he did not. She recorded that he had seen a psychiatrist in 2003 and that he said he suffered from depression. She did not annotate the form to show the man's mood on reception but said he reported feeling depressed.

The nurse wrote in the man's physical care record:

"New detainee admitted from Ipswich. Depressed and low in mood. Alleges that he suffers from mental illness. Maintained good eye contact. Has no intentions of self harm. Would like to see Immigration officers tomorrow."

In her statement, the nurse recorded that during the interview she assessed the man's eye contact, orientation and past history of self-harm and suicide attempts. She recalled that he said he suffered from depression and was on anti-depressants (this had been passed to her by the reception officers). Although the man had told the nurse he had been seeing a psychiatrist, he was apparently unwilling to tell her why or to talk about his past self-harm. The nurse commented that the man was very polite, co-operative and quiet and appeared to take pride in himself. The nurse concluded that he was not at risk of self-harm.

During interview with Mrs Mannion and Ms Campbell, the nurse said the man had presented himself well and was clean and tidy. He did not offer any detail about his previous self-harm and she did not feel it was appropriate to press him in this, considering that his privacy should be respected. She said she noted details of his medication on his physical care record, took the medication to healthcare and entered the man's name on the admissions list for the doctor to see. She said she left the man's medication with his medical file, attached with an elastic band.

The nurse was pressed on the question of the man's mental illness and depression and whether this should have alerted her to the possibility of suicide risk. She commented that most detainees were depressed when they arrived due to the fact of their detention. She repeated that the man was quiet and polite when she saw him. She could not say whether he was more or less depressed than other detainees and it was common for detainees who had been detained for a long time to be on anti-depressants.

The nurse said that the man was accompanied by an IS91 form (authority to detain) and that the medication he was taking was clearly noted on it. It also said he was depressed, but there was no suicide marker. She confirmed that she did not consider the man a suicide risk on reception.

Ongoing Care

The man was allocated to Alpha Unit but was subsequently moved to Bravo Unit on 30 September.

29 September

On 29 September, an officer filled out a form on the detainee's behalf, saying that he would like to meet an Immigration Officer as soon as possible to discuss why he was being detained.

The casework information database showed that arrangements had been made for a travel documents interview. A reply was sent to the man the same day by post. This said:

"You have failed Asylum and exhausted all appeal rights on 15.4.04. The reason why you are being detained is so arrangements can be made for a Travel Document."

The man sent a further fax that evening. He ticked a box to show he wanted to discuss the current position of his case, and added that he wanted to discuss his case with Immigration.

30 September

A minute on his Immigration case file noted that they had received the request from the man. It was noted that the Immigration Officer at Felixstowe had sent a request to complete bio-data forms for the man – "As a Liberian national he is removable on an EU letter and I feel a bio data i/v as further info is appropriate." The officer noted that she would do this the next day and speak to the man at the same time about his fax.

1 October

A file note dated 1 October recorded that the officer had attempted to complete bio-data forms with the man. However, he had told her that he left Liberia as a baby and lived on the streets of Nigeria. She recorded that she had not obtained any useful information from him.

4 October

On 4 October, Immigration Service officials at Colnbrook received a fax from the man's solicitor. This constituted a request for temporary admission or release and deferral of the man's removal directions. The solicitor advised that the man was unlikely to abscond because he was being persecuted in his country of origin and maintained that he would be mistreated on his return. They also said:

"Our client is very venerable [sic] and mentally sick. According to police's report our client was released from St Clement's mental hospital. If he was released from mental hospital he is not acting to be disruptive. The fear of detention may have deteriorated his mental condition.

"Doctor has declared him fit for detention but the longer he is detained his mental condition may deteriorate. This type of mental condition is a result of our client's past persecution. It is possible that the fear of his return to his country of persecution will aggravate his condition. If he is banging his head against the wall and being disruptive his condition may be serious and we request you to reconsider his case as soon as possible and release him. His release will be beneficial better for his recovery ...

"Contrary to Immigration Law and regulations, discretion should be used in his favor under the home Office Policy and under the Mental Health Act he should be treated in the hospital and should not be deported in these circumstances."

The fax was forwarded to Felixstowe the same day. There is nothing to suggest that any action – such as consultation with medical staff – was taken.

The Investigators asked Colnbrook's Medical Officer whether she was aware of the letter. She told them that she was not and that there was nothing on his file at the time she saw him (the first time was on 9 October). She added that she had no influence over detention, so that, even if she had seen the letter, there was nothing she could have done. The doctor told the Investigators that she was not aware of a requirement in Detention Centre Rules that the Medical Officer should report to the Centre Manager on the case of any detained person whose health was likely to be injuriously affected by continued detention or conditions of detention.

9 October

On 9 October, it was recorded in the man's file that he had refused to get out of the office and was very rude and non-compliant. He apparently threatened to take over the office and swore at staff. Premier's own investigation report noted, "There does not appear to be any reason behind this, part from frustration on [the man's] part. He also threatened to take over the office before leaving the office of his own accord and no force was necessary."

On the same day, he attended healthcare, complaining that he had been suffering from abdominal pain for three days and had not passed urine for two days. He was referred to the medical officer. This was the first time since his arrival at the centre that he was seen by a medical officer. (At fact check stage, the Centre Manager said he was certain that the man had been seen by a doctor within two hours of his admission to Colnbrook. The documentary evidence does not, however, support this.) The doctor appears to have assumed that this was his admission assessment, as she has filled in the relevant form and noted that the man had been in custody for one day (in fact, by this time, he had been in detention for 11 days.) She diagnosed a urinary tract infection and prescribed medication to treat it and the pain. She also

noted that the man had previously been admitted to a psychiatric hospital and had received treatment for depression. His mood was low, he said he had previously self harmed (including once within the last six months), was thinking of self harm (the man told the doctor that he was thinking of hanging himself) and felt he had a bleak future. In her notes, the doctor recorded that the man had attempted to stab himself a year ago in Liverpool "in prison". He had made a further attempt while in detention at Ipswich and had been kept in hospital for two weeks. She noted that he had been given medication and questioned "What?"

A nurse recorded separately that the man had been placed on SHARF level 3 (that is, observation twice every hour) and a SHARF form was duly completed. The doctor advised that all dangerous objects – especially those usable for hanging, cutting and stabbing – should be removed.

10 October

The man was seen again the next day. He complained of some discomfort whilst eating, but said there was none when he urinated. He told the doctor that he dreamed about being tortured and could not sleep as a result, as it woke him up. He also imagined that he was talking. The doctor noted that he was to see a psychiatrist.

A nurse noted later that day that the man's urine sample had been discarded because the laboratory transport had not called back after messages were left on the answer phone.

A case conference was carried out just before 10:00pm on 10 October. A nurse noted that the man was still feeling very upset about his past. He seemed tearful, depressed and hurt about things that had happened. He was fed up, having nightmares and felt no-one cared. Under "Action", the nurse wrote:

"To speak to the DCM if he's got problems
To continue to share a room with someone
To be referred to psychiatrist/counsellor
Make sure no contact to objects that he is likely to use to harm."

His level of risk was raised to 2 (that is, observation five times an hour) and the form was signed by the nurse and the DCM.

11 October

A file note on the man's Immigration file dated 11 October said:

"DCM ... on B wing spoke to me re. the subject. He is on a level 2 SHARF at the moment and he feels that, if any RDs are served in advance, he will go up to a level one and will pose a real risk of suicide. Front cover noted."

At 8:57pm on 11 October, the man submitted a request for information from the Immigration office. In this he said he had made requests and had not heard anything. He wanted to talk to someone from Immigration.

12 October

The next SHARF review was carried out at midday on 12 October. The man apparently opened up and spoke about his past experiences and his parents whom

he had lost. A Registered Mental Nurse (RMN) noted that he burst into tears during the interview and appeared depressed and angry about his past in his own country. He was, however, co-operative and verbalising all his problems. The man said thoughts of self-harm came and went, mainly when he thought too much. The nurse noted that the man had been referred to a psychiatrist and the appointment was to be confirmed. He was to be closely observed and all harmful objects removed from his room. He remained on level 2. The form was signed by the nurse and a Detention Custody Manager (DCM).

A note in his physical care record for the same date stated that the man had also complained of hearing voices and that he sometimes talked to himself.

The RMN made a much fuller note in the man's mental health record. She commented that he was neat and seemed physically healthy and strong. He had poor eye contact throughout the interview, however, and was disorientated with regard to the time and date (but knew the year). He could not recall how long he had been at Colnbrook – "only remembers that he was handcuffed and was sent to prison." Although he burst into tears when talking about family he had lost, the man gave a good account of what had happened and of incidents that led to his escape from his country. The nurse noted that the man complained of "hearing voices when alone of the secret cult religion which he betrayed that say, 'Musta you haven't fulfilled your promise. You must die.'" The man apparently claimed that he was paid by them to kill people, but he had escaped because he did not wish to continue. He said he felt his body did not belong to him. The nurse commented that the man appeared depressed, angry and pre-occupied. She recommended him for psychiatric review.

That same day, the DCM noted that he had carried out a routine check on the man. A further entry was made at 11:05am, to the effect that the man had been in his room throughout the morning but had popped out for breakfast. At 12:00 he took a phone call. At 12:55pm a SHARF review concluded that he should remain at level 2.

At about 3:30pm, the man apparently tried to kill himself. An Incident Report said:

"At about 3:30pm on Tuesday 12 October 2004, [the man] was found on the second floor landing by the railings on Bravo Unit. He had a ligature attached to his neck and tied to the railings. Once staff approached [the man] he jumped from the railings, as [the man] jumped the ligature broke and he landed on the safety netting. [The man] then climbed back over the railings to where the staff were. [The man] was then escorted to healthcare and put on level 1 watch and located in Healthcare in-patients."

A report by an officer who witnessed the incident said that, when the man landed on the safety netting, he got up and jumped over the railings back on to the first floor landing. He was then escorted to a room with another detainee before being taken to Healthcare.

The centre manager noted on the incident report form that a pattern was developing and that the situation should be monitored. I understand that there had been a previous jump on to the net.

A report of injury form noted that the man had received a "snick" on his middle finger and was complaining of pains in his right leg. No injuries were noted, however.

A note on his physical care record reported that the man was very angry and distressed and did not want to talk. He apparently said he had a lot of problems but could not talk about them then. He would do so the next day. The man was moved to level 1 (constant watch) and admitted to healthcare.

13 October

A further case conference took place the next day. Nothing new was noted, the man remained on level 1.

An Immigration Officer replied to the man's request for information on 13 October. He told the man:

"It will reduce the time spent in detention if you admit your true identity and nationality. Even your legal representatives state that you are Nigerian. You should contact them on 020 8672 2865 for advice."

The officer's file note recording the action he had taken was directly beneath that reporting that the man was on SHARF level 2. There is nothing on the file in relation to the man's apparent suicide attempt the day before.

At 5:00pm that day, the man asked to have something faxed for him. There is no record of what this was.

14 October

A SHARF case conference was held on the morning of 14 October. The man made some eye contact but was apparently very low in mood and said, "there seems nothing in life to live for". He said he was seeking bail. He also asked to visit the gym. This was duly arranged for him for 2:30pm that day. It was noted that the man banged his head against the wall during the conference. He was maintained on level 1 watch.

During the evening, the man complained that he felt sick and had a headache. A nurse saw him and told him he had to wait until the medication kicked in before they could give him anything else. The officer watching him noted that he seemed upset and quiet. He also noted that the man was very restless during the night and seemed quite distressed, calling out in his sleep. The officer commented that, from what he had observed and read in the man's notes, he thought he needed extensive counselling to talk about all his unresolved issues.

15 October

The following day (15 October), the man told the case conference that he had had a lot of problems throughout his life. He sometimes felt angry and thought about hurting himself or committing suicide. The man apparently said he had no problems with the staff and wanted to return to the wing. He promised not to hurt himself. Even though he seemed a little better, the review team decided to keep him in the healthcare centre for the next 24 hours under level 2 watch, but agreed he would be moved to the wing the next day, depending on that day's observations. In addition, and at the man's request, the priest was to be asked to visit.

A file note in the man's Immigration file recorded that Premier had informed them that SHARF level had been reduced from 1 to 2.

16 October

On 16 October, it was noted that the man had been calm and quiet for the last two days and wanted to go back to the unit. The review team decided to keep him on a level 2 watch for a further 24 hours, but to transfer him to D unit to enable staff to monitor his behaviour. Potential ligatures were to be removed.

The nurse involved (the same one as initially screened the man for risk of self harm) explained the decision in her statement. She said they decided to leave the man on level 2 but transfer him to Delta unit where he could interact with other detainees and also attend the gym as permitted. The man had informed them that he was getting even more depressed because he could not attend the gym and interact with other detainees whilst in healthcare. She added that they decided to place him on Delta unit as there were fewer detainees on that unit but the same number of staff as the others. The review team therefore inferred that the man would receive more supervision there.

The Investigators also spoke to a DCO member of the review team. The DCO said he had had suicide and self-harm awareness training and was confident he knew what signs to look for. He thought, however, that he formed part of the review team purely because he happened to be there. Nevertheless, it was not the first case conference in which he had taken part and he was comfortable with the role. The DCO said he did not have any worries about the man killing himself and agreed with the others to reduce his SHARF level and to keep an eye on him to ensure he interacted with others. The DCO could not recall whether the man was present at the conference.

The DCO explained that the detainees on D unit were always watched closely as there were not as many as on the other units. Even those on SHARF level 3 were carefully monitored. The DCO commented that the man's mood was changeable. He went on to explain that detainees were sometimes eased back to normal location from temporary confinement or removal from association via D unit as it represented a half way house. D unit was different from the other units because detainees were not allowed to leave the unit and enjoyed fewer privileges. The DCO emphasised, however, that the man was placed on D unit for his own protection so he could be watched – he was not being punished.

The Investigators pressed the DCO on whether it was appropriate to locate a vulnerable detainee such as the man in question on a unit with a reduced regime and less opportunity to engage in activities. The DCO said that, in actual fact, many detainees preferred being on D unit, as it was quiet and more peaceful than other units because there was less coming and going. Detainees did not have to queue for the phones or for their food. They still received structured gym and education sessions and staff were able to give them more attention.

A note on the man's personal file dated 16 October said:

“After spending some time in healthcare, [the man] calmed down and its been agreed he can transfer to Delta wing for a while before moving on to A or B unit. He also has been given permission to attend the gym at the time of A wing. This was authorised by Oscar 1.”

Premier's investigation report notes that the man was depressed about being located on Delta unit as he wanted to be on Bravo unit.

The man was placed in a twin room by himself at the far end of the unit from the office. There was no-one in either of the adjacent rooms.

17 October

The next case conference took place at 9:00am on 17 October. The team identified lack of sleep as a significant factor and noted that "some good advice, attention and social interaction would help this greatly". The man seemed more approachable and happier. While it was considered appropriate for the man to be observed on a regular basis, the team agreed that five times per hour appeared excessive. They therefore reduced his SHARF level to 3 and agreed to keep an eye on him and ensure he interacted more. Under "Other Conditions" the team noted:

"Social interaction;
Advice about how to relax;
Seeing the doctor for sleeping tablets;
Being allowed to use the gym."

The next review was scheduled for 25 October.

The nurse referred to this decision in her statement. She said the man seemed less depressed on 17 October than he had done the previous day. He also appeared happier and more approachable. They therefore decided to reduce his SHARF level from 2 to 3.

(There is no record of this further reduction in the man's Immigration file.)

18 October

On 18 October, it was noted on the man's SHARF daily supervision and support record that he went outside to play football and then went to the gym. The DCO on the review team told the Investigators that he thought he had probably played football with the man that day and that he seemed fine. Another officer reported at 5:20pm, however, that the man had said he felt like dying. The officer making the entry said the man seemed in good spirits while attending the gym, but seemed withdrawn when he returned to his wing.

19 October 2004

At 11:05am on 19 October, a DCO wrote:

"[The man] is not happy. I think he is not feeling well but he is down. I have tried to motivate him but he says that he doesn't want to do no gym activity."

The DCO said in his statement that, at about 11:00am, he went to the man's room. The detainee was sitting on the floor at the door, leaning against the wall. The DCO knelt down and asked him if he wanted to go to the gym, as he knew the man always went. The man told him, however, that he did not want to go. The DCO noted that he looked depressed. He asked the man if he wanted to exercise in the courtyard, but the man declined. The DCO then left him and went to the DCM office. The DCO said that he had just completed his SHARF entry when another DCO called him and pointed to the second landing where the man was tying a blue sheet around the railing. He said he activated his personal alarm and ran up the stairs. As he got to the second landing, however, he looked round and saw the man on the netting. He

turned and ran down the stairs and called for the medical team before he reached the detainee.

The trainee DCO who first spotted the attempt said he was playing draughts with a detainee when he saw the man start to tie the sheet round the railing. He went to the office to raise the alarm. He then ran up the stairs with the other DCO. As they got to the top of the stairs, the man jumped. The trainee said he saw him fall on the net having apparently banged his head on the first floor railings.

A second trainee DCO said he was playing table tennis with a detainee when he heard and saw the other trainee shouting and running to the office and then run up the stairs with another DCO. He said he looked up and saw someone falling onto the net. The person bounced at an angle and hit his head against a metal support. The second trainee said the man's head hung off the net, and when his arm fell off the net, his body followed. The trainee grabbed him round the shoulders and supported him as he came down, placing his upper body on the floor. He said that at no stage did the man hit his head on the floor or a table.

A DCM was also in the office at the time. She too started to run up the stairs but turned back when the man jumped. As she ran back down she hit both her personal alarm and the general alarm. The DCM said that, when she reached the far end of the unit, the man was hanging through the netting. She and the DCO helped him down.

The whole of the incident was caught on CCTV, which I and the investigation team viewed. (While this is not something I would wish to view every day, I welcome its availability. It was invaluable in helping us understand what happened.) At 11:13am, the man left his room carrying a towel and went up to the top floor landing. There was nothing about his pace or gait to attract attention. He went to the far end of the landing from the stairs and tied a sheet, which he had concealed under the towel, round the railings. He then slipped the other end, which was formed into a noose, around his neck. He then climbed over the railings, paused a moment and jumped. (The safety netting is placed on a level with the first floor.) The man was jerked back in towards the landing, where he apparently caught his head on one of the stanchions. The noose gave way, and the man fell onto the safety netting. His weight then appeared to carry him towards the edge of the netting and he fell through onto the floor below (the netting is attached on two sides only, and not at either end). Detention officers and another detainee managed to break his fall and prevent him from hitting his head again. The whole incident took just 38 seconds from start to finish.

The Assistant Director of Healthcare said in her statement that she was just leaving the healthcare unit at about 11:15am. She heard a call for medical assistance on Delta unit and went straight there.

She reported that she arrived in Delta unit on the first floor and saw a detainee on the ground floor between the table tennis table and the dining table. She was told by a DCO that the detainee had jumped. She said the man was conscious and lying on his side. He was turned on to his back while she kept his neck and head straight. She said the man had blood around his mouth and she could see that some of his teeth were broken and missing. Medical assistance arrived one minute after the Assistant Director and she placed the stiff neck collar round the man's neck to immobilise it. She assessed the situation and asked for an ambulance to be called. First response, who had also arrived by this time, called for an ambulance and for

second response at 11:18am. The second response arrived at 11:19am with the doctor. All detainees were locked up by 11:21am.

The Assistant Director then stayed with the man until the ambulance crew arrived at 11:43am and took him to Hillingdon hospital. They left the centre at 12:13pm. The Assistant Director told us that the ambulance had apparently gone first of all to Harmondsworth Removal Centre (immediately next door to Colnbrook) before being re-directed. Nevertheless, she said she had absolutely no complaints about the response time.

She described the protocol that exists for such circumstances whereby officers go to each of the intervening doors to ensure they are opened as healthcare officers approach to enable quick passage. The Assistant Director told us that the system worked extremely well on this occasion.

Period in hospital

The escorts have recorded that they arrived at hospital at 12:30pm. The man refused to talk to them and seemed to be in some pain. The man would not communicate with the nurse either. They noted that he “seems to have all movement”. A nurse advised at 1:40pm that there was nothing wrong with the man and he would be returned to Colnbrook as soon as possible. At 2:00pm, however, the man brought up blood and it was decided that more tests were needed. A scan was carried out at 3:30pm. The escorts reported that there was apparently a lot of bruising and bleeding around the brain.

The man’s physical care records show that it was originally thought that he would be transferred to Charing Cross as the CT scan showed subarachnoid haematoma. Further investigation diagnosed a floor haematoma and Hillingdon staff decided to admit him to Hillingdon probably for 48 hours. A file note on the man’s Immigration file recorded that it was Charing Cross that decided not to admit him, because the haematoma was not serious enough. They noted that Hillingdon hoped to discharge him on either 20/21 October.

The Assistant Director contacted Immigration staff at 8:30am on 20 October to advise that the man’s condition had deteriorated overnight and he was now in the Intensive Care Unit (ICU) at Charing Cross on a life support machine. At 5:10pm, Immigration staff contacted healthcare for an update, but were told the results of the latest scan would not be available for a couple of hours. The Chief Immigration Officer asked his staff to pursue the question of temporary admission with Felixstowe colleagues the next morning. The file noted that the man was ventilated in the ICU, was unable to abscond and was unlikely to make a speedy recovery.

At 8:00am on 21 October, an Immigration Officer noted that the man was still neurologically unstable. She contacted Felixstowe about temporary admission and was told the Chief Immigration Officer would consider the matter that day. She was told that Felixstowe had in fact received a bail application from Bail for Immigration Detainees (BID) on 13 October, but Felixstowe had not responded because they were trying to sort out a timescale for documenting the man for his removal.

At 10:30am on 21 October, the man was reported to be in a critical condition. He had a large blood clot on his brain and was too ill to operate on. The Immigration Officer called the Chief Immigration Officer at Felixstowe to request urgent temporary admission. He agreed. The officer advised the Deputy Centre Manager to stand down the bed guards immediately.

On 22 October, Immigration learned that the hospital was slowly reducing the man's sedative – he was still not awake. An officer contacted the Nigerian High Commission but was advised that the information on the bio data was minimal. The man's father and brother were both dead and he had not seen his mother for 13 - 14 years and had no address for her. The Nigerian High Commission had no facilities to trace anyone with the very brief details Immigration had been able to provide.

On 23 October, the man was on the critical list and still heavily sedated. The position remained the same until 29 October when Immigration were informed that the man was off sedation but had not regained consciousness and was still critical and very unstable. By 31 October, he was back on sedation and on a ventilator. On 6 November, Felixstowe staff (who had been liaising with the hospital on at least a daily basis) advised Immigration staff at Colnbrook that they would reduce their updates to one every two days. The man died at 11:30pm on 7 November.

Post Mortem report

The post mortem report noted that death was not due to natural causes and there was no pathological evidence to indicate any third party involvement. The pathologist noted that pneumonia was a common and often fatal complication in patients with severe trauma. Cause of death was:

Multi organ failure
Pneumonia
Severe head injury.

Examination of the Issues

Medical care

The independent clinical review has identified a number of areas of concern in relation to the care afforded to the man and to the lack of effective systems and communication in the healthcare centre at Colnbrook. These are:

- The man was not seen by a doctor on the day after his reception and, in fact, was not seen for a further 11 days, when he self-reported. During all this time, he had been without his anti-depressant medication;
- Despite numerous entries on the man's records stating the need to refer him to a psychiatrist, this never happened. Nor was he seen by a counsellor. This is particularly worrying in light of the instruction in the Detention Centre Rules that:

“The Medical Officer, Clinical Manager and HRAT Co-ordinator shall ensure that every ‘at-risk’ detainee who is identified as having a possible psychiatric condition is referred to the Psychiatrist at the earliest opportunity. The Psychiatrist will evaluate the detainee and prescribe treatment as required”;

- No test results were received on the man's urine sample;
- There is a lack of clarity in terms of systems and responsibility for following up on referrals and tests;
- Both the nurse who saw the man on reception at the centre and Colnbrook's Medical Officer said they had received no induction at the centre;
- There are concerns over communications between the doctors and nursing staff; and

- The Medical Officer reported that it was not uncommon for detainees to miss mental health reviews – sometimes because no escort was available.

These areas are discussed in more depth in the clinical review attached at Annex A. I entirely endorse Ms Campbell's recommendations, which are that:

- **A key worker system be introduced;**
- **Effective systems need to be established to ensure detainees are seen by a doctor within 24 hours of reception;**
- **Clear lines of reporting and responsibility need to be established [this relates particularly to follow-up action];**
- **Multi-disciplinary team meetings should be held on a regular basis; and**
- **Healthcare professionals should be reminded of the need to maintain clear, thorough documentation which should always be signed, dated and name printed.**

Communication/Role of Immigration Service

In light of the evidence of the Medical Officer and the nurse relating to lack of induction, Ms Campbell also recommended that induction for new staff should be developed as a matter of priority and should include a thorough briefing about the care of a detainee's mental and psychological health as well as their physical health.

The Detention Centre Rules state:

“(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.

“(2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.

“(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.

“(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.”

When the investigation team spoke to the Medical Officer, she was unaware of these requirements. The Centre Manager commented at fact check stage that “all incidents, such as self-harm are recorded on incident reports which got to UKIS”. Nevertheless, it seems that the only information relayed to the Immigration Service (the Secretary of State's on-site representatives) about the man's risk of self harm came about purely because an officer visited Bravo unit on 11 October and a DCM mentioned it to him. There is only one other reference on the Immigration papers to suicidal ideation (the reduction from level 1 to level 2) until the man's suicide attempt on 19 October. There is not even any reference to his attempted self-harm on 12 October.

In addition, while I accept that it had not been confirmed that the man was suffering from mental illness (itself a matter of serious concern), this was clearly relevant to his

continued detention. There was, however, no communication with the Immigration Service about this. I therefore endorse Ms Campbell's recommendation about induction.

I also recommend that all healthcare staff (directly employed or agency) should receive a comprehensive induction to the centre. This should cover, inter alia, their responsibilities as set out in the Detention Centre Rules.

Equally, I have noted with concern that the Immigration Service did not refer the man's solicitor's letter alleging mental illness to the Medical Officer for advice, despite the instruction in the Operational Enforcement Manual that those suffering from mental illness are "normally considered suitable for detention in only very exceptional circumstances".

I recommend that Immigration Service staff be instructed routinely to refer to the Medical Officer in all cases where it is suggested the detainee is suffering from mental illness.

This lack of communication is a matter for real concern. Of all the many and various stresses on detainees, the most significant relate to their immigration cases and the likelihood of removal. Any communication from Immigration Service officials might serve to push a detainee over the edge. In this instance, Immigration Service were dealing with the man's case largely oblivious to his state of mind. Worryingly, the information they did receive appears to have served only as a warning not to serve Removal Directions in advance. The tone of the Immigration response of 13 October to the man's application – a response that may be characterised as blunt and perhaps as unfeeling – was not appropriate had the writer read the preceding note on the file that the recipient was someone already contemplating self harm. I can only imagine what effect it might have on the man, given his state of mind.

I recommend that Immigration Service staff be reminded of the need to tailor their communications with detainees according to the circumstances of the individual detainee. Particular care should be taken in dealing with those at risk of suicide or self-harm.

I should say here that, while I understand the reasons for not giving advance notice of removal – that detainees can become disruptive and even violent when they are told they are going - I deprecate the practice. It might help forestall difficulties with particular detainees but it can only serve to heighten the general tension and stress in removal centres, since no-one knows when they might be leaving.

I recommend that the Immigration Service ceases the last minute serving of Removal Directions and takes steps instead to manage cases on an individual basis.

Management of Detainees at Risk of Self Harm

Colnbrook's "Management of Detainees at Risk of Self Harm" policy document says:

"Continuity of care is essential to increasing the detainee's confidence and ability to cope: involve the same people on the case review wherever possible."

The document says that the Detention Custody Manager and relevant nursing staff should jointly establish the initial care plan together with the initiating officer and any

other appropriate staff forming the initial case conference. Under “High Risk Assessment (HRAT)”, the guidance says, “The “At Risk” Intervention Co-ordinator (Duty Operations Manager), is responsible for convening the HRAT to review detainees ‘at risk’ of self-harm or suicide.” It says that HRAT “will” comprise the following:

- Duty Detention Custody Manager of the area in which the detainee is located.
- Counsellor/Programme Representative (if required).
- Clinical Manager or Registered Nurse (ideally the assessing Nurse).
- Detainee’s Personal Officer.
- Religious and Activities Manager (where possible).
- Other relevant persons, as required and in any event the “At Risk” Intervention Co-ordinator.

The guidance describes the role of the HRAT and states that, “Date of evaluation of each care plan will be decided at the preceding case conference but in any case no longer than 5 days.”

The guidance in place at Colnbrook is comprehensive. I am concerned, however, that implementation in this man’s case fell short in several respects. Although regular case reviews were carried out and properly documented, a number of them were carried out by just two staff – usually a nurse and a DCM. I do not know whether the personal officer scheme had by that time been established, but, given that no single DCO attended all the case conferences, it seems that no personal officer was present. In addition, the Religious and Activities Manager was not involved either.

Even more worrying, however, and particularly so given the emphasis placed in the guidance on continuity of care, is the lack of any such continuity in this man’s case. A total of nine case conferences were held. Twenty-one members of staff took part, only four of whom attended more than once. Of the four who took part in the final case conference that decided to downgrade the man to level 3, only one (the reception nurse) had taken part in an earlier review (the day before). Any assessment of whether risk of self-harm has increased or decreased must be a comparative thing – that is, based on an evaluation of the detainee’s state of mind as it compared with the previous day. To attempt to make such a crucial assessment on the basis of such little personal knowledge seems to me to be fraught with danger.

In addition, there is the question of the sort of support this afforded to the man. In order to feel properly supported he would need to feel he had established relationships with those charged with his care. As well as constant change in terms of those participating in the case conference, there was little consistency in the officers deployed to watch him while he was on level 1. Given the constant change in personnel, it is difficult to see how relationships could be built up.

I recommend that Premier establishes a personal officer scheme, if it has not already done so. At the very least, a personal officer should be allocated to at-risk detainees, even if it is not possible to provide one for every detainee.

I recommend that Premier emphasises to staff the need for properly multi-disciplinary high risk review teams and to ensure that a core of the review team membership remains constant throughout the period of risk.

I recommend that the Suicide Prevention team regularly reviews the make-up and operation of case conferences.

Placement on Delta Unit

The nurse involved with the final review explained in her statement and again during interview the thinking behind the man's placement on Delta Unit. Essentially, this was because there was less movement into and out of the wing and fewer detainees than on other units. Staff numbers, on the other hand, were the same as on other units. It was therefore thought that better supervision could be afforded the man on this unit.

However, Delta Unit is the unit to which those detainees whose behaviour falls short of what is required but is not so poor as to warrant placement on Rule 40 or 42 are allocated. (Worryingly, the nurse told us she was unaware of this function of Delta Unit.) The Centre Manager advised at fact check stage that the unit was not solely for difficult detainees and that most were on standard regime and partook in activities. We were told, however, that this was effected by bringing activities to detainees, rather than by allowing them off the unit. (The man who died was exceptionally allowed to use the gym.)

Whether or not the restricted regime is intended as a punishment, it may well be perceived as such. Indeed, I am uncertain to what extent Delta Unit complies with either Detention Centre Rules or the general ethos governing the management of Removal Centres. That aside, the provision of a reduced regime cannot be desirable for those at risk of self-harm. What they need is stimulation and activity and the chance to forget their problems (in the short term at least). I was immediately struck by the paradox of placing a vulnerable detainee on such a wing. It is noteworthy that the man had repeatedly requested a return to normal location for this reason and that one of the late case conferences concluded that part of his sleep problems derived from lack of activity during the day. From this point of view, and notwithstanding that he was given special dispensation to attend the gym, the decision to place the man on Delta Unit was inappropriate and to be regretted.

In saying this, I acknowledge that the investigation team was told by one of the officers who was involved in the final case conference that many detainees preferred to be on Delta unit. This was because of the better detainee to staff ratio, because it was quieter and less stressful than other units and it was much easier to access the phone.

I recommend that IND and Premier review the use of Delta Unit both in terms of the Detention Centre Rules and as a location for those at risk of self harm.

Single room

It is a staple element of many custodial suicide prevention strategies that those who are identified as being at risk of self-harm should be placed in shared accommodation. The advantages of this are that someone is on hand at all times to keep an eye on the vulnerable person, but more importantly, there is a constant source of support. It is perhaps regrettable that the man was not placed in a shared room. Certainly, he might have been placed next to the wing office, meaning that staff were always close by both for supervision and support. At the very least, he should have been placed in a room with occupants on either side. In the event the man was located in a room almost at the far end of the unit from the wing office and

with nobody in the rooms on either side. While this may have afforded him some peace and quiet, it also left him very isolated.

I recommend that shared accommodation be made a key strand of the management of detainees at risk of suicide or self-harm. Where this is not appropriate, consideration should be given to the precise location of the detainee within the unit.

Sheet/towel

When the man was transferred to Delta Unit, one of the “Other conditions” of his Care Plan was, “Remove ligatures, shoe laces etc.” This requirement was not repeated the following day when his SHARF level was reduced. I note that he used a sheet with which to hang himself and that he had concealed this in a towel (which might also have been used as a ligature). Those at risk of self harm need to be treated in conditions as normal as possible. A risk-free environment would not be a humane environment. But, considering that Mr Peter was still judged to be at risk of self harm, albeit reduced, and had previously attempted to hang himself, some might question whether he should have been allowed to retain a towel and sheets in his possession.

I recommend Premier reviews its policies on which items may be retained in possession by those detainees at risk of self-harm.

Safety net

Each unit at Colnbrook consists of three floors with a central well going down to the ground floor. A safety net is placed in the well on a level with the first floor. The safety net is designed to ‘give’ when someone falls on to it, to absorb some of the impact. It is attached along its two lengths only, thereby leaving a gap between the net and the first floor at either end. It was through this gap that the man fell.

Some concern has been expressed following the man’s death about the adequacy or appropriateness of the safety net. DS Hughes commented in his report:

“There is steel mesh to prevent detainees jumping from the first floor landing, yet none on the upper landing. This allows detainees to jump and gain sufficient momentum to carry them through the end of the mesh on the first floor landing which is unsecured at the ends and allow them to fall to the ground below. It also allows them to gain sufficient momentum to sustain a serious head injury if they hit any of the Steelwork, as did [the man].

“The absence of a mesh on the second floor also gives sufficient drop (approximately 15 – 20 feet) for a detainee to hang themselves. Although on level 2 watch [sic] a detainee checked five times per hour it only took [the man] 38 seconds to hang himself. Although hanging was not the cause of death there is still clearly potential for this to happen in the future.”

The Senior Investigations Officer of Premier Custody Group/Serco Ltd recommended that the retaining supports for the netting be padded as a matter of urgency. He also suggested that the issue might be addressed by ensuring that a DCO is present on the top landing at all times when detainees are unlocked. He acknowledged that it might be difficult for one DCO to prevent a detainee jumping, but thought the presence of an officer might act as a deterrent.

The Investigators sought advice on safety netting from Property Services Group in the Prison Service. They advised:

“Originally safety netting consisted of Fishing net material suspended across wing landings and retained by lengths of steel conduit, over a period of time the netting rotted and needed to be replaced. In the late eighties two systems were evaluated using a steel mesh and slightly different end fixings, the North system fixed directly into the walls and used a single spring to absorb energy whilst the south system retained the landing edge fixing and used a double spring.

“The south system was adopted in the early nineties with a modification to a single spring and this is the system depicted on the standard drawings.”

Miss McMurray sent the specifications for the Colnbrook safety netting to Property Services Group to clarify whether the design specification for Colnbrook mirrored that used in prisons. They told her:

“I confirm the details shown on the Huffey Construction Ltd drawing number 254-181A-N32 are broadly in line with Prison Service practice and the details shown on our standard drawings STD X 046-048.

“The Huffey drawing differs from Prison Service practice in that,

- a) The safety mesh is shown at the same level as the top of the landing, Prison Service details show the mesh below the landing so that it can be run under obstructions such as cross bridges and return landings and can be abutted to a vertical face. The mesh on drawing 254-181A-N32 being at the level it is has been stopped at obstructions; this practice leaves an unguarded vertical edge.
- b) The mesh detailing around the stairwell leaves a large area unprotected. The Prison Service recognises stairs are a problem and are difficult to protect but the methodology set out on the standard drawings has not been followed. (This might be because of the stair configuration chosen by the builder not giving sufficient headroom on half landings)

“Safety mesh is normally installed at alternate levels starting at the one’s and working up, a trial with mesh fixed at every level was conducted but the overall effect became claustrophobic and was abandoned. The system has been developed in conjunction with the Road Research Laboratory who carried out extensive tests with their calibrated dummies, however the system is designed to prevent life threatening injury from falls and the incident you describe is unique.”

I conclude from this that a situation whereby there was a gap between the safety netting and the landing would not arise in the Prison Service.

Property Services Group also advised that the different manner of fixing might have led to greater ‘sag’ in the netting than might normally be expected.

I recommend that Premier reviews the specification for its safety netting at Colnbrook and brings it into line with Prison Service practice so that there is no unguarded vertical edge.

Conclusions

While I have serious concerns about some aspects of the man's medical care - the fact he did not see a doctor for 11 days during which time he was without his anti-depressants, and especially the failure to refer him to a psychologist - I am satisfied that, generally speaking, the care afforded to him at Colnbrook was adequate. He was kept under close supervision while he was considered to be at risk of self-harm and staff took reasonable decisions about his management.

Inevitably, where someone is deemed to be at reduced risk of self-harm and they kill themselves within a couple of days, the decision to downgrade the level of supervision must be subject to some scrutiny. Certainly, I do not consider that the large array of people involved in his case management was conducive to informed decision making. However, I would not second-guess the judgement of those involved in those case conferences that agreed to downgrade the man. I have no reason to suppose that he did not present as a lower suicide risk. It might of course be the case that the man made a special effort in order to ensure he was returned to normal location. I am also satisfied that the response by all staff after he jumped was prompt and appropriate.

Recommendations

I recommend that:

- **A key worker system be introduced;**
- **Effective systems need to be established to ensure detainees are seen by a doctor within 24 hours of reception;**
- **Clear lines of reporting and responsibility need to be established [this relates particularly to follow-up action];**
- **Healthcare professionals should be reminded of the need to maintain clear, thorough documentation which should always be signed, dated and name printed.**

I also recommend that all healthcare staff (directly employed or agency) should receive a comprehensive induction to the centre. This should cover, inter alia, their responsibilities as set out in the Detention Centre Rules.

I recommend that Immigration Service staff be instructed routinely to refer to the Medical Officer in all cases where it is suggested the detainee is suffering from mental illness.

I recommend that Immigration Service staff be reminded of the need to tailor their communications with detainees according to the circumstances of the individual detainee. Particular care should be taken in dealing with those at risk of suicide or self-harm.

I recommend that the Immigration Service ceases the last minute serving of Removal Directions and takes steps instead to manage cases on an individual basis.

I recommend that Premier establishes a personal officer scheme, if it has not already done so. At the very least a personal officer should be allocated to at-risk detainees, even if it is not possible to provide one for every detainee.

I recommend that Premier emphasises to staff the need for properly multi-disciplinary high risk review teams and to ensure that a core of the review team membership remains constant throughout the period of risk.

I recommend that the Suicide Prevention team regularly reviews the make-up and operation of case conferences.

I recommend that IND and Premier review the use of Delta Unit both in terms of the Detention Centre Rules and as a location for those at risk of self-harm.

I recommend that shared accommodation be made a key strand of the management of detainees at risk of suicide or self-harm. Where this is not appropriate, consideration should be given to the precise location of the detainee within the unit.

I recommend Premier reviews its policies on which items may be retained in possession by those detainees at risk of self-harm.

I recommend that Premier reviews the specification for its safety netting at Colnbrook and brings it into line with Prison Service practice so that there is no unguarded vertical edge.