The Death in Custody of a Detainee
Dungavel Immigration Removal Centre – 23 July 2004

Report by the Prisons and Probation Ombudsman for England and Wales

August 2005

This is the report of an investigation into the circumstances of the death of a Detainee at Dungavel Immigration Removal Centre in Lanarkshire on Friday 23 July 2004, he was a Vietnamese man who had arrived in the UK in March.

The man was arrested on 18 July in a London flat where he was living with his girlfriend. The Immigration Service planned to remove him to Germany as he first come to the attention of the authorities in that country. He spent just over 24 hours at Harmondsworth Removal Centre near Heathrow. However, Harmondsworth had to be evacuated as a result of a major disturbance that started on the evening of 19 July. Sixty detainees were moved to Dungavel. The man arrived on the first coach on Wednesday 21 July. The next day, he was served with Removal Directions by the Immigration Service and told he was booked on a flight to Germany the following Tuesday. On Friday evening, the man hung himself in his dormitory wash room area and was found by another detainee at 9.50pm. Attempts by staff and paramedics to resuscitate him failed.

I personally opened the investigation on 26 July. I returned to Dungavel the following week with my Assistant Ombudsmen. She made a subsequent visit to the Centre on 11 and 12 August.

I would like to extend our condolences to the family of the man and to his partner.

I would like to thank the management and staff at Dungavel Immigration Removal Centre for their assistance and co-operation during the course of this investigation. I am also grateful to Strathclyde Police for providing copies of their detailed witness statements.

Whilst I do not think that the man's suicide could have been predicted by staff at Dungavel I recommend that procedures are put in place to ensure medical and unit staff are made aware of immigration decisions that may have a significant impact on a person's state of mind. Greater awareness of important decisions would encourage closer observation of detainees by staff during potentially critical periods.

I make a number of other recommendations and commend some examples of good practice.

Stephen Shaw
Prisons and Probation Ombudsman **August 2005**

Contents

Summary ....

The investigation process ....

Background ....

The detainee

The man's arrival in the UK and his asylum application

The time prior to his arrest

The man's period in custody ....

Arrest on 18 July 2004 and Harmondsworth Removal Centre

The man's arrival at Dungavel Immigration Removal Centre

Friday 23 July 2004

The discovery of his body in E2 dormitory

Issues considered during the investigation ....

The influx of detainees arriving from Harmondsworth

Self Harm and Suicide Prevention at Dungavel

Communication issues at Dungavel

Events after the man's death

Recommendations and Good Practice ....

Summary

1. The man, a Vietnamese national, died at Dungavel Removal Centre on 23 July 2004.

2. The man had entered Britain on 19 April 2004. Initially granted temporary admission, he failed to comply with his reporting conditions and was arrested and detained on 18 July.

3. The man was first held at Harmondsworth Removal Centre. He was transferred to Dungavel following the major disturbance at Harmondsworth that occurred on the night of 19 July following the death of a detainee.

4. On arrival at Dungavel, on 21 July, he was not assessed as presenting a special risk of suicide or self harm. The following day, he was informed that Removal Directions had been served on him and he would be flown to Germany the following week.

5. The report details the circumstances leading to the man being found hanging on 23 July and the subsequent staff response, he left a letter in Vietnamese that has been translated. On the face of it, the letter is not a suicide note. However, the translator has suggested that the form of the letter reflects Vietnamese custom to make a wish before you die.

6. The report is critical of some aspects of family liaison between Dungavel, the Immigration Service and the man’s bereaved relatives.

7. I suggest that having been arrested and detained, having experienced the events at Harmondsworth, and having been transferred many hundreds of miles to a Centre where nobody else spoke his first language, the man would have been in a vulnerable state. However, I suggest that the incident leading to his feeling potentially suicidal was the serving of his Removal Directions.

8. The report makes six recommendations and indicates four areas of good practice.

Investigation Process

I opened the investigation on 26 July. When I arrived at Dungavel Immigration Removal Centre I met with the Director and was given a full briefing on the circumstances surrounding the man's death regarding family contact and actions instigated by the Centre. I was also updated in the aftermath of his death. A notice to staff and a notice to detainees was issued by Dungavel. These invited anyone who might have information relating to the man's death to make themselves known to the inquiry team. No one came forward from these notices.

My colleague and I visited Dungavel again on 2 August. My colleague read the man's records and the police statements that had been taken. She made one further visit on 11 and 12 August and spoke with staff on an informal basis.

One of my family liaison officers contacted the man's partner. They spoke on the telephone and a letter was sent offering to meet with the man's partner and saying that an interpreter could be provided if necessary. At the time of the draft report this meeting has not taken place. The final report may include information that emerges from the meeting.

Dungavel Immigration Removal Centre

Dungavel is the only removal centre in Scotland. At the time of my investigation, it held a mixture of single adults and families. Its maximum occupancy is 148 people. Dungavel's role is to hold those detained by the Immigration Service as overstayers, illegal entrants or failed asylum seekers prior to their removal from the country. It also holds a proportion of detainees whose cases have not yet been determined, but who are considered to be at risk of absconding or whose identities are being established.

Dungavel is operated by Premier Detention Services Ltd.

The main accommodation is a former country estate mansion house that had been used by the Scottish Prison Service as a prison before its change of use and refurbishment as a detention centre. There is also a separate single storey family unit and education block and a single storey gymnasium and leisure complex.

The last published inspection of Dungavel was in October 2002. HM Chief Inspector of Prisons came to the view that staff were dealing positively and conscientiously with detainees, but that they were unable to compensate for the profound feelings of insecurity and anxiety that detention at Dungavel involved. Only 15 per cent of the detainees surveyed at that time told the inspection team that they felt safe. The reasons for this were attributed to three factors. Detainees said being detained in a prison-like environment was difficult and some detainees reported being intimidated by others. The second factor was the length and stress of the journeys many had experienced to get to Dungavel, often in escort vans. The third factor that led to detainees feeling insecure was weakness in communication and case management by the Immigration Service, and the difficulty of accessing competent legal representation for their cases.

The inspection report said that Dungavel provided a generous provision of both constructive and leisure activities compared with other centres. Detainees felt the centre was fair, decent and that they were well treated by staff.

A more recent inspection was carried out towards the end of 2004 after the man’s death, but the report into that inspection has not yet been published.

The most relevant recommendations from the inspection in 2002 relate to immigration casework. The first was that interpreters or ‘Language Line’ should always be used for interviews where detainees are being informed of important decisions or of their rights. The second was that on-site immigration staff should be able to communicate up-to-date case information directly to detainees. The man was given his Removal Directions by an immigration officer without the assistance of an interpreter. The man spoke only broken English. I repeat this recommendation to the Immigration Service and Dungavel.

There had been no deaths of any detainees at Dungavel prior to the death of the man.

The Detainee

The man was born in Vietnam and he was one of five children. The man said that his father was dead and that his mother remarried ten years ago and moved to another city. He said that he last saw his mother two years before his arrival in the UK. The man's sister says that both his parents are alive and that he may have painted a different picture in order to stay in the UK. The man had attended school in Vietnam for a short period of time.

The detainee's arrival in the UK and his asylum application

The man was found by officials at Dover shortly after 8am on 19 April 2004, concealed in a road train vehicle that had arrived from Calais. The vehicle had been selected at random for searching. The man was found in the rear trailer with two other men and a woman. The man was detained at Dover.

At about 2pm that afternoon, a search via Eurodac identified the man as having already been apprehended in Berlin in 2003. Under the Dublin Regulation, the EU Member State in which a person first claims asylum is the Member State responsible for considering the application, even if the person subsequently travels to another Member State and makes a new asylum claim there. Because the man had already applied for asylum in Germany, the Secretary of State would not give substantive consideration to his asylum claim, but sought to remove him to Germany instead.

The man was interviewed by an immigration officer at 3pm and said that he had entered the UK because he wanted to seek freedom and added that he wanted asylum. The man said that he had no medical conditions, criminal convictions and had never previously been detained or arrested in the UK or another country. Officials knew this to be untrue, but did not question the man about this at the time.

Form IS151 'Notice to a person liable to removal' was completed on 19 April. It indicated that the man was considered to be an illegal entrant as defined in section 33(1) of the Immigration Act 1971. It informed the man that he was liable to be detained prior to his removal from the UK. Form IS91 was also completed, giving authority for the man to be detained. The form states that the man speaks Vietnamese and does not highlight any risk factors such as suicide or self harm risk, psychiatric illness, or violent tendencies. The reasons given for his detention on Form IS91R were that there was insufficient reliable information to decide whether to grant him temporary admission or release, and that he had not produced satisfactory evidence of his identity, nationality or lawful basis to be in the UK. The part of the form that ensures the man has had the reasons explained to him was unsigned.

A later interview at 7.45pm was more in-depth. During this interview, the man said that he was a 24 year old single man who had last worked about four months ago. He told the interviewer that his father had died ten years ago and that his mother had remarried and moved elsewhere. The man said that he

was a Buddhist. The interviewer said that, in order to qualify for asylum, the man must demonstrate that he had a well founded fear of persecution in his country of nationality, on account of his race, religion, nationality or membership of a particular social group or political opinion. The man stated that he did not qualify for any of the above but that he was in the UK for a better life.

He went on to say he had left Vietnam in early 2004 with 12 others, using a small boat. They arrived some three days later in China and stayed overnight in a house before getting into a lorry which drove for five days to a train station. The man said he did not know which country he was in at this stage, but that he got onto a train and travelled for two more days. After this the man claimed that he had been in various lorries that had driven for two to three days at a time before dropping him off and another lorry picking him up. The man claimed that he had been in the last lorry, the one that had arrived in Dover for one day, without any food, water or toilet facilities. The man denied ever having had his fingerprints taken before and said that he was telling the whole truth to the interviewer. The interviewer then asked the man to explain why the police in Berlin had his fingerprints on file dated October 2003. At this point the man became very quiet and could not explain how this happened. The interview ended shortly before 10pm.

A further screening interview was conducted just after 2am on 20 April 2004. This interviewer noted that the man was very vague in his account of what happened. The man said he had left Vietnam about five or six months previously and that he arrived by boat into China, where he stayed for two or three days. The man then said he travelled for various periods, but that he never knew which country he was in until he arrived in the UK. He said all the swapping of transport had been done in secluded places. The man said that he had been picked up in Germany as he was walking down the street, but he did not know at the time which country he was in and that he did not claim asylum when there. The man told the interviewer he wanted to claim asylum in the UK because the English were nicer and more helpful. The man said his aunt had paid for him to get to the UK. He had no problems in Vietnam, but wanted a better life and a better job. The interviewer noted that the man was uncooperative with the interview and that he contradicted himself on occasions.

The man’s file was sent to the Immigration Service's Third Country Unit on 20 April. The unit is responsible for returning asylum seekers to their original country of claim. Chasing phone calls on 22 and 23 April indicated that the unit were unable to take any new cases and had no bed spaces until 25 April at the earliest.

Because of the lack of available beds a decision was made to grant the man temporary release. This was for one week, commencing 23 April. The man was told that he must stay at the Cliff Court Hotel in Dover and report to Folkestone Police Station on 30 April. He was issued with Form IS96 'Notification of Temporary Admission to a person who is liable to be detained.'

On 29 April, the Dover Induction Centre received a message via the Migrant Helpline that the man had absconded from his hotel and given no forwarding address.

The time prior to his arrest

On 9 June the Immigration Service was informed that the man was living at in London. The source of the information is thought to have been the man's solicitors at that time.

The man's UK asylum claim was refused on 22 June 2004 by the Third Country Unit. He had already first claimed asylum in Germany. Under the Third Country procedures (Dublin Regulation), the man had to return to the country where asylum was first claimed for his case to be decided. Germany had agreed to accept the man back.

A Third Country Unit Starring Pro-Forma was completed and forwarded to Communications House (an Immigration Service building in London) in order that they could locate the man and remove him to Germany. The Starring Pro-Forma indicated that the man's asylum had been refused on 22 June 2004 and that there was no appeal procedure.

The man was granted temporary admission on 22 June 2004 using form IS96. He was told to reside at where to reside and to report to an Immigration Officer at Communications House on 22 July 2004 and then every month thereafter. Another form dated 21 June, form ICD1161 from the Integrated Casework Directorate, also appeared to give the man temporary admission and told him to report to Communications House on 5 July. It is unclear whether the man was served with both of these forms. (The latter form was sent by the ICD Change Of Address Team in response to a letter sent in by his solicitor advising the Home Office of his address. This letter sought to regularise his temporary admission.)

The man continued to live at the agreed address with his partner, who was granted British Citizenship on 29 June 1998.

The detainee's arrest on 18 July and Harmondsworth Removal Centre

On 7 July the information provided by the Third Country Unit was researched and assessed by the Communications House Joint Intelligence Unit. It was noted that there was no information on police or Home Office indexes to suggest that there were any mental health or other special conditions associated with the man.

In the early hours of 18 July, a Communications House arrest team went to the home of the man's partner. The man was still asleep in the main bedroom with her. He arrived at Islington Police Station at 6:20am. Communications House Enforcement Unit decided the man was to be detained and not granted temporary release. The reasons given for his detention at this time was that his removal from the UK was imminent, he was likely to abscond if given temporary release, and he had previously failed to comply with the conditions of his temporary release.

The first assessment in the police station stated the man was single with no family or dependants in the UK. The man said he had no medical conditions. The Third Country Unit was faxed on 18 July and informed that the man had been arrested and detained. The custody record in the police station showed that the man said he had no history of self harm, had no illnesses or medical conditions and was not taking any medication. The form was not signed by the man.

At 10:45pm, the escort contractor (Wakenhut) arrived at Islington Police Station and transferred the man to Harmondsworth Detention Centre near Heathrow. Harmondsworth is run by UK Detention Services and UKDS staff made an initial profile of the man on his arrival. This was completed at 1am. The man must have been very tired by this time. He had been in detention since 6am on 18 July. The profile stated his religion to be 'none' (he was Buddhist), that he spoke no English and indicated there were no warnings on his IS91 paperwork. (This list of 'warning' subjects includes self harm or suicide risk.) A medical induction was carried out at 2.30am. This did not raise any medical concerns about the man. It is not clear if this profile was created with the assistance of an interpreter. A note at the end indicates that the person completing it thought the man spoke Chinese.

The man was put into a houseblock A. His room mate was a male from Afghanistan. The room mate had first been detained on 15 June 2004. On the evening of 19 July, a male detainee at Harmondsworth was found hanging in a shower room. (I have conducted a separate inquiry into that death.) This sad event seemed to trigger a disturbance which spread throughout the whole of Harmondsworth. It continued until the next morning and led to the evacuation of all detainees from the centre. After the riot, the man's room mate was taken to Dover. He was served with his Removal Directions and subsequently self harmed and was placed on a suicide watch. The room mate was not aware of the man's death and I decided not to interview him in case knowledge of this fact might upset his fragile state of mind still further. The two men had only shared a room for just over one day.

The man was on the houseblock that was least involved in the disturbance. The report into the disturbance at Harmondsworth by the Head of Security Group in the Prison Service, said: "It is likely that the participation of detainees on A wing was limited to their damaging CCTV cameras on the wing. Indications are that they remained passive throughout the incident, even after staff withdrew from the wing." The report goes on to say "The centre was only finally clear of detainees at 1300 hours on 20 July. About half had been transferred to prison accommodation, the rest to other establishments in the secure immigration estate."

The detainee's arrival at Dungavel Immigration Removal Centre

On 21 July 2005, two coaches arrived from Harmondsworth Removal Centre. The first bus, with 25 detainees on it, arrived around 11.15am. A further bus with 35 more people arrived between 3.30pm and 4.30pm. The man arrived on the first bus. A reception officer remembered being part of the team that looked after the arriving detainees and remembered the man. He said that the man spoke very little English, but that nothing stood out in his mind about any of the arriving detainees apart from one man who had mental health problems. He said this person was not the man. The Officer's job that afternoon was to process the new detainees. This involved searching them and recording their property in reception. He remembered that all the detainees looked tired because they had been travelling all day. In total 60 new detainees arrived that day. Most of the new detainees were put onto the family unit (which had no families on it at that time). The man was given a bed in the main part of the centre, which had six beds in it.

The medical admission process at Dungavel is that each detainee is seen by a registered nurse after they have been through the reception area. The nurse assesses them for any current or previous health issues and the new arrivals are screened for previous mental health or self harm problems. Each detainee is then seen by a doctor within 24 hours.

A Nurse recalled being one of the medical team who screened arriving detainees that Wednesday. Her role was to see each detainee individually and complete a Medical Admission Form and conduct a nurse assessment. The Nurse saw the man. She remembered that she needed to get the assistance of a Cultural Advisor who could speak Cantonese, because the man spoke very little English. The Nurse noted nothing untoward about the man. She checked his blood pressure and noted he had a TB vaccination. She said he was pleasant, had good eye contact with her and positive body language. The cultural advisor then came into the room and the Nurse was able to complete the rest of the medical assessment on the man. The cultural advisor said that he and the man were able to converse easily together using Cantonese. The cultural advisor does not speak Vietnamese. He remembers interpreting the questions asked by the Nurse. He thought that the man gave his family name differently to those already identified. The Nurse completed the relevant parts of the Detainee Medical Record and notes the time she did this to be 12.40pm. She recorded that the man was married and that his wife was in London. She indicated that the man's emotional state at that time was appropriate and that he had no history of self harm and no current thoughts of self harm or suicide.

On the cultural advisor's way back to the dining room with the man, they spoke generally about Scotland and Dungavel. The man asked for the telephone number of Dungavel and the cultural advisor explained that he would be able to receive calls as soon as he was allocated a dormitory and that he would receive a free five minute call to anywhere in the world. The man completed a form detailing property that was missing following his

transfer from Harmondsworth. This list comprised a mobile phone, footwear and paperwork.

The medical officer saw the man and made further entries in his medical record. She noted the man had no history of any illnesses or allergies and that he was not taking any medication. She described his mood, appearance, attitude, speech and behaviour as normal and that he had no thoughts of self harm or hopelessness. She concluded that no special watch or medication was required.

The man settled onto a dormitory around 7pm and was given a telephone call the following morning.

On Thursday afternoon, the man approached a second Officer. The officer remembers that the man showed him his ID card and then asked him the visiting times of the centre. The man said he was expecting visits. The Officer said he was unsure whether the man said the visits would be from his girlfriend or his sister. He said the man spoke in broken English.

An Immigration Officer arrived at Dungavel around 2pm on Thursday. During her handover she was told that a fax had arrived from Communications House with Removal Directions for the man. At around 4.30pm she met the man in an interview room and served the Removal Directions (IS151). The man was booked on a British Airways flight to Germany scheduled to leave Heathrow at 7.10am on 27 July. The Immigration Officer did not have an interpreter with her but said that she was happy that the man understood what she was saying. She said he replied “Germany, no” but that he was not angry or agitated. She went on to explain to the man that he was being returned to Germany because that was where he had first claimed asylum. The immigration officer told the man that he might want to speak to his solicitor. The man then left the room. A second Immigration Officer completed a form advising Premier of the man’s planned removal on 27 July. This is normal practice. A sentence on this form reads: “You may wish to monitor his/her reaction to this news”. However, this is a standard letter and the intention was not to draw particular attention to the man or any potential vulnerabilities he may have had. It was faxed by the first immigration officer to the reception office at Dungavel. There is no requirement for that office to alert the Healthcare Department or unit staff of the removal directions.

Friday 23 July

The cultural advisor was back in Dungavel on Friday morning, escorting a visitor from Japan. He recalled that, as he was walking with his visitor from the main building to the family unit, he saw the man standing with an African detainee. He said that, as he approached, the man turned towards him and was concerned and upset. The cultural advisor asked the man what was wrong. They spoke in Cantonese. The man showed him his Removal Directions. The cultural advisor explained the contents to the man, but did not tell him that he had no right of appeal. The cultural advisor did ask the man if he had a solicitor and on hearing that the man had been unable to get one, offered to try to get one for him later in the day, or the following Monday. The

cultural advisor said that the man looked much happier, smiled and thanked him for offering to help.

The Immigration Service's Third Country Unit faxed Germany on 23 July 2004 with the details of the man's transfer from London Heathrow to Berlin due to take place at 7:10am on 27 July 2004.

Several detainees described the man as often being on his own. They said he had obvious difficulties communicating as no one else at the centre spoke Vietnamese and he only spoke a very limited amount of English. One detainee said he knew the man to say hello to, but that he could not communicate very easily with anyone. He recalled seeing the man on Friday morning on the telephone and said that he seemed upset. Another detainee said he saw the man about lunchtime and that he had appeared okay.

Another detainee recalled seeing the man on Friday and said he had shown him the papers from Immigration stating that he was to be sent back to Germany. He said the man was upset and crying. He said the man was trying to tell him something but that he could not understand him fully. The man apparently pointed to his wedding ring finger and said 'married in one month'. A Chinese detainee had first met the man in Harmondsworth but said they did not understand each other's language.

The cultural advisor was in the visits area with his Japanese visitor when he saw two solicitors. He approached one of the solicitors and asked him if he would speak to the man as he wanted a solicitor urgently. This was duly arranged and the cultural advisor went personally to get the man and introduce him to the solicitor. The cultural advisor said that he did not offer to do any translation work for the solicitor, as it was not part of his normal duties. He said that, as he left the visits area, the man was buoyant, cheerful, smiling and grateful for his assistance.

The man's case was taken by another solicitor in the same firm as the previously referred to solicitor (based in Glasgow). At 4.35pm on 23 July, the man's solicitor faxed the Duty Officer at Communications House and asked that they suspend the removal directions. This solicitor stated in his fax that "The Dublin Convention allows choice of a place of claim if a close relative lives in the UK. The man has a wife in the UK... As she also wishes his claim to be heard here we would ask you to suspend removal. See article 7 of Dublin Convention." These representations were not answered.

Between 6 and 7pm the man's partner received a phone call from the man. The phone call was apparently short and the man said that he was going to get his meal. Another detainee had got to know the man a little since he arrived at Dungavel. He said that the man's English was not very good but that they could communicate. The detainee said that the man was very concerned about going back to Germany and that he said he was not going to dinner that evening.

The detainee in the bed next to the man was from Cameroon. He said it was difficult to communicate with him because the man could not speak French or English. He thought he last saw the man at about 9pm walking up and down

the corridor. This detainee told him to come to the party that was going on downstairs but he refused. This detainee said that the man had been sad since he received his removal letter.

The man was seen leaving the education area just before it closed at 9.30pm.

The discovery of the detainee hanging

At about 9.50pm on Friday 23 July, the second officer to have seen the man on his arrival at Dunglaven was in the landing office on the top level of the main house. A detainee came in looking flustered and said: “China gone, China sleeping”, and gestured with his hands as if someone was hanging. The Officer was immediately aware that something was very wrong and asked the detainee to show him where. The detainee took him to the toilet area between E2 and E1 and pointed to the cubicles. There are four cubicles, two toilets and two showers. The Officer could see the man hanging from the top bar in the second left hand cubicle. There was a dark leather belt around the man’s neck. The Officer used his personal radio to call for a medical response. The Officer noticed that the man’s feet were still touching the floor, so he got hold of the man’s waist to take some of the weight and then cut the belt with his issued ligature knife. He lowered the man to the floor and told the detainee to go into the hallway so that he could direct arriving staff. Due to the position that the man was in, the Officer was unable to give mouth to mouth resuscitation so he started to do chest compressions.

A Detention Custody Manager was arriving through the gates for the nightshift when she heard the call for a first response / medical response to the top male dormitory. On arrival a second Detention Custody Manager, was behind her and the Officer was on the floor administering CPR to the man. A Nurse arrived and he and the second Detention Custody Manager checked for a pulse. The first Detention Custody Manager radioed for the control room to call an ambulance. The control room timed this request to be at 9.52pm. The ambulance was called via 999 at 9.54pm and Dungavel were told it would arrive in less than 15 minutes. The Nurse went over the partition of the cubicle and began mouth to mouth resuscitation. The second Detention Custody Manager took over from the Officer in giving chest compressions. The staff decided to move the man slightly in order to get more room to work in. Two further officers were also present by this time. One Officer started a log of events. The first Detention Custody Manger then went to gates and opened then in order to ensure that they were no delays in the ambulance getting to the dormitory as quickly as possible.

An Officer was walking down a corridor towards the staff room when he heard ‘personal alarm activated’ come over his radio earpiece. He ran up the stairs towards the top male dorm on the second floor. As he was going up the stairs, two more officers joined him. They arrived on the male dorm but there was confusion about what the incident was and where it was. One of those officers thought that an officer was in trouble. They checked Rooms E3, E4, E2, E1, D1, D2 and the TV room before noticing some detainees going into Room E2 and decided to follow them. On going into the toilet area in room E2, the officer and the others saw the man. The officer and nurse that first attended the man were already administering CPR. The staff cleared the area of detainees and locked them into areas away from room E2.

The officer that first administered chest compressions went to the office for about one minute in order to note down timings of what had happened. He then returned and took over from the Nurse doing mouth to mouth. Two of the officers went to the Healthcare centre and obtained the green medical bag and some oxygen. One of the officers opened the green bag up for the Nurse. The Nurse took some equipment out but then both this officer and one other went back to Healthcare to get a suction machine. The Nurse used the suction machine and inserted a plastic airway. The man's chest was seen to raise successfully and CPR was continued. The police were called at 10.06pm. The ambulance arrived at the main gates at 10.13pm. One of the officers was on hand to direct the paramedics straight up to where the man was. They arrived at the dormitory at 10.18pm. Throughout the resuscitation attempts, who first administered chest compressions noticed that the man's lips and fingers were blue. The paramedics took over resuscitation and worked on the man for about 20 minutes.

The police arrived at the centre at 10.30pm and got to the scene at 10.37pm.

The ambulance team put the man onto a stretcher at 10.48pm and, following a further period of resuscitation on the ground floor of the unit, into the ambulance. The ambulance left Dungavel just after 11pm with another officer. This Officer said that ambulance staff continued to try to resuscitate the man on the way to Hairmyers Hospital. Once at the hospital she gave his details to reception. The man was confirmed dead at the hospital.

The deceased left a letter in Vietnamese which has been translated. The letter asks the authorities to help him to be a refugee in England. The man says who he is, that his father was shot and his mother left town and sold her body. He goes on to say that he came to England and on his way stopped in Germany. He says he did not want to seek asylum in Germany. The man says that he wants to stay in England and that he is in love and engaged to his partner. The man says they love each other and cannot be separated. He says "I now leave this letter as I hope you can help me stay in England as I cannot go back to Germany". The interpreter offers the opinion that, although on the face of it the letter does not appear to be a suicide note, it is Vietnamese custom to make a wish before you die and that the deceased is clearly making a wish in this letter.

Issues considered during the investigation

The events after the detainee's death

The Centre Manager at Dungavel, arrived and met with the Day Shift Manager who had come back in and the two Detention Managers to discuss how the news should be broken to the other detainees. The police had told the Centre Manager that the man had died. The centre staff spoke to all the detainees during the early hours of the morning of 24 July and advised them of the man's death and how it had happened. The Contract Monitor had also arrived at Dungavel by this time.

The Handover Book for the accommodation within the main house did not include any reference to the man's death. This seemed unusual, but my investigator was told that it had been decided instead that the Duty Manager on Saturday 24 July would brief all staff prior to them starting their shifts. Staff were asked to ensure they mingled with the detainees extensively that day and to offer reassurance and support. Managers and staff had concerns about detainee unrest in light of the death of a detainee and subsequent disturbance at Harmondsworth only a few days earlier. In fact, there were no acts of indiscipline amongst the detainees and the staff's action may well have prevented such events occurring. The Centre Manager sent an e-mail to all staff in the early hours of 24 July informing them of the man's death and thanking staff for their professionalism and care. He also highlighted the need for staff to be particularly vigilant in the coming days and weeks about how detainees might be feeling, and to speak to senior managers about any concerns they had. Both the pre-shift briefing and e-mail are examples of good practice.

Early on Saturday 24 July the deceased's partner telephoned and spoke to an immigration officer at Dungavel. One of her sons also spoke to this immigration officer and asked to speak with the man. He was told that the man was not currently in the centre. The immigration officer contacted the duty Chief Immigration Officer at Communications House, at 9.15am. They agreed that the duty Chief Immigration Officer would take urgent steps to find the appropriate next of kin for the man. Later that morning, a family friend rang and told the immigration officer of their concerns about the welfare of the deceased man. The immigration officer said that he was not able to divulge personal information and suggested that they make contact via the deceased's solicitor.

It is regrettable that the deceased's partner had not been identified as the next of kin by this stage, and that steps had not been taken to inform her of her partner's death. It is also unacceptable that his partner and her family were ringing in order to try to find out what was happening, but without any information being relayed to them. However, I understand the position that the immigration officer found himself in that morning and his concern to not divulge sensitive information to people whose identities he was uncertain of. Nevertheless, this must have been a time of great distress and uncertainty for the deceased's partner and her family.

It was not until 3.15pm in the afternoon of Saturday 24 July, some 15 hours after the man had died, that two chief immigration officers made arrangements to visit his partner's address with two police officers and a Vietnamese interpreter. The deceased's partner was not at her home at that time and so they all returned at

7.25 that evening. Again, the deceased's partner was not at home but some children playing nearby said that she is normally home shortly after 9pm. The team therefore arranged to return at 10pm that night. This time she was at home. She said she was the girlfriend of a name previously stated by the deceased in conversation with the cultural advisor and that he lived with her and her two sons from a previous relationship. On hearing the news of her partner's death, his partner became very upset and blamed the Immigration Service for his death. She asked to go to Scotland immediately to see the body. As it was very late, the visiting staff told his partner that they would make enquiries and seek the agreement of the Procurator Fiscal in the morning. His partner contacted her sister-in-law by telephone and told her the news. Several minutes later deceased man's brother-in-law rang and he decided to come and stay with the partner. The Immigration Service seemed unaware that the deceased had any family living in the UK as he had told staff on interview that he had no family or dependants in the UK.

The partner said they were planning to get married and that the deceased had come to the UK in order to marry her. She said she wanted to arrange for the deceased's body to be taken to London so she could arrange a cremation.

The next day, discussions took place between Dungavel and the Immigration service. Arrangements were made for travel and accommodation for the partner and her children to visit Scotland in order to view the deceased's body. The police visited the partner to inform her of this and she told them that the deceased's sister was arriving from Europe and that she also wanted to see his body.

A Buddhist religious ceremony (Freeing of the Spirit) was conducted in E2 dormitory on 25 July 2004.

The deceased's partner and sister visited Wishaw General Hospital on 26 July. They were not offered the opportunity of visiting Dungavel or E2 dormitory although I was told that they could have visited had they asked to do so. There was no policy in place at Dungavel about communication with families at difficult times such as this.

The influx of detainees arriving from Harmondsworth

On Wednesday 21 July, the two coaches carrying detainees from Harmondsworth arrived at Dungavel. These two coaches had the effect of doubling the previous population of Dungavel up to 111 detainees.

One officer said he normally knew every detainee by name, but that with such a large number of detainees arriving in one day he had only just started to recognise some of the new faces by Friday 23 July. It is very unfortunate that one of the side effects of the riot at Harmondsworth was that staff at Dungavel were faced with 60 new detainees in one day. Processing such a large number of men through reception and medical screening would have meant that procedures were more hurried than would normally have been the case. All of the detainees had already experienced a very long coach journey from London to Dungavel, and some may well have been traumatised and shocked by what they had witnessed at Harmondsworth. The deceased was on the

unit at Harmondsworth that had not taken part in the disturbance. Whilst the Nurse indicated that the deceased's demeanour and behaviour were calm and normal, no specific questions were asked in relation to the riot and how the deceased felt about what had happened. Nevertheless, I do not think that his reception and medical screening were at error in identifying that the deceased did not present a special risk of suicide or self harm when he first arrived at Dungavel.

Suicide and Self Harm Prevention at Dungavel

Although the deceased was not on any form of suicide or self harm watch, my investigator looked at the policies and procedures in place at Dungavel.

The policy on Management of Detainees at Risk is comprehensive and sets out clearly that any member of staff can and should open a monitoring form if they have any concerns about a detainee. The form used by Premier Detention Services at Dungavel for monitoring is modelled on the system that the Prison Service in England and Wales use. The level of observations that can be implemented stretch from constant observations at no more than an arm's length away, through timed observations every 2 to 60 minutes down to general staff observations at least twice per shift. The policy states regular case reviews must be held, with input from the Healthcare team.

There were nine detainees on the self harm at risk form at Dungavel at the time of my investigation. My investigator looked in detail at three of these forms. They were comprehensive in both their initial assessments of the detainees and in relation to the case reviews. Case reviews were held every three to four days and included a multi-disciplinary group of staff, including Healthcare. Staff seemed aware of their responsibilities in relation to detainees considered to be at risk.

I was also shown a letter used by the medical officer at Dungavel to alert Immigration Officers to a detainee who may react badly to adverse news. The letter asks the Immigration Officer to alert Healthcare, prior to giving the named person Removal Directions or other adverse news, so that appropriate support can be given to the detainee. This is good practice and seeks to ensure that medical staff are made aware of immigration decisions that may adversely affect someone's mental or physical health when they are already identified as being at risk. The deceased had not been brought to the attention of medical staff as being a possible suicide or self harm risk. Medical staff who had first met and screened the deceased on Wednesday 21 July had not identified him as being at risk of self harm and he had arrived with no such history. As a result, there was no letter asking Immigration Officers to alert Healthcare to any unexpected or adverse news being given in respect of the deceased.

Having been arrested and detained, having experienced the major disturbance at Harmondsworth, and having been transferred hundreds of miles from his partner in London to a Centre where nobody else spoke his first language, I have no doubt that the deceased was in a vulnerable state. However, the evidence suggests that the incident that led to the deceased feeling distraught and potentially suicidal was the serving of his Removal

Directions on Thursday afternoon. It was then he learnt that he was to be sent to Germany early the following week.

The response to finding the detainee

Dungavel have a written instruction called a 'Manager's Rule' on Cut Down Procedures. Cut down knives are carried by residential staff and others in case of emergency. This is good practice. The fact that the officer who found the deceased had a cut down knife on his belt meant that there was no delay in cutting him down and commencing treatment. Medical assistance was called for immediately but some of the arriving staff seemed unsure of where the emergency was. Staff should be reminded to ensure that emergency radio messages include their precise location so that responding staff know where an incident is occurring.

The staff involved in the attempt to resuscitate the deceased are to be commended for their efforts. However, there may have been a short delay in getting the right medical equipment to dormitory E2. The Nurse had to go back to the medical room to get suction equipment. I do not think that this brief delay would have made a difference for the deceased, but it may be significant on a different occasion. The director may want to consider using distinctly coloured equipment bags, such as blue for someone not breathing and red for someone bleeding. This would help to ensure that any member of staff could quickly bring the right equipment to the scene of an emergency.

Dungavel have a defibrillator machine and the majority of medical staff are trained appropriately in its use. It is not clear why it was not taken to dormitory E2, and whilst it is very unlikely to have made a difference in this case, the healthcare manager may wish to remind medical staff to consider taking the defibrillator machine to every emergency situation.

Recommendations and Good Practice

Recommendation 1 – Immigration Service
Immigration Officers should be reminded to ensure that decisions and their reasons are explained to asylum seekers in a language they understand, using interpreters when necessary. Immigration forms should be completed in full and signed appropriately by immigration staff and the individual concerned.

Recommendation 2 – Immigration Service and Removal Centre Contractors
Immigration staff based in Removal Centres and those responsible for the management of such centres should consider drawing up a protocol that ensures significant information given to detainees is communicated to medical and unit staff that are involved in their day to day care. This should include the serving of Removal Directions.

Recommendation 3 – Dungavel Centre Manager
Staff should be reminded that emergency radio messages should include their precise location so that responding staff know where an incident is occurring.

Recommendation 4 – Dungavel Centre Manager
The Centre Manager should consider using distinctly coloured equipment bags, such as blue for someone not breathing and red for someone bleeding. This would help to ensure that any member of staff could bring the right equipment to the scene of an emergency quickly.

I understand from the Dungavel Centre Manager that all relevant equipment is stored in one emergency bag. During the night this emergency trolley is now located outside the pharmacy and is therefore accessible by any staff in an emergency.

Recommendation 5 – Dungavel Centre Manager
The Centre Manager may wish to ask the healthcare manager to remind medical staff to consider taking the defibrillator machine to emergency situations.

Recommendation 6 – Dungavel Centre Manager
A policy should be developed to cover family liaison in the event of a fatal or potentially fatal incident. The policy should include details of who will break news of a person's death or serious self harm attempt to the next of kin and how ongoing support, contact and information can be provided to them.

Good practice 1 - I was pleased to note that ligature scissors are carried by all unit staff.

Good practice 2 - I believe the personal involvement of the cultural adviser in this sad case has been an example of good practice and wish to commend him.

Good practice 3 - The fact that managers and staff told detainees in person about the circumstances of the deceased's death was good practice.

Good practice 4 – A final example of good practice was the briefing of all staff arriving for shift on the Saturday morning, and the e-mail sent by the Centre Manager to all staff informing them of the deceased's death, offering his thanks and asking that they be particularly vigilant in the aftermath.