

**Circumstances surrounding the death of a detainee in Harmondsworth
Removal Centre in July 2004**

Report by the Prisons and Probation Ombudsman for England and Wales

April 2005

A young man of 31 arrives in this country seeking a better life. He speaks hardly any English. Through an interpreter, he says it has been his 'dream' to work in England. He is placed into detention and within days has told officials at Harmondsworth Removal Centre that he wants to go home. He remains in detention. Four weeks later it transpires that no action has been taken to remove him from the country. No-one from the Immigration Service goes to see him. Instead, he receives a two-line note from them informing him in English that his case is now being dealt with by the Management of Detained Cases Unit, a unit of which he would never have heard and whose function he could only have guessed at. Two weeks later he is found hanging in a shower.

The discovery of this man's death led to a serious, prolonged disturbance at the centre. A considerable amount of damage was done. The police accordingly have carried out their own investigation into both the man's death and the disturbance. A number of detainees have been charged. Pending completion of court proceedings, the police have primacy over any other investigations carried out. Although a protocol was established, this delayed our own investigation into the man's death. I should record here, however, my thanks to the police for sharing with us a number of statements from staff and other documents.

I am also grateful to staff at Harmondsworth for their help during the course of the investigation.

Although I do not think that the man's death could have been anticipated, this is a sad and shameful story.

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Summary

This is the report of my investigation into the death by hanging of a man in a shower cubicle at Harmondsworth Removal Centre in July 2004.

It starts by setting out some background. I describe how the man first came to the attention of the Immigration authorities, when he claimed asylum having arrived in the country in the back of a lorry. I look at the purpose of the removal estate and IND's guidance on determining who should be detained. This makes it clear that there is a presumption in favour of temporary admission or temporary release while the cases of asylum seekers are decided or while they are awaiting removal.

The report also provides some information about Harmondsworth, noting that it is a large purpose built centre capable of accommodating up to 500 detainees. It gives some information about the regime and facilities and describes how, at the time of the man's death, detainees had considerable freedom of movement round the centre. I also refer to HM Chief Inspector of Prisons' report of an inspection carried out in 2002, where she expresses misgivings about the ability of the centre effectively to care for those in its charge.

Harmondsworth has a dedicated fast track facility and I describe how the fast track process is intended to operate. The whole process, from start to finish, should take 34 – 40 days.

In 'Investigation' I describe the investigation process. This included visits to Harmondsworth where the Investigators spoke to some staff and other interested parties and interviewed others. The Investigators also obtained a number of documents specific to the man, and others setting out the centre's policies in specific areas, as well as viewing CCTV footage of the man going to the shower. In addition, they obtained copies of statements given to the police. They invited staff to contact us and wrote to the man's parents to invite them to contribute.

In 'The man's detention history', I describe how the man was first taken to Oakington Reception Centre, where his behaviour gave cause for concern. He was talking to himself and damaged his room. Staff there arranged for him to transfer to Harmondsworth, who were better able to cope with 'disruptive' detainees. I describe how, on reception at Harmondsworth, the man was interviewed by a nurse. She found no evidence of suicide risk.

The next section deals with the handling of the man's case by the Immigration Service. It documents how the man said he simply wanted to return home and promised to obtain his ID card to facilitate this. No further action was taken, until four weeks later when his case was transferred to another section of the Immigration Service without any prior reference to the man. I also look at the arguments put forward by the Immigration Officer to back his recommendation that the man should continue to be detained.

I then describe events on 19 July 2004. The man's room-mate apparently left him at 11:15am. At 1:40pm, he (the room-mate) returned to the room and, unusually, the other man was not there. At 2:45pm, an Immigration Officer asked to see the subject of this report. A 'runner' went to get him, but the man could not be found. The request was repeated at 3:30pm and again the man could not be found. At 7:20pm, a supervisor was informed that the man had been missing for several hours and instigated a thorough search. The man was discovered in a shower room near to his room.

'Post mortem report' sets out the findings of the post mortem. This was that death was the result of hanging and there was evidence of previous self-harm by the man.

I then go on to discuss issues arising in this case. I express concern about the induction given to the nurse who carried out the reception screening and that she did not understand the significance of a question on the pro forma relating to torture. I am also critical that relevant documentation was not transferred with the detainee from Oakington to Harmondsworth.

Under 'Ongoing care', I offer some thoughts about the difficulties of providing effective care in an environment such as that which obtains at Harmondsworth. I suggest there is a need for structured contact between staff and those detainees, like the subject of this report, who keep themselves to themselves and spend a large amount of time in their rooms.

Although I am surprised from a security point of view by the failure to find the man much earlier in the day, I say that I am satisfied that this did not impact on his death. I am also satisfied that staff conducted the search in a way that was consistent with what was expected of them.

Generally speaking, I find the response to the discovery of the man's death to have been good. I express some concern, however, that the man was able to attach a ligature to the shower unit and about the failure of the communications room to use the correct code when summoning staff to the scene. I conclude that it made no material difference in this case, however. I also note that details of the man's clothing were changed from when he was found to when he arrived for post mortem.

My strongest criticisms will be found in 'Role of the Immigration Service'. I find shortcomings in the way pro forma documents are completed and express very real concern about the failure to drive the man's case forward to effect his early removal. I am also critical of the thinking underpinning the recommendation that he should continue to be detained.

In conclusion, I find that there was nothing UKDS could have done to prevent the man's death. I question, however, what impact the Immigration Service's handling of the case might have had on his actions.

I make a total of ten recommendations.

Glossary of terms

ASU	-	Asylum Screening Unit
CID	-	Certificate of Identity
CIO	-	Chief Immigration Officer
DCO	-	Detention Custody Officer
DDU	-	Detainee Departure Unit
DEPMU	-	Detainee Escorting and Population Management Unit
DMS	-	Detainee Management System
ETD	-	Emergency Travel Documents
F2052SH	-	Self harm management form
HFTP	-	Harmondsworth fast Track Programme
Hotel 3	-	Healthcare radio call sign
IND	-	Immigration and Nationality Directorate
IS151A	-	Notice to a Person Liable to Removal
ISI91	-	Detention Authority
ISDU	-	Immigration Service Documentation Unit
MODCU	-	Management of Detained Cases Unit
PFMS	-	Primecare Forensic Medical Service
RDs	-	Removal Directions
RGN	-	Registered General Nurse
SDCO	-	Senior Detention Custody Officer
SFT	-	Super Fast Track
TA	-	Temporary Admission
Victor 2	-	Duty Manager Call Sign

Background

The man gave his date of birth as 9 February 1973. He claimed to have arrived in London on 24 May 2004 after sneaking into the back of a lorry carrying refrigerators. He went to the Asylum Screening Unit (ASU) in Croydon the next day and claimed asylum. The officer who interviewed him on that occasion noted that the man said he had arrived the previous day from the Ukraine and spent the night on the road. She recorded that he “has a very bad smell and marks on his face which suggest that he has been in a fight”.

The man told the Screening Officer that he had travelled through Poland, Germany, Luxembourg, the Netherlands, Belgium and France to reach this country. He had spent a little time in some of these countries while he waited for cars. He had also worked in Poland. Asked why he had not sought asylum in any of the countries through which he had passed, the man replied, “During my childhood, I dreamed to live in U.K. And I could I did.” In relation to his claim for asylum, he said, “I want live in England have an proper job and live as an human being. I can’t live in Ukraine because there is no job.” He had no travel documents with him.

The man was issued with authorisation to access emergency accommodation and given an appointment for a screening interview the following day.

At that interview, the man revealed that he was divorced and had one son, whose whereabouts he did not know. His parents were alive and living in the Kerova region. He last saw them on 13 May 2004. He gave his occupation as a driver. (During induction at Harmondsworth, he said he was a bricklayer.)

The man said he had previously sought leave to enter the United Kingdom in 1995.

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 if 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.

Harmondsworth Removal Centre

An 8-year contract to build and manage Harmondsworth Immigration Removal Centre, near Heathrow airport, was awarded to UKDS by the Immigration and Nationality Directorate (IND) in October 2000. The centre opened in September 2001 and provides accommodation, healthcare, education and recreational activity for 500 people detained by the Immigration Service and awaiting removal from the UK. Also on site is a Hearing Centre run by the Court Service to decide on appeals and applications as part of the fast track programme to have cases heard within four weeks of application.

The centre holds 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 smaller proportion of detainees whose cases have not yet been determined, but who are considered to be at risk of absconding or whose identity is being established.

It was originally assumed that each detainee would stay for between 2/3 months and that there would be around 15 movements in and out of the centre per day. The picture changed very quickly, however. While some detainees remain at the centre for several weeks, many spend barely a day there, simply passing through on their way to the airport. The number of movements in a single day has been as high as 150. At the time of the man's death, the centre held 436 detainees comprising 69 nationalities. There was only one other Ukrainian at the centre.

Harmondsworth is a purpose built centre on three floors. It was designed to hold men, women and families, with single men and women sharing communal areas, though eating in separate dining areas. (At the time of the man's death, however, the centre only held males.) Bedrooms are mostly shared, although there are some single rooms. Generally, the rooms are fitted with a wardrobe and storage facilities, a television with video, and a telephone for incoming calls. Accommodation is on long, narrow corridors with no natural light.

The centre has four residential wings. Each wing is L shaped and joined by a central block containing common services, thus producing four quadrangles within a secure perimeter. At the time of the man's death, movements were controlled off the wings and detainees could gain access off the wing every hour. Detainees were allowed free access to regime opportunities, such as education – English, Art and Craft, I.T. – the library, games room, hairdressing salon and gym. The education and world faith centres could be accessed between the hours of 9am and 8:30pm. In addition, detainees had unrestricted access to internal courtyard areas between the hours of 7am and 11:30pm. The detainees were restricted from going to and from other residential units, but were not locked in their rooms at any time and had free access to showers, toilets, drinks, snacks and meals within their residential block.

All detainees on the enhanced regime (that is, those whose behaviour is acceptable) are credited with 86p per day to spend.

HM Chief Inspector of Prisons conducted an announced inspection of Harmondsworth in September 2002. She concluded that the centre did not meet three of the Inspectorate's four tests for a healthy custodial environment. In particular, the Inspectorate found that suicide, self-harm and anti-bullying procedures were not effectively managed and that the centre was neither a safe nor a respectful environment. The report was published in August 2003.

Fast track programme

Harmondsworth has 180 beds (120 at the time of the man's death) ring-fenced for fast track cases. These are cases that are deemed capable of speedy resolution. Following an initial induction interview, detainees are given a substantive interview two days later to establish their claim. A decision is made on the claim the following day. If the claim is refused, a Reasons for Refusal letter is issued. This explains why the claim has been refused. The detainee then has two days in which to appeal. If no appeal is made, the detainee is deemed to have exhausted all rights to remain in the United Kingdom. If an appeal is made, it is heard by the Independent Appellate Authority two or three days afterwards, in front of an Adjudicator. The Adjudicator has 24 hours in which to determine the case. If the appeal is dismissed, the detainee has two days to appeal to the Tribunal – but may only do so on a point of law. The whole process takes approximately 34 – 40 days.

Where the claim is unsuccessful, detainees may have to apply for an emergency travel document, if they have no travel papers in their possession. This process can take up to six months according to nationality. Some detainees are released while a travel document is applied for (temporary release or temporary admission). If, however, the detainee is likely to abscond, is guilty of deception or has been arrested for a criminal offence, then they will most likely continue to be detained.

If a fast track case takes longer than 21 days to resolve (28 days at the time of the man's death), it is transferred to the Management of Detained Cases Unit (MODCU).

Investigation

An Assistant Ombudsman and a Fatal Incident Investigator investigated the man's death on my behalf.

The investigator and other members of my office visited Harmondsworth immediately after the man's death. There was not much to see, however, as all detainees had been transferred out after the major disturbance and fire that followed the discovery of the death. By the time the Assistant Ombudsman and the investigator visited in December, many regime changes had been made in response to the disturbance. As a consequence, we have not been able to get a feel at first hand for how the centre was at the time of the man's death.

During their visit, the Assistant Ombudsman and the investigator spoke to the Deputy Centre Manager, the Chair of the Independent Monitoring Board (IMB) and the Chief Immigration Officer. Unfortunately, they were unable to arrange a meeting with the Contract Monitor before he left his post.

The investigator and the Assistant Ombudsman had a very brief tour of those parts of the building relevant to the man who died. This included the reception area and the unit in which he was accommodated. They viewed a room identical to that in which the man stayed and also the shower room where his body was found. They received briefing from staff at each of these locations. The investigators also viewed CCTV coverage of the man walking from his room to the shower on 19 July. UKDS provided us with all the records they held on the man and a number of policy and other documents. The Investigators also obtained copies of all the Immigration Service records for the man.

Subsequently, the investigator and the Assistant Ombudsman interviewed the fast track caseworker in the man's case, and the investigator interviewed the nurse who interviewed the man on first reception at Harmondsworth.

We were advised that there would be little mileage in issuing a notice for detainees wishing to give evidence to the investigation as everyone had been removed from the centre following the disturbance. However, a note to staff inviting them to contact the investigation team was issued. In the event, no-one contacted us.

We wrote to the man's parents explaining our role and inviting them to contribute to the investigation if they so wished. At the time of writing they have not responded. If they do so, I shall amend this report accordingly in due course.

Prior to embarking on the investigation proper, my investigators held a number of meetings with the DCI who led the police investigation into the disturbance at the centre. Close liaison was necessary to ensure that we did not compromise the police investigation. A protocol was agreed and the DCI made available to the investigators the statements provided to him by staff and detainees.

The man's detention history

At his interview in Croydon on 26 May, the interviewer noted:

“Apps behaviour is very strange. App has a cross around his neck which he says is a mobile phone and used to speak to his brother. Apps claims the cuts on his face were caused by wood in the lorry.”

The man was issued with an IS151A – Notice to a Person Liable to Removal. This advised that the Immigration Officer was satisfied that he was an illegal entrant as defined in section 33(1) of the Immigration Act 1971 and that he was therefore liable to be detained pending completion of arrangements for dealing with him under that Act. The form advised that the Immigration Officer proposed to give directions for his removal from the United Kingdom in due course and that details would be given to him separately.

A decision was duly taken to detain him “in accordance with Oakington fast track procedures”. The grounds he was given for this were that his “application could be decided quickly using the fast track procedures” and “On initial consideration, it appears that your application may be one which can be decided quickly”. (There was no reference to any likelihood of absconding.) Nothing was recorded on the form in relation to the documentation to be used to effect the man's removal.

An IS91 Detention Authority form was raised. Nothing was marked under Risk Factors. A note on his immigration file said he had been served with several forms, including an IS91, and that the reasons had been explained to him in Russian.

The man was duly sent to Oakington Reception Centre at 8pm. A computer-generated form was raised. This recorded that he had no “special needs” and had a good understanding of English. He also spoke Russian, Polish and Ukrainian. Under “Obvious Illness”, “Suspect mental illness (talking to himself)” has been entered. Abrasions to his face and arms were also recorded. Under “Remarks”, it was noted that he had no money, was not in possession of any immigration papers and had been issued with a hygiene pack and phone card.

A manuscript note with the man's immigration papers recorded that on the evening of 26 May, Primecare Forensic Medical Service (PFMS – the contracted healthcare providers) advised of concerns about his behaviour. The note referred to concerns that cuts to his arms and face might have resulted from self-harm. It continued:

“The case had been referred on 26/5/04. It had been noted that subject had been talking to himself but, when questioned, answered lucidly and with clarity.

“Group 4 have advised that subject was placed in the DDU having damaged property in his room. PFMS advised that subject had lain on the floor and not responded when spoken to. [PFMS] was unable to determine whether subject had behavioural problems, whether his behaviour was a result of substance abuse or whether his behaviour was feigned. ... (Group 4 site manager) has spoken to the subject and believes he may be feigning.”

It is recorded on a document with a Harmondsworth heading that:

“The same evening we were notified by medical staff at Oakington that they had concerns over subject’s behaviour (subject had cuts on arms/marks on face – possible concern that it was self-harm.) Subject was moved into the DDU (Secure Holding Area) as damaged property in room. Immigration at Oakington spoke to [named person] on 27 May as subject cannot remain at Oakington. [Named person] stated that if we received confirmation from medical staff that subject does not have behavioural problems then Harmondsworth may be able to deal with this case. PFMS now confirm that subject is fit and well.”

The man’s Medical Records had the following entries:

“21:00 On entering det rep this gentleman was found talking to his cross – other hand in ear – pretending/believing it is a phone, I believe – very hard to make conversation. Does speak English but unable to communicate. Interpreter sought via CIO who were aware of this gentleman’s mental health needs although nothing written on IS91. Has facial injuries and scarring to both arms again not mentioned. Assistance sought via on-call team. DSM sought to ensure DDU available – more for [the man’s] own safety overnight. Plan to proceed as normal and put in single room. DDU on stand-by.

22:30 Call to block – very unsettled.

0:00 Radio call – very distressed. Smashing up room. PFMS on stand-by – visit block.

0:15 Moved to DDU – minimal assistance used. Saying all my fault and in the morning I will be shot for this demonstrating shot gun action at me. For full assessment in the morning.

3:00 Appears to be sleeping.

7:15 Sleeping. Unable to arouse.”

There then appears to be a page missing. The record continues:

“27/5/04 GP arrived. [The man] advised he should now be co-operative and remain calm and he would be reviewed regularly to ensure

any health needs are met. On leaving, [the man] compliant, sitting on bed and calm.

27/5/04
12:30 Returned to DDU with interpreter. Sitting on bed. Entered cell. [The man] states he's "fine". Agree to eat lunch. Advised by security staff that if he remains compliant he will be able to go for cigarette outside. [The man] happy with this.

28/5/04
16:45 Routine visit. Sitting watching TV. Says he is okay and has no problems."

An immigration note timed at 19:05 on 27 May said:

"Spoke to PFMS ... There is nothing wrong with the subject. He was feigning. Once he had been spoken to by an interpreter, he calmed down. We now need to seek ETD for subject and get into HFTP. He was examined by [nurse] FMS and a doctor."

An RGN for Primecare Forensic Medical advised on 28 May:

"Reading for his medical notes [the man] will be fit for travel and has no medical needs at present. Also no problems to be further detained."

On the same date, it was recorded that the man's representatives had advised that he wished to depart voluntarily.

On the afternoon of the same day, Oakington faxed Harmondsworth fast track to see whether they would accept the man. They did.

On 29 May at 1:30pm, the man signed a form to confirm that he wished to withdraw his application for asylum. It was explained to him by an interpreter that arrangements would be made for him to return to the Ukraine as soon as possible

An IS91 RA Part C: Supplementary Information form dated 29 May recorded:

"The applicant has been disruptive in that he damaged property in his room at Oakington, as a result he is currently held in the unit DDU. He has been seen by the site medical services who are concerned that marks on his arms and face may be the result of self-harm. There is no evidence to support this nor has he attempted self-harm at Oakington. He appeared to have behavioural problems in that he laid in the floor but nothing else noted."

"No further incident – seen by medical services – fit for detention" has been added in manuscript. The form was apparently raised by an Immigration Officer at Oakington. The bottom of the form, which is to be completed either by DEPMU or MODCU, has also been signed by the Immigration Officer. He has indicated that the detainee's location did not need to be changed and there was no need to issue a revised IS91.

A movement order was issued by DEPMU for the man's transfer to Harmondsworth. Under "Special Needs" on the escort note, it was recorded that the man was a suicide risk – "(Possible self harm as sub has cuts on arms/marks on face)" – and was disruptive – "(damage property in room)".

Detention at Harmondsworth

Reception

The man arrived at Harmondsworth at 10:45pm on 29 May. A Detainee Profile Report was created for him. Under "Warnings (IS91)" it has been recorded that he was a suicide risk and disruptive. A manuscript note on the man's Detainee Personal Record System expanded slightly on this information, but noted that the man had no "special needs". It was recorded that he was O.K. in reception.

The man was seen by an RGN shortly after midnight. She recorded that he had never suffered from mental health problems or depression. He did not use drugs and drank alcohol occasionally. Under a section dedicated to mental health, the RGN has recorded that the man had never been under a psychiatrist, but that he had deliberately hurt himself. He had scars and sutures on his left wrist which he said he caused in 1994. He said he had never tried to kill himself and did not want to kill himself at that time. He had never been in custody before, but, although he said no-one knew he was there, he said he was expecting visitors. The RGN recorded that the man said he had been subject to/affected by torture and that he seemed "excessively anxious, withdrawn or depressed". She has not qualified this. Finally, she noted that no concerns had been raised by outside agencies. Under "Additional Information", the RGN repeated the information about the man's wrist, but noted that he stated he was fine.

The investigator interviewed the RGN. She said she vaguely recalled the scars because the man had been reluctant to show them. He had said he did them some time back and did not want to do anything about it. He did not feel suicidal and had no intention of killing himself. He just said he wanted to go home. The RGN said that the detainee's IS91 did not have any pertinent information on it. She was shown a copy of the escort note and asked if she had seen it. She said she had not, but that she would not necessarily have reached a different conclusion even if she had. She said he simply did not present as a suicide risk. The RGN did not remember receiving any medical information about the man. (This, and the fact that the detainee did not apparently consult healthcare during his stay, accounts for the fact that no medical record could be found at Harmondsworth for this man.)

The investigator asked the RGN about the reference on the pro forma to torture. She said, "To me, it's just what we have on the computer to click on. To me, what I am saying, it's just like statistics. It doesn't have any area to explain any further about what they actually have done or when they were tortured." She added, however, that if there was any additional information about this, she would pass it on for any medical assessment.

The investigator also pressed the RGN about the entry recording that the man was “excessively anxious, depressed or withdrawn”. The RGN said she thought the man had said he was depressed because he wanted to leave. He was not clinically depressed, it was more a question of mood at that time. She confirmed that she was satisfied the decision not to raise an F2052SH form was appropriate.

The RGN said that new detainees did not routinely see a doctor following their arrival. This only happened where they were identified as being ill or asked to do so. She said the man did not come to the attention of healthcare after this time – “He never came out even for a paracetamol”.

Finally, the RGN talked about the length of time detainees were held in removal centres. She commented, “It’s just such a stressful situation. They are stressed before they get here and it just goes on and on.” She thought the average length of stay was about six months.

The RGN told the investigator that she did not receive any induction at Harmondsworth – her first shift was a night shift – but that she was satisfied she knew what she was doing.¹

A note confirming the man had undergone detainee residential induction and timed at 00:25 on 30 May, noted that he had no questions – he was eager to get to his room.

UKDS have no further records of the man until 19 July, other than that he was given a razor on 16 and 23 June and 1 July. Staff to whom the Investigators spoke said he never came to their attention particularly. He was quiet, polite and co-operative and just went about his business as normal – he associated occasionally, fetched drinks and had all his meals with the exception of a couple of breakfasts, which is apparently quite normal.

The man’s room-mate, a Nigerian national, said of the Ukrainian man:

“He was not able to speak much English so we could not talk very much. He is a quiet man who keeps to himself. I would say he is an introvert and spent a lot of time in the room or maybe outside in the courtyard smoking.”

He said his room-mate was a nice man and that he (the Ukrainian man) had helped him a lot when he first came to the centre. There was, however, a language barrier between the two men. He commented that the other man did not seem to be the type to kill or hurt himself.

¹ It emerged at the inquest that the RGN had been employed as a ‘Bank Nurse’ for some time previous to this event. She had received a reduced induction and had worked an average of 31 hours per week in the preceding 14 week period. She also had relevant previous experience in the Prison Service.

Progress of case

The Ukrainian man was interviewed by an Immigration Officer on 7 June in the presence of a solicitor and an interpreter. The man signed a disclaimer to confirm that he did not wish to pursue a claim for asylum and wished to leave the United Kingdom.

The Immigration Officer noted:

“Applicant signed disclaimer and helped complete ETD and bio-data form. He will contact his family in the Ukraine to send travel documents over to quicken up his removal. Photographs need to be taken. Set RDs to Ukraine.”

The investigators spoke to the Immigration Officer. He said he could not recall when he interviewed the man substantively about his claim, but thought it was in June or July. He did not think the man had spoken in English to him and confirmed that an interpreter was present. He added, however, that this was standard practice for the avoidance of any doubt. The Immigration Officer checked all the detainee’s personal details were correct and asked him about five questions. The detainee then told the interpreter that he wanted to go home. He told the Immigration Officer that he had come to the United Kingdom to work and did not want to be detained. The Immigration Officer said this did not happen very often with asylum claims, so he double-checked that the interpreter had understood correctly. The interpreter confirmed that the man said that he did not want to claim asylum, wanted to return to the Ukraine and confirmed that he had spoken to his solicitor about his decision.

The Immigration Officer said that Oakington had noted the detainee as being disruptive but this was not apparent during the interview. The man was very polite, calm and co-operative and just wanted to go home as soon as possible. He recalled that the man was noted to be at risk when he was seen at Oakington but had felt he was fine when he saw him.

The Immigration Officer said that the man did not have a passport, so he obtained a form for him to complete for a travel document. The man was very co-operative, so he helped him fill out parts of the bio-data form. The Immigration Officer had anticipated that it might take two-three weeks to obtain a travel document for him. However, the man offered to arrange to have his ID card sent to him. The Immigration Officer told the Investigators that, although this was not strictly necessary to effect removal, it would speed up the travel document application. He therefore told the man to send the ID card to him when it arrived. In light of this, the Immigration Officer delayed applying for the emergency travel document. However, he said that, on checking the position approximately two-three weeks later, no ID card had been received. He therefore referred the man’s case to MODCU, as the 21 day time limit had been exceeded.

The Immigration Officer told the investigators that he had been confident that the man would obtain his ID card, as he had been co-operative from the

outset. He said that, if he had not believed this would be the case, he would have forwarded his travel document form to ISDU sooner.

On 5 July, the immigration Officer noted in the man's immigration file:

"[The man's] ID card has still not arrived. Have applied for his ETD and referred him to MODCU for a long term bed."

The Immigration Officer completed a "Transfer of Detention Review to MODCU" form. This recorded that the man had entered the United Kingdom on 24 May, claimed asylum the next day, but signed a disclaimer on 7 June. The form said the man had stated he would have his national ID card sent, but this had still not arrived. Emergency Travel Documents had been applied for on 2 July. The form requires the Immigration Officer to provide full details to substantiate grounds for opposing temporary admission (TA) or bail. The Immigration Officer has written:

"Used clandestine entry in back of a lorry to come to UK. Claimed asylum then withdrew claim. Stated when detained he just wanted to work. Has shown a complete disregard to immigration rules and has used the asylum system to delay his removal. Has no legal right to remain in the UK and is very likely to abscond if granted bail."

He recommended that surety of £10,000 be obtained if TA/bail were granted and that the man should be required to report daily.

On an IS91R, Notice to Detainee – Reasons for Detention and Bail Rights, the Immigration Officer indicated that it had been decided that the man should remain in detention because he was likely to abscond if given temporary admission or release and there was insufficient reliable information to decide on whether to grant him temporary admission or release. The form advised that the decision had been reached on the basis that the man did not have enough close ties (family or friends) to make it likely he would stay in one place, and he had attempted to use deception in a way that led the Immigration Service to consider he might continue to deceive. The Immigration Officer has signed a box indicating that the contents of the notice had been explained to the detainee, but he has not indicated whether this was in English or through an interpreter. The Immigration Officer did not see the man after 7 June.

On 11 July, MODCU acknowledged that they had accepted the man into long term detention. On 16 July, they faxed through a letter for him. This said simply:

"This is to inform you that your case has been transferred. Your case will now be dealt with by the Management of Detained Cases Unit."

On 18 July, an Immigration Officer in MODCU minuted the file with details of the man's case to date. She wrote:

“Lack of ETD is only bar to removal. Sub keen to return home.

The ETD app has not been minuted by SFT as being sent to ISDU and there is no mention of it on CID. I therefore assume that no ETD application has ever been submitted for this man who wants to return home! He signed his disclaimer on 28/05/04.” [Emphasis in the original.]

Actions

URGENT

ETD app to be sent to ISDU asap as sub signed disclaimer on 28/05/04.

Request photos be sent directly from det centre.

According to file minutes ETD form was completed on 07/06 but no sign of it on file.

We should also see if sub has managed to get any ID docs from home.

We should give him tel no. for Ukr Emb and tell him to contact them to speed things up.”

The man’s next detention review was marked as being due on 26 July.

19 July 2004

The Assistant Ombudsman viewed CCTV coverage featuring the man. According to the time on the disc, the coverage began at 10:39am. It showed the man coming out of his room and going down the corridor to the right. He disappeared for a while and then returned to his room. A few minutes later he came out again, and went down a different corridor that apparently leads to one of the association rooms. He quickly returned and went back into his room. He then went down the first corridor again before returning. Finally, at 10:50am, he is shown emerging from his room with a towel and going into the shower.

However, the man’s room-mate, said that the other man left their room at about 11:15am. He remembered this, as it was the time at which the door was opened to cross over to the other block to go to activities. He said that, when he left, the man was lying on the bed watching television. He seemed okay, although the room-mate told UKDS officers after the event that the other man was “quite depressed”. The room-mate said he had not seen the other man at lunch as he was running late. The room-mate did not return to the room until 1:40pm. The television was off and he was surprised to find the other man was not there “as he usually would be”. The room-mate went to the shower/bathroom nearest to their room, but the door was locked. It could only be locked from the inside. He therefore went to one further down the corridor. He said he did not hear any noise or water coming from the locked shower cubicle.

The Ukrainian man's immigration file is minuted to show that an IS33 form had been faxed to ISDU. A bio-data form had been faxed through to Harmondsworth along with a request for the man to phone the Ukrainian Embassy.

UKDS's policy document on Legal Visits Procedures says:

"A separate log sheet will be completed for all local Immigration interviews. The desk officer will liaise with the wings to arrange for collection of Detainees. In the event that there is difficulty finding a Detainee the desk officer will liaise with Immigration to keep them informed every 15 minutes, as to when the Detainee is likely to be produced."

I understand that the Harmondsworth contract requires UKDS to produce detainees for immigration interviews within 15 minutes. The Deputy Manager explained to the Investigators that this meant that, generally speaking, staff ceased looking for a detainee after 15 minutes as they had already incurred a penalty on that detainee. They therefore switched their attention to another detainee to avoid penalties being incurred for that detainee also.

The UKIS Legal Visits Log shows that they first asked at 2:45 for the man to be brought for interview. Under "Reason for Delay", is written "Informed Charlie 1 and [??] Done room to room search. Immi informed. Photos as well."

A Detention Custody Officer (DCO) said in his UKDS statement that he was on duty in legal visits when, at 2:45pm, he was given the names of several detainees required to attend from B and C wings. He said legal visits were very busy at this time, but that he found everyone on the list except for the Ukrainian man. He then asked C wing officers to locate him.

Another DCO said in his police statement that he was posted to work on C wing on 19 July. He said he had worked on C wing before, so was familiar with some of the detainees. At around 3pm, he received a request for the man to be taken to visits. He phoned the room but there was no reply. The DCO said he checked the meal records from lunch and saw that the man had not eaten. A legal 'runner' then went to look for him.

The DCO said that he received a further call from legal visits for the man at about 3:30pm. At this time, he and another DCO went to look. They checked his room but his room-mate said the man was not there and he had not seen him since late morning. The DCO said he and the other DCO then looked in every bedroom on level 3 without finding him. They told legal services and a Senior DCO (SDCO) that they had not been able to find him and then went to do other duties.

The second DCO said in his police statement that he learned at about 3:45pm that one of the detainees had gone missing. He said he and the first DCO conducted a search of C wing. This consisted of a room to room search in

level 3, and a search of the central spine block of the centre where there were computer rooms, games rooms, hairdressers etc. They could not find the man, so eventually resumed their normal duties, having first informed the SDCO and visits.²

A female DCO said in her police statement that she was advised at 7:20pm by a legal runner that Immigration had been looking for the man since 12:00. She considered this to have been a long time and checked the computer system. She said the security icon was flashing red and indicated that the man was violent and disruptive. She then informed another SDCO and went to level 3 to help search for the man.

The Residential Manager said the second SDCO phoned him at about 7:20pm to say they had been looking for the man all afternoon, without success. The man had not had his lunch or evening meal. The Residential Manager logged on to the DMS System to find out more about the man. He observed there were no concerns noted on his reception notes, but that the suicide box was ticked on his Immigration details. The Residential Manager had already checked that the man was not on F2052SH. He said he did not recognise the man and had not heard his name. He said this was not unusual, as the detainees he knew about tended to be those who caused difficulties. The Residential Manager said he immediately rang the on site Chief Immigration Officer (CIO), to ask about the suicide flag. The CIO apparently explained that it was there solely because of some superficial injuries they had noted on their records. The CIO advised that the injuries had been done some time ago and Immigration had no real concerns about the man.

The second SDCO, who was responsible for the overall running of the four blocks of the detention centre, said that he was made aware at about 7:10pm that legal visits were looking for the man and that they had been wishing to speak to him since about midday. He sent a message for all senior officers to check their wings to try to locate the man. He also asked for a check of the perimeter patrol to be made. The SDCO said that he and a DCO then started a sweep of C block intending to work their way down to the ground floor. He said, "Everything that opened we checked from cupboard to bathroom, rooms everything." He said that when they got to the man's room, it was empty. While a couple of DCOs were checking the room, the second SDCO checked other rooms in the vicinity. When he checked the shower room one door up the corridor from the man's room, the door did not move when he pushed it. Using a disc on his key ring, he was able to turn the latch from the outside in order to open the door. He pushed the door open and saw a shower curtain drawn across the shower cubicle in front of him, as if someone was behind it having a shower. He said he then noticed a pair of legs from the knees up sticking out from under the curtain. The soles of the feet were towards him with the feet pointing up. When he opened the curtain, he saw the man slumped against the back wall of the shower. His eyes were closed and he

² I understand it is not uncommon for detainees to try to avoid legal visits if they suspect they may receive unwelcome news regarding their immigration status. They have on occasion hidden in other rooms or even in wardrobes.

was wearing only trousers (though his flip-flops were in the cubicle). Around his neck was a “very thin” cord, which was attached to the shower control unit behind him. The man was suspended with his backside raised off the floor. The SDCO observed that the man was yellow with lots of purple dots and concluded that he had been dead for some time.

A DCO who responded to the SDCO’s summons noted that the shower rail curtain was bent.

The SDCO informed the Residential (also Duty) Manager and called for Healthcare to attend the scene. He then started to clear the area and locked both the shower cubicle and the man’s room.

The Residential Manager said in his UKDS statement that, as soon as the man’s death was discovered, he sealed and evacuated the immediate area and contacted emergency services. He informed the Immigration Service, the Deputy Centre Manager and the Centre Manager and instigated the centre’s contingency plans for a death in custody. The command suite was opened at about 8:00pm.

A Supervisor said in his UKDS statement that, at 7:55pm, they heard the call “999” on the radio and nothing else. An officer asked for the message to be repeated. The Supervisor said they then had a call for Healthcare to attend room 310 (the man’s room). This was followed by a call for Healthcare to, “Drop everything” and attend room 310. The Supervisor said he then received a call from Victor 2 explaining what had happened and instructing him to call the Manager and Deputy Manager. He said that, after this, he followed the contingency manual.

A nurse said that at about 7:50pm she was called over the radio by the communications room and told to “drop everything and attend room C310 immediately”. She said she had no idea what she was required for, “as this terminology is not often used”. The nurse told the police that a code system existed for use in medical emergencies, with code yellow 1 indicating that someone was unconscious and code yellow 2 indicating that someone was bleeding. She said that, if she was called to a code yellow, she was immediately aware that it was a medical emergency and responded accordingly by collecting her emergency response bag and making her way to the relevant location. Even though there was no reference to code yellow in this instance, however, the nurse said she collected her emergency bag nonetheless. This was kept in a cupboard opposite the nurses’ base.

As she approached the shower room, the nurse said she realised from people’s expressions that it was something serious, and asked someone to contact Hotel 3 over the phone to bring the resuscitation equipment. She used the ligature scissors on her belt to cut through the ligature. She said the man appeared waxy and yellow in colour.

Because space was restricted, the nurse asked for assistance to pull the man forward so that she could better assess his condition. When she tried to move

him, his body remained rigid. She said he was cool to the touch and there were no signs of spontaneous respiration. She checked for a pulse but there was none. She said she did all this already knowing that he was dead. She recognised from various signs that there would be no benefit in administering CPR. She added that, in her professional opinion, the man was dead and had been so for some time.

The nurse said she was informed that the police and ambulance had already been called. She left the room and contacted a doctor and the healthcare manager. She said that the doctor attended within about 20 minutes. By the time they reached C wing, the police had cordoned off the area.

The doctor completed a medical report. This confirmed that the nurse had called him at 8:00pm at home. He said he saw the man in the shower room with a lightpole [sic] around his neck – “he is not breathing very pale Rigor mortis”. The doctor noted that he certified the man dead at 8:39pm in the presence of two detention officers.

A disturbance broke out in the centre while the police were investigating. It was apparently sparked by rumours that staff had killed a detainee. Staff and police withdrew. As a result, the man’s body was not removed until about 4:35am the following morning, when officers entered via the roof space.

The disturbance has been the subject of a separate investigation and extensive police inquiries. I say no more about it here, nor about the dispersal of Harmondsworth detainees to prisons and other removal centres. The subsequent death of a detainee sent to Dungavel Removal Centre is the subject of a separate investigation by my office.

Post mortem report

The post mortem report identified the ligature as a lace from a training shoe. Of the man’s clothing and personal effects, it was noted that he wore grey jeans, which were unzipped and open at the waistband, his underpants were in position and he had sandals on his feet.

The forensic pathologist concluded that death had resulted from hanging. He also noted that the location and appearance of a number of linear scars to the man’s arms were “strongly suggestive of a previous episode of self-harm”.

Examination of the issues

Reception screening

The man did not arrive at Harmondsworth until 10:45pm, and it was almost 12:30am before he was finally taken to his room. I understand the constraints relating to the availability of transport, but consider it unsatisfactory that a routine, pre-arranged transfer between Immigration centres could not have been effected much earlier in the day. The lateness of the hour can only have increased the stress of the situation.

Even so, the man was seen by a nurse and screened for possible suicide risk. It is very unfortunate that the nurse only had (an unhelpful) IS91 form by way of background information and knew nothing about concerns that had been raised earlier about the man's mental state. What was potentially vital information remained at Oakington. I note that the screening nurse said she would not have reached a different conclusion about the man even had she seen this other documentation, but it is nevertheless a cause for concern.

I recommend that all records, but particularly healthcare records, created in relation to a particular detainee be forwarded with him or her when s/he transfers from one Immigration centre to another.

It is also a matter of concern that the screening nurse told the investigator that she did not receive any induction. (I note that in fact she received a 'reduced' induction.) Detainees present quite distinct types of risk – especially in terms of mental health – and it is essential that healthcare staff are fully aware of this and that they understand something of the Immigration detention process and regulations. I am saddened and alarmed that the nurse believed the question about torture to be no more than a box to be ticked for the purpose of collecting statistics.

The Detention Centre Rules 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.”

IND's Operational Enforcement Manual says that those who have been subject to torture should “normally be considered suitable for detention in only very exceptional circumstances, whether in dedicated IS detention accommodation or elsewhere”. There is no evidence that the man had in fact been tortured, but the matter should have been properly investigated by a doctor and, if found to be true, the Centre Manager should have been informed.

I recommend that UKDS reviews the training needs of its existing medical staff.

I recommend that all staff (directly employed and agency) coming into contact with detainees receive a full induction before commencing duty.

Ongoing care

From the date on which he was received at Harmondsworth, the man did not come to the particular attention of staff. Those who did remember him recalled that he was a polite and co-operative individual who simply went

about his business. His room-mate has suggested, however, that the man stayed in his room most of the time, that he kept himself to himself, and that on the day of his death he was quite depressed. Given the nature of the regime in operation at the time at Harmondsworth, it was unlikely that staff would have known anything about the man's mood. I understand that, as part of the induction process, detainees are advised to tell staff if they have concerns about anyone and that there are posters around the centre about this (the Investigators did not see any on their admittedly brief tour). But where most people are depressed or worried about the thought of returning home and are consumed by their own difficulties, it is perhaps unlikely that they would be able to identify whether someone else was at risk. Language and cultural differences are a further barrier.

The nature of the regime at Harmondsworth was such that a detainee need hardly ever have come into contact with a member of staff. It is debatable, therefore, to what extent staff could ever be capable of caring effectively for detainees, especially given the difficulties inherent in managing a population constantly in a state of flux. It seems to me that some sort of structure needs to be built into the regime to ensure there is regular contact between staff and detainees. There needs to be some way of monitoring (in a non-intrusive manner) those who choose to keep themselves to themselves. This would also ease feelings of isolation that detainees might feel.

In my report on the disturbance at Yarl's Wood (House of Commons Paper 1257, 2004), I recommended that detainees should be locked in their rooms at night. Aside from the specific considerations that led me to make that recommendation, it strikes me that the simple process of locking and unlocking detainees would at least ensure there was some opportunity for contact between staff and detainees twice each day.

I recommend that UKDS considers how best they can ensure adequate care for those detainees who do not readily come to their attention.

The search

It is simply not possible to tell when exactly the man killed himself. The CCTV coverage was timed at between 10:39am and 10:50am and shows the man going into the shower. However, his room-mate said the man was in the room when he left at 11:15am. The room-mate also told those looking for the man on 19 July that he had not seen his room-mate since "late morning". The Deputy Centre Manager suggested to the Assistant Ombudsman that either the room-mate might have been mistaken about the time (movement was allowed off the wing every hour – not solely at 11:15am) or the timing on the CCTV might have been wrong. I have not been able to establish the truth of the matter.

On the face of it, it seems incredible that someone could remain effectively lost in a place of detention for several hours. Certainly, it carries security implications. In some cases, there might also be implications for those who are at risk of self-harm.

In the case of the Ukrainian man, it is manifest that the searches that were carried out were peculiarly ineffective. We now know that for a matter of hours he was in a shower room two doors away from his own bedroom. However, any criticism of staff must be tempered by the fact that the regime in the centre at the time was such that detainees could go anywhere. Harmondsworth is a large centre and it would not be easy to track someone down. Indeed, the word 'search' may be inappropriate. The Deputy Centre Manager has explained that, because of the contractual requirement to produce detainees for Immigration interviews within 15 minutes, staff do what they can to find detainees in that time, but then move swiftly on to fetch the next one. (This probably accounts also for the fact that the desk officer did not keep Immigration updated on the position with regard to the man as required in UKDS's policy document on legal visits.) The DCO has said that legal visits was very busy that day. It must have been difficult to keep on top of all the requests to produce detainees. (The Deputy Centre Manager refuted the suggestion in some staff statements that the centre was short-staffed, however. He said it was fully up to complement – albeit that additional duties imposed on the contractor meant that the same number of staff had more work to do than envisaged at planning stage.) In all the circumstances, there is no reason to suppose the officers concerned did not do the best they could to locate the man. The failure to keep Immigration informed may have meant, however, that the matter was not pursued as rigorously as it might have been.

In any case, it seems likely that the man was dead long before the first search was carried out. The room-mate said he left the other man in the room at 11:15 and that, when he returned at 1:40pm, he was gone. He said he tried to use the shower nearest their room but was unable to do so because it was locked from the inside. It seems certain that this was because the Ukrainian man was inside. The first search was not instigated until 2:45pm. I do not believe, therefore, that an effective search would have prevented his death.

Discovery of the man's death

It is apparent from the first SDCO's statement that the man had first tried to hang himself from the rail supporting the shower curtain, since she observed that this was bent. I understand that the rails are designed to bend or break easily. In the event, the man hanged himself by attaching a shoe lace to the shower attachment. Given the particular design of the attachment (short and curving downwards immediately from the wall), it is difficult to see how he managed to keep the ligature in place.

I recommend that UKDS reviews the design of the shower unit to ensure it is fully safe.

Harmondsworth's instructions on action to be taken in the case of an attempted suicide are quite clear that the ligature should be cut immediately. I was initially concerned that those who found the man did not do so, but waited instead for the nurse to come. I understand, however, that it was perfectly

clear that the man was dead and had been for some time. In that case, the officers took the view that it was more important to preserve the scene.

Staff appear to have responded quickly to the discovery of the man's death. Healthcare, the doctor, the police and ambulance were all called promptly (I note, however, that there was a delay in the police attending due to arguments about jurisdiction). I am concerned, however, that even though the centre has codes for different types of emergency that alert staff to what they might expect, these were not used on the night. Instead, the message was simply to drop everything and attend. It emerged at the inquest that the code yellow call sign was not used because it was clear that the detainee was dead and that all staff are trained in resuscitation. I have concerns, however, about non-clinical staff making such a judgement. Those without relevant professional qualifications should always assume that resuscitation might be possible. In the event, the nurse took the emergency bag with her in any case but this lack of basic information might have proved crucial.

I recommend that staff in the communications room be reminded to use the appropriate codes in emergency situations and that additional training be provided if necessary.

I am also struck by some discrepancies in the accounts of how the man was found and his appearance when at the post mortem. A number of staff mention that the man was bare-footed when he was found, albeit that his flip-flops were in the cubicle. In addition, the Assistant Ombudsman was informed that the man's trousers were properly fastened. The forensic pathologist has noted, however, that the man was wearing sandals and that his trousers were undone. I cannot account for these discrepancies.

I recommend that staff be reminded of the need to touch as little as possible on the body or the immediate environment beyond what is necessary for the effective administration of CPR.

Role of the Immigration Service

I have been struck as I have gone through the relevant papers to note the slipshod way in which many Immigration Service forms have been completed. Many have not been completed fully or irrelevant sections have not been deleted "as applicable". I understand the pressures under which Immigration Service staff operate, but detention is a serious matter and the relevant forms should be filled out completely and in detail.

I recommend that the Immigration Service reminds staff of the need for care when completing forms and that line managers be instructed to monitor this.

The man declared soon after his arrival at Harmondsworth that he wanted to return home. Some six weeks later, however, he was still detained. The Immigration Officer has explained that he delayed applying for ETDs for the man because the man had assured him he would ask his parents to send his

ID card. I cannot criticise the Immigration Officer for this decision, which seems to me entirely reasonable.

However, no further action was taken on the man's case until 5 July – that is, exactly 28 days after the Immigration Officer's interview with the man. In the meantime, the man had no further contact with the Immigration Service. It is difficult to imagine what he would have made of this. It seems no attempt was made to check on progress with obtaining the ID card during the four week period, and no-one sought to find out what exactly the problem was – and whether the man had the means to contact his family. Instead, the next thing the man heard after his initial interview with the immigration Officer was a two-line letter telling him in English that his case had been transferred to a unit of which he would never have heard and of which he would have had no understanding. He might even have assumed that this meant he was to be detained long term. I consider the failure actively to progress the man's case and the complete lack of engagement with him by the Immigration Service to have been wholly unacceptable. It will never be possible to determine to what extent, if at all, this contributed to his death but there must be a real fear that it did.

I should emphasise here, that it is not my intention in any way to single the Immigration Officer out personally for criticism, or to hold him responsible for the man's death. The Investigators interviewed him in the presence of his line manager. They got the impression that the Immigration Officer's handling of the case was wholly in line with what was expected of him. Indeed, legally, there is no requirement to review detention cases more frequently than monthly. It seems to me that the shortcomings revealed by this investigation are systemic.

I recommend that the Immigration Service reviews its processes for actively driving cases to effect early removal. Tighter timescales for reviewing cases should be introduced. There should also be a requirement for Immigration staff to engage personally with those whose cases they are managing.

I cannot take issue with the original decision to detain the man. It is clear that he met the necessary criteria under the Immigration Service's fast track procedures. I am concerned, however, by the decision to keep him in detention once he was removed from the fast track process.

In making a recommendation to this effect, the Immigration Officer drew attention to the man's clandestine entry, his withdrawal of his asylum claim, and the likelihood of his absconding (I have quoted the Immigration Officer's words in full earlier). It is clearly true that the man entered the country clandestinely and that, as such, he was guilty of deception. However, I consider that the Immigration Officer has stated the case for detention too strongly. After entering the country, the man could simply have disappeared. Instead, he reported to the Immigration Service and claimed asylum. It is not clear that he really understood what asylum meant, as he made no attempt to suggest he was persecuted, but spoke instead about the lack of employment

in the Ukraine and his “dream” to work in England. I do not consider this suggests a man showing a “complete disregard to immigration rules”, simply a man who wanted to find a better life. In addition, the man made it clear early on to a number of people that he just wanted to return home. It seems likely that he realised he had made a mistake and just wanted to go. Finally, everybody who remembers anything about him has described him as polite and co-operative.

Again, as I have quoted earlier, IND’s Operational Enforcement Manual says there is a presumption in favour of temporary admission or temporary release and that if detention is authorised it must be kept under close review to ensure that it continues to be justified. I do not believe “strong grounds” existed in this case and find it difficult to see how the Immigration Officer, on the basis of one interview when he noted that the man was co-operative, could conclude that he was very likely to abscond if granted bail.

I accept there is an argument that anyone who enters the country clandestinely or without proper documentation has flouted the rules. But to how many asylum seekers and illegal immigrants does this apply? In addition, I am concerned about the lack of consistency in the interpretation of the guidance and therefore in whom is detained. Coincidentally, while investigating this death, I was also investigating the death of a man at Colnbrook Removal Centre. This man too arrived as a stowaway and without documents. But he was given temporary release. Despite the fact that he reported only sporadically and changed addresses without informing the authorities, he remained in the community for several months. The man lied about his nationality and refused to co-operate with the Immigration Service. He was taken into detention at one point, but almost immediately released again before finally being taken to Colnbrook. His experience calls into question the decision to continue to detain the subject of this report and may suggest that the system is arbitrary in whom it detains and whom it releases.

I recommend that Immigration staff be reminded of the need properly to review the need for continued detention – and especially at the point when a detainee is transferred from the fast-track system to MODCU.

Conclusion

There appears to have been nothing to suggest that the man intended to kill himself and, generally speaking, I can find little to criticise about the way the man was cared for at Harmondsworth. My only observation is that there are real limits on the degree of care that can be offered in relation to an extremely transient population where English is not the first language and detainees are allowed to come and go pretty much as they please. I have, however, identified some particular areas for concern in relation to the sharing of information between centres and training for healthcare staff. I am satisfied, however, that there was nothing UKDS could have done to prevent the man’s death.

In contrast, I have very real reservations about the role of the Immigration Service in this case. There was a lamentable failure to drive the man's case and to engage with him. It seems, however, that this was not unrepresentative of the way other cases are handled. Although one can only speculate on this point, a man such as this with some history of self-harm may simply have felt lost in the system and in the sway of forces he could neither control nor understand.

Recommendations

I recommend that all records, but particularly healthcare records, created in relation to a particular detainee be forwarded with him or her when s/he transfers to another Immigration centre.

I recommend that UKDS reviews the training needs of its existing medical staff.

I recommend that all staff (directly employed and agency) coming into contact with detainees receive a full induction before commencing duty.

I recommend that UKDS considers how best they can ensure adequate care for those detainees who do not readily come to their attention.

I recommend that UKDS reviews the design of the shower unit to ensure it is fully safe.

I recommend that staff in the communications room be reminded to use the appropriate codes in emergency situations and that additional training be provided if necessary.

I recommend that staff be reminded of the need to touch as little as possible on the body or the immediate environment beyond what is necessary for the effective administration of CPR.

I recommend that the Immigration Service reminds staff of the need for care when completing forms and that line managers be instructed to monitor this.

I recommend that the Immigration Service reviews its processes for actively driving cases to effect early removal. Tighter timescales for reviewing cases should be introduced. There should also be a requirement for Immigration staff to engage personally with those whose cases they are managing.

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