



# death in immigration detention

2000 - 2015

# medical justice

is the only organisation in the UK to send independent volunteer clinicians in to all the Immigration Removal Centres across the UK. The doctors document detainees' scars of torture and challenge instances of medical mistreatment. We receive over 1000 referrals from detainees each year and have gathered a sizeable, unique and growing medical evidence base. We help detainees to access competent lawyers who properly harness the strength of the medical evidence we generate. Evidence from our casework is the platform for our research into systemic failures in healthcare provision, the harm caused to detainees by these shortcomings, as well as the toxic effect of immigration detention itself on the health of detainees. We and others use our research to secure lasting change to the detention regime through policy work, strategic litigation and by raising awareness of the conditions inside places of immigration detention.

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Death in  
immigration detention  
2000 - 2015

a report by Medical Justice

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# foreword

The investigation and inquest process is a way of shining a spotlight on the closed world of detention and holding to account those responsible for treatment and care of some of the most vulnerable detainees. So many of these cases reveal fundamental failings in the treatment and care of detainees, and expose unsafe systems and practices.

They reveal the reality of detention and its impact on the physical and psychological health of detainees as well as the often cruel and degrading treatment that they are subjected to and the cultures of racism, sexism and dehumanisation that prevails. Inquests have also exposed the impact of privatisation and the lack of accountability and additional secrecy this results in with the sub-contracting of various services and distancing of government from these.

In the case of Jimmy Mubenga were it not for the family's legal representation (and we cannot underestimate the importance of legal aid funding here) then the truth about his death would never have emerged with all it revealed about the levels of racism and degradation in detention/forcible deportations and the racist and brutal culture operating within G4S. Without that involvement there would not have been the 'unlawful killing' finding at the inquest, the detailed Rule 43 (Prevention of Future Deaths) report which made numerous recommendations regarding the use of force, training, culture, racism etc. and the CPS being forced to reconsider their decision not to prosecute.

This is why the role of Medical Justice, INQUEST and the wider network of NGOs campaigning around these issues is so important. They serve a vital function in speaking up for those without a voice, particularly where there are no family members to speak out, to demand accountability and scrutiny of these institutions and safeguarding the human rights of detainees. With the visible increase of racism and intolerance and the punitive treatment of those fleeing conflict, persecution and poverty this work has never been more necessary.

**Deborah Coles**

Director, INQUEST

# executive summary

Each death in detention is an avoidable tragedy. Every year more than 30,000 people are detained under Immigration Act powers in the UK. Immigration detention is only intended to be used in exceptional circumstances and not for those who suffer from serious physical or mental illness. As a result it might be expected that no one will die in immigration detention. Yet, we have been able to identify 35 such deaths since 2000 and there might be more as there is no specific monitoring or definitive list of such deaths.

Those held in immigration detention are held for administrative convenience ostensibly to aid in the processing of their immigration case. Each death in detention takes place in a hostile environment, far away from loved ones and support systems. Often the family of the deceased reside abroad, are frightened of the authorities or lack the resources to make sure that the interest of the deceased is represented in what is often a prolonged and confusing process. Where there is no family present it is very difficult for organisations or others to act as properly interested parties on behalf of the deceased at the investigations and inquiries that may follow.

The average age of those who died in detention between 2000 and 2015 was 38, with nearly 90% under the age of 50. Thirteen (36%) of these deaths have were self-inflicted, reflecting the high rates of mental despair among immigration detainees in a system which is difficult to understand and seen as unjust. Many also suffered from mental illness, a very common occurrence among those who are detained, despite Home Office policy stipulating that those with mental health issues that cannot be satisfactorily managed within detention should not be detained. Indefinite detention is intrinsically harmful to mental health<sup>1</sup> which may lead to self-inflicted deaths. Heart attacks were the cause of death in as many as 1 in 5; there were 3 sudden and currently unexplained deaths; 2 dying from TB and others dying from a wide range of natural illnesses.

Every death in detention is investigated by the Prison and Probation Ombudsman (PPO) who has identified a number of systemic failings which contributed to the deaths and also in how the deaths were handled in the aftermath. These include breakdowns in communication both internally within the detention facility and in relation to notification of the next of kin of the deceased. The use of restraint contributed to 2 deaths, but for many more restraints played a role in the events leading up to their deaths. In some cases handcuffs were even left on dying detainees creating an unnecessary as well as a profoundly inhuman and degrading experience.

In around half the investigations into deaths in detention the PPO directly criticised healthcare provisions with many of the same systemic failures repeated year after year across a range of facilities. In two cases, the PPO found that neglect contributed to the death of the detainee and for others they found that had care been better, the death might well have been avoided. The practice of individual healthcare practitioners has also been found lacking in several cases. Clearly, the provision of healthcare within detention facilities falls short of that which can be expected when liberty is being deprived. The lacking standard of healthcare is linked to deaths in detention.

- Those with serious mental or physical illness should not be detained.
- There should be public knowledge of all deaths and proper investigations even of those deaths that happen within 7 days of release from immigration detention.

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<sup>1</sup> <http://bjp.rcpsych.org/content/bjprcpsych/194/4/306.full.pdf>

- All systemic failures identified by the Parliamentary and Prisons Ombudsman and other investigators must be addressed;
- Segregation should not be used in immigration detention; emergency responses must be improved; inappropriate use of restraints must be addressed;
- Support must be put in place for other detainees following a death in detention.
- Healthcare in immigration detention should be equivalent to that provided by the NHS elsewhere and where provision falls short of that available in the community, detainees must be released so they can access the care they need.

Detention under the Immigration Act is optional and viable alternatives exist<sup>2</sup>. The current system of detention has been widely criticised as 'expensive, ineffective and unjust'<sup>3</sup>. Medical Justice believes that Immigration Removal Centres (IRCs), and the conditions of detention, are so detrimental to the health and wellbeing of those detained that the only way to remedy this situation is to close the IRCs.

As long as IRCs remain open there will continue to be unnecessary deaths in detention but prompt action to address systemic failures may help limit the number of deaths and help to ensure that detainees will not suffer inhuman and degrading treatment.

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<sup>2</sup> <http://www.ohchr.org/Documents/Issues/Migration/Events/IDC.pdf>

<sup>3</sup> The report of the Inquiry into the use of Immigration Detention in the UK. A joint report by the All Party Parliamentary Group on Refugees and the All Party Parliamentary Group on Migration 2015

# background to immigration detention

More than 30,000 people a year are detained under the Immigration Acts, of whom 3500 are held in facilities across the UK at any one time. Most are held in Immigration Removal Centres (IRCs). A significant number are also held in prisons following completed sentences. Those detained are asylum seekers and other migrants whose immigration claims have yet to be determined or who have been refused the right to remain.

Although immigration detention is expected to be used sparingly and as a last resort when community alternatives are not appropriate, in practice this is not the case<sup>4</sup> and vulnerable migrants end up detained inappropriately. Detention can in effect be indefinite as there is no upper limit on how long someone can be detained. The numbers detained have been steadily increasing over the years whilst the percentage removed from the UK from detention has declined. In 2015 only 45% of detainees were removed<sup>5</sup>. No other European country detains so many migrants in this way. The system has been heavily criticised as ‘expensive, ineffective and unjust’<sup>6</sup>.

Immigration detention is not subject to meaningful automatic judicial oversight. Detention results from an executive decision by often relatively junior Home Office officials for their own administrative convenience. The legality depends on the common law duty of following official policy and guidelines, such as those in the Enforcement Instructions and Guidance (EIG)<sup>7</sup>.

Whilst decisions about immigration status are mostly still made by directly-employed Home Office officials, the custodial aspects are delivered for them by outsourced bodies they commission, mostly private sector, such as G4S, SERCO and Mitie, but also some from the prison service (NOMS). Until 2014 health services for immigration detainees were also under the Home Office, but these are now commissioned by NHS England, sometimes from the same private contractors, but also from NHS providers. Healthcare is free and expected to be equivalent to that in the wider NHS<sup>8</sup>. Through our work Medical Justice has documented that healthcare provision fails to meet community equivalence and has identified gross inadequacies in the services provided.

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<sup>4</sup> Detention Action. The State of Detention. Immigration detention in the UK in 2014 2014 on [http://detentionaction.org.uk/wordpress/uploads/2014/10/The.State\\_of\\_Detention.pdf](http://detentionaction.org.uk/wordpress/uploads/2014/10/The.State_of_Detention.pdf)

<sup>5</sup> Home Office Quarterly Immigration Statistics <https://www.gov.uk/government/publications/immigration-statistics-january-to-march-2016/detention>

<sup>6</sup> APPG. The report of the Inquiry into the use of Immigration Detention in the UK. A joint report by the All Party Parliamentary Group on Refugees and the All Party Parliamentary Group on Migration 2015

<sup>7</sup> Home Office Enforcement Instructions and Guidance (EIG) on <https://www.gov.uk/government/collections/enforcement-instructions-and-guidance>

<sup>8</sup> NHS England service specifications for Colnbrook, Harmondsworth, Brook House, Tinsley House and Yarl's Wood IRCs (summer 2014) available after release after a request under the FOI on [www.medicaljustice.org.uk](http://www.medicaljustice.org.uk)



# when a death happens...

Most immigration detainees are young men in whom deaths are not anticipated. When a death occurs it triggers a series of investigations to determine what happened. An outline of the processes in the event of a death in detention is set out for custody providers in the Home Office Detention Service Order (DSO 08-2014<sup>9</sup>) which extends responsibility for a death up to 7 days after release.

When a death takes place in immigration detention the police and the coroner will be notified immediately. All deaths in custody are automatically investigated by the coroner and, since the 1<sup>st</sup> of April 2004, by the Prison and Probation Ombudsman (PPO). A Home Office certified pathologist will carry out a post mortem examination of the body and submit a report of their findings to the coroner as well as issue an interim death certificate.

## police

The police carry out initial investigations on behalf of the coroner in order to establish if there are suspicious circumstances surrounding the death. If the police suspect a crime may have been committed, they will carry out further investigations. If they find evidence of a crime they will, upon completion of their investigation, pass the file and report to the Crown Prosecution Services (CPS) who will decide whether or not to bring criminal charges. It is very rare for such charges to be brought.

In addition, if the PPO suspects that a crime has been committed at any point during their investigation they should hand over the investigation to the police. However, this puts a halt to the ongoing PPO investigation until the criminal investigation is completed. This may result in a delay of months or even years before the investigation can be concluded. An example of this is the death of Prince Ofose in Harmondsworth (see textbox on page 25).

## coroner's inquest

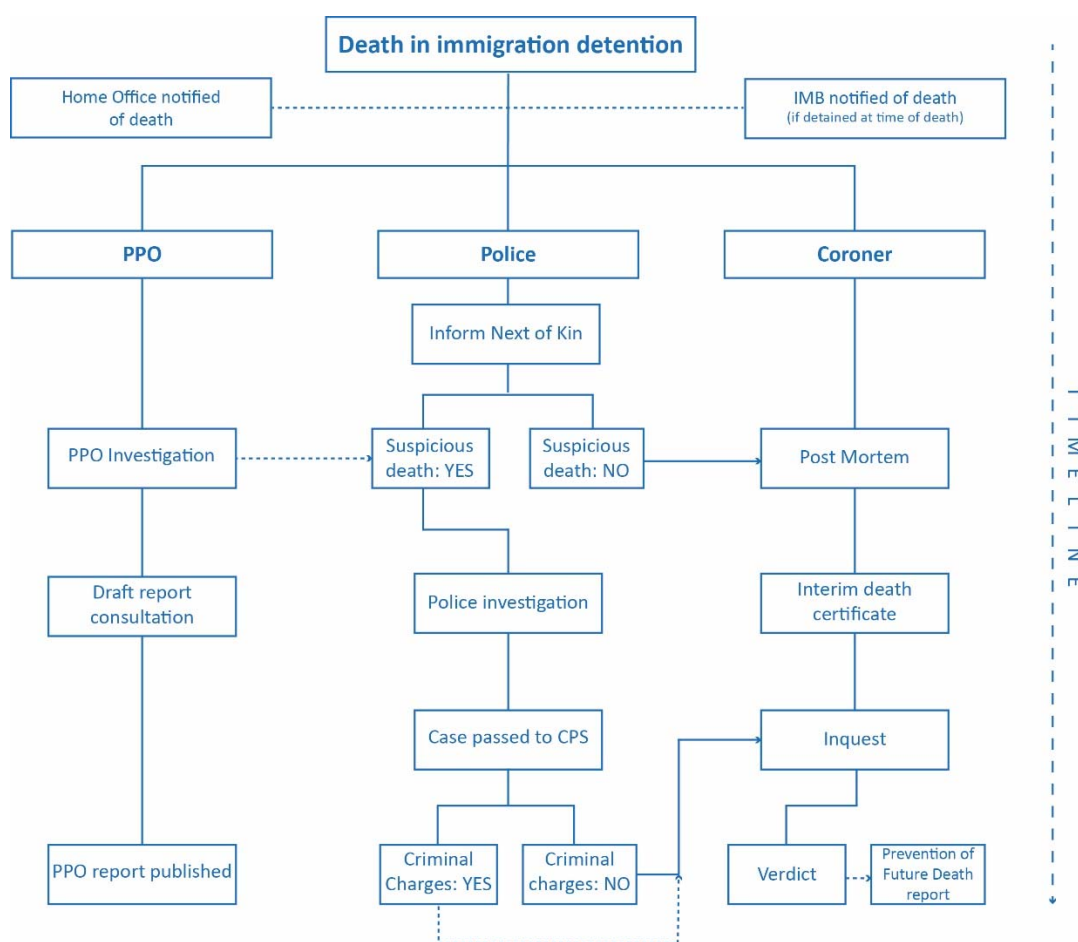
Following the police investigation, unless there is a criminal prosecution, the coroner will automatically organise for an inquest to be carried out. The purpose of an inquest is not to apportion blame but to ascertain who died, where and when that person died as well as how they came to their death. The timing of the inquest depends on the geographical location of the death as well as the circumstances surrounding that death. Some Coroner's courts struggle with long backlogs and, depending on where the death occurred, there could be a delay of several years before the case is heard in front of a coroner. New guidance stipulates that a coroner's investigation must now be concluded within 6 months<sup>10</sup>. Inquests following a death in state custody will engage Article 2 of the ECHR, the right to life. This means that the question of "how" a person came by their death is read to mean "*how and in what circumstances*". This means that the coroner's inquest will be broader in scope than would be the case in a non A2 inquest. This may enable the coroner and jury to investigate the wider systems and systemic failures involved in a detainee's death.

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<sup>9</sup> Detention Service Order Death in Detention 08/2014 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/388601/Death\\_in\\_Detention\\_DSO\\_08-2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388601/Death_in_Detention_DSO_08-2014.pdf)  
<sup>10</sup> <https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-9-opening-inquests.pdf>

Inquests, the PPO and coroners all have a very specific and very limited remit. Their focus is on the events that can be said to have caused a death. If a detainee died from natural causes yet was given inadequate care, e.g. provided with paracetamol for chest pain, this does not feature in the verdict unless the lack of care can be shown to have directly contributed to the death. There is little appreciation of the mental strain caused by indefinite detention.

If the coroner feels there are more general lessons to be learnt from the death then a 'Prevention of Future Deaths' report can be issued. Those in receipt of a Prevention of Future Deaths report are now required to report back to a coroner within 56 days to explain what action will be taken to address the concerns raised. There have been concerns raised about the quality and capacity of some coroners and individual coroners may remain in post despite repeated complaints against them<sup>11</sup>. One IRC is based in Scotland (Dungavel IRC) where the system is very similar but with the procurator fiscal substituting for the coroner.



## prison and probation ombudsman

The Prisons and Probation Ombudsman (PPO) is expected to report on all deaths in custody including deaths from natural causes, self-inflicted deaths, homicides and accidental deaths. Since 2004 this has included those in immigration detention. The PPO should also ensure that organisations such as National Offender Management Services (NOMS), Home Office Immigration Enforcement and Ministry of Justice learn lessons from deaths that occur in

<sup>11</sup> Hansard HC Deb, 16 December 2015, c599-610WH <https://hansard.parliament.uk/Commons/2015-12-16/debates/15121636000001/WestLondonCoroner%E2%80%99SCourt>

custody. The Ombudsman can also choose to investigate the death of someone recently released from custody if they feel there are particular lessons to be learnt. There is no listing of, and explanation for, those deaths following release that the PPO could have investigated but chose not to.

The PPO is funded by the government but is an independent body. PPO investigators should gather evidence on what was happening to the person before they died. Investigators will have access to all relevant records and policies including healthcare records and will conduct interviews with staff and other detainees. The PPO also works with NHS England to commission an independent clinical review of the health care provided. A family liaison officer should be in touch with the bereaved family and keep them informed about the progress of the investigation. At the end of the investigation the PPO produces a report which summarises their findings and recommends changes to improve the quality of care in the future. A draft report is circulated to all properly interested parties so they can comment on factual inaccuracies. Whilst the PPO should start their investigation in the days immediately following the death, the Fatal Incident Report may not get published for a couple of years, since they wait for the inquest and any legal proceedings to be completed. The PPO's investigation is independent of the coroner's inquest but their findings are submitted to the coroner and jury for consideration during the inquest.

Since the PPO has been cut back, and self-inflicted deaths in prisons have rocketed, the PPO has not had the resources to investigate all deaths related to detention, and in particular those from natural causes taking place outside of the detention setting. Following a FOIA request we were told that *"The PPO considers whether to investigate post-release deaths each time we are notified of such a death, taking into account whether it appears there are significant lessons to be learned and whether we have sufficient resources at the time. In practice the PPO has not used its discretionary powers for a number of years, as the rising number of deaths we obliged to investigate under our terms of reference, combined with increasingly stretched resources, has made this unfeasible. The last post-release death, which we used our discretionary powers to investigate, was in September 2010"*. Since 2010 the PPO have been notified of 2 deaths following release from immigration detention which they have chosen not to investigate. So, such deaths may not receive any external scrutiny other than that by the coroner, who has a limited remit.

In addition, despite great emphasis on learning lessons from investigations, the PPO has no power to enforce its recommendations and the same failings appear again and again, year after year in Fatal Incident Reports without any apparent improvements to the quality of care or evidence that lessons are indeed being learnt. In order to address particularly poor areas of care the PPO sometimes produce thematic reports that draw on collective analysis of investigations in order to improve quality of care in areas such as e.g. segregation<sup>12</sup>, emergency response<sup>13</sup> and the use of restraints<sup>14</sup>.

## other inspectorates

The Independent Monitoring Board (IMB) and Her Majesty's Inspectorate of Prisons (HMIP) both have a monitoring function in IRCs but are constrained over what they can say about individuals. If there are internal reports on the death, say for the Home Office Professional Standards Unit

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<sup>12</sup> Learning lessons bulletin Issue 8 Fatal incident investigations June 2015 – Segregation.

<http://www.ppo.gov.uk/wp-content/uploads/2015/06/Learning-Lessons-Bulletin-Segregation-final.pdf#view=FiTH>

<sup>13</sup> Learning lessons bulletin Issue 2 PPO investigations March 2014 – Immigration Removal Centres. Fatal Incident emergency response and detainee property.

[http://www.ppo.gov.uk/wp-content/uploads/2014/07/LLB\\_Cross\\_Office\\_IRC\\_final\\_web.pdf#view=FiTH](http://www.ppo.gov.uk/wp-content/uploads/2014/07/LLB_Cross_Office_IRC_final_web.pdf#view=FiTH)

<sup>14</sup> Learning lessons bulletin Issue 2 Fatal incident investigations February 2013 – Restraints.

[http://www.ppo.gov.uk/wp-content/uploads/2014/07/LLB\\_FII\\_Restraints\\_web\\_version.pdf#view=FiTH](http://www.ppo.gov.uk/wp-content/uploads/2014/07/LLB_FII_Restraints_web_version.pdf#view=FiTH)

(PSU) or a serious incident report (SUI) for the healthcare provider and the NHS hierarchy, these are not public documents. Limited access to redacted reports may be obtainable through use of the Freedom of Information Act (FOI), but there has to be knowledge the report exists in the first place. There is also scope for investigations to take place by professional bodies such as the General Medical Council (GMC) into individuals who appear to have breached their professional guidelines, but we are unaware this has happened even in cases where neglect or incompetence has been reported as contributing to the death.

**Brian Dalrymple** died in Colnbrook IRC in July 2011 but his inquest was not held at West London Coroners Court until almost three years later in June 2014.

*A report from the inquest notes that “the coroner started the proceedings by telling the jury that this was not a question of attributing blame, but it was to establish how and in what circumstances he came by his death whilst detained by the state. The lawyers, however, seem to have other ideas. There were a lot of them at this inquest, representing each of the seven interested parties, none of which want to be blamed for Dalrymple’s untimely death: the Home Office, the NHS, and the other five companies that run the detention centre and private health clinics Mr Dalrymple encountered (or not) during his incarceration. These businesses include Serco, GEO Group, Nestor Primecare Services and the Practice PLC (...) Such is the extent of Home Office privatisation and outsourcing that it looks set to wash its hands of any responsibility for Mr Dalrymple’s death in its custody”.*

Brian Dalrymple Inquest: Day 1 Corporate Watch 17<sup>th</sup> June 2014 <https://corporatewatch.org/news/2014/jun/17/brian-dalrymple-inquest-day-1>

None of the NGOs were alerted when **Mr C** died in Harefield Hospital in November 2012, within 7 hours of being ‘released’. His death was not reported at the time by the Home Office and there has been no investigation by the PPO due to ‘resource constraints’. This death could have gone unremarked were it not for a mention by the HMIP in their report of the Harmondsworth inspection in 2013. Medical Justice followed that up with specific questions under the FOI, exposing an adverse internal Home Office report about this death by the Professional Standards Unit.

Medical Justice submitted a FOI request for the report but were told that the report would not be shared as it may cause damage to the mental health of the bereaved family. The decision was overturned on appeal. Without regular reporting and independent investigation of all deaths within 7 days of leaving detention cases like this risk going unnoticed and unrecorded.

# friends and family

For those left behind, there are so many unanswered questions: the biggest is whether things might have turned out differently had their loved one not been in detention. After the often poor communication surrounding the death, the family may be left unsupported by the state apparatus that may have contributed directly or indirectly to the death.

A thorough inquest may go some way towards explaining what happened. An inquest should be a non-adversarial process in which the court hears from those who were directly involved in the care of the person that died and other interested parties. The coroner cannot indicate civil or criminal liability of a named person but findings of the Coroner's Court can sometimes be drawn on in subsequent civil or criminal proceedings. As such, the various interested parties are often represented at the inquest and it is not uncommon to see legal teams from the Home Office, the private companies who run IRCs and multiple healthcare providers all present at the inquest in an attempt to avoid any blame or culpability. The deceased, on the other hand, often go unrepresented.

There is scope for relatives to be present and represented at the inquest, but they may not be in a position to take this up at the time. Many families reside abroad or lack the resources to engage with the inquest process. The current system leaves relatives out of pocket and they may not have access to the sort of legal support which would make a difference. The legal funding is very complex and if a family retains a solicitor without significant experience of the inquest process they may not be familiar with how to take advantage of any legal aid that may be available. Families may therefore end up incurring high legal costs. Though there is 'Exceptional Funding' legal aid available for families of those who die in state custody in principle, in reality this funding is still dependent on the financial circumstances of the family who may have to contribute towards the cost themselves. In addition, the application process has been described as complex and the forms that must be filled in are very detailed and are often experienced as invasive by the families of the bereaved.<sup>15</sup>

The system is complex, difficult to navigate and prohibitively bureaucratic. The bereaved are often left in the dark as uninformed bystanders throughout these formal processes. Organisations such as INQUEST<sup>16</sup> try to help relatives understand and navigate the system so they can ensure justice for their loved one. For those who have no family to represent them, or whose family are unable or unwilling to participate in the process, there is theoretically scope for NGOs or others to take on the role of a Properly Interested Person to raise concerns of public interest and to highlight systemic issues that may affect others in a similar position. However, it is the coroner who decides who will be given Properly Interested Person status<sup>17</sup>. In the past applications for Properly Interested Person status made by Medical Justice have been rejected even where there was no family representing the deceased. The chief coroner has called an 'equality of arms' with legal aid funded representation for the family where the state has agreed to provide representation for one or more people<sup>18</sup>.

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<sup>15</sup> Inquest's Handbook. A guide for bereaved families, friends and advisors. <http://www.inquest.org.uk/help/handbook/section-3-1-legal-advice-and-how-to-fund-it>

<sup>16</sup> <http://www.inquest.org.uk/>

<sup>17</sup> Ministry of Justice - A guide to Coroners and Inquests [https://www.bucksc.gov.uk/media/133407/Coroners\\_and\\_Inquests\\_booklet\\_final\\_pdf\\_version\\_25-01-10\[1\].pdf](https://www.bucksc.gov.uk/media/133407/Coroners_and_Inquests_booklet_final_pdf_version_25-01-10[1].pdf)

<sup>18</sup> "Chief coroner calls for legal aid provision in state-involved inquests" <https://www.theguardian.com/law/2016/jul/25/chief-coroner-calls-for-legal-aid-provision-in-state-involved-inquests>

*A caseworker at INQUEST describes the experience of supporting families  
and the role of NGOs in the inquest process.*

(INQUEST is a small charity that provides free advice to people bereaved by a death in custody and detention.)

*Working with families*

When it comes to deaths of immigration detainees, the first hurdle we face is often obtaining information in relation to what happened and how the person died. These deaths are too often shrouded in secrecy. When a person dies in prison, we will be notified by the Ministry of Justice but there is no formal notification process when it comes to a death in Immigration Removal Centres. Speculation is rife in the centres following a death and it is a deeply unsettling and difficult time for those in detention. Given the nature of detention there may be significant delay in locating the family of the deceased. Families are often given no information about the various legal processes following a death from post mortem rights, funeral costs through to the role of the investigation and inquest. They also have no idea where to go for support and or advice or what their rights are.

Those who eventually contact INQUEST (often via NGOs working with detainees) will get specialist advice in relation to the investigation and inquest process and will get assistance in terms of finding suitable legal representation.

Even when families have a solicitor, funding will always be an issue. Though families of those who die in custody may be eligible for 'exceptional funding', families often have to jump through hoops to get funding for representation at inquests. The process is intrusive, protracted and complex with immediate family members being required to provide detailed financial information even when some of them might be living abroad. There are additional difficulties for families accessing funding in relation to deaths which are recorded as 'natural causes'. Access to funding is not automatic even where there is an Article 2 responsibility on the part of the state.

The government perpetuates the myth that inquests into a death in custody are informal hearings where grieving families can be expected to represent themselves and yet these are complex inquests where they come face to face with state lawyers and lawyers from private contractors who are there to defend their policies and practices. It is not unusual in an inquest involving the death of an immigration detainee that the family or the family's legal team face a team of 5 or 6 lawyers and barristers representing the state and the various private providers.

***"Families are not at the heart of the process and are often alienated by its impenetrable nature. Often they are not even allowed to show a photo of their loved one to the jury. The person who died gets totally lost in the proceeding"***

Families are not at the heart of the process and are often alienated by its impenetrable nature. Often they are not even allowed to show a photo of their loved one to the jury. The person who died gets totally lost in the proceeding. It is even more difficult when families reside abroad. Some, as in Brian Dalrymple's case, may be able to join in over videolink. Others are not so lucky. Tahir Mehmood's widow and children, who wanted to attend the inquest, were refused a visiting visa by the Home Office.

*Dealing with a death in detention*

Because of the fragmented nature of care provided in IRCs it is quite difficult for families to get a complete picture of what happened to their loved one before they died. Private contractors and the state all try and blame each other and nothing is joined up. Many of the deaths of immigration detainees involve repeated 'basic errors' by staff ignorant of mental health risks and also risks associated with physical health conditions. The indifference and lack of humanity is what underlines the care provided to immigration detainees.

*(continues next page...)*

(continued from last page...)

Brian Dalrymple died in July 2011 from a ruptured aorta. Brian suffered from schizophrenia and had dangerously high blood pressure. If his mental health problems were identified earlier, he could have received the right treatment and his death could have been avoided. The majority of staff giving evidence had no mental health training or skills to identify mental distress. Their evidence was also marred with prejudices against the detainees and lack of appreciation in relation to their vulnerabilities.

Mohamoud Ali was found on the floor of his cell at privately run Parc prison in February 2014. He died from SUDEP (sudden unexpected death from epilepsy). Despite hospital appointments made for him to see a neurologist, the prison failed on a number of occasions to provide transport for his appointments because of staff shortages. The jury in his inquest identified unacceptable failures in his care incl. basic information sharing.

The families feel understandably frustrated that there seems to be a lack of consequences following the death of their loved one. Nothing seems to happen to providers or staff involved. Their loved ones lost their life yet no one seems to lose their job or even suffer a fine as a consequence. There is no reassurance that this will not happen to someone else, and someone else's family, in the future.

***“Their loved one lost their life yet no one seems to lose their job or even suffer a fine as a consequence. There is no reassurance that this will not happen to someone else, and someone else's family, in the future.”***

Information and support for other detainees in detention following a death is also severely lacking. Following the death of Muhammed Shukat his cellmate was severely traumatised by having to witness his death and the neglect that led up to it. Yet he was placed in a single cell in the austere 'Assessment and Integration Unit' and segregated from other detainees that may have offered support.

### *The role of NGOs*

In addition to supporting families and finding legal counsel, NGOs play a vital part in exposing the details of a death in a very closed and secretive setting. There is a lack of openness and transparency about deaths in detention. This presents a number of serious problems in terms of the effective and robust scrutiny of these deaths and their vital role in uncovering what happened, and any systemic or individual failings. This is especially so when there is no family around to represent the interest of the deceased. Following the death of Mohammed Shukat his cellmate applied to be a Properly Interested Party but the application was denied. INQUEST together with Medical Justice and Hodge Jones Allen Solicitors decided to share the monitoring of this inquest because of the issues involved. The jury found that neglect contributed to his death but this neglect is not detailed anywhere as inquest transcripts are not readily available. We believe that the presence of NGOs at the actual inquest and the knowledge of the coroner that their conduct of the inquest was being scrutinised played a role in getting the deeply worrying aspects of this death exposed.

The circumstances surrounding deaths are never reflected in official statistics. A death of 'natural causes' is recorded as merely that. But when you attend the inquest and liaise with the family it becomes apparent that there is so much more behind that label. Look at the case of Bruno Dos Santos. His death is merely recorded as death from 'natural causes'. However, it was very clear during the inquest that, had he attended the scheduled MRI, this condition may have been diagnosed and successfully treated. We will never know if Bruno Dos Santos would have succumbed to his illness either way but he was not afforded the chance he deserved. However, his death is recorded simply as 'natural causes'.

One of the most serious concerns about deaths in detention is the lack of effective mechanisms for 'learning lessons'. Inquests are held in isolation from each other, often involving different providers. Contracting out immigration detention to private providers can obfuscate accountability and any potential systemic improvements following a death may get lost in changes of providers. There is no centralised responsibility for the collation, monitoring and following up of recommendations made as part of the PPO investigation or arising from the individual inquests.

There is a real accountability gap that frustrates the learning process and the prevention of future deaths. Until this is addressed people will continue to die unnecessarily in immigration detention.

# methodology

There is no official listing of deaths of those held under immigration powers, even though Home Office policy<sup>19</sup> requires all deaths of detainees in, and within 7 days of release of, detention to be reported to the Home Office. FOI requests for this information revealed that partial and incorrect information was held.

Medical Justice has pulled together the information in this report from published PPO reports<sup>20</sup>, inquest documents where available (not all inquests have written reports and even where they exist, they are not easily available online), reports in the media, direct approaches from family and other detainees and other intelligence<sup>21</sup>, some of which is anecdotal. Many of these deaths have been covered in previous reports, such as reports from Medical Justice<sup>22</sup> and the Institute of Race Relations<sup>23</sup>. However, this report provides an analysis of the systemic failings these deaths represent and presents an overview of a system that allows detainees to die unnecessarily in detention.

We have tried to include all those who died whilst held under immigration detention, whether they were in hospital, prison or IRC at the time of death. There have been especial problems of identifying those who died in prison whilst under immigration powers, since National Offender Management Services reporting seems unable to distinguish them from other prisoners<sup>24</sup>. We also include those whose deaths were related to detention, since they had just been released, or the death was related to immigration removal, or who were ex-detainees otherwise covered by a report from the PPO. We believe our list is the most complete there is.

Up until the 1<sup>st</sup> of January 2015 published PPO reports did not include the name of the deceased. However, we have decided to include the names that are already in the public domain in the report in order to identify those who have lost their lives. We have provided further details of individual cases in textboxes throughout this report.

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<sup>19</sup> DSO 08/2014 Deaths in detention [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/388601/Death\\_in\\_Detention\\_DSO\\_08-2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388601/Death_in_Detention_DSO_08-2014.pdf)

<sup>20</sup> Fatal incident reports available on the PPO website <http://www.ppo.gov.uk/document/fii-report/>

<sup>21</sup> [www.no-deportations.org.uk/Media-6-4-2011/DeathInRemovalCentres.html](http://www.no-deportations.org.uk/Media-6-4-2011/DeathInRemovalCentres.html)

<sup>22</sup> Medical Justice Annual Report 2014-15 <http://www.medicaljustice.org.uk/wp-content/uploads/2016/04/annual-report-2014-15.pdf>

<sup>23</sup> Institute of Race Relations Dying for Justice (March 2015) Deaths in immigration detention and during deportation on [www.irr.org.uk/wp-content/uploads/2015/03/Dying\\_for\\_Justice\\_web.pdf](http://www.irr.org.uk/wp-content/uploads/2015/03/Dying_for_Justice_web.pdf) and Roll call of deaths of asylum seekers and undocumented migrants <http://www.irr.org.uk/news/roll-call-of-deaths-of-asylum-seekers-and-undocumented-migrants-2005-onwards/>

<sup>24</sup> Deaths in prison custody 1978 to 2014 England and Wales. October 2015. On [www.gov.uk](http://www.gov.uk)



# those who died

The lack of transparency around deaths amongst those detained under immigration powers, and the absence of centralised monitoring, means the full story is hard to come by. Others have commented that it feels like while “*other areas improve, those in charge of immigration detention seem determined to muddy the waters and hide tragic incidents like this from public gaze*”<sup>25</sup>. The full list of those who have died in detention whilst held under Immigration powers, as far as we have been able to identify, is available as an Annex to this report.

There have been some spectacular and abhorrent failings which have led to the death of individuals in immigration detention. Situations where safeguards have failed and a sequence of events have combined to catastrophic result. However, of equal concern are the systemic failings that are allowed to continue unaddressed as these affect a much larger number of detainees and place a great number of those that pass through immigration detention at risk. These systemic failings roughly break down into four main areas: failings attributed to the handling of immigration enforcement; failings attributed to custody & escort staff and services; failings attributed to poor healthcare; and, lastly, failure to coordinate and communicate across the system. Each of these will be dealt with in turn below, with the main emphasis on failings in health and wellbeing structures and poor healthcare provision as this is such a frequent critique and it is where Medical Justice’s core expertise lies.

## **Recommendation 1:**

There must be public knowledge of all deaths that take place in or within 7 days of release from immigration detention, with the PPO resourced so all these deaths can be subject to full independent investigation. The Home Office must publish annual statistics on all deaths, near deaths and attempted suicides for detainees held in immigration detention and prisons.

*There have been deaths in most IRCs in the UK. Out of 35 deaths in detention between 2000-2015:*

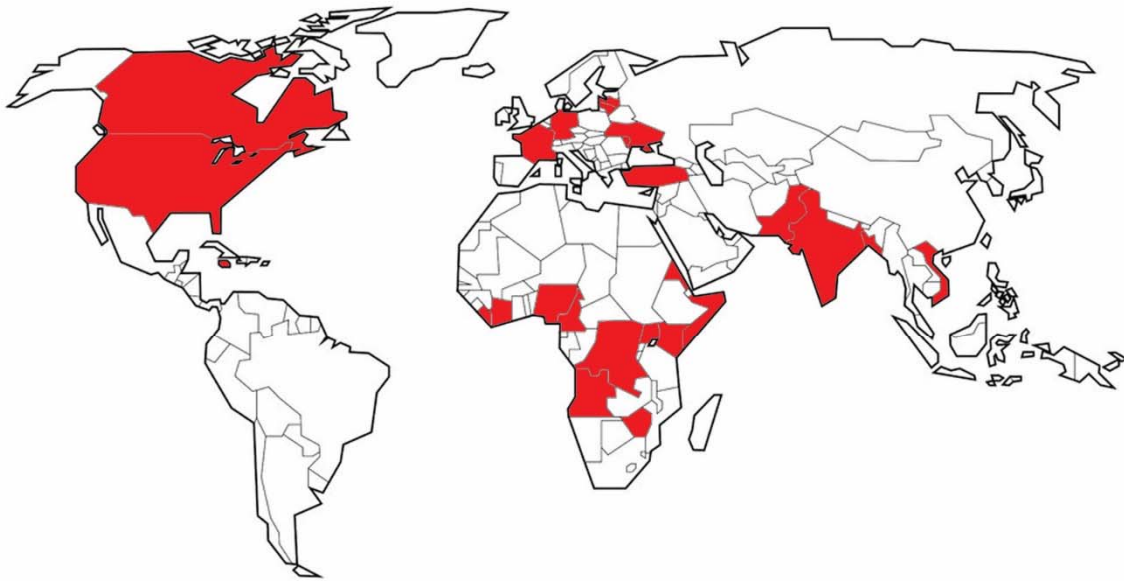
- 32 were male and only 3 (9%) were female. This reflects the gender breakdown of the detained population where roughly 15% of those detained are women.
- The oldest person to die in immigration detention was 84 years old whilst the youngest was 18, with an average age of 38.
- There was great variety in how long the deceased had been detained under immigration powers prior to their death. The shortest had been in detention less than a day before taking his own life. Whilst the longest had been held for 716 days (or 1 year, 11 months and 16 days).
- Those who died came from all over the world (see map below) and roughly match the demographic profile of the detained population in general. Exceptions to this is a slightly higher number of deaths in Angolans and Ukrainians than would have been expected as these only make up 0.2% and 0.8% of the detained population respectively. Conversely, fewer Indians died (only 2.9% of the dead) despite this nationality constituting 9.8% of the detained population.

<sup>25</sup> Mona Arshi, Liberty lawyer for the Grabys family in April 2003 on <https://www.liberty-human-rights.org.uk/news/press-releases/official-investigation-condemns-care-suicidal-asylum-detainee>

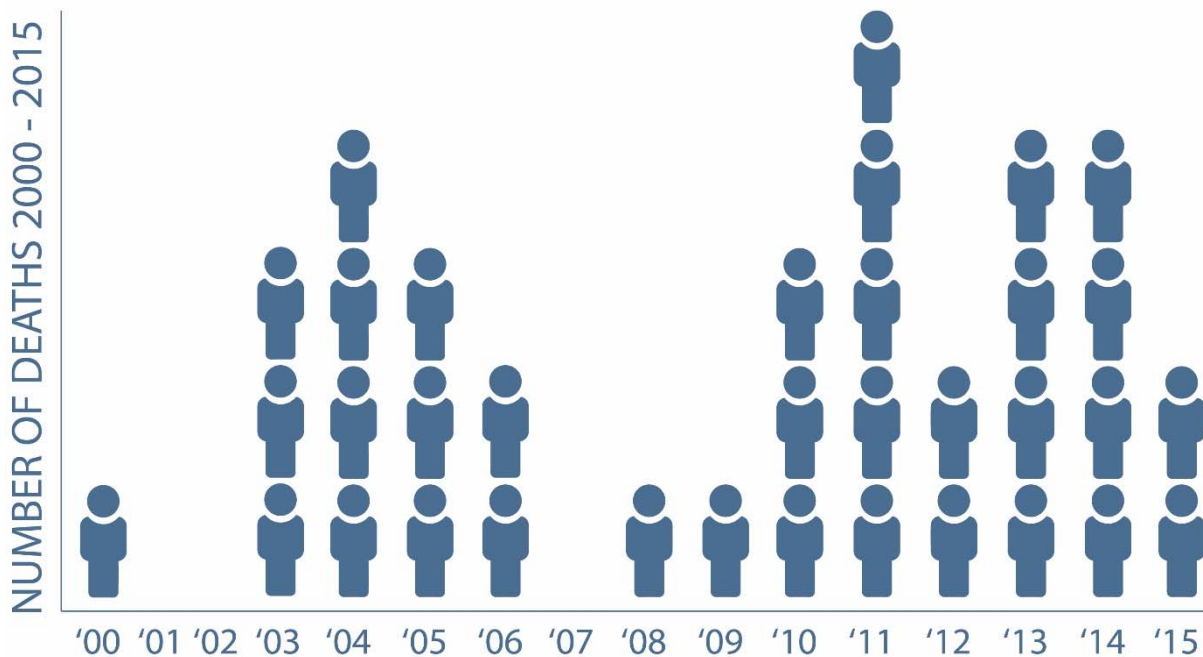
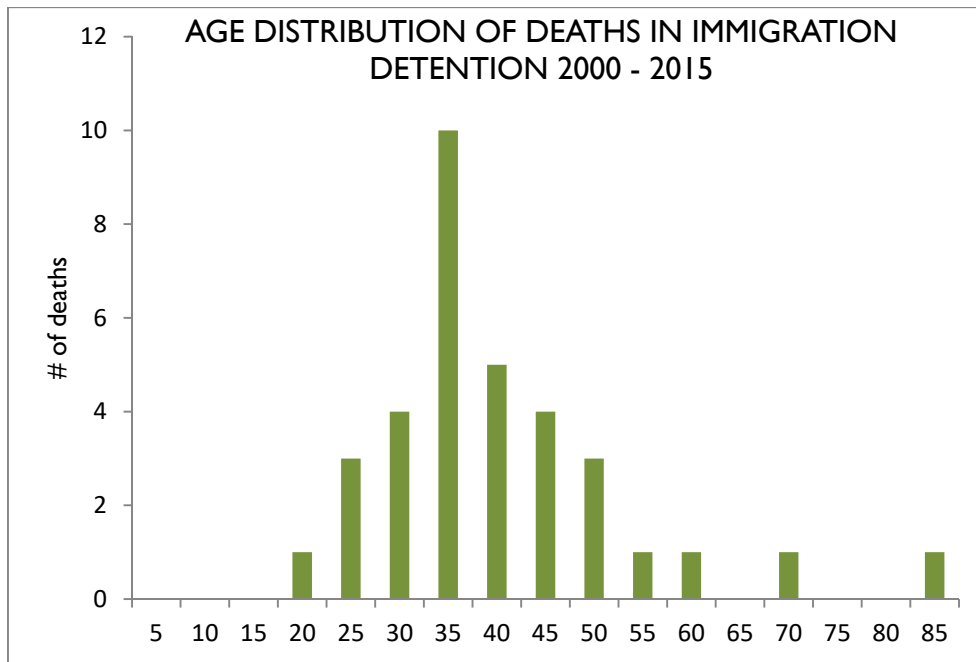
- Of those who died whilst detained under immigration powers 22 died in Immigration Removal Centres, 7 died in prisons, 1 died in a Short Term Holding Facility, 1 died aboard an airplane during a removal attempt. 4 died post release into the community of which 2 were released whilst in the hospital.

It is likely that there are more deaths in recently released detainees that we are not aware of. Deaths in this group is not monitored. Out of the 4 deaths we are aware of the PPO only used their discretion to investigate two of these deaths, one which happened 5 weeks after release from immigration detention. The other 2 were not investigated due to resource restrictions despite being released very shortly prior to death, in fact, one of the dead was only released from detention whilst he was unconscious and being admitted to the intensive care unit a mere 5 hours before he died.

DEATHS IN IMMIGRATION DETENTION BY COUNTRY OF ORIGIN 2000 - 2015



Angolan	3	American	1	French	1	Kenyan	1	Nigerian	1	Vietnamese	1
Pakistani	3	Cameroonian	1	German	1	Latvian	1	Somalian	1	Zimbabwean	1
Ukrainian	3	Canadian	1	Ghanaian	1	Liberian	1	Turkish	1		
Bangladeshi	2	DR Congolese	1	Indian	1	Lithuanian	1	Turkish (Kurdish)	1		
Unknown	2	Eritrean	1	Jamaican	1	Moldovan	1	Ugandan	1		



### cause of death

Death from natural causes and illness are part of life. Home Office policy stipulates that those suffering from serious physical and mental health issues that cannot be satisfactorily managed in detention should not be detained. Yet, the majority of deaths involve just such cases (summarised in Table 1). Locking people up in detention centres without meaningful judicial oversight is unnecessary and by avoiding this practice we could avoid the majority of deaths inside detention.

In detention, as in prisons, the most common cause of death is self-inflicted. The average age of those who died in detention between 2000 and 2015 was 38, with nearly 90% under the age of 50. Heart attacks were the cause of death in as many as 1 in 5; there were 3 sudden and currently unexplained deaths; 2 dying from TB and others dying from a wide range of natural illnesses. There were two deaths where the PPO found that neglect contributed to the death and one where the Coroner’s Court returned a verdict of ‘unlawful killing’.

*Table 1: overview of causes of death in detention 2000 - 2015 where cause known (n=35)*

Cause of death	Number (%)	Age range/mean
Self-inflicted	13 (36%)	18-49, mean age: 30
Heart attack	7 (20%)	33-84, mean age: 51
Violence (unlawful killing/murder)	2 (6%)	29-46, mean age: 37
Sudden unexplained death	3 (9%)	31-39, mean age: 35
TB	2 (6%)	32-40, mean age: 36
All others (pulmonary embolism, epilepsy, rheumatic valve disease, ruptured aortic aneurysm, liver cancer, septicemia, AIDS, neurosarcooidosis)	8 (23%)	31-69, mean age: 42

## self-inflicted deaths

Thirteen (36%) of the deaths in detention were self-inflicted, most were the direct or indirect result of hanging, using shoe or boot laces, bed sheets, belts or electric flex. It is not feasible or appropriate to remove all ligature risks<sup>26</sup> from all detainees. Detainees should be held in as unrestrictive an environment as possible<sup>27</sup>. The high rate of self-inflicted deaths reflects the high rates of mental despair among immigration detainees caught in a system which is difficult to understand and seen as unjust. It is not a question of improving the management of vulnerable people but to ensure they are released to avoid unnecessary deaths.

*“Whereas prisoners are statistically less likely to kill themselves as they move through their sentence, the opposite may be true for detainees. The fact of detention itself, and the very real prospect of being returned somewhere they do not wish to go, are inherently stressful. In the man in question’s case, these strains may have manifest themselves in a range of physical symptoms. It is important, therefore, that the question of self-harm and suicide risk be kept under review throughout the period of detention”*

*(PPO Ramazan Kumluca report)*

Many of those who took their own lives suffered from mental illness but knowledge of this mental illness and other risk factors was not necessarily passed on between organisations. In addition, detention often represented an interruption in the continuity of mental health care which should have been ongoing (eg for Riluwano Balogan). For about a third (30%) the risk of self-harm and suicide had been previously recognised yet these had not been picked up nor acted upon within detention. Sergey Baranyuk, Kenny Peter, Bereket Yohannes and Riluwano

<sup>26</sup> <http://www.ppo.gov.uk/wp-content/ReddotImportContent/A050.05-Death-of-a-male-Immigration-Service-detainee1.pdf#view=FitH>

<sup>27</sup> [http://www.legislation.gov.uk/uksi/2001/238/pdfs/uksi\\_20010238\\_en.pdf](http://www.legislation.gov.uk/uksi/2001/238/pdfs/uksi_20010238_en.pdf)

Balogan's previous self-harm incidents were a matter of record. Despite such clearly recognised risk, they were still kept in detention.

A minority had also been put on plans for enhanced surveillance of suicide risk (Assessment Care in Detention and Teamwork (ACDT), or Assessment Care in Custody Team (ACCT) for those held in prison) – *see box below*. In one case (Riluwanu Balogan) the ACDT had recently been closed and a new one opened in the run up to his death, whilst in another case (Kenny Peter) the risk had been downgraded prior to the detainee taking his own life. The current ACDT process seems haphazard and inconsistently applied, is led by custody staff with frequently changing team members, meaning continuity of care and oversight is lost. The ACDT monitoring often runs in parallel rather than intertwined with other monitoring such as by healthcare. According to Home Office policy healthcare personnel ought to play an integral part in ACDT procedures, however this often fails to happen. More needs to be done within detention to recognise signs of ongoing and future self-harm as well as around sensitivity to issues, such as room sharing. There was a wide range in the duration of detention under immigration powers for those who took their own lives. For some, like Trang Quang Tung and Manuel Bravo, the stresses proved overwhelming within the first days of detention. For others, it was the frustration of long detention (longest 135 days) without meaningful review and with no end in sight which was finally too much (Sergey Baranyuk and Ramazan Kumluca).

Greater integration between immigration, custody and healthcare staff may help prevent some self-inflicted deaths. Knowledge of provoking factors within the immigration process may well assist healthcare and custody staff to be more vigilant at times of increased stress such as when a detainee is served with notice of removal back to a country they may have fled in fear or when a prisoner is told they will not be released from prison but rather continue to be detained indeterminately under immigration powers. Healthcare staff are usually not informed of the progress of the immigration case, so are unable to provide extra support at times of added stress, such as the serving of removal directions (RDs) (e.g. for Riluwanu Balogan and Rubel Ahmed). Frequently changing staff and lack of follow up led to a situation where, following the death of Rubel Ahmed, it emerged that no one knew much about him and none of the staff knew him well enough to identify the body. This is despite him having spent more than a month (46 days) at Morton Hall.

**Recommendation 2:**

When an enhanced risk of self-harm has been recognised an ACDT process must be instigated. This must be linked to the decision to detain, must include the involvement of healthcare personnel, must be effective and must adequately protect vulnerable people.

**Assessment Care in Detention Teamwork (ACDT)**

ACDT is a system used for monitoring detainees considered to be at risk of self harm, is operated across the detention estate and is modelled on that used in prisons where it is called Assessment Care in Custody Teamwork (ACCT). Detainees who are distressed, who are self-harming, or who have suicidal thoughts, are monitored and managed on ACDT plans by custody officers rather than healthcare staff. Healthcare staff often do not partake in the ACDT process and, thus, cannot make the connection between self-harm/suicidal intentions and other symptoms. ACDT can involve people being placed on periodic or constant watch by guards. There is evidence that ACDT does not catch all those at risk and that the process itself is seen as invasive and damaging to its intended audience.

**Manuel Bravo** hanged himself in a stairwell at Yarl's Wood IRC during his first night in detention. It was the day of his 35th birthday and the day of his planned deportation back to Angola. The inquest into his death criticized failings in the immigration process which had left Mr Bravo representing himself during his appeal.

Following the dismissal of his appeal Mr Bravo saw no other option than to take his own life. He left behind a note stating: *"I kill myself because I don't have a life to live anymore. I want my son Antonio to stay in the UK to continue his studies"*.

**Kenny Peter** was an African asylum seeker who died in Charing Cross Hospital nearly three weeks after jumping from a second-floor landing in a self-harm attempt at Colnbrook. He had a previous history of mental illness and had spent time in a psychiatric hospital after seeking asylum in the UK.

He was detained at Colnbrook IRC and told healthcare about his ongoing mental health problems and the anti-depressants he was taking during the initial health screening. The medication he brought with him was confiscated on arrival and he was told he would see the doctor the next day who could prescribe new medication. In fact, it took 11 days until Mr Peter was seen by a doctor who prescribed antidepressants for him. Sudden interruption of this kind of medication is known to cause mood swings and in the 11 days he went without medication Mr Peter expressed suicidal ideations and was placed on ACDT. Doctors in detention repeatedly indicated that he should be assessed by a psychiatrist but this was not followed up. There was no mention of his previous stay in psychiatric hospital or of his being placed on ACDT in his medical notes.

On the 12th of October Mr Peter attempted to take his own life by jumping from a landing with a ligature around his neck. Again a note was made for him to receive a psychiatric assessment, in total this recommendation was made on six separate occasions but never acted on. On 7 November 2004, Mr Peter hanged himself from the second floor landing from a sheet fashioned into a noose. He survived the initial attempt but died from his injuries three weeks later in hospital. The inquest following his death identified a number of deficiencies, failures and missed opportunities in his care.

**Mr Rubel Ahmed**, a young Bangladeshi man, took his own life in Morton Hall IRC shortly after being served with removal directions. The inquest into his death returned an 'open verdict' noting that *"[w]e the jury believe that the fact that Mr Ahmed received his removal directions on the 30th August 2014 reinforced by the fax Mr Ahmed's solicitors sent on the 5th September 2014 to the National Removal Command Centre contributed and caused Mr Ahmed to take the actions he did on the evening of the 5th September 2014 between 20.30 and 23.28 hours. We agree that various factors contributed to the death of Mr Ahmed such as inadequate levels of communication between multi-disciplinary teams surrounding Mr Ahmed from the time of him being served his removal directions."*

During the inquest it emerged that none of the guards knew Mr Ahmed by sight and were thus unable to provide a positive identification of his body. There were also severe shortcomings in the notification of Mr Ahmed's family who were only informed of his death after a fellow detainee contacted Mr Ahmed's solicitor who in turn contacted the family.

# failures of the immigration processes

*“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.”*

(PPO investigation into death of Sergey Baranyuk)

According to Home Office policy detention is meant to be reserved for exceptional circumstances for the shortest possible time. All other immigration cases should be processed in the community under the presumption of liberty. The decision to detain is taken by a civil servant at the Home Office without the involvement of a judge or meaningful judicial oversight over the process. In addition, the safeguards that exist to ensure that vulnerable individuals are not detained, or those who become vulnerable in detention, are identified and released (such as Rule 35 of the Detention Centre Rules) have been demonstrated not to work as intended<sup>28</sup>. This means that vulnerable migrants are often inappropriately detained for administrative convenience. Sometimes these vulnerable migrants die unnecessarily in detention.

Many of the systemic failings identified by investigations into deaths in detention relate to the handling of the immigration case and the immigration process itself. The immigration process is confusing and pretty incomprehensible even to those with English as their first language. It is especially difficult for those who are mentally ill or otherwise lack the mental capacity to fully understand what is being expected of them.

## inappropriate detention

The deaths identified in this report demonstrate how detention is being used routinely without proper justification. The majority of those who died locked up in immigration detention could have had their immigration claims processed in the community. For those who had completed a prison sentence and were detained under immigration powers after the completion of their sentence, if deportation was not arranged during the time in prison, the chance of early deportation afterwards must be slight, hence logic (but not the current practice) is this should be done with the now ex foreign national offender (FNO) in the community.

The complex and potentially unintelligible immigration processes were sometimes recorded as provoking factors in PPO investigations. In relation to Sergey Baranyuk, a man who had indicated he wanted to return to his own country, the PPO reported that he may simply have felt *‘lost in the system’*. Similar comments on the incomprehensibility of some of the immigration processes and how these could adversely impact on vulnerable detainees were also made by the PPO in relation to Manual Bravo, Kenny Peter and Bereket Yohannes.

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<sup>28</sup> [http://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Admin/2014/2245.html&query=\(EWHC\)+AND+\(2245\)](http://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Admin/2014/2245.html&query=(EWHC)+AND+(2245))

When it comes to immigration detainees one of the most salient questions is ‘why is this person in immigration detention in the first place?’ Though some of the investigations may comment on the institutional and immigration context it is not within the remit of the PPO or coroner to investigate the decision to detain or maintain detention specifically. Though some of the investigations, such as the investigation into the death of Sergey Baranyuk, comment on these issues.

Not all deaths are avoidable but, as immigration detention is optional, all deaths in detention should be avoidable. So, why then do people die in detention? If they were vulnerable, why was this not discovered? And if discovered, why did the safeguards not ensure they were released from detention? Some of those who died spent a very long time detained under immigration powers yet this was not addressed in most of the investigations. This is particularly true of sentence-served foreign national prisoners.

- **Reza Ramazani** died suddenly on the 23<sup>rd</sup> of April 2010, following exercise at HMP Nottingham. The report into his death neglects to engage with his immigration situation at all, to the extent that we do not even know his country of origin. It makes a brief note that he finished serving his sentence in 2008 but does not question why he has been detained under immigration powers for over 18 months after time served, or if there was any realistic prospect of removal.
- **Richard Abeson** was remanded into custody in October 2008 and due for release on the 27<sup>th</sup> of July 2009. He was a frail 69 year old man with mobility issues and in July 2009 his health started deteriorating significantly. After finishing his sentence he was held in prison detained under immigration powers whilst his health slowly deteriorated until his death on the 23<sup>st</sup> of August 2009. He did not have an immigration solicitor so was ill equipped to challenge his continued detention. The clinical reviewer notes there was no follow up of abnormal test results by the prison doctor between December 2008 and July 2009 but as this inadequate care is not considered to have contributed directly to his death it is given little consideration. His death from liver cancer may not have been avoidable but he needn't have died an immigration detainee. During his hospital stay he was restrained with an escort chain until the point when resuscitation attempts were started, despite the fact that he was so frail he walked with the aid of a walking frame. Nowhere in the PPO investigation is his continued detention questioned or even discussed. So absent is any consideration of his immigration status from the report that we do not even know his country of origin.
- **Bruno Dos Santos** was held for over 8 months under immigration powers before his death. **Mohamoud Ali** was held for almost two years under immigration powers, longer than his initial sentence. Both missed vital medical appointments whilst detained due to a lack of escort staff or being transferred between institutions. Neither investigation looks at whether there was a realistic prospect of removal or whether there were alternatives to continued detention.
- The investigation into the death of **a Zimbabwean man** released from Colnbrook where he had been held for more than 2 years under immigration powers notes that the political situation in Zimbabwe meant that he could not be removed. He was eventually granted bail by the courts and died 5 weeks later in the community. The report does not comment on the length of detention prior to being granted bail.
- **Riluwan Balogan** was only 21 years old when he died and the investigation into his death notes that it is *“undesirable for people to remain in prison beyond their normal release date whilst awaiting removal from the country”* but goes on to comment that it is not within the office's remit to comment on deportation decisions, however, it was clear that *“he was very upset about the prospect of going to an unfamiliar country where he had no family or friends, no connections or attachment, and of which he had few memories.”*



## failing or missing safeguards

Rule 35 of the Detention Centre Rules, is intended as a key safeguard for those who have been subject to torture or whose health is likely to be injuriously affected by continued detention – *see box below*. There is evidence among these cases, as seen so often in other cases helped by Medical Justice, that Rule 35 reports are ignored and detention continues in those who should have been regarded as unfit to detain<sup>29</sup>. The failings of this system has been repeatedly highlighted by NGOs and official inspectorates. Stephen Shaw's *'Review of Vulnerable People in Detention'* concluded that *"rule 35 does not do what it is intended to do – to protect vulnerable people who find themselves in detention – and that the fundamental problem is a lack of trust placed in GPs to provide independent advice."*<sup>30</sup> The current system for assessing those covered by Enforcement Instruction and Guidance 55.10 (*see box below*) fails the physically and mentally ill, just as it does the pregnant and those who have been tortured (Rule 35(3))<sup>31</sup>. The especially vulnerable should not be detained yet this happens again and again<sup>32</sup>.

Even when safeguarding mechanisms have been activated, this is not enough. In the case of Alois Dvorzac (*see box on page 33*) the doctor had submitted a Rule 35 report and everyone involved in the case considered that he should not be in detention. Despite this, detention was maintained and Mr Dvorzac died in hospital a few days later whilst handcuffed to a guard.

Others, such as Brian Dalrymple and Mr C, were not identified as unfit for detention so no Rule 35 report was completed for them despite compelling evidence that they were being injuriously affected by detention.

### **Recommendation 3:**

The Home Office must operate on the assumption that indefinite detention under immigration powers is intrinsically harmful to mental health.

### **Recommendation 4:**

Effective safeguards must be in place to ensure vulnerable people are not detained and that those who become vulnerable in detention are identified and released.

### **Detention Centre Rules - Rule 35**

The purpose of Rule 35 is to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. A Rule 35 report must be completed by a doctor after seeing someone: (1) whose health is likely to be injuriously affected by continued detention or any conditions of detention; (2) they suspect of having suicidal intentions ; (3) they are concerned may have been the victim of torture. The Rule 35 report is then submitted to the Home Office caseworker who must review and respond within a set time frame.

### **Enforcement Instruction and Guidance 55.10**

This guidance stipulates that certain persons, such as pregnant women, victims of torture and those suffering from serious physical or mental illness "are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration accommodation or prisons"

<sup>29</sup> Pickles H Fitness to Detain in those held under immigration powers in the UK and rule 35(1) PSJ 2015 220 43-48

<sup>30</sup> Review into the Welfare in Detention of Vulnerable Persons A report to the Home Office by Stephen Shaw 2015 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/490782/52532\\_Shaw\\_Review\\_Accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf)

<sup>31</sup> Medical Justice, *The Second Torture: The immigration detention of torture survivors*. Medical Justice. <http://www.medicaljustice.org.uk/wp-content/uploads/2016/03/the-second-torture-full-version.pdf> 2012 & *Expecting Change: the case for ending the detention of pregnant women* <http://www.medicaljustice.org.uk/wp-content/uploads/2016/03/expectingchange.pdf> 2013

<sup>32</sup> Home Office. Review into the welfare in detention of vulnerable persons: chaired by Stephen Shaw Cm9186 Sept 2015 published 14 Jan 2016 on [www.gov.uk/government/publications](http://www.gov.uk/government/publications)

# failures of custody and escort providers

In addition to the systemic failings that exist around decisions to place vulnerable migrants in immigration detention and the shortcomings in handling of individual immigration cases, the deaths also highlight poor practice by custody providers and staff. The provision of immigration detention is commissioned by the Home Office who have contracted private companies such as G4S, Serco, Tascor and Mitie to run detention centres across the UK and to act as escorts in removals and deportations. Many of the deaths highlight shortcomings in this provision.

## restraints

There is a systemic overreliance on the use of restraints during removal and during appointments outside of detention centres. All use of restraints should only happen in response to a thorough risk assessment yet this is often missing or inadequate<sup>33</sup>. Immigration detainees are not held as part of a criminal sentence and rarely present a risk of escape or a risk to others. The PPO and the HMIP have repeatedly made adverse comments about unnecessary use of restraints.

Alois Dvorzac and Mr C both spent their final hours of life in handcuffs despite being incapacitated and not posing a risk to themselves or others. Mr C was chained to guards throughout his 1 week stay in hospital including when he was having x rays and when undergoing an angioplasty (an operation where catheters are inserted into the heart). This was clearly *“inappropriate as it may impede the ability of the hospital staff to provide medical care”*<sup>34</sup>. Reviewing the cases HMIP concluded that *“a lack of intelligent individual risk assessment had meant that most detainees were handcuffed on escort and on at least two occasions, elderly, vulnerable and incapacitated detainees, one of whom was terminally ill, were needlessly handcuffed in an excessive and unacceptable manner. These men were so ill that one died shortly after his handcuffs were removed and the other, an 84 year-old-man, died while still in restraints. These are shocking cases where a sense of humanity was lost”*<sup>35</sup>.

***“[i]t is a tragic indictment of the system that such a frail and vulnerable man should have spent his final days in prison-like conditions of an immigration removal centre (...) It is particularly shameful that he should have spent his last hours chained to a custody officer without justification (...) We consider it wholly unacceptable for anyone to die in restraints”***

- ***PPO report on death of Alois Dvorzac***

At the inquest into Mr Dvorzac’s death escort providers testified that the issues with excessive use of restraints had been resolved and the court concluded the issue had been adequately addressed through the issuing of a new DSO on the use of restraints. However, HMIP continues to criticise the use of handcuffs even after the issuing of this DSO. There is anecdotal evidence that the use of restraints is increasing in some centres<sup>36</sup> and a concern that the use may become more prevalent following a recent escape<sup>37</sup>. This may be because escorts are penalised

<sup>33</sup> Pickles H, Norton E, Ginn E, Schleicher T. Physical Restraint and the protection of the human rights of immigration detainees in hospital *Clinical Medicine* 2015;4:334-6

<sup>34</sup> Home Office Professional Standards Unit (PSU) report on investigation into his death

<sup>35</sup> <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/harmondsworth-2014.pdf>

<sup>36</sup> IMB Annual Report Yarl’s Wood 2015 <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2015/08/Yarls-Wood-web-20151.pdf> and National Audit Office Yarl’s Wood Immigration Removal Centre <https://www.nao.org.uk/wp-content/uploads/2016/07/Yarls-Wood-Immigration-Removal-Centre.pdf>

<sup>37</sup> IMB Annual Report 2015 – Heathrow IRCs <http://www.imb.org.uk/wp-content/uploads/2016/05/Heathrow-IRC-2015.pdf>

£10,000 if someone absconds and they do not wish to take the risk, regardless of Home Office policy on the use of restraints.

Most disturbingly, the excessive use of restraints led to the death of Jimmy Mubenga during a removal attempt (see box below). So excessive was the use of restraints that the coroner ruled the death an unlawful killing at the hands of the escorts.

**Recommendation 5:**

There should be a presumption against the use of restraints during medical treatment and external hospital appointments. Restraints should only be applied in response to a thorough risk assessment. Current risk assessments are inadequate and do not prevent inappropriate use of restraints.

**Recommendation 6:**

NHS staff must be aware of BMA guidelines on handcuffing in consultation.

## inappropriate use of segregation

Segregation is one of the most severe and dangerous sanctions that can be imposed on detainees and its devastating impact on mental and physical health is widely recognised<sup>38</sup>. Medical Justice's research report "*A Secret Punishment*"<sup>39</sup> found that every year between 1200 and 4800 detainees are segregated in IRCs. Segregation is misused as a form of punishment, used to manage detainees with mental illness or those at risk of self-harm. The use of segregation to manage these vulnerable individuals is a response to confrontational behaviours which are often rooted in on-going and untreated mental illness. Segregation is an entirely unsuitable environment for detainees in crisis and only serves to compound mental health issues. Some are held in segregation for months or repeatedly segregated as their conditions are allowed to deteriorate in detention. At least two of the recent deaths had spent time in segregation prior to their death – schizophrenic Brian Dalrymple died alone in a single cell and the circumstances around Prince Ofosu's death are still unclear (see box on page 26).

**Recommendation 7:**

The use of segregation in immigration detention is disproportionately retributory for a low risk population detained for administrative purposes. Segregation is inappropriate in immigration detention and the Detention Centre rules should be amended to reflect this fact.

<sup>38</sup> S Shalev, *A Sourcebook on Solitary Confinement*. London: Mannheim Centre for Criminology, London School of Economics. Available online at: [www.solitaryconfinement.org/sourcebook](http://www.solitaryconfinement.org/sourcebook). 2008.

<sup>39</sup> 'A Secret Punishment' - The misuse of segregation in immigration detention. Medical Justice 2015. <http://www.medicaljustice.org.uk/images/stories/reports/SecretPunishment.pdf>

## poor notification practice

After a death, serious criticisms are frequently levied at the Home Office and providers around how deaths are communicated to the bereaved families. There are repeated calls from the PPO and coroners for better information for families, with trained family liaison officers. The PPO have repeatedly called for a more secure system for recording the next of kin or alternative emergency contact details. Yet, again and again, this information is missing.

- Following the death of **Mohamoud Ali** the family of another prisoner with a similar name was notified of the death to great distress for the 'wrong' family as well as delay in notification of his actual family.
- Even when the family themselves have contacted the Home Office or the centre they have been turned away. **Rubel Ahmed's** family learnt of his death from other detainees contacting his solicitor. When they contacted Morton Hall IRC they were told to get in touch with the Home Office Press Office but got only an answer machine. **Trang Quang Tung's** partner was only informed of his death after 24 hours despite calling Dungavel IRC to inquire about him shortly after his death.
- For many of the deceased next of kin information had not been properly collected thus causing a delay in the notification of the families. This was the case following the death of **Kabeya Dimuka-Bijoux** and **Ramazan Kumluca** in 2005, **Oleksiy Baronovsky** in 2006, **Eliud Nyenze** in 2010, **Ianos Dragutan** and **Gonzales Jorite** in 2011 and **Tahir Mehmood** in 2013. Clearly practices are not improving.
- **Ramazan Kumluca's** next of kin had to be deduced from entries in the visitor's book.
- IRC staff could not track **Kabeya Dimuka-Bijoux's** family to notify and his brother was finally contacted by PPO staff who managed to track him down via a friend who had visited.
- **Eliud Nyenze's** family were never notified and had to learn about his death by reading about it on the internet.
- The absence of next of kin information caused delay in notification, in the case of **Oleksiy Baronovsky** and **Gonzales Jorite** their families were not notified until months later.

Even when contact information is available, or finally traced, there have been numerous inconsistencies in notification procedures. Tahir Mehmood's family (see box below) were notified by a Customer Service employee at Manchester Airport since he happened to speak the same language. Ramazan Kumluca's family was contacted by the IRC Imam and with Manuel Bravo there was general confusion over who should contact his wife. According to Home Office policy all death notifications should be carried out by the police.

## poor aftercare and support for detainees

A death in detention is a trauma not only to the deceased and their family but also to the other detainees at the facility. Deaths and rumours of deaths have an enormous impact on other detainees, causing fear, anger and distress. However, there is frequently inadequate attention given to the wellbeing of other detainees or to putting in place adequate support to ensure that all detainees are properly cared for following a death.

Rumours of neglect by custody or healthcare staff are common, for example seen after Eliud Nyenze's death at Oakington, Muhammed Shukat's at Colnbrook, Christine Case at Yarls Wood and Rubel Ahmed's death at Morton Hall. This can then lead on to protests like hunger strike (after Pinakin Patel's death at Yarls Wood) other disturbances (eg after Eliud Nyenze's death at Oakington) or even a full riot (after Sergey Baranyuk's death at Harmondsworth)<sup>40</sup>. Fear of such disruption may lead to lock down in the facility, which itself leads to disruption of the normal processes for other detainees' access to health and legal advice and visits from family.

Some individuals, such as Muhammed Shukat's roommate, suffered severe trauma from being witness to the death of Muhammed Shukat following neglect by IRC staff (see box on page 36). Yet he was placed in a single cell in the austere 'Assessment and Integration Unit' and segregated from other detainees who may have been able to offer support. The lack of information and general distrust within immigration detention encourages the spreading of rumours and half-truths about a death. This speculation has extended to the death having resulted from the brutality of guards, as with Prince Ofofu. His death is currently with the CPS following a criminal investigation. Detainees are left locked up with little support perhaps fearing for their own safety.

**Recommendation 8:**

Coordinated action is needed to ensure that fellow detainees are appropriately supported following a death in detention.

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<sup>40</sup> Whalley R 2007. Report of the Investigation into the disturbances at Harmondsworth and Campsfield House Immigration Removal Centres

**Jimmy Mubenga**, a father of five, had been living in the UK legally for 17 years and had 5 British children. He was convicted of a crime and after serving his sentence was told he would be deported back to Angola. He died of positional asphyxia during his deportation from Heathrow Airport.

Mr Mubenga is alleged to have become violent in the aircraft, and three G4S guards restrained him in his seat in a manoeuvre dubbed 'carpet karaoke'. Witnesses heard Mr Mubenga crying out '*I can't breathe*' and '*They are killing me*', before he died. An inquest jury in 2013 found that he was unlawfully killed as a result of the use of unreasonable force. It later emerged that the three G4S guards had been exchanging racist text messages. The finding of the inquest and the existence of the racist text messages was withheld from the jury during the criminal proceedings and all three guards were acquitted of the charge of manslaughter.

**Prince Ofosu** died whilst detained at Harmondsworth. The pathologist was unable to find a cause of death and determined the death a case of Sudden Adult Death Syndrome. During the investigation other detainees at the centre reported that Prince Ofosu had been forcibly restrained by guards and taken to the segregation unit. Other detainees at the centre report that he was held in segregation, naked, without heating and without blankets. Due to the seriousness of the allegations made during the investigation of the case the death has been referred to the Crown Prosecution Services who are currently determining whether or not to bring criminal charges. An inquest into the death had not been carried out and is pending the decision of the CPS.

**Tahir Mehmood** was found dead in Pennine House, a short term holding facility, and a post-mortem found he died from ischaemic heart disease. Mr Mehmood complained of pain in his shoulder and chest. Despite the fact that Mr Mehmood spoke little or no English no professional interpreter was used so we cannot be sure an accurate account of his symptoms was obtained. No efforts were made to obtain his GP records and the medical examination was not properly recorded. He was examined by a nurse who found that he had low blood pressure and told him to get some rest in his cell. She did not contact a GP for a second opinion or consider transfer to hospital. Shortly after he returned to his cell his breathing became laboured. His cellmate, being concerned about his state, called for help. Custodial staff found Mr Mehmood unresponsive and called the nurse who attended but did not bring emergency equipment with her. The PPO report criticises the emergency response, stating there were delays in calling an ambulance and delays due to not bringing emergency equipment when attending the call.

At the time of detention no next-of-kin information was collected and PPO found that initial contact with his family was not handled sensitively. Instead of following protocol staff at Pennine House asked an employee from Manchester Airport to inform his family by telephone.

# failures in healthcare

## systemic failures

Medical Justice has seen hundreds of cases where failing healthcare provision in IRCs causes harm to some of the most vulnerable detainees. Many detainees, because of past or present trauma, have complex health needs and find it difficult to access healthcare and this is exacerbated by short consultations, late screenings, poor use of interpreters, poor clinical assessments, and lack of adherence to clinical protocols. The last few years have seen 5 High Court rulings of ‘inhuman and degrading’ treatment of detainees and the recent All Party Parliamentary Group Inquiry into detention found that *“[a]ccess to necessary treatments is frequently delayed or not available, and the screening process at the beginning of a period of detention does not allow for health conditions to be identified (...) following the initial assessment, on-going healthcare, particularly relating to mental health, was inadequate and inappropriate.”*<sup>41</sup>

Healthcare provisions within IRCs have been the cause of ‘significant concern’<sup>42</sup> for some time and the only themed HMIP report into healthcare at an IRC found that though *“basic healthcare provision was usually adequate for those detainees who stayed for only a short time(...) However, underpinning systems were inadequate and the healthcare service was not geared to meet the needs of those with serious health problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well being.”*<sup>43</sup>

Although the emphasis, rightly, should be on systemic failings as the root causes of deaths in detention, there have also been some prominent failings by individuals. Failures in safeguards, management and training allow individuals to fail. Despite frequent recommendations, a lack of willingness to take collective responsibility means that systems in place fail to catch these failures before they led to catastrophic consequences for individuals.

Healthcare failings identified in PPO reports cover a wide range of issues. Failings range from inadequate screening and medical care upon arrival in detention.

- **Sergey Baranyuk** who was not offered a doctor’s appointment within 24 hours of arrival in detention as stipulated by Rule 34 of the Detention Centre Rules.
- Inadequate follow on care which allowed **Kenny Peter** to go for 11 days without seeing a doctor and without his antidepressants.
- Though **Trang Quang Tung** spoke no English, there is no indication on the health screening form that an interpreter was used, indeed the person filling in the form indicated that he spoke Chinese when in fact he spoke Vietnamese.
- **Bruno Dos Santos** missed an MRI appointment, which could have led to early diagnosis and treatment, due to being transferred between institutions.

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<sup>41</sup> The Report of the Inquiry into the Use of Immigration Detention in the United Kingdom A Joint Inquiry by the All Party Parliamentary Group on Refugees & the All Party Parliamentary Group on Migration. 2015 <https://detentioninquiry.files.wordpress.com/2015/03/immigration-detention-inquiry-report.pdf>

<sup>42</sup> HMIP, *Report on an announced inspection of Harmondsworth Immigration Removal Centre 11–15 January 2010*, [http://www.justice.gov.uk/downloads/publications/inspectoratereports/hmipris/immigration-removal-centre-inspections/harmondsworth/Harmondsworth\\_2010\\_rps.pdf](http://www.justice.gov.uk/downloads/publications/inspectoratereports/hmipris/immigration-removal-centre-inspections/harmondsworth/Harmondsworth_2010_rps.pdf). 2010.

<sup>43</sup> HMIP, *Inquiry into the quality of healthcare at Yarls Wood Immigration Removal Centre (20-24 February 2006)* by HM Chief Inspector of Prisons.

[http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/yarls-wood/yarls\\_wood\\_inquiry\\_final-rps.pdf](http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/yarls-wood/yarls_wood_inquiry_final-rps.pdf). 2006.

- Due to a lack of escorts **Mohamoud Ali** missed at least 4 neurology appointments leading up to his death.
- In the most severe cases, such as with the death of **Muhammed Shukat** and **Brian Dalrymple**, where the coroner found healthcare failings so severe as to rule that *'neglect contributed to their death'*.
- The PPO investigation into the **death of a Cameroonian man** in 2005 noted that healthcare facilities and healthcare provision at the Short Term Holding Facility at Manchester Airport were lacking.

## inadequate clinical records

In some cases there was a failure to obtain or pass on clinical records which contributed to the death. Brian Dalrymple spent 6 weeks in detention clearly exhibiting signs of mental illness yet no one tried to obtain his previous medical records. For Riluwanu Balogan there was no communication between institutions and the fact that he had previously self-harmed was not communicated to HMYOI Glen Parva. The PPO found that *"There was also little continuity of care offered to help him, a clearly vulnerable and troubled young man, address his mental health needs."*<sup>44</sup>

The clinical reviewers concluded that Tahir Mehmood received *'[c]linical care below the standard expected in the community'*. He was treated by a nurse who failed to keep proper records and failed to recognise the significance of a very low blood pressure and pulse, nor did she recognise that he needed to go to hospital. Whilst Gonzales Jorite experienced delays in TB diagnosis and treatment as he went 3 days without proper examination by an IRC doctor. The doctor also failed to keep proper records of their basic observations.

## poor training

The deaths have shown up a chronic lack of training and supervision of healthcare staff in IRCs. During the inquest into the death of Brian Dalrymple it became clear that the doctor who treated him had not received any induction training and was unfamiliar with vital Home Office safeguards (such as Rule 35) and also testified that he was unfamiliar with the Mental Capacity Act. The screening nurse who saw Sergey Baranyuk had not received any induction training or training on recognising signs of torture. She clearly failed to understand the significance of the torture question on the screening form and explained that *"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."*

The PPO investigation into the death of Ramazan Kumluca notes that immigration officers had not received training in suicide awareness and that there was a lack of cultural awareness and understanding of the impact of detention. Whilst the clinical reviewer who examined the care Ianos Dragutan had received prior to death found that healthcare personnel lacked training in CPR and that as a result the *"...the actions taken by nursing staff to resuscitate him were seriously outside reasonable and acceptable practice"*.

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<sup>44</sup> <http://www.ppo.gov.uk/wp-content/uploads/2014/07/G038-11-death-of-a-male-prisoner-in-hospital-16-5-2011-Glen-Parva.pdf#view=FitH>



Following a death in detention the PPO investigation will work with the NHS to carry out a clinical review of healthcare leading up to the death. Substandard healthcare that fails to match that expected from the NHS for those in the community has been a frequent complaint. The recent transfer of commissioning responsibility to the NHS brought hope of improvement that has yet to be realised. In addition to fatal incidents like those covered in this report, there are also many 'near misses' which we do not hear about. If healthcare is involved, these should be regarded as Serious Untoward Incidents (SUIs) with a report expected for the NHS hierarchy. It is important any such SUI reports, and the clinical reviews undertaken after deaths, are considered together and for the detention estate as a whole. To get nearer NHS equivalence, lessons then need to be shared across the healthcare providers, with actions for improvement that are monitored.

**Recommendation 9:**

Healthcare for immigration detainees must be equivalent to that provided in the community. Where equivalent care cannot be ensured detainees must be released so they can access the care they need.

**Brian Dalrymple** died 6 weeks after first entering detention from a rupture aorta caused by elevated blood pressure. The coroner's inquest delivered a verdict of natural causes contributed to by neglect. This finding demonstrates that the jury considered that there were gross failures in the medical care that Brian Dalrymple received which ultimately contributed to his death and described the medical record keeping at the IRC as shambolic.

During the inquest Dr Ilsley, an expert cardiologist, testified that *"Brian's blood pressure had been "ridiculous" and in 30 years he had never seen one that high. It was a "medical emergency" requiring a degree of attention which was absent from the medical notes. Had Brian been treated as he should have been, and as he had been when such problems had arisen in the US, he would not have died. Four to five days of oral hypertensive medication – pills – would have prevented the death."*<sup>1</sup>

Despite his medical condition being life threatening Brian was left for 9 days without medical monitoring whilst his physical and mental health continued to deteriorate. *"Expert witness Dr Needham-Bennett, a psychiatrist, has told the jury that "there was a gap between 17 July and 27 July between Mr Dalrymple and healthcare at Harmondsworth and his blood pressure was known to be dangerously high. There was no contact, no monitoring, no persuading or cajoling him to take medication". Needham-Bennett agreed that this was a "lamentable failure"."*<sup>2</sup>

The inquest also heard that there was a general lack of training for medical staff and that the locum doctor who attended to him was unaware of Rule 35 (a vital safeguard) as well as the Mental Capacity Act. All in all the Jury set out a catalogue of errors which contributed to Brian's death: Inadequate healthcare; Lack of training for health personnel; lack of any computerised system for storing and accessing medical records; lack of access to and awareness of custody records such as ACDT by healthcare staff; Limited mental health awareness among staff; Lack of transfer of medical records or any attempt to trace previous records; Lack of psychiatric assessment. The jury concluded that neglect contributed to his death in detention.

<sup>1</sup> BlackletterPress, 2014. Inquest into US citizen's death in immigration custody finds neglect.  
<http://www.blackletterpr.co.uk/news/inquest-dalrymple-death-immigration-custody-finds-neglect/>

<sup>2</sup> Medical care in UK detention centre a 'lamentable failure': Brian Dalrymple inquest report, Phil Miller, Open Democracy, 26 June 2014,  
<https://www.opendemocracy.net/ourkingdom/phil-miller/medical-care-in-uk-detention-centre-lamentable-failure-brian-dalrymple-inquest>

## mental health

Mental health issues are common in detention despite Home Office guidelines stating that those “suffering from serious mental illness which cannot be satisfactorily managed within detention”<sup>45</sup> should only be considered suitable for detention in very exceptional circumstances. Research from across the world shows that migrants, due to pre and post migration stressors, have high rates of mental disorders<sup>46</sup>. Despite this increased need, the provisions for mental health care in IRCs is less than that offered in the community and there is little access to expert interventions or specialist therapeutic input required to treat conditions such as post traumatic stress disorder.<sup>47</sup>

Detention is particularly detrimental to those suffering from mental disorders<sup>48</sup>, sometimes to the point of requiring hospitalisation. Research demonstrates that the conditions of detention exacerbates symptoms of mental illness and that the harm increases with length of detention<sup>49</sup>. Distress and mental illness is widespread in immigration detention, with very high rates of depression<sup>50</sup>. Much of this mental illness goes unrecognised or poorly treated<sup>51</sup>. There is a general lack of awareness of mental health issues and a lack of training in recognising signs of mental illness among staff as can be seen in the death of Brian Dalrymple recounted below. Even when there is concern about someone’s mental health this cannot be adequately addressed in detention as it is not a therapeutic environment and those held are removed from their communities and usual support mechanisms. Safeguards intended to ensure that those whose health is likely to be injuriously affected by continued detention or any conditions of detention, Rule 35(1), are rarely used and often fail to lead to release from detention<sup>52</sup>.

Many of those who took their own lives were suffering from mental illness in addition to the stressors of detention. Other detainees who died from natural causes or where the cause of death has yet to be made public were also known to have had mental illness – e.g. Brian Dalrymple, Prince Ofosu and Amir Simon-Tov and one suffered from dementia (Alois Dvorzac). None of these are likely to have met the usual acceptance criteria for administrative detention and should therefore all have been released from detention. The PPO and others such as coroners have made recommendations in an attempt to help prevent such tragic deaths in the future.

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<sup>45</sup> HO, *Home Office Enforcement Instructions and Guidance. Version 10 (June 2014)* [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/307995/Chapter55.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307995/Chapter55.pdf)

<sup>46</sup> Sinnerbrink I, et al., *Compounding of premigration trauma and postmigration stress in asylum seekers* J Psych, 1997. 131: p. 463-70. & Porter M and Haslam N, *Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. A meta-analysis.* JAMA, 2005. 294(602-12).

<sup>47</sup> The Royal College of Psychiatrists Working Group on Asylum Position Statement on detention of people with mental disorders in Immigration Removal Centres <http://www.rcpsych.ac.uk/pdf/Satisfactory%20Treatment%20in%20Detention%20document%20December%202015%20edit.pdf>

<sup>48</sup> Robjant K, Hassan R, and Katona C, *Mental health implications of detaining asylum seekers: systematic review.* Br J Psychiatry, 2009. 194(4): p. 306-12

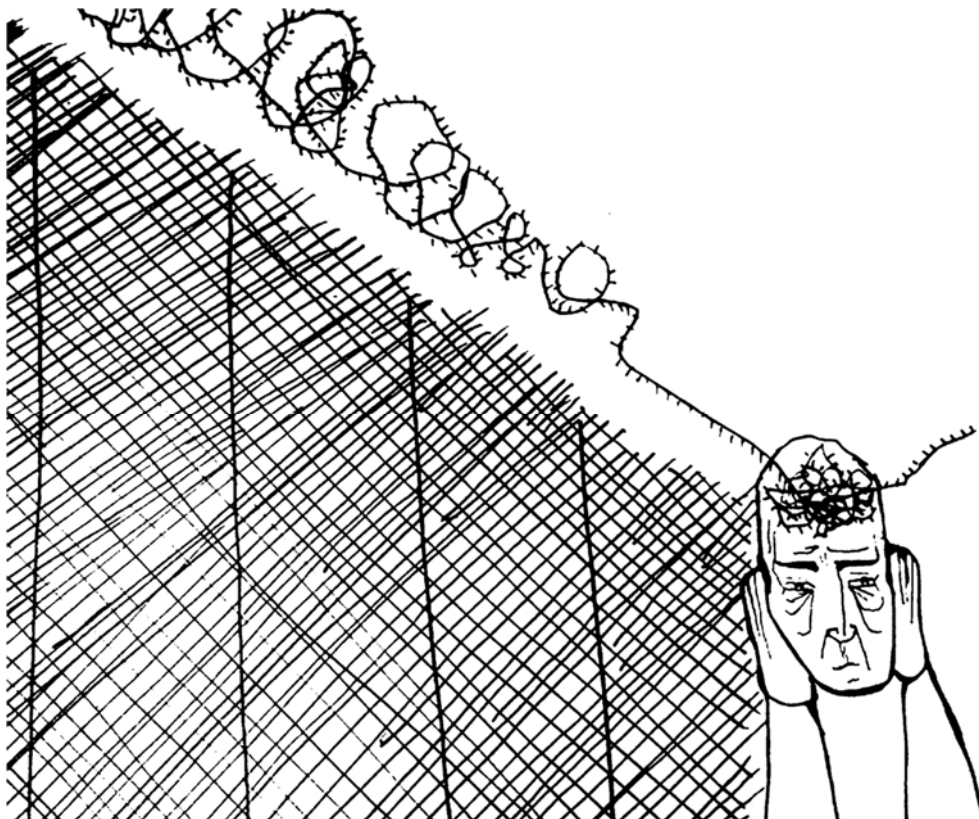
<sup>49</sup> Mary Bosworth 2015 The impact of immigration detention on mental health: a literature review. Annex 5 in the report on the Review into the Welfare in Detention of Vulnerable Persons, by Stephen Shaw Cm9186 Sept 2015 published 14 Jan 2016 on [www.gov.uk/government/publications](http://www.gov.uk/government/publications) & Mental Health in Immigration Detention Action Group interim report Dec 2013 on [www.medicaljustice.org.uk](http://www.medicaljustice.org.uk)

<sup>50</sup> Bosworth M and Kellezi B Developing a Measure of the Quality of Life in Detention. *PSJ* 2013;205:10-15 on [www.crimeandjustice.org.uk/opus1989/PSJ\\_January\\_2013\\_No.\\_205.pdf](http://www.crimeandjustice.org.uk/opus1989/PSJ_January_2013_No._205.pdf)

<sup>51</sup> Grant-Peterkin H, Schleicher T, Fazel M et al Inadequate mental healthcare in immigration removal centres. *BMJ* 2014;349:g6627

<sup>52</sup> Fitness to detain in those held under immigration Powers in the UK and rule 35(1) Dr Hilary Pickles, *Prison Service Journal*, July 2015 No 220, <https://www.crimeandjustice.org.uk/sites/crimeandjustice.org.uk/files/PSJ%20220%20July%202015.pdf>

**Brian Dalrymple** suffered from schizophrenia and severe hypertension (dangerously high blood pressure). He came to Britain for a two-week holiday on 14 June 2011. Immigration officials at Heathrow airport were suspicious at his lack of luggage and odd behaviour, and detained him in Harmondsworth IRC pending removal back to the US. No attempts were made to trace his medical records. This was even when Mr. Dalrymple refused the hypertensive medication which he so desperately required, and exhibited increasingly bizarre behaviour in detention; being rude, aggressive and incoherent, standing in the corner muttering to himself, urinating on the floor of his cell and throwing food. Still, no concerns were raised about his mental health. During the inquest two officers stated *“that they were not concerned about people in Harmondsworth muttering to themselves”, because a lot of people in Harmondsworth did that.*” Though they accepted during questioning that this might mean that all those people were in fact exhibiting signs of mental illness. At the inquest one member of staff stated that she felt underequipped to deal with the particularly vulnerable cohort of people she had to look after. GEO managers reacted to this odd behaviour by placing Brian in segregation which is known to lead to a deterioration of mental health. No psychiatric assessment was carried out during the full six weeks that Mr Dalrymple remained detained. Brian Dalrymple died isolated and alone in a single cell on the 31st of July 2011. The coroner ruled that neglect contributed to his death from natural causes.



## serious physical illness

The Enforcement Instructions and Guidance (EIG) stipulate that there have to be very exceptional circumstances to justify the detention of those with a serious medical condition which cannot be satisfactorily managed within detention<sup>53</sup>. The inadequacies in healthcare are extremely worrying not least so because of the failure of immigration processes to exclude those suffering from serious mental and physical illnesses from detention in accordance with Home Office policy. This means that many who have serious prevailing physical illnesses end up in detention. These cannot be satisfactorily managed within detention as the standard of healthcare falls short of that provided in the community and detention itself is not a therapeutic environment.

Some of the deaths covered in this report were sudden and unexpected, even though, with hindsight, many of them may have been preventable. However, not all deaths in detention are sudden. Some take place after an established physical illness, maybe with death taking place in hospital.

### *Some should not have been detained:*

Appropriate release of those too ill for detention happens too rarely: even some of the obviously dying have not been given temporary admission, and some remain restrained to the end. Safeguards put in place to protect against inappropriate detention of the mentally or physically ill are failing, either because doctors do not submit rule 35(1) reports alerting the Home Office to the illness, thereby triggering a review of detention. Or, when such a report is filed, because there was a failure to act on this information, as was the case with Alois Dvorzac.

There are exceptions. A doctor at Oakington examined a seriously ill Cameroonian detainee with AIDS, and realised how sick he was, as well as referring him immediately to Addenbrookes Hospital, he took steps to ensure he was granted temporary admission. This meant he was no longer detained, no longer needed to be on bed watch and his final few days were as any other patient in the community, albeit in hospital.

However, for the majority of those who died in detention signs of serious illness were ignored. Despite clear signs that they were unfit for detention, detention was maintained nonetheless:

- **Richard Abeson** died of liver cancer in hospital. He was unwell throughout his prison sentence and when subsequently held under immigration powers pending deportation, he should have been released back to the community. Instead he was admitted to hospital when nearly bed-bound, remaining under detention with the restraining chain removed only when he went into intensive care after resuscitation.
- **Brian Dalrymple** obvious signs of mental illnesses were ignored and no psychiatric assessment provided. He refused treatment for his hypertension but no capacity assessment was carried out to see if he had capacity to make this decision nor was there adequate follow up by healthcare staff and he went 16 days without seeing a doctor.
- **Alois Dvorzac** died of a heart attack in Hillingdon hospital. He was a vulnerable and frail 84 year old man who spent his final hours handcuffed to a guard. IRC doctors were trying to activate safeguards

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<sup>53</sup> Home Office Immigration Enforcement Instructions and Guidance 55.10 Persons considered unsuitable for detention Rule 35 on [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/400022/chapter55\\_external\\_v](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400022/chapter55_external_v)

(Rule 35) to get him released but it was deemed there was no alternative place to send him. So he was kept in detention until his death.

- **Gonzales Jorite** 2011 died of a haemorrhage from TB in Hillingdon Hospital. Although the IRC doctor considered submitting a rule 35 due to his vulnerability, it was decided to be in his 'best interests' to remain detained as he was homeless and did not have a support network outside. However, someone's liberty cannot be deprived simply because they lack a support network, in which case alternative arrangements must be made outside of detention with adequate follow up. In the end, he was on 'bedwatch' until his death with a guard sitting by his bedside. The sight of his final moments were so horrific the attending guard needed a month off work in the aftermath.

*Some received inadequate care in detention:*

For others there may not have been such clear long term symptoms but there were often indications leading up to their death where things could have been handled differently thereby perhaps preventing their death in detention:

- **Elmas Ozmico** died in Dover IRC in 2003 of septicaemia. There had been at least 5 opportunities missed by staff to call for an ambulance and had she been taken to hospital earlier, her life could have been saved.
- **Bruno Dos Santos** died of neurosarcoidosis. He had been scheduled to have an MRI which may have revealed the condition which could then have been treated. However, the scan was cancelled due to a technicality, Bruno was moved to another facility and before the scan could be rescheduled the condition proved fatal. Medical experts testified that if he had had the scan it is possible that his death could have been averted.
- For **Mohamoud Ali** information held by the prison service was not communicated to the medical specialists. Multiple appointments were made with for him with an external neurologist, but were cancelled by the IRC due to a lack of escorts.
- Following **Ianos Dragutan's** death the independent Reviewer concluded that actions [or rather inactions] of nursing staff to resuscitate him were seriously outside reasonable and acceptable practice.
- **Muhammed Shukat** received inadequate investigation and response to his initial request for help – when he, sweaty and grey, complained of chest pain, he was given an antacid.

*Inadequate clinical follow up:*

There is often a failure to obtain previous medical records prior to detention. Also detainees are often released back into the community without proper follow up. In some cases where vulnerable individuals were released in recognition of their serious medical conditions this was done without proper clinical follow up leading to their death in the community shortly after release.

- In 2008 a **32 year old Zimbabwean man** who had been diagnosed with TB at Colnbrook IRC was released on bail without pre-release arrangements being made or any information passed to him about his illness, medication or where to access medical care. A little over a month later he was found dead from TB. It became clear he had been trying to register with a GP without success and had thus not received treatment and died as a result.

- **Khalid Shahzad** died of a heart attack whilst travelling home alone on a train. He was detained for three months and suffered what fellow detainees described as breathing difficulties throughout his detention. His family stated that a stent had been fitted to help his heart and that he had had several hospital stays, the latest four days before his death. Following a collapse in detention he was deemed unfit for detention due to poor health, including heart disease, thrombosis and diabetes. He was released the following day and left to travel home alone. He was released from Colnbrook IRC without follow up and put on a train by himself. Before he could reach his home he had suffered a fatal heart attack. As the death did not occur in detention the death was not investigated by the PPO, thus any lessons to be learned may have not been identified.

**Recommendation 10:**

Immigration detention is not a therapeutic environment. Vulnerable people with serious mental or physical illness should not be held in detention.

**Alois Dvorzac** was an 84 year old Canadian citizen suffering from dementia, heart disease and mental health issues. He arrived at Gatwick on his way from Canada to Slovenia to visit his daughter. Border agents became suspicious after realising he was travelling without luggage and was unable to give a clear account of his intentions. Mr Dvorzac was detained and taken to Harmondsworth. One of the doctors at the IRC was so concerned about his condition that she campaigned to have him released. Despite his obvious frailty and vulnerability Mr Dvorzac was taken to hospital in handcuffs and kept in handcuffs at hospital until he died later that day of coronary heart disease. The chain was not removed until the officer noticed he had stopped breathing. According to the Chief Inspector of Prisons Nick Hardwick, Mr Dvorzac was one of at least two elderly, vulnerable and incapacitated detainees ‘needlessly handcuffed in an excessive and unacceptable manner’. The other man, who was terminally ill, died shortly after his handcuffs were removed. The HMIP described them as “shocking cases where a sense of humanity was lost”

Nigel Newcomen, the Prison and Probation Ombudsman (PPO), stated in his report that *“[i]t is a tragic indictment of the system that such a frail and vulnerable man should have spent his final days in prison-like conditions of an immigration removal centre (...) It is particularly shameful that he should have spent his last hours chained to a custody officer without justification and the Home Office needs to ensure such a situation cannot reoccur (...) We consider it wholly unacceptable for anyone to die in restraints (...) In the man’s case, we believe that this is likely to have reached the threshold of inhuman and degrading treatment.”*

# lack of coordination

The investigation of a death in detention looks at the actions of the Home Office and custody staff as well as healthcare leading up to the death. Often, it is failings across the board that led up to a death. Inappropriate decisions to detain, poor management by custody staff and inadequate systems combined with inadequate healthcare. In addition, there is a lack of coordination and communication across these systems.

## failure to communicate

Too often the Fatal Incident Report from the PPO identifies systemic failures in internal communications and a lack of coordination between different systems and staff members. The care provided is fragmented and characterised by a lack of coordination and oversight. Healthcare staff are unaware of immigration status and immigration caseworker may be unaware of the medical situation. Even within centres there is a disconnect between different departments and healthcare are often unaware that someone is on ACDT. This can have tragic implications for individuals.

### *Failure to communicate between healthcare and custody:*

Healthcare staff often do not take part in ACDT reviews so they may be treating a patient yet be unaware that this person is on suicide watch or has been self-harming. Healthcare staff are not informed when Removal Directions are served on patients, an act which often triggers additional stress and despair where medical intervention might be helpful. Nor are healthcare always informed when a patient is released from detention and are therefore unable to carry out proper preparations for release.

For example,

- The immigration case worker was unaware that **Mr C** had been taken to hospital, unaware that he was being held in restraints, and unaware of the seriousness of his medical situation (see box below).
- **Mohamoud Ali** missed vital medical appointments due to lack of escort staff and inadequate communication between custodial and specialist clinical staff.
- Next of kin information for **Gonzales Jorite** was available in medical notes yet custodial staff were not aware of this.
- **Kenny Peter's** solicitor sent a letter detailing his mental health issues but this was not passed on to the Medical Officer for advice or information.

*“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. (...) 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. “*

*(PPO investigation into death of Trang Quang Tung)*

#### *Failure to communicate between institutions:*

There is also frequent problems when people are transferred between IRCs and between IRCs and prisons which are both common occurrences. For example,

- **Riluwanu Balogan’s** closed ACCT from HMP Woodhill was not passed on nor were previously known risks properly recorded at induction. As a result, arrangements were not made for ongoing mental health care.
- **Brian Dalrymple’s** medical notes were not transferred with him from Harmondsworth to Colnbrook nor were concerns about his mental health when apprehended at Heathrow passed on or efforts made to get his previous medical records.

## e m e r g e n c y   r e s p o n s e

Communication failures are also a large part of the shortcomings in emergency responses. One of the most commonly repeated criticisms from the PPO has been about the incompetence of emergency response, ranging from confused codes and messages to summon help, lack of means to sever ligatures, missing and broken equipment for examination and resuscitation, and lack of training of staff in even the basics. This has been the case in prison as well as IRCs. For example, the defibrillator brought to Muhammed Shukat’s aid was not working and the pads were missing from the defibrillator and there was *‘unacceptable and avoidable delay’* in getting the paramedics to Rene Frings’ cell in Wormwood Scrubs. The PPO has included this topic in their Learning Lessons bulletin<sup>54</sup>.

A Detention Service Order was recently introduced setting out the steps to follow in an emergency. There is no evidence this has made any difference to what happens in practice. Although allowed to have mobile phones, detainees are unaware of the potential for accessing advice through 111 and local ambulance services have been instructed not to respond to residents in IRCs, so here there is no NHS equivalence. For some detainees, with illnesses like those of Muhammed Shukat and Tahir Mehmood, who were unable to get local staff to realise the significance of their symptoms, this could mean the difference between life and death.

### **Recommendation 11:**

The response to in-house medical emergencies has to improve. It is unacceptable that repeated recommendations have not been addressed. Even after the introduction of a DSO governing Medical Emergency Codes the system is still not working.

<sup>54</sup> PPO Learning Lessons bulletin March 2014 Immigration Removal Centres Fatal incident response.



**Mr C** died of heart failure in rheumatic valve disease in Harefield Hospital. He had been taken to hospital from Harmondsworth IRC but was formally released from detention a few hours before he died. Up until this point he had been in handcuffs, including during an angioplasty.

Because of a lack of proper communication the Home Office caseworkers did not realise he was in hospital nor that he was being restrained by an escort chain. Once the case worker realised they asked for the handcuffs to be removed. The contractor, GEO, refused to do so. When a nurse asked that the handcuffs should be removed, she was told that the officers had to speak to their manager first. It seems the contractors are reluctant to remove restraints because there is a 10,000 pound fine for absconding. The officers on bed watch have discretion to apply handcuffs, but not to remove cuffs.

The Home Office did not realise how ill he was as they were not informed of his deteriorating condition. When they did finally realise he was unfit for detention and dying it took several hours for him to be released.

**Muhammed Shukat** died in his cell at Colnbrook IRC after suffering a heart attack. Staff had failed to obtain his medical records despite his written authorisation, medical records which contained details which might have proven critical to his care. Mr Shukat had previously complained that healthcare at Harmondsworth had failed to follow up on his health issues in an appropriate manner. Mr Shukat became unwell during the night and collapsed in pain complaining of chest pain. His cellmate raised the alarm immediately. He rang the emergency bell in their locked cell 10 times before he was taken seriously. Custodial and healthcare staff attended the cell but did not call emergency services. Mr Shukat was told he could see the doctor in the morning. By the morning he had suffered a cardiac arrest and was pronounced dead upon arrival at hospital.

The coroner returned a highly critical verdict which found that neglect contributed to his death, inducing the fact that the defibrillator was not working. Following the trauma of being locked in a cell with a dying man the cell mate was moved to a small group segregation unit which was inappropriate for someone who had recently experienced a traumatic event.

**Oleksiy Baronovsky** was a 33 year old man from Ukraine. Despite being granted parole at the end of his sentence he was not released but was instead held unlawfully for over 6 weeks, without proper authorisation from either the Ministry of Justice or the Home Office. The PPO report states that *“prior to May 2006, the processes [for dealing with deportation] were poorly defined and (...) it appears there may simply not have been any immigration powers under which the man could have been detained beyond his release date.”* It is clear the he believed he would be killed were he to be deported back to Ukraine and he wrote letters to Buckingham Palace, the Prime Minister and official inspectorates stating that he did not care if he lived or died and expressed his fear of what would happen were he to be deported.

For the last few months of his life he was on suicide watch because of his serious self harming behaviour. The PPO report *“reflects a tragic catalogue of self harm and abuse. Sadly, [HMP] Rye Hill did not provide sufficient care to protect him”*. His self-harming behaviour grew increasingly serious and led to such blood loss that it left him ‘ghostly white’ and in an extremely weakened state. On occasion, his cell was covered in blood from the window to the door. He was left in these unsanitary and undignified conditions for at least 12 hours with only a plastic mattress cover to cover himself. The PPO investigator concluded that *“it is neither decent nor dignified that he had to live in this condition”*.

There seems to have been a lack of communication between healthcare, custodial and immigration staff. Medical care was mostly provided through a locked door, a totally unacceptable practice in any setting. There were other serious failings in the care provided. Medical records were incomplete, staff failed to recognise signs of mental health issues, there was no care plan in place and individual healthcare personnel failed to *“provide the standard of care reasonably expected”* or to *“provide even the most basic nursing care for the man”*. In an extremely weakened state he was made to crawl across the floor to access a drink of water.

He continued to refuse treatment, as was his right, but no efforts were made to ascertain why he was refusing treatment nor was a psychiatric assessment carried out to assess if he had capacity to make this decision. *“The level of care in prison should be equivalent to that available in the community. It would be hard to imagine a situation in any hospital where it was acceptable for a nurse to allow a patient to remain on the floor, knowing they did not have the energy to return to bed without assistance. The final moments of the man’s life – frail, presumably exhausted, kneeling at the end of his bed with arms extended – are painful to consider.”*

Mr Baranovsky was held in prison unlawfully after the end of his sentence and eventually detained under immigration powers. Despite ample evidence of extreme despair and self harming behaviour no psychiatric assessment was carried out. As he was held in prison and not in an IRC there was no Rule 35 mechanisms to trigger a review of his detention as continued detention was clearly injurious to his health and posed an ongoing risk of self harm and suicide. Instead he was left to deteriorate until his death under shocking circumstances. Little effort was made to trace his family and it was over 6 months before his family were informed of his death.

# foreign national prisoners

There are about 10,000 foreign national prisoners held in prisons in the UK<sup>55</sup>. Deaths are not infrequent, e.g. in 2007 there were at least 23 self-inflicted deaths amongst foreign national prisoners<sup>56</sup>.

In addition to the deaths in immigration removal centres, there is another group of deaths that are closely related.

These are deaths of foreign national offenders in prisons, especially where:

- *The death in foreign national prisoners detained beyond normal release.*  
Foreign national prisoners who are given a prison sentence of 12 months or more<sup>57</sup> will usually be considered for deportation at the end of their sentence. Many are detained under immigration powers even after the end of their sentence. This is not always clear to prisoners who may have been looking forward to their release date and are unable to face continued imprisonment.
- *The death takes place shortly prior to deportation.*  
Often self inflicted deaths by prisoners who fear being returned to the country they fled.
- *The death of foreign national prisoners held for immigration offences.*  
Many foreign national prisoners are convicted of immigration offences, such as trying to enter the country on a false passport. Many are considered for deportation at the end of their sentence. This category will only increase as there has been a drive to further criminalise immigration in recent years.

These are not mutually exclusive categories.

Some prisoners are 'doubly detained' pending deportation, meaning they are held as part of criminal sentence, or on remand, whilst at the same time having been served with IS91 'notice of deportation' papers. We have chosen not to include these individuals in the above analysis as they were not purely immigration detainees and their inclusion would muddle the categories. Nor do we attempt to present a complete listing of such deaths. However, there are some very worrying issues and we feel this is a category of individuals who often gets forgotten about.

Some are detained for 'immigration offences' which are intimately linked to their immigration process. **Avtar Singh** tried to enter the country on a false passport and was sentenced to 15 months imprisonment with a recommendation for deportation. He grew increasingly frustrated because he could not return to India and could not support his family. He took his own life less than 2 months into his sentence.

**Abass Usman** was arrested in a police raid on his home and was questioned by police and immigration services for several days. He was taken to HMP Preston where he appeared confused about the charges and anxious about being in prison. He expressed unhappiness about his solicitor, was demonstrating 'bizarre behaviour'. He took his own life 4 days after being remanded.

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<sup>55</sup> On 30 June 2015, about 9,300 foreign nationals were held in prisons in England and Wales; about 11% of the total prison population. <https://www.justicespectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/11/HMIP-Immigration-detainees-findings-paper-web-2015.pdf>. On 11 of March 2016 there were 10,442, 12% of total prison population. Hansard HC Deb, 11 March 2016, c545 <https://www.theyworkforyou.com/debates/?id=2016-03-11b.545.2>

<sup>56</sup> <http://www.ppo.gov.uk/wp-content/ReddotImportContent/126.07-Death-of-a-male-prisoner.pdf#view=FitH>

<sup>57</sup> Immigration Directorate Instructions. Deporting non-EEA foreign nationals. Version 3.1 April 2015 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/426906/Deport-non\\_eea\\_Foreign\\_Nationals.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/426906/Deport-non_eea_Foreign_Nationals.pdf)

**Delaili Kwadzo Abusah** was held on immigration offences of trying to enter the country on a false passport. On the 4<sup>th</sup> of December he was notified of his conditional release date of 25<sup>th</sup> of February and his sentence expiry date of 26<sup>th</sup> of August. Then on 16<sup>th</sup> of January he was served with a liability to deport notice stating the intention to deport him on the 18<sup>th</sup> of February, *"in response he wrote a letter in which he stated his intention to take his own life as he refused to be in prison after 25 February and that, 'I cannot continue living in prison after my sentence'."* He also quoted immigration law and human rights rulings stating that immigration detainees should be held in immigration removal centres after the expiry of their sentence. His sentence came to an end on the 25<sup>th</sup> of February and it is not clear under what power he was detained between that date and his self-inflicted death on the 28<sup>th</sup> of March but he was most likely doubly detained under immigration powers and on remand for another crime. The PPO commented that *"the man's immigration status and his false identity seems to be at the heart of this tragic story"*. After his death a letter to his fiancé and unborn daughter was found where he apologised for his actions but explained that he could not go on as he was suffering too much in prison. *"It seems highly likely that the man's growing concern about his immigration status, the fear that he might not see his child, and the inevitable pressures of living with a false identity, combined to cause him to take the action he did."*

**Abdullah 'Joker' Idris** was only 19 years old when he took his own life in HMP Chelmsford on Christmas Day. He had only 13 days left on his 12 month sentence when he died. He had been looking forward to his release. The day before his death he was issued with a notice of intention to hold him in custody at the end of his sentence pending deportation to Sudan. The member of staff who delivered the order had no training in immigration matters and did not use an interpreter. After receiving the news he appeared confused, angry and, later, quiet. Other prisoners report that Mr Idris was terrified of being deported and said he would rather kill himself than be deported and have the Government kill him in Sudan.

PPO investigators commented that HMP Chelmsford did not have a policy for dealing with foreign national prisoners and there was a general lack of awareness of issues affecting foreign national prisoners among staff. The PPO concluded that *"when the man was given the notice of detention document, he probably did not understand what was happening to him. His English was limited and, when told that he would be deported, he presumably felt vulnerable, confused and angry. He was genuinely afraid of returning to the country of his birth and appears to have believed that he would be killed. I conclude that in the case of the man, it seems very likely that the notice of detention – both its message and the means of delivery – were the trigger for what followed."*<sup>1</sup> What makes this case doubly tragic, in addition to his young age, is the fact that had he *"been able to speak to a solicitor he would have realised Britain had stopped sending immigrants back to Darfur because of violence and that his claim for asylum had a real prospect of success."*<sup>2</sup> There were failings in the immigration enforcement process which led up to, and may have contributed to, his death. *"The officer described the man as being confused and remembered him repeating that he was going to be released from prison, and not deported. The prison officer offered the man the opportunity to make a telephone call to his solicitor, but the man said he did not know who his solicitor was. The prison officer said he stressed to the man the need to speak to his solicitor. The prison officer said at interview that he told him that he could appeal against any decision to deport him, but that the man did not appear to understand."*

Had he received proper immigration advice he might have appealed the decision to deport him and would most likely have been granted leave to remain. Instead he was left to his own devices and despair, isolated in prison without support of peers or access to proper advice. He was overcome by despair and chose to take his own life. The lack of access to immigration advice and barriers to communication with legal representatives for foreign national prisoners and immigration detainees held in prisons has been repeatedly criticised by NGOs<sup>3</sup> and official inspectorates<sup>4</sup>.

<sup>1</sup> <http://www.ppo.gov.uk/wp-content/ReddotImportContent/152.07-Death-of-a-male-prisoner.pdf#view=FitH>

<sup>2</sup> *"Darfuri teenager killed himself after being told 'wrongly' of deportation"*, Home Affairs Editor, Robert Verkaik Wednesday 2 June 2010, The Independent, <http://www.independent.co.uk/news/uk/home-news/darfuri-teenager-killed-himself-after-being-told-ndash-wrongly-ndash-of-deportation-1990011.html>

<sup>3</sup> *Bail for Immigration Detainees. Denial of Justice: the hidden use of UK prisons for immigration detention* [http://www.biduk.org/sites/default/files/2014-09-16%20FINAL%20version%20prisons%20report%20Denial%20of%20Justice%20\(2\).pdf](http://www.biduk.org/sites/default/files/2014-09-16%20FINAL%20version%20prisons%20report%20Denial%20of%20Justice%20(2).pdf)

<sup>4</sup> *People in prison: Immigration detainees. A findings paper by HM Inspectorate of Prisons.*

# repeated recommendations not implemented

*“When you repeat a mistake, it is not a mistake anymore: it is a decision” – Paulo Cohelo*

Many of the systemic failings identified in PPO reports recur in report after report, year after year. Tragic as each death in detention is for the individual and for those left behind – the even greater tragedy is that few lessons seem to be learnt by the immigration detention system and its providers. Thus, the same failings are allowed to persist and contribute to ever more deaths.

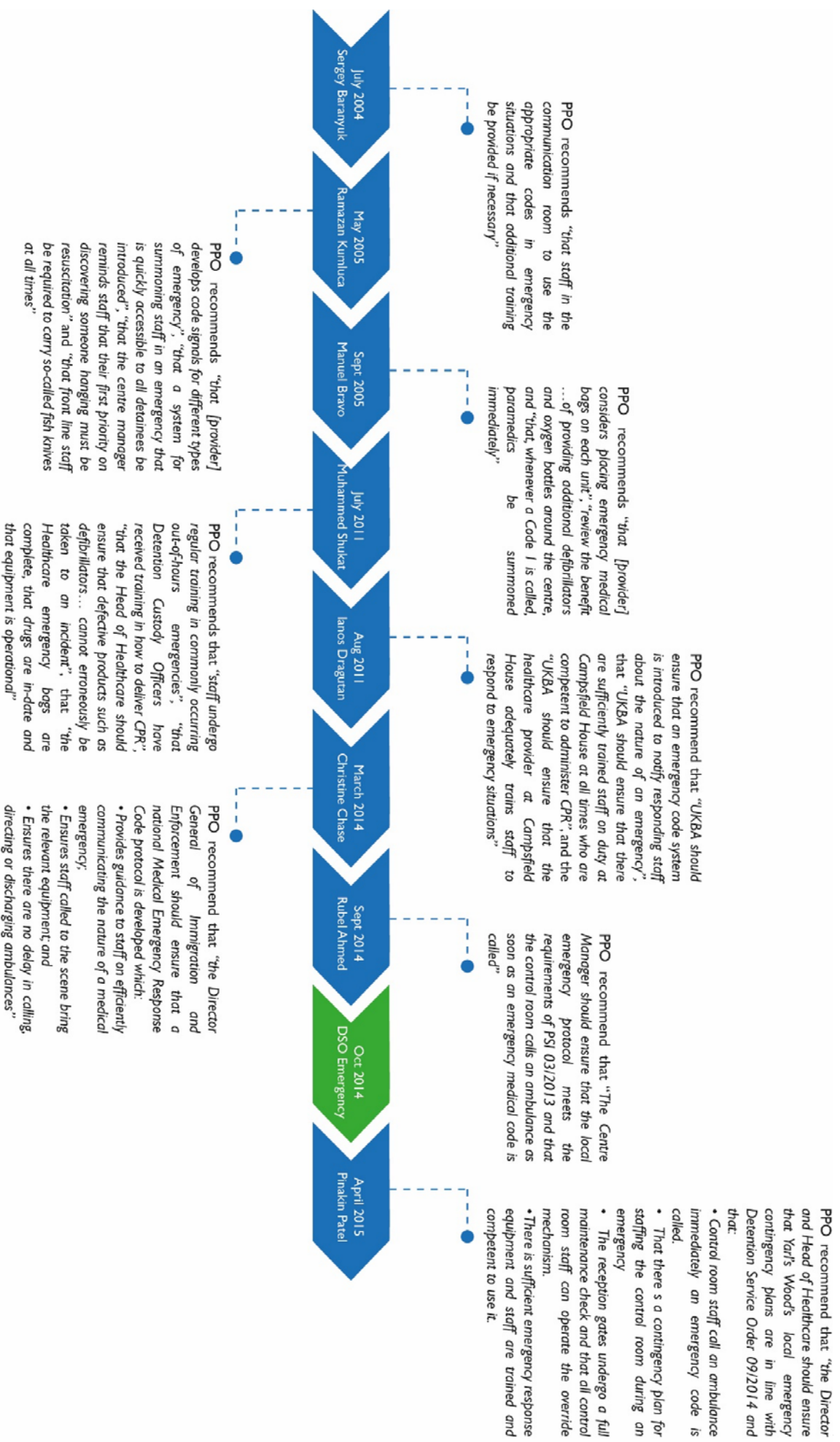
When we fail to learn from past mistakes there is nothing to stop others from losing their lives due to the same shortcomings. Mistakes that do not lead to serious consequences for individuals or financial repercussions for providers are unlikely to ensure change is prioritised. As it stands, there are limited mechanisms for ensuring that recommendations are realised.

The problems seen again and again in PPO reports and inquests is the apparent failure to learn from past mistakes, e.g. poor communications about self-harm risks; poor identification and then the non-release of those too ill to be detained; inadequate healthcare response including for the terminal cases; poor communication with families; poor follow up of the sick post-release on bail, etc. There should also be learnings from serious untoward incidents and other near misses, again with post-event action plans. If this happens, they are not made public.

In 1991 Omasase Lumumba was killed by prison guards in Pentonville Prison. No one was prosecuted for the death despite the inquest finding that he died *“as the result of the use of improper methods and excessive force in the process of control and restraint”*. Almost 20 years later a very similar scenario played out when Jimmy Mubenga was killed during a removal attempt. The inquest found that escorts had applied excessive and improper restraints causing his death and returned a finding of ‘unlawful killing’. This time the escorts were prosecuted but both the findings of the inquest and the racist text messages the guards had shared prior to the incidence were withheld from the jury in case it would cause prejudice. Without access to all the relevant facts the jury chose not to convict. The impetus for change was again thwarted.

Some PPO reports now include the response from the authorities to recommendations being made, and these are frequently worded dismissively as if there is no real intention to change. The PPO does not follow up on the actions promised in response to its recommendations, so there is a lack of public monitoring and calling to account. This means not only is the detention system broken but the systems for repairing it are ineffective.

Inadequacies in emergency responses are frequently raised in PPO investigations and recommendations. Yet, with no authority to implement these recommendations, and in the absence of financial or other sanctions when there is a failure to implement, the shortcomings are rarely addressed adequately. So it is not surprising when another death brings the same issues to the forefront. As can be seen in the illustration below the same recommendations have been raised time and time again over a period of 10 years and in relation to at least 8 deaths. Even after the Detention Service Order (DSO 09/2014) on Medical Emergency Response Codes was brought in to clarify the procedures for the use of medical emergency response codes, this remained an issue in connection with the death of Pinakin Patel in 2015.



# conclusions

All death in custody is a human tragedy. Death may be inevitable but should never take place in administrative detention.

There is a lack of transparency and accountability around death in detention. There is no central or coordinated oversight and monitoring of deaths in detention. So monitoring of this currently falls to NGOs and other interested parties. The Home Office makes it difficult to access information around these tragic deaths and even sought to block access to the report of a highly critical investigation by the Professional Standards Unit.

PPO reports and inquests provide a window into the hidden world of immigration detention and allows us to get a rare insight into the state of detention under immigration powers. Failures of individuals and of providers have been laid out in this report and the verdict is damning. Immigration detention is not fit for purpose. The system is characterised by a lack of humanity. Unless systemic failings are addressed we will continue to have avoidable deaths in detention. Numerous and actionable recommendations have come out of the many Fatal Incident Reports but what is needed is real commitment to make the necessary changes, authority to impose the recommendations and sanctions if improvements are not achieved.

The use of private sector companies to deliver what was previously government core business allows some protection from prying eyes as these are not subject to the Freedom of Information Act. Extensive sub-contracting also serves to fudge liabilities. However, the Home Office and NHS England cannot avoid ultimate responsibility for the systemic failures uncovered. The rules are set by the Home Office and they remain accountable for immigration and immigration detention policy. The Home Office and NHS England both bear ultimate responsibility for the adequacy of the services they commission.

Since 2005 Medical Justice has been alerting the Home Office, and now more recently NHS England, about the systemic failures in immigration detention and warned that these will lead to further deaths unless they are addressed. We take no pride in being vindicated. This failure to learn from past mistakes is shameful, and deadly.

Medical Justice calls on the PPO, the National Preventative Mechanism, the Chief Coroner, parliamentarians, NGOs, the legal profession, detainees, ex-detainees, the families of those who have already died in detention and other interested parties to join us in putting pressure on the Home Office and NHS England to ensure that recommendations are followed through and systemic failures addressed so that deaths in immigration detention can be avoided in the future.

Medical Justice believes that IRCs, and the conditions of detention, are so detrimental to the health and wellbeing of those detained that the only way to remedy this situation is to end immigration detention. Ultimately, the only way to ensure that no one dies in immigration detention is to close IRCs for good.

**Recommendation 12:**

Immigration Detention is “expensive, ineffective and unjust”. It should be abandoned so no further deaths take place in immigration detention.

# recommendations

1. There must be public knowledge of all deaths that take place in or within 7 days of release from immigration detention, with the PPO resourced so all these deaths can be subject to full independent investigation. The Home Office must publish annual statistics on all deaths, near deaths and attempted suicides for detainees held in immigration detention and prisons.
2. When an enhanced risk of self-harm has been recognised an ACDT process must be instigated. This must be linked to the decision to detain, include the involvement of healthcare personnel, be effective and adequately protect vulnerable people.
3. The Home Office must operate on the assumption that indefinite detention under immigration powers is inherently harmful to mental health.
4. Effective safeguards must be in place to ensure vulnerable people are not detained and that those who become vulnerable in detention are identified and released.
5. There should be a presumption against the use of restraints during medical treatment and external hospital appointments. Restraints should only be applied in response to a thorough risk assessment. Current risk assessments are inadequate and do not prevent inappropriate use of restraints.
6. NHS staff must be aware of BMA guidelines on handcuffing in consultation.
7. The use of segregation in immigration detention is disproportionately retributory for a low risk population detained for administrative purposes. Segregation is inappropriate in immigration detention and the Detention Centre rules should be amended to reflect this fact.
8. Coordinated action is needed to ensure that fellow detainees are appropriately supported following a death in detention.
9. Healthcare for immigration detainees must be equivalent to that provided in the community. Where equivalent care cannot be ensured detainees must be released so they can access the care they need.
10. Immigration detention is not a therapeutic environment. Vulnerable people with serious mental or physical illness should not be held in detention.
11. The response to in-house medical emergencies has to improve. It is unacceptable that repeated recommendations have not been addressed. Even after the introduction of a DSO governing Medical Emergency Codes the system is still not working.
12. Immigration Detention is “expensive, ineffective and unjust”. It should be abandoned so no further deaths take place in immigration detention.



# acknowledgments

We would like to thank those who helped us with the preparation of this report, such as Dr. Hilary Pickles, INQUEST and those who answered frequent FOI requests, eg at the PPO.

Any mistakes and omissions in this report are entirely our own. © Medical Justice 2016

# glossary

ACCT	Assessment Care in Custody and Teamwork
ACDT	Assessment Care in Detention and Teamwork
CPS	Crown Prosecution Service
DSO	Detention Service Order
FNO	Foreign national offender
FOI	Freedom of Information
HMIP	Her Majesty's Inspectorate of Prisons
HMYOI	Her Majesty's Youth Offending Institution
IMB	Independent Monitoring Board
IRC	Immigration Removal Centres
NOMS	National Offender Management Services
PFD	Prevention of Future Death reports
PPO	Prison and Probation Ombudsman
PSU	Professional Standards Unit
PTSD	Post-Traumatic Stress Disorder
SUI	Serious Untoward Incident

# annex 1

## Listing of deaths of those held under immigration detention chronologically

2000

Date	Facility	Name	Sex	Age	Nationality	Cause of death
24/01/2000	Harmondsworth	Robertus Grabys	M	49	Lithuanian	Hanging
31/01/2003	Haslar	Michael Bodnarchuk	M	42	Ukrainian	Hanging
07/05/2003	Harmondsworth	Olga Blaskevica	F	29	Latvian	Murdered by husband
11/07/2003	Dover	Elmas Ozmico	F	40	Turkish	Septicaemia
01/05/2004	Haslar	Kabeya Dimuka-Bijoux	M	34	DR Congolese	Collapse on running machine
19/07/2004	Harmondsworth	Sergey Baranyuk	M	31	Ukrainian	Hanging
23/07/2004	Dungavel	Trang Quang Tung	M	24	Vietnamese	Hanging
07/11/2004	Colnbrook	Kenny Peter	M	24	Liberian	Trauma related to hanging
14/03/2005	Ex-Oakington	(name unknown)	M	33	Cameroonian	AIDS
27/06/2005	Campsfield	Ramazan Kumluca	M	18	Turkish (Kurd)	Hanging
15/09/2005	Yarls Wood	Manuel Bravo	M	35	Angolan	Hanging
19/01/2006	Harmondsworth	Bereket Yohannes	M	26	Eritrean	Hanging
10/06/2006	HMP Rye Hill	Oleksiy Baronovsky	M	34	Ukrainian	Self-inflicted, cutting
01/09/2008	Ex- Colnbrook	(name unknown)	M	32	Zimbabwean	TB
23/08/2009	HMP Wandsworth	Richard Abeson	M	69	Unknown	liver cancer
15/04/2010	Oakington	Eliud Nyenze	M	39	Kenyan	Irregular heartbeat
23/04/2010	HMP Nottingham	Reza Ramazani	M	56	Unknown	coronary
12/10/2010	In aircraft ex-Brook House	Jimmy Mubenga	M	46	Angolan	Unlawful killing
16/05/2011	HMYOI Glen Parva	Riluwanu Bologan	M	21	Nigerian	Hanging
02/07/2011	Colnbrook	Muhammed Shukat	M	47	Pakistani	Heart attack
31/07/2011	Colnbrook	Brian Dalrymple	M	31	American	Ruptured aortic aneurysm, hypertension, psychosis
02/08/2011	Campsfield	Ianos Dragutan	M	31	Moldovan	Hanging
06/12/2011	Harmondsworth	Gonzales Jorite	M	40	French	Massive haemoptysis in TB and disseminated TB
30/10/2012	Harmondsworth	Prince Kwabena Ofori	M	31	Ghanaian	Sudden adult death syndrome
17/11/2012	Ex-Harmondsworth	(name unknown)	M	43	Bangladeshi	rheumatic valve disease
10/02/2013	Harmondsworth	Alois Dvorzac	M	84	Canadian	Heart attack in dementia
14/04/2013	Train, ex-Colnbrook	Khalid Shahzad	M	52	Pakistani	Heart attack?
26/07/2013	Pennine House	Tahir Mehmood	M	43	Pakistani	Heart attack
23/11/2013	HMP Wormwood Scrubs	Rene Frings	M	44	German	Coronary heart disease
01/02/2014	HMP Parc	Mohamoud Ali	M	36	Somalian	Sudden unexpected death in epilepsy
30/03/2014	Yarls Wood	Christine Case	F	40	Jamaican	Pulmonary embolism
04/06/2014	HMP The Verne	Bruno dos Santos	M	26	Angolan	Neurosarcoidosis
05/09/2014	Morton Hall	Rubel Ahmed	M	26	Bangladeshi	Hanging
20/04/2015	Yarls Wood	Pinakinbhai Patel	M	33	Indian	Heart attack
06/08/2015	The Verne	Thomas Kirungi	M	30	Ugandan	Hanging

2015

## annex 2

### Listing of deaths of those held under immigration detention alphabetically

Date	Facility	Name	Sex	Age	Nationality	Cause of death
23/08/2009	HMP Wandsworth	Richard Abeson	M	69	Unknown	liver cancer
05/09/2014	Morton Hall	Rubel Ahmed	M	26	Bangladeshi	Hanging
01/02/2014	HMP Parc	Mohamoud Ali	M	36	Somalian	Sudden unexpected death in epilepsy
16/05/2011	HMYOI Glen Parva	Riluwanu Balogan	M	21	Nigerian	Hanging
19/07/2004	Harmondsworth	Sergey Baranyuk	M	31	Ukrainian	Hanging
10/06/2006	HMP Rye Hill	Oleksiy Baronovsky	M	34	Ukrainian	Self-inflicted, cutting
07/05/2003	Harmondsworth	Olga Blaskevica	F	29	Latvian	Murdered by husband
31/01/2003	Haslar	Michael Bodnarchuk	M	42	Ukrainian	Hanging
15/09/2005	Yarls Wood	Manuel Bravo	M	35	Angolan	Hanging
17/11/2012	Ex-Harmondsworth	Mr C (name unknown)	M	43	Bangladeshi	rheumatic valve disease
31/07/2011	Colnbrook	Brian Dalrymple	M	31	American	Ruptured aortic aneurysm, hypertension, psychosis
01/05/2004	Haslar	Kabeya Dimuka-Bijoux	M	34	DR Congolese	Collapse on running machine
02/08/2011	Campsfield	Ianos Dragutan	M	31	Moldovan	Hanging
10/02/2013	Harmondsworth	Alois Dvorzac	M	84	Canadian	Heart attack in dementia
23/11/2013	HMP Wormwood Scrubs	Rene Frings	M	44	German	Coronary heart disease
24/01/2000	Harmondsworth	Robertus Grabys	M	49	Lithuanian	Hanging
06/12/2011	Harmondsworth	Gonzales Jorite	M	40	French	Massive haemoptysis in TB and disseminated TB
06/08/2015	The Verne	Thomas Kirungi	M	30	Ugandan	Hanging
27/06/2005	Campsfield	Ramazan Kumluca	M	18	Turkish (Kurd)	Hanging
26/07/2013	Pennine House	Tahir Mehmood	M	43	Pakistani	Heart attack
12/10/2010	In aircraft ex-Brook House	Jimmy Mubenga	M	46	Angolan	Unlawful killing
15/04/2010	Oakington	Eliud Nyenze	M	39	Kenyan	Irregular heartbeat
30/10/2012	Harmondsworth	Prince Kwabena Ofori	M	31	Ghanaian	Sudden adult death syndrome
11/07/2003	Dover	Elmas Ozmico	F	40	Turkish	Septicaemia
20/04/2015	Yarls Wood	Pinakinbhai Patel	M	33	Indian	Heart attack
07/11/2004	Colnbrook	Kenny Peter	M	24	Liberian	Trauma related to hanging
23/04/2010	HMP Nottingham	Reza Ramazani	M	56	Unknown	coronary
04/06/2014	HMP The Verne	Bruno dos Santos	M	26	Angolan	Neurosarcoidosis
14/04/2013	Train, ex-Colnbrook	Khalid Shahzad	M	52	Pakistani	Heart attack?
02/07/2011	Colnbrook	Muhammed Shukat	M	47	Pakistani	Heart attack
17/02/2016	Colnbrook	Amir Siman-Tov	M	41	Moroccan	unknown
23/07/2004	Dungavel	Trang Quang Tung	M	24	Vietnamese	Hanging
01/09/2008	Ex- Colnbrook	(name unknown)	M	32	Zimbabwean	TB
14/03/2005	Ex-Oakington	(name unknown)	M	33	Cameroonian	AIDS
19/01/2006	Harmondsworth	Bereket Yohannes	M	26	Eritrean	Hanging

“Every death in custody is a human tragedy. All the more so as here, when the man who died was thousands of miles from his home, family and friends”

- PPO investigation