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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man  
at Morton Hall Immigration Removal Centre  
in September 2014**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanged in his room at Morton Hall Immigration Removal Centre in September 2014. He was 26 years old. I offer my condolences to the man's family and friends.

A clinical reviewer reviewed the man's clinical care. Morton Hall and the Home Office cooperated fully with the investigation.

The man came to the UK from Bangladesh in 2009. His visa expired in 2011 and he applied for leave to remain in the UK, but his application and a subsequent appeal were denied. He was detained under immigration powers on 21 July 2014 and taken to Morton Hall until he could be deported. On 29 August, the Home Office notified the man that he would be sent back to Bangladesh on 8 September. On 5 September, the man made a claim for asylum. His friends said he was happy about this because he believed this would prevent his removal to Bangladesh. He spoke to his father, a brother-in-law and one of his cousins on 5 September and appeared to be fine. Later that night, a night patrol officer found the man hanged in his room. Paramedics pronounced him dead, shortly after midnight.

I have not found any evidence that the man presented an obvious risk of harming himself and I do not believe that staff at Morton Hall could reasonably have foreseen or prevented his death. However, I am concerned that it took too long to inform the man's family of his death and the investigation has identified a need for more effective family liaison arrangements. While there was a swift emergency response on this occasion, there is a need for Morton Hall to revise its emergency procedures, in line with current requirements.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and detainees at the immigration removal centre.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**May 2015**

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## SUMMARY

1. The man arrived in the UK from Bangladesh in 2009. His visa expired in 2011. An application to stay in the UK and a subsequent appeal were denied. In April 2014, the immigration authorities found him working illegally in a restaurant in Canterbury. They detained him briefly, and then released him with a requirement to report regularly.
2. In July 2014, a registrar told immigration officers that he was concerned that the man intended to enter a sham marriage in order to remain in the country. On 21 July 2014, immigration staff detained him because they were concerned he would not continue to comply with the terms of his release. He was taken to Morton Hall.
3. The man was a quiet person who mixed well with his friends at Morton Hall. He attended a Muslim religious service every week and told his family that the food and accommodation at Morton Hall were ok. He saw a nurse once, when he had a cough, but otherwise appears to have been in good health.
4. On 29 August, the Home Office issued removal directions for the man to return to Bangladesh on 8 September. On 5 September, he instructed his solicitor to apply for asylum and said he was anxious about returning to Bangladesh. He received confirmation the same day that his solicitors had lodged his application for asylum. The man's friends and family said he was not worried about returning to Bangladesh but was happy about his asylum application as he preferred to stay in the UK. He spent the evening of 5 September singing with his friends.
5. At 11.28pm on 5 September, a night patrol officer found the man hanged in his room. Staff began cardiopulmonary resuscitation promptly and efficiently and called emergency services. Paramedics pronounced him dead at 12.09am on 6 September.
6. The investigation found that staff at Morton Hall could not reasonably have foreseen or prevented the man's death. Although the emergency response was swift, Morton's Hall's local instructions for emergencies needs updating to comply with current guidance to ensure staff call an ambulance immediately. We are also concerned that there were significant delays contacting the man's family after his death, indicating a need to improve family liaison arrangements. We make three recommendations.

## THE INVESTIGATION PROCESS

7. The investigator issued notices about the investigation to staff and detainees at Morton Hall inviting anyone with information to contact her. No one asked to speak to her in response.
8. NHS England (East Midlands Team) commissioned a clinical reviewer to review the man's clinical care at Morton Hall.
9. The investigator visited Morton Hall on 10 September 2014 and met the NOMS centre manager. She saw where the man had lived and collected relevant records and CCTV coverage of the night of 5/6 September. She subsequently interviewed eight staff and seven detainees. She also spoke to two Home Office family liaison officers, the Home Office contact point for the detention service order on deaths in IRCs, the Home Office senior on-call manager at the time of the man's death and a representative of the company which supplied and managed Morton Hall's CCTV and room bell system. She informed the NOMS centre manager of the preliminary finding of the investigation. She liaised with the police and the Coroner's Officer. The police and Coroner shared information including statements from staff and detainees and the post-mortem report.
10. The investigator and one of our family liaison officers met the man's family and their solicitor. His family wanted details of what had happened on the night of 5/6 September. They said they had heard rumours about their relative's death some hours before they received official confirmation from the Home Office. One of the man's cousins, Mr A, had called Morton Hall several times on 6 September to try to find out what had happened but no one would tell him. Mr A played the investigator a recording of one of his conversations with the person he spoke to at Morton Hall. He said he did not think the person had been sensitive or sympathetic. The family said that the way they had found out about his death had been extremely distressing. The family also said they had made a formal complaint to the Home Office by letter on 19 September and to date they had not received a satisfactory response. When the family visited Morton Hall on 11 September, they said they found staff defensive and unapologetic and this had compounded their sense of desperation and distress.

## **MORTON HALL IMMIGRATION REMOVAL CENTRE**

11. Morton Hall Immigration Removal Centre near Lincoln was previously a prison and is run by the Prison Service on behalf of the Home Office. It holds up to 392 adult men in single rooms in six units. G4S is contracted to provide health services at the centre until April 2015.
12. The man lived on Windsor Unit, which has four landings. Landings 1 and 3 are on the ground floor either side of a central office. Landings 2 and 4 are directly above and are reached by stairs at the far end of the ground floor landings. There are 20 rooms on each landing. Rooms 1-10 are on one side of each corridor and rooms 11-20 on the other side. The man lived in room 5 on landing 4. Room 5 is opposite rooms 16 and 17.
13. Windsor Unit is one of two residential units (the other is Fry Unit) at Morton Hall with rooms that have en suite showers and toilets. At the time of the man's death, detainees on both units were locked in their rooms from about 8.30pm until about 8.00am. An operational support grade, night patrol officer was based on Windsor Unit every night. A nurse and a healthcare assistant were also on duty during the night, based in the healthcare centre or in reception. The Windsor Unit night patrol officer is required to complete two welfare and security checks, during the night shift. The first takes place between 11.00pm and midnight and the second between 6.00am and 7.00am.
14. Each room on Windsor Unit has a bell for detainees to press if they need help. The bell rings when pressed and a light flashes outside the detainee's room. The audible alarm and the light can only be turned off at the panel outside each room. The bells are audible on the landing and in the unit office. Electronic panels at the end of each landing and in the main office show which room bell has been pressed. Officers check the room bell is working as part of a daily check of each room.
15. A Home Office team of contact management officers based at Morton Hall are responsible for facilitating contact with the detainees' Home Office caseworkers and have some input into induction. The on-site team do not make casework decisions.

## **HM Inspectorate of Prisons**

16. The last inspection of Morton Hall was in March 2013. Overall, inspectors found very good relationships between staff and detainees, particularly on the residential units. Room bells were answered promptly. Healthcare was of a good standard, as was accommodation. However, inspectors found some practices such as locking detainees in their rooms at night on Windsor and Fry Units, unnecessarily restrictive and unsuitable for an establishment where people are not held on criminal charges. Inspectors recommended that this practice stop.
17. The number of self-harm incidents was high but they were mostly low level. Case management was effective and the quality of entries in self-harm

monitoring documents reflected good standards of care. Three quarters of all self-harm monitoring documents were opened during the initial stages of detention or after removal directions were served. The suicide prevention policy was relevant to detainees and understood by staff.

18. Inspectors noted that the Home Office contact management officers conducted induction interviews reasonably well, but did not ask detainees for their next of kin details. Instead, they asked if they had friends or family in the UK. Inspectors said Home Office staff should confirm detainees' next of kin, regardless of whether they were in the UK or abroad.

### **Independent Monitoring Board**

19. The Independent Monitoring Board (IMB) consists of unpaid volunteers from the local community who help ensure that detainees are treated fairly and decently. In its most recent annual report for the year ending December 2013, the IMB noted some concern about staffing levels and the quality of food supplied by the contractors. Overall, the IMB said relationships between staff and detainees were good.

### **Previous deaths at Morton Hall**

20. This man's death is the first death at Morton Hall since it became an immigration removal centre in 2011.

## KEY EVENTS

21. The man arrived in the United Kingdom from Bangladesh in 2009. His visa expired in 2011 and he applied for leave to remain under Article 8 of the European Convention on Human Rights (a right to respect for private and family life) as he had family in the UK. The application and subsequent appeals were refused. In April 2014, immigration officers discovered the man working in a restaurant in Canterbury. He was required to report weekly to an immigration reporting centre. In July 2014, immigration officers received information from a registrar at Huntingdon Register Office, who believed he intended to enter a sham marriage. He was detained on 21 July 2014, because immigration officers were concerned that he would not continue to comply with reporting conditions.
22. The police completed the man's person escort record, a form that accompanies detainees between police, court and immigration removal centres, and did not list any risk factors for suicide and self-harm. They noted that he thought he was asthmatic, although this had not been diagnosed. A supervisory officer (SO) completed the man's first night interview and assessment when he arrived at Morton Hall on 21 July. She recorded on NOMIS (the electronic detainee record) that he had raised no issues.
23. The SO also completed a "detainee transferable document". This form is completed the first time a detainee enters an immigration removal centre and then travels with them if they transfer to other centres. It contains information about their nationality, religion, appearance and next of kin. The man gave the address of the restaurant where he had been arrested as his home address and just the first name of one of his cousins as his next of kin. The SO wrote "Surname unknown" on the form. There were no home address details on his NOMIS record and the next of kin/emergency contact details noted only the man's cousin's first name. There were no other contact details on either record.
24. A nurse completed a first night health assessment. The man said he had no mental or physical health problems apart from allergies. He said he had never been in hospital and did not use drugs. He said he did not have any thoughts of suicide or self-harm. The nurse asked how he was coping with being detained and he said he was "coping at present". He said he had a GP in Canterbury but did not know the name or address. The nurse checked his blood pressure and pulse, and these were normal.
25. All new detainees spend their first two days on Seacole Unit and complete an induction programme to introduce them to life at Morton Hall. The man's record shows that on 22 July, he registered his religion at his religious affairs induction and attended an education information talk. An officer explained some of the rules and services available at Morton Hall. A further officer recorded that the man had not raised any issues during his induction.
26. A Home Office contact management officer based in Morton Hall interviewed the man the same day using a telephone interpreting service. He told the

investigator the purpose of the interview is to explain the role of the Home Office in an IRC, make sure the detainee knows who his Home Office caseworker is, record the detainee's next of kin, religion and level of English and ask if they have any welfare issues. The officer said he did not recall speaking to him in detail and did not recall what the man said in response to his question about next of kin. Looking at the detainee induction sheet, he said the man did not appear to have given any next of kin details. He said there are a variety of reasons why detainees do not want to give these details. He said he did not remember being concerned about him during the induction interview.

27. On 23 July, the man went to a gym induction and the same afternoon moved to room 5 on landing 4 of Windsor Unit. The man's personal officer did not remember the man arriving on Windsor unit but wrote in his record that he had not raised any issues. He said all new detainees are given a brief tour of the unit and shown the laundry and association rooms. They have an ID card, which has the Samaritans, and detainee crisis line telephone numbers printed on the back. Officers explain and demonstrate the room bell system. The officer said staff introduce new detainees to any compatriots on the unit to make the settling in process easier. He could not recall the man ever approaching him with any specific questions or issues. He said he did not show any obvious signs that he needed extra support.
28. On 24 July, the man refused to transfer to Dungavel IRC in Scotland. An immigration form (IS91RA (part C) noted that he had refused to pack his belongings and said he did not want to move to Dungavel and wanted to stay at Morton Hall.
29. On 28 July, the man told a nurse in the daily nurse clinic that he had had a dry cough for about five or six months. The cough was occasionally chesty, though not at that time. He said he smoked cigarettes and the cough was usually worse in the morning. He had not lost any weight recently. The man did not have a high temperature and his chest was clear. The nurse advised him to stop smoking and to see the GP if the cough persisted. He also complained of occasional bleeding from the rectum. The nurse examined him but found no sign of haemorrhoids or other illness.
30. On 29 July, the man's solicitor sent a statement to the Home Office, National Removals Command (NRC) setting out why he should be allowed to stay in the UK. On 22 August, the NRC decided to certify the man's removal to Bangladesh. On 29 August, they issued removal directions to Home Office staff at Morton Hall for him to return to Bangladesh on 8 September.
31. Each night, Home Office staff at Morton Hall email to the night orderly officer (responsible for the operation of the centre) a list of detainees who will receive removal directions the next day. They include information about any risks identified on the immigration case information database (CID). The orderly officer completes a removal directions risk assessment for each detainee on the list, adding information from their NOMIS record and the Mercury Intelligence System (security record). The night orderly officer puts the risk

assessments in a bound book and the orderly officer on duty the next day uses them to brief the officers who accompany the contact management officers serving the removal directions.

32. A custodial manager, the night orderly officer, completed a removal directions risk assessment for the man. She included information from the case information database that the man had refused to go to Dungavel on 24 July. There were no alerts on his NOMIS record and no security reports on the Mercury system. She noted that he had no history of disruption, suicide or self-harm, escape attempts or assaults on staff. An operational manager, the duty manager on 30 August, countersigned the form. She commented that an officer should be present when the man received his removal directions to give feedback and that the Home Office might wish to consider suitable transport for the removal as he had previously refused to go to Dungavel.
33. The Home Office contact management officer served the man the removal directions later on 30 August. He told the investigator that removal directions are served in person in one of the meeting rooms. There is no formal list of questions and contact management officers are not required to explore the detainee's circumstances or undertake a risk assessment, though he said he always asks them if they are okay. The contact management officers do not see the removal directions risk assessment completed by the orderly officers. The officer said he only vaguely remembered speaking to the man and did not remember his reaction. He said he remembered that no one who he had served with removal directions that day had appeared upset.
34. The man said if he is concerned about a detainee's reaction to receiving removal directions, he tells the officer who is present at the meeting. An officer recorded on the man's NOMIS record that he had received his removal directions and had not raised any immediate concerns.
35. The man kept in regular telephone contact with several members of his family and spoke to his father several times a day. The man's family told us that he said he was all right at Morton Hall and that the food and accommodation were okay. He seemed his normal happy self despite his circumstances. On 4 September, he rang one of his cousins to tell her a bail hearing had been cancelled and that he would let her know the new date. She said they had a normal conversation about family and he seemed to be okay.
36. A detainee told the investigator that he met the man on Windsor Unit and they became good friends. He said that after the man received his removal directions he had told him that he was not worried about going back to Bangladesh. He said his solicitor was applying for asylum on his behalf in the UK, but, even if he had to return to Bangladesh, he planned to come back to the UK by marrying his girlfriend.
37. A detainee told the investigator that he regularly prayed in the mosque with the man. He had moved to Colnbrook Immigration Removal Centre on 31 August but came back to Morton Hall on 4 September. He said he prayed in the mosque with the man that evening and he seemed fine.

38. The Morton Hall Imam said he remembered the man from Friday prayers. He kept a low profile and did not appear to want to bother anyone or come to anyone's attention. He was very approachable and friendly and smiled a lot. He said the man did not appear to be in distress and he had no concerns about him. He engaged with his religion and came to prayers. He appeared to have close friends if he needed support.

#### **Friday 5 and Saturday 6 September 2014**

39. One of the man's brothers-in-law told the investigator that he had phoned him at about 3.45pm on Friday 5 September. He had told him that he had a ticket to fly to Bangladesh on Monday 8 September but his solicitor had asked him to call back after 5.00pm, as he might not be going. The man's brother-in-law said it was a normal conversation and they shared a joke. They discussed what he would do if he returned to Bangladesh and he offered him use of his shop there to run a business. His brother-in-law rang him back three times after 10.00pm to see if he had heard from his solicitor, but his phone was off.
40. The man's cousin said she spoke to him briefly between 4.30 and 5.00pm. She said he told her about his flight on 8 September. She said he was not worried about returning to Bangladesh but hoped to stay in the UK. He sounded like his normal self. She told him she would visit him at Morton Hall on Sunday 7 September.
41. The man's father spoke to his son at 4.30pm and again at about 8.00pm. He said their conversations were normal, they had a close relationship and talked many times each day. His father said his son was confident he would not be going back to Bangladesh on 8 September. He called his son at 11.00pm as usual to say goodnight but his son's phone was off. He called again at about 1.00am because he was anxious about this, but his phone was still switched off.
42. The man told his solicitors that he feared returning to Bangladesh and wanted to claim asylum. His solicitors spoke to him at 5.35pm to tell him they had faxed an asylum claim to the Home Office and would send him a copy for his records. According to Morton Hall's fax log, the fax arrived at 5.45pm and the man received it at 6.30pm.
43. A detainee said that the man told him that evening that he had applied for asylum and would not be going to Bangladesh on 8 September. He said the man was happy about this and they spent the evening together singing outside with other detainees. A detainee who lived opposite him said that the man knew he was not going back to Bangladesh and seemed very happy on the evening of 5 September.
44. A detainee told the investigator that he had met the man on Windsor Unit on 10 August. They became friends and saw each other every day. He was in the room next door. He said he had had lunch with the man on 5 September and he told him he was happy because his solicitor had applied for asylum.

The man spent the evening singing with friends. Just before he was locked in his room that evening, at about 8.42pm, the detainee in the room next door to the man found a letter pushed under his door about his own immigration case. He showed the man the letter before they were locked up for the evening.

45. A detainee said, in a statement to police, that he knew the man and the man in the room next door to him. He thought they were both named Ahmed. He said he sometimes read letters in English out for them. In his statement, he referred to Mr Ahmed (short) and Mr Ahmed (tall). CCTV shows that Mr Ahmed (tall) is the man living next door to the man who is the subject of this report. He said that before lock up on 5 September, the detainee stopped him as he passed him on the way to his room and asked him to read a letter. The man was standing with his fellow detainee. He thought the letter related to the detainee living next door to the man. He could not remember exactly what it said but thought a judicial review had been rejected which meant a deportation would go ahead. He said the detainee thanked him. As he walked away, he saw the detainee give some of the papers to the man.
46. An operational support grade (OSG) was the night patrol officer on Windsor Unit that night. She told the investigator that she knew the man by sight but had never spoken to him. She remembered two detainees pressing their room bells that night. The detainee in room 3/3 pressed his bell repeatedly because he wanted her to pass him something from the room opposite. She reported this and a custodial manager, the night orderly officer, asked the assistant night orderly officer to speak to the detainee in room 3/3, which he did. The detainee in room 4/19 had a headache and asked for a tablet. She told him she would call the nurse. He rang his bell again to ask where the nurse was and she explained that they were busy in reception.
47. A nurse told the investigator she remembered going to Windsor Unit at some point during the evening to give a detainee paracetamol for a headache. According to the night shift handover record, the detainee received painkillers at 10.50pm.
48. An officer was on duty that night based on Johnson, Sharman and Torr Units, with two further officers. The officer said he and his colleague went to Windsor Unit after 10.00pm because the operational support grade (OSG) was having problems with a detainee on landing 3, in room 3 or 4. He said the detainee wanted something passed to him and they told him this was not possible. The officer described the detainee as “ranting and raving and kicking and bashing his door quite violently”. He said they left him to calm down and could hear him still making a noise as they left the unit. The officer told the investigator that he could not remember going to Windsor Unit to see the detainee that night.
49. The room bell record for Windsor Unit from 8.36pm on 5 September until 7.03am on 6 September, shows calls from the following rooms on landings 3 and 4 at the following times:

8.36pm	Landing 4 room 20	Name	Cancelled at 8.36pm
8.53pm	Landing 4 room 3	Name	Cancelled at 8.53pm
10.10pm	Landing 4 room 19	Name	Cancelled at 10.13pm
10.23pm	Landing 3 room 3	Name	Cancelled at 10.24pm
10.28pm	Landing 3 room 3	Name	Cancelled at 10.32m
10.33pm	Landing 3 room 3	Name	Cancelled immediately
10.36pm	Landing 4 room 19	Name	Cancelled at 10.37pm

50. CCTV on landing 4 showed the following timings:

8.30pm	The man and his next door neighbour walk down the corridor and stand outside their rooms. As a detainee passes, they have a conversation and a piece of paper is passed between them.
8.32pm	The man goes into his room.
8.34pm	A female officer locks the man's door.
8.35pm	Room light from room 20 (detainee) flashes and a female officer answers within a minute.
8.51pm	OSG completes pegging check. As she is coming back down the landing, she answers room 3 bell (detainee) and spends a minute in conversation at the door.
10.07pm	OSG completes a pegging check.
10.08pm	Room bell light for cell 19 (detainee) begins flashing.
10.11pm	OSG answers room 19 bell.
10.34pm	Room 19 room bell light flashes again.
10.36pm	OSG answers room 19 bell.
10.50pm	A nurse and a female colleague go to room 19 and pass something through the door.

51. No one went to the man's door between 8.32pm and 11.17pm.

52. The OSG said she started the first welfare check at about 11.10pm on landing 1. When she got to landing 3, the detainee had covered his observation panel but she could hear him moving around. On landing 4, the man's light was on and his bedclothes were disturbed but she could not see or hear him. He did not respond when she knocked and called his name. She returned to his door twice more, during and after checking the remaining rooms on landing 4. The second time she said she knocked and kicked on the door and made a lot of noise. She contacted an officer and told him she could not see either of the detainees in 3/3 and 4/5. The officer went to the unit immediately with two colleagues.

53. The officer said they managed to persuade the detainee to uncover his observation panel before going to the man's room. His colleague said this took about a minute. The third officer said he could not see the man in his room so he opened the door immediately without knocking or calling out first. He found him hanging from the bathroom door, by the electric lead from his

kettle. He used his cut-down tool to release him and began cardiopulmonary resuscitation. At 11.27pm, the OSG radioed a code 1 emergency (the code for a medical emergency).

54. A nurse said she and a qualified emergency medical technician (EMT) who was acting as a healthcare assistant were in the health care unit when they heard the code 1. They picked up the two emergency bags and went immediately to Windsor Unit through the main entrance and up the stairs to landing four. The officers told her that the man had used a ligature to hang himself. An officer was doing chest compressions. The nurse asked for the defibrillator from the unit office. The OSG brought it and the nurse attached it to the man's chest. The defibrillator did not find a shockable heart rhythm.

55. CCTV footage from landing four shows the following:

11.16pm	OSG begins welfare check.
11.17pm	OSG looks through the man's observation panel. She spends about a minute at his door apparently trying to gain a response from him.
11.19pm	OSG checks the other side of landing 4 and looks through the man's observation panel again.
11.20pm	OSG returns to the man's door a third time after completing her checks and knocks on the door again. She then leaves the landing
11.28pm	Three officers go into the man's room.
11.30pm	A nurse and a qualified emergency medical technician (EMT) go into the man's room

56. The nurse said the man had no signs of rigor mortis but no signs of life. There was a ligature mark around his neck. She gave him oxygen using a bag and mask and then, after she inserted an airway, via a bag and airway. She said it was easy to move his head back to insert the airway. She took over chest compressions from the officer. The nurse and the EMT then alternated chest compressions. The first paramedic arrived on the unit at 11.45pm and attached his own defibrillator. The paramedic inserted a cannula (a small tube inserted into a vein) and administered adrenaline. All three then continued cardiopulmonary resuscitation until a second ambulance crew arrived and took over.

57. The fast response paramedic said that when he got to the man's room, two nurses and an officer were administering cardiopulmonary resuscitation. He said they were using the correct ratio of breath to compressions and appeared competent. In his police statement, the paramedic noted that the man was cold. He administered adrenaline. A second ambulance crew arrived and they began advanced resuscitation procedures using a cardiac pump and six more shots of adrenaline. After 20 minutes, paramedics pronounced the man dead.

58. The communications log and other incident records show:

11.27pm	Code one. (OSG call sign India 2.)
11.29pm	Ambulance required. (Officer, call sign India 4.)
11.30pm	Ambulance called by communications officer.
11.44pm	Fast response paramedic at main gate.
11.45pm	Fast response paramedic on Windsor Unit.
11.53pm	Second ambulance at main gate.
11.54pm	Second ambulance crew on Windsor Unit.
00.09am	The man pronounced dead by paramedics.

### Evidence from detainees

59. A detainee (room 3/15 - landing 3 room 15) said he had heard intermittent banging coming from a cell upstairs on landing 4 between 9.30 and 10.30pm but was not sure of the exact location. He said he heard several officers running upstairs at about 11.30pm.
60. A detainee (room 4/4, next door to the man) said he had heard a room bell between 9.30 and 10.00pm. He said that he knew it was the man's room bell because he saw a male officer answer it after about four or five minutes. The male officer said, "They are coming". Ten minutes later, he said he heard the bell again and banging and screaming. He tried calling the man's mobile phone but could not get through. He said the wall between the two rooms was shaking and the cell bell noise was continuous. The man next door said he heard an officer shout, "Why are you calling and pressing the bell, I told you the nurse is coming." A male officer did the roll check, knocked at the man's cell and then went away. Other officers and nurses then arrived and the nurses came out of the man's room, crying. Between 1.00 and 2.00am, three male officers came to his cell. They told him the man was dead. They said the banging he had heard could have come from downstairs. The man's next door neighbour said officers checked him throughout the night and he saw the Imam the next morning.
61. A detainee (room 4/6 – the other side of the man) said that about 10.00 or 11.00pm he had heard him ask to see a nurse. He dozed off and then heard a woman say, "He's not breathing." He heard the resuscitation attempt. He told police he did not hear anyone shouting, screaming or banging that evening.
62. A detainee (room 4/16, opposite the man) said he had heard knocking from the man's room between 9.30-10.30pm. He said he was watching a film and thought he might still be happy. He thought the knocking came from the man's room because it sounded close. He did not hear anything else. At about 11.45pm, the light in the corridor went on and he saw staff through his door panel. He tried to phone the man at midnight but his phone went through to voicemail and he could not understand the message because it was in English. He said at the time he thought staff were taking the man for deportation.

63. A detainee (room 4/17, also opposite the man) said, after 8.30pm he had heard a female officer answer a room bell. He thought it was the man because he recognised the voice. A male voice asked for a nurse and a female officer told him he would have to wait. He assumed the same man pressed the bell again because the officer came back and the same conversation took place – a male voice asked for a nurse and a female voice said he would have to wait. A while later, he heard officers outside his room. He heard a man say, “Shit he’s not breathing” and a woman crying. There was a lot of noise and he heard the attempt to resuscitate him.
64. A detainee (room 4/3) said, about 15 minutes after the female officer locked his room, he had told her that his kettle was not working, he had a headache and he wanted a cup of tea. She told him he would have to wait until the next morning. He heard a room bell pressed twice at about 9.30pm and felt a door shaking. He thought it was the man’s room because the next morning a detainee opposite told him the man had pressed his bell. He later heard more than two people coming and going but could not understand what they were saying.
65. A detainee (room 4/13) said that at some point after 9.00pm, he had heard a female officer go to one of the rooms. He did not know whose room it was but he heard a male voice ask for a nurse. The female officer replied she would ask for one but it might take a while. This happened again shortly after and the female officer said the nurse was in reception and would be about half an hour. Apart from this, he did not hear anything else until after 11.00pm when an officer checked his room. Shortly after this, he heard a number of footsteps and the sound of keys in one of the doors. He heard a male officer say “Oh shit” and afterward a female officer crying and saying, “He’s not breathing”. He said he heard nurses arrive and the sound of a defibrillator.
66. A detainee (room 4/7) said the detainee living next door to the man had told him he was due to be deported on Saturday 6 September. At about 10.30pm he was watching TV when he heard footsteps, a door open and a struggle. He heard a woman say, “He’s not breathing again.” At the time, he thought that detainee was being deported.
67. A detainee (room 4/19) said in a statement to police, that he had been suffering from a headache on 5 September and had rung his room bell between 9.00 and 10.00pm to ask for a tablet. An officer responded to his bell and then left. Then the man “next door” started to bang on his door and ring his bell. The man was shouting and sounded angry. He was not sure who was making the noise but thought it was from room 5. He could not tell what the man was shouting as it was in a different language. After 15 minutes, an officer brought him a tablet for his headache. He heard someone talk to the man making the noise. The man carried on banging, shouting and pressing his bell after the officer left. About ten minutes later he heard several officers on the landing. One called for an ambulance.

68. A detainee (room3/3) said in a statement to the police that he did not see anything or hear anything during the evening. He went to sleep about 1.00 or 2.00am and slept undisturbed until morning.

### **Events after the man's death**

69. Officers secured the man's room after the ambulance staff left. The police and Coroner's officer attended and secured evidence including the man's mobile phone and CCTV of landing 4. A member of the staff care team and the Imam were called in. The Imam said prayers over the man's body. A short meeting took place at 7.45am to debrief the staff who had been on duty or involved in the emergency response. A second debrief took place shortly afterwards with the nurse, the qualified emergency medical technician and the night orderly officer (NOO).
70. An officer told the man's neighbour in the early hours of the morning that he had died. Officers checked him regularly during the night. The imam spoke to him in his room the next morning. The other detainees learned that the man had died the next day – mostly from each other. Some said that officers told them in the morning that he had committed suicide using his kettle cable.
71. After news of the man's death became more widely known, an incident took place involving a number of detainees, which led to some minor damage to a small number of windows in the shop and health care centre. Movement in and out of the centre was restricted on 6 September while the National Offender Management Service's National Tactical Response Group (a specialist national resource that helps manage serious incidents) helped restore order.

### **Family liaison**

72. The Home Office immigration manager at Morton Hall said that the night orderly officer rang him at home at 1.05am and told him of the man's death. (Subsequent timings are from the manager's on-call log.) The NOO passed on the next of kin details held on the man's detainee transferable document (his cousin's first name and the address of the restaurant where enforcement officers had arrested him). At 1.20am, the manager rang the Home Office senior on-call manager and said he would find more details for the man.
73. At 1.23am, the immigration centre manager rang the detainee escorting and population management unit (DEPMU) to obtain the man's immigration case history. DEPMU told him there was no next of kin information on the Home Office case information database (CID). The immigration manager relayed the information to the Home Office senior on-call manager at 1.44am. At 1.51am, the immigration manager gave the police permission to access the man's Home Office file at Morton Hall to see if it contained any information about next of kin. At 2.36am, the NOO told the immigration manager there were no next of kin details in the file.

74. At 3.29am the Duty Manager told the immigration manager that the Coroner's Officer and Detective Inspector, the senior police investigator, were at Morton Hall and needed the next of kin details as a matter of urgency.
75. The immigration manager rang DEPMU again at 3.40am and found out that the man's passport was at Heathrow Airport. The duty officer at Heathrow Terminal 4 checked the case information database and found another address and a mobile phone number for him. The duty officer checked the central reference system (CRS) and found that an aunt and a restaurant in Canterbury had sponsored the man's visa application. At 4.55am, the NOO told the immigration manager that the address on his NOMIS record was a restaurant and gave him the phone number. At 4.58am, the manager rang the Home Office senior on-call manager and gave her the information he had gathered. She told him to tell Morton Hall that the Home Office would contact the man's next of kin.
76. The duty manager told the investigator that when he last spoke to the immigration manager, his understanding was that the Home Office family liaison officer would take responsibility for informing the next of kin. The DI told the investigator that he had offered to take responsibility for breaking the news to the man's next of kin, but he had told him the Home Office would do it. The Coroner's officer remembered the conversation and that by the time he and the DI left Morton Hall everyone agreed that the Home Office family liaison officer would contact the family.
77. The Home Office senior oncall manager told the investigator that she passed the number the immigration manager gave her for the restaurant to the designated Home Office family liaison officer who was based at an immigration removal centre in Scotland. She said her role was to notify strategic managers, and pass next of kin information to the family liaison officer, in this case, the designated Home Office family liaison officer.
78. The FLO told the investigator that the Home Office senior oncall manager contacted her at 8.06am on 6 September and gave a telephone number for a restaurant, the cousin's first name from the man's NOMIS record and a mobile phone number linked to another address. After a few unsuccessful attempts, she got through to the restaurant at 11.53am but they told her no one of the cousin's first name worked there. She also called the mobile number and left a voicemail at about 11.45am.
79. At some point in the morning of 6 September, a detainee sent a text message to the man's solicitors' emergency number telling them that he had died. The solicitors rang Morton Hall and were told to call the Home Office press office. When they rang, the press office was closed. Other detainees also contacted the solicitors giving conflicting information about the cause of his death. The solicitors asked the detainees to send a written statement by fax. The fax, received at 2.41pm, said that the man had been feeling ill that evening and had asked for a nurse. His request had been ignored and he had died as a result.

80. Detainees also contacted the man's relatives in Bangladesh and told them he had died. The relatives in Bangladesh contacted the man's cousin in the UK, Mr A. Mr A told the investigator that he had phoned Morton Hall and was told to call Home Office press office, which he too found to be closed. Mr A then rang the man's solicitors.
81. The man's solicitor rang Morton Hall again and left his contact details with the command and control unit managing the incident. They contacted the Home Office senior on-call manager, who passed the solicitor's number to the family liaison officer. The FLO called the solicitor at 1.38pm and he gave her Mr A's number.
82. The FLO spoke to Mr A at about 1.54pm on 6 September. Mr A said the FLO had only been able to tell him that his cousin had been pronounced dead at 12.09am and had no other information about the circumstances of his death. She rang Mr A again at 3.35pm, 5.01pm and 8.42pm after speaking to senior managers at Morton Hall and the Coroner's Officer and gave him more details about what had happened.
83. A second family liaison office took over from the original FLO on 8 September. He supported the man's family, offered funeral expenses in line with national policy and helped with arrangements to fly his body back to Bangladesh.

### **Post-Mortem**

84. There were two post-mortem examinations. Both concluded the cause of the man's death was by hanging. A toxicology report found no evidence that he was under the influence of alcohol or drugs at the time of his death.

## **ISSUES**

### **Assessing the risk of suicide and self-harm**

85. We have found no evidence that the man gave any indication that he was at risk of suicide or self-harm before his death. Family and friends who spoke to him on 5 September said that he appeared happy and his usual self. We do not consider that staff at Morton Hall could have reasonably foreseen or prevented his death.

### **The night of Friday 5 and Saturday 6 September**

86. Witness accounts from detainees on Windsor unit differ. Most detainees agree that at some point there was some form of banging or shouting from a room on the unit and that they heard someone ask to see a nurse. Almost all those interviewed heard some part of the emergency response. Some said that they had thought it was the man who was making the noise at the time and asking for the nurse. Some appear to have connected what they had heard with the man, only after they knew he had died.
87. Family and friends were concerned that the man's mobile phone was turned off when they tried to call him. Usually he left it on and spoke to his father to say goodnight at around 11.00pm.
88. CCTV shows that no one went to the man's door between 8.34 and 11.17pm. According to the room bell record, he did not press his bell at any time that night. The investigator tested the room bell on her opening visit to the centre and the police informed her that they had also done this. It was in good working order.
89. Evidence from staff, supported by CCTV and the room bell record, is that only three detainees pressed their room bells on landing 4 that night. A detainee on landing 3 pressed his bell three times between the first and second times a detainee on landing 4 used his bell. There is no evidence that the man attempted to contact staff or other detainees on the night of 5/6 September.
90. It appears that some detainees who were locked in their rooms at the time and could not see what was happening, confused the noises they heard from another detainee who wanted something passed to him and from a further detainee, who had asked for a painkiller, with the emergency response when staff found the man hanged. The next day, when they heard that he had died, they seem to have conflated these incidents, which led to a story that the man had died after he had asked for and been denied medical attention. We are fully satisfied that this was not the case.

### **Emergency response**

91. The OSG called a Code 1 emergency and, two minutes later, an officer radioed to ask for an ambulance. According to Governor's Order 036/10, 'Emergency medical assistance radio code', which is the policy currently in

force at Morton Hall for medical emergencies, a Code 1 indicates a detainee has been found hanging. Officers and the emergency response nurse are required to attend immediately. There is no instruction in the order to call an ambulance. Morton Hall's local policy instructs the orderly officer or night orderly officer to tell the control room to call an ambulance.

92. Prison Service Instruction (PSI) 03/2013 requires all prisons and NOMS-operated immigration removal centres to operate an emergency code system to effectively communicate the nature of an emergency and ensure there is no delay in calling an ambulance. Paragraph 5.4 requires that:

*“when the emergency is called over the radio network an ambulance must be called immediately [the italics mean that the action is mandatory.]”*

93. Overall, the emergency response was good. There was only a very slight delay in calling an ambulance and there is no evidence that it affected the outcome for the man, as the resuscitation attempt was prompt and competent. However, in such cases, every second can be crucial to the success or failure of resuscitation and we are concerned that local instructions do not reflect up to date national emergency instructions in PSI 03/2013. We make the following recommendation:

**The Centre Manager should ensure that the local emergency protocol meets the requirements of PSI 03/2013 and that the control room calls an ambulance as soon as an emergency medical code is called.**

In response to the draft report, Morton Hall said that they did have an up to date protocol in the control room that met the requirements of PSI 03/2013 at the time of the man's death but the OSG on duty did not follow it. When the investigator asked for a copy of their current protocol during the investigation, she was only given a copy of Governor's Order 036/10. We were therefore not aware of any updated protocol in the control room. Governor's order 036/10 has since been cancelled and replaced with a new Centre Manager's Order that reflects the protocol (see action plan).

### **Locking rooms on Windsor Unit**

94. One of the two main recommendations by HM Inspectorate of Prisons at their last inspection of Morton Hall in 2013 was:

*“Detainees should not be locked into cells and should not be restricted to units in the early evening.”*

We agree that it is not appropriate that detainees, who are not at Morton Hall as a result of criminal charges, should be locked in their rooms for almost 12 hours overnight. We do not know whether the fact that he was locked in his room had any bearing on the man's death, but if he had not been it might have led to his earlier discovery by one of his friends. We recognise that the man could have spoken to his family or friends by phone if he needed

support, but leaving the door unlocked would have meant that he could have spoken face to face with his friends that evening if he was feeling low. Detainees told the investigator that the man's death had made them anxious that if they felt low at night they would not be able to seek help.

95. In response to the Inspectorate's recommendation, Morton Hall successfully obtained funding to install gates at the ends of each landing on Windsor and Fry Units. Two members of staff will be on duty at night and the detainees will no longer be locked in their rooms. The implementation date for the new gates and increase in staffing is April 2015. We therefore make no recommendation about this matter.

### Contacting the man's family

96. At the time of the man's death, the instructions to immigration removal centres about contacting next of kin were contained in Detention Service Order (DSO) 02/2012 'Deaths in Detention'. However, this was under revision following the creation of a network of seven family liaison officers trained to be the contact point for bereaved relatives. The family liaison officers are based at different removal centres around the UK and work on a rota basis published on the Home Office intranet. There was no formal interim guidance, but the Home Office policy lead told the investigator that staff across the estate were made aware of the family liaison officer network at meetings and by email. A new DSO 08/2014 'Death in detention' was issued after the man's death, in October 2014.
97. When a detainee dies, DSO 08/2014 now requires the immigration removal centre to give the next of kin details to the local Home Office immigration manager. The immigration manager must inform the deputy director of detention operations (or senior on-call manager), who in turn contacts the duty family liaison officer (FLO). This requires three separate handovers of information. DSO 08/2014 states:

"The FLO role will start from the point that news of death is broken to the next of kin; this will be done by the police and **not** the Home Office FLO." [The bold is in the original].

Although DSO 08/2014 had not been issued when the man died, to some extent, this was the guidance that staff were following. There is no requirement in DSO 08/2014 for any Home Office staff to inform the police of the death. The immigration removal centre is required to summon police to the scene but there is no instruction to them to pass on next of kin details so the police can deliver the news to a family after a death. The Home Office does not have a memorandum of understanding or protocol with the police about this and it is not clear who is responsible for passing the information about the circumstances of the death to the police.

98. We were consulted about DSO 08/2014 at draft stage. In response, we said that we were concerned that the police have sole responsibility for informing the next of kin as they are unlikely to know any details about the person

concerned, the events leading up to their death or information about the immigration removal centre, which bereaved relatives would be likely to want to know. We considered that the instructions were too brief to cover adequately an issue as sensitive and complex as first contact with bereaved families. We said that we believed that, where possible, trained family liaison officers from the centre where the death occurred or from the Home Office should break the news of the death in person.

99. The events after the man's death have reinforced our concerns that the arrangements and guidance in DSO 08/2014 are inadequate. They do not place the interests of the deceased's family at its heart. The guidance relies on the police taking responsibility for breaking the news to the family, yet there is no evidence that the police are aware of this responsibility. No one sought to involve the police on the night of the man's death. The police investigator and the duty manager at Morton Hall were told the Home Office would take responsibility.
100. The flow of information between various officials is too complex and with three handovers, is prone to delay and miscommunication of facts. The man's family did not receive official confirmation of his death until 14 hours after his death. The appointed family liaison officer was unable to deal directly with the man's family when they contacted Morton Hall as she was based several hundred miles away and knew little about the circumstance of his death. This is unacceptable and contributed significantly to the family's distress. We consider that managers from the immigration removal centre where the death takes place should be responsible for arrangements for informing families. They are best placed to ensure that families get accurate information and to answer any immediate questions that bereaved families will have. We make the following recommendation:

**The Home Office should ensure that where possible, managers and/or trained family liaison officers from the immigration centre where a death takes place break the news to families in person.**

#### **Next of kin details**

101. After a death in an immigration removal centre in 2011, we recommended that United Kingdom Border Agency (UKBA) – which was then the responsible body - ensured that detainees in removal centres were encouraged to give next of kin details when they arrived, repeating a previous recommendation from a death in 2005. UKBA accepted the recommendation and said that detainees were now asked for the information when they arrived, during the initial health screening and during induction. A Detention Service Order was issued in November 2013, which specifically requires reception staff to ask for emergency contact details.
102. The man was asked for his details in line with the guidance but gave only the address of a restaurant where he had worked and the first name of one of his cousins. Staff at Morton Hall told the investigator that they explain why giving accurate information is important but there are a number of reasons why

detainees do not want to give such information. We accept that the detainee must take some responsibility for this but, as the Home Office acknowledges there is a widespread reluctance on the part of detainees to do so. We consider that the Home Office should consult their records in cases where next of kin information is evidently inadequate.

103. The immigration manager eventually tracked down further information about the man's family from his passport and his visa application but there was no agreed process for this. Both are likely sources of more accurate information and are held by the Home Office. There is also likely to be further information on the case information database. The address on the man's visa application was the current address of his family and had it been consulted or used earlier to complete next of kin details, would have resulted in earlier contact with his family. We are surprised that throughout the delay in establishing contact with the man's family, no one appears to have considered using numbers from his mobile phone. We make the following recommendation:

**The Home Office should ensure that staff in immigration removal centres use all sources of next of kin information where the information supplied is inadequate or incomplete.**

## **RECOMMENDATIONS**

1. The Centre Manager should ensure that the local emergency protocol meets the requirements of PSI 03/2013 and that the control room calls an ambulance as soon as an emergency medical code is called.
2. The Home Office should ensure that where possible, managers and/or trained family liaison officers from the immigration centre where a death takes place break the news to families in person.
3. The Home Office should ensure that staff in immigration removal centres use all sources of next of kin information where the information supplied is inadequate or incomplete.

**Home Office Action Plan**

**Morton Hall Immigration Removal Centre**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/Not Accepted</b>	<b>Response</b>	<b>Target date for completion</b>	<b>Progress</b>
1.	The Centre Manager should ensure that the local emergency protocol meets the requirements of PSI 03/2013 and that the control room calls an ambulance as soon as an emergency medical code is called.	Accepted	<p>The local emergency protocol was in place in the control room at the time of the incident. It was and still is fully compliant with PSI 03/2013 (and DSO 09/2014 issued in October 2014) and includes the instruction for control room staff to call an ambulance as soon as an emergency medical code is called.</p> <p>The Governors Order 36/2010 has been withdrawn and replaced with a Centre managers order that reflects the protocol. The Order was issued on 7 April 2015.</p>	Complete	
2.	The Home Office should ensure that where possible, managers and/or trained family liaison officers from the immigration centre where a death takes place break the news to families in person.	Accepted in part	A lot of consideration was given to the role of the FLOs and previous deaths in detention have highlighted the fact that the FLO needs to be someone from the Home Office rather than the service provider as many of the queries are related to the decision to detain. Home Office teams within the IRCs are relatively small and the FLO network relies on volunteer members of staff who have been assessed as possessing the appropriate skill set and personal qualities to undertake this sensitive and complex role. The geographical spread of the centres and the range of next of kin's addresses (including overseas) means that informing the next of kin in person may not, in all cases, be possible. Where achievable the Home Office will give consideration to	Complete	

			assigning FLO duties to a FLO from the IRC where the death takes place.		
3.	The Home Office should ensure that staff in immigration removal centres use all sources of next of kin information where the information supplied is inadequate or incomplete.	Accepted	An instruction will be issued to staff at all Immigration Removal Centres underlining the importance of utilising all information sources at their disposal to obtain next of kin details in the case of detainees who provide only partial or limited information.	End of May 2015	