

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lukasz Debowski a detainee at Morton Hall Immigration Removal Centre on 11 January 2017

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Debowski was found hanged in his room at Morton Hall Immigration Removal Centre on 11 January 2017. He was 27 years old. I offer my condolences to Mr Debowski's family and friends.

While there was little to indicate that Mr Debowski was at high or imminent risk of suicide before his death, I am concerned that staff did not take into account all his risk factors as a newly arrived detainee facing deportation. New psychoactive substances are too prevalent at Morton Hall and were detected in Mr Debowski's system when he died. It is possible that they may have played a role in his death.

It took too long to tell Mr Debowski's family of his death and, once again, we identified a need for more effective family liaison arrangements in immigration removal centres.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2017

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Summary

Events

1. On 16 November 2016, Mr Lukasz Debowski was arrested for offences that he had committed in Poland and was told that he was liable to be deported. He had been released from a psychiatric hospital five months earlier. In police custody, Mr Debowski was identified as at risk of suicide.
2. On 17 November, he arrived at Morton Hall Immigration Removal Centre, with a suicide and self-harm warning form. Reception staff assessed that he was not at risk of suicide and self-harm. It is not clear that staff fully considered the information available to them about his risk. Mr Debowski's personal officer noted he settled well and she had no concerns about him.
3. Mr Debowski submitted a number of bail applications to court after he arrived at Morton Hall. On 1 December and 10 January 2017, the court refused the bail applications. After the court hearings, he was told that he would be deported to Poland as soon as possible. Staff recorded no concerns.
4. At 11.51am on 11 January 2017, two detention custody officers went to Mr Debowski's room to conduct a routine roll check and found that Mr Debowski had hanged himself. They radioed a medical emergency code and healthcare staff arrived quickly and tried to resuscitate Mr Debowski. When paramedics and a doctor arrived, they took over his care but, at 12.26pm, they pronounced that Mr Debowski had died.
5. Mr Debowski's partner was not told of his death until 9.30pm that night.
6. A toxicology examination found NPS in Mr Debowski's bloodstream when he died

Findings

Assessing the risk of suicide and self-harm

7. There was little evidence to demonstrate that staff took sufficient account of the available information when assessing Mr Debowski's risk of suicide or self-harm and when assessing his mental health during his reception screening. Subsequently, however, there was little to indicate that he was at heightened or imminent risk in the period before his death. It would have been difficult given these circumstances for staff to have foreseen or prevented his actions on 11 January 2017.

NPS

8. NPS were detected in Mr Debowski's bloodstream after his death and we cannot exclude the possibility that they played a part in him taking his life. While there was no security intelligence to indicate that Mr Debowski had taken illicit drugs and he gave staff no indication that he was under the influence of an illicit substance before his death, it is important that Morton Hall focuses on the prevalence and dangers of NPS and does all it can to eradicate their use.

Contacting Mr Debowski's next of kin

9. It took too long (nine hours) until Mr Debowski's partner, his next of kin, was told he had died. The Home Office family liaison officer should have kept in closer contact with the police and escalated the police delay promptly to the Head of Home Office Detention Services to decide how to proceed.

Recommendations

- The Centre Manager and Head of Healthcare should ensure that staff manage detainees at risk of suicide and self-harm in line with national guidelines, in particular, staff should:
 - Have a clear understanding of their responsibilities and the need to record relevant information about risk.
 - Consider and record all the known risk factors of newly arrived detainees when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.
 - Start suicide and self-harm prevention procedures (known as ACDT) whenever a detainee has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.
- The Centre Manager should ensure that there is an effective supply and demand reduction strategy to help eradicate the availability of NPS, and that staff are vigilant for signs of its use.
- The Head of Home Office Detention Services should ensure that in line with Detention Services Order 08/2014, where the police delay in notifying a detainee's next of kin of his/her death, Home Office family liaison officers escalate the matter promptly to the Head of Detention Services to liaise with police about how to proceed so that further delay is avoided.

The Investigation Process

10. The investigator issued notices to staff and detainees at Morton Hall Immigration Removal Centre informing them of the investigation and asking anyone with relevant information to contact him. No one came forward.
11. NHS England commissioned a clinical reviewer to review Mr Debowski's clinical care at Morton Hall.
12. The investigator visited Morton Hall on 17 January 2017. He obtained copies of relevant extracts from Mr Debowski's detention and medical records and CCTV footage recorded on 11 January 2017. He interviewed 15 members of staff and three detainees at Morton Hall, some jointly with the clinical reviewer.
13. We informed HM Coroner for Central Lincolnshire of the investigation and sent him a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Debowski's partner to explain the investigation. She had no specific matters for the investigation to consider.
15. Mr Debowski's family's legal team received a copy of the initial report and chose not to comment or provide feedback

Background Information

Morton Hall Immigration Centre

16. Morton Hall Immigration Removal Centre is managed by HM Prisons and Probation Service (HMPPS) on behalf of the Home Office. It holds up to 392 adult men in single rooms in six units. Nottinghamshire Healthcare NHS Trust provides healthcare at Morton Hall.
17. Morton Hall has two residential units which hold 160 detainees over two floors and provide more secure accommodation for detainees identified as at high risk to share a room. Fry Unit also houses some detainees on detoxification programmes.
18. A Home Office team of contact management officers facilitate contact with the detainees' Home Office immigration caseworkers, contribute to detainees' induction and issue monthly reports to detainees about their immigration position.

HM Inspectorate of Prisons

19. The last inspection of Morton Hall was in November 2016. Overall, inspectors found Morton Hall was generally well run. The reception area remained cramped and too small for purpose but screening of new arrivals was thorough. Many detainees reported feeling depressed or suicidal on arrival. There had been a three-fold increase in incidents of self-harm since the previous inspection in 2013. The inspectors also found strong evidence of a serious increase in the availability and use of new psychoactive substances (NPS).

Independent Monitoring Board

20. 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 2015, the IMB noted that Morton Hall was a very well-run establishment which provided a safe and secure environment for detainees. It reported that in the previous 12 months, there had been an increase in the number of incidents of drug-taking and the availability of drugs and this was reflected in increasing levels of violence, disturbance and self-harm. It raised concerns about the initial interviewing procedure in reception and a lack of use of Language Line, where detainees had a limited comprehension of English.

Previous deaths at Morton Hall

21. Mr Debowski was the second detainee to take his life at Morton Hall since it became an immigration removal centre in 2011. In our previous investigation, we raised concerns about the family liaison process.

Assessment, Care in Detention and Teamwork (ACDT)

22. ACDT is the Home Office care-planning system used to support detainees at risk of suicide or self-harm. The purpose of ACDT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the detainee.

23. After an initial assessment of the detainee's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the detainee anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the detainee. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACDT plan should not be closed until all the actions of the caremap have been completed.
24. All decisions made as part of the ACDT process and any relevant observations about the detainee should be written in the ACDT booklet, which accompanies the detainee as they move around the removal centre. Guidance on ACDT procedures is set out in Detention Service Order (DSO) 6/2008.

New psychoactive substances (NPS)

25. NPS, previously known as 'legal highs' (although they are now illegal), are an increasing problem across immigration removal centres. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Individuals under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide and self-harm.
26. In July 2015, we published a Learning Lesson Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and individuals of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies. Unlike prisons, Immigration removal centres are not permitted to conduct mandatory testing for specified NPS.

Family liaison

27. Detention Services Order (DSO) 08/2014 on Death in Detention sets out responsibilities when handling a death in immigration detention. It says that Home Office Detention Operations has a small, central network of trained family liaison officers who are appointed to be the main point of contact between the named next of kin and the Home Office when there has been a death in an immigration removal centre.
28. The DSO requires the police – and not the Home Office family liaison officer or the immigration removal centre – to break the news of a death to the deceased's next of kin. It says that if there is a delay with the police notifying the named next of kin, the Home Office family liaison officer should raise this with the Head of Home Office Detention Operations who will decide how to proceed, in consultation with the police. It says that the family liaison role begins from the time the news of the death is broken to the family.

Key Events

Background

29. Mr Lukasz Debowski, a Polish national, moved to the UK in around 2014. In 2016, UK immigration intelligence indicated that Mr Debowski had been convicted of eight offences in Poland between 2010 and 2016 and had previously served a two year prison sentence. On 16 November 2016, the police arrested Mr Debowski and told him he was liable to be deported. Mr Debowski told the police that he felt suicidal and had previously tried to take his life.

17 November 2016

30. At 2.28am on 17 November, Mr Debowski was taken to Morton Hall Immigration Removal Centre. Mr Debowski arrived with a Person Escort Record (PER, which accompanies detainees on all journeys between police stations, courts, prisons and all places of immigration detention) and a suicide and self-harm warning form. The PER noted that Mr Debowski was Polish and needed an interpreter. It noted that Mr Debowski had anxiety, had been released from a psychiatric ward five months earlier and had a history of attempted suicide and current thoughts of suicide. Mr Debowski's suicide and self-harm warning form noted Mr Debowski was withdrawn, low in mood and had told the police that he wanted to kill himself.
31. A Detainee Custody Officer (DCO) booked Mr Debowski into Morton Hall. At 2.40am, a nurse completed Mr Debowski's medical health screen and used the interpretation service to do so. (She was unavailable to be interviewed during the investigation). She recorded in Mr Debowski's medical record that he engaged well during the examination. Mr Debowski told her he was fit and well, had no health issues and was not taking any medication. He said he was not registered with a GP in the community. She asked Mr Debowski about his statement to the police that he wanted to kill himself. Mr Debowski said that he no longer had thoughts of suicide or self-harm and was okay.
32. The nurse noted Mr Debowski had no history of mental health or substance misuse issues and had not been admitted to a psychiatric hospital. There is no evidence that in doing so she had fully reviewed the person escort record which stated otherwise (even though she was aware that he had told police he wanted to take his life). She completed an alcohol screening which raised no concerns and noted Mr Debowski's physical observations. She had no concerns about Mr Debowski and told him about the support networks available at Morton Hall.
33. A DCO completed Mr Debowski's first night in custody assessment. She told the investigator that she could not remember Mr Debowski well but was aware that his first language was Polish and that he could speak a little English. She said he did not need the interpreting service. She recorded that Mr Debowski had no current thoughts of suicide or self-harm. He declined the offer of a telephone call to a friend or family member. She said she could not recall seeing any recorded information about Mr Debowski's risk of suicide and self-harm, despite him arriving with a PER and a suicide and self-harm warning form, both of which indicated he was at risk. She gave Mr Debowski a smoker's pack and a mobile phone SIM card. Mr Debowski was housed in the induction unit (Seacole Unit).

Later that morning, another DCO completed a comprehensive induction with Mr Debowski and recorded no concerns.

18 November - 29 November 2016

34. A Home Office contact manager completed Mr Debowski's induction on 18 November and explained his immigration status to him. She used an interpretation service. She explained the reason for his detention and told him that he could apply for bail. Mr Debowski said he did not want to return to Poland as he has been in the UK for six years and his girlfriend was heavily pregnant. He identified his partner as his next of kin.
35. On 20 November, staff moved Mr Debowski to Fry Unit. A DCO told him about Morton Hall's personal officer scheme (a detainee's first point of contact if they had any concerns).
36. On the evening of 29 November, a DCO introduced herself to Mr Debowski as his new personal officer. She was on night duty but told Mr Debowski that she would assess his needs shortly. She said Mr Debowski's level of English was okay and he understood the purpose of their conversation. She reminded Mr Debowski that he could speak to any member of staff if he had any problems. Mr Debowski said he had no concerns.

December 2016

37. Mr Debowski submitted four bail applications to the First Tier Tribunal (Asylum and Immigration) after he arrived at Morton Hall. The Home Office opposed Mr Debowski's stay in the UK because he had been convicted of serious criminal offences in Poland and they considered that it was not in the public interest for him to remain in the UK. The Home Office did not accept that Mr Debowski had demonstrated a genuine and subsisting relationship with his partner. On 1 December, the court refused Mr Debowski's first bail application. On 7 December, the Home Office told Mr Debowski of their decision to deport him. (Mr Debowski's withdrew his other two bail applications but submitted another application, which was scheduled to be heard on 10 January 2017.)
38. On 18 December, the personal officer assessed Mr Debowski's immediate needs and noted that Mr Debowski had no issues of immediate concern. Mr Debowski said his partner was expecting their baby and he wanted to remain in the UK.

January 2017

39. On 7 January, the personal officer again saw Mr Debowski. She recorded that he had had no issues over the Christmas period, and was socialising well with other detainees. Mr Debowski told her that he was looking forward to progressing his right to remain in the UK.

10 January

40. At 11.25am on 10 January, Mr Debowski attended his bail hearing by video-link. The judge refused his bail application. There was no evidence that Mr Debowski subsequently discussed the outcome of his bail hearing with staff. A DCO was on duty in the video-link room and told the investigator that he briefly saw Mr

Debowski before and after his hearing. He said that he had no concerns about him. He said he telephoned the staff in Fry Unit about the outcome of the hearing. Two DCOs were on duty on Fry Unit and told the investigator that they had no recollection of receiving a phone call about Mr Debowski's bail hearing or welfare.

41. At around 2.00pm, a Home Office contact manager gave Mr Debowski his monthly report, updating him on his immigration position. He said that he did not recall much about Mr Debowski and it was the first time he had met him. Mr Debowski's immigration records said that he did not speak English well and so the manager used the interpretation service.
42. Mr Debowski's immigration report noted that the Home Office had decided to deport him to Poland as soon as possible. Mr Debowski signed a document to confirm that he understood. The Home Office contact manager said that he did not recall Mr Debowski raising any concerns.
43. A detainee who lived on Windsor Unit told the investigator that Mr Debowski had told him that day that his child had been born and that he was having problems sleeping. He said Mr Debowski had asked the doctor at Morton Hall for medication to improve his sleep but the doctor had not prescribed any. There was no evidence in Mr Debowski's IRC or medical records that he had any further contact with healthcare staff after his initial reception screening.

11 January

44. Two DCOs said that, on the morning of 11 January, Mr Debowski's room was unlocked at around 7.45am. Neither of them knew Mr Debowski and were not concerned about him at the time. CCTV footage showed Mr Debowski leaving and returning to his room a number of times throughout the morning for short periods. None of his actions suggested that he was distressed or in crisis.
45. Residents can collect their breakfast from the dining hall and Mr Debowski left his room at 8.01am. A detainee who lived on Fry Unit said that he last saw Mr Debowski at breakfast and while Mr Debowski appeared upset, he did not question him about it. Mr Debowski had previously told him that he was worried about being deported but he had never given any indication that he would harm himself.
46. A DCO said he saw Mr Debowski walk past the staff office that morning. He said that he appeared okay and raised no issues with staff.
47. At 8.13am, Mr Debowski returned to his landing on Fry Unit and went into another detainee's room. The detainee told the investigator that Mr Debowski asked him for some tobacco, which he gave him. He said he had no concerns about him. He said he saw Mr Debowski again at around 10.00am when he borrowed his kettle from him.
48. At 10.00am, a DCO completed the fabric check on the unit, which included checking Mr Debowski's room. At 10.22am, Mr Debowski left his room and the landing and returned to his room five minutes later.

49. CCTV footage showed that at 10.49am, a detainee visited Mr Debowski. He opened and looked through Mr Debowski's room door observation panel and immediately stepped back as if he had seen something that had either surprised or shocked him. He told the investigator that he had not seen anything.
50. Between 10.50am and 11.10am, Mr Debowski left his room twice and walked off the landing on both occasions for short periods before returning to his room.
51. At 11.45am, detention custody officers across Morton Hall started a roll check and all detainees were instructed to return to their rooms. Two DCOs were assigned to complete the roll check on the first and second landing on Fry Unit. They checked Mr Debowski's room at 11.50am and found his door observation panel covered with white paper. A DCO knocked on the room door while simultaneously calling Mr Debowski's name, unlocking, and opening the door. Mr Debowski was hanging behind the door, with his feet off the floor, from a ligature tied above the door. The ligature appeared to have been made from a plaited piece of bedding.

Emergency response

52. The DCO radioed an emergency medical code one. This was recorded in the control room log at 11.51am. Ambulance records showed an ambulance was called at 11.53am. He cut the ligature while his colleague supported Mr Debowski's weight and they lowered him to the floor. They assessed Mr Debowski but found no signs of life. Two more officers arrived at Debowski's room within a minute.
53. Within two minutes of the code one emergency call, two nurses arrived with an emergency response bag and oxygen. They took over Mr Debowski's care but found no signs of life. His pupils were fixed and there was a clear ligature mark on his neck. A nurse started cardiopulmonary resuscitation by doing chest compressions. The other nurse applied oxygen and attached a defibrillator (a device that monitors heart rhythms and administers an electric shock if required) to Mr Debowski. The defibrillator instructed to continue cardiopulmonary resuscitation efforts.
54. The paramedics already on site at Morton Hall arrived at Mr Debowski's room at 12.03pm and continued resuscitation efforts. A doctor arrived from the air ambulance service and pronounced at 12.26pm that Mr Debowski had died. In line with Morton Hall's death of a resident contingency plan, the police were notified that Mr Debowski had died.

Support for detainees and staff

55. The Manager of Morton Hall debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. On the same day, staff met other detainees on Fry Unit, told them of Mr Debowski's death and offered support. Staff reviewed all detainees assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Debowski's death.

Family liaison and contact with Mr Debowski's next of kin

56. The Lincolnshire police started to arrive at Morton Hall from 1.40pm. At 2.15pm, a Home Office operations manager asked the police to tell Mr Debowski's partner, his next of kin, that he had died. She told the police that Mr Debowski's partner was heavily pregnant and that they should phone an officer who had been appointed as the Home Office family liaison officer once they had broken the news.
57. The Home Office family liaison officer told the investigator that at 7.30pm that evening Lincolnshire Police had still not contacted her, so she phoned them to check that the family had been told the news. The police told her that they had emailed Lancashire Police (who served the area where Mr Debowski's partner lived) about Mr Debowski's death but they had not responded. She phoned Lancashire Police directly to explain the situation and they later agreed to break the news to Mr Debowski's partner. The police phoned her to say that they had located Mr Debowski's partner on a maternity ward in hospital.
58. At around 9.00pm, the police arrived at the hospital. At around 9.30pm, they broke the news to Mr Debowski's partner (through her daughter who spoke English) that Mr Debowski had been found dead in his room. The police, the family liaison officer and a Home Office manager agreed not to disclose the full details of his death that night as it was a particularly sensitive situation. Mr Debowski's partner's daughter phoned the family liaison officer immediately. They spoke briefly and the family liaison officer offered support.
59. The next day, the family liaison officer phoned Mr Debowski's partner's daughter, gave her more information about Mr Debowski's death, offered support and explained the next steps. Mr Debowski's partner's daughter had told his sister and mother in Poland, and the family liaison officer spoke to them, using an interpretation service. She continued to liaise with Mr Debowski's partner and mother by telephone, with assistance from a DCO who spoke Polish. She and another Home Office family liaison officer visited Mr Debowski's partner after she had been discharged from hospital. She said that she had asked that the DCO accompany her, but management refused this request for operational reasons. In line with national instructions, Home Office Immigration Enforcement contributed to the cost of Mr Debowski's funeral and repatriation.

Post-mortem report

60. A post-mortem examination concluded that the cause of Mr Debowski's death was hanging. A toxicology examination found Spice (a NPS) in Mr Debowski's bloodstream when he died.

Findings

Assessing the risk of suicide and self-harm

61. Mr Debowski had a number of risk factors for suicide and self-harm, including that he had recently arrived in custody, he allegedly had a history of self-harm and mental health issues, and he was a foreign national, who was expecting to be deported.
62. Mr Debowski had been identified as at risk of suicide and self-harm while in police custody. The suicide and self-harm warning form and the person escort record that accompanied him to Morton Hall in November 2016 noted he had previously attempted suicide and had thoughts of killing himself. The person escort record also indicated that he had been released from a psychiatric hospital five months earlier.
63. The reception nurse who completed Mr Debowski's health screen asked him about his current risk of suicide and self-harm, and noted that he had said he wanted to kill himself while in police custody. Despite his comments, the person escort record and his suicide and self-harm warning, she did not identify that Mr Debowski was at risk of suicide and self-harm. We are concerned that the nurse did not find out more information about Mr Debowski's time in a psychiatric hospital and that she does not appear to have used the available information about Mr Debowski's risk as a tool to assist her assessment of him.
64. Similarly, the reception officer told us she could not recall seeing information about Mr Debowski's risk of suicide or self-harm. Staff may well not remember detailed interactions after a period of time, but neither the officer nor the nurse appear to have addressed or acknowledged any of the concerns recorded in Mr Debowski's person escort record and suicide and self-harm warning form. Nor, critically, had they recorded what led to their conclusion that he was not in fact at risk of suicide or self-harm, despite the clearly documented risks.
65. While reception staff overlooked some initial risk information which led to poor quality early assessments of Mr Debowski's risk of suicide and self-harm, we do not know how material these failings were, ultimately, for Mr Debowski. Staff reported positive interactions with Mr Debowski during his subsequent two months at Morton Hall, and we found no evidence that he was at imminent risk of suicide or self-harm in the days before his death. Staff and detainees who saw and spoke to him on the day he died, raised no concerns about him. We make the following recommendation:

The Centre Manager and Head of Healthcare should ensure that staff manage detainees at risk of suicide and self-harm in line with national guidelines. In particular, staff should:

- **Have a clear understanding of their responsibilities and the need to record relevant information about risk.**
- **Consider and record all the known risk factors of newly arrived detainees when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.**

- **Start suicide and self-harm prevention procedures (known as ACDT) whenever a detainee has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.**

Clinical care

66. The clinical reviewer noted that the clinical care Mr Debowski received while at Morton Hall was equivalent to the level of care he would have received in the community.

NPS

67. We are concerned about the prevalence of NPS in immigration detention centres and their effect on the behaviours and health of those taking them, including an association with suicide and self-harm. In July 2015, we published a Learning Lessons Bulletin about the deaths associated with the use of NPS. It identified the need for better awareness of the dangers of NPS, the need for an effective drug supply and demand reduction strategy and better monitoring by drug treatment services.
68. While there was no security intelligence to indicate that Mr Debowski might have been taking illicit drugs and he gave staff no indication that he was under the influence of an illicit substance before his death, we are concerned that Spice was detected in Mr Debowski's bloodstream when he died. We cannot exclude the possibility that it played a part in him taking his life. Inspectors found strong evidence of a serious increase in the availability and use of new psychoactive substances (NPS) at Morton Hall, and we consider it important that Morton Hall focuses on the prevalence and dangers of NPS and does all it can to eradicate their use. We make the following recommendation:

The Centre Manager should ensure that there is an effective supply and demand reduction strategy to help eradicate the availability of NPS, and that staff are vigilant for signs of its use.

Contacting Mr Debowski's next of kin

69. The instructions in DSO 08/2014 require the immigration removal centre – Morton Hall is managed by HM Prisons and Probation Service - to tell the police about a detainee's death and sets out that the police should break the news of the death to the deceased's next of kin.
70. Mr Debowski died at 12.26pm on 11 January 2017 and the police were informed of this within an hour and started to arrive at the centre from 1.40pm. The Home Office manager informed the police at 2.15pm and asked them to contact the Home Office family liaison officer once they had told Mr Debowski's partner of his death. She chased the police directly over five hours later when she had not heard from them. It took the police a further two hours to break the news. This was an unacceptable delay of nine hours after Mr Debowski's death, which may have added to his family's distress. DSO 08/2014 is clear that when the police delay contacting the next of kin, the Home Office family liaison officer should escalate the issue to the Head of Detention Services who should, in consultation

with the police, decide how to proceed. This did not happen and informing Mr Debowski's partner was not given the urgent attention and priority it warranted. Given the importance and sensitivity of the issue, we would have expected the family liaison officer to have kept in closer contact with the police and escalated the matter to the Head of Detention Services to decide how to proceed within a couple of hours of notifying the police of the death.

71. In a previous investigation about the death of a detainee at Morton Hall in September 2014, we identified concerns about contacting the deceased's next of kin, including the delay and miscommunication of information between staff. We are concerned that these issues have not been addressed and we make the following recommendation:

The Head of Home Office Detention Services should ensure that in line with Detention Services Order 08/2014, where the police delay in notifying a detainee's next of kin of his/her death, Home Office family liaison officers escalate the matter promptly to the Head of Detention Services to liaise with police about how to proceed so that further delay is avoided.

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