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Home Office

HOME OFFICE
Operations Group
Professional Standards Unit

A Home Office review into the circumstances of the detention of xxxxx who died on 17 November 2012 at Harefield Hospital, having been previously detained at Harmondsworth Immigration Removal Centre (IRC).

IMG Ref: 13/1562/1617/1

Investigating Officer
[redacted]

[redacted]

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1. EXECUTIVE SUMMARY

1.1 The Professional Standards Unit (PSU) was commissioned by Operations Director, to review the circumstances of the detention of xxxxx who died on 17th November 2012 at Harefield Hospital, having previously been detained at Harmondsworth Immigration Removal Centre (IRC). The terms of reference for the review are highlighted at Section 2 of this report.

1.2 A representative of the medical staff at Harefield hospital has confirmed that xxxxx died of heart failure and his detention and use of hand restraints during his hospital stay did not influence that outcome. However, whilst at hospital, xxxxx was detained in a closet chain handcuff for nearly the entirety of his one week stay, including during as angioplasty; the cuff was removed seven hours before his death. Current guidance issued to detention staff is clear: handcuffs should be removed at the request of medical staff, but no request was made. This review outlines some of the issues involving the use of hand restraints in a hospital environment and has recommended that improved guidance is developed.

1.3 The relevant Criminal Casework Directorate (CCD) policies and procedures related to the detention of xxxxx appeared to have been adhered to, although a number of issues were identified regarding the decisions to maintain his detention and a number of recommendations have been made to improve this process including specific guidance to CCD caseworkers when reviewing the detention of detainees admitted to hospital in addition to improved communications regarding the conditions in which detainees are held in hospital.

1.4 It was found that there was a failure in the DEPMU process to notify senior managers of xxxxx's stay in hospital and recommendations are made regarding introducing a process to allow better oversight by senior managers in Detention Operations, as well as the detainee risk assessment process operated by their contractors.

1.5 This review has found that overall GEO officers who conducted the bed watch whilst xxxxx was in hospital demonstrated a high level of consideration for his welfare. Although recommendations are made regarding the risk assessment process operated by contractors, along with better oversight by the Home Office and improved guidance regarding the use of restraints in a hospital environment.

2. TERMS OF REFERENCE

To investigate: the circumstances of the death of xxxxx who died on 17 November 2012 at Harefield Hospital in Uxbridge having been previously detained at Harmondsworth Immigration Removal Centre (IRC).

- To identify whether all relevant processes within Detention Operations (both at the IRC and at DEPMU) and CCD were complied with following xxxxx's transfer to Harefield Hospital from Harmondsworth IRC.
- To investigate if GEO managed the bed guard appropriately, with particular reference to their risk assessment process.
- To identify if there were failings in the duty of care to xxxxx and if so what they were.
- To consider and report on whether there is any learning for any individual UK Border Agency officer or contractor. Or organisational learning for the UK Border Agency, including whether any change in UK Border Agency policy or practice is required.

3. METHODOLOGY

3.1 In conducting the review I have examined the records of GEO, the Home Office records of CCD in Liverpool and UKBA, Harmondsworth IRC and DEPMU. I have also spoken to the case officers at CCD, Harmondsworth, CCU along with various members of the GEO team involved with xxxxx case and examined the available guidance on Horizon. I obtained xxxxx's medical notes from Primecare, the medical contractors responsible for healthcare at Harmondsworth Immigration Removal Centre (IRC). I met the AD who was responsible for IRCs at the time. In addition I visited the Royal Brompton Harefield National HealthTrust hospital and visited the wards where xxxxx was cared for. I also spoke to members of the hospital staff caring for xxxxx, along with more senior members of the hospital staff who provided an overview of the circumstances of this case. References to their comments are made throughout this report but a full account of their comments is largely recorded in section 7 of this report.

3.2 Since 01/04/13, UKBA was integrated into the Home Office. However, UKBA is used in this report when historical reference is made to the officer's unit status at that time.

Hospital Medical Review

3.3 It may be useful at the outset to detail the medical overview of xxxxx's condition provided by xxxxx, Lead Clinician in Clinical Risk from Harefield hospital in order to put into context the corresponding actions taken by UKBA and GEO in this review.

3.4 xxxxx was referred to Harefield hospital on 09/11/12 he was relatively unwell but not considered an emergency at this stage. An angioplasty was carried out: catheters were inserted into his heart. His aortic valve was failing which is a serious condition.
On 10/11/12 medication was prescribed to reduce the pulmonary oedema.
On 11/11/12 xxxxx was relatively stable.
On 13/11/12 the doctors held a multi disciplinary conference to discuss his treatment and the consensus was that he required an operation; this was major cardiac surgery which could be scheduled, but was semi urgent.
On 15/11/12 xxxxx was stable

[redacted]

On 16/11/12 xxxxx became unwell and was taken to ICU at around 1900hrs. At around 20:50 hrs he had increased heart failure and multi organ failure, at this point he would have been very drowsy and very unwell
On 17/11/12 at 01:25hrs xxxxx died.

Review of the initial decision to detain xxxxx. (UKBA enforcement instructions and guidance, Chapter 55: Detention and Temporary Release)

3.5 xxxxx was a time served foreign national ex prisoner and was detained following a period when he failed to report regularly as required by his bail conditions. Permission to split the family was granted prior to his detention. xxxxx had a wife and three sons in the United Kingdom. Detention can only lawfully be exercised where there is a realistic prospect of removal within a reasonable period and the only bar to xxxxx's removal was his travel document, which had been applied for and was regularly reviewed and therefore his circumstances appear to meet the requirements.

3.6 On 10/08/12, xxxxx was detained at Becket House Reporting Centre when he attended for his scheduled reporting appointment. On his detention xxxxx advised the officer at Beckett House that he had shaking heart syndrome and GP told him 2 years ago he required a small operation but he became afraid and did not return to his GP thereafter. He reported left arm pain and headaches but had not taken any medication. The officer contacted the CCD caseworker to ensure the detention should proceed, which was confirmed and the officer correctly recorded details of his medical condition on CID, his detention paperwork along with information that he had a marker on his PNC entry stating he was violent [redacted]. His movement order from DEPMU included the medical risk on IS91 and this information was recorded also on his Personal Escort Record (PER) when he was escorted to Harmondsworth IRC.

3.7 xxxxx was detained at Harmonsdworth IRC from 10/08/12 until 09/11/12. He was seen by healthcare the day following his arrival, as per the induction process. His healthcare records show that the doctor was aware of his medical condition and was concerned about his medical history and requested sight of his previous medical records to review. DSO 3/2008 Special illness and Conditions (Rule 35) is to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. There was no record of a Rule 35 report being raised for xxxxx at any time during his detention. The medical care provided to xxxxx falls outside of the remit of this review.

3.8 Once admitted at Harefield hospital on 09/11/13, as per procedure, healthcare at the IRC liaised with the medical staff at the hospital and reported to the case owner regarding xxxxx's fitness for detention. Xxxxx's detention paperwork appeared to have been correctly issued and amended when required to the extent that his medical conditions were known to UKBA and Detention Operation staff. The medical records show that xxxxx had a pre-existing heart condition. The CCD caseworker confirmed that she was not advised at any stage that xxxxx was not fit for detention until the evening of 16/11/12.

CONSIDERATION OF THE TERMS OF REFERENCE AND RECOMENDATIONS

4. To identify whether all relevant processes within Detention Operations (both at the IRC and at DEPMU) and CCD were complied with following xxxxx's transfer to Harefield Hospital from Harmondsworth IRC.

Detention Operations:

4.1. UKBA at IRC.

4.1.1 UKBA officers were notified that xxxxx was taken to hospital and signed GEO manager's risk assessment form on 09/11/12. The records held by officers are limited but there are some notes on CID dated 11/11/12, made by Deputy UKBA Manager at the IRC, regarding enquiries made with GEO regarding xxxxx's condition, following the receipt of the IS91 RA. (Dated 09/11/12, faxed on 10/11/12). The Deputy UKBA manager was advised that she should contact GEO for an update the following day and she left a note for another office to do this.

4.1.2 There is no record of any further actions by UKBA at the IRC until 16/11/12. The Deputy UKBA manager was again on duty and was advised at around 15:45 by GEO manager that the officers on bed watch had advised him xxxxx's condition was deteriorating and he was close to death and their healthcare manager was trying to find out further information. The Deputy UKBA manager was then asked to confirm whether xxxxx was handcuffed by the senior UKBA Manager so she contacted GEO again who confirmed he was in restraint and that he was partially restricted and could only go to A and G unit. The senior UKBA manager requested a copy of the Part C from GEO and the Deputy UKBA manager contacted the GEO senior manager asking him to remove that hand restraint. The GEO senior manager declined and said that UKBA should instead release him from detention.

4.1.3 At 16:21 Primecare advised the Deputy UKBA manager in writing that xxxxx was not fit for detention and she forwarded this email to the senior managers and caseworkers. The Deputy UKBA manager liaised with Primecare, caseworkers, GEO and senior managers and she contacted the GEO manager, to request the removal of xxxxx's hand restraints, which was refused.

4.1.4 At 18:33 the Deputy UKBA manager received a follow up email from Primecare stating xxxxx was close to death; again she advised all the relevant parties.

4.2 DEPMU

4.2.1 xxxxx was detained at Harmonsdworth IRC and therefore, under the current contract, the bed guards for any hospital stays are provided by GEO and DEPMU therefore had limited involvement with xxxxx's case as they are not involved in the movement order process. However, DEPMU are responsible for providing senior managers within Detention with an update on all detainees in hospital and this did not happen in xxxxx's case. In Harmondsworth IRC when a detainee is sent to hospital Home Office staff at the IRC are notified and are required to sign the paperwork but there does not appear to be a formal process to notify DEPMU. GEO are responsible for updating DEPMU with any changes in the detainee's condition and I was advised by DEPMU staff that I should be mindful that the IS91RA process is not used for ongoing monitoring of a

detainee's condition, but is for the notification of when risks change; the case owner remains responsible for the monitoring of the detention and should liaise with the IRC's Healthcare provider to get the necessary updates as required.

4.2.2 DEPMU are responsible for notifying senior managers within Detention of all the cases where the subject has gone into a hospital on 'bed watch' via the DEPMU Daily Review which is circulated each evening. I am advised by a DEPMU CIO that there is no set procedure for obtaining the updates for this list and this is considered on a case by case basis and gathered as required from different sources, such as CID, as required.

4.2.3 In xxxxx's case GEO faxed copies of the IS91 RA to DEPMU on 10/11/12, following xxxxx's refusal to have his operation. I have examined the DEPMU daily review records for 11/11/12-17/11/12, but xxxxx is not included. (Records for 9/11/12-10/11/12 are not available)

4.2.4 Home Office staff at Harmondsworth IRC have stated that they do not currently advise or update DEPMU on detainees in hospital as a matter of course and currently DEPMU are as likely to advise them some one is in hospital as they are to advise DEPMU.

4.2.5 There would therefore, appear to be a serious breakdown in communication under the current detention reporting process. It is also noted that the CCD case owner contacted UKBA at the IRC on Monday morning, (12/11/12) to enquire about xxxxx and she was advised that the UKBA IRC officer she spoke to was unaware xxxxx had been hospitalised, yet GEO did advise UKBA at the IRC of this on 09/11/12; suggesting again that there is not a clear process in place to immediately identify detainees in hospital. It would appear that no one within Detention Operations was monitoring xxxxx's detention in hospital.

4.2.6 Senior managers within Detention Operations remained unaware of xxxxx's case until 16:29hrs on 16/11/12, when the Deputy UKBA manager at the IRC, sent an email advising senior managers that xxxxx was no longer fit for detention and was extremely unwell. By this time xxxxx had been on bed watch for one week and remained in a closet chain virtually the entire time. This meant that senior managers did not have the opportunity to monitor his case and potentially discuss the continued detention with the CCD case owners at an early stage.

4.3 <u>DSO 2/2012: Deaths in detention</u>

4.3.1Following xxxxx's death the records show that UKBA staff at Harmondworth IRC and the senior staff within Detention Operations completed the correct notifications and procedures required, including notifying the Prison and Probation Ombudsman (PPO) and Independent Monitoring Board (IMB). The PPO wrote to Returns Directorate Director on 21/12/12 advising that they would be unable to investigate due to staff shortages.

4.3.2 The guidance also states that contractors should conduct an internal review of the death and share this with the UK Border Agency. GEO senior manager, was asked whether he was conducting a review by the UKBA area manager. He responded that he did not intend to as it was not a death in custody, although GEO may review this decision following any PPO investigation. When I spoke to the Harmondsworth IRC centre manager, as part of this review he advised that their legal advisors have advised GEO not to conduct any reviews prior to the conclusions of PPO

investigations and that he considered this advice would similarly apply to PSU reviews. However, they had reviewed their processes informally and this had led to amendments in their managers' risk assessment form. Their form now provides managers with a fuller and clearer history of information on which to base their risk assessment.

4.3.4 Senior Investigator, PSU, met with the IMB chairman at Harmondsworth IRC to discuss this review. The IMB chairman raised his concern that xxxxx was released from detention shortly before his death to circumvent the requirement for the PPO to investigate the circumstances surrounding xxxxx's death. However, UKBA were notified that xxxxx was not fit for detention on 16/11/12 at 16:21hrs and therefore his continued detention would have been inappropriate. The circumstances of his death were referred to the PPO to investigate in accordance with the current guidance, which includes their remit to investigate deaths following recent detention. The PPO declined to investigate this case due to their lack of resources. There is no evidence to support to the suggestion that xxxxx's release was authorised purely to avoid such a review

4.4 CONCLUSION

The current process in DEPMU for monitoring detainees on bed watch in hospital allows for omissions to occur and senior managers within Detention Operations remained unaware of xxxxx's situation until he was not fit for detention. It is therefore recommended that there is a review of the notification of hospitalisation process to ensure every detainee who is in hospital is monitored by detention operations and senior managers are aware.

4.5 Criminal Casework Directorate (CCD)

4.5.1 xxxxx was taken to the Royal Brompton Harefield National Healthcare Trust hospital, (Harefield site) on 09/11/12. The CCD caseworker received the IS91 RA advising her of this information when she returned to work on Monday 12/11/12. She contacted the UKBA officer at the IRC and was advised that the officer did not know xxxxx was in hospital and she was advised to contact Primecare, the IRC healthcare provider, which she did. She was advised by Primecare that xxxxx was stable, he had refused to have treatment and they were awaiting a date for an operation. She advised xxxxx's solicitor that he was in hospital and his solicitor submitted a request for temporary admission, which was refused the same day. The CCD caseworker drafted a submission to release xxxxx which was referred to the CCD SEO that afternoon, but he was of the opinion that xxxxx should remain in detention whilst the outcome of his medical checks were awaited; but the CCD caseworker was asked to review the situation daily, which she did with Primecare.

4.5.2 On Tuesday 13 /11/12 xxxxx's solicitors telephoned the CCD caseworker requesting xxxxx's release be reconsidered, this was refused. This would appear to have been a difficult call and resulted in a letter of complaint from the solicitor, but the CCD caseworker passed the telephone call on to the team leader who explained xxxxx would not be released at that time, but he could apply for bail at any time. No bail application was subsequently received. The CCD caseworker contacted GEO regarding xxxxx and was advised that he would require an operation and that the hospital will be testing xxxxx and they would not have further information until Thursday, so the case was to be reviewed Friday. The CCD caseworker started to prepare a submission for xxxxx release in case it was required.

4.5.3 On Wednesday 14/11/12 the healthcare team at Harmondsworth IRC advised xxxxx that the hospital were conducting tests regarding his fitness for surgery as the initial

tests were of concern and there would be no update until Thursday 15/11/12. She was advised that xxxxx would require a long rehabilitation period which would affect his fitness to fly. The CCD caseworker spoke to the SEO who agreed they should complete the submission to release him from detention.

4.5.4 On Thursday 15/11/12 Team Leader received the letter of complaint from xxxxx's solicitor. This was dated 14/11/12, but post is distributed at certain times within CCD so it was not delivered until around midday on 15th. This was passed to the CCD caseworker to review and answer the points raised. At around 15:00hrs the caseworker noted that it stated in the solicitor's letter that xxxxx was handcuffed. She had not been aware of this prior to then and she stated that this information horrified her and she immediately raised this with both the team leader and senior team leader, but the CCD officers thought that the solicitors must be mistaken. When I visited the officers they stated that they had not been aware that it is common place for detainees to be handcuffed on hospital visits. The CCD case owners remained unaware that xxxxx was in a closet chain cuff until I informed them and had believed he was in handcuffs and believed at one point he was handcuffed to a radiator. There is absolutely no evidence to support this and I am satisfied that he was in a closet chain as recorded by GEO but again this miscommunication demonstrates that lack of channels for clear communication to the case owners to know the conditions of detention of the detainees they are responsible for. The CCD caseworker and Team Leader started to update the submission to release xxxxx, in case it was required.

4.5.5 The CCD caseworker completed her submission to release for xxxxx on the morning of Friday 16/11/12. The submission stated 'xxxxx was at Harefield hospital and is "very poorly" he is awaiting an aortic valve replacement surgery and will not be released from the hospital until his surgery is completed. Once surgery is completed xxxxx will remain in hospital for a further 5 days and then a lengthy rehabilitation period. Senior caseworker advised not going to release until medical condition is clear.' The CCD caseworker's CID notes state that the SEO had advised that they should wait until xxxxx had had his operation before they referred him for release.

4.5.6 The CCD senior officer considered that as xxxxx was in hospital and receiving the requisite care and they should await the outcome of his operation. (NB The Lead Clinician in Clinical Risk of Harefield hospital also stated that the medical staff were not concerned over the legalities of detention as such, as this does not affect their ability to provide medical care, although by default this resulted in him being handcuffed, something which remained largely unbeknown to the case owner.)

4.5.7 CCD Detention Process Instruction states that a detainee may become unsuitable for continued detention if they are suffering from serious medical conditions which cannot be satisfactorily managed within detention and in effect xxxxx's condition was being managed, as he was in hospital. He may have been unsuitable to return to the detention estate post operatively, but the CCD SEO had stated that he intended to release him at this point.

4.5.8 The CCD caseworker stated that at around 11am on 16/11/12, the manager from Primecare called her explaining she could not say much at that time, but she asked how long it would take to release xxxxx. The CCD caseworker stated that she was alarmed by the implication of this and raised the issue with her team leader and senior manager.

4.5.9 The exact timing of what happened after midday on 16/11/12 is hard to clarify, given the passage of time and the number of people involved and that numerous

conversations took place between the parties involved. During these conversations the CCD SEO confirmed with UKBA at the IRC that xxxxx was in handcuffs.

4.5.10 At 16:21 Primecare sent an email stating that xxxxx was not fit for detention. CCD SEO sent an email to GEO asking for the handcuffs to be removed at 16:56, which included the information that there was 'no need to release him at this juncture as he is in hospital for major heart surgery and they planned to release him for post operative care.' This appears to suggest that the comment from the nurse that xxxxx was not fit for detention was overlooked, although when I spoke to the CCD officers they stated that they were aware that it would take time for the submission to be authorised and they wished the handcuff to be removed as a priority.

4.5.11 The AD in charge of IRCs at that time contacted CCD at the request of the Detention Operations Director and demanded that the submission to release was sent to xxxxx as soon as possible. The CCD SEO confirmed CCD had submitted the submission to release at 17:23 and then contacted their strategic director office in an attempt to ensure the submission was cleared, but he was not available. AD in charge of IRC's and Detention Operations Director were also attempting to identify a strategic director to clear the submission and this was done by xxxxx. Detention Operations Director made a verbal referral to xxxxx in advance of the submission being received in order to expedite its clearance.

4.5.12 The CCD officers remained on site until 19:15pm in case they were able to assist further but they were advised the release would be dealt with by CCU.

4.5.13 Detention reviews.

The current guidance to CCD staff states that additional reviews may also be necessary on an ad hoc basis, e.g. where there is a change in circumstances relevant to the reasons for detention, but this does not need to be a formal written review. In this case xxxxx's medical emergency may have triggered a new review and it is noted that the caseworker stated that xxxxx's detention was under daily review. It would therefore appear that his detention was being reviewed and it was monitored sufficiently closely that the CCD team leader was in a position to consider any changes in circumstance and whether detention remained appropriate.

4.5.14 The decision to maintain detention.

xxxxx remained in UKBA detention until a few hours before he died. The current guidance on time spent foreign nationals has a suggested presumption that detention should be maintained. In xxxxx's case his detention was monitored and he was in hospital receiving the requisite care, therefore the SEO considered that he should remain in detention until he had had his operation and required post operative care, at which point they intended to propose he was released as it would not be possible to manage his recuperation within the detention estate, other than the later part of 16/11/12. On the information available to them this appears to be in line with the guidance, however the caseworkers do not appear to have been made aware of how serious his medical condition was or that he was in a closet chain handcuff.

4.5.15 Section 6 of CCD Detention Process instructions states that detention should be reviewed when a new detention risk is identified. The guidance suggests examples of when this is reviewed, but this does not state medical aspects. Consideration should be given whether this should be expanded to provide officers with instructions on what may be appropriate actions upon a detainee being admitted to hospital.

4.5.16 The AD, formerly head of IRCs, has suggested that when any detainee is admitted to hospital, a mandatory formal detention review should be required and reviewed from that time either daily, or at another agreed time frame, as the admittance into hospital in itself, would suggest a detainee has a genuine medical condition and the Home Office duty of care to that detainee must be reviewed.

4.5.17 This would also seem a sensible point for cross department/unit consideration. Had this happened, it could have been considered whether, as xxxxx would have to be released at some point, whether this could be done prior to his operation. A multi unit review could take into account all the relevant factors such as the requirement to be detained, the medical prognosis, (medical staff) the conditions of detention at the hospital, the resource implications and the considerations for continued detention post hospitalisation. Nominating a Home Office SPOC at this point to oversee the care of the detainee at hospital may assist in ensuring all available information is considered and alleviate the pressures of multiple parties contacting the medical authorities for updates. (This may also be a suitable point for a SPOC to conduct a hospital visit, see section 7)

4.5.18 **CONCLUSION**

The relevant CCD guidance on detention and release appears to have been followed. Xxxxx's documentation correctly reflected his risks and recorded his medical conditions when they were notified. He remained in detention where he was receiving the appropriate medical care, with a view to releasing him when he required post operative care, which could not be provided within the provisions of detention.

4.5.19 However, some of the current processes in place have hindered the ability for immediate action when it was required, such as releasing him immediately from detention and the removal of the closet chain hand cuff.

4.5.20 It would appear that the caseworker did not have a full or accurate reflection of xxxxx's deteriorating health as she was solely reliant on the information provided by Primecare, who were not on site at the hospital and were themselves waiting for confirmation from the medics at Harefield . CCD stated on their submission to release that they would not submit this until xxxxx's medical condition was clear and this was not provided until 16:21 hrs on 16/11/12, when Primecare sent an email stating he was not fit for detention; xxxxx died the following morning at 01:25hrs. There was a delay in submitting the submission to release which was not sent until after an intervention from senior mangers at Detention Operations, and the fact that there was written confirmation that he was not fit for detention may have been overlooked, however, instead the SEO at CCD attempted to have the hand restraints removed, which was seen as a priority, despite it being unknowingly, outside of their remit.

4.5.21 There was the additional issue that the caseworkers were unfamiliar with the conditions of detention and that there was a possibility that a bed watch could involve the use of restraints. There appears to be no mechanism in place in xxxxx's case to advise the caseworker of this and therefore she only became aware of this on Thursday 15/11/12, one week after he had been admitted to hospital.

4.5.22 Recommendations regarding these points are made in section 6

5. To investigate if GEO managed the bed guard appropriately, with particular reference to their risk assessment process.

5.1 xxxxx left Harmondsworth IRC as an emergency. A risk assessment was conducted by the duty manager and UKBA were notified. (It is not practice for a detainee's departure from the IRC would not be delayed for completion of this document). Once he was admitted to Harefield hospital the escorts then changed to bed guards. There are extensive records completed by the GEO officers on bed watch, which records changes in his condition, records of conversations with medical staff and confirmation that the officers phoned the duty manager at agreed intervals. These records are currently not shared with Home Office staff but it is clear that GEO have extensive records on xxxxx's situation that could be of value.

5.2 xxxxx was taken to Harefield hospital by ambulance accompanied by 2 DCOs and he underwent an angioplasty soon after his arrival; catheters were inserted into his heart to enable the doctors to identify what was wrong. During this operation xxxxx remained in hand restraints, although the DCO changed this to a long chain to enable him to be a greater distance from xxxxx and the medical team. The closet chain is about 2 metres in length attached to a single wrist. This DCO has since left GEO employment, but I spoke to the other officer present. (Statement attached). DCO xxxxx stated that he had not realised that they were in an operating room and that xxxxx was having an operation; he added that xxxxx was surrounded by medics and his view was sometimes restricted so he could not see what was happening, xxxxx was conscious, although he may have been sedated. At no time did the medical staff request removal of his handcuffs. DSO 8/08 states that handcuffs should be released on request by medical staff but such a request was not made and therefore this did not happen.

5.3 xxxxx also underwent an X-ray at this time, whilst handcuffed to the DCO (X-raying whilst handcuffed occurred several times during xxxxx's stay at Harefield and the medics at Harefield have questioned the safety of this for the DCOs)

5.4 I discussed the application of handcuffs during this procedure with the Lead Clinician in Clinical Risk at Harefield hospital. He has stated that the handcuffing of a patient undergoing an angioplasty would seem inappropriate as it may impede the ability of hospital staff to provide medical care. However the doctor who carried out the procedure, did not request their removal and there was no suggestion that this caused any impact on the medical procedures carried out on xxxxx.

5.5 Whilst it could be said that common sense should have come into play and that even though the medics had not requested the handcuffs to be removed, the DCOs could have proactively contacted their supervisor to request the removal of the closet chain, it was clear that DCO xxxxx was unaware of the seriousness of the procedure that was taking place. It would seem be unfair to expect him, as a lay person, to identify complex medical procedures and he therefore relied on the instructions that were issued to him by his manager that handcuffs should remain on unless prior authority is granted. This exact issue was identified by the Harefield Bereavement and Family Officer, who stated that at Harefield hospital in particular, some of the very serious procedures they carry out may not appear to be intrusive to the non clinical observer as there is not a lot of blood, if judgments are made on what is seen, these judgements could be incorrect. Lead Clinician in Clinical Risk at Harefield hospital stated that hospital staff may not be providing clear instructions to the DCOs. However, if instructions are not given, or are not clear it would by default seem unfair for DCOs to make assessments on the nature of the medical procedures taking place.

5.6 This issue reinforces the reliance DCOs have on their instructions from their own managers and it is therefore essential that the risk assessment on leaving for hospital visits is correct and in xxxxx's case the risk assessment would appear to be reasonable and based on the information available. DCO xxxxx stated that the initial arrival at hospital is a high risk time as detainees can fake illness in order to escape detention and therefore the handcuffs generally stay on. He added that his job is at risk should some one abscond. By implication, this would suggest there would be an automatic reluctance for the DCOs to proactively suggest any removal of handcuffs might be appropriate.

5.7 Following his angioplasty the doctors told xxxxx he would die without an operation. The DCOs reported this to the duty manager and DCO xxxxx stated that he and his colleague spent hours trying to persuade xxxxx to have the operation, which xxxxx did not want. (xxxxx's Primecare records show that the nurse contacted Harefield at 21:00hrs on 09/11/12 and was advised that xxxxx refused to be operated on and he was receiving intravenous treatment and was kept in for further investigations but there was no time for his operation as they could not make any arrangements until he gave his consent.)

5.8 Once xxxxx was admitted to hospital he became a bed watch, with two DCOs. The GEO officers completed the bed watch records.

5.9 I visited the ward on which xxxxx stayed and met the sister, Sister xxxxx, who was in charge whilst xxxxx was at Harefield. He was situated on a six bedded ward. Upon his admittance the single rooms were occupied and Sister xxxxx stated that given the seriousness of his condition he did require nursing and monitoring and a single room would have required a full time nursing presence and would therefore not be appropriate. Xxxxx's beds had very limited space around it and with the presence of 2 bed guards there would have been very little space left for the nurses and his family around the bed. Sister xxxxx stated that they attempted to keep the curtains closed to maintain his privacy but this was not always possible and would seem to me to be more claustrophobic.

5.10 The bed guards changed over shifts each evening and morning, which is recorded. DCO xxxxx took over the bed guard with a colleague on the evening of 09/11/12, and completed his records. These show that he gave xxxxx the GEO phone so he could advise his wife he was in hospital. DCO xxxxx recorded that at 21:30 xxxxx stated that he did not want his operation and that he should be released from detention so he can die at home with his family. DCO xxxxx recorded that xxxxx had a heart scan the following morning (10/11/12) at 06:20 and the results were told to him at 07:00hrs. He was advised his condition was very serious and the DCO advised the duty manager of this. Upon his return to Harmondsworth IRC DCO xxxxx reported this on a security incident report, explaining the seriousness of xxxxx's condition and his reluctance to have his treatment. This report was submitted to GEO's security department and the senior duty manager was informed. This information was reported to the duty doctor to request that the doctor spoke to the hospital to inquire how serious his condition was.

5.11 The Primecare records show that the hospital was contacted at 13:55hrs on 10/11/12 and was told that doctors would review his surgery on Monday but he was pain free and stable. This was communicated to the GEO duty manager and who were advised that the next review would be in a couple of days. The Primecare records do not appear to contain the alarming information as reflected in DCO xxxxx records and this may demonstrate a difference in understanding of medical situations when medics talk to each other and then when this is information is then interpreted to the non medical.

5.12 GEO officers completed an IS91RA which was sent to UKBA at Harmondsworth IRC and DEPMU. This form stated that he refused to have the operation and would die without it.

5.13 Whilst it is arguable that Primecare, as the medical experts, should identify the seriousness of his condition, DCO xxxxx's report contained more information that, if made available to the caseworkers, may have led to a detention review, or led the caseworker to ask further questions to confirm the seriousness of his condition following the more limited response they received from healthcare. These records also show that xxxxx made a verbal request for release which should also have been considered by the caseworker. (The caseworkers stated that this was a request for temporary admission that should have been considered; although this would not necessarily have meant he was released as they were advised on Monday 12/11/12 that he was fit for detention.)

5.14 DCO xxxxx acted professionally by reporting this incident and the matter was referred to the IRC Healthcare to assess the situation. It should be considered whether the security incident report, in some circumstances, should be made available to Home Office staff such as attaching it to an IS91RA to provide UKBA with more information on what has taken place to enable the Home Office staff to consider whether any action is required , or alternatively state that a fuller report is available.

5.15 A Detainee Individual Support Plan was opened by GEO on 11/11/12 for xxxxx. This is opened when a detainee is considered to be at risk and his welfare needs to be monitored. It is not clear whether the security report from DCO xxxxx was the instigator of this, but the DCOs were requested to 'monitor any findings as the full extent of his condition was awaited.' The plan was updated daily. The safer Custody Manager and Welfare officers also visited xxxxx in hospital.

5.16 On Monday 12/11/12 the records show that xxxxx was subjected to many medical checks. The handcuffs were not removed, but there is no record of this being requested.

5.17 On Tuesday 13/11/12 the records showed that at 10:20hrs xxxxx was seen by the doctors and was advised he required an operation to save his life. The officer, DCO xxxxx advised his senior managers of this and he obtained further information from the doctors who advised him they were preparing to give xxxxx an operation after he had more X-rays and ultrasounds. The records showed that at 13:30 hrs xxxxx received a call from his solicitor advising him not to have the operation until he was released from immigration detention. (The officer's statement is attached.) DCO xxxxx recalled the medical staff explaining to him that they were not involved in his immigration case, but he required the operation urgently. The DCO reported this to his senior managers again and was advised that the medical team are responsible for his medical care and he must ensure xxxxx was safe at all times. DCO xxxxx stated that xxxxx was upset and stated that they would involve the media and he would not have his operation until he was released from detention; DCO xxxxx stated that they explained to him the importance of the operation and the doctors stated they would carry out the operation as soon as possible.

5.18 Medical staff requested that his handcuffs were removed at 15:30 hrs for his X-ray and ultrasound and permission was sought and granted by the duty manager. This occurred without incident. The officers offered xxxxx the company phone to discuss the operation with his wife. xxxxx also requested some money from his

Harmondsworth account which was provided to him by the manager when he visited later that day.

5.19 On the evening of 13/11/12 the DCO noted that xxxxx seemed very weak and could hardly talk and was given oxygen by the nurses. The DCO advised the duty manager that xxxxx had become more ill that day and he had agreed to have his operation.

5.20 The records show that xxxxx made and received calls on the GEO phone and that the officers bought his cold drinks when requested.

5.21 The records of Wednesday 14/11/12 show that xxxxx was very calm and polite and is recorded as very quiet. At 22:00hrs the officer has stated that xxxxx did not talk to them and 'looked pissed off'. There are no further details and the records of this officer provide little detail on xxxxx's actions.

5.22 On Thursday 15/11/12 the doctors stated that xxxxx would be prepared for surgery that day. The DCOs record that he only spoke when spoken to and appeared tired. There is no further notes on these records regarding the preparation for an operation, or any updates from the doctors. xxxxx reported trouble breathing that night.

5.23 xxxxx was taken to have an X-ray at 21:50hrs that night. The nurse asked at this point asked for the handcuffs to be removed. DCO xxxxx explained that he would need to get authorisation from his manager and the nurse decided to go ahead with xxxxx in handcuffs. The nurse asked what if the patient required resuscitation or a defibrillator and the DCO explained that "if it is life threatening the authority is there already in the escort paperwork to uncuff detainee". DCO xxxxx's statement regarding this is attached. It may be that the escorting staffs certainty about the obtaining authority to remove the handcuffs adds to the uncertainty of the medical staff and their understanding of their ability to ask for them to be removed, meant that during the week xxxxx was in Harefield, the hand restraints were removed just once.

5.24 xxxxx continued to feel sick and have breathing problems and the DCOs ensured the medical staff were aware of his discomfort.

5.25 Throughout Friday 16/11/12 xxxxx received medical attention and an ultra sound, but there is no record of his handcuffs being removed or this being requested or discussed by medical staff. At 15:25 the officers recorded that xxxxx was too unwell to speak to his brother. xxxxx received further medical attention. Following an email from The Deputy UKBA Manager Harmondsworth reporting [redacted] was not fit for detention and was too unwell to have his operation, senior GEO manager contacted the bed guards and authorised the removal of the closet handcuff at 18:10. This was as he was being prepared for the Intensive Care Unit and more intensive treatment.

5.26 The bed watch records continue until 20:30.hrs although medical staff confirmed the officers did not accompany him to ICU, which was after 19:00hrs.

5.27 Not all the officers' records are detailed, but where they are, the officers appeared to have demonstrated a great concern for his welfare and health.

5.28 It was also noted that some of the bed watch duties were carried out by the same members of staff. I was advised by GEO managers that the duties are not planned this was, but, it would seem good practice for the continuity of the patient that where possible the same DCOs look after the detainees; this will allow them to build a rapport but also note the differences in the detainee, should there be any.

5.29 Review of risk assessment.
A manager visited xxxxx every day whilst he was in hospital and completed a Manager's Bed-watch Visit Report. This records that the staff are briefed and the handcuffs are checked. It also includes a section to recommend any change to risk assessment, which would also include the requirements to handcuff.

5.30 In xxxxx's case there was no recommendation to amend his risk assessment on any day. The last visit was on 15/11/12, as xxxxx was in the process of being released from detention by the evening of 16/11/12. GEO Manager xxxxx visited xxxxx daily from 12th to 15th. He stated that during his visits he was unaware of any complaints from medical staff and he considered that the use restraints were appropriate and that xxxxx's condition deteriorated on 16th, following his visit on the 15th. (Statement attached). Deputy UKBA Manager, Harmondsworth statement refers to a conversation with the GEO manager where he was advised by the bed watch officers that xxxxx was close to death at 15:45 hours, yet the hand restraints remained on and there is no recorded review of his risk assessment at this point regarding the use of hand restraints. Although it was later stated by GEO Senior Manager that they would remain on whilst he was remained detained.

5.31 The Lead Clinician in Clinical Risk of Harefield hospital who reviewed xxxxx's medical notes stated that following his arrival at Harefield when he underwent a cardiology procedure, xxxxx was in a stable, but serious condition from the 9th until 16th November when his condition deteriorated very quickly and he was transferred to the ICU that evening. During the time that xxxxx was being cared for in the ward 'there would not appear to be an absolute reason to remove his handcuffs'. He stated that he considered that when xxxxx was receiving intensive medical care (at the time of the initial cardiology procedure and the final admission to the ICU) the continued use of restraints may have become inappropriate. However, this does not mean that the hand restraints should have remained on.

5.32 It has been confirmed by the medical staff treating him that by the time he entered ICU on the evening on 16/11/13 he was no longer in restraint and the DCOs did not accompany him. The use of restraints during the initial procedure has already been considered above in paragraph 5.5.

5.33 The risk assessment for xxxxx stated that if the medical staff requested the removal of handcuffs a manager's authority was required in advance, this was not changed during his stay, despite his medical situation deteriorating. The escort staff are not medically qualified and were only aware of xxxxx's condition through overheard conversations between the medics and xxxxx and therefore should not be expected to make informed medical decisions on the appropriateness of the use of handcuffs, they could raise their concerns for consideration. A significant issue identified is the way deterioration in condition in between managers' visits is managed and whether risk assessments are proactively reviewed. The officers' records demonstrated that xxxxx was gravely ill and his medical condition was not in doubt and therefore it is likely that the use of handcuffs was not required. It is therefore recommended that risk assessments must be reviewed and recorded and justified when significant changes occur, even if this falls in between the managers visits.

5.34 It is likely that GEO have a cautious approach to assessing the risk of a detainee absconding, as this would results in a £10,000 fine. Whilst their officers did demonstrate concern for xxxxx's welfare, it is also understandable that they would be

reluctant to recommend the removal of hand restraints in case a detainee did then abscond.

5.35 The decisions on the conditions of detention appear to remain solely with the contractor, in this case GEO. GEO managers have stated that the Home Office is not able to request the removal of handcuffs and this is on the assumption that we are aware they are being used. Whilst GEO under the current arrangements appear to have managed the bed guard appropriately, recommendations regarding improved oversight by HO are considered in section 6.

CONCLUSION

5.36 The GEO records are extensive and show that bed watch officers demonstrated concern for xxxxx's welfare and raised matters of concern to their managers. However, the current communication channels meant that there is not a process in place for all of the relevant information to be passed on to UKBA officers.

It would appear that the current procedures in place for bed guards were followed correctly and the risk assessment process followed by GEO was conducted in accordance with their procedures. Although it is a matter of opinion, it is likely that xxxxx's risk assessment of absconding and violence did change as his condition deteriorated and there was no formal mechanism in place to have this reviewed proactively. Consideration should be given to whether improved guidance to the bed guards is required to cover situations where medical conditions deteriorate in between manager visits.

5.37 It is also noted that the Manager's Bed-watch Visit Report largely comprise of tick boxes, which when related to the change in risk assessment may be inappropriate as there is no record of the factors considered and how a mangers reached their assessment. Whilst there is a comment box to use if required, consideration should be given whether this form needs to be amended so that the manger is required to comment that they have assessed the risk daily and the reasons they have reached their decision to maintain, increase or reduce the assessment made. This will act as a better audit that changes have been monitored and considered

6. To identify if there were failings in the duty of care to xxxxx and if so what they were.

6.1 Guidance issued to CCD and GEO appeared to have been adhered to, however, these parties do not appear to have an avenue of communication between them to ensure that the case owner, in particular, can make decisions based on all the information available. For example, the GEO records would appear to demonstrate that it was known on 09/11/12 that xxxxx could die at any time, the severity of his situation was repeated several times in the presence of GEO staff. This was reported to the caseworker on the first occasion, but the impact was lost when she was advised by healthcare xxxxx was stable and awaiting an operation. It may be that at this point, had the full GEO records been available; there was an opportunity for the caseworker to consider whether she required further clarification or whether xxxxx should be released at that point.

6.2 Another concern identified is the apparent lapse in the process in place to ensure that Detention staff monitors all detainees in hospital. GEO advised UKBA that xxxx had been taken to hospital on 09/11/12 and was refusing an operation via an IS91RA sent to DEPMU on 10/11/12, yet xxxxx's details were not included in DEPMU daily update to senior managers in Detention Operations. This would have allowed oversight of his

case at a senior level within Detention Services, and the possibility of questions being asked about the use of restraints and his continued detention. In xxxxx's case senior managers were first made aware of xxxxx's case when he was judged unfit for detention and he was as we now know dying; this lapse was a serious concern for the Detention Operations Director and a process will need to be developed to ensure the details of all detainees in hospital are captured to ensure oversight by senior managers and to allow intervention when required.

6.3 There are a number of processes identified in the review that if done differently would have improved the care shown towards xxxxx.

Use of restraints: Handcuffs

6.4 It is important to note the Lead Clinician in Clinical Risk stated that the fact xxxxx was handcuffed did not affect the end result and that xxxxx died of heart failure. However, the fact that xxxxx remained in a closet chain during his angioplasty, when he would have been sedated and having a medical operation may be considered as a failing in our duty of care towards xxxxx and therefore improved oversight is recommended.

Reaction to xxxxx deterioration in medical condition.

6.5 The Lead Clinician in Clinical Risk stated that there was no absolute reason for the handcuffs to be removed following his angioplasty until xxxxx was prepared for transfer to ICU, but was it necessary for xxxxx to remain in a closet chain following his admittance to hospital, when the medics established he required a major heart operation?

6.6 The GEO managers have stated that they reviewed the risk assessment and consider that this was satisfactorily monitored.

6.7 The GEO bed watch records showed a decline in xxxxx's health over the period he remained in hospital and in particular, overnight on 15th and on 16th. The description given by the bed guards suggested he was in discomfort, sick and we now know he was not going to recover. The current procedure adopted by GEO reviews this risk assessment once a day and in xxxxx's case his condition declined dramatically after the review of the 15/11/12 and therefore the risk assessment was not reviewed and the closet chain remained on.

6.8 It is noted that there does appear to be reluctance by officers to request the removal of handcuffs proactively. The GEO guidance issued to them states:

"Under normal circumstances, escort staff do **not** have the power to use discretion in the use of handcuffs, ie. The proper authorities must be obtained. In the event that staff are instructed by hospital staff to remove handcuffs (contrary to risk assessment instructions), escort staff **must** contact the Duty Operations /Duty Manager at Harmondsworth for further guidance and instructions prior to removing any handcuffs."

6.9 DCOs have the ability to apply handcuffs prior to obtaining authority, but not remove them. It has already been discussed that there would appear to be a predisposition of bed guards for the handcuffs to remain on, the lack of review of the risk assessment in between managers' visits and the lack of information may have led to the handcuffs remaining on longer than required.

6.10 It should be considered whether a system for the risk assessment for detainees in hospital to be monitored more robustly by their managers, with particular regard to the continued use of restraints and to respond to changes in a detainees health is declining considering whether alternatives are more appropriate- strategically placed guards at door and windows etc.

Lack of Home Office oversight of the risk assessments by contractors

6.11 The guidance on the use of handcuffs is clear however, xxxxx's case has highlighted some limitations in this guidance.

6.12 Notably GEO appear to be solely responsible for the risk assessment of detainees; yet they also face financial penalties should a detainee abscond. Therefore it should be considered whether this leads to an undue influence for the presumed use of handcuffs to avoid any such penalties. Consideration should be given to whether national guidance on the suitability of the use of handcuffs for an extended period is required and whether other contactors adopt a different approach.

6.13 GEO's responsibility for deciding the risk assessment is divorced from any Home Office influence, and Home Office staff can not demand the immediate removal of restraints. UKBA officers (at the time) at Harmondsworth IRC were advised that xxxxx was being taken to hospital and that this was in handcuffs, but there does not appear to be a process taking place for Home Office staff to monitor the managers' daily risk assessment reviews and whether handcuffs remain in use. xxxxx remained in a closet chain for the majority of his stay at Harefield hospital but this was not known by the UKBA case owners until day seven, and this was because xxxxx's solicitor lodged a complaint about it.

6.14 Whether the removal of hand restraints would have been appropriate earlier is a matter of opinion, but this decision remains with the contractor alone. There is a suggestion that the contract allows us to make requests for removal of handcuffs via security section and their AD but the concern is the lack of immediate remedy available and this should be reviewed whether the contract should be amended to exceptional circumstances, when directed at an appropriate level, that HO will take responsibility for any subsequent absconding, removing the financial penalty

7. To consider and report on whether there is any learning for any individual UK Border Agency officer or contractor. Or organisational learning for the UK Border Agency, including whether any change in UK Border Agency policy or practice is required.

Hospital stays

7.1 On 03/04/13, as part of this review, I visited the Royal Brompton and Harefield Hospital NHS Foundation Trust (RBHT) and met with their Bereavement and family Service Officer, their Lead Clinician in Clinical Risk and a consultant anaesthetist, their Quality and safety Lead (who was in the process of writing guidance for hospital staff on the use of restraints) and some of the nursing staff who treated xxxxx, including Sister xxxxx who was in charge of Oak ward where he stayed for the majority of his time at Harefield. Their Lead Clinician in Clinical Risk was representing the Hospital Board and reviewed xxxxx's medical records for my review, but he also sought to understand the Home Office Policy on the use of restraints and when hospital staff were able to request for them to be removed. There appeared to be a general lack of understanding around this amongst the medical staff and the hospital Board wished to address this.

7.2 The hospital Board at RBHT would like to publish clear guidance to their staff when dealing with police, prison and Home Office detainees in handcuffs. There was an implication that xxxxx's case had identified the lack of clarity on their part of their ability to request the removal of hand restraints. Lead Clinician in Clinical Risk stated that he was trying to understand the Home office position and would like a consistent approach regarding the use of handcuffs from prison, police and HO, although he accepted the process for this would differ depending on the agency. I was advised ideally the Board would like a uniform approach to the circumstances when handcuffs would be removed between all three types of detainee, but the Quality and safety Lead explained that this is something that is causing them great difficulty as she was not receiving responses from these authorities. (It may be worthwhile for detention policy officers to liaise with her regarding our policy as this may also assist the Home Office in the development of its own policies.) I asked the Lead Clinician in Clinical Risk if medical staff would find it helpful, when a HO detainee is admitted, to be given a Home Office point of contact for the medical staff. He stated that their principle concern was the restraint issues and not the matter of detention. They had the overall concern that detention staff did not have the ability to be flexible. Lead Clinician in Clinical Risk stated that some of the issues may be that staff at Harefield are not stating clearly enough that the restraints should be removed.
The Bereavement and family Service Officer requested that the relevant findings of this report be shared with the hospital to enable the RBHT to also learn from any of the findings that would assist them to improve their performance towards future patients. I explained that this would be for the Detention Operations Director to consider, but the request would be included in the review.

7.3 The hospital staff were keen to point out that there are safety concerns for detention staff who remain handcuffed to detainees whilst they are being X- rayed or receiving medical treatment such as emergency resuscitation, when the risk of shocks to the detention staff at the end of any restraints would be unsafe. Whilst clearly one would hope detention staff would understand this and remove the restraints immediately, as demonstrated in xxxxx's case, it is not always clear what procedures are be undertaken and also what procedures are safe. (DCO xxxxx stated that sometimes he is present for X-rays and no safety concern have been raised by the medical staff, whilst on other occasions officers have been asked to leave the room) It is therefore

recommended that the safety aspects of medical treatments is considered and guidance is developed regarding the circumstances when staff should not be present, for either their own, the detainees or the safety of others, and this is incorporated into the risk assessment process.

7.4 Sister xxxxx stated that she has now adopted the practise of asking detention staff (police, prison and HO) when a patient is first admitted, to confirm with their managers at that point that in the event of emergency, they have permission to remove the restraints. It is suggested that we adopt this practise and that managers advise the DCOs going on hospital visits that in the case of medical emergencies, operations, resuscitation or X-rays, (or whatever the approved criteria maybe) they can remove the handcuffs without contacting the manager **in advance**. There is already guidance in place about what actions they should take whilst the handcuffs are removed.

7.5 I also visited Harefield Intensive Care Unit(ICU). Whilst xxxxx was not restrained at the point he reached ICU, it is an open multi bedded ward with lots of machinery surrounding every bed. The Lead Clinician in Clinical Risk stated that the use of hand restraints in this environment would never be appropriate at Harefield. I would therefore suggest that the use of restraints for any Home Office detainee in any ICU would need serious consideration and that the safety of the detainee, other patients, medical staff and the detention staff could be at risk based of the environment; including the amount of equipment, the potential for emergency treatment, the increased risk of infection to all patients, and the potential hazard caused by chains; not to mention patients are generally sedated in ICU. It would seem more appropriate for officers to remain outside ICU, if detention is maintained, except in the most exceptional circumstances.

7.6 When I visited Harefield hospital I was asked many questions by various members of medical staff. Whilst the Lead Clinician in Clinical Risk stated that they did not require a Home Office contact, consideration should be given to whether there would be an advantage for a member of the Home Office (IRC/DEPMU?) to visit the detainees where an extended stay is anticipated. This would have a number of benefits:

- Currently the only management of the hospital relationship is through our contractors, the bed guard, their managers, their welfare officers and the contracted medical providers. If, in cases of extended hospital stays or serious illness, a member of Home Office detention staff visited the hospital it would enable them to talk to the bed guards, the detainee and be able to review the records of the bed guards and identify, at an early stage, any circumstances that may need consideration by either the case owner or Detention Operations. This would enable Home Office oversight and confirmation that the duty of care is being met by our contractors, whilst the care is ongoing.
- They would be able to report on the conditions and suitability of bed guards and advise relevant Home Office staff of any use of restraints.
- Consent for disclosure of medical records could be obtained from the detainee to allow the officer to discuss the medical situation with the medical team and confirm the medical prognosis and fitness for detention and discuss any areas of concern highlighted in the bed watch records.
- This officer could then act as a SPOC for the other parties involved in the detainee's case to ensure that all the relevant information was known by all the interested parties, such as in this case, senior managers within Detention Operations and the CCD case owners.
- Another benefit is the overall stakeholder engagement and improved relationships. It would also enable medical staff to direct any questions they

have regarding the bed guards or the use of handcuffs and would assist in developing a relationship with the medical teams.

Release from detention

7.8 There is also the issue of how quickly xxxxx could be released from detention, once that decision was made. UKBA were advised at 16:12hrs that xxxxx was not fit for detention, the release papers were faxed at 18:55hrs (The related CID minutes are not timed) and xxxxx was released at 20:30hrs. There were delays with CCD caseworkers submitting the submission to release and then in getting the submission authorised and lastly in serving the release paperwork.

7.9 But in circumstances such as these, when doctors have stated that a detainee has hours to live, this lengthy approach may not seem appropriate and puts both the Home Office and the contractors reputations at risk. Therefore consideration should be given where in specific circumstances, the dignity of the patient is paramount and to enable them to spend time with their families without the presence of detention staff the Home Office should have a mechanism for immediate/expedited release from detention.

7.10 CCD had prepared the submission to release in anticipation it would be required. Their guidance states that a written submission must be emailed for approval at strategic director level, which is a recognised lengthy process. Advance warning to (director level) of the possible submission may have been helpful, such as at 11 am that morning when xxxxx's medical condition was raising concern. In reality the submission was sent at around 17:20hrs and xxxxx was not available, necessitating the requirement to find another suitable Director and Operations Director provided a verbal referral to xxxxx, prior to the written submission's arrival. Consideration should be given to whether, in circumstances such as these when a detainee is dying or seriously ill, the Director of Detention Operations can have the authority to release a detainee from the Home Office detention estate.

IMB concern

7.11 The IMB raised concerns that GEO staff had advised them informally that xxxxx had on 12/11/12 refused an operation because he thought that the more ill he was the more likely he would be to be released. Xxxxx's GEO records do reflect xxxxx being upset following a conversation with his solicitor on that day, it is documented that xxxxx's solicitor advised him not to have the operation and they would involve the press in an attempt to get released. Xxxxx was recorded as upset following the conversation, but he became more ill and agreed later that day to have the operation.

7.12 Xxxxx medical history demonstrates he had an established pattern of reluctance to undergo medical treatment and he was described as hospital phobic by the doctor in the IRC

- In 2005 xxxxx underwent an angioplasty but did not take medication following this, the doctor attempted to get his medical records and the suggestion of the lack of medication is that xxxxx did not present himself for follow up care.
- He stated when he was detained on 08/08/12, that he had shaking heart syndrome and that his doctor advised him 2 years ago that he needed a small operation, but he did not return to his doctor as he was scared .
- During his stay at Harmondsworth the doctor requested his previous medical history I note that xxxxx did not turn up for all his scheduled appointments.
- On 7/11/12 xxxxx was seen by the doctor at Harmonsdworth IRC and refused to go to hospital for treatment and signed a disclaimer. He was described as hospital phobic.

- On 9/11/12 when he was admitted to Harefield it is documented that he refused to have an operation, which was required to save his life.

7.13 Xxxxx's history of refusing to have earlier treatment was not related to an attempt to secure his release from detention and whilst GEO did document that xxxxx spoke to his solicitor on 13/11/12 and was advised not to have the operation, this was also the day he finally agreed to have it. A request for bail could have been made and was not and therefore there is no conclusive evidence to support the IMB's suggestion that xxxxx deliberately delayed his operation in order to become more ill and be released.

8. Recommendations:

HOME OFFICE/DETENTION OPERATIONS

1. Consideration should be given to ensuring better communication between the parties involved in the care of detainees admitted to hospital, ensuring that the relevant information is made available to the case owner, and senior managers in detention operations as required. This may include consideration of whether this could be achieved by nominating a Home Office SPOC for individuals admitted to hospital, with this individual paying a visit to the patient and examining the bed guard records and ensuring the Home Office is meeting its duty of care towards every detainee.

2. It is recommended that there is a review of the notification of hospitalisation process within Detention Operations to ensure every detainee who is in hospital is monitored and senior managers are aware, in particular the notification process for detainees hospitalised from Harmondsworth IRC and Colnbrook IRC who provide their own bed guards.

3. It is recommended that the current authority of the Home Office to request the removal of handcuffs is reviewed, and consideration given to whether this is required in certain circumstances and that consideration is given to develop national guidance for all contractors to adopt when providing bed guards.

4. Detention Operations have established practise of ensuring staff welfare following a critical incident, other departments may wish to consider adopting a similar approach. of contacting staff and advising them where to get help, should they require it.

5. Contractors should be encouraged to share their learning with other contractors providing bed guards with a view to developing Home Office national standards regarding risk assessments of hospitalised detainees and whether a uniform risk assessment process and assessment form is required for all three contractors who carry out bed watches on behalf of the Home Office.

6. I am aware that a second detainee recently died shortly after his release from detention and he too had recently undergone an angioplasty at Harefield hospital. Whilst the circumstances are very different, it should be considered whether the Home Office require guidance to its staff regarding the duty of care to be afforded to detainees who have required certain medical procedures, including what these procedures may be, as these may suggest a detainee could be potentially vulnerable.

7. Consideration should be given to whether, when a detainee is not fit for detention, it is desirable for the Director of Detention Operations to be able to authorise the release

from the Home Office detention estate, or whether there is another solution to expedite a detainees release is required.

8. Consideration should be given to whether detention guidance should be developed for contractors regarding the use of hand restraints in hospital environments in addition to developing guidance on the medical procedures when it is inappropriate for detention staff to be present either for their own, the detainees or the safety of others, and this guidance is incorporated into the risk assessment process. This should include consideration of what is appropriate when detainees are chemically restrained (sedated).

9. It should be considered whether the security incident report, in some circumstances, should also be attached to the IS91RA to provide UKBA with more information on what has taken place to enable the Home Office staff to consider whether any action is required, or alternatively state that a fuller report is available.

10. The Bereavement and family Service Officer requested that the relevant findings of this report be shared with the hospital to enable the RBHT to also learn from any of the findings that would assist them to improve their performance towards future patients. I agreed this request would be included for the Detention Operations Director to consider.

CCD (Case working Teams)

11. Section 6 of CCD Detention Process instructions states that detention should be reviewed when a new detention risk is identified. The guidance suggests examples of when this is reviewed, but this does not refer to hospitalisation. Consideration should be given whether staff would benefit from guidance on actions that may be appropriate actions when a foreign nation upon a detainee being admitted to hospital. This may include the requirement for CCD officers to ask directly whether a detainee is fit to be detained and whether his detention is interfering with the ability of medical staff to provide medical care, and this should be recorded.

12. Consideration should be given to how CCD case owners can become more familiar with the conditions of detention, such as the use of hand restraints to enable them to ask more informed questions when detention is being reviewed.

GEO

13. Consideration should be given to the benefits of using the same DCOs for a detainees bed guard duties to enable the officers to build a rapport but also note the differences in the detainee, should there be any.

14. The managers risk assessment regarding the use of restraints must be formally reviewed and the review recorded when a significant change occurs, including in between the managers daily reviews, and that corresponding guidance to the bed guards is developed in relation to changes in a detainee's medical condition.

15. The GEO manager's risk assessment record should be reviewed and it is recommended that this is made clearer, with written comments regarding the recommendation of whether the risk has increased, decreased or been maintained.

16. It is suggested that managers advise the DCOs going on hospital visits that in the case of medical emergencies, operations, resuscitation or X-rays, (or whatever the approved criteria maybe) they can remove the handcuffs without contacting the manager in advance.

APPENDICES

A. Statement of xxxxx, Harefield hospital
B. Statement of xxxxx,CCD.
C. Statement of xxxxx,CCD.
D. Statement of xxxxx,CCD.
E. Statement of xxxxx, UKBA Harmondsworth IRC
F. Statement of xxxxx, GEO
G. Statement of xxxxx
H. Statement of DCO xxxxx
I. Statement of DCO xxxxx
J. Statement of DCO xxxxx
K. Emails form Prime care from 16/11/12
L. GEO hospital records
M. DEPMU records
N. GEO contract information
O. IS91 RA
P. DCO xxxxx incident report
Q. GEO Manager daily reviews