HM CORONER
Central Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Home Office** **2. The Ministry of Justice**
1.	**CORONER** I am Stuart P G Fisher, Senior Coroner, for the coroner area of Central Lincolnshire, Lindum House, 10 Queen Street, Spilsby, Lincolnshire, PE23 5JE.
2.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 17 September, 2014 I commenced an investigation into the death of Rubel Ahmed, aged 26 years at the time of his death. The investigation concluded at the end of the Inquest on 18th May 2015. The Jury returned an open conclusion with a Narrative Conclusion. The medical cause of death was: 1a. Hanging
4.	**CIRCUMSTANCES OF THE DEATH** Mr Ahmed came to the United Kingdom from Bangladesh in 2009. His Visa expired in 2011. Mr Ahmed was detained under immigration legislation on 21st July 2014 and was taken to Morton Hall Immigration Removal Centre pending deportation. It was intended that Mr Ahmed would be sent back to Bangladesh on 8th September 2014. On 5th September Mr Ahmed made a claim for asylum. He spoke with family members on the telephone on 5th September 2014. Later that evening Mr Ahmed was found by staff hanging in his room. Despite attempts to resuscitate Mr Ahmed he was pronounced deceased shortly after midnight on 6th September, 2014.
5.	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – i. THE LOCKING OF SOME DETAINEES IN THEIR ROOMS OVERNIGHT: In 2013, H.M Inspectorate of Prisons inspected IRC Morton Hall and recommended that detainees should not be locked into cells (rooms) and should not be restricted to units in

	the early evening. Despite this recommendation, those in the Windsor Unit, in which Mr Ahmed resided, were locked into their rooms daily from 8:30pm to 8:00am on the following morning. This situation prevailed at the time of Mr Ahmeds death. Whilst it was clear that significant efforts had been made to comply with the above HMIP recommendation, detainees in the Windsor Unit were still being locked into their rooms overnight at the time of the Inquest. My concern relates to whether the above HMIP recommendation has now been fully complied with and if not when compliance will be achieved. I consider that the practice of locking detainees in their rooms in the evenings and/or overnight should be discontinued as soon as is practically possible at Morton Hall I.R.C. ii. DETENTION AWARENESS TRAINING: I am concerned that the detention awareness training given to the staff at Morton Hall I.R.C was not sufficiently robust to be of continuing assistance to staff in their understanding of detainees needs or to have an ongoing impact on their working practices. Further, little or no provision had been made to provide regular refresher training. I consider that there is a need for an urgent review of the provision of detention awareness training to detention staff at Morton Hall IRC with a view to effective training and refresher training courses being provided. iii. STAFF AWARNESS OF CHANGES IN DETAINEES CIRCUMSTANCES INCLUDING REMOVAL DIRECTIONS: It was disclosed at the Inquest that staff members, who dealt with Mr Ahmed on the evening of 5th September, 2014 were not aware that he had been served with removal directions. Had staff been aware of this information it may have resulted in Mr Ahmed being monitored more comprehensively than was the case. My concerns relate to there being a need to implement a robust system to ensure that all relevant detention staff at Morton Hall IRC are aware of significant changes in detainees circumstances, including the service of removal directions upon them. iv. PERSONAL OFFICER DETAIL: Despite the fact that Mr Ahmed had been allocated a Personal Officer it was abundantly clear that the officer had spent very little time with him, owing to other work pressures. It was also evident that there was no adequate system at Morton Hall for ensuring that staff have protected time to carry out this important work to enable detainees to discuss sensitive or distressing issues with an officer who was familiar to them. I consider that this situation needs to be reviewed to ensure that personal officers at Morton Hall IRC assigned to detainees are given protected time to carry out these duties. v. USE OF ELECTRICAL ITEMS IN ROOMS: Evidence at the Inquest established that Mr Ahmed utilised the electrical lead on his kettle to form a ligature with which he hanged himself. The electrical lead was noted to be two feet six inches in length. The lead could have been very much shorter and thus have avoided the risk of it being utilised as a ligature. This issue needs to be reviewed throughout Morton Hall IRC.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action.
7.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 October, 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8.	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons a) The Home Office b) The Ministry of Justice c) Solicitors representing Mr Ahmeds Family – Bhatt Murphy I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
	5 August 2015 [redacted] **.....** **S P G Fisher** **H.M Senior Coroner, Central Lincolnshire**