ASYLUM DEATHS: WHAT TO DO NEXT

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INSTITUTE OF
RACE
RELATIONS

Introduction

As a result of ongoing research into the deaths of asylum seekers and other migrants,[1] the Institute of Race Relations (IRR) has become increasingly concerned at the rising number of suicides of asylum seekers in the community and in detention. The current situation faced by asylum seekers and undocumented migrants is dire as more and more coercive and draconian laws have been passed in recent years, criminalising and dehumanising them.

The IRR has produced this report to document the circumstances that may lead an asylum seeker or migrant to take his/her own life. It is intended as a basic guide to inform those concerned after the death of an asylum seeker - family, friends, neighbours, be-frienders, caseworkers, health professionals, campaigners - on official procedures and possible practical steps to take. We hope it will aid those who may speak for or represent the interests of the deceased person.

After such a death occurs, very often the family of the deceased is overseas and may therefore find it difficult to know the official procedures following a death. In many cases, the authorities in the UK, e.g. the Immigration and Nationality Department (IND) or police, may be unable to contact the family of the deceased. In such cases, there is very rarely anyone to speak for the deceased person and to ensure that the reasons for his/her death are examined.

The extent of the problem

In the last five years alone the IRR has documented at least 41 suicides – 13 in detention and 28 in the community.[2] In 2004, 12 people died at their own hand. In the last year there have been 8 suicides in the community. Deaths that occur in detention are routinely reported to interested parties such as INQUEST, the Howard League for Penal Reform and the Prison Reform Trust and are subject to official inquiries and or investigations. However, deaths of asylum seekers in the community are not being officially counted. Therefore our figures are likely to be a gross underestimate of the actual number of deaths. The IRR relies heavily on news reports and information supplied by various informal sources e.g. lawyers, asylum caseworkers and campaigners.

Points of risk

Through our research, we have identified a number of stages in the treatment of asylum seekers where they are most at risk to self-harm attempts.

Dispersal

The practice of dispersal – sending asylum seekers from the area where they initially sought asylum (usually the South-east of England) to another area (usually in the North) while their asylum claim is decided - has resulted in asylum seekers being sent to areas unable to meet their needs. Such areas are predominantly white, lack a history of diversity and are deprived. Because local agencies have not prepared the way for asylum seekers, they can encounter high levels of popular racism. Inevitably, dispersal means asylum seekers are removed from relatives, friends and support networks to areas that cannot cater to their complex needs.

It is highly unlikely that suitable specialist legal advice will be available in such dispersal areas. And without the knowledge about, or financial resources to travel to obtain, adequate legal help, an asylum seeker is likely to face an intimidating system without the necessary legal help and protection.

Legal aid cuts

Recent cuts in legal aid funding for asylum cases have made the process of seeking asylum even more fraught. Many asylum seekers are unable to find solicitors willing to take on their case. Or, alternatively, they are only able to access poor legal advice which means their cases are not correctly presented.

Length of decision making

The process of seeking asylum can be lengthy, with many people waiting years for decisions. During this time, most asylum seekers are unable to work or complete long-term study until a decision has been made on their asylum application. As a result, asylum seekers are left feeling powerless and helpless – in limbo. Delays in processing asylum applications have been cited as a factor in a number of recent deaths. At the other extreme, under the New Asylum Model (NAM), the new fast-track system to deal with asylum claims, the process can be extremely fast, with decisions delivered after the most cursory of hearings. Evidence is emerging that this process, which does not allow asylum seekers to fully put their cases, is also leading claimants to harm themselves.

Bureaucratic blunders

In a number of cases, incorrect information on a decision has been sent to an asylum seeker regarding his/her claim, which has obviously affected the decision to take a life.

Destitution

Once an asylum claim is refused, all support, housing and money in the form of vouchers, is withdrawn, and access to healthcare is restricted. Asylum seekers are invariably made homeless and are left to the mercy of charities, churches or friends. The policy of forced destitution has resulted in numerous deaths. The inability to access services and support clearly has serious consequences on those who are already vulnerable.

Lack of health care

Asylum seekers often have complex health needs. They may have had illness and physical problems when they arrived. And the reasons for flight - persecution, war, conflict, and torture - can themselves create health issues that require treatment. But very often these health problems are not treated especially if an asylum seeker finds himself/herself in detention where healthcare is below par. The healthcare at Yarl's Wood removal centre was criticised in a report by Anne Owers, the Chief Inspector of Prisons, in October 2006, which found that the the healthcare unit was 'not geared to meet the needs of those with serious health care problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well being.' The report made seventy-nine recommendations.[3]

Staff at Colnbrook (maximum secure) removal centre next to Harmondsworth near Heathrow airport were criticised after the death of Kenny Peter in November 2004. The inquest jury listed twelve pages of deficiencies, failures and missed opportunities by staff. Criticisms of the healthcare unit, in particular, found that Kenny was not seen by a doctor within 24 hours of admission; the healthcare unit failed to arrange assessment by a psychiatrist, counsellor or Registered Mental Nurse (RMN) following referrals and his first suicide attempt; a failure of communication within the healthcare department and a failure to assume professional responsibility for follow-up.[4]

Failed asylum seekers still in the community are only able to access emergency care, which means that follow-up care and long term medication are denied. There is also often a breakdown in continuity of care and in a person's medical history being followed up.

Detention

The punitive and arbitrary nature of detention itself can be a contributory factor to a death. Asylum seekers have committed no crime other than to seek asylum and yet they are locked up. Asylum seekers can be detained indefinitely for long periods while their claims are decided or while awaiting deportation. In both cases the long wait obviously affects their mental health.

Removal centres, where asylum seekers are held, are mostly run by private companies contracted by the Home Office to build and run centres.[5] In recent years, the Chief Inspector of Prisons has issued a number of critical inspection reports. For example, in September 2007, an inspection found that at Dover removal centre detainees were being held for long periods which was threatening the safety and security at the centre. In November 2006, a major disturbance erupted at Harmondsworth removal centre, following the alleged refusal of staff at the centre to allow detainees to watch television news reports on the results of an HM Inspector of Prisons inspection of the centre. The Chief Inspector of Prisons Anne Owers, commented: 'This is undoubtedly the poorest report we have issued on an Immigration Removal Centre'. The inspection found that detainees feared the bullying, aggressive, intimidating and unhelpful staff. In June 2006, an inspection of Lindholme removal centre found a lack of accessible legal advice and officers carrying wooden staves to deal with detainees.

Imminent deportation

The highest risk of self-harm is once a removal notice has been served on an asylum seeker, whether in detention or in the community. Facing imminent deportation has been a factor in most deaths in detention. Many asylum seekers, when faced with the prospect of deportation and return

to a country they fled, find it too much to endure and the result can be self-harm.

Criminalisation

Recent changes to immigration laws have criminalised the possession of false documents (which may be used by asylum seekers to enter the UK). A number of asylum seekers have taken their lives, while being held in prison after being convicted for the possession of false documents.

Foreign national prisoners who face a double punishment - of a prison term and then deportation - are at risk. After serving their sentence for criminal offences they are being detained for an indeterminate period while their deportation is arranged. The situation, exacerbated by the furore over the Home Office's failures over foreign prisoners in April 2006, has already led to a number of deaths.

After a death

If a death occurs while an asylum seeker is being held in detention (in an immigration removal centre, in police, prison or psychiatric custody), the organisation INQUEST should always be contacted. INQUEST is the organisation best-placed to assist families of those who die in custody. (Unfortunately, due to its limited resources, INQUEST is unable to offer advice to families affected by deaths that occur in other situations.) In many cases of deaths in custody, lawyers from the INQUEST Lawyers Group have been able to assist families by providing legal advice and support through inquests and other legal proceedings. INQUEST's information pack is essential reading for anyone wishing to find out more about the inquest process.

Deaths that occur in detention are subject to a Coroner's inquest held in front of a jury and are also subject to internal investigations, carried out by the prison service or private company that may operate a removal centre. Since 1 April 2004, deaths in detention are also investigated by the Prisons and Probation Service Ombudsman. If health care issues are involved, a death may also be investigated by an NHS body.

But if a death occurs in the community, the only real forum for any facts to be established surrounding the circumstances that led to the death is the inquest, which is presided over by a Coroner without a jury. A Coroner will have a legal/and or medical background and is appointed by the local authority.

What the inquest does

An inquest is an inquiry into the circumstances of a person's death that determines its cause. It establishes the identity of the deceased and examines when, where and how a person came to die. An inquest is not a trial and does not apportion blame. If a death occurs in custody (immigration removal centre/prison or police custody) then the Coroner sits with a jury which decides upon the verdict.

For a family or friend, an inquest can be quite traumatic for it involves hearing evidence on how a loved one died. However, an inquest is very often the only venue at which the circumstances behind a death can be established. An inquest may be able to establish the salient facts surrounding the death, for example, medical treatment the deceased did or did not receive, how an asylum claim was handled, the deceased's mental health, living conditions, etc.

The post mortem

Post mortems are usually held when the cause of death is unknown or the death was unnatural. Post mortems are carried out by a pathologist. Independent post mortems can be carried out and do cost money but this has to be agreed with the Coroner. A death certificate cannot be issued if there is uncertainty about the cause of death. If a post mortem is to be held, the Coroner has a duty to inform the family of the deceased when it is to take place.

Repatriation and burial

The deceased can be repatriated to his/her country of origin before an inquest is held, with the agreement of the Coroner and this service is carried out by specialists. The deceased can also be buried before an inquest is held but again the Coroner has to agree.

However, with many deaths of asylum seekers there is no-one to claim the body or take responsibility for the funeral, so very often, the deceased remains in a mortuary for long periods of time.

In a number of deaths, community and religious groups have raised funds from within their own networks to pay for repatriation. Public fund raising campaigns through networks or local newspapers are also another alternative. And the International Organization for Migration (IOM) which usually 'pays' asylum seekers relocation grants under the Voluntary Assisted Return and Reintegration Programme (VARRP) has been known to assist in the cost of a repatriation.

Inquest proceedings

When a suspicious death occurs, an inquest is usually opened within days of a death, where identity of the deceased person is established. The inquest is then resumed some time later after a post mortem has been carried out and investigations have been completed. When a death occurs in custody, inquests can be held some years after the death occurred. With deaths in the community, inquests are usually held within months of the death.

Once a date has been set for a full inquest, the Coroner informs witnesses and other interested parties – e.g. the family, IND and a private company that runs a removal centre.

Inquests are legal proceedings at which witnesses (friends, detention centre staff, medical personnel etc) give evidence. Witnesses are questioned by the Coroner and can also be questioned by the family, or lawyers from the Treasury acting for the IND, lawyers acting for a medical professional, lawyers acting for a private company running a removal centre, lawyers acting for the family of the deceased. After all the evidence has been heard, either the Coroner decides how the deceased died or, if a jury is present, it retires to consider a verdict – after usually having been presented with a range of options by the Coroner.

Legal representation (for the family) at an inquest is advisable. A solicitor/barrister acting for the family would represent the interests of the deceased at the inquest by asking pertinent and relevant questions of any witnesses that may be called. Legal representation at an inquest is not available through legal aid, except in exceptional circumstances.[6]

The jury

Inquests are held before a jury when a death has occurred in detention. The jury consists of 7-11 people who are sworn in at the beginning of the inquest and can ask questions of witnesses. A jury's verdict does not have to be unanimous, up to two jurors can dissent from a majority verdict.

For deaths other than those in detention a family can ask the Coroner for an inquest to be held in front of jury however they would have to explain their request and it is likely that such an inquest would have to be in the 'public interest'. (Legal advice should be sought in any case.)

Witnesses

The Coroner decides which witnesses to call. Witnesses can include friends, family, medical staff, detention custody staff, police officers, asylum caseworkers, IND staff. The family can also suggest possible witnesses to the Coroner. Alternatively, if interested parties feel that they are able to provide information on how a person came to die, they should make themselves known to the Coroner.

Witnesses are questioned first by the Coroner and then can be questioned by the family or their representative (as is their right) and then any lawyers acting for any other interested parties. If a jury is present it is allowed to ask witnesses questions.

Evidence, which could be medical or from witnesses who cannot be present (e.g. they may have been deported), is also sometimes read to the court.

Prior disclosure of evidence

The family of the deceased has no right to prior disclosure of documents /evidence before an inquest. However, in certain circumstances, in deaths in custody, prior disclosure of material has been recommended.

Verdict

Once all of the evidence is heard, the Coroner will usually give his/her opinion on how the deceased came to die and then present a verdict. If a jury is present, the Coroner sums up the evidence and then presents the possible verdicts available to the jury who then retire to deliberate the verdict. The verdicts that maybe presented to a jury include:

* Natural causes – where the deceased died as a result of a naturally occurring illness or disease;

* Killed himself/herself while the balance of mind was disturbed. When returning such a verdict the Coroner/jury have to be satisfied beyond reasonable doubt that the person intended to take his or her own life;

* Misadventure or accidental death;

* Neglect – can be added as a rider to a verdict – that a death was 'contributed to by neglect';

* Narrative – where a short factual statement sets out the circumstances of a death;

* Open vedict - where the cause of death cannot be established;

* Unlawful killing - where the death was due to an unlawful act or gross negligence.

For a Coroner or jury to reach a verdict of 'Killed himself/herself while the balance of mind was disturbed' there has to be evidential proof, for example a suicide note or something else indicating it was definitely the person's intention to take his/her own life.

Criticisms arising from the inquest

Under Rule 43 of the Coroners' Rules, Coroners can make observations or recommendations to prevent further deaths occurring under similar circumstances. They can write to the person or authority (e.g. IND/Home Office, NHS, private company) that can take action to prevent other similar fatalities. Though these comments are not legally binding and cannot be enforced, some examples are worth noting.

* A Yorkshire Coroner recording a verdict of suicide who was critical of the Home Office's handling of Sirous Khajeh's asylum application.

* A Coroner criticised the Home Office for the delay with the asylum application of 25-year-old Shiraz Pir, a Pakistani asylum seeker, who died in May 2002 five days after being found hanged in his Bristol home after his asylum claim was rejected.

* The jury into the death of Kenny Peter at Colnbrook removal centre in November 2004 returned a narrative verdict that listed numerous deficiencies, failures and missed opportunities by staff at the privately owned centre, immigration staff at the centre and medical staff at the centre that could have prevented his death.

* The fatal accident inquiry into the death of Tran Quang Tung death recommended that detained people, who did not speak good English, should

have access to interpreters during interviews and that documents should also be translated.

* The solicitor for Souleyman Diallo made a complaint to the Immigration Commissioners following his death saying the 'inability to access competent legal advice, difficulties in communicating his case and tight deadlines for submission of statements have contributed to his case not being properly heard'.

* An internal Home Office inquiry into the death of Robertas Grabys in Harmondsworth in January 2000 found that the company running the centre did not have a formal policy to prevent suicides and that there was insufficient care. However this report was only released after Liberty, the human rights organisation, took legal action on behalf of the Grabys family.

After the inquest

Challenging the verdict

If the family of the deceased or an interested party is unhappy with a verdict, it can be challenged in court through judicial review. However, this must be done within three months of the verdict being delivered. For such actions, legal advice should be sought. Verdicts can be amended or new inquests ordered. However such actions are unusual and before being attempted would require discussion with lawyers.

Options for families

Unfortunately, once an inquest has been completed, there are very few further avenues for families to find out more about a loved one's death. If they are unhappy with the verdict, then it can be challenged. Alternatively, if a Coroner made any recommendation they could try to ensure that these recommendations are acted upon by the relevant organisation. Other options could include trying to raise awareness around the issue of suicides, seeking out families and friends in a similar situation. The United Families and Friends Campaign has provided great support to the families and friends who have died in custody, by campaigning and providing support to one another. The family of Joy Gardner, who died during a deportation attempt in 1993, is actively involved in the campaign.

Things you can do immediately after a death

* Make yourself known to the Coroner, what your 'interest' is and any concerns you may have had about the deceased person. The same with the Prison and Probation Ombudsman (PPO), if the death has occurred in custody.

* Ensure other important witnesses, who may have known the deceased person or can give relevant evidence about their situation and state of mind, make themselves known to the coroner (and PPO if necessary).

* Download and read INQUEST's information pack for families and friends.

* If you have any concerns about the inquest process, seek independent legal advice.

* Attend the inquest and monitor the proceedings.

Endnotes

[1] This guide refers specifically to the deaths of asylum seekers, undocumented migrants and other 'foreign nationals' in removal centres or in police/prison/psychiatric custody and in the community.

[2] *Driven to desperate measures* (pdf file, 401kb), download at: http://www.irr.org.uk/pdf/Driventodesperatemeasures.pdf. IRR Factfile, 'Roll call of deaths of asylum seekers and undocumented migrants, 2005 onward's', http://www.irr.org.uk/2006/december/ak000016.html

[3] HM Chief Inspector of Prisons 'Inquiry into the quality of healthcare at Yarl's Wood immigration removal centre', http://www.ind.homeoffice.gov.uk/6353/aboutus/Yarlswoodhealthcarereport.pdf (pdf file, 960kb)

[4] 'Kenny Peter's inquest points to asylum failures', IRR News Team, 5 October 2006, http://www.irr.org.uk/2006/october/ha000013.html

[5] There are ten removal centres in the UK where asylum seekers are held, most are run by private companies: Campsfield House removal centre in Oxford is run by GEO; Colnbrook removal centre near Heathrow is run by SERCO Home Affairs; Dover removal centre in Dover is run by the Prison Service; Dungavel House removal centre in Scotland is run by G4S; Harmondsworth removal centre near Heathrow is run by Kalyx; Haslar removal centre near Portsmouth is run by the Prison Service; Lindholme removal centre near Doncaster is run by the HM Prison Service; Oakington reception centre in Cambridge is run by GSL UK Ltd; Tinsley House removal centre near Gatwick is run by GSL UK Ltd and Yarl's Wood removal centre near Bedford is run by SERCO. For further information see: http://www.ind.homeoffice.gov.uk/aboutus/immigrationremovalcentres/

[6] Following the inquiry into the racist murder of Stephen Lawrence, recommendations were made in the report in relation to the public funding of inquests – especially for deaths in custody cases,'The Stephen Lawrence Inquiry - Report of an Inquiry by Sir William Macpherson of Cluny', February 1999. Also see Guidance on Applications for Exceptional Funding (Lord Chancellor's Department).

[5] Official investigations include IND/Home Office Inquiries, Prison and Probation Service Ombudsman's investigation reports, internal investigations carried out by a private company operating a removal centre, police investigations etc.

USEFUL CONTACTS

The Coroners' Society of England and Wales
HM Coroner's Court
The Cotton Exchange
Old Hall Street
Liverpool
L3 9UF
Tel: 0151 233 4708
Web: http://www.coronersociety.org.uk/index.aspx

INQUEST
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Email: inquest@inquest.org.uk
Web: http://inquest.gn.apc.org/
INQUEST, 'An Information Pack for Families, Friends and Advisors', Download at:
<http://inquest.gn.apc.org/pdf/info_all.pdf>

International Organization for Migration (IOM)
21 Westminster Palace Gardens
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London SW1P 1RR
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Fax: 020 7233 3001
Free Phone number: 0800 783 2332
Email: iomuk@iom.int
Web: http://www.iomlondon.org/
The IOM in the UK also has sub-offices in Bristol, Liverpool, Manchester and Glasgow.

National Coalition of Anti Deportation Campaigns (NCADC)
Registered office:
110 Hamstead Road
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NCADC: North West England & Greater Manchester contact Emma Ginn on 07703 189 665 or email: ncadc-north-west@ncadc.org.uk

NCADC: Midlands, Wales, London, South West and South East England and Scotland contact John O on 0121 554 6947 or email: JohnO@ncadc.org.uk

Prison and Probation Ombudsman (PPO)
Ashley House
2 Monck Street
London
SW1P 2BQ
Tel: 020 7035 2876 or 0845 010 7938 (lo-call)
Fax: 020 7035 2860
Email: mail@ppo.gsi.gov.uk
Web: http://www.ppo.gov.uk/index.htm
Published reports into deaths:
http://www.ppo.gov.uk/fainrep.htm

United Families & Friends Campaign
c/o Inquest , see address above
Tel: 07770 432 439
Email: info@uffc.org
Web: http://www.uffc.moonfruit.com/

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