

**REPORT OF AN
INVESTIGATION INTO
THE DISTURBANCE AT
HARMONDSWORTH IMMIGRATION
REMOVAL CENTRE ON
19 & 20 JULY 2004**

Sue McAllister
Head of Security Group
H M Prison Service

*Return to an Address of the Honourable the House of Commons
dated 16th November 2004
for*

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1. EXECUTIVE SUMMARY

- 1.1 On 19 July 2004 detainees at Harmondsworth Immigration Removal Centre staged a disturbance, possibly in reaction to the death of a detainee, Sergey Baranuyck, whose body had been found earlier that evening, hanging in a shower room on C wing. The incident started in one of the wings at about 2300 hrs and spread rapidly across the whole centre. Prison Service and police resources were deployed to support UKDS, the contractors who operate Harmondsworth on behalf of the Immigration and Nationality Department (IND).
- 1.2 Detainees smashed fixtures and fittings in the accommodation areas, and the central areas which houses shared facilities. There was some damage to walls, doors and windows, as well as water damage from sprinkler systems which were activated where detainees had started fires. The incident was resolved early the next morning through intervention by Prison Service Tornado Units.
- 1.3 Following the incident, all detainees were transferred from Harmondsworth to alternative secure accommodation, either elsewhere in the Secure Immigration Estate or in prison establishments.
- 1.4 Seventeen detainees have been charged with criminal offences directly related to the disturbance.
- 1.5 The investigation into the disturbance identified some issues relating to the management of an incident where a number of agencies are involved and where there is the potential for those agencies to have conflicting priorities. There is, following this incident, an opportunity to review and improve the protocols which exist for joint working between agencies and to give more clarity to the command arrangements which should pertain.
- 1.6 This was a successful operation; there were no escapes from the centre and, other than the tragic death of Sergey Baranuyck, there were no injuries to staff or to detainees. There are lessons to be learned, both in the way the incident was managed and in the way accommodation is used across the Secure Immigration estate.

2. METHODOLOGY

- 2.1 I received Terms of Reference for the Investigation on 23 July 2004. These are attached at Annex A. I received an oral briefing from Brodie Clark, Senior Director, IND and Brian Pollett, Director of Detention Services IND on 23 July 2004.
- 2.2 Members of the investigation team arrived at Harmondsworth on the morning of 26 July 2004 and had an initial briefing with Ravinder Walia, the Home Office Contract Manager at Harmondsworth. We visited all areas of the establishment. The investigation team remained at Harmondsworth until 27 July 2004. Team members subsequently spent time at Harmondsworth on 29 & 30 July and on 2 August 2004. I spent a further day at Harmondsworth on 31 August 2004.
- 2.3 I attended a debrief, held on 28 July 2004 at Prison Service HQ, chaired by Mitch Egan and Ian Lockwood who had been the Prison Service Gold Commanders during the early and late stages of the incident respectively. This debrief was, necessarily, narrowly focussed to consider only the Prison Service management of the incident from the time it was reported to National Operations Unit (NOU) via the Single Incident Number until the transfer of all detainees out of the Centre was completed the following day.
- I attended a multi-agency strategic de-brief on 8 September 2004.
- 2.4 The Investigation team spoke with staff from UKDS, including a director of the company as well as Detention Custody staff employed at Harmondsworth, to IND staff including the Contract Monitor and his immediate line manager, and to Prison Service staff involved on the night of the incident. However, the need to afford primacy to the parallel police investigation into the actions of detainees at Harmondsworth, coupled with concerns regarding the status of any interviews we might conduct with staff or detainees involved in the incident led to a decision not to conduct formal interviews as part of our investigation process.
- 2.5 The Investigation Team had access to documentation pertaining to the incident, notably incident logs and the statements of UKDS staff who were on duty on 19 & 20 July 2004. We viewed documents relating to the management of and regime at Harmondsworth and we had access to Security Information relating to a period of about a month leading up to the events of 19 & 20 July. We read a range of background documentation, including the contract for the management of Harmondsworth by UKDS (Operational Specification).

3 BACKGROUND

- 3.1 Harmondsworth Immigration Removal Centre, located at Heathrow Airport on the site of the old Harmondsworth Detention Centre, was purpose built as an Immigration Removal Centre, opening in September 2001. It comprises 4 wings and has a Health Care Centre with in-patient facilities. The maximum capacity is 501; on 19 July 2004 the roll was 432.
- 3.2 A diagram showing the layout of the establishment is at Annex B.
- 3.3 The contract for the Centre is managed by UK Detention Services (UKDS). UKDS have run the contract, which was awarded in 2001 for 8 years, from its inception. A Contract Monitor from IND supported by two Deputy Monitors on site, is responsible for monitoring the level of service delivered by UKDS, including alerting the Immigration Service to any concerns. Additionally, the monitor is required to approve any requests for detainees to be segregated.
- 3.4 The accommodation at Harmondsworth is made up of 2-bed and 3-bed rooms, with 22 more secure single rooms designed to hold detainees who have been removed from normal location in accordance with Detention Centre Rule 40 (Removal from Association) and 6 for detainees confined under Rule 42 (Temporary Confinement). Only the 3-bed rooms, which were originally used for families, and the more secure rooms, have integral sanitation.

Physical Security

- 3.5 A serious incident of concerted indiscipline at Yarl's Wood IRC on 14 February 2002 identified shortcomings in the physical security of those centres, including Harmondsworth, required to hold an increasing number of individuals detained under the Immigration Act who were considered to have the potential, or the will, to cause disruption within the Immigration Removal Estate.
- 3.6 Following the Yarl's Wood incident physical security at Harmondsworth was upgraded at a total cost of £22.5m. The upgrade included the installation of sprinkler systems in all areas of the centre, the expansion of CCTV coverage, and the strengthening of parts of the centre's infrastructure in order to create zones which could be isolated from one another in the event of a widescale disturbance.

- 3.7 The centre's fire alarm system is linked to fire doors, which grant access to external courtyards. In the event of a fire alarm, these external doors are automatically unlocked; we were told that the alarms were easily activated, for example by detainees throwing talcum powder at the overhead sprinklers. This gave detainees ready access, in large numbers and at any time of day or night to courtyards. Once in the courtyards, which are enclosed on all sides, it is possible to gain access to other wings, or to the central spine of the building by smashing windows and prising open the window bars.

Procedural Security

- 3.8 The regime at Harmondsworth is based on 24-hour access to association with only minimal restrictions during the night-time period. Between 2300hrs and 0630hrs, detainees are confined to their home wing but have unrestricted access to all areas within the wing.

With the exception of those detainees held in the more secure accommodation, in accordance with Detention Centre Rules 40 and 42, detainees are not routinely locked in their rooms.

- 3.9 The contract for the Operation of Harmondsworth (Operational Specification) includes arrangements for securing detainees in their rooms for control purposes where necessary. In practice, however, these arrangements are rarely, if ever, used.
- 3.10 It was clear that staff could not easily account for the whereabouts of detainees within the establishment at any time. We became aware that it could take several hours to find a detainee required to attend a legal visit or an interview with Immigration Officers. Although detainees were issued with pagers which would notify them if they were needed at a particular time or place, it appeared that co-operation with this system was patchy.
- 3.11 The Operational Specification requires that Harmondsworth's Contingency Plans are tested at the level of six exercises per year, and that these exercises allow for the testing of all plans annually. We did not have access to the records of these exercises and so cannot comment on compliance or effectiveness.

Dynamic Security

- 3.12 According to the contract for the Operation of Harmondsworth IRC (Operational Specification), the stated ethos of establishments holding immigration detainees is,
- “to provide for the secure but humane accommodation of detainees in a relaxed regime with as much freedom of movement and association as possible (consistent with control and safety), and to encourage and assist detainees to make the most productive use of their time, whilst respecting their dignity and the right to individual expression.”
- 3.13 The Operational Specification includes a requirement for detainees to have the opportunity to spend 24 hours per week in purposeful activity. This activity includes education classes, PE, and more general ‘leisure’ activities; however of the 510 activity places available only 40 places offer work, on either a paid or voluntary basis.
- 3.14 Detainees could not be required to participate in the activities available; a culture of involvement was said to be encouraged but in reality many detainees chose to associate in an unstructured way, sitting around, watching television with time to dwell on what must often have seemed a hopeless situation.
- 3.15 In the context of this aimless, arguably hopeless, existence, there is scant potential to incentivise good behaviour or participation in regime activities. There is no meaningful Incentives/Earned Privileges system, as detainees are automatically given access to all available privileges such as television, free incoming telephone calls and full association. Loss of any of these was impossible to police in the absence of the ability to confine the affected individual to his room.
- 3.16 The operational specification includes requirements for all detainees to be admitted and for adequate staffing to be provided and to maintain safety, order and control. Each wing is staffed by four Detention Custody Officers, one of whom is a first line manager grade. Wing staff were encouraged to interact with detainees, staff and detainees ate their meals together in the wing dining rooms and the open nature of the regime meant that detainees had 24 hour access to staff. Senior UKDS managers believed staff – detainee relationships to be very good; although the contract monitor was more critical and described a culture where staff were likely to base themselves in wing offices and engage with detainees less readily.

4 EVENTS PRIOR TO THE INCIDENT

- 4.1 The day before the incident staff attendance systems were changed. This was done in order to comply with the European Working Time Directive and to accommodate the re-opening of A wing following the establishment-wide security upgrade.
- 4.2 Staff reported an increase in graffiti across the establishment in the weeks leading up to the incident. The graffiti was offensive in its content and indicative of a mis-trust of the authorities on the part of the detainees. No action was taken in response to the increase, which was reported in SIRs.
- 4.3 In the week preceding the incident, detainees found they were required to pay for drinking water from vending machines. The water had previously been dispensed free of charge and the move to levy a charge was made without evidence of consultation – with staff or detainees – and with no apparent consideration of any potential reaction.
- 4.4 The Intelligence Assessment for the period 9 – 16 July indicated an increase for that week in the number of SIRs submitted. Previous weeks typically had between 40 – 60 SIRs; in the week 9 – 16 July there had been 73. An increase was also evident in the number of reported incidents. In the most recent Intelligence Assessment specific mention was made of tension amongst particular groups of detainees who were said to be targeting members of staff. No action was taken in response to this assessment.
- 4.5 On 19 July 2004 at about 1345 hrs staff began looking for a detainee, Sergey Baranuyck, who was required to attend a legal visit. At 1530 hrs, Mr Baranuyck had still not been found; wing staff temporarily abandoned the search in order to undertake other duties. Following a resumption of the search, Mr Baranuyck was found in a shower room on C wing at about 1950 hrs; he was hanging by a shoelace from the shower control button and was, apparently, dead. Local Contingency Plans for a death in custody were activated, police were called in to attend what was, now, a potential crime scene.

- 4.6 UKDS staff at the scene acted immediately to clear the landing of all detainees. Detainees were moved to the landing below, and C3 landing was isolated by securing the doors at each end of the landing. Detainees, surmising correctly that a fellow detainee had died, became suspicious about the manner of his death and demanded to see the body in order to be satisfied that there had been no foul play on the part of UKDS staff. Owing to the need to preserve the scene, staff were unable to accede to the request. A small group of detainees became very angry and began to urge others to join in their protests. By about 2000 hrs C wing was reporting unrest amongst a large number of detainees.
- 4.7 The police at the scene alerted the local Police Commander to the deteriorating situation within the centre. The Police Commander deployed police resources, including a TSG, to the centre. The police priority, at this stage, was to deal with the potentially suspicious death and the associated possible crime scene.
- 4.8 Despite the heightened tension on C wing, which was reported to staff coming on duty at 2100 hrs as part of the handover process, it appears that no arrangements were made to keep additional staff on duty, nor to activate contingency plans.

5 THE INCIDENT

- 5.1 By about 2300 hours the tensions on C wing, initially confined to shouting and some jostling of staff by detainees, had escalated into a situation where detainees were running amok in the wing, damaging fixtures and fittings and arming themselves with items with which they began to try to break out of the wings into other parts of the centre, and into the courtyard areas outside.
- 5.2 The disturbance on C wing spread first to D wing and, subsequently, to B wing. As detainees joined in, UKDS staff quickly withdrew from each wing in turn.
- 5.3 Detainees destroyed vending machines, smashed televisions and broke windows. CCTV cameras, mounted on flimsy ceiling tiles were quickly torn down and rendered useless. The consequent absence of camera cover, and the withdrawal of staff, meant that staff were unaware of how, and to what extent, the incident was spreading. Detainees probably used the wing payphones, which had not been disabled, to communicate from wing to wing.
- 5.4 It is likely that the participation of detainees on A wing was limited to their damaging CCTV cameras on the wing. Indications are that they remained passive throughout the incident, even after staff withdrew from the wing, an event shortly followed by detainees breaking into A wing from B wing. The consequent presence of those detainees on the wing seems to have suggested to those managing the incident that detainees from all four main wings were involved.
- 5.5 Detainees managed to breach the zoning which separates each wing from the central area which holds the shop, education and healthcare centre. They did this by smashing open the strengthened 'Atlas' doors, which delineate the zones, and via the courtyards, from where they smashed their way into neighbouring wings through windows. Detainees entered the shop, taking items from the shelves and damaging fixtures and fittings, including computer equipment. In the education department, classrooms were vandalised and a fire was set in the library, causing extensive damage to books, papers and furniture.
- 5.6 During the incident a number of small fires were started; this appears to have been with the intention of activating fire alarms which would automatically open the external doors. This gave detainees access to courtyards, from where they also broke into the central area by smashing windows and prising open the window bars.

- 5.7 Detainees did not gain access to the healthcare centre; however healthcare staff withdrew leaving behind four patients locked in the centre. Three of the four patients were known to be active self-harmers, and were subject to close observation by staff. The four were only rescued later the next morning when the centre was calm. It is unclear who ordered the withdrawal of staff from the Healthcare Centre; the SILVER Commander was certainly not aware that detainees were left behind in the centre. The activation of alarms in the Healthcare Centre led those managing the incident to believe that the centre had been lost to the rampaging detainees. It was subsequently discovered that the alarms had been raised by the detainees who had been abandoned in there.
- 5.8 Two landings on D wing (D2) & (D3), comprise more secure accommodation; these rooms typically hold detainees for short periods where they are kept apart from the general population. During the incident, staff withdrew from D2 & D3 landings, leaving 7 detainees locked in these secure rooms. Other detainees subsequently gained access to the landing and used fire extinguishers to break into the rooms and release those held there. Fortunately, no vulnerable detainees were located in those rooms at the time, although individuals are sometimes held in this secure accommodation when they are thought to be at risk from the general population.
- 5.9 The setting of fires activated the sprinklers which caused some water damage, but also prevented the fires from spreading further.
- 5.10 By 0015 hours staff had withdrawn from all wings and the centre was, effectively, in the control of detainees.
- 5.11 The Harmondsworth staff mustered in the sterile area outside the accommodation blocks.

6 RESPONSE TO THE INCIDENT

THE 'HOLD' STAGE

- 6.1 At 2345 hours, almost 3 hours after staff reported the deteriorating situation on C wing, and about an hour after the incident became violent, the incident was reported to the Prison Service National Operations Unit (NOU) via the single incident number. The NOU Duty Officer contacted the IND Director of Detention Services who gave authority for the activation of Prison Service Mutual Aid arrangements (TORNADO). Staff were despatched to Harmondsworth from a number of prison establishments in the South East, in accordance with the agreed response plans. These units began arriving from about 0210 hours. Prison Service National C & R advisors arrived at Harmondsworth shortly after 0030 hours.
- 6.2 In line with the Prison Service/IND protocol for managing serious incidents in IRCs, the Prison Service GOLD Command Suite was opened with a Senior Prison Service Operational Manager as GOLD Commander. An IND official was present in the GOLD Suite throughout the incident.
- 6.3 At about 2350 hours, the Centre Manager, Ron Oliver arrived at Harmondsworth and assumed the role of SILVER Commander. Other UKDS Managers were called in to support SILVER in the Command Suite, and to act as BRONZE Commanders. Detention Custody Officers were called in to support those already on duty and to perform some tasks not directly related to intervention in the incident.
- 6.4 The IND Contract Monitor, Ravinder Walia, was present in the SILVER Command Suite, in accordance with the local contingency plans until he was relieved, after a short hiatus, by another IND representative.
- 6.5 The police presence at the incident in response to the call from the police attending the death in custody, was prompt and the numbers of police officers sent to Harmondsworth was considerable. Police with dogs were deployed to patrol the outside of the building to prevent detainees breaking out of the wings and attacking the perimeter fence. Dog handlers from the Prison Service National Dog and Technical Support Group (NDTSG) subsequently arrived and worked with the police to protect the perimeter. The presence of staff with dogs around the external walls of the building appears to have deterred detainees who were attempting to climb out of external windows into the sterile area.

- 6.6 There was also a police presence in the SILVER Command Suite, and a police GOLD based at New Scotland Yard.

THE 'PLAN' STAGE

- 6.7 The plan to re-take control of the centre was devised by the Prison Service National C & R advisors deployed to Harmondsworth as part of the Prison Service/IND mutual aid arrangements. It was agreed by the SILVER Commander and subsequently discussed with the Prison Service GOLD Commander who approved the plan.
- 6.8 The initial intervention plan was straightforward, and followed a model which has been successfully executed on many occasions in incidents of this type. It was proposed that Prison Service TORNADO units would sweep each wing in turn and secure detainees in rooms on the wings, leaving UKDS staff behind once each wing was secure. The operation to transfer detainees out of Harmondsworth could then be managed from this secure position.
- 6.9 Objections to this plan, voiced by the UKDS SILVER Commander, centred on the view that detainees could not be locked into rooms, even in circumstances as extreme as the ones which pertained, and for a relatively short time, because of concerns about fire.
- 6.10 The validity of this view appears to have been accepted at the time, and led to a revision of the Intervention Plan to require TORNADO staff to place detainees who appeared compliant in rooms, but not to secure the doors using the 'top locks'; ie the locks which could only be locked or unlocked by staff from the outside.
- 6.11 The remaining, hostile and, in some cases, armed, detainees would be driven through the centre to be corralled in courtyard 3, from where they could be arrested and taken to the reception block prior to being swiftly transferred out of the centre.
- 6.12 The revised plan was discussed with, and approved by the GOLD Commander.
- 6.13 Other than some early enthusiasm probably emanating from the police units on site, to be involved, all agencies were clear that the execution of any plan to re-take control of the centre was the responsibility of the Prison Service. The contribution of the police was to secure the perimeter and to manage any issues relating to public order outside the centre. This approach was sensible and all parties were content with it.

- 6.14 The presence of Sergey Baranuyck's body, and the consequent status of an area on C3 landing as a potential crime scene, was a concern to the police, and presented an additional challenge to those involved in devising an Intervention Plan.
- 6.15 It was agreed that the police would retrieve the body of Sergey Baranuyck from the shower room on C3, a police SOCO would have access to the area to preserve evidence at the scene, before TORNADO staff entered the wings to clear the centre.
- 6.16 At about 0210 hours, a police TSG unit, supported by two Prison Service C & R advisors and two UKDS managers entered C wing via the roof space above C3 landing. The body of Sergey Baranuyck was removed shortly after 0400 hours. Those involved in removing the body reported passing groups of detainees along the way but none were hostile or threatening towards the staff.
- 6.17 A document transferring responsibility for the management of an incident to the police was completed and signed by the UKDS SILVER Commander and the Senior Police Officer at Harmondsworth at about 0135 hours. This document forms part of Harmondsworth's Contingency Plans, and is intended to be used when transferring management of an incident in its entirety. The precise status of the transfer was not discussed with, nor approved by, Prison Service GOLD, although she was content with the plan, including the proposal that the police unit be accompanied by Prison Service & UKDS personnel. Responsibility was transferred back to UKDS, via a similar document, at 0505 hours.
- 6.18 Once the body of Sergey Baranuyck had been removed, and steps to preserve evidence at the scene completed, the Intervention Plan was actioned.

THE 'ACT' STAGE

- 6.19 The Operation to re-take control of the centre began at 0512 hours when Prison Service C & R units entered A wing. The planned sweep of the centre started in A wing, moving through B wing, then the central spine area and D wing finally clearing C wing. All wings were cleared and under the control of staff by about 0900 hours.

- 6.20 As the wings were cleared, those detainees who appeared compliant, or who offered no resistance to staff, were placed in rooms, either individually or in pairs in accordance with the approved plan. It became evident almost immediately that the requirement not to lock detainees in was unrealistic, unworkable and unsafe. Staff had to lock the doors to prevent a number of individuals coming back out of the rooms behind the advancing TORNADO units undermining the entire intervention strategy, and preventing the wings being brought back under the control of staff.
- 6.21 The remainder of the detainees were driven, or made their way, in front of the advancing staff, where a hardcore of about 120, some armed and most still showing some reluctance to surrender, ended up on courtyard 3.
- 6.22 A small number of, mostly, unresisting detainees remained on courtyard 1 for a short time, but these were moved into accommodation on the wings, leaving only those on courtyard 3.
- 6.23 It was clear to the Prison Service GOLD Commander that the detainees on courtyard 3, armed and hostile, represented a continuing threat to the centre and that the incident could not be considered to be at an end until these detainees had been disarmed, dispersed and securely located. GOLD's view, shared by the Senior IND advisor, was that transferring this hard-core of apparent ringleaders out quickly to secure, probably prison, accommodation would be a significant step in restoring order and allowing for the subsequent decanting of the rest of the population.
- 6.24 The police however, were insistent that these detainees could not be transferred until they had undergone police procedures to formally identify and process them as part of the police strategy to improve the chances of any subsequent criminal charges being successful. These procedures could not start until enough police officers were available at Harmondsworth.
- 6.25 This situation represented a conflict of priorities between the Prison Service and the Police. Prison Service GOLD was responsible for overseeing the execution of the Intervention and Surrender Plans, which included disarming the detainees remaining on courtyard 3 and subsequently arranging for detainees to be transferred to alternative accommodation. The police priority was to ensure that the detainees were formally identified and processed individually so that evidence could be gathered and preserved for any consequent criminal charges and prosecutions.

- 6.26 Once police were available in sufficient numbers, and vehicles had arrived at the centre, Prison Service Units moved onto courtyard 3 in the final stage of the plan to re-take control of the centre.
- 6.27 All of the detainees on the courtyard surrendered to staff and all were disarmed without resistance. They were taken, via a second courtyard, to the gymnasium, where the police processing procedures began.
- 6.28 Seventeen detainees were arrested by the police and taken to Charing Cross Police Station for questioning and, in some cases, charging others were transferred directly to prison establishments.
- 6.29 The subsequent operation to process and transfer those detainees who had been held on the wings could then begin. The police insistence that all should be subject to the same procedures as those who had been arrested on courtyard 3 made this a lengthy process. An early expectation that it would be completed, and Prison Service staff stood down during the morning of 20 July proved to be unachievable and the stand down time was subsequently revised several times. In the event two replacement TORNADO units were sent to relieve some of those which had been there from the previous evening, and to oversee the final stages of the evacuation.
- 6.30 The centre was only finally clear of detainees at 1300 hrs. About half had been transferred to prison accommodation, the rest to other establishments in the secure immigration estate, and 17 were in police custody.

7 FINDINGS AND CONCLUSIONS

- 7.1 The routines in operation at Harmondsworth were intentionally relaxed and permitted constant association between detainees on each wing, together with the absence of any requirement, or incentive, to participate in structured activities. Many of the detainees were young, fit men, some, at least, were known to have had involvement in criminal activity or to have criminal links; the combination of a boring regime in detention, and little hope at the end of it, was likely to increase the potential for trouble.
- 7.2 There were no systems in place to assess the suitability of detainees for the open regime at Harmondsworth. The information staff had on detainees was patchy and, in some cases, non-existent.
- 7.3 Internal controls within the centre were inadequate to provide an environment which was safe for staff and detainees. The ability to secure detainees in their rooms would allow for proper levels of control and safety and would improve the possibility that staff could deal with incidents of indiscipline in their early stages. This need not undermine the overall ethos of the centre, although some further discussion with the Fire Services may be necessary to agree how concerns about fire safety can be met.
- 7.4 In the weeks leading up to the events of 19/20 July 2004 there were some indications of an increase in tensions within the centre. In addition to an increase in the number of SIRs of offensive graffiti, and of reported incidents, there were also reports of staff being targeted by particular groups of detainees. No management action appears to have been taken in response to this heightened tension.
- 7.5 There appeared to be an absence of effective communication between UKDS managers and staff and between UKDS staff and detainees, resulting in decisions being made and changes introduced with little or no consultation.
- 7.6 The death of Sergey Baranuyck appears to have provoked the active unrest amongst detainees on C wing, which escalated into the act of concerted indiscipline. It is not uncommon for detainees to react aggressively to the death of a fellow detainee and to suspect foul play by staff. Staff might have been expected to anticipate this and to have taken action to defuse the situation.

- 7.7 There is no evidence of any real attempt by staff on C wing at the time to de-escalate the situation quickly, before detainees became violent and staff took the decision to withdraw from the wing. The inability to secure detainees in rooms may have influenced this decision.
- 7.8 The zoning arrangements were not effective against concerted action by detainees, who were able to breach the reinforced doors between wings and the central area.
- 7.9 Detainees were clearly aware that the fire doors could be opened by setting small fires to activate fire alarms. They did this at a number of sites to gain access to the outside areas.
- 7.10 The presence of a sprinkler system prevented fires spreading; although there is no evidence that detainees intended to set fire to large parts of the centre. The only fire of any significance appears to have been in the library within the education block. There is some suggestion that the pumps which serve the sprinkler system can only provide enough pressure for about 6 sprinklers at anytime. There is also a need to balance the cost of water damage from the sprinklers against any likely benefit from them.
- 7.11 Local contingency plans for responding to a serious incident were in place. However, there was a delay in reporting the incident via the Prison Service National Operations Unit via the Single Incident Number.
- 7.12 The arrangements for providing Prison Service Assistance to IRCs in the event of a serious incident were activated and worked well.
- 7.13 There was evidence of the police, prison staff and UKDS staff working collaboratively in a number of areas during the incident. The protection of the perimeter and the retrieval of the body of Sergey Baranuyck are examples of where this worked well.
- 7.14 There was some tension between the Prison Service and the police at GOLD Commander level. This was due to different perceptions of priorities and a possible lack of clarity around command arrangements.
- 7.15 There were no escapes from Harmondsworth as a result of the incident. No injuries were sustained, either by staff or detainees, and no allegations have been made against any staff involved in the incident or its aftermath. Seventeen detainees have been charged with criminal offences directly related to the incident.

8. RECOMMENDATIONS

- 8.1 Detainees should undergo an Observation/Assessment process in the initial days of detention to assess the risks they present for an open regime such as the one at Harmondsworth. Whilst the high turnover rate of those detained might make this difficult, it need not be complex and could be built into the early processing arrangements.
- 8.2 Better, and more systematic, use should be made of the Secure Immigration Estate including the use of more secure accommodation for those detainees assessed as being unsuitable for a more open regime or those likely to require a more secure and better controlled environment.
- 8.3 A strategy should be developed for managing individuals, or groups, who threaten the stability of an establishment within the Secure Immigration Estate. This can be based on simple protocols between the elements of the estate, but should not simply rely on moving difficult people from one establishment to another.
- 8.4 Consideration should be given to permitting staff in IRCs, including Harmondsworth, to secure detainees in their rooms in certain circumstances. Although the doors to the rooms would be unlikely to withstand a serious attempt to break out of a room, a locked door would provide some physical barrier and would be an indicator of control on the part of the staff.
- 8.5 Participation in structured regime activities should be linked to a system of incentives and access to privileges. The quality and range of regime activities should be reviewed, to ensure that activities reflect the needs and interests of the population.
- 8.6 The Command and Mutual Aid arrangements in the event of a serious incident within the Secure Immigration Estate should be reviewed and a revised protocol issued. This should include the role of the police where there are issues relating to Public Order and Safety, and a clear agreement regarding Command arrangements between IND, Contractors, Police and Prison Service.
- 8.7 Consideration should be given to training and enabling Senior Managers from the Immigration Service to act as GOLD Commander in the event of a serious incident in the Secure Immigration Estate. This would simplify command arrangements, in particular the relationship between GOLD & SILVER.

TERMS OF REFERENCE AND COMPOSITION OF INVESTIGATION TEAM

On 23 July 2004 I was directed by Brodie Clark, Senior Director IND to carry out an investigation into the act of concerted indiscipline at Harmondsworth IRC on 19/20 July 2004. My Terms of Reference were as follows:

Direction

You are directed to carry out an investigation into the act of concerted indiscipline, which took place at Harmondsworth Immigration Removal Centre on 19/20 July 2004.

Authority

You act with my authority in conducting this investigation.

Objectives

Your investigation should find out what preceded the incident, what took place, its causes, and the manner in which it was managed and resolved and how a similar occurrence may be prevented or avoided in the future.

Recommendations

Your report will make recommendations to prevent recurrence specifically related to Harmondsworth or to the IND Removal Estate in general and on better handling of incidents in the future. You may make recommendations on good practice that becomes apparent during your investigation.

Resources

You should appoint such staff as necessary to ensure the effective conduct and completion of the investigation.

Timetable and Costs

You are to provide an interim report by 4 August 2004 and a final report by 31 August 2004. Your final report must include an assessment of the total cost of the investigation.

Composition of the Investigation Team

I was assisted by Tess Kirkby from Prison Regime Services, Richard Chester from Prison Health, Helen Savage from HMP Belmarsh and Michelle Scott from Prison Service Security Group. The Liaison Officer at Harmondsworth was the Contract Manager, Ravinder Walia.

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