Upper Tribunal

(Immigration and Asylum Chamber)

R (on the application of Lawal) v Secretary of State for the Home Department (death in detention; SoS's duties)

[2021] UKUT 00114 (IAC)

THE IMMIGRATION ACTS

Heard at Field House by Skype	**Decision & Reasons Promulgated**
On 3 and 4 March 2021	
Further evidence and submissions received on 11 and 18 March 2021	**14 April 2021**

Before

THE HON. MR JUSTICE LANE, PRESIDENT

UPPER TRIBUNAL JUDGE CANAVAN

Between

THE QUEEN ON THE APPLICATION OF

AHMED LAWAL

(ANONYMITY DIRECTION NOT MADE)

Applicant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation :

For the applicant: Ms S Naik QC, Mr R Halim and Mr S Clark, instructed by Duncan Lewis Solicitors

For the respondent: Mr C Thomann, instructed by the Government Legal Department

(1) In considering the Strasbourg caselaw as to the extent of the Article 2 procedural duty to investigate a suspicious death (including a death that occurs whilst in immigration detention in the United Kingdom), it is important to bear in mind that the ECtHR is concerned with the entirety of the process, beginning with the initial steps to secure evidence and ending with the actual investigation or trial. Although the investigation or trial must be conducted with the requisite degree of independence, it by no means follows that the duty to secure evidence cannot involve those such as the Secretary of State for the Home Department and her service providers, who will not be

conducting the subsequent independent investigations. On the contrary, given that, in the context of a death in detention, the service providers and the Secretary of State's relevant officials at the detention centre will inevitably be the first on the scene, they clearly must take the initial steps to secure evidence. This is so, irrespective of the fact that, in order of likely appearance, the police, the Prisons and Probation Ombudsman's investigators and HM Coroner will also become actively involved.

(2) Furthermore, it is important to acknowledge that the ECtHR has been at pains to state that the steps to be taken are "reasonable" ones. What is reasonable will depend, not only on the circumstances of the death but also the nature and purpose of the detention facility, such as whether it is holding individuals who face removal by the Secretary of State from the United Kingdom, in pursuance of her functions, conferred by Parliament, of enforcing immigration controls.

(3) The irreducible minimum obligations of the Secretary of State in this area are:

(a) to take immediate steps to ascertain whether any detainee has evidence to give regarding the death in detention;

(b) to record, or facilitate the recording of, a statement of such evidence;

(c) to determine whether the individual is willing to give evidence at the inquest;

(d) to record relevant contact details of the individual, including in the country of proposed removal; and

(e) to consider the practicability of the individual giving evidence at the inquest either (i) by returning to the United Kingdom for that purpose or (ii) by giving evidence by means of video-link.

(4) The Detention Services Order 08/2014: Death in Immigration Detention (August 2020) fails adequately to address the vital function of detention centre staff in identifying those detainees who, because of physical proximity to the deceased or other known associations, are likely to have relevant information, whether or not they have chosen to come forward of their own accord. The current policy of the Secretary of State is, therefore, not compliant with Article 2 in its procedural form.

(5) The Secretary of State's present policy framework is also legally deficient in that there is nothing in her policy concerning removals; namely Judicial Reviews and Injunctions – Version 20.0 (10 October 2019), which guides her immigration officials to act compliantly with Article 2 in its procedural form, when making decisions as to the removal of an individual.

JUDGMENT [1]

A. THE DEATH OF OSCAR OKWURIME

1.
At 11.12 am on 12 September 2019, Mr Oscar Lucky Okwurime, a Nigerian national, was found dead in his room at Gauze House, which is part of the Harmondsworth premises of the Heathrow Immigration Removal Centres. He was 36 years old. Mr Okwurime (hereafter "OO") was being detained by the respondent, in order to effect OO's removal to Nigeria. The claimant, also a national of Nigeria, was at that time also in detention at Gauze House.

2.
An inquest into the death of OO was formally opened by the coroner for West London on 8 October 2019. An inquest hearing, before a jury and Mrs Lydia Brown, Coroner, was held on 13 November 2020. The record of the inquest states that OO died of a spontaneous subarachnoid haemorrhage at

approximately 2300 hours on 11 September 2019, having last been seen alive at 2100 hours on 11 September. The jury's conclusion as to the death of OO was as follows:-

"We find the death to be considered unnatural. Mr Oscar Lucky Okwurime died of a spontaneous subarachnoid haemorrhage which can rupture due to hypertension. His blood pressure reading on 22 August 2019 demonstrated Grade II hypertension. This reading was not repeated due to multiple failures to adhere to healthcare policy. Given the multiple opportunities to repeat this basic medical test on a vulnerable person, neglect contributed to the death."

3.
At the inquest, the jury heard evidence from Dr Alan Bates, a pathologist. Dr Bates told the jury that his post-mortem examination of OO disclosed that OO had coronary artery disease, in the form of atheroma (hardening of the arteries). Dr Bates said it was common in his experience for people to die very rapidly of subarachnoid haemorrhage. It was therefore entirely consistent with the cause of death that OO collapsed, was unconscious and died fairly rapidly.

4.
The events which brought the applicant to be in immigration detention at Gauze House on 11 September 2019 are as follows. On 29 March 2012, the applicant entered the United Kingdom, in possession of a visitor visa valid until 29 September 2012. The applicant subsequently overstayed and worked in breach of his conditions. On 26 June 2015, the applicant was encountered after he had been arrested for shoplifting. Having been served with papers as an overstayer, the applicant was granted temporary admission on reporting conditions. The applicant failed to comply with those conditions. A visit by the respondent's officers on 4 January 2016 to the applicant's address failed to find him.

5.
On 12 June 2018, the applicant attended the respondent's Asylum Support Unit and claimed asylum. He then absconded from the supported initial accommodation provided to him by the respondent. On 26 July 2018, the applicant's asylum claim was treated as withdrawn.

6.
On 6 August 2019, police encountered the applicant loitering without a valid ticket in Birmingham New Street Station. He was detained as an immigration absconder and detention was authorised with a view to his removal.

7.
On 26 August 2019, the applicant made further representations, which were rejected on 6 September 2019. On that day, removal directions were set for 17 September 2019. This was the date of a charter flight to Nigeria, organised by the respondent.

8.
On 13 September 2019, a text message was prepared (but not ever sent) by the service suppliers to detainees stating "Hello, notices to detainees following the recent passing of a detainee will be issued out this evening providing an update on all the information C & C have". According to the witness statements of Terrence Gibbs, Service Delivery Manager for the Heathrow Immigration Removal Centres, following OO's death the staff of the respondent's service supplier at Harmondsworth prepared and distributed a notice to detainees "to ensure that support was offered to those individuals affected and that all detainees were made aware of the investigation taking place into [OO's death]". The notice was delivered to each detainee's bedroom at both the Harmondsworth and Colnbrook sites. It read as follows:

“You may be aware that unfortunately there was a death of a detainee at the Harmondsworth site earlier today.

This is clearly very sad and tragic event. If you or a fellow detainee require any support regarding this issue, please do not hesitate to contact any member of staff. [PW] of our Religious Affairs team will also be providing additional pastoral support during this time.

This matter is now being independently investigated by the Prison and probation Ombudsman and Care & custody are also conducting an internal investigation.

Please be assured we are doing all we can to reduce the risk of such incidents happening again in the future. If you are concerned about a fellow detainee or indeed just want to speak to someone about your own concerns, please raise this with a member of staff immediately.

[PR]

Centre Manager”

9.
Also on 13 September 2019, an emergency Detainee Consultative Committee Meeting was convened by service supplier staff at both Harmondsworth and Colnbrook. At the meeting, detainees were advised of the investigation procedures in train into the death of OO and were informed that the Prisons and Probation Ombudsman (hereafter “PPO”) would be visiting the centres as part of his investigative process.

10.
The minutes of the Detainee Consultative Meeting include the following:-

“There is no evidence that [OO] was shouting throughout the night as there was [sic] no call bells activated in his room or the neighbouring rooms that detainees allegedly heard however this will still be investigated.

The PPO will be attending the Centre in the next coming days. Building a case and formulating an investigation.

Detainees are welcome to speak with them if they wish.

C & C will be sending out more correspondence either with notices or SMS regarding the process of the investigation/PPO.”

B. THE APPLICANT’S JUDICIAL REVIEW

11.
On 16 September 2019, the applicant was served with notice refusing his latest representations. On the same day, the applicant applied in person for judicial review and interim relief. At 3pm on 16 September 2019, Upper Tribunal Judge Pitt refused interim relief. She observed that there was no evidence to support a protection claim, human rights claim or claim by the applicant that he was not fit to fly.

12.
Also on 16 September 2019, certain detainees, including the applicant, made contact with Duncan Lewis Solicitors. Witness statements were settled, setting out the detainees’ knowledge and awareness of the circumstances of OO’s death and what matters they wish to speak about in this

regard. It appears to be common ground that, as at 16 September, no statements had been taken by the service provider (or anyone else) from any detainee at Gauze House, concerning OO's death. This included the detainee known as Mr Ullah, who occupied the room next to that of OO.

13.
On 17 September 2019, Butcher J granted interim relief, preventing the removal of the applicant until further order, following the application made on his behalf by Duncan Lewis Solicitors. The applicant's grounds were accompanied by a witness statement from Toufique Hossain, Director of Public Law at Duncan Lewis, stating that the applicant knew OO "very well" and that he had evidence to give as to the efforts made by OO to get an appointment with healthcare in the weeks prior to OO's death. The applicant's own witness statement said that there were no hourly checks on rooms during the night in question and that around 11pm the applicant heard a lot of banging coming from where OO's cell was located. The applicant understood that OO was screaming and shouting, that he was banging on his door and also pressing the buzzer/alarm in his room. The applicant could hear all this noise from his own cell.

14.
The application for interim relief was framed in such a way as to extend to everyone detained in Heathrow Immigration Removal Centres at the time of OO's death, not just the named claimants. That wider application was refused by Butcher J. Later in the evening of 17 September, the application was renewed before the Court of Appeal but refused by Leggatt LJ. The charter flight departed at 10.30pm on 17 September 2019.

15.
On 18 September, an investigator from the PPO attended the detention centres. Three detainees were spoken to by the investigator, although it is unclear how these were selected or identified.

16.
On 24 September, Mr Gibbs informed the PPO of the legal action commenced by Duncan Lewis Solicitors in respect of their clients, enquiring if the PPO had identified any detainees with whom she wished to speak. The PPO responded that, based on the assessment made during the visit, she did not intend to interview any additional detainees. Statements in writing would, however, be accepted. Subsequently, the PPO advised that she did not require the assistance of any further detainees, in connection with her investigation into OO's death, but statements would be accepted from any detainee who felt that they had information relevant to her investigation.

17.
On 5 November 2019, the respondent filed summary grounds of defence. These submitted that, since the applicant's removal had been deferred, the judicial review brought by him had been rendered academic. On 15 January 2020, the applicant filed and served a reply to the summary grounds. The applicant contended that his removal would render him non-compellable as a witness and thus materially impair the effectiveness of the pending coronial inquest and, thus, the discharge of the respondent's procedural obligation under Article 2 of the ECHR.

18.
On 21 January 2020, the application for permission to bring judicial review was transferred by the High Court to the Upper Tribunal, Immigration and Asylum Chamber, pursuant to section 31A(2) of the Senior Courts Act 1981. On 20 February 2020, Upper Tribunal Judge Canavan granted permission to the applicant to bring judicial review proceedings. She observed that, even though the applicant

had not been considered to be of assistance to the PPO, it was at least arguable that he might be a relevant witness with respect to the inquest.

C. THE CORONER

19.
Also on 20 February 2020, the respondent wrote to Duncan Lewis Solicitors to inform them that the respondent had written to Mr Chinyere Inyama, the coroner assigned to the inquest of OO, advising him that certain detainees had prepared witness statements and others had had their evidence summarised in the witness statement of Toufique Hossain. The emphasis of the letter was, nevertheless, on the respondent's removal powers. Nothing appears to have been said by the coroner by way of reply to the respondent's letter before 9 September 2020, when the coroner produced a list of witnesses for the inquest. That list did not include the applicant. In response to further enquiries from the respondent, however, the newly-appointed area coroner for West London, Mrs Lydia Brown, sent an email to the respondent on 21 October 2020, in which she said:-

"I have been asked to consider the position of Mr Lawal giving evidence at the inquest into this death. I have recently inherited this matter after I took up post as area coroner to West London and have now had a chance to fully review the papers.

I have seen Mr Lawal's statement. He is an important witness of fact and I require him to attend this inquest to give live evidence if he is still within England and Wales. A summons will be served upon him imminently, to attend on 30 November 2020 until he is released or at the conclusion of the inquiry.

I am obliged to sit with a jury as this was a death in custody and I have reason to suspect it may have been unnatural due to culpable human failing. The Chief Coroner's Guidance 38 is clear that:

"Partial remote hearings are generally not suitable save in the most exceptional and limited circumstances for any jury request."

If Mr Lawal is no longer in the country, he would be the only witness who would present his evidence remotely and I have concerns that the quality of that evidence may be impacted. There is a risk that any IT link would fail, or be of inadequate quality, and would impinge on the questioning of this witness by HMC and the various interested parties. It is of note that all the other witnesses will be giving evidence for the immigration control centre or for healthcare and they will be legally represented and supported, where else Mr Lawal will not. He is the only live witness who can speak to certain parts of the evidence particularly the presentation of the deceased in the days before his unfortunate death."

20.
We have already noted certain of the medical evidence given at the inquest. So far as the applicant's evidence is concerned, relevant information is to be found in the witness statements of Amanda Hoad, of the Government Legal Service, who attended the inquest between 13 November and 7 December 2020; and in the witness statements of Jamie Bell of Duncan Lewis Solicitors. Despite the criticisms made by Ms Hoad and Mr Bell of each other's evidence, we consider that, together, they are likely to have given a useful account of what transpired at the hearing. In his evidence to the jury, the applicant said he heard a call bell go off. However, computerised records showed that no call bells in G25 or G26 (respectively, OO's, Mr Ullah's rooms) had been activated in the evening in question. The applicant also gave evidence to say that he heard what had been shouted. When asked why he had not

mentioned details about that in his initial witness statement, when his memory was fresh, the applicant was unable to answer. He then appeared to say that this was because he was told it by somebody else.

D. THE REPORTS OF THE PRISONS AND PROBATION OMBUDSMAN

21.
In the present proceedings, on 12 August 2020 the applicant sought disclosure of the PPO's report into the death of OO. Following an order made by the Upper Tribunal, the PPO sought its discharge. Eventually, the final PPO report was disclosed, redacted in compliance with obligations under the General Data Protection Regulation and related legislation. The interim PPO report was not, however, disclosed. Given the impending date for the inquest hearing, the substantive hearing of the judicial review was, by agreement, set for a date thereafter. The substantive hearing took place on 3 and 4 March 2021. The Upper Tribunal is grateful for the written and oral submissions of Ms Naik QC and Mr Thomann; and for those who respectively assisted them in this regard.

E. THE OUTSTANDING ISSUES IN THE PROCEEDINGS

22.
In their skeleton argument, Counsel for the applicant categorised the outstanding issues in the proceedings as follows:-

(a) Whether the decision communicated on 16 September 2019, to set directions for the applicant's removal on 17 September, amounted to a breach of Article 2 ECHR;

(b) Whether the respondent can lawfully remove a potential material witness to a death in custody in circumstances where their evidence has not been secured and a coroner has not made a decision as to whether they are required to give evidence at the final inquest hearing; and

(c) Whether the respondent's failure to have in place a policy framework, which makes clear provision for a proper investigation into witnesses to a death in custody prior to any enforcement action being taken, is lawful.

23.
Depending on the answers to those questions, there is the issue of whether and, if so, what declaratory relief the Upper Tribunal should make.

F. LEGAL BACKGROUND

(a) Article 2 of the ECHR

24.
Article 2.1 of the ECHR is in the nature of an absolute, as opposed to a qualified, right. It provides as follows:-

" Right to Life

1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

25.

In the present case, we are concerned with Article 2 in what is known as its procedural sense. This procedural duty can be summarised as requiring an effective, independent investigation into circumstances concerning the loss of life within the territory of the Member State concerned.

26.
In Őneryildiz v Turkey (Application No 48939/99), the ECtHR said:-

“94. … the judicial system required by Art 2 must make provision for an independent and impartial official investigation procedure that satisfies certain minimum standards as to effectiveness and is capable of ensuring that criminal penalties are applied where lives are lost as a result of a dangerous activity if and to the extent that this is justified by the findings of the investigation. In such cases, the competent authorities must act with exemplary diligence and promptness and must of their own motion initiate investigations capable of, first, ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system and, secondly, identifying the state officials or authorities involved in whatever capacity in the chain of events in issue.”

27.
In another Grand Chamber case, Da Silva v the United Kingdom (Application No 5878/08) we find the following expostulation of the investigative duty:-

“233. In order to be “effective” as this expression is to be understood in the context of Article 2 of the Convention, an investigation must firstly be adequate (see Ramsahai and Others , cited above, § 324, and Mustafa Tunç and Fecire Tunç , cited above, § 172). This means that it must be capable of leading to the establishment of the facts, a determination of whether the force used was or was not justified in the circumstances and of identifying and – if appropriate – punishing those responsible (see Giuliani and Gaggio , cited above, § 301, and Mustafa Tunç and Fecire Tunç , cited above, § 172). This is not an obligation of result, but of means (see Nachova and Others v. Bulgaria [GC], nos. 43577/98 and 43579/98 , § 160, ECHR 2005-VII; Jaloud v. the Netherlands [GC], no. 47708/08 , § 186, ECHR 2014; and Mustafa Tunç and Fecire Tunç , cited above, § 173). The authorities must take whatever reasonable steps they can to secure the evidence concerning the incident, including, inter alia , eyewitness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of the clinical findings, including the cause of death (as regards autopsies, see, for example, Salman v. Turkey [GC], no. 21986/93 , § 106, ECHR 2000-VII; on the subject of witnesses, see, for example, Tanrıkulu v. Turkey [GC], no. 23763/94 , § 109, ECHR 1999-IV; and, as regards forensic examinations, see, for example, Gül v. Turkey , no. 22676/93 , § 89, 14 December 2000). Moreover, where there has been a use of force by State agents, the investigation must also be effective in the sense that it is capable of leading to a determination of whether the force used was or was not justified in the circumstances (see, for example, Kaya v. Turkey , 19 February 1998, § 87, Reports 1998-I). Any deficiency in the investigation which undermines its ability to establish the cause of death or the person responsible will risk falling foul of this standard (see Avşar v. Turkey , no. 25657/94 , §§ 393-95, ECHR 2001-VII); Giuliani and Gaggio , cited above, § 301; and Mustafa Tunç and Fecire Tunç , cited above, § 174).

234. In particular, the investigation’s conclusions must be based on thorough, objective and impartial analysis of all relevant elements. Failing to follow an obvious line of inquiry undermines to a decisive extent the investigation’s ability to establish the circumstances of the case and the identity of those responsible (see Kolevi v. Bulgaria , no. 1108/02 , § 201, 5 November 2009, and Mustafa Tunç and Fecire Tunç , cited above, § 175). Nevertheless, the nature and degree of scrutiny which satisfy the minimum threshold of the investigation’s effectiveness depend on the circumstances of the particular

case. The nature and degree of scrutiny must be assessed on the basis of all relevant facts and with regard to the practical realities of investigation work (see Velcea and Mazăre v. Romania , no. 64301/01 , § 105, 1 December 2009, and Mustafa Tunç and Fecire Tunç , cited above, § 175). Where a suspicious death has been inflicted at the hands of a State agent, particularly stringent scrutiny must be applied by the relevant domestic authorities to the ensuing investigation (see Enukidze and Girgvliani , cited above, § 277).” (Our emphasis)

28.
Earlier, the ECtHR in Jordan v United Kingdom (Application No 24746/94) had spoken in similar terms:-

“107. The investigation must also be effective in the sense that it is capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances and to the identification and punishment of those responsible. This is not an obligation of result, but of means. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including inter alia eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard.

108. A requirement of promptness and reasonable expedition is implicit in this context. It must be accepted that there may be obstacles or difficulties which prevent progress in an investigation in a particular situation. However, a prompt response by the authorities in investigating a use of lethal force may generally be regarded as essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts.”

29.
In Edwards v United Kingdom (Application No 46477/99) the Third Chamber of the ECtHR was concerned with a complaint brought by the parents of a prisoner who had been killed by another inmate. The inquiry into the death had been conducted in private, and those investigating had no power to compel witnesses. A number of witnesses failed to appear, including a crucial witness; namely, a prison officer who had passed by the deceased’s cell shortly before he died. It was submitted that the inquiry had been deprived of “potentially significant evidence”. In this context, the Court held:-

“70. For an investigation into an alleged unlawful killing by State agents to be effective, it may generally be regarded as necessary for the persons responsible for and carrying out the investigation to be independent from those implicated in the events. This means not only a lack of hierarchical or institutional connection but also a practical independence.

71. The investigation must also be effective in the sense that it is capable of leading to a determination of whether the force used was or was not justified in the circumstances and to the identification and punishment of those responsible. This is not an obligation of result, but of means. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including, inter alia , eyewitness testimony, forensic evidence and, where appropriate, an autopsy providing a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard.

72. A requirement of promptness and reasonable expedition is implicit in this context. While there may be obstacles or difficulties which prevent progress in an investigation in a particular situation, a prompt response by the authorities in investigating a use of lethal force may generally be regarded as essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts."

30.
So far as concerned a lack of a power to compel witnesses, the Court said:-

"78. The inquiry had no power to compel witnesses and as a result two prison officers declined to attend. One of the prison officers had walked past the cell shortly before the death was discovered and the inquiry considered that his evidence would have had potential significance. The Government have drawn attention to the fact that this witness had, in any event, submitted two statements and that there is no indication that he had anything different or additional to add. However, the Court notes that he was not available for questions to be put to him on matters which might have required further detail or clarification or enabled any inconsistency or omissions in that account to be tested. The applicants had argued in their observations on admissibility that the evidence of the witnesses on the scene at the prison had been of particular importance since it potentially concerned the timing and duration of the attack (see the decision of admissibility in this case of 7 June 2001) and therefore might disclose matters relevant to their claims for damages.

79. The Court finds that the lack of compulsion of witnesses who are either eyewitnesses or have material evidence related to the circumstances of a death must be regarded as diminishing the effectiveness of the inquiry as an investigative mechanism. In this case, as in the Northern Irish judgments referred to above, it detracted from its capacity to establish the facts relevant to the death, and thereby to achieve one of the purposes required by Article 2 of the Convention."

31.
In Al-Skeini v United Kingdom (Application No 55721/07), the applicants were the relatives of Iraqi citizens who had been killed in Iraq following the invasion of the country by the United Kingdom, the United States and their coalition partners in 2003. Some of the applicants have been shot and killed by British soldiers. For our purposes, the following passages of the judgment are relevant:-

"163. The general legal prohibition of arbitrary killing by agents of the state would be ineffective in practice if there existed no procedure for reviewing the lawfulness of the use of lethal force by state authorities. The obligation to protect the right to life under this provision, read in conjunction with the state's general duty under art 1 of the Convention to "secure to everyone within their jurisdiction the rights and freedoms defined in [the] Convention", requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force by, inter alios, agents of the state. The essential purpose of such an investigation is to secure the effective implementation of the domestic laws safeguarding the right to life and, in those cases involving state agents or bodies, to ensure their accountability for deaths occurring under their responsibility. However, the investigation should also be broad enough to permit the investigating authorities to take into consideration not only the actions of the state agents who directly used lethal force but also all the surrounding circumstances, including such matters as the planning and control of the operations in question, where this is necessary in order to determine whether the state complied with its obligation under art 2 to protect life.

…

166. As stated above, the investigation must be effective in the sense that it is capable of leading to a determination of whether the force used was or was not justified in the circumstances and to the identification and punishment of those responsible. This is not an obligation of result, but of means. The authorities must take the reasonable steps available to them to secure the evidence concerning the incident, including, inter alia, eyewitness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard.

167. For an investigation into alleged unlawful killing by State agents to be effective, it is necessary for the persons responsible for and carrying out the investigation to be independent from those implicated in the events. This means not only a lack of hierarchical or institutional connection but also a practical independence. …"

32.
We now turn to domestic cases. R (Amin v Home Secretary for the Home Department) [2003] UKHL 51 involved the murder by a cellmate of a person who was serving a custodial sentence in a young offender institution. The opinion of Lord Bingham included the following:-

"31. The state's duty to investigate is secondary to the duties not to take life unlawfully and to protect life, in the sense that it only arises where a death has occurred or life-threatening injuries have occurred: Menson v United Kingdom (Application No 4791/99) (unreported) 6 May 2003, p 13. It can fairly be described as procedural. But in any case where a death has occurred in custody it is not a minor or unimportant duty. In this country, as noted in paragraph 16 above, effect has been given to that duty for centuries by requiring such deaths to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.

32. Mr Crow was right to insist that the European Court has not prescribed a single model of investigation to be applied in all cases. There must, as he submitted, be a measure of flexibility in selecting the means of conducting the investigation. But Mr O'Connor was right to insist that the Court, particularly in Jordan v United Kingdom 37 EHRR 52 and Edwards v United Kingdom 35 EHRR 487, has laid down minimum standards which must be met, whatever form the investigation takes. Hooper J loyally applied those standards. The Court of Appeal, in my respectful opinion, did not. It diluted them so as to sanction a process of inquiry inconsistent with domestic and Convention standards.

33. There was in this case no inquest. The coroner's decision not to resume the inquest is not the subject of review, and may well have been justified for the reasons she has given. But it is very unfortunate that there was no inquest, since a properly conducted inquest can discharge the state's investigative obligation, as established by McCann v United Kingdom 21 EHRR 97. …"

33.
In Tyrrell v HM Senior Coroner County Durham and Darlington and Another [2016] EWHC 1892 (Admin), the Divisional Court observed that the Strasbourg jurisprudence provides that, whenever a

person dies in custody, an explanation of the cause of death must be provided; and that a suspicious death in custody inevitably raises the question of a breach of Article 2 on the part of the authorities. Burnett LJ continued by noting that the “consistent jurisprudence of the Strasbourg Court is that in this second circumstance a procedural obligation arises of the sort considered in the Jordan case …” (paragraph 24).

34.
In MA and BB v Secretary of State for the Home Department and Another [2019] EWHC 1523 (Admin), May J was concerned with the extent of the powers which the PPO should have to ensure her investigation fully discharges the Secretary of State’s duty under Article 3 of the ECHR. This followed a television expose of serious ill-treatment of detainees at Brook House, Gatwick Airport. The claimants submitted that a compliant inquiry in these circumstances necessitated the power to compel the attendance of witnesses and the obligation to hold at least some hearings in public.

35.
At paragraph 62, May J held that an effective inquiry into the allegations required there to be a power to compel the attendances of witnesses. At paragraph 69, she said she would have “significant concerns about the prospect of key witnesses in this case being asked questions by the PPO privately”. Amongst her reasons were that “a detention centre, with its population of vulnerable persons, is a place where erosion of the rule of law may be thought to be both particularly likely and (because of that) particularly dangerous”. This meant that “it may be thought to be of especial importance that detainees’ rights should be publicly vindicated and the rule of law thus publicly upheld”.

(b) Law and procedure relating to coroners

36.
For our purposes, the relevant provisions of the Coroners and Justice Act 2009 are as follows:-

“ **1. Duty to investigate certain deaths**

(1) A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.

(2) This subsection applies if the coroner has reason to suspect that—

…

(c) the deceased died while in custody or otherwise in state detention.”

…

5. Matters to be ascertained

(1) The purpose of an investigation under this Part into a person's death is to ascertain—

(a) who the deceased was;

(b) how, when and where the deceased came by his or her death;

(c) the particulars (if any) required by the 1953 Act to be registered concerning the death.

…

6. Duty to hold inquest

A senior coroner who conducts an investigation under this Part into a person's death must (as part of the investigation) hold an inquest into the death. …

7. Whether jury required

(1) An inquest into a death must be held without a jury unless subsection (2) or (3) applies.

(2) An inquest into a death must be held with a jury if the senior coroner has reason to suspect—

(a) that the deceased died while in custody or otherwise in state detention, and that either—

(i) the death was a violent or unnatural one, or

(ii) the cause of death is unknown,

…"

37.
Rule 6 of the Coroners (Inquest) Rules 2013 (SI 2013/1616) provides that a coroner "may at any time during the course of an investigation and before an inquest hearing hold a pre-inquest review hearing". Rule 23(1) provides:-

"(1) Written evidence as to who the deceased was and how, when and where the deceased came by his or her death is not admissible unless the coroner is satisfied that –

(a) it is not possible for the maker of the written evidence to give evidence at the inquest hearing at all, or within a reasonable time;

(b) there is a good and sufficient reason why the maker of the written evidence should not attend the inquest hearing;

(c) there is a good and sufficient reason to believe that the maker of the written evidence will not attend the inquest hearing; or

(d) the written evidence (including evidence in admission form) is unlikely to be disputed."

38.
By virtue of paragraph 1(1)(a) of Schedule 5 to the Criminal Justice Act 2009, a coroner in England and Wales has power to compel witnesses, who are within that jurisdiction. As for those outside the jurisdiction, the Divisional Court in R (Shafi) v HM Senior Coroner for East London [2015] EWHC 2106 said:-

"There is only so much that a coroner can do to obtain evidence from a foreign state, however friendly. The coroner has no power to investigate overseas, send investigators overseas or require police to investigate overseas. Nor can the coroner compel the disclosure of documentation from the overseas country or compel witnesses from the country to attend to give evidence." (paragraph 26)

39.
Paragraph 7(1) of Schedule 5 to the 2009 Act provides that if, at the conclusion of the inquest, evidence has been heard which gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and if a coroner is of the opinion that action should be taken to address those circumstances, then the coroner must make a report to the person

responsible for addressing that risk. Such reports are made under regulation 28 of the Coroners (Investigations) Regulations 2013. They are known in practice as “Prevention of future deaths” reports. Such a report may be made irrespective of whether there has been a critical narrative verdict at the inquest.

40.
In the Chief Coroner’s Guidance No 22 (Pre-inquest Review Hearings), guidance is given on the operation of rule 6 of the 2013 Rules. Pre-inquest review hearings (PIRs) are to be held “in more complex investigations where there is a need for issues to be aired prior to the inquest and which cannot easily be dealt with by email”. Amongst the agenda items listed in paragraph 7 are: “Whether Article 2 engaged” and “Provisional list of witnesses”. Details of a PIR are published in advance on the coroner’s or local authority’s website. No evidence is called at a PIR and no witness should be asked or required to attend. A coroner should take care not to appear to be expressing a view about any aspect of the evidence which is the subject of a decision at the inquest.

41.
The Chief Coroner’s Guidance No 17 (Conclusions: Short-form and narrative) provides that the conclusion in an Article 2 case may be in short form or narrative form, or a combination of the two. A narrative conclusion is frequently required in order to satisfy the procedural requirement of Article 2, including a conclusion on the events leading up to the death or on relevant procedures connected with the death: R (Middleton) v HM Coroner for West Somerset [2004] 2 AC 182. A conclusion in an Article 2 case may be “a judgemental conclusion of a factual nature … directly relating to the circumstances of death” (Middleton at [37]). Permitted judgemental words include “inadequate”, “inappropriate”, “insufficient”, “lacking”, “unsuitable”, “unsatisfactory”, and “failure”.

G. THE SECRETARY OF STATE’S POLICIES

(a) Policy in force at the time of OO’s death

42.
At the time of OO’s death, the relevant policy of the respondent was contained in the Detention Services Order 08/2014: Death in detention (June 2016/version 2.0). The DSO provides guidance for all staff operating in Immigration Removal Centres and related premises, about their responsibilities if a detainee dies in Home Office detention, or under escort. Paragraph 2 states that supply centre managers are responsible for developing, implementing and maintaining their own local contingency plans and protocols for handling the aftermath of a death in detention. Plans should be renewed annually or in the event of a death. Once a death has been confirmed, the centre supplier must immediately report the death to the Home Office. Paragraph 7 reads as follows:-

“7. The suppliers’ actions are to include but not be limited to:

• Acting as the first person on scene summoning help and requesting local emergency clinical assistance.

• Summoning an ambulance and the police. The police are responsible for alerting the named next of kin of the death, as detailed in any existing local Memorandum of Understanding. All centres should ensure that they have a Memorandum of Understanding in place with local police.

• Clearing the area of other detainees as soon as possible after the discovery of an apparent death, giving equal consideration to the safety of others and the responsibility to preserve all evidence at the scene.

• Reporting immediately the confirmed death to the Independent Monitoring Board (IMB).

• Noting the information required by the Home Office Family Liaison Officer (FLO) network – this should include ensuring that the next of kin details are available or that these are sought if not already in possession.

• Recording the details of any witnesses to assist in any investigation.

• Communicating the death to other detainees within the centre, both by talking to them and in the form of a notice, which also directs the detainees to sources of support available in the centre (see paragraphs 31-34 below).

• Reviewing the Room Sharing Risk Assessment of the roommate(s) of the deceased, where applicable.

• Ensuring all open Assessment Care in Detention and Teamwork (ACDT) documents are reviewed effectively.

• Inviting the relevant faith chaplain or religious leader to administer official rites, prayers or other ritual observation.

• Ensuring the deceased's personal belongings and any other property is immediately sealed and secured safely, after the police have attended and released the scene. "

43.
Beginning at paragraph 10, the DSO deals with the Home Office's responsibilities and actions. The relevant duty director is to inform by email the persons listed in paragraph 13 of the death, citing the most immediate facts and confirming that a submission will follow. Those listed include the private office of the relevant minister, the PPO and HM Chief Inspector of Prisons.

44.
The issue of support for staff and detainees is specifically dealt with:-

"31. Centre suppliers are reminded that staff and detainees affected by a death in detention may require support at any time throughout the investigation process. Suppliers must ensure that they have procedures in place to support both staff and those who are detained appropriately, for example the opportunity for face to face meetings, chaplaincy team support, healthcare team support, Samaritans or bereavement help lines.

32. Centre suppliers must ensure that a death is communicated to other detainees in the centre, both verbally and via a notice placed around the centre, and that individuals are signposted to the welfare office (or designated support lead) to access appropriate support. "

45.
Paragraph 40 of the DSO states that "As soon as possible after the death, all documentation must be gathered together and securely locked in a cabinet with signed access only". The documentation includes "Case work/Home Office file, [which] is to be requested by onsite immigration team from the case working department in anticipation of the Prison and Probations Ombudsman's (PPO) investigation". Another specified form of documentation comprises "Incident reports and Security Information Reports … involving the detainee".

46.

Paragraphs 41 to 52 comprise what may be described as a hierarchy of investigations following a death in detention. Paragraphs 41 and 42 concern the police investigation. This “will have primacy over all other investigations”. Reference is made to a national memorandum of understanding with the PPO as to how an investigation will proceed when there may be evidence of crime. Centre supplier staff and onsite Home Office personnel “must all comply with the police investigation in any way they can including attending interviews and providing witness statements if requested”.

47.
Paragraphs 44 to 50 concern the investigation by the PPO. She is responsible for investigating all deaths in Immigration Removal Centres throughout the United Kingdom. The Home Office Duty Director is required to notify the PPO of all deaths, using a specified notification form. As with the police, all centre staff, Home Office personnel, etc. must comply with the PPO investigation, including attending interviews and providing witness statements if requested. During the course of the PPO’s investigation, “copies of all paperwork relating to the deceased including medical reports, documents, incident reports and case files will be required. It is imperative that these are made available to the PPO as and when requested”. After each investigation “the PPO writes a report which is shared with the coroner, the Home Office and the family of the deceased prior to the inquest”.

48.
Paragraphs 51 and 52 deal with coroner’s inquests, which as we have seen are held for all deaths in detention.

“An inquest is usually opened soon after a death to record that it has occurred. It will then be adjourned until all other investigations have been completed (e.g. by the police and the PPO) and any inquiries instigated by the coroner have been completed. The inquest will be resumed and concluded as soon as any other investigations are completed.” (paragraph 51)

49.
The DSO concludes by stating that a “prevention of future deaths report will be issued by a coroner if it is found that there are lessons to be learned”. Organisations in receipt of such a report are required to respond in writing to the coroner within 56 days of the report’s receipt.

(b) The present policy

50.
The present policy is the Detention Services Order 08/2014: Death in Immigration Detention (August 2020). It is likely that the catalyst for the August 2020 changes was the inquest in 2019 in Lincolnshire, to which we refer in paragraph 58 below. For our purposes, the relevant changes, compared with the June 2016 version, are as follows.

51.
What was previously paragraph 32 is now paragraph 43, expanded as shown in bold type:-

“43. Centre suppliers must ensure that a death is communicated to other detained individuals in the centre, both verbally and via a notice placed around the centre, and that individuals are signposted to the welfare office (or designated support lead) to access appropriate support. **It is important that anyone who shared a room, or was a friend of the bereaved is told face to face and not via a notice, perhaps just before other individuals are informed. The notice communicating the death will include the right of all individuals to speak to the Police and/or PPO investigator**

to make a witness statement in relation to any information they have which may be relevant to the deceased's death. "

52.
Secondly, what was paragraph 43 is now paragraph 60, expanded as shown in bold type:

"60. Centre supplier staff and all onsite Home Office staff must comply with the police investigation in any way they can, including attending interviews, providing witness statements if requested **and making available names of any detained individuals who may be potential witnesses/have relevant information relating to the death."**

53.
Thirdly, what was paragraph 48 is now paragraph 65, expanded as shown in bold type:-

"65. All centre staff (supplier, Home Office, healthcare etc) must comply with the PPO investigation. This may include attending interviews, providing witness statements if requested **and making available names of any individuals who may be potential witnesses/have potentially relevant information relating to the death.** "

54.
Finally, what was paragraph 51, dealing with coroner's inquests, is now paragraph 68, expanded as shown in bold type:-

"68. In England, Wales and Northern Ireland, a coroner's inquest is held for all deaths in detention. An inquest is usually opened soon after a death to record that it has occurred. It will then be adjourned until any other investigations have been completed (e.g. by the police and the PPO) and any inquiries instigated by the coroner have been completed. The inquest will be resumed and concluded as soon as any other investigations are completed. **Staff may be required to give evidence at an inquest and the support should be made available to them in such circumstances** ."

(c) Proposed changes

55.
The respondent is currently considering further changes to her policy. Frances Hardy, Head of Risk and Assurance, Immigration Enforcement, states that, following the coroner's inquest hearing, there is a proposal to amend paragraph 60 of the August 2020 DSO, by adding the words shown in italic bold type:

"60. Centre supplier staff and all onsite Home Office staff must comply with the police investigation in any way they can, including attending interviews, providing witness statements if requested **and making available names of any detained individuals who may be potential witnesses/have potentially relevant information relating to the death . It is important that we are able to identify any staff or detained individuals who may be potential witnesses or have potential relevant information relating to the death and the checklist attached at Annex XX should be used for these purposes** ."

56.
The proposed checklist provides for details to be given of the staff involved, and other staff on the scene, together with command suite staff. So far as residents are concerned, there are three headings: residents who witnessed the incident; other residents involved; and other residents with possible knowledge of circumstances of death. Together with the name of the relevant person, each

category requires a reason to be supplied. For residents who witnessed the incident, an example of a reason is given as “responded to incident”. For other residents involved, an example of a reason is “entered scene, in area”. For those other residents with possible knowledge of the circumstances of death, an example of a reason is “shared room, known associate, claims to have relevant information”.

57.
Following the death in February 2021 of a detainee at Morton Hall Immigration Removal Centre in Lincolnshire, Mr Thomann informed us that the draft checklist is being trialled in connection with that unfortunate incident.

H. THE DEATH OF CARLINGTON SPENCER

58.
Mention of Morton Hall brings us to a separate but related evidential strand, which emerged late in the proceedings. It concerns the earlier death in detention at Morton Hall of Mr Carlington Spencer, whose inquest was held in 2019. An application by Ms Naik to file a letter of 27 August 2020 from the Senior Coroner of the County of Lincolnshire to the Secretary of State for the Home Office was made on the first day of the hearing. It arose because the Carlington Spencer inquest had been mentioned in Mr Thomann’s skeleton argument. In compliance with directions made at the hearing, Ms Hardy has filed a witness statement in which she regrets that the coroner’s letter of 27 August was not referred to in her earlier witness statement. She had overlooked the need to draw the letter to the Tribunal’s attention and apologises. She also exhibited other letters written by the coroner to the Legal Aid Agency and the Chief Constable of Lincolnshire Police, dealing in whole or in part with the death of Carlington Spencer. She also exhibits the reply dated 25 January 2021 to the coroner’s letter. The reply was from Chris Philp MP, Minister for Immigration Compliance and the Courts.

59.
In all the circumstances, we consider it appropriate to admit the letter of 27 August 2020 and the letters annexed to Ms Hardy’s statement. It is plainly expedient, given the nature of the present application for judicial review, that the Upper Tribunal can have regard to the issue of the death in immigration detention of Carlington Spencer, since it is relevant to whether the respondent’s policies are legally adequate.

60.
We accept Ms Hardy’s apology for her earlier oversight regarding the correspondence. In their submission of 18 March 2021, counsel for the applicant urge us find that the oversight amounted to a serious breach of the respondent’s duty of candour and to make a declaration to that effect. Whilst there regrettably has been a breach of that duty, its gravity is tempered by the fact that the case of Mr Carlington Spencer was raised by the respondent, in Mr Thomann’s skeleton argument. We nevertheless agree that it should not have been necessary for those acting for the applicant to have to procure a copy of the coroner’s letter. This is a matter that may sound in costs.

61.
The letter from the Senior Coroner to the Secretary of State enclosed a copy of the coroner’s regulation 28 report to prevent future deaths, following the outcome of the Carlington Spencer inquest.

62.
The letter continues as follows:-

“This was a case where I was compelled to issue two witness summonses for the attendance at inquest of two former Morton Hall IRC detainees. These witnesses had not made formal statements to the police but I accepted submissions from lawyers acting on behalf of the deceased that they were important and relevant direct witnesses to the events within the scope of the inquest.

The case raises the following matters of concern:

1. As part of the internal Morton Hall IRC investigation and police investigation, the importance of these detainees as material witnesses to a potential inquest was not appreciated;

2. No formal, declared statements were obtained timeously from these witnesses;

3. As part of the process of deportation, two detainees were on the point of being physically deported in circumstances where the Home Office either was not aware, or chose to ignore the fact that these detainees were important witnesses required to give evidence at a forthcoming inquest hearing;

I make it clear that these concerns are in no way designed to fetter or control the exercise of your responsibilities to deport individuals from the jurisdiction. Rather, it is an attempt to bring to your attention an important matter which needs to be taken into account when considering whether a detainee ought, properly to be deported.

The two witnesses gave important and critical evidence commensurate to their anticipated values.

It is vital for on-going public confidence in the coronial process that at inquest a coroner or interested person to the proceedings has the ability to call and receive the best evidence.”

63.
The letter in reply from the Minister for Immigration Compliance and the Courts is dated 25 January 2021. For our purposes, the relevant passages are as follows:-

“With regards to the issues raised in your letter, you mentioned that you had issued witness summonses for attendance at the inquest of two former Morton Hall IRC residents to give key evidence in relation to the death of Mr Spencer. You expressed concerns that as part of the internal Morton Hall IRC investigation and police investigation into Mr Spencer’s death, the importance of these individuals as material witnesses was not appreciated; specifically, that no formal statements had been obtained from the witnesses; and that removal processes for these individuals continued, despite being important witnesses in the forthcoming inquest.

The Home Office has recently taken action on these matters, having published updated guidance for staff and service providers on responsibilities when dealing with a death in immigration detention facility, in hospital or under escort. This guidance can be found in Detention Services Order 08/2014 “handling a death in detention” …

The updated guidance makes it clear that centre service providers must ensure that a death is communicated to other detained individuals in the centre, both verbally and via a notice placed around the centre, and that individuals are signposted to the welfare office (or designated support) to access appropriate support. The notice communicating the death will include the right of all individuals to speak to the Police and/or Prisons and Probation Ombudsman (PPO) investigator to make a witness statement in relation to any information they have which may be relevant to the deceased person’s death. Following a death in detention, centre service providers and all onsite Home Office staff must comply with the Police and/or PPO investigation in any way they can, including attending interviews, providing witness statements if requested and making available the names of

any detained individuals who may be potential witnesses and have potentially relevant information relating to an individual's death.

Additionally, I can also confirm that the Home Office are reviewing current guidance in relation to the enforcement action (such as the deportation or removal) of individuals who have witnessed the death in detention and may be required to give evidence in person at inquest. We will write to you further on this matter following the outcome of this review."

I. DISCUSSION

(a) The nature of the respondent's duty

64.
In considering the Strasbourg caselaw as to the extent of the Article 2 procedural duty to investigate a suspicious death, it is important to bear in mind that the ECtHR is concerned with the entirety of the process, beginning with the initial steps to secure evidence and ending with the actual investigation or trial. Although the investigation or trial must be conducted with the requisite degree of independence, it by no means follows that the duty to secure evidence cannot involve those such as the respondent and her service providers, who will not be conducting the subsequent independent investigations. On the contrary, given that, in the context of a death in detention, the service providers and the relevant officials of the respondent at the detention centre will inevitably be the first on the scene, they clearly must take the initial steps to secure evidence. This is so, irrespective of the fact that, in order of likely appearance, the police, the PPO's investigators and the coroner will also become actively involved.

65.
Furthermore, it is important to acknowledge that, both in Da Silva and Edwards , the ECtHR has been at pains to state that the steps to be taken are "reasonable" ones. What is reasonable will depend, not only on the circumstances of the death but also the nature and purpose of the detention facility, such as whether it is holding individuals who face removal by the respondent from the United Kingdom, in pursuance of her functions, conferred by Parliament, of enforcing immigration controls.

66.
On several occasions in her written and oral submissions, Ms Naik sought to categorise the respondent's stance as being that the respondent's view of what is reasonable in this area is susceptible to review only on Wednesbury grounds. We do not consider that this criticism is valid. Since we are in the area of fundamental rights, it is trite law that the Tribunal must determine whether, in the particular circumstances, the steps the respondent takes to secure evidence are objectively reasonable, albeit having due regard to the respondent's overall statutory responsibilities. We did not take Mr Thomann to be contending otherwise.

67.
In the present case, the respondent accepts that whether she has complied with her Article 2 procedural obligations falls to be determined by reference to (i) the particular circumstances surrounding the death of OO and the decision to remove the applicant; and (ii) the general compatibility of the respondent's policies on death in detention with her Article 2 obligations.

68.
So far as the latter is concerned, Ms Naik relied upon the judgments of the Court of Appeal in R (FB) (Afghanistan) and Another v Secretary of State for the Home Department [2020] EWCA Civ 1338. The

court was there concerned with the respondent's so-called "removal window" policy. The court held that the policy was unlawful because "an irregular migrant who applies for deferral [of the removal window] and is refused within the removal window – as will almost always be the case – will be at immediate risk of removal, without having had an opportunity of challenging the refusal in a claim for judicial review … before a court or tribunal" (Hickinbottom LJ, paragraph 142). Consequently, at that point there was "a real risk of denial of access to justice" (ibid). Ms Naik urged us to follow the analysis adopted by Hickinbottom LJ in FB, rather than the approach adopted by the Court of Appeal in R (BF) (Eritrea)) v Secretary of State for the Home Department [2019] EWCA Civ 872. There, the court was concerned with the lawfulness of the respondent's policy on the detention of young people, which gave guidance on how to assess whether such a young person was under 18. At paragraph 63, Underhill LJ held that:-

"The correct approach in the circumstances of the present case is, straightforwardly, that the policy/ guidance contained in paragraph 55.3.9.1 of the EIG and the relevant parts of "Assessing Age " will be unlawful, if but only if, the way that they are framed creates a real risk of a more than minimal number of children being detained. I should emphasise, however, that the policy should not be held to be unlawful only because there are liable, as in any system which necessarily depends on the exercise of subjective judgment, to be particular "aberrant" decisions – that is, individual mistakes or misjudgements made in the pursuit of a proper policy. The issue is whether the terms of the policy themselves create a risk which could be avoided if they were better formulated."

69.
We see no conflict between FB and BF . In FB , it was inherent in the removal window policy that persons could face removal before they had had an opportunity to obtain legal advice on an adverse decision made by the respondent on their latest submissions. They would be at risk of immediate removal because such a decision could be reached during the period of the removal window. In BF, by contrast, the policy in question was concerned with the making of an evaluative assessment as to an individual's age. No policy which seeks to guide the making of such an assessment can guarantee that incorrect decisions will never be made, unless the policy is framed in such a way as unduly to circumscribe, or even eliminate, its usefulness (e.g. by specifying that only those considered to be over the age of 50 should be regarded as adults in age-disputed cases).

70.
In the present case, the policy with which we are concerned is far more akin to the evaluative policy considered in BF than it is to the removal window policy considered in FB . No policy designed to comply with the Article 2 procedural duty of taking "reasonable steps" to secure evidence, following a death in detention, can guarantee that potentially relevant evidence will always be secured and made available to the investigating body or bodies. Although the respondent's responsibilities for immigration control cannot dilute what would otherwise be her Article 2 procedural obligations, they must nevertheless inform the tribunal or court's assessment of what is reasonable in the context of the investigation of a death occurring in immigration detention. This point can be seen from the applications for interim relief made by Duncan Lewis Solicitors following OO's death, where the claim that no one in detention in the relevant facilities could be removed was rejected by the Court of Appeal.

71.
The fact that, in this general area, the tribunal or court is engaged in an assessment of whether an admitted risk is acceptable was expressly made in the judgments of the Court of Appeal in R (Delezuch) and Others v Chief Constable of Leicestershire Constabulary and Others [2014] EWCA Civ

1635. In that case, the issue was about the compatibility or otherwise of policies concerning post-incident management of investigations into deaths that follow the use of force by police officers. At paragraph 54, Richards LJ said:-

“54. It should be stressed that the principle on which the claimants rely is that a policy is unlawful if it creates an unacceptable risk that individual decisions or action taken in application of the policy will be unlawful – in this case, that investigations carried out in accordance with the 2014 guidance will be in breach of the procedural requirements of article 2. The principle is not that any risk of an unlawful outcome must be avoided.”

(b) The role of the coroner

72.
In the present case, the applicant submits that the only lawful policy which the respondent can adopt in relation to deaths in immigration detention is one in which the coroner plays a pivotal role. Ms Naik accepts that where a death occurs in detention, it does not follow that all individuals who have any evidence to give must remain in the jurisdiction until the conclusion of the inquest. She submits, however, that the respondent not only must identify the pool of material witnesses, secure their evidence, identity and whereabouts and provide all this to the responsible investigating authorities, but also that she must permit the coroner to reach a conclusion as to which witnesses are required and by what means their evidence should be provided. Until then, no removal of anyone in the pool is possible. Ms Naik says it is for the coroner alone to reach a conclusion as to whether evidence by video-link, from abroad would be a satisfactory way of enabling an individual to give evidence to the jury at the inquest.

73.
For the respondent, Mr Thomann submits that such a fixed role for the coroner in these cases is neither necessary nor appropriate. We agree with Mr Thomann on this issue. To insist that the coroner, in effect, approves of the removal of any individual who may have evidence that might fall to be considered at an inquest goes beyond what is reasonable in order to comply with the Article 2 procedural duty, as articulated by the ECtHR and interpreted by the domestic courts. We find that the irreducible minimum obligations of the respondent in this area are:

(a) to take immediate steps to ascertain whether any detainee has evidence to give regarding the death in detention;

(b) to record, or facilitate the recording of, a statement of such evidence;

(c) to determine whether the individual is willing to give evidence at the inquest;

(d) to record relevant contact details of the individual, including in the country of proposed removal; and

(e) to consider the practicability of the individual giving evidence at the inquest either (i) by returning to the United Kingdom for that purpose or (ii) by giving evidence by means of video-link.

74.
The actual implementation of these obligations may, of course, involve liaison with other relevant actors, such as the police, the PPO and the coroner. Depending on the circumstances, the views of the coroner may well need to be sought: for example, where the individual is the sole eyewitness to the death and their evidence is likely to be controversial. The rigidity of the model proposed by the

applicant, however, goes far beyond what is reasonable. It would put an undue fetter on the ability of the respondent to discharge her statutory functions in the immigration field. We agree with Mr Thomann that it would be open to abuse by those opportunistically seeking to benefit from a death by prolonging their stay in the United Kingdom. There is no evidence that coroners would regard such a system as desirable or, indeed, practicable from their perspective. The letter from the Senior Coroner for Lincolnshire cannot be prayed in aid in this regard. On the contrary, he was at pains to recognise the respondent's immigration functions and to emphasise he was not suggesting fettering them. Provided that the respondent's policy mandates appropriate action to be taken to identify and secure the evidence, as described above, the respondent must be able to exercise her judgment in deciding what, in a particular case, constitutes a reasonable response, following a death in detention. As Mr Thomann pointed out, the respondent will still be susceptible to legal challenge in any individual case.

75.
The applicant made much of the fact that the coroner cannot compel the attendance of witnesses outside (in this case) England and Wales. Whilst the lack of compellability was, as we have seen, an important matter in Edwards , we agree with Mr Thomann that it cannot properly be suggested that guaranteeing the compellability of each and every potential witness regarding a death in detention is a sine qua non of an Article 2-compliant investigation. As Mr Thomann submits, that suggestion can be tested by reference to a witness who does not wish to remain in the United Kingdom. If a foreign visitor to the United Kingdom witnesses an unnatural fatality here and provides a written statement, but then understandably wishes to return home, it cannot be the case that Article 2 requires the United Kingdom to prevent them from doing so. We accept, of course, that the respondent bears a particular responsibility, where the death occurs in her immigration detention facility. Nevertheless, just as it would be unreasonable to prevent the visitor from leaving the jurisdiction of the part of the United Kingdom in which the death occurred, despite the possible consequences arising from the coroner's inability to compel the visitor to attend the ensuing inquest, so the assessment of what is reasonable (that is to say, what Article 2 requires) needs to be made by reference to the fact that those in immigration detention are there in order that the respondent can remove them from the United Kingdom. Lack of compellability is, thus, a factor that must be considered, in the round, in deciding whether and, if so, how a person's potential status a witness at an inquest impacts upon the respondent's immigration functions, on the facts of a particular case. For example, if a person has expressed willingness to return to the United Kingdom, if requested to do so by the coroner, this factor may be such as, overall, to make it reasonable in terms of Article 2 for the respondent to remove them.

76.
Ms Naik submits that the coroner is unlikely to regard video evidence given to a jury as a satisfactory alternative to live evidence. She also points to the findings of the Supreme Court in relation to the Article 8 ECHR procedural duty in the case of Kiarie v Byndloss [2017] UKSC 42; [2017] Imm AR 1299. We do not consider the comparison with Kiarie to be apt. In that case, the individual facing removal was the actual appellant in an appeal involving his human rights. If outside the United Kingdom, he or she might face, amongst other things, difficulties in instructing, and being advised by, legal representatives; and in being the subject of any meaningful report by doctors or social workers. None of that is relevant here. So far as technology is concerned, matters have, of course, moved on since the point under consideration by the Supreme Court in Kiarie . This is true of all jurisdictions, including the coronial. The Lord Chief Justice was at pains to underscore the point at paragraph 198 of FB . Again, in the circumstances of a particular case, the respondent may need to pay particular attention to whether video evidence from abroad would be satisfactory. This may require liaising with

the coroner before removal is effected. The general proposition that evidence given by video is inherently less satisfactory than evidence given by a person physically present in the courtroom, even if correct, is not, however, a justification for requiring coroners to play the fixed role urged on them by the applicant.

(c) Defects in the respondent's policies

77.
Having made these findings, we turn to address the specific policies of the respondent. As we have seen, at the time of OO's death, the relevant policy was the DSO 08/2014, Version 2.0 of June 2016. There is no doubt that the policy contained in the June 2016 document created an unacceptable risk that the respondent would fail to comply with her Article 2 procedural duties of securing relevant evidence, following a death in immigration detention. The focus of the previous DSO was upon staff; and the evidence of staff. So far as detainees were concerned, the DSO dealt merely with their welfare needs when it also needed, crucially, to address the question of the evidence that detainees may have about the death.

78.
The inadequacy of the previous DSO can, we consider, be seen from the description we have given earlier about the events surrounding OO's death on 11 September 2019. This is not a matter of failures occurring despite the existence of a reasonable policy. It is, rather, illustrative of the deficiencies of the policy. The notice delivered to detainees, set out at paragraph 8 above, followed the DSO in focusing upon their welfare needs without including a message urging detainees to come forward if they had relevant evidence to give. The previous DSO also lacked any exhortation to staff to be proactive in seeking such evidence. In the circumstances, it was entirely unsurprising that Mr Ullah, who occupied the room next to OO, was not interviewed; that his whereabouts became unknown.

79.
For these reasons, we conclude that the respondent's decision of 16 September 2019 to remove the applicant to Nigeria on 17 September 2019 was unlawful, in that, at that point, the respondent failed to take reasonable steps to secure the applicant's evidence concerning the death of OO (and to take the other minimum steps described in paragraph 73 above) contrary to her Article 2 procedural obligations.

80.
It is plain that the August 2020 DSO is a marked improvement on its predecessor. The new words in what is now paragraph 43 highlight the right of detainees to speak to the police and/or PPO investigator to make a witness statement in relation to any information they have which may be relevant to the deceased's death. That is to be communicated in the notice given to detainees. Paragraph 60 requires staff to make available names of detainees who may be potential witnesses or have potentially relevant information. Paragraph 65 imposes on staff the obligation to comply with a PPO investigation, making available names of any individuals who may be potential witnesses or who have potentially relevant information.

81.
Ms Naik submits that these amendments are inadequate to eliminate the real risk of a breach of Article 2 in its procedural form. She says that the policy does not require staff to be proactive in identifying those who may have relevant evidence to give. In essence, the DSO merely relies upon detainees coming forward of their own accord.

82.
On this issue, we agree with Ms Naik. Whilst it would be inappropriate to expect centre staff to usurp the roles of the police and the PPO, as we have said at paragraph 64 above, they have a vital function to perform in identifying those detainees who, because of physical proximity to the deceased or other known associations, are likely to have relevant information, whether or not they have chosen to come forward of their own accord. In our view, the current policy fails to address this matter and is, therefore, not compliant with Article 2 in its procedural form.

83.
It will be recalled that a further revision to the DSO is proposed. Ms Hardy has stated that paragraph 60 will contain the words "It is important that we are able to identify any staff or detained individuals who may be potential witnesses or have potentially relevant information relating to the death and the checklist attached at Annex XX should be used for these purposes". The checklist is, in our view, significant, in that it requires names of residents to be entered, together with reasons why they may have relevant evidence. Those reasons are, as we have seen, objectively couched. They require names to be given where staff are aware of a relevant reason, whether or not the detainee has come forward. Thus, for example, a detainee who is a "known associate" of the deceased must feature on the checklist, as must those who "responded to incident" or "entered scene".

84.
It is emphatically not the place of the Tribunal to prescribe the final form of paragraph 60 and any checklist. Nor would it be appropriate for us to state categorically that the adoption of the words provided by Ms Hardy and the checklist will necessarily result in a legally sufficient policy document. It will be for the respondent to decide how, if at all, to react to what we have said. For the purposes of the present proceedings, we intend to make a declaration to the effect that the DSO in its August 2020 form is unlawful, in that it gives rise to a real risk of an Article 2 procedural breach because it does not direct relevant personnel actively to identify, and to take steps to secure the evidence of, those detainees whom there is reason to believe may have relevant information concerning the death of the person concerned.

85.
Finally, the present policy framework of the respondent is legally deficient in a further important respect. The respondent candidly admits that there is, at present, nothing in her policy concerning removals; namely Judicial Reviews and Injunctions – Version 20.0 (10 October 2019), which guides her immigration officials to act compatibly with Article 2 in its procedural form, when making decisions as to the removal of an individual. As we have seen, the Senior Coroner for Lincolnshire, in his letter of 27 August 2020 to the Secretary of State, raised as a particular point of concern that "two detainees were on the point of being physically deported in circumstances where the Home Office either was not aware, or chose to ignore the fact that these detainees were important witnesses required to give evidence at a forthcoming inquest hearing". That chimes dismally with events at Gauze House, Harmondsworth, following the death of OO.

86.
We conclude that there needs to a policy for the respondent's immigration officials, who are charged with making decisions on removal, which requires those officials to have regard to the core obligations described in paragraph 73 above. Any policy needs to provide a process, whereby the relevant immigration official is made aware if a person scheduled for removal has been identified by centre staff and/or the respondent's officers at an immigration detention facility as a person with potentially relevant information or evidence to give in respect of a death in custody in that facility. The

official must then consider the likely importance of the evidence; the likely ability of the respondent to maintain contact with the individual, if removed; and the likelihood of the individual being able to return to the United Kingdom or give evidence by video-link from abroad, at the inquest. These are matters for the respondent's officials who are tasked with the discharge of her immigration functions, rather than the centre staff.

87.
Accordingly, we shall declare that the absence of a policy which deals with these matters means that the respondent is in breach of her Article 2 procedural obligations in respect of deaths in immigration detention.

88.
We invite counsel to seek to agree an order that gives effect to this decision.

No anonymity direction is made.

Mr Justice Lane

The Hon. Mr Justice Lane

President of the Upper Tribunal

Immigration and Asylum Chamber

14 April 2021

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[1] Both members of the panel have contributed to this judgment.