Home Office

Detention Services Order 08/2014

Death in Detention

Process**:** To provide information for staff and suppliers on responsibilities when handling a death in immigration detention, in hospital or under escort.

Implementation Date**:** October 2014 (reissued June 2016)
Review Date: June 2018

Contains Mandatory Instructions

For Action: Home Office staff and suppliers operating in immigration removal centres, short-term holding facilities and pre-departure accommodation.

For Information: Home Office caseworkers

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Processes Affected: Home Office processes within the detention estate relating to the death of a detainee or resident while in Home Office detention; under escort; or up to 7 days after release from detention.

Assumptions: All staff and suppliers will have the necessary knowledge to follow these procedures.

Notes:

Issued: June 2016
Version: 2.0

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Deaths in Detention

Contents

Introduction

1. This detention services order (DSO) provides guidance for all staff operating in immigration removal centres (IRCs), pre-departure accommodation (PDA), short-term holding facilities (STHFs), and escort staff about their responsibilities if a detainee dies in Home Office detention, or under escort (including when under bed watch). References to “centre” in this document cover IRCs, STHFs and PDA.

Suppliers’ responsibilities and actions

2. Supplier 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 and ensuring that lessons are learned and shared across the detention estate, where appropriate. These plans should be reviewed annually or in the event of a death. This also applies to STHFs, PDA and escort suppliers.

3. Once a death has been confirmed, the supplier must follow their own relevant contingency plans to deal with a death in detention. Local plans must follow this DSO and specify the responsibility of named people/roles/grades to contact immediately in the event of a death in detention.

4. The centre supplier must **immediately** report any death to the Home Office. Between the hours of 09.00hrs to 18.00hrs (office hours) the death should be reported to the most senior member of the on site HOIE team on duty who will then escalate as appropriate. If there is no member of the team on site during these hours notification should be made directly to the local HOIE on call officer.

5. Out of office hours, the local HOIE on call officer should be contacted. If they cannot be reached the centre supplier should contact the Duty Director for Detention. This information is recorded on the weekly on-call duty sheet.

6. If the deceased is a child this must be reported immediately to the Head of Detention Operations who will undertake the usual notification process set out in this DSO, in addition to contacting the local authority and any family liaison officer.

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

8. The centre must comply fully with instructions from the police and coroner/Procurator Fiscal about the transfer of the body to hospital for a post mortem.

9. The supplier centre manager must ensure that a hot debrief is held immediately after any death in detention with a senior member of staff acting as the debriefer. A member of the healthcare team should be in attendance. A record of those in attendance and meeting minutes should be taken and kept.

Home Office's responsibilities and actions

10. The onsite or on-call HOIE manager for the centre should immediately contact the area manager or senior on-call manager (whoever is appropriate) once notification of a death in detention is received.

11. The HOIE lead (area manager for the centre or senior on-call manager) should ensure the local police have been notified of the death and confirm that the police will contact the named next of kin if not done already. The HOIE lead should then notify the following people of the death as a matter of urgency:

During office hours	Out of hours
Delivery Manager	On call duty director
Head of Detention Operations	Head of Detention Operations
Director of Returns	Director of Returns
Detainee's case-owning team (G7 as a minimum)	On call casework manager
Detention Operations Family Liaison Officer (FLO) (by telephone and to the FLO POISE inbox)	Detention Operations FLO (by telephone and to the FLO POISE inbox where possible)

The Detainee Escorting and Population Management (DEPMU) Duty Manager inbox	DEPMU on call officer
Senior on call manager (if this is not themselves)	
Litigation Operations	

12. It is the responsibility of the HOIE lead to ensure the FLO is notified and then deployed (for FLO actions see paragraphs 20 – 30 below).

13. The HOIE duty director will inform the following people/teams of the death via email at the poise addresses listed below (as set out in DSO 05/2015 Reporting Incidents), citing the most immediate facts and confirming that a submission will follow (see paragraph 19):

    - Private Office – out of hours
    - James Brokenshire – Private Office
    - Immigration Enforcement Secretariat
    - DGIE Private Office
    - Director of Strategy, Transformation and Partnerships
    - Press Office News Desk / SMT / Immigration Desk
    - Prisons and Probation Ombudsman (see below at section 44 to 50)
    - Immigration and Borders Secretariat
    - Command and Control Unit CIO
    - Returns Logistics SMT
    - Her Majesty's Chief Inspector of Prisons (HMCIP) at HMIPrisons.Enquiries@hmiprisons.gsi.gov.uk

14. If the death occurs Monday to Friday the HOIE duty director must inform the Returns Logistics Senior Management Team who will notify (i) the relevant Foreign and Commonwealth Office (FCO) desk and post; and (ii) the relevant embassy or high commission.

15. If the death occurs over a weekend the HOIE duty director must contact the FCO Duty Officer via the FCO general enquiries switchboard 020 7008 1500 who will provide out of hours contact details for the relevant diplomatic mission. The HOIE duty director must then inform the diplomatic mission directly and confirm via email to the Returns Logistics Senior Management Team. If the deceased was an asylum applicant, details of this must **not** be disclosed to the diplomatic mission.

16. The HOIE duty director will agree press lines with press office during office hours or Immigration and Borders Secretariat out of office hours.

17. It is the responsibility of the HOIE lead to ensure the death is communicated to the rest of the detention estate via the onsite/on-call HOIE Manager, as soon as possible, so that supplier centre managers at other centres also review ACDT files in their own centre as above.

18. If notification is received that a detainee has died in hospital after being released from detention (up to 14 days) or after being released into the community (up to 14 days), the nominated Home Office lead should liaise with the detainee's case owner and agree which of the actions at paragraphs 12 and 14 above are required, taking into consideration the circumstances of the death, and who will be responsible for taking them forward. In the event that, exercising their discretion, the PPO does not conduct an investigation into a death after release the Director of Returns or the Head of Detention Operations may commission a review of the circumstances of the death by the Home Office Professional Standards Unit (or other means) to establish if any lessons can be learned to prevent future deaths. Based on the circumstances of the death, the nominated Home Office lead may also contact the relevant coroner's office to register an interest in being notified of any future inquest and to determine whether the Home Office will be called to participate in the inquest as an interested party.

19. The Home Office area/delivery manager will be responsible for drafting a submission to the Immigration Enforcement Director General and Immigration Minister about the death, for clearance by the Head of Detention Operations. This must be promptly submitted.

Next of kin and family engagement – role and responsibilities of the Family Liaison Officer (FLO)

20. Home Office Detention Operations has a small network of trained FLOs. The weekly FLO on-call is listed on the Detention Operations on-call duties list. The role of the FLO is to be the Home Office main point of contact between the named next of kin and the Home Office when a death has occurred. It is not to manage the death in detention.

21. The FLO role will start from the point that news of death is broken to the named next of kin; this will be done by the police and **not** the Home Office FLO. If there is a delay with the police notifying the named next of kin, the Home Office FLO should raise this with the Head of Detention Operations who will make a decision on how to proceed, in consultation with the police. The FLO will maintain contact from this point onwards and provide practical support and information where appropriate and as requested by the named next of kin. If the named next of kin does not want contact, their wishes must be respected.

22. Equally, if the family or named next of kin express wishes not to have an FLO, then the Head of Detention Operations, in conjunction with the case working team, is to decide who is to maintain contact in place of the FLO.

23. If the named next of kin is overseas, the expectation that the police notify them of the death remains in place. Subsequent contact by the Home Office FLO will be made via telephone and if the named next of kin is resident in the UK, then all attempts will be made to make and maintain contact in person by the Home Office FLO.

24. All Home Office FLOs, in liaison with the Family Liaison Co-ordinator (FLC), have a personal responsibility to ensure they conduct a full risk assessment for personal contact with the family or named next of kin. It is not always possible to deploy FLOs in pairs. FLOs within Detention Operations will be deployed and supported by a FLC.

FLO notification process

25. FLOs should be notified of the death in detention by the Home Office area manager/senior on call manager via both a telephone call and an email to the Detention Operations FLO inbox as soon as possible.

26. The initial message/telephone call should include as much of the following information as possible:

- Full details for the detainee
- Location and time of death
- Full details of next of kin – to include contact details (this should have been recorded by both the Home Office staff on induction to the centre and the supplier staff at reception)
- Application of handcuffs or any use of force at any time prior to death
- Any known healthcare conditions of the deceased
- Who has been notified of the death as per the DSO
- Whether the centre supplier has its own FLO; to include their contact details
- When the police FLO has or will be contacting the named next of kin or family of the deceased and to include details of the police FLO
- Relevant information about the circumstances and/or cause of death (if known)
- Contact point from the onsite Home Office Immigration Enforcement (HOIE) team for the FLO to speak to for information and other purposes. It is vital that the FLO has a single point of contact from within the onsite HOIE team to ensure consistency in information gathering.

27. The duty FLO will take on responsibility as the FLO for that family or named next of kin and all discussions between the FLO and the family or named next of kin will be recorded within the FLO log for auditable purposes. It is imperative that a log is opened for each case irrespective of level of content and contact.

28. There may be circumstances where the supplier has a trained FLO at the centre. They should **not** be deployed until the Home Office FLC has authorised for this to happen.

29. If the deceased's family or named next of kin ask to visit the centre, this should be arranged as soon as possible after the death and the Home Office should be represented at this visit. This should be the FLO (where possible due to geographical location) **and** the Delivery Manager or Head of Detention Operations, in addition to a supplier senior manager.

30. It is important that deployed FLOs are given time away from their standard duties to fulfil this valuable role. In order to maintain clarity and professional boundaries it is advisable that when possible, staff who may be significantly involved with any investigation into the death are not deployed as FLOs.

Support for staff and detainees

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 detainees 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 detainee notice placed around the centre, and that detainees are signposted to the welfare office (or designated support lead) to access appropriate support.

33. When a death occurs, the Home Office must ensure the centre supplier undertakes an immediate review of all open ACDT files in that centre, and any closed cases within the last 7 days, to ensure that detainees are not unduly affected by the death. The reviews should offer additional support to detainees and assess any heightened risk with those on ACDTs and the wider population.

34. HOIE managers must ensure that they have procedures in place to support staff appropriately at any time throughout the investigation process, such as access to the Employee Assistance Programme (EAP), of which details are available on Horizon. Occupational Health Service (OHS) referrals are also in place for staff if so required; these can be arranged for via line management.

Funeral and repatriation arrangements

35. The Home Office will either meet the cost of a funeral or cremation within the UK (up to £3,000) or provide a set amount (approximately the same as UK funeral costs) towards the cost of repatriating the body or cremated remains to the country of origin. **These decisions must be authorised by the Head of Detention Operations.**

36. As a guide, reasonable funeral costs include:

- Funeral director's fees
- Hearse
- Simple coffin
- Cremation/burial fees (burial plot costs not included)
- Minister fees

37. The Home Office point of contact for the funeral and repatriation arrangements should be the FLO; however if the family or named next of kin have expressed no desire for the FLO to be involved then this responsibility will sit with the HOIE area manager.

38. Upon receipt, the funeral director's invoice (required on company headed paper) must immediately be passed to the Head of Detention Operations for approval. This must then be forwarded to the Home Office Commercial to approve as a one-off expenditure.

39. Once the funeral, cremation or repatriation date has been set, Immigration and Borders Secretariat and Press Office should be provided with an update by the Head of Detention Operations.

Retention of documents

40. It is vital that all documentation relating to a detainee and their death is retained. As soon as possible after the death, all documentation must be gathered together and securely locked in a cabinet with signed access only. This should include:

- Medical files – to be retained by healthcare staff
- Prison files, if applicable
- Wing/unit files
- Local detention files
- Case work/Home Office file is to be requested by the on site immigration team from the case working department in anticipation of the Prison and Probations Ombudsman's (PPO) investigation
- Local policies and protocols in operation at the time of death in particular policies on suicide prevention and segregation
- Any evidential video footage, phone records and cell call logs
- Any other evidential information or documentation including relevant risk assessments
- Any/all ACDT paperwork for the detainee
- Detainee Transferrable Document (DTD) and Person Escort Record (PER)
- Incident reports and Security Information Reports (SIRs) involving the detainee.

Investigations following a death in detention

<u>Police Investigation</u>

41. The police investigation will have primacy over all other investigations.

42. The police service has a national memorandum of understanding with the Prison and Probation Ombudsman (PPO) as to how an investigation will proceed when there may be evidence of a crime.

43. Centre supplier staff and the onsite HOIE team must all comply with the police investigation in any way they can including attending interviews and providing witness statements if requested.

Prison and Probation Ombudsman (PPO)

44. The PPO is responsible for investigating all deaths in IRCs (including death on escort), PDA and STHFs in the United Kingdom, including Scotland and Northern Ireland.

45. The HOIE Duty Director must notify the PPO of **all** deaths using the notification form at Annex A. This must contain accurate and detailed information. The form should be emailed to mail@ppo.gsi.gov.uk.

46. The PPO should be notified of deaths that occur out of office hours (including over a weekend or bank holiday) as soon as possible on the next working day.

47. For the duration of each PPO investigation, there should be both a Home Office single point of contact for the centre as well as a supplier single point of contact to assist the PPO. This is not the FLO.

48. All centre staff (supplier, HOIE, healthcare etc) must comply with the PPO investigation. This may include attending interviews and providing witness statements if requested.

49. During the course of the PPO's investigation (which will often include a review of clinical care commissioned by the relevant healthcare provider), copies of all paperwork relating to the deceased including medical records, documents, incident reports and case files will be required. It is imperative that these are made available to the PPO as and when requested.

50. 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. An anonymised report is published on the PPO's website after the inquest has concluded. The initial report may also be shared with any other interested parties, such as staff union representatives.

Coroner's Inquests

51. 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.

52. 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 a prevention of future deaths report must respond in writing to the coroner within 56 days of the report's receipt. These reports, and the responses to them, are copied to all

interested persons and to the Lord Chancellor. A summary of the reports is published twice a year, by the Ministry of Justice.

Revision History

Review date	Reviewed by	Review outcome	Next review
March 2016	Emily Jarvis	Updated in line with reporting incidents DSO, new support section	March 2018

Annex A – PPO Notification Form

PRISONS AND PROBATION OMBUDSMAN'S OFFICE
RECORD OF NOTIFICATION OF FATAL INCIDENT TO DUTY PPO OFFICER
BY HOME OFFICE DUTY DIRECTOR

FOR COMPLETION BY PPO	
Case number	
Investigator	
Investigation Manager	
FLO	
SO	

Title	
Surname	
Forename	
Date of birth	
Date and time of death	
Nationality	
Ethnic origin	
Date and time incident discovered	
Date and time PPO notified	
Establishment type and name	
Home Office Reference	
Prison number (where applicable)	
Category (where applicable)	
Offence (where applicable)	
Location of death	
Type of death	
Date of reception to current establishment	
Date of reception to custody (if known)	
On open ACDT?	
Has the named next of kin been informed?	

Additional information: