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Document Details

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

**Implementation Date:** October 2014 (reissued August 2020)

**Review Date:** August 2022

**Version:** 3.0

**Contains Mandatory Instructions**

**For Action:** All Home Office Detention and Escorting Services (DES) staff and suppliers operating in immigration removal centres, short-term holding facilities, pre-departure accommodation and escorting suppliers.

**For Information:** Home Office Caseworkers and Detention Engagement Teams

**Author and Unit:** Shadia Ali, Corporate Operations and Oversight Team

**Owner:** Alan Gibson, Head of Detention Operations

**Contact Point:** Kevin Teefey, Corporate Operations and Oversight Team

**Processes Affected:** Home Office processes within the detention estate relating to the death of an individual while detained in a Home Office immigration detention facility; while under escort; or after release from detention.

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

**Notes:**
Instruction

Introduction

1. This detention services order (DSO) provides guidance for all staff operating in immigration removal centres (IRCs), pre-departure accommodation (PDA), residential short-term holding facilities (RSTHFs), and escort staff about their responsibilities if an individual dies in an immigration detention facility, in hospital or under escort (including when under bed watch).

2. This instruction does not apply to individuals detained in prison under immigration powers.

Definitions

3. For the purpose of this guidance and of investigations into deaths in immigration detention facilities, in hospital, under escort or of those not detained at the time of death, deaths in detention are defined as:

Deaths in detention

Any death of an individual while detained under immigration powers in an IRC, residential short-term holding facility (RSTHF), pre-departure accommodation (PDA) or under escort, or

After leaving detention if the death was as a result of an incident occurring while detained or where there is some credible information that the death might have resulted from their period of detention and the Home Office has been informed.

This excludes deaths that occurred after the individual has left detention (and is not under escort) and the cause of death was unrelated to the detention period, or occurred outside the direct control of the state (for example, a road traffic accident).

4. References to “centre” in this document cover IRCs, RSTHFs and PDA.

Suppliers’ responsibilities and actions

5. Supplier centre managers are responsible for developing, implementing and maintaining their own local contingency plans and protocols for handling a death in detention. Any lessons learned following a death in detention should be shared with the Head of Detention Operations to enable wider dissemination across the detention estate, where appropriate. These plans should be reviewed annually or in the event of a death. This also applies to RSTHFs, PDA and escort suppliers.
6. 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 be contacted immediately in the event of a death in detention.

7. Between the hours of 09:00hrs to 18:00hrs (office hours) the centre supplier must immediately report any death to the local Compliance Team. The death must be reported to the most senior member of the Compliance Team on duty who will then escalate as appropriate within the established Home Office management structure. If there is no member of the team on site during these hours notification should be made directly to the local Compliance Team on call manager.

8. Between the hours of 18:00 and 09:00 (out of office hours), the local Compliance Team on call manager should be contacted. If they cannot be reached the centre supplier should contact the Duty Senior Manager for Detention and Escorting Services. Details of the on call officers and Duty Senior Managers are circulated in the DES weekly on call duty list.

9. If the deceased is a child in the PDA this must be reported immediately to the Head of Detention Operations (during office hours) who will undertake the usual notification process set out in this DSO, in addition to contacting the relevant local authority and any family liaison officer. Out of office hours, the death of a child must be immediately reported to the Duty Director for Detention and Escorting Services.

10. The actions of suppliers’ staff are to include but not be limited to:

   • Acting as the first person on scene and calling for emergency medical response (DSO 9/2014 refers).

   • Summoning an ambulance and the police. The Home Office Family Liaison Officer (FLO) and/or 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.

   • Vacating other individuals who are not staff from the scene as soon as possible after the discovery of an apparent death, giving equal consideration to the safety of others and the responsibility to secure the area and 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 individuals who are detained within the centre, both by talking to them and in the form of a notice, which also directs them to sources of support available in the centre (see paragraphs 40-42 below).

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

• Ensuring all Assessment Care in Detention and Teamwork (ACDT) documents currently open or in the centre are reviewed effectively as soon as possible.

• 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. The family of the deceased should be consulted on how they would like to retrieve their relative’s belongings.

• Ensuring all detention records relating to the deceased are preserved and secured safely.

• Notify the local Compliance Team manager of any planned appointments or visits recorded for the deceased. This information must be made available to the Family Liaison Officer (FLO) as soon as possible.

11. 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.

12. The supplier centre manager must ensure that a debrief, for all relevant staff, is held immediately after any death in detention with a trained 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 must be taken and kept.

Home Office’s responsibilities and actions

13. Once notification of a death in detention is received, the local Compliance Team manager (on site or on call) must immediately contact the relevant senior manager.
14. The HOIE lead (Compliance Team area manager for the centre or DES senior on-call manager) must ensure the local police have been notified of the death and, if not done already, provide them with details of the named next of kin. The DES lead must confirm when the police are able to contact the named next of kin. It is the responsibility of the HOIE lead to pass the details of the named next of kin to the FLO (see paragraph 29). The HOIE lead must consider whether the police or FLO are best placed to notify the named next of kin. If the responsibility lies with the police, the HOIE must confirm to the FLO whether the notification to the next of kin has already occurred or when the police have committed to doing so.

15. In accordance with DSO 06 2013 (Reception, Induction and Discharge), next of kin details for all detained individuals should be recorded as special conditions in the Case Information Database (CID) and ATLAS, and also be available on the centre suppliers’ detention files and the detainee transferable document (DTD). If a detained individual has refused or been unable to provide such details, all efforts must be made to ensure a suitable next of kin is found. The following checks must be requested and documented by the HOIE lead:

- If next of kin details were provided to the healthcare provider;
- If the individual’s local file or any legal correspondence received contain any indication of a next of kin;
- If the supplier’s local detention file and visits records for the deceased contain any mention of someone close to them.
- Review Home Office CID and ATLAS records for any mention of an individual with a close relation to the deceased (such as linked immigration cases, interviews previously conducted, or sureties provided for bail hearings);
- Ask Home Office case workers to access the Home Office immigration file and search for any indication of a next of kin (out of hours the request should be made to the National Command and Control Unit);
- Contact the solicitor who was acting for the deceased; and
- Where appropriate and only when all other options have been exhausted, ask other individuals who are detained in the centre if they know of the deceased’s family contact details.

16. The HOIE lead (Compliance Team SEO for the centre or DES senior on-call manager) should then notify the following people of the death as a matter of urgency by phone at first instance and then confirmed by email to:
<table>
<thead>
<tr>
<th>During office hours</th>
<th>Out of hours</th>
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<tr>
<td>Delivery Manager</td>
<td>On call duty director</td>
</tr>
<tr>
<td>Head of Detention Operations</td>
<td>On call casework manager or, alternatively, National Command and Control Unit</td>
</tr>
<tr>
<td>Director of Detention and Escorting Services</td>
<td>Detention Operations FLO (by telephone and to the FLO POISE inbox where possible)</td>
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<tr>
<td>Deceased’s case-owning team (G7 as a minimum)</td>
<td>DEPMU on call officer</td>
</tr>
<tr>
<td>Detention Operations FLO (by telephone and to the FLO POISE inbox)</td>
<td>DES Litigation and Deaths Inbox</td>
</tr>
<tr>
<td>The Detainee Escorting and Population Management (DEPMU) Duty Manager inbox</td>
<td></td>
</tr>
<tr>
<td>DES Litigation and Deaths Inbox</td>
<td></td>
</tr>
<tr>
<td>Senior on call manager (if this is not themselves)</td>
<td></td>
</tr>
<tr>
<td>Detention Engagement Team Manager</td>
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17. It is the responsibility of the HOIE lead to ensure the FLO is notified and then deployed (for FLO actions see paragraphs 27 – 39 below).

18. The Head of Detention Operations (during office hours) or on-call duty director (out of hours) 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 26):

- Immigration Minister’s Private Office or Private Office out of hours
- Immigration Enforcement Secretariat
- Director of Strategy, Transformation and Partnerships
- Press Office News Desk / SMT / Immigration Desk
- BICS Hub
• National Command and Control Unit (NCCU) CIO
• Returns Logistics SMT – see paragraphs 20 and 21 below
• Her Majesty’s Chief Inspector of Prisons (HMCIP)
• Prisons and Probation Ombudsman (see below at section 53 to 59)
• Litigation Operations
• CC Secretariat (for deaths of former FNOs)

19. If the death occurs Monday to Friday, during office hours the Head of Detention Operations 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.

20. If the death occurs over a weekend or out of hours, the Detention and Escorting Services 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 Detention and Escorting Services 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, outstanding or concluded application, details of this must not be disclosed to the diplomatic mission.

21. The DES duty director will agree press lines with BICS Hub out of office hours.

22. It is the responsibility of the local 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 (para 16).

23. If notification is received that a person has died in hospital after being released from detention or after being released into the community and the death was as a result of an incident occurring while detained or where there is some credible information that the death might have resulted from their period of detention (as set out at paragraph 3) the nominated Home Office lead should liaise with the deceased’s case owner. They should agree which of the actions at paragraphs 15 and 17 above are required, taking into consideration the circumstances of the death, and who will be responsible for taking them forward.

24. In the event that, exercising their discretion, the PPO does not conduct an investigation into a death after release, the Director of Detention and Escorting Services 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 (or Procurator Fiscal in Scotland) 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.

25. The local HOIE lead will be responsible for drafting a submission to the Immigration Enforcement Director General and Immigration Minister about the death. This must be submitted for clearance by the Head of Detention Operations within 24 hours of the original notification (during weekdays).

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

26. Home Office Detention and Escorting Services has a small network of trained FLOs. The role of the FLO is to be the named point of contact for the family or next of kin of the deceased person. It is not to manage the actions flowing from the death in detention. The role of the FLO starts after the point that the news of the death is broken to the family, maintaining contact throughout this period and providing information and practical support where appropriate. If the family do not want contact with the Home Office, their wishes will be respected.

27. The details of the weekly FLO on-call is provided on the Detention Operations on-call duties list.

28. Where practical it will be the FLOs role to break the news of the death to the next of kin, however it may at times be advisable for the police to do so. The HOIE lead will make the decision based on the following factors:

- Geographical location and the speed at which the news of the death can be relayed by the FLO. Consideration of how the news of the death is to be relayed is also vital e.g. in person or via the telephone, including the need for an interpreter.

- The relevant risk factors.

- The ability to deploy an individual with the FLO (who should not deliver the news of the death in person alone).

29. Where it becomes the role of the police to break news of the death the FLO, at first contact with the police, must establish that the police hold the most up to date details of the deceased’s next of kin, where these are known. If there is a delay with the police notifying the named next of kin (in accordance with the notification from
the HOIE local lead in paragraph 15) the Home Office FLO should raise this with the Head of Detention Operations or on call director if out of hours, 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.

30. 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.

31. Every contact with the family and their representatives must be recorded by the FLO, wherever possible. Log entries need to be an accurate and transparent record, and should be written up as soon as possible after a meeting. The Prisons and Probation Ombudsman (PPO) may wish to see the log as part of their investigation.

32. If the named next of kin is overseas, the expectation that the FLO notify them of the death remains in place. The FLO will break the news of the death via telephone where possible and all subsequent contact will be made as agreed between the FLO and named next of kin. 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.

33. It is not always possible to deploy FLOs in pairs after the news of the death has been shared. 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. FLOs within Detention Operations will be deployed and supported by a FLC.

34. FLOs may also be deployed in cases of medical emergency or where medical advice is that the death of an individual in detention is likely or a significant possibility. In such cases the named next of kin should be informed at the earliest possible opportunity by the FLO. In the event of a medical emergency or event where there is no medical advice stating that death is likely or a significant possibility then the named next of kin should be informed by the local HOIE lead.

35. Several organisations can provide assistance at both a local and national level, FLOs should do their own research about these agencies and how they operate locally in order to give families informed advice. This can be written information that the family can refer to in their own time. FLOs should familiarise themselves with this material and make use of it as appropriate to meet individual family’s needs. The FLO should assess the correct time to introduce this information.
FLO notification process

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

37. The initial message/telephone call should include as much of the following information as possible:
   - Full details for the deceased
   - Location and time of death
   - Full details of next of kin – to include contact details (this should have been recorded by both the DET 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)
   - Who 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 Compliance 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 Compliance team to ensure consistency in information gathering.

38. The duty FLO will take on responsibility as the point of contact for the 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 evidential purposes. A log must be opened for each case irrespective of level of content and contact.

39. 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 this to happen.
40. 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 include the FLO (where possible due to geographical location) and the local DES Delivery Manager or Head of Detention Operations, in addition to a supplier senior manager.

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

Support for staff and those who are detained

42. Centre suppliers are reminded that staff and detained individuals 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. Consideration of support should be a feature of a “hot debrief” held by suppliers as soon as possible after the initial actions in response to a death have been taken, and in more detailed de-briefs in slower time when operationally appropriate. This should also include support in the event that staff are required to give evidence at an inquest.

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.

44. DES 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 required; these can be arranged via line management.

45. The Home Office is committed to promoting active learning across the organisation. It is important that we learn from incidents in IRCs, such as deaths in detention, as well as incidents in which those in detention suffer harm or their care is compromised. All suppliers in every centre must have procedures in place to
facilitate and disseminate learning to prevent future occurrences and improve local delivery of safer detention.

46. To ensure that lessons are learned following a death, the Home Office will arrange for a multi-agency lessons learned review as soon as practical after the death has occurred. These reviews will consider the information available immediately or shortly after a death. Lessons learned reviews will follow an agenda set by the Home Office and will be minuted. The contents of these minutes are intended for internal, operational learning purposes only and do not provide a full or definitive account of the circumstances or the response to the death. Caution must be exercised when using information resulting from lessons learned reviews as details may change as further, more formal investigations, are undertaken. Information from these reviews must not be shared wider without the approval of the Head of Detention Operations.

47. Independent investigations will take primacy over this review and any other internal (supplier or Home Office) investigation into the circumstances of the death. No action should be undertaken that may compromise independent investigations. Any indication of wrongdoing in relation to the death as a result of the review should immediately be reported to the relevant party and appropriate action taken. Any suggestion of criminal action must be reported to the police.

48. Lessons learned reviews will be chaired by the Head of Detention Operations, or nominated delegate, and will include representation from the Home Office, IRC supplier, NHS England and IMB for the IRC. An invitation to attend will also be extended to the Independent Advisory Panel to the Ministerial Board on Deaths in Custody.

**Support for detained individuals under ACDT**

49. When a death occurs in any centre, all suppliers in every centre must undertake an ad-hoc assessment of all open and post closure local ACDT files. Formal ACDT reviews must be completed and documented in the ACDT files for those who are considered particularly vulnerable to the news and at increased risk of self harm or suicide and for **all** the following cases:

- All detained individuals on an open ACDT of the same nationality of the deceased. This is to ensure that there is no specific underlying trigger that may encourage a self-harm trend.

- All individuals on an open ACDT that have transferred from the Centre where the death occurred in the last 4 weeks.

- All individuals on a High Risk ACDT.
• All individuals that are being managed under the ACDT process but separately meet one of the indicators of risk set out in the adults at risk policy.

50. If the deceased was discharged from the Centre in the previous 4 weeks, a formal ACDT Review must be completed of any individual that shared a room with the deceased in the centre, or who was on an open ACDT at the time of the person’s death.

Funeral and repatriation arrangements

51. 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.

52. As a guide, reasonable funeral costs include:

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

53. 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 will become the responsibility of the Home Office local lead.

54. 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 sent to the Home Office Finance Team to approve as a one-off expenditure.

55. Once the funeral, cremation or repatriation date has been set, Immigration Enforcement Secretariat, the Detention and Escorting inbox for Litigation and Deaths and Press Office should be provided with an update by the Head of Detention Operations.

56. Any further disbursements in relation to the funeral and repatriation arrangements are at the discretion of the Head of Detention Operations.
Retention of documents

57. It is vital that all documentation relating to the deceased 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 must 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 local Compliance Team from the case working department in anticipation of the 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 (CCTV, hand held video or body worn camera), phone records and room call logs
- Any other evidential information or documentation including relevant risk assessments
- Any/all ACDT paperwork for the detained individual
- Any current or historical careplans open for the detained individual
- Detainee Transferable Document (DTD) and Person Escort Record (PER)
- Incident reports and Security Information Reports (SIRs) involving the individual. All members of staff directly involved in the finding or resuscitation of the individual must complete an incident report or Security Information Report (SIR) as soon as possible after their death.

Investigations following a death in detention

Police Investigation

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

59. The police service has a national memorandum of understanding with the PPO as to how an investigation will proceed when there may be evidence of a crime.
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.

**Prisons and Probation Ombudsman (PPO)**

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

62. 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 PPOFIIAdmin@ppo.gov.uk

63. The PPO should be notified as soon as possible of deaths that occur out of office hours (including over a weekend or bank holiday).

64. For the duration of each PPO investigation, there should be both a Home Office single point of contact for the centre (such as the area manager) as well as a supplier single point of contact to assist the PPO. This should not be the FLO.

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.

66. During the course of the PPO’s investigation (which will often include a review of clinical care that was commissioned by healthcare), 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.

67. 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. A 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

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.

69. A prevention of future deaths report will be issued by a coroner if it is found that there are lessons to be learned by any organisation. 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.

70. For Scotland the equivalent would be the Procurator Fiscal who makes the decision if it is appropriate to hold a fatal accident inquiry.

71. The family may request that the Home Office pay for their costs associated with attending the inquest. This may also include accommodation and travel. There is no requirement for the Home Office to pay these costs and any request to do so is at the discretion of the Head of Detention Operations.

Revision History

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<th>Reviewed by</th>
<th>Review outcome</th>
<th>Next review</th>
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<tr>
<td>Case number</td>
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<tr>
<td>Investigator</td>
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<td>Investigation Manager</td>
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<thead>
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<th>Title</th>
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<tr>
<td>Surname</td>
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<tr>
<td>Forename</td>
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<tr>
<td>Date of birth</td>
</tr>
<tr>
<td>Date and time of death</td>
</tr>
<tr>
<td>Nationality</td>
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<tr>
<td>Ethnic origin</td>
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<tr>
<td>Date and time incident discovered</td>
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<td>Date and time PPO notified</td>
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<tr>
<td>Establishment type and name</td>
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<td>Home Office Reference</td>
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<td>Location of death</td>
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<tr>
<td>Type of death</td>
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<tr>
<td>Date of reception to current establishment</td>
</tr>
<tr>
<td>Date of reception to custody (if known)</td>
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<tr>
<td>On open ACDT?</td>
</tr>
<tr>
<td>Has the named next of kin been informed?</td>
</tr>
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</table>

Detained under immigration powers at time of death?  
**i.e.** No – released whilst in hospital

Time, date and location of release from detention (if applicable)  
**i.e.** 3pm on 01/01/2017 in hospital

Reason for release from detention (if applicable)  
**i.e.** They were “administratively released” following doctor’s advice that further medical intervention would not be successful and the doctor advised life support would be turned off.
Additional information:

i.e. a brief description of the circumstances of their death, what treatment was provided and a description of why they were released from detention (if applicable)