Home Office

Detention Services Order 08/2014

Death in immigration detention

July 2021

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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.

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Contains Mandatory Instructions

For Action: All Home Office Immigration Enforcement (Detention and Escorting Services (DES) and Detention Engagement Team (DET) 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 or those detained at the border.

3. Two different Home Office teams operate in IRCs:

    - Detention and Escorting Services Compliance team (Compliance Team)

    - Immigration Enforcement Detention Engagement team (DET)

    The compliance team are responsible for all on-site commercial and contract monitoring work. The DETs interact with detained individuals face-to-face on behalf of responsible officers within the IRCs. They focus on communicating and engaging with people detained at IRCs, helping them to understand their cases and detention.

    There are no DETs at the Gatwick PDA or residential STHFs. Functions which are the responsibility of the DET in RSTHFs are carried out by the supplier and overseen by the Escorting Contract Monitoring Team (ECMT). The local Gatwick DET will undertake the DET role at the Gatwick PDA for the purposes of this DSO.

Definitions

4. 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).

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

Suppliers’ responsibilities and actions

6. Supplier centre managers are responsible for developing, implementing and maintaining their own local contingency plans and protocols for handling a death in detention. These plans should be reviewed annually or in the event of a death. 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. This also applies to RSTHFs, PDA and escort suppliers.

7. 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.

8. Between the hours of 09:00hrs to 18:00hrs (office hours) the centre supplier must immediately report any death to the local Detention and Escorting Services (DES) Compliance Team or ECMT (for RSTHF/escorting). The death must be reported to the most senior member of the DES Compliance Team or ECMT (for RSTHF/escorting) 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 DES Compliance Team or DEPMU/ECMT (for RSTHF/escorting) on call manager.

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

10. If the deceased is an adult or 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 (FLO). Out of office hours, the death of a child must be immediately reported to the DES Duty Director.

11. 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 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. The police are responsible for informing the coroner of the death.
- 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 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 potential witnesses to assist in any investigation (see paragraph 26).
- 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 45-46 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 thoroughly 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, including outgoing mail 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 DES Compliance Team manager of any planned appointments or visits recorded for the deceased. This information must be made available to the FLO as soon as possible.

12. 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.

13. 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 securely, with a copy sent to the local compliance team for their records.

Home Office's responsibilities and actions

14. Once notification of a death in detention is received, the local DES Compliance Team or ECMT manager (on site or on call) must immediately contact the relevant senior manager.

15. The HOIE DES lead (DES Compliance Team area manager for the centre, ECMT manager 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 DES lead to pass the details of the named next of kin to the FLO (see paragraph 39). The HOIE DES 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 DES lead 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.

16. 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 DES 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

- Arrange for onsite DET (or ECMT for RSTHF/escorting) to 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)

- Arrange for DET (or ECMT for RSTHF/escorting) to liaise with 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)

- Ensure the Home Office case work team 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

17. The HOIE DES lead (DES Compliance Team SEO for the centre, ECMT for RSTHF/escorting 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:

During office hours	**Out of hours**
Delivery Manager and Senior on call manager (if this is not themselves) Detention Engagement Team Regional Managers (G7 national managers, SEO Area manager and HEO Operations manager) Head of Detention Operations Director of Detention & Escorting Services (DES) Director of the Returns and Detention Operations Directorate Deceased's case-owning team (G7 as a minimum) Detention Operations FLO (by telephone and to the FLO POISE inbox) The DEPMU Duty Manager inbox DES Litigation and Deaths Inbox	On call duty director On call casework manager or, alternatively, National Command and Control Unit Detention Operations FLO (by telephone and to the FLO POISE inbox where possible) DEPMU/ECMT on call senior officer DES Litigation and Deaths Inbox

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 (marked 'urgent') at the Poise addresses listed below (as set out in DSO 05/2015 Reporting Incidents), citing the most immediate facts and advising internal colleagues that a submission will follow (see paragraph 25):

    - Immigration Minister's Private Office or Private Office out of hours
    - Immigration Enforcement Secretariat
    - Director of Returns and Detention Operations Directorate
    - Press Office News Desk / Comms Immigration Desk
    - Migration & Borders Rapid Response Team
    - National Command and Control Unit (NCCU) CIO
    - IRC SLT
    - Returns Logistics SMT – see paragraphs 20 and 21 below
    - Her Majesty's Chief Inspector of Prisons (HMCIP)
    - Prisons and Probation Ombudsman (see below at paragraphs 63-69)
    - Litigation Operations
    - FNORC Secretariat (for deaths of former FNOs who have transferred into the detention estate)

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, Commonwealth & Development Office (FCDO) 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 FCDO Duty Officer via the FCDO general enquiries switchboard 020 7008 1500 who will provide out of hours contact details for the relevant diplomatic mission. The DES 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 HOIE DES duty director will agree press lines with Migration & Borders Rapid Response Team out of office hours.

22. It is the responsibility of the local HOIE DES lead to inform all the other IRCs of the death (via the onsite/on-call HOIE DES Manager), as soon as possible, so that an ad-hoc assessment of all open and post closure local ACDT files can be undertaken across the estate, with the completion of formal ACDT reviews for those who are considered particularly vulnerable to the news and at increased risk of self-harm or suicide.

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 4) the local Home Office DES lead should liaise with the deceased's case owner. They should agree which of the actions at paragraphs 16 and 19 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 similar 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 DES 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).

Identification of potential witnesses to a death in detention

26. Following a death in detention, it is important that we are able to identify at an early stage any staff or detained individuals who may be potential witnesses or have potentially relevant information relating to the death. This may include people who witnessed the incident, were on the scene or have possible knowledge of the circumstances of the death. The Home Office service delivery manager (or ECMT G7 for RSTHF/escorting) is responsible for ensuring that the checklist attached at Annex B is completed by the IRC/PDA/RSTHF/escorting supplier and provided to the DES Head of Risk and Assurance and the relevant DET G7 within 3 days of the death. On receipt of the completed Annex B checklist the DET G7 (or ECMT for RSTHF/escorting) should work with the centre supplier to interview people in detention who would be deemed as potential witnesses within 4 calendar days of receipt of the Annex B checklist.

27. In addition, following notification of a death in detention the local DET G7 (or ECMT for RSTHF) will work with the Home Office service delivery manager and the centre supplier to ensure that all individuals who are scheduled for return within the next 7 days and may be a potential witness are identified, interviewed and their case owner informed as a matter of urgency. This will ensure that consideration can be given as to whether the witnesses' removal from the UK should be put on hold to allow them to give evidence at any subsequent inquest or should continue as originally planned. Information captured should record:

    a. Whether the individual identified as a potential witness is willing to provide a statement and give evidence at an inquest, including by returning to the United Kingdom for that purpose, or by giving evidence by means of video link

    b. The recording of a statement of evidence (if they are willing to provide one)

    c. Checking all relevant contact details of the individual, including in the country of proposed removal (to include address, email and phone number where possible)

28. This information should be recorded by the local DET (or ECMT for RSTHF/escorting) on the template in Annex C 'Resident witness template'. All sections of this form must be completed before uploading to CID/Atlas. The DET (or ECMT for RSTHF/escorting) should also contact the relevant detained casework teams to inform them that the person is a potential witness and provide a copy of the completed Annex C form. In line with the Home Office's interim policy on witnesses to a death in detention, Detained Casework teams/management will then use the information supplied in the Annex C template to give immediate consideration to whether the witnesses' removal is still appropriate, and if not, whether detention should continue. Any decision to pause a witnesses' removal or removal directions (if set) will require SCS approval.

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

29. The Home Office 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.

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

31. Where practical it will be the FLO's 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 DES 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 that might affect the safety of the FLO.

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

32. 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 DES 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.

33. If the family or named next of kin does not wish to have support from the FLO, then the Head of Detention Operations, in conjunction with the case working team, will identify a named individual to maintain contact with the family or named next of kin in place of the FLO.

34. 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.

35. If the named next of kin is overseas, the expectation that the FLO will notify them of the death still applies. 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.

36. It is not always possible to deploy two FLOs to work together 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.

37. 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 DES lead.

38. The FLO must ensure a copy of the information leaflet for bereaved families is provided to the named next of kin. 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, which may include a copy of the Ministry of Justice's Guide to Coroner Services for Bereaved People that explains the coronial process: https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

FLO notification process

39. FLOs should be notified of the death in detention by the HOIE DES area manager (during office hours)/senior on call manager (out of hours)/ECMT (for RSTHF/escorting) via both a telephone call and an email to the Detention Operations FLO inbox as soon as possible.

40. 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
- 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/ECMT 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.

41. 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.

42. 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.

43. 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.

44. 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

45. 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, 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.

46. 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.

47. HOIE 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. The Civil Service Management Code includes a commitment to provide staff called as a witness at an inquest or fatal accident enquiry as a result of their official duty with legal representation, provided there is no conflict of interest: https://www.gov.uk/government/publications/civil-servants-terms-and-conditions

48. The Home Office is committed to promoting active learning across the organisation. It is important that we learn from incidents in centres, 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.

49. 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 and once the PPO has spoken to witnesses, where possible. 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.

50. 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.

51. Lessons learned reviews will be chaired by the Head of Detention Operations, or nominated delegate, and will include representation from HOIE (both DES and DET), IRC supplier, NHS England and IMB for the centre. An invitation to attend will also be extended to the IAP.

Support for detained individuals under ACDT

52. 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.

53. 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

54. 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.**

55. As a guide, reasonable funeral costs include:

    - Funeral director's fees
    - Hearse
    - Simple coffin
    - Cremation/burial fees
    - Minister fees

56. 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.

57. Upon receipt, the funeral director's invoice (required on company headed paper) must immediately be passed by HOIE DES 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.

58. 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.

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

Retention of documents and property

60. It is vital that all documentation and property 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
    - Property belonging to the deceased (see paragraph 11)
    - Prison files, if applicable
    - Wing/unit files including wing observation books
    - 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, including copies of statement made by potential witnesses.
- 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

61. All deaths in custody are treated as suspicious by the police and the police investigation will have primacy over all other investigations. 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.

62. Centre supplier staff and all onsite Home Office staff must comply with the police and PPO investigations and the subsequent Coroner investigation and inquest into the death in detention in any way they can, including attending interviews, providing witness statements and/or attending to give evidence if requested. As set in paragraph 26 the local Home Office delivery manager/ECMT is responsible for working with the centre supplier to identify all individuals who may be a potential witness or have potentially relevant information relating to the death. The completed Annex B will be provided to the Coroner and the PPO by DES COOT. In addition, supplier, healthcare and Home Office staff should keep a record of key documents that may be relevant following a death in detention to assist the Coroner in due course.

Prisons and Probation Ombudsman (PPO)

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

64. 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.

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

66. 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.

67. 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.

68. 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.

69. 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

70. 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. It will usually 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 once 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. As indicated, above detained persons, or former detained persons, who witnessed the death may also be required to give evidence at inquest. This may be by pausing their removal from the UK pending the inquest taking place or, alternatively, by via video link from abroad, or returning the person to the UK at the time of the inquest.

71. A prevention of future deaths report will be issued by a coroner if they consider that there are lessons to be learned by any organisation to prevent future deaths. 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 provided to all interested persons. The Chief Coroner publishes the reports and the responses to them on his website.

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

73. 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

Review date	Reviewed by	Review outcome	Next review
June 2020	S Ali/ K Teefey	Introduction of the Home Office lead role, strengthening of the notification process for next of kin. Introduction of the detention engagement teams.	July 2021
July 2021	F.Hardy	Inclusion of witness checklist and supporting narrative	July 2023

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?	
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 jn 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)

Annex B – Witness Checklist (TO BE COMPLETED BY THE CENTRE SUPPLIER)

To note that staff should ensure that all documentation relating to the deceased and their death is retained securely.

Reference Number	STAFF INVOLVED	
	First on scene	
	Comms officer	
	Oscar 1	
	Duty Director	
	Home Office Family liaison officer	
OTHER STAFF ON SCENE (SUPPLIER, HOME OFFICE, HEALTHCARE)		
Reference Number	**NAME**	**ROLE**
COMMAND SUITE STAFF		
Reference Number	**NAME**	**ROLE**
OTHER STAFF INVOLVED (SUPPLIER, HOME OFFICE, HEALTHCARE)		
Reference Number	**NAME**	**ROLE**

RESIDENTS WHO WITNESSED INCIDENT		
Reference Number	**NAME**	**REASON (eg responded to incident)**
OTHER RESIDENTS INVOLVED		
	NAME	**REASON (eg entered scene, in area)**
OTHER RESIDENTS WITH POSSIBLE KNOWLEDGE OF CIRCUMSTANCES OF DEATH		
	NAME	**REASON (eg shared room, known associate, claims to have relevant information)**

Annex C – Resident Witness Template

(TO BE COMPLETED BY THE DETENTION ENGAGEMENT TEAM (DET) OR ECMT FOR RSTHF/ESCORTING)

Resident who witnessed incident on __/__/__		
1	**Name**	
2	**HO reference number**	
3	**Reason (taken from details contained in Annex B checklist)**	
4	**Are they willing to provide a statement? Y/N (If already provided state date and where it is retained)**	
5	**Are they willing to provide evidence at any inquest (Y/N)?**	
6	**Contact details (UK)**	
7	**Contact details (post removal)**	
8	**Are removal directions in place? If so, please provide details**	
9	**Would they be willing to give evidence at any inquest either by (a) returning to the UK for that purpose or (b) by giving evidence via video link?**	

	Please note that where a person indicates they are unwilling to return to the UK to give evidence or do so by video link from abroad this does not automatically mean that their removal from the UK will be paused.	