Home Office

Detention Services Order 02/2020

Commissioning reviews of serious incidents occurring in the immigration detention estate and during escort

July 2020

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Document Details

Process: To inform staff and suppliers of mandatory instructions for commissioning management and independent reviews of incidents in the immigration detention estate and during escort

Implementation Date: July 2020

Review Date: July 2022

Version: 2.1

Contains Mandatory Instructions

For Action: All Home Office and supplier staff in immigration removal centres, residential and non-residential STHFs, pre-departure accommodation and on escort

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Processes Affected: Commissioning management and independent reviews

Assumptions: All staff will have sufficient knowledge of Articles 2 and 3 of the European Convention of Human Rights (ECHR)

Notes: This DSO replaces DSO 1/2011 version 1.0, which is cancelled.

Instruction

Introduction

1. This Detention Services Order (DSO) provides guidance on the circumstances under which independent or management reviews of serious incidents occurring in the immigration estate and/or while detained individuals are under escort may be commissioned and where an independent investigation under Articles 2 and/or 3 of the European Convention on Human Rights (ECHR) may be required.

2. All references within this guidance to a SEO Area Manager include both at immigration removal centres (IRC) or pre-departure accommodation (PDA), as well as a senior manager (SEO) in the Escorting Contract Monitoring Team (ECMT) for reviews of incidents occurred at short term holding facilities (STHF) or under escort.

3. All references to “Centre” include IRCs, STHFs and PDA.

Background and relevant policy

4. An effective investigation by an independent official body must be conducted when there is sufficient evidence that one or more of the substantive obligations set out in Articles 2 or 3 of the ECHR has been, or may have been breached (see Annex A).

5. Both Articles 2 – protection of the right to life and 3 – protection against torture, inhuman or degrading treatment or punishment, impose an investigative obligation on the Home Office. All incidents where there is an alleged breach of these rights must be fully reviewed in order to ascertain whether the ECHR test is met. What constitutes an appropriate level of investigation thereafter will depend on all the circumstances of the case.

6. Other incidents, such as alleged or suspected criminal activity, staff misconduct or serious breaches of security may also require the commission of a review.

7. This guidance must be used in conjunction with DSO 08/2014 (death in detention) for any incidents of death in detention that prompt the commission of a review.

8. Incidents are categorised as red, amber and green in line with DSO 05/2015 (reporting and communicating incidents in the immigration detention estate). The categories within DSO 05/2015 should be used when commissioning management reviews.

Procedures

Collation of Evidence During an Incident

9. It is imperative that all staff keep accurate records during any incident. Records of incidents should include written reports and other related material including CCTV or other hand-held or body worn video footage, contemporaneous notes and logs. These records will enable a decision to be made on whether escalation by the local SEO Area Manager is necessary and may become evidential material in the course of a review.

10. As set out in DSO 05/2015 a red incident or a serious incident which may require a wider IE response (beyond the detention estate) could result in a formal command structure being initiated to manage the incident. If a command structure is put in place staff should follow the command processes for notetaking including the use of decision logs. Any Home Office staff in the command suite during the incident should maintain their own decision log.

11. Ideally, written statements should be completed within 72 hours of the incident occurring, when reasonable to do so and taking into consideration the welfare of the officer completing the report. In certain cases, when it is not possible to complete written reports during or immediately after an incident, it is important that they are written up as soon as possible afterwards, while events are still fresh in the mind of the officer(s) concerned.

12. It is important that when more than one staff member is involved in an incident or witness to an incident, that each officer should write their report independently and without conferring with the other officers involved in the incident. The evidential value of statements can be reduced if officers have had an opportunity to discuss what occurred before making them.

13. It is preferable to hold any debrief concerning an incident after the completion of reports by the officer(s) concerned. However, where it is essential to hold an immediate debrief, managers should be very clear from the outset that officers are not to discuss events with one another while incident reports and statements are being made. The debrief itself should be neutral and kept short and factual, for example to establish whether any officer has been injured.

14. A record must be made of all debriefs. This record must include the date, time and location of the meeting; who attended, what was said and by whom. All officers involved in any incident of use of force must be fully identified in the debrief records of the incident. Debrief records, written or recorded by video, must be stored in accordance with the retention instruction set out in paragraph 57.

Preliminary considerations and incident summaries

15. In accordance with DSO 05/2015, the following actions should be undertaken at the conclusion of a reportable incident:

    - IRC suppliers will provide a factual summary of the incident to the SEO Area Manager

    - The escort supplier will provide a factual summary of an incident occurring at a STHF, holding room or during escort, including incidents that occur outside of the United Kingdom that are witnessed by detainee escort officers, to the ECMT Duty Officer

    This report must include a time line of key events, actions, interventions and notifications occurring and the outcome / lessons learned from any post incident de-briefs. A summary of all incident reports, observations from CCTV or body worn cameras, interviews or other intelligence gathered must be made available to the Home Office as soon as operationally possible.

16. In accordance with DSO 03/2015 (handling of complaints), any incident of a criminal nature must be immediately reported to the police and a crime reference number or CAD reference should be obtained and passed to the victim. This should happen even if the detained individual does not wish to report the incident to the police and/or make a complaint.

17. A police investigation will always take primacy over any other investigation. When a suspected crime has occurred that is likely to be the subject of a police investigation it is important to preserve any evidence that would assist the police; wherever possible, the crime scene should be sealed off and evidence preserved. In line with the four principles of crime scene preservation, efforts should be made to prevent the evidence being contaminated or destroyed and to ensure that the evidence is not moved or removed from the scene. A designated supplier manager should be appointed as police liaison and maintain a log of all actions taken in relation to managing the crime scene.

18. If a police investigation is ongoing, all other Home Office or IRC staff incident investigation should cease until its conclusion, unless the police have agreed otherwise. Any potential criminal offences not immediately identified but revealed during a Home Office or IRC incident investigation must also be immediately referred to the police as above.

19. The local SEO Area Manager at an IRC, or ECMT can request that a supplier conducts a fact finding exercise in relation to any incidents reported under any RAG (Red, Amber) rating, in accordance with DSO 05/2015. In addition, the Home Office may also request a supplier to report as above on any concerns raised in other ways,

e.g. an unreported incident mentioned in a complaint or raised by a contract monitor or IMB member.

20. The fact finding exercise is not a review or investigation and should simply present the facts as they are known at that time, to enable the SEO Area Manager to determine the appropriate level of escalation required. The SEO Area Manager should be provided with any relevant information, including written reports, CCTV or body camera footage or any other available intelligence. The SEO Area Manager can escalate, where appropriate, an incident under any RAG rating to the attention of the Delivery Manager responsible for the area where the incident occurred.

Amber and red incidents

21. Following an amber or red incident, the supplier will always conduct a fact finding exercise and submit a full report of the incident to the SEO Area Manager within 5 working days (or sooner if requested). A summary of the incident, together with any evidence gathered as described in paragraph 9 must be made available to the SEO Area Manager as soon as operationally possible and no longer than 24 hours after the incident has occurred. All communications used to report amber or red incidents must be clearly marked with their RAG rating.

22. The SEO Area Manager will compile the information produced by the fact finding exercise, together with any relevant information available in the HO systems – such as detainee case history or an account of previous interactions with HO staff. The incident must then be escalated to the Delivery Manager responsible for the concerned centre or escorting contract who will consider, where appropriate and in accordance with paragraphs 26-29, whether further escalation or a management review are required.

Incidents involving Healthcare staff

23. Regardless of its RAG rating, it is the responsibility of local healthcare teams to conduct any preliminary reviews of any incident involving their staff. If an incident involving healthcare staff is being referred for a management review, the NHS Commissioner responsible for the local area will advise the local HOIE Delivery Manager if they believe a review should be conducted by the healthcare provider, jointly with the Home Office or if an independent external investigation is required.

Home Office and cross cutting incidents

24. It is the responsibility of the local Delivery Manager to commission any fact finding exercise or preliminary reviews of any incidents involving Home Office staff. Within centres, this will usually be conducted by the SEO Area Manager – unless the circumstances require a higher grade or someone independent from the local team. The officer investigating the incident will report any findings to the local Delivery Manager.

25. Cross cutting incidents, involving the supplier staff and other agencies or departments, will require separate fact finding exercises for each body involved. It is the responsibility of the local Delivery Manager to collate all findings resulting from cross cutting incidents. All reviews of cross cutting incidents must be escalated to the Head of Detention Operations.

Commissioning Reviews and Investigations

26. When considering the commission of a management review, the Delivery Manager responsible for the centre concerned must escalate to the Head of Detention Operations or for escorting contract to the Head of Escorting Operations any incident found to potentially involve gross or serious misconduct of staff, criminal action or a serious breach of security or safeguarding measures.

27. When considering the commissioning of an independent (ECHR) investigation (including a Professional Standards Unit Investigation), the Head of Detention Operations will inform the Detention and Escorting Services Director of any incident that may arguably have breached either article 2 or 3 of the ECHR for consideration of an independent investigation (see paragraph 42).

28. Following any review or investigation it is the responsibility of the Delivery Manager responsible for the concerned centre or escorting contract to implement a local action plan, assigning relevant owners and due dates, to respond to any recommendations made.

29. Expected reporting times should be detailed in the terms of reference of every review or investigation. A guide to the expected timings for each type of review or investigation can be found at paragraph 47.

Local Home Office or supplier management reviews

30. Following the completion of a local fact finding exercise or the direct escalation of any serious incident, the local Delivery Manager may commission a management review of any incident involving Home Office or supplier staff. The review may be commissioned to a Home Office Manager (SEO or above) or to the supplier's Centre Manager.

31. Where the commission of a management review is deemed appropriate, Centre Managers and Delivery Managers should liaise and agree the appropriate type of review and who should lead its commissioning, thus preventing two parallel reviews being conducted at the same time.

32. Although a single review of an incident is preferable, the commission of a management review by the Delivery Manager does not prevent suppliers from conducting their own internal review. Suppliers must notify the local Delivery Manager when conducting an internal review. When the review is concluded, all findings must be reported to the Delivery Manager.

33. The investigating officer and terms of reference will be determined by whoever is commissioning the review. A Home Office or supplier's management review may include:

- Interviews with any officers, detainees or other parties involved in the incident,
- An account of any decisions made during the management of the incident.
- Consultation with professional bodies or expert advisors (such as HO monitors, C+R Instructors, trade unions)
- Lessons learned and a summary of hot or cold debriefs held in the aftermath of the event.
- Findings and recommendations.

Home Office or supplier independent reviews

34. When considering commissioning a review, the Delivery Manager may reach the conclusion that it is more appropriate that an external team undertakes the review of the incident. Such instances must be escalated to the Head of Detention Operations who may, where appropriate, commission an independent Home Office or supplier review to guarantee the reporting of independent and unbiased findings.

35. The Head of Detention Operations will commission such independent reviews to a Home Office or supplier senior manager, who, albeit being part of the same organisation or department, should not be based at the location where the incident occurred.

36. This review is not to be confused with an independent (ECHR) investigation. Home Office or supplier independent reviews are not subject to the same requirements as under Article 2 or 3 ECHR.

Professional Standards Unit (PSU) Investigations

37. In cases where any preliminary considerations, fact finding exercises or management reviews contain allegations or suspicions of gross or serious misconduct, these must be escalated to the Head of Detention Operations by the Delivery Manager. For a HMPPS run centre, the centre manager must be consulted ahead of any PSU investigation being conducted.

38. The Head of Detention Operations may commission any incident containing allegations or suspicions of gross or serious misconduct to be investigated by PSU.

39. Serious misconduct categories may include:

- Theft
- Assault
- Sexual Assault
- Fraud / Corruption
- Racism and other Discrimination.

40. The responsibility of PSU to investigate allegations of serious misconduct set out in DSO 03/2015 (Handling Complaints) is not affected by the power of the Head of Detention Operations to commission an independent PSU investigation into specific incidents.

41. The PSU can also be the first stage of an independent (ECHR) investigation. This is particularly the case where there is no evidence of wider systemic issues involved in the mistreatment and where the evidence suggests that any mistreatment is limited to a single or small number of individual(s). The PSU investigation, together with the right to appeal to the PPO may be sufficient in a particular case to satisfy the Article 3 ECHR investigative obligation.

External Independent (ECHR) Investigations

42. It is the responsibility of the Detention and Escorting Services Director to commission standard independent (ECHR) investigations; to determine the most appropriate person to conduct the investigation and to agree its terms of reference. However, more complex investigations may require elevation to the Secretary of State if it requires statutory powers, such as under the Inquiries Act 2005.

43. An external independent (ECHR) investigation will aim to establish the full facts of the incident (which is likely to be major) and make recommendations that relate to lessons to be learned for the future.

44. While it is important that the investigation is commissioned quickly, it will be a matter for the investigator to decide the rate at which the review proceeds, in particular where either a police investigation or coroner's inquest takes precedence.

Disciplinary action

45. Any staff misconduct alleged or established after any review of an incident or PSU investigation must be further investigated under disciplinary proceedings. Suppliers are responsible for undertaking any disciplinary action and must inform the SEO Area Manager, who will notify the Delivery Manager and the Home Office Certification Team of the outcome - in line with DSO 02/2018 (DCO Certification).

46. This DSO does not affect any disciplinary processes available to line managers in relation to any Home Office staff in line with Home Office and Civil Service policy.

Expected timings for reviews and investigations

47. The timings proposed in the table below are indicative. The expected timings for all Home Office reviews and investigations should be prescribed in its terms of reference by the commissioning officer.

Review	Time to complete
Preliminary fact finding	5 days
HOIE or Supplier management review	4 weeks
HOIE or Supplier independent review	12 weeks
PSU commissioned investigation	12 weeks

The role of the Prison and Probation Ombudsman

Death in detention

48. The following chapter must be read in conjunction with DSO 8/2014 (death in detention) that sets out the reporting and escalation procedures for all cases of death in detention.

49. Where there has been a death in detention, there will be a coroner's inquest (or, in Scotland, a Procurator Fiscal's review) and a review by the Prisons and Probation Ombudsman (PPO) which will meet the investigative requirement of Article 2 of the ECHR, where required.

50. Where there has been a near death incident which has posed a real and immediate threat to the life of the detainee involved or has left him or her with serious long-term injuries that have significantly affected his or her ability to take action in relation to the incident, an obligation under Article 2 to commission an independent investigation will be triggered.

51. All cases in which there has been a death will be referred by the Head of Detention Operations (or duty director outside of working hours) to the PPO for review. In a case where there has been a near death, the Detention and Escorting Services Director will decide whether to commission an independent (ECHR) investigation. In reaching that decision the Detention and Escorting Services Director shall have regard to whether the criteria set out in Annex A have been met.

52. Where the individual is able to provide instructions to a legal representative or refer the matter to the PPO, and judicial proceedings and/or a review by the PPO may provide an effective remedy, a HOIE commissioned independent (ECHR) investigation will not normally be required.

Allegations of torture, inhuman or degrading treatment or punishment

53. Where an incident raises an allegation of torture, inhuman or degrading treatment or punishment having taken place in detention, the Detention and Escorting Services Director must consider whether there is credible evidence to suggest that there has been an arguable breach of Article 3 and whether the individual can secure adequate investigation, retribution and redress without the need for a HOIE commissioned independent (ECHR) investigation.

54. If it is concluded that the ECHR has been breached, the Detention and Escorting Services Director must consider whether:

    - Civil proceedings (by way of judicial review or a claim for damages) can satisfy the investigative obligation.

    - A PSU investigation, together with the right to complain to the PPO can satisfy the investigative obligation.

    - A police investigation and the prospect of criminal proceedings can satisfy the investigative obligation.

    - A combination of the above can satisfy the investigative obligation.

55. In the majority of cases, the availability of the PPO to consider a complaint, coupled with the availability of judicial proceedings, civil or criminal, will satisfy the investigative obligation of Article 3.

56. HOIE will only commission an independent (ECHR) investigation in the most serious of cases where the Detention and Escorting Services Director considers the issues to be so serious as to warrant this type of review (such as where there is evidence of wider systemic issues involved in the mistreatment and where the evidence suggests that any mistreatment is not limited to a single or small number of individual(s).

Retention of documents

57. It is vital that all documentation relating to the allegation or incident are gathered together and securely stored. This may include:

    - All evidential video footage - recorded and retained for 6 years in accordance with DSO 04 2017 Surveillance Camera Systems.
    - Detainee Transferrable Document (DTD) and Person Escort Record (PER)
    - Incident reports and Security Information Reports (SIRs) involving the detainee.
    - Prison files
    - Residential files
    - Local detention files
    - Any/all ACDT paperwork for the detainee
    - Local policies and protocols in operation at the time of death in particular policies on suicide prevention and segregation if applicable
    - Any other evidential information or documentation including relevant risk assessments

58. All evidential documents used for any PSU or independent external reviews must be retained for 10 years.

59. These documents must be made available to the investigator undertaking the review.

Revision History

Review date	Reviewed by	Review outcome	Next review
June 2020	S Ali	Reformat and general update to include specific information on commissioning a review.	June 2022

Annex A

Articles 2 and 3 of the European Convention on Human Rights (ECHR)

Article 2 of the ECHR states: “Everyone’s right to life shall be protected by law”. We therefore have an obligation not only to ensure detainees’ lives are not taken while in our care, but also to take reasonable steps to ensure their lives are protected. Article 2 will usually be engaged where there has been a death in the immigration detention estate, or where there has been a ‘near death’ incident which has left the individual with serious long term injuries or an ongoing medical condition.

Article 3 of the ECHR states: “No one shall be subjected to torture or to inhuman or degrading treatment or punishment”. We must ensure detainees are not subjected to such treatment while in our care.

When considering whether or not Article 3 is engaged, the circumstances of each case must be considered carefully to decide whether the treatment in question has reached the level of severity required for there to be a possible breach of Article 3. For example, the use of restraint may be justified to control a violent or disruptive detainee but the same restraint may be considered degrading if used on a compliant detainee and may therefore arguably engage Article 3.

The detainee’s personal circumstances (for example, physical or mental health) are also relevant and, for that reason, staff should remain alert to the conditions of detention and the effects they are having on detainees individually, particularly where circumstances arise in which it is necessary to depart from the usual regime (for example, during the management of an incident). This is because the threshold at which treatment will constitute a breach of Article 3 will depend on the detainee’s particular vulnerabilities or personal characteristics; for example, the same treatment might breach Article 3 in respect of a very vulnerable detainee but not in respect of a detainee without any particular vulnerabilities.

As set out at paragraph 4 of this Detention Services Order, an effective investigation by an independent official body must be conducted when there is sufficient evidence that one or more of the substantive obligations set out in Articles 2 or 3 of the ECHR has been, or may have been, violated and it appears that agents of the State are, or may be, implicated in some way.

What constitutes an effective investigation will depend on all the circumstances of the case, but the investigative obligation may be met in a number of ways including judicial proceedings, a combination of internal and external complaints procedures, a formal independent (ECHR) investigation and/or a coroner’s inquest.