Home Office

Detention Services Order 02/2020

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

September 2025

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Document Details

Process: To ensure staff and contracted service providers are aware of the mandatory instructions for commissioning management and independent reviews of incidents, that have occurred within the immigration removal estate and during escort.

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Contains mandatory instructions

For Action: All Home Office and contracted service provider staff operating in immigration removal centres, short-term holding facilities (residential and non-residential), pre-departure accommodation and during escort.

For Information: Home Office case owners.

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Processes Affected: All processes relating to 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).

Instruction

Introduction

1. This Detention Services Order (DSO) provides instructions and operational guidance about the circumstances under which independent or management reviews of serious incidents occurring within the immigration removal 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 to a SEO or Area Manager within this guidance include those located both at immigration removal centres (IRCs) and pre-departure accommodation (PDA), as well as a senior manager (SEO) in the International and Returns Services Escorting Operations (Escorting Ops) (IRS) who undertake reviews of incidents that have occurred at short-term holding facilities (STHFs) or under escort.

3. This instruction **does not** apply to Residential Holding Rooms (RHRs).

4. For the purpose of this guidance, references to “centre” include IRCs, STHFs and the Gatwick PDA.

5. Two separate Home Office teams operate in IRCs:

    - Detention Services (DS) Compliance team (Compliance team)
    - 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 within the IRCs, on behalf of responsible officers within the removal centres. They focus on communicating and engaging with people detained at IRCs, serving paperwork on behalf of caseworkers, helping them to understand their cases and reasons for detention.

    There are no DETs at RSTHFs or the Gatwick PDA. Some of the functions which are the responsibility of the DET in IRCs, are instead carried out by the contracted service provider and overseen by the International and Returns Services (IRS) Escorting Operations (Escorting Ops) in RSTHFs. In the Gatwick PDA, engagement with detained individuals is undertaken by the local Compliance Team.

Background and relevant policy

6. 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).

7. Both Article 2 (protection of the right to life) and Article 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 there is credible evidence that these rights were breached. What constitutes an appropriate level of investigation thereafter will depend on all the circumstances of the case.

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

9. This guidance must be used in conjunction with DSO 08/2014 Death in Immigration Detention for any incidents of death in detention that prompt the commission of a review.

10. 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

11. 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, and relevant notes and logs. Where necessary, and in line with any considerations regarding medical confidence information and consent, healthcare staff should provide written reports to Home Office staff relating to any injuries and any relevant comments relating to an individual's medical records. These records will enable a decision to be made on whether escalation by the local Area Manager (SEO or equivalent) in the compliance team is necessary and may become evidential material during a review. These reports must be documented in the individual's health record. The contracted service provider must complete an IS91 RA Part C and share with on-site DETs who will notify caseowners. It is DEPMU's responsibility to upload a copy of the Part C to ATLAS via 'Manage Documents' for incidents in IRCs and the PDA. For RSTHFs, Escorting Ops will be responsible for notifying caseowners and updating ATLAS.

12. As set out in DSO 05/2015 Reporting and communicating incidents in the immigration detention estate, a red incident or a serious incident which may require a wider Immigration Enforcement (IE) response (beyond the removal estate) could result in a formal command structure being initiated to manage the incident. Such an incident must be escalated immediately to the DS rostered or duty manager (SEO or above) providing as much information as possible in line with the checklist at Annex A. 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.

13. Ideally, written statements should be completed within 24 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.

14. 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.

15. 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 or 'hot' 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 "hot" debrief itself should be neutral and kept short and factual, for example to establish whether any officer has been injured.

16. A record must be made of all debriefs by the contracted service provider. This record must include the date, time and location of the meeting; who attended (the Training Manager or a nominated deputy must be in attendance), 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 paragraphs 60-62. The minutes of the debrief are to be shared with the onsite compliance team to allow for lessons to be learnt from incidents.

Preliminary considerations and incident summaries

17. In accordance with DSO 05/2015 Reporting and communicating incidents in the immigration detention estate, the following actions should be undertaken at the conclusion of a reportable incident:

    - IRC contracted service providers will provide a factual summary of the incident to the DS Area Manager (grade SEO or above)

    - Escorting Ops 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 detained individual escort officers, to the Escorting Ops Duty Officer.

    This report must include a timeline of key events, actions, interventions and notifications occurring, in addition to 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.

18. In accordance with DSO 03/2015 Handling of Complaints, any incident of a criminal nature must without exception be immediately reported to the police by the contracted service provider 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.

19. 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 situ. 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 contracted service provider manager should be appointed as police liaison and should maintain a log of all actions taken in relation to managing the crime scene.

20. If a police investigation is ongoing, all other Home Office or IRC staff incident investigations 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.

21. Escorting Ops or the SEO Area Manager at an IRC can request that a contracted service provider conducts a fact finding exercise in relation to any incidents reported under any RAG (Red, Amber, green) rating, in accordance with DSO 05/2015 Reporting and communicating incidents in the immigration detention estate In addition, the Home Office may also request a contracted service provider to report as above, on any concerns raised in alternative ways, e.g. an unreported incident mentioned in a complaint or raised by a contract performance monitor, an independent regulator of healthcare or IMB member. All investigations should be completed and shared with the Home Office within 21 days of commission. Any extension to this period will require agreement, in writing, from the commissioning member of staff. Healthcare practitioners would conduct this in accordance with the Patient Safety Incident Response Framework (PSIRF) as part of the NHS contractual requirements.

22. 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 (or Escorting Ops) 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

23. Following an amber (at the discretion of the Area Manager) or red incident, the contracted service provider 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 11 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.

24. 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 detained individual 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 28-32, whether further escalation or a management review are required.

Incidents involving Healthcare staff

25. 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 responsible regional NHS Commissioner will advise the local DS 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. Where necessary in line with the Care Quality Commission (CQC) Registration Regulations 2009: Regulation 18, the healthcare provider/commissioner must notify CQC of all incidents that affect the health, safety and welfare of people who use services.

Cross-cutting incidents

26. 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 DS Area Manager (grade SEO or above) 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.

27. Cross-cutting incidents, involving the contracted service provider 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

28. When considering the commission of a management review, the Delivery Manager responsible for the centre concerned must escalate to the relevant G7, sighting the DS Counter Corruption & Intelligence Unit via email DSCountercorruption@homeoffice.gov.uk, any incident found to potentially involve:

    - gross or serious misconduct of staff,

- criminal (which would require police involvement for investigation) action, or;
- a serious breach of security or safeguarding measures.

Where required, the G7 can escalate this to the Head of Detention Operations (G6)/escorting contract to the Head of Escorting Operations, via the escalation process.

29. When considering the commissioning of an independent (ECHR) investigation (including a Professional Standards Unit Investigation), the Deputy Director of Detention Services will inform the Deputy Director International & Returns Services Command of any incident that may arguably have breached either article 2 or 3 of the ECHR for consideration of an independent investigation (see paragraph 46).

30. 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.

31. 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 50.

32. The IRC contracted service provider shall conduct a review to which DS compliance team and Incident and Counter Corruption Hub will be invited following the resolution of any incident which required command mode to be enacted. Any review conducted after the resolution of an Incident shall be completed within 14 working days and will include:

    - analyse all aspects of the Incident, including the procedures used to resolve the incident;
    - View all available footage;
    - assess the reactions and responses of staff at the IRC to the incident;
    - review the effectiveness of the Contingency Plans in the light of the Incident; and
    - seek prior written approval from the Authority and consider the media responses, if any, to the Incident.

Local Home Office or contracted service provider management reviews

33. 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 contracted service provider staff. The review may be commissioned to a Home Office Manager (SEO or above) or to the contracted service provider's Centre Manager.

34. 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.

35. Although a single review of an incident is preferable, the commission of a management review by the Delivery Manager does not prevent contracted service providers from conducting their own internal review. Contracted service providers 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.

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

    - Interviews with any officers, detained individuals 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, Control and Restraint (C+R) Instructors, trade unions)
    - Review of the CCTV, hand-held video footage and body-worn video footage (DSO 04/2017 Surveillance Camera Systems refers)

37. Lessons learned and a summary of hot or cold debriefs held in the aftermath of the event. Any review conducted after the resolution of an Incident shall be completed within 14 working days.

    - Findings and recommendations.

Home Office or contracted service provider independent reviews

38. 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 or Head of Escorting Operations (G6) who may, where appropriate, commission an independent Home Office or contracted service provider review to guarantee the reporting of independent and unbiased findings. The relevant G7 will commission such independent reviews to a Home Office or contracted service provider senior manager, who, albeit being part of the same organisation or department, should not be based at the location where the incident occurred. Where required, the G7 can escalate this to the Head of Detention Operations (G6)/escorting contract to the Head of Escorting Operations, via the escalation process.

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

Serious misconduct investigations

40. 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. The relevant G7 may commission any incident containing allegations or suspicions of gross or serious misconduct to be investigated by Professional Standards Unit (PSU). Before the PSU are commissioned, sign off from the relevant G6 is required, or if a management review is being commissioned, the appropriate Senior Civil Service (SCS) grade.

41. Serious misconduct categories may include (but are not limited to):

- Theft
- Assault
- Sexual Assault
- Fraud / Corruption
- Racism and other Discrimination.
- Serious breach of security/safeguarding measures

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

43. 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.

44. The DS Counter Corruption & Investigations Unit which sits within the DS Incident and Counter Corruption Hub will be notified of all allegations of corruption or wrongdoing by contracted service providers and subcontracted staff. They will work with the Local Counter Corruption Teams to develop and pursue any corroborated allegations or evidence of wrongdoing.

45. All allegations must be reported to the DS Counter Corruption and Investigations Unit within 48 hours of the information being received. The allegations must be shared in full and include any actions that have been taken.

External Independent (ECHR) Investigations

46. It is the responsibility of the Deputy Director of Detention Services 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.

47. 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.

48. 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

49. Any staff misconduct alleged or established after any review of an incident or PSU investigation must be further investigated under disciplinary proceedings. Contracted service providers 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 Detainee Custody Officer Certification.

50. 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

51. 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 (working days)
Preliminary fact finding	5 days
HOIE or Contracted service provider management review	4 weeks
HOIE or Contracted service provider independent review	12 weeks
PSU commissioned investigation	12 weeks
Supplier self-investigation	Within 7 days

The role of the Prison and Probation Ombudsman

Death in detention

52. The following section must be read in conjunction with DSO 08/2014 Death in Detention that outlines the reporting and escalation procedures for all cases of death in detention, and the identification of potential witnesses at an early stage. 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 fatal incident investigation by the Prisons and Probation Ombudsman (PPO) which will meet the investigative requirement of Article 2 of the ECHR, where required.

53. 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.

Near death incidents

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

55. Where the individual is able to provide instructions to a legal representative or refer the matter to the PSU, any judicial proceedings and/or a PSU investigation, may provide an effective measure. In this instance, a HOIE commissioned independent (ECHR) investigation will not normally be required.

Allegations of torture, inhuman or degrading treatment or punishment

56. Where an incident raises an allegation of torture, inhuman or degrading treatment or punishment having taken place in detention, both the Detention Services Deputy Director, in addition to the International and Returns Services Command (IRSC) Deputy 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.

57. If it is concluded that it is likely that Article 3 of the ECHR has been breached, the Detention Services Deputy 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.

58. 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. Following an incident, relevant organisations/legal firms should be signposted to individuals to provide a fair opportunity to seek legal advice.

59. Home Office Immigration Enforcement (HOIE) will only commission an independent (ECHR) investigation in the most serious of cases where the Detention Services Deputy 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

60. 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 (such as use of force, assault, or any other serious incident) must be recorded and retained for 6 years in accordance with DSO 04/2017 Surveillance Camera Systems.

- Detained individual Transferrable Document (DTD) and Person Escort Record (PER)
- Incident reports and Security Information Reports (SIRs) involving the detained individual.
- Prison files
- Medical records/files (in line with NHS retention of records guidance)
- Residential files
- Local detention files
- Any/all assessment care in detention and teamwork (ACDT) paperwork for the detained individual
- Vulnerable Adult Care Plan (VACP)
- 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

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

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

Revision History

Review date	Reviewed by	Review outcome	Next review
June 2020	Shadia Ali	Reformat and general update to include specific information on commissioning a review.	June 2022
September 2025	Akash Shourie	Updated to reflect standard changes to DSO process, incorporating comments from NHS Commissioners. Recommendations from the PPO have been assimilated. Including references to DS Incident & Counter Corruption Hub	September 2027

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 detained individuals’ 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 detained individuals 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 detained individual but the same restraint may be considered degrading if used on a compliant detained individual and may therefore arguably engage Article 3.

The detained individual’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 detained individuals 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 detained individual’s particular vulnerabilities or personal characteristics; for example, the same treatment might breach Article 3 in respect of a very vulnerable detained individual but not in respect of a detained individual without any particular vulnerabilities.

As set out at paragraph 6 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.