Home Office

Detention Services Order 08/2014

Deaths in immigration detention

July 2026

This publication is available at www.gov.uk/government/collections/detention-service-orders

Any enquiries regarding this publication should be sent to us at DSOConsultation@homeoffice.gov.uk

Contents

Document Details

Process: To provide information for Home Office staff, Contracted Service Providers (CSPs) and healthcare teams on responsibilities when managing a death in an immigration removal centre (IRC), residential short-term holding facility (RSTHF), pre-departure accommodation (PDA) or on escort; in hospital; under escort; or after release from detention.

Implementation Date: July 2026

Review Date: July 2028

Version: 3.0

Contains Mandatory Instructions

For Action: All Home Office Immigration Enforcement (Detention Services (DS) and Detention Engagement Team (DET) staff; CSPs operating in IRCs, RSTHFs, pre-departure accommodation (PDA); escorting providers.

For Information: N/A

Author and Unit: S Patel, Detention Services Orders Team

Owner: M Smith, Head of Detention Operations

Contact Point: Detention Services Orders Team.

Processes Affected: Home Office processes within the immigration removal estate relating to the death of an individual while detained in an IRC, PDAs, RSTHF or on escort; in hospital; under escort; or after release from detention.

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

Notes: N/A

Instruction

Introduction

1. This Detention Services Order (DSO) provides guidance for all staff (including escort staff) operating in immigration removal centres (IRCs), pre-departure accommodation (PDA) and residential short-term holding facilities (RSTHFs), about their responsibilities if an individual dies in an immigration detention facility, in hospital or under escort (including when under bed watch). This guidance applies, where relevant, to deaths that occur after a person is released from detention where the death resulted from an incident that occurred while detained, or where there is credible information that the death may have resulted from their period of detention (see definition at paragraph 6).

2. This instruction **does not** apply to:

    - Individuals detained in prison under immigration powers
    - Non-residential STHF, or
    - Residential Holding Rooms (RHRs).

3. Two different Home Office teams operate in IRCs:

    - Detention Services 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 on behalf of responsible casework teams. They focus on communicating and engaging with people detained at IRCs, serving paperwork on behalf of caseworkers and helping them to understand their cases and 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 conducted by the CSP and overseen by the International and Returns Services (IRS) Escorting Operations (Escorting Operations) in RSTHFs. In the Gatwick PDA, the local Compliance Team cover the role of detained individual engagement.

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

5. Caseworkers have overall responsibility for the immigration case and detention of individuals held in IRCs. They are responsible for reviewing detention regularly, considering representations, medical or vulnerability information, and making

decisions on release or removal. Caseworkers work closely with onsite teams to ensure decisions are communicated clearly and that appropriate action is taken in response to changes in a detained person's circumstances.

Definitions

6. For this guidance and for the purpose of investigations into fatal incidents, deaths in detention are defined as:

   - Any death of an individual while detained under immigration powers in an IRC, RSTHF, PDA, under escort, after leaving detention, or following removal, if the death was the 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 occur after an individual has left detention and is not under escort, where the cause of death was unrelated to the detention period or occurred outside the direct control of the state.

Contracted Service Providers' responsibilities and actions

7. CSP centre managers for IRCs and the PDA (managers for RSTHFs) are responsible for developing, implementing, and maintaining their own local contingency plans and protocols for managing a death in detention. These plans must include the requirements set out in this guidance as a minimum. These plans should be reviewed at least annually and in the event of a death.

8. The first person on scene must summon help and request an emergency medical response using the medical codes as set out in DSO 09/2014 Medical Emergency Response Codes, to alert clinical staff to the type of emergency and type of first aid equipment that will be needed. Local contingency plans must clearly explain the code definitions. Local contingency plans must also provide for the summoning of an ambulance and alerting key personnel, in addition to clearly setting out who should do this.

9. If the apparent death has taken place in a residential room, the preservation of life must take precedence and where there is, or appears to be, danger to life, then the room (or rooms) may be unlocked without any further authority and an individual member of staff may assess the risks and enter the room on their own. Local protocols must contain clear instructions covering entry into a room, especially during night state (DSO 04/2018 Management and security of night state). If the death has taken place elsewhere within the centre, the local strategy for clearing the area of other detained individuals should be followed. Emergency first aid procedures should be continued until medical assistance arrives. A concise report must be given to medical staff upon their arrival by the first attending member of CSP or Home Office staff, who must then assume responsibility for the casualty.

10. Many hospital trusts train and licence paramedics and/or senior nursing staff to verify the fact of death at the scene, in writing, and coroners are giving this widespread recognition. If the attending clinical staff are so qualified, it may not be necessary to call a doctor to the scene solely to certify death. Local protocols must make clear what arrangements have been agreed with the local hospital trusts, ambulance service, the police and the coroner.

11. CSPs must invite the relevant faith chaplain or, if unavailable and as appropriate, other religious leader to administer official rites, prayers or other ritual observances, bearing in mind the overriding need to preserve evidence.

12. Once a death has been verified by a qualified person, the CSP must invoke their contingency plan for a death in detention which will adhere to this DSO and specify the responsibility of named people/roles/grades to be contacted immediately in the event of a death in detention. This will include but is not limited to on-call personnel, the local Compliance Team and the Independent Monitoring Board (IMB).

13. The CSP is responsible for putting a cordon in place, with a member of staff posted to remain at the scene, keeping a record of the names of all those entering the area, which must be limited only to those directly involved with the incident. Pending the arrival of the police, all relevant evidence must be preserved, including documentation, property, incoming and outgoing post, and any centre-issued mobile phone.

14. Any roommate of the deceased must be relocated, following a room-sharing risk assessment (DSO 12/2012 Room sharing risk assessment). When a roommate vacates the room, consideration must be given to the preservation of evidence. CSPs must ensure that nothing is removed from the area unless authorised by the police. If the roommate requires personal provisions such as clothing or washing items, alternatives must be provided until the police authorise the release of any property. Support systems must be in place for all detained individuals during this difficult period.

15. CSPs must record the details of any potential witnesses to assist in investigations into the death (see paragraphs 24 to 30). As a minimum this should include detained individuals in adjacent and opposite rooms or, if the death occurs elsewhere in the centre, the names of others present who may have been a witness. CSPs should share this list with on-site DETs at the earliest convenience, to ensure that Home Office staff can maintain appropriate contact with identified witnesses, provide necessary case updates, coordinate any required interviews, and prevent any unintentional movement of potential witnesses.

16. The body must be removed in accordance with local protocols agreed with the police and coroner (or procurator fiscal for Scotland), making sure that detained individuals located nearby cannot see the removal of the body and that staff without a role in the procedures do not remain in the area unnecessarily. Once the body has been removed, CSPs must seal the room/area until the police give authority for it to be re-

opened. Local procedures should clearly set out how rooms across the centre will be secured, and all staff should be familiar with this.

17. If the deceased is a parent in the PDA, CSPs are responsible for checking on the wellbeing of accompanying children, in addition to contacting the relevant local authority social services department to arrange appropriate care for the accompanying children. Any explanation to accompanying children must be dealt with sensitively and appropriately, using a translator if necessary and observing any religious sensitivities.

18. The Home Office Family Liaison Officer (FLO, see paragraphs 61 to 78) and / or police are responsible for alerting the named next of kin of the death, as detailed in any existing local Memorandum of Understanding in place for deaths in detention / fatalities in custody. All centres should ensure that they have a Memorandum of Understanding in place with the local police. The police are responsible for informing the coroner of the death. The information required by the FLO is set out in paragraph 74 and must be collated and shared at the earliest opportunity.

19. The CSP must ensure the death is communicated promptly to other detained individuals in a way they can understand. This must be done verbally, using plain language, and by notices displayed around the centre. Where practicable, anyone who shared a room with, or was a close friend of, the deceased should be informed face to face immediately before wider notification. The CSP must use interpretation/translation facilities as required, including providing translated notices where needed, and must signpost individuals to available sources of support in the centre (see paragraph 32).

20. All individuals subject to the Assessment Care in Detention and Teamwork (ACDT) process at the centre where the death occurred, and those whose ACDT has entered post-closure, must undergo an urgent case review as soon as possible following a death in detention (see DSO 01/2022 Assessment care in detention and teamwork (ACDT)). This review must consider the individual's wellbeing and risk, and the adequacy and currency of the associated ACDT documentation. Completion of the urgent case reviews must be confirmed in writing to the Head of Detention Operations (Head of Escorting Operations for RSTHFs) and copied to the LFRL inbox (DSLitigation-FatalitiesandReflectiveLearning@homeoffice.gov.uk) once complete.

21. The local DS Compliance Team must be provided details of any planned and previous appointments or visits recorded for the deceased, including dates and times. This information must be made available to the FLO as soon as possible. The information must also be provided to the DS Litigation, Fatalities and Reflective Learning team by emailing: DSLitigation-FatalitiesandReflectiveLearning@homeoffice.gov.uk.

22. The CSP centre manager or nominated deputy must ensure that switchboard operators are told where any calls relating to the death should be transferred or directed. The CSP centre manager must ensure that a debrief, for all relevant staff, is held immediately after any death in detention with a senior member of staff acting as the debriefer. A member of the healthcare team should be in attendance. A record of

those in attendance and meeting minutes must be taken and kept securely in a restricted folder, with a copy sent to the IRC Service Delivery Manager and local DS compliance team for their records (see DSO 01/2016 Medical Information Sharing), ensuring that information sharing is in line with UK GDPR.

23. Arrangements should be made for the chaplain or other religious leader to hold a memorial service for the family, other detained individuals and staff, both employed and contracted (subject to any specific faith considerations and the views of the family, staff and detained individuals). Consideration should be given to holding this by video link to accommodate families where travel may not be possible. A service via video link should also be considered where security concerns are identified in conducting a service for large family groups.

Identification of potential witnesses to a death in detention

24. It is important that any staff or detained individuals who may be potential witnesses or have potentially relevant information relating to the death are identified at an early stage. Witnesses to identify include people who witnessed the incident, were on the scene or have knowledge of the circumstances of the death.

25. The DS Duty Head of Detention Operations (G7 or Escorting Operations G7 for RSTHF/escorting) is responsible for ensuring that Annex B (Witness Checklist) is completed by the IRC/PDA/RSTHF/escorting CSP and provided to the local DET lead (G7), the DS Head of Corporate Operations and Oversight Team (COOT) and the relevant DET G7 within 3 calendar days of the death.

26. On receipt of the completed Annex B (Witness Checklist), DET (or Escorting Operations for RSTHF/escorting) should work with the centre CSP to engage with people in detention who would be deemed as potential witnesses to complete Annex C (Detained Individual Witness Template) within 4 calendar days of receipt of the Annex B checklist.

27. The IRC/PDA/RSTHF/escorting CSP must ensure that completed Annexes B and C are sent to the DS Litigation, Fatalities and Reflective Learning team at :dslitigation-talitiesandreflectivelearning@homeoffice.gov.uk at the earliest stage possible for onward sharing with the coroner and PPO, where appropriate. Only information required to complete Annexes B and C should be taken from witnesses before the PPO begins its investigation. Home Office staff must not seek completion of Annexes B and C during the PPO investigation.

28. In addition, following notification of a death in detention, the local DET Team (or Escorting Operations for RSTHF) will work with the DS Senior manager (G7) and the centre CSP to identify individuals scheduled for removal within the next 7 days who may be potential witnesses. Those individuals must be met with urgency to complete Annex C, and their case owner must be informed as a matter of urgency. This will ensure that consideration can be given as to whether the witness's 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, as set out in published guidance Removal/deportation of witnesses (publishing.service.gov.uk) Information captured should record:

- 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
- The recording of a statement of evidence, where the individual is willing to provide one
- All relevant contact details of the individual, including in the country of proposed removal, where possible, including address, email address and telephone number

29. This information should be recorded by the local DET (or Escorting Operations for RSTHF/escorting) on the template in Annex C 'Detained Individual Witness Template.' All sections of this form must be completed before uploading to Atlas. The DET (or Escorting Operations 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. Detained Casework teams/management must consider the information supplied in the Annex C template when deciding whether the removal of any witness remains appropriate and, where removal is not appropriate, whether detention should continue. Any decision to pause a witness's removal or removal directions, where set, will require Casework SCS approval.

30. Direct witnesses of the incident may need specialised support and should be made aware of all avenues of available support as soon as possible. Paragraphs 32 and 33 of this DSO refer to available methods of support for staff and detained individuals.

Retention of documents and property

31. It is vital that all documentation and property relating to the deceased and their death is retained for the duration of all investigations and conclusion of any legal proceedings. As soon as possible after the death, all documentation must be gathered 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 paragraphs 12 and 13)
- Prison files, if applicable
- Wing/unit files including wing observation books
- Local detention files

- Casework/Home Office file is to be requested by the local Compliance Team or Escorting Operations (for RSTHF/escorting) from the caseworking 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 use of restraints or Removal from Association and Temporary Confinement, including the centre's emergency response procedures.

- Any evidential video footage (CCTV, handheld video, or body worn camera), phone records, radio logs, and room call logs.

- Any other evidential information or documentation including relevant risk assessments, and copies of statements made by potential witnesses.

- Any/all ACDT paperwork for the detained individual

- Any current or historical care plans 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.

- This information should be made available to the DS Litigation, Fatalities and Reflective Learning team on request, to enable sharing for the coronial inquest or procurator fiscal investigation, where appropriate.

Support for staff and detained individuals

32. Centre CSPs must ensure detained individuals affected by a death in detention are signposted to appropriate support, including the welfare office or designated support lead, healthcare, chaplaincy or faith provision, and any other available services. Where practicable, individuals who shared a room with, or were known to be close to, the deceased should be offered support as soon as possible after being informed. CSPs must ensure that translation or interpretation is used where needed so that detained individuals can understand the support available. The notice issued under paragraph 19 must also explain that individuals may speak to the police and/or PPO investigator if they have information that may be relevant to the death.

33. DS managers must ensure that procedures are in place to support Home Office staff appropriately throughout the investigation process, through access to the Employee Assistance Programme (EAP) and access to the Mental Health First Aider (MHFA) network, of which details are available on the Home Office Intranet hub. 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 inquiry because 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

Support for detained individuals under ACDT

34. When a death occurs in any centre, or on escort, centre CSPs must undertake an ad-hoc assessment of all open and post-closure local ACDT files. Formal ACDT reviews must be completed and documented as soon as possible for individuals 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 particularly impact individuals of that nationality or 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 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.

35. If the deceased was discharged from the centre in the previous 4 weeks, a formal ACDT review must be completed for those who are considered particularly vulnerable to the news and at increased risk of self-harm or suicide, such as previous roommates, friends that shared a room with the individual in the centre (buddies through the onsite buddy system for example), or who was on an open ACDT at the time of the person's death.

Reporting Process

36. DS and IRS Escorting Services operate an on-call structure, with a weekly rota (see DSO 05/2015 - Reporting and Communicating Incidents in the Immigration Removal Estate).

37. Contact details for on-call officers and Family Liaison Officers (FLOs) are circulated weekly in advance by DS It is the responsibility of each local DS Compliance team to provide the DS on-call list to the centre CSP at their centre as soon as it is available. Local arrangements should be put in place to ensure that all staff operating at the centre (e.g., healthcare) are aware of how to raise an incident through a single point, for example the IRC CSP.

38. The three Compliance on-call levels for centres are:

- A local DS Compliance on call officer (EO/HEO) for each IRC who is the initial out of hours point of contact for IRC CSP and Home Office staff based at IRCs.

- A DS rostered or duty on-call senior manager (SEO or above), who is the first point of contact for the local Compliance team on call officer to report and escalate a category Red or Amber incident (see DSO 05/2015 - Reporting and Communicating Incidents in the Immigration Removal Estate), which would include a death in detention.

- The DS Duty Head of Detention Operations (Grade 7 or above), who is the point of escalation for the IE on-call manager in the event of a Red or Amber incident. The DS Duty Head of Detention Operations can also be contacted directly if the DS rostered or on-call duty senior manager is not available.

39. For escorting matters and short-term holding facilities, the Detention Services Detainee Escorting and Population Management Unit (DEPMU) provides a 24-hour duty officer. Where an issue is complex or requires escalation, the DEPMU/Escorting Operations senior on-call manager will be contacted.

40. Where required, the DEPMU/Escorting Operations senior on-call manager will escalate Red incidents to the DS rostered or duty on-call senior manager, the Duty Head of Detention Operations (Grade 7 or above) and DS Deputy Director (SCS). Amber incidents will be escalated to the DS rostered or duty on call senior manager and Duty Head of Detention Operations (Grade 7 or above). Where the incident concerns short-term holding facilities, it will also be escalated to the International Returns & Services Leadership team.

41. The DS Security Team provides on-call support to DS and IRS operational teams and may be contacted where an estate-wide security bulletin needs to be circulated.

42. Any contact by the Compliance team with the rostered or duty on-call senior managers should be made to their mobile telephone number, failing which, the Duty Head of Detention Operations should be the second point of contact. Officers who know they are not going to be available for short periods should arrange in advance for their mobile telephones to be diverted to a colleague who is competent and authorised to undertake on call duties.

43. Incidents in IRCs should be reported to the most senior member of the on-site Compliance team on duty who will then escalate as appropriate. If there is no member of the team on site, notification should be made directly to the local DS on-call officer.

44. All incidents should be reported in line with DSO 05/2015 Reporting and communicating incidents. Incidents that begin during regular working hours must be appropriately handed over to the rostered or duty on-call senior manager and, where necessary to the Duty Head of Detention Operations. The rostered or duty on-call senior manager and/or Duty Head of Detention Operations must be copied into local incident notifications and any update thereafter, with a courtesy phone call made from the Service Delivery

Manager, or their deputy, to brief the oncoming staff of the situation before logging off at the end of their working day. Where possible, a decision on whether an incident should be circulated to the wider incident copy list should be made before 5pm. This timing provision applies only to general incidents. In the event of a death in detention, the full incident copy list must be notified immediately and without exception.

45. The Head of DS or IRS Escorting Services senior manager (Grade 6 or above), or DS Duty Head of Detention Operations (Grade 7 or above) (whoever is in command) will consider and, if appropriate, commission an internal review or independent investigation into incidents where a death has occurred.

46. Where a death occurs in the PDA, follow the PDA specific requirements at paragraphs 16 to 18 (including actions in relation to accompanying children, local authority engagement and NOK/FLO arrangements). In addition, during office hours the death must be reported immediately to the Head of Detention Operations. Out of office hours, the death of a child must be reported immediately to the relevant rostered/on call duty senior manager (SEO or above) and the Duty Head of Detention Operations (G7 or above).

Home Office's responsibilities and actions

47. Once notification of a death in detention is received, the local DS Compliance Team or Escorting Operations manager, on site or on call, must immediately contact the relevant rostered or duty on-call senior manager (SEO or above). If they cannot be reached, they must contact the DS Duty Head of Detention Operations (Grade 7 or above).

48. When a fatality has occurred, it is the responsibility of the centre DS Compliance Team area manager (SEO or above) or Escorting Operations manager (on site or on call) or DS rostered or duty on-call senior manager (SEO or above) to function as the Single Point of Contact (SPOC) for the centre.

49. The DS SPOC 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. It is the responsibility of the DS SPOC to pass the details of the named next of kin to the FLO (see paragraph 74). The DS SPOC in consultation with the Head of Detention Operations or Head of Incident and Counter Corruption Hub and the DS Family Liaison and Implementation Co-Ordinator (FLIC) (during office hours) or the Duty Head of Detention Operations (Grade 7 or above out of hours) 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 DS SPOC must confirm when the police are able to contact the named next of kin (see paragraphs 64 and 68).

50. The DS SPOC or Escorting Operations G7 for RSTHF/escorting is responsible for ensuring that the Annex B process is completed within the timescales set out at paragraph 25.

51. In accordance with DSO 06/2013 (Reception, Induction and Discharge Checklist and Supplementary Guidance), next of kin details for all detained individuals should be recorded as special conditions on ATLAS, and also be available on the CSPs 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 DS SPOC:

    - If next of kin details were provided to the healthcare provider
    - If the individual's local file, any legal correspondence received, or property, including stored property contain any indication of a next of kin
    - If the CSP local detention records and/or prison files or visits records for the deceased contain any mention of someone close to them
    - Arrange for the local DS Compliance Team (or Escorting Operations for RSTHF/escorting) to liaise with the responsible case-working team to access the Home Office immigration file and identify any indication of a next of kin. Where required, DET should support this activity by sharing any next of kin details obtained during engagement/induction and any relevant links identified on Atlas. Out of hours, requests should be escalated via the local on call list
    - Notify the Home Office caseworking team so they can contact the legal representatives who were acting for the deceased, and any previous establishment where the deceased had been detained, as soon as possible.
    - Arrange for the FLO, with the assistance of Returns Logistics, to contact the individual's Embassy or Consulate to help identify family members in the individual's country of origin; 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 any contact details for members of the deceased's family

52. The DS SPOC (SEO or above), Escorting Operations for RSTHF/escorting or DS rostered or duty on-call senior manager should carry out notifications of the death, following the guidance set out in DSO 05/2015 Reporting incidents.

53. The Head of Detention Operations (during office hours) or Duty head of Detention Operations (out of hours) will inform the following people/teams of the death via email (marked 'urgent') 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 60):

    - Immigration Minister's Private Office or Private Office out of hours
    - Immigration Enforcement Secretariat

- Director of Returns
- Director of Immigration Detention
- 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 54 & 55
- His Majesty's Chief Inspector of Prisons (HMCIP)
- Prisons and Probation Ombudsman (PPO) – see paragraphs 96 to 101.
- Litigation Operations
- FNORC Secretariat (for deaths of former FNOs who have transferred into the detention estate)
- Independent Advisory Panel on Deaths in Custody (IAPDC) (iap@justice.gov.uk)

54. 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.

55. If the death occurs over a weekend, public holiday or out of hours, the DS Duty Head of Detention Operations (G7 or above) 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 DS Duty Head of Detention Operations must then inform the diplomatic mission directly and confirm via email to the Returns Logistics Senior Management Team, ReturnsLogisticsSMT@homeoffice.gov.uk. If the deceased was an asylum applicant, whether the application was outstanding or concluded, this must not be disclosed to the diplomatic mission.

56. The DS Duty Head of Detention Operations (G7 or above) will agree press lines with the Home Office News Desk out of office hours.

57. The DS SPOC must inform all the other IRCs of the death as soon as possible, via the onsite/on-call DS rostered or duty on-call manager at SEO grade or above, so that each centre can undertake an ad-hoc assessment of all open and post-closure local ACDT files. Each centre's Duty Operations Manager must provide written confirmation

to the centre's Area Manager and Compliance Team once all required assessments have been completed. The DS SPOC must confirm to the Head of Detention Operations and the LFRL inbox when confirmation has been received from each centre.

58. If notification is received that a person has died in hospital after being released from detention, or after being released into the community, including where the individual is now overseas (e.g. following removal to another country), and the death was the 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 6), the local Home Office DS SPOC must liaise with the deceased's responsible caseworker. They must agree which of the family liaison, reporting, notification, review and submissions actions at paragraphs 49, 52 to 57, 59 and 60 are required, taking into consideration the circumstances of the death (including location), and who will be responsible for taking them forward.

59. The PPO has the discretionary power to investigate a death after release. Should the PPO decide not to exercise discretion in these circumstances, the Deputy Director of DS or the Head of Detention Operations may commission a review of the circumstances of the death. to establish whether any lessons can be learned to prevent similar future deaths. Based on the circumstances of the death, the DS SPOC 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.

60. The local DS Service Delivery Manager (Grade 7) 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 or by the next working day should the death occur on a weekend or public holiday.

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

61. The Home Office has a small network of trained FLOs and where practical it will be the role of the FLOs 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 DS SPOC in consultation with Head of Detention Operations or Head of Incident and Counter Corruption Hub and Family Liaison and Implementation Co-Ordinator (FLIC) (during office hours) or DS Duty Head of Detention Operations (out of hours) will make the decision who is best placed to deliver the news (see paragraph 49). The following factors will be considered when reaching that decision:

    - Geographical location and the speed at which the FLO can relay the news of the death. 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. News of a death should never be delivered in person alone. Checks will also need to be completed to determine any risks that could be encountered (see paragraph 68).

- Any relevant religious or cultural considerations when visiting the family home.

62. The role of the FLO is to be the named point of contact for the family or next of kin of the deceased person. They will not manage any actions flowing from the death in detention. The role of the FLO starts once the family has been notified of the death. If it is the police who deliver this news, the FLO will maintain contact from this point onwards and provide practical support and information where appropriate and as requested by the named next of kin. If the family do not want contact with the Home Office, their wishes will be respected.

63. The details of the weekly FLO on-call are provided on the DS and IRS Escorting Services On-call weekly rota.

64. Where it becomes the role of the police to break news of the death to the next of kin, at first contact with the police, the FLO 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 DS SPOC in paragraph 48), the Home Office FLO should raise this with the Head of Detention Operations, Head of Incident and Counter Corruption Hub and FLIC or the Duty Head of Detention Operations out of hours, who will decide 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.

65. The FLO must consult the family of the deceased on how they would like to retrieve their relative's belongings.

66. If the family or named next of kin does not wish to have support from the FLO, then the FLIC, in conjunction with the caseworking team, will identify a named individual to maintain contact with the family or named next of kin in place of the FLO.

67. The FLO must commence a case log for all engagement relating to the death. Every contact with the family and their representatives must be recorded accurately, transparently and at the earliest opportunity. The PPO will want to see the log as part of their investigation, and this should be made available upon request.

68. 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 a resident in the UK, then all attempts will be made to make and maintain contact in person by the Home Office FLO. Where there is no named next of kin, the FLO will make attempts to identify one. This may include contacting the appropriate embassy, high commission or consulate and, where

appropriate, speaking to other detained individuals who may be able to provide further contact details (see paragraph 51).

69. It is not always possible to deploy two FLOs to work together when meeting the family or named next of kin (NOK) in person after the death has been communicated. All Home Office FLOs, in liaison with the FLIC, have a personal responsibility to conduct a full risk assessment before any direct, in-person contact with the family or NOK; this must include, but is not limited to, a Police National Computer (PNC) check. FLOs within Detention Operations will be deployed and supported by the DS FLIC. Where two FLOs cannot be deployed, another designated Home Office staff member may accompany the FLO for the visit.

70. FLOs may also be deployed in cases of medical emergency, terminal illness, or where medical advice indicates 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, subject to the detained individual's consent where they are conscious. See DSO 06/2026 Inpatient hospital admissions for people detained under immigration powers.

71. The FLO must ensure a copy of the Home Office information leaflet for bereaved families (in a language they understand where available) is provided to the named next of kin at the earliest and most appropriate time. Several organisations can provide support at both a local and national level. FLOs should identify appropriate agencies and understand how they operate locally so they can 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

72. A letter of condolence should be sent to the family with minimal delay once the named next of kin has been identified. The letter should be issued on behalf of the Deputy Director of DS (or another nominated senior Home Office official). The author/drafter must liaise with the Home Office FLO to ensure the content is appropriate and that any logistical arrangements for its dispatch are properly coordinated. The method of issuing the letter may vary depending on the circumstances of the case. When authorised by the police, the FLO will arrange the handover of personal possessions and monies, keeping a list of items handed over and obtaining a receipt.

FLO notification process

73. FLOs should be notified of the death in detention by the local DS Area manager (SEO or above) during office hours or the rostered or duty on-call senior manager (DS SPOC) for out of hours/Escorting Operations for RSTHF/escorting, via both a

telephone call and an email to the Detention Operations FLO inbox as soon as possible.

74. 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, and the CSP staff at reception with any changes or new information updated during the individuals stay made in the centre) and, if possible, an indication as to whether an interpreter is required
    - 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 CSP or healthcare provider 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)
    - A single, designated point of contact must be provided for the FLO, normally the DS SPOC, to ensure consistent and accurate information gathering. Onsite Compliance or Escorting Operations staff may support this process, but all information should be coordinated through the DS SPOC.

75. The duty FLO will act as the point of contact for the family or named next of kin. A FLO log must be opened for each case, irrespective of level of contact.

76. There may be circumstances where the CSP has a trained FLO at the centre during office hours. They should **not** be deployed until the Home Office FLIC has authorised this to happen.

77. 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), FLIC **and** the local DS Service Delivery Manager (G7) or Head of Detention Operations, in addition to a CSP senior manager.

78. It is important that deployed FLOs are given time away from their normal duties to fulfil this valuable role. To maintain clarity and professional boundaries, where possible,

staff who are significantly involved in any investigation into the death should not be deployed as FLOs unless strictly necessary. Any concerns should be raised to the DS Head of Incident and Counter Corruption Hub or DS FLIC.

Learning from a death

79. The CSP must hold a hot debrief as soon as practicable after the immediate actions in response to a death have been completed. The purpose of the hot debrief is to support staff welfare and capture immediate learning while events are fresh.

80. The CSP must then undertake a lessons learned review (LLR) as soon as practicably possible, subject to known facts and ensuring that independent investigations are not compromised. The purpose of the LLR is to identify factors that need to be addressed to mitigate against future deaths in detention of the same nature. The outcome of the LLR must be shared with the Head of Detention Operations and the DS Fatalities and Reflective Learning team: Litigation, Fatalities and Reflective Learning Inbox. This requirement also applies to the relevant manager for the escort provider, who must send the outcome of the LLR to the Head of Escorting Operations and the DS Fatalities and Reflective Learning team.

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

82. To ensure that lessons are learned following a death, the Home Office will arrange for a multi-agency lesson learned review to take place as soon as practical after the death has occurred and once the PPO has had an opportunity to engage with the relevant witnesses,, where this is possible and does not delay necessary immediate learning.. These reviews will consider the information available immediately or shortly after a death.

83. Attendees at a lesson learned review must participate fully and share information that is necessary and proportionate to support a full understanding of the circumstances of the death, organisational learning and service improvement. Information relating to a deceased person is not protected by UK GDPR; however, it should be handled sensitively and in line with wider legal, ethical and organisational considerations. Any information relating to living individuals must continue to be handled in accordance with UK GDPR, Data Protection Act 2018, and relevant information governance requirements. Healthcare information may be shared for the purposes of the review where this is necessary, justified and proportionate, but remains subject to the common law duty of confidentiality and must be handled securely and must only be disclosed where there is a clear justification. Information disclosed during the review must be limited to what is relevant to the review, recorded appropriately as part of the audit trail, and must not be shared more widely unless there is a clear and lawful basis to do so.

84. Lesson 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 more widely without prior approval from the Deputy Director of DS, except where disclosure is required to support an independent investigation.

85. Independent investigations will take primacy over this review and any other internal (CSP 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 identified through the review should immediately be reported to the DS Incident and Counter Corruption Hub who will raise this directly with the PPO, and appropriate action taken. Any suggestion of criminal action must be reported to the police.

86. Lessons learned reviews will be chaired by the Deputy Director of DS, or nominated delegate, and will include representation from HOIE (both DS and DET), IRC, RSTHF or escorting CSP, healthcare provider and IMB for the centre. An invitation to attend will also be extended to the Independent Advisory Panel on Deaths in Custody.

Funeral and repatriation arrangements

87. The Home Office will contribute towards the reasonable cost of a funeral or cremation within the UK or provide an amount broadly equivalent to reasonable UK funeral costs towards repatriating the body or cremated remains to the country of origin and funeral arrangements in that country. **These decisions must be authorised by the Head of Detention Operations.**

88. As a guide, reasonable funeral costs include:

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

89. The Home Office point of contact for the funeral and repatriation arrangements should be the FLO; however, where the family or named next of kin does not wish the FLO to be involved, the DS SPOC or nominated deputy at SEO grade or above, must assume the liaison role normally undertaken by the FLO.

90. Upon receipt, the funeral director's invoice (required on company headed paper) can be paid by the FLO using an authorised Government Purchase Card (GPC). The FLO must seek approval from the Head of Detention Operations to approve this payment. The invoice must then be sent to the Home Office Finance Team to approve as a one-off expenditure.

91. Once the funeral, cremation or repatriation date has been set, Immigration Enforcement Secretariat, the Litigation, Fatalities and Reflective Learning Inbox and Press Office should be provided with an update by the Head of Detention Operations.

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

Investigations following a death in detention

Police Investigation

93. All deaths in detention are treated as suspicious by the police and the police investigation will have primacy over all other investigations. The police have a national memorandum of understanding with the Prisons and Probation Ombudsman (PPO) as to how an investigation will proceed when there may be evidence of a crime.

94. Centre CSP staff and all onsite Home Office staff must comply with the police and PPO investigations, and the subsequent coronial or Procurator Fiscal 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. The local DS manager (G7) / Escorting Operations manager is responsible for working with the CSP to identify all individuals who may be a potential witness or have potentially relevant information relating to the death.

95. The completed Annex B will be provided to the coroner and the PPO by the DS Litigation, Fatalities and Reflective Learning team. CSP, healthcare and Home Office staff must keep a record of key documents that may be relevant to investigations. The Home Office SPOC, supported by the relevant local lead and the DS Litigation, Fatalities and Reflective Learning team, must ensure relevant information and documents are collated and made available to investigation teams as required. This ensures a single, consistent Home Office liaison route and avoids conflicting or incomplete information being provided to the coroner or procurator fiscal.

Prisons and Probation Ombudsman (PPO)

96. 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.

97. The HOIE Duty Manager (G7 or above) must notify the PPO of all deaths by completing the notification form at Annex A and sending to:

'PPOFIIAdmin@ppo.gov.uk' This must contain accurate and detailed information. A copy of Annex A should also be sent to DS Litigation, Fatalities and Reflective Learning team inbox at Litigation, Fatalities and Reflective Learning Inbox..

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

99. For the duration of each PPO investigation, there should be both a Home Office single point of contact (SPOC) for the centre, usually the DS SPOC at SEO grade or above, and a CSP single point of contact to support the PPO. This responsibility must not sit with the FLO or FLIC. Where the DS SPOC does not have capacity or is unavailable, a designated deputy SPOC may assume this role to ensure continuity of engagement with the PPO. The Home Office SPOC (or their deputy) will act as the primary liaison point for the PPO throughout the investigation, ensuring timely coordination, provision of information, and clarity of communication.

100. During 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.

101. After each investigation, the PPO shares a written report 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, identifying the deceased. The initial and final reports may also be shared with any other interested parties, such as the CSP, healthcare provider or staff union representatives.

Coroner's Inquests

102. In England, Wales and Northern Ireland, a coroner's inquest is held for all deaths in detention. An inquest is 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 support should be made available to them in such circumstances. As indicated, (paragraphs 28 and 29), detained individuals, or former detained individuals, who witnessed the death may also be required to give evidence at inquest. This may be facilitated by pausing their removal from the UK pending the inquest taking place or, alternatively, by video link from abroad, or returning the person to the UK at the time of the inquest.

103. 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 responses on the Chief Coroner's website.

104. For Scotland, the equivalent is the procurator fiscal (who works within the local sheriffdom) and decides whether it is appropriate to hold a fatal accident inquiry. Fatal accident inquiries are presided over by a sheriff, who will issue a 'Determination' once the inquiry has concluded. It is standard for the Determination to be published on the Scottish Courts' website within days of it being sent to parties without a HO response. The Scottish Court rules allow 8 weeks for a response to be provided.

105. 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.

Training

106. The CSP initial training course must contain information that supports this instruction and must be refreshed bi-annually. CSPs must keep a record of training attendance and submit completion results to the DCO Training Oversight Team (DTOT) within one calendar month of training completion VCAT-DCOTrainingoversight@homeoffice.gov.uk.

Self-audit

107. CSPs are required to complete an annual self-audit of adherence to this DSO to ensure that the processes are being followed and recorded. This audit should be made available to the Home Office on request.

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

Review date	Reviewed by	Review outcome	Next review
April 2026	Dean Foulkes	• Further clarification of the role of the FLOs and strengthening the notification process of next of kin and completion of all annexes, particularly the identification of potential witnesses. • Adding clarity to the engagement of centre staff and the notification to the PPO, review of guidance for funeral and repatriation arrangements.	April 2028
July 2026	C Dance-Jones	• Strengthening the CSPs responsibilities and actions • Introduction of the DS Family Liaison & Implementation Co-Ordinator role. • Removal of the Family Liaison Co-ordinator role. • Inclusion of the DS Incident and Counter Corruption Hub. • New responsibility for CSPs to share witness lists with DETs for the purpose of prioritisation.	July 2028

Annex A – PPO Notification Form

(To be sent to (PPOFIIAdmin@ppo.gov.uk)

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	
Family Liaison Officer (FLO)	
Support Officer (SO) /DS SPOC	
Centre contact details (if known)	*Name, number, email*

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 or Vulnerable Adult Care Plan?	
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 whilst in hospital*
Reason for release from detention (if applicable)	*i.e., They were 'administratively released' following doctor's advice that further medical intervention would not be successful, and the doctor advised life support would be turned off.*

Additional information:

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

Annex B – Witness Checklist

To be completed by the CSP.

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 (CSP, HOME OFFICE, HEALTHCARE)		
Reference Number	**FULL NAME**	**ROLE**
COMMAND SUITE STAFF		
Reference Number	**FULL NAME**	**ROLE**
OTHER STAFF INVOLVED (CSP, HOME OFFICE, HEALTHCARE)		
Reference Number	**FULL NAME**	**ROLE**

DETAINED INDIVIDUALS WHO WITNESSED INCIDENT		
Reference Number	**FULL NAME (including any aliases)**	**REASON (e.g., responded to incident)**
OTHER DETAINED INDIVIDUALS INVOLVED		
	FULL NAME (including any aliases)	**REASON (e.g., entered scene, in area)**
OTHER DETAINED INDIVIDUALS WITH POSSIBLE KNOWLEDGE OF CIRCUMSTANCES OF DEATH		
	FULL NAME (including any aliases)	**REASON (e.g., shared room, known associate, claims to have relevant information)**

Annex C – Detained Individual Witness Template

(To be completed by the Detention Engagement Team (DET) or Escorting Operations for RSTHF/Escorting)

Detained Individual who witnessed incident on __/__/__		
1	**Full Name (including any aliases)**	
2	**HO reference number**	
3	**Reason (taken from details contained in Annex B checklist)**	
4	**Are they willing to provide a statement to the Police or PPO? 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.***	