Ministry of Justice | Home Office | Department of Health & Social Care

Independent Advisory Panel on Deaths in Custody

Chair: Juliet Lyon CBE
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Phil Riley
Head of Detention & Escorting Services
Immigration Enforcement, Home Office

Dear Phil,

Priorities for a prevention of deaths strategy in Immigration Removal Centres

In 2018 the Home Office asked the Independent Advisory Panel on Deaths in Custody (IAP) to provide advice on issues pertaining to deaths, 'near misses', and incidents of serious self-harm in immigration detention. This request was made in support of three recommendations relating to deaths in detention made by Stephen Shaw in his independent *Review into the Welfare in Detention of Vulnerable Persons* in 2016. These were:

- Recommendation 34: The Home Office should review whether figures relating to deaths in and after detention should be issued on a regular basis.
- Recommendation 37: That the Home Office commission research into deaths in immigration detention, 'near misses' and incidents of serious self-harm.
- Recommendation 38: The Home Office should devise and publish a strategy for reducing the number of deaths from natural causes and those that are self-inflicted in, and shortly after, immigration detention.

The IAP was provided with information from the Home Office relevant to these recommendations and supplemented this with additional research findings. Professor Seena Fazel, Professor of Forensic Psychiatry at the University of Oxford and an IAP member, gave advice on research and research priorities.

A consultation was carried out with staff members at Colnbrook Immigration Removal Centre in November 2019. This consisted of a roundtable discussion with eight members of staff of differing grades and teams from private provider Mitie. The IAP also undertook a tour of facilities at Colnbrook IRC ahead of the consultation led by John Wadham, Chair of the National Preventative Mechanism and IAP member. John Wadham also attended a 'Lessons Learned Review' following the death of an individual at Harmondsworth IRC. It was held a few weeks after the death and was the second review that had occurred to determine what lessons could be learned from this particular death.

Our final report contains 24 specific deliverables for a Home Office strategy grouped into the following six themes:

1. *Transform the transparency of policy, data and other information around deaths in the immigration estate to improve accountability and lessons learned.*
2. *Dedicate resource and focus on building a greater understanding of those at risk and scope for support from family and friends.*
3. *Reconsider the immigration population in the context of the impact of detention on the mental health of detainees*
4. *Take steps to ensure adequate healthcare provision to suit the needs and circumstances of the immigration population.*
5. *Provide staff with appropriate training, tools, and supervision to support detainees and identify signs of physical and mental health risk.*
6. *Improve learning processes and ensure public, independent, transparent investigation.*

We were grateful for the opportunity to present our findings to the Home Office's Immigration Detention Reform Board on 29 October, and look forward to working with you and colleagues to progress this important work in the coming months.

With kind regards,

Juliet Lyon CBE
Chair, Independent Advisory Panel on Deaths in Custody