Independent Advisory Panel on Deaths on Custody

Priorities for a prevention of deaths strategy in Immigration Removal Centres

Advice to the Home Office: Shaw report recommendations

October 2020

About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel (IAP)
- Practitioner and Stakeholder Group

The remit of the IAP (and overall of the Council) covers deaths, natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents in approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAP, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAP's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAP. The other members are:

- John Wadham, Chair, National Preventative Mechanism
- Jenny Talbot OBE, Prison Reform Trust
- Professor Jenny Shaw, professor of Forensic Psychiatry, University of Manchester
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Deborah Coles, Director, INQUEST

Further information on the IAP can be found at https://www.iapondeathsincustody.org/.

For more information on this paper – or on the IAP more generally – please contact: Kishwar Hyde, Deputy Head of Secretariat (kishwar.hyde1@justice.gov.uk).

Contents

Introduction

1. In accordance with the functions of its terms of reference, the Independent Advisory Panel on Deaths in Custody was asked in 2018 by the Home Office to provide advice on issues pertaining to deaths, 'near misses', and incidents of serious self-harm in immigration detention[1]. This request was made in support of three recommendations relating to deaths in detention made by Stephen Shaw, former Prisons and Probation Ombudsman, in his second review of immigration detention[2].

    - *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.*

2. Two people died while being held solely under immigration powers in detention in 2014. In 2015 there were two deaths, one in 2016, four in 2017, one in 2018 and one in 2019.[3]

Methodology

3. The IAP has been provided with information from the Home Office relevant to these recommendations and has supplemented this with additional research findings. This includes a review of the Prison and Probation Ombudsman (PPO) and coroners' prevention of future deaths reports, as well as fatal incident summaries and ACDT (Assessment Care in Detention and Teamwork) and self-harm data. Professor Seena Fazel, Professor of Forensic Psychiatry at the University of Oxford and IAP member, gave advice on research and research priorities.

4. The IAP carried out a consultation with staff members at Colnbrook Immigration Removal Centre (IRC) 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 attended a 'Lessons Learned Review' following the death of an individual at Harmondsworth IRC in September 2019. 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.

[1] For the purposes of this review, a death in immigration detention comprises deaths that occur in Home Office administered immigration removal centres, or the death of a foreign national offender in Her Majesty's prison estate.
[2] Home Office, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons' <https://www.gov.uk/government/publications/welfare-in-detention-of-vulnerable-persons-review-progress-report> accessed 18 June 2020.
[3] Home Office, 'National Statistics' <https://www.gov.uk/government/publications/immigration-statistics-year-ending-june-2019/summary-of-latest-statistics> accessed 18 June 2020; Casework by the charity INQUEST includes after detention deaths. See INQUEST, 'Deaths of immigration detainees', https://www.inquest.org.uk/deaths-of-immigration-detainees> accessed 18 June 2020.

Towards a Home Office strategy for eradicating detainee deaths

5. This paper is split into four sections. The first looks at data on deaths, definitions and notifications, advice on which the IAP understands has been put to and agreed by Home Office Ministers. The second briefly reviews existing literature on deaths in immigration detention. The third summarises and draws conclusions on the suitability of current immigration policies. The fourth summarises findings from the sources provided to the IAP by the Home Office. The conclusions drawn from discussion in the main body of this paper are summarised in the final section.

6. The IAP's expertise covers all places of state custody. Learning from best practice, or at least better practice, within other places of detention is included where appropriate in this analysis. Cross-sector learning and collaboration should be embraced where possible, with the National Suicide Prevention Strategy a good example of how this can be delivered in practice.[4]

7. However, cross-setting comparisons are not required to reach many of the key conclusions of this report. Most importantly, this includes the need to better identify and respond to people with mental or physical health needs within detention settings and to provide reliable healthcare provision that identifies potential concerns at a sufficiently early stage to prevent further deterioration which could otherwise lead to death.

8. It is important to recognise that people detained in IRCs have characteristics, outlined below, that differ from other custodial populations and are unique to the immigration estate. There are also notable differences, and sometimes tensions, between people who have been received into IRCs having served time in prison custody and those who have been received directly from the community or Border.

    a. Someone detained in prison may have had regular access to healthcare within the community and therefore have a greater awareness of their own health needs. This may not be the case for people detained in IRCs, who may have received varying levels of healthcare from different countries or might not have had recent access to healthcare in the UK.
    b. There is a greater need to be aware of, and adequately address, factors such as language barriers, greater distance of family members, and differences in culture and diet within the immigration population.
    c. The population of an IRC does not represent the local community in which the removal centre is situated. This means the community information sharing processes used, for example, within the prison service, are not usually applicable. Furthermore, this population tend to be placed in centres far away from their local community, again making it difficult for detainees to access advice and for information to be shared.

9. The IAP welcomes its involvement in this important work. In drawing conclusions, this report highlights areas where the IAP can continue to lend expertise, as well as key work that could be taken forward by the Ministerial Board on Deaths in Custody, to which the IAP provides advice.

[4] HM Government, 'Preventing suicide in England - A cross-government outcomes strategy to save lives'<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf> accessed on 18 June 2020.

10. In drawing its overall conclusions, the IAP endorses the sentiment, made by Stephen Shaw in his follow-up review, that *"fairness and transparency are key, in this area of public policy as in any other."*[5]

While the Home Office is not currently considering an implementation of detention time limits, the IAP repeats the calls made by many, including recently by a group of Conservative MPs[6], for a 28-day time limit on detention to limit its damaging impact on the mental health of those held under immigration powers.

[5] Stephen Shaw, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons - A follow-up report to the Home Office' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728376/Shaw_report_2018_Final_web_accessible.pdf> accessed 18 June 2020.

[6] Toby Helm and Mark Townsend, 'Tory rebels call for 28-day limit on detention of migrants' The Guardian (London, 22 June 2020) <https://www.theguardian.com/uk-news/2020/jun/27/tory-rebels-call-for-28-day-limit-on-detention-of-migrants> accessed 20 June 2020.

Data, notifications and definitions

11. Stephen Shaw's review raised a lack of transparency as a key concern, particularly around statistics concerning deaths which occur within IRCs. Only the number of deaths that occur in detention are currently available online and only published annually. This information is difficult to find and not disaggregated according to characteristics (age, sex, ethnicity), and place or cause of death (whether as a result of natural causes or other factors). In addition, there is a lack of published information in relation to the number of detainees on an Assessment Care in Detention and Teamwork (ACDT) due to the risk of self-harm.[7]

12. There are also questions around the adequacy of the current definition of a 'death' in immigration detention. Firstly, deaths that occur shortly after an individual leaves an IRC are not currently considered or reported as a death in immigration detention. The death is noted by the Home Office, though the PPO is afforded a level of discretion as to whether they investigate the death or not. This undermines the opportunity for learning from these cases (though lessons learned exercises are still carried out in the absence of a PPO investigation).

13. Secondly, HMPPS, not the Home Office, collect and hold data on those who die in prison while being held under immigration powers (although this is not differentiated). As these individuals are detained by the Home Office, responsibility for learning lessons from such cases should at least partly fall to this department.

Learning from: community and prison data sharing and definitions

14. Within the community, published information on suicides, for example, is broken down into several different categories such as suicide method, suicide pattern by age and geographical location.[8]

15. For deaths in prisons, HMPPS publishes quarterly updates on all deaths (self-inflicted or other) in standalone Safety in Custody reports. The published data is also separated into several different categories such as age, gender, race, ethnicity, type of sentence, type of death (natural, self-inflicted, other) and method, among others.[9]

16. In addition, HMPPS defines a 'death in prison custody' as any death of a person in prison custody arising from an incident occurring during (or, on rare occasions, immediately prior to) prison custody. This therefore includes those who go to hospital under escort and remain in custody and those who are released on account of their injuries (on ROTL or bail etc).

17. Notifications of deaths are provided to key external stakeholders in the interests of transparency.

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[7] Home Office, 'National Statistics' <https://www.gov.uk/government/publications/immigration-statistics-year-ending-june-2019/how-many-people-are-detained-or-returned> accessed 18 June 2020

[8] Office for National Statistics, 'Suicides in the UK: 2018 registrations' <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations> accessed 20 July 2020

[9] Ministry of Justice 'Safety in custody quarterly: update to September 2019' <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2019> accessed 18 June 2020

Looking forward

18. Publishing a larger data set and expanding the definition of what is considered a ‘death’ within the immigration estate will permit greater independent scrutiny and promote greater learning. This data can also be used to support operational and strategic decisions, including building design and staffing deployment.

19. Issues with data reflect a need, identified by the Shaw review and many of the contributors who made representations, to move towards a wider culture of transparency within immigration detention. This includes independent and judicial oversight. These issues are referred to as a theme throughout the remainder of this paper.

Summary – principles for a prevention of deaths strategy:

- Improve transparency of data in relation to deaths in detention by improving Home Office website signposting and through publication of a quarterly statistical report. Provide disaggregated data covering ethnicity, age, location, possible risk groups, type of death.

- To improve transparency and enhance learning, expand the definition of a ‘death’ in an IRC, for example by collecting and publishing details of detainees who die in prison while under immigration powers and those who die shortly after leaving detention.

- Introduce reporting to mirror that of HMPPS to provide notification of deaths to key external stakeholders.

Existing research into deaths in immigration detention

20. Over the last twenty years, a significant number of high-profile inquiries, academic research and reports from expert groups have been published on the immigration detention estate concerning causes of deaths. This section briefly summarises these findings, especially with regard to self-inflicted deaths, and draws upon relevant research related to other custodial settings where appropriate.

Meeting mental health needs

21. Academic research, most notably Professor Mary Bosworth's review into the impact of immigration detention on both physical and mental health, repeatedly demonstrates that immigration detention is, in itself, damaging to the mental health of detainees.[10] In addition, those with previous mental health issues or previous trauma are particularly at risk of harm. It is widely accepted that the magnitude of the damage on mental health rises as the length of detention increases.[11]

22. Professor Bosworth's review also highlighted how relevant literature consistently called for *"more research access to understand these sites and the mental health needs of those within them better."*[12] The IAP is not aware of any scale prevalence studies on mental health in IRCs nor any robust studies on service requirements.

Learning from: mental health in prisons

23. Meeting mental health needs is also a key priority within the prison estate. The IAP's 2017 report *Keeping Safe* bought together views from 150 prisoners across 60 prisons to explore what had caused the increase in self-inflicted deaths up to 2016. It cited, among other factors, the need for prisons to meet mental health needs of their populations and provide mental health support to keep prisoners safe.

24. The 2017 National Audit Office report, *Mental Health in Prisons* noted that 31,328 people in prison (approximately 37% of the average monthly prison population) report having mental health or well-being needs at any one time, based on HM Inspectorate of Prisons surveys.[13] Furthermore, 7,917 people were recorded by NHS England as receiving treatment for mental illness in prison in England in March 2017. The PPO

[10] Stephen Shaw, 'Review into the Welfare in Detention of Vulnerable Persons. A report to the Home Office' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf> accessed 18 June 2020.

[11] A range of NGOs working in this area have reached similar conclusions around the harmful impact of detention on detainee mental health. See for example Freedom from Torture, 'Submission of to the Joint Committee for Human Rights inquiry into immigration detention' August 2018 < www.freedomfromtorture.org/sites/default/files/2019-02/Freedom_from_Torture_submission_to_the_Joint_Committee_for_Human_Rights_inquiry_into_immigration_detention_%28September_2018%29.pdf> accessed 28 August 2020; Medical Justice, September 2019, 'Failure to Protect from the Harm of Immigration Detention' < www.medicaljustice.org.uk/wp-content/uploads/2019/09/Failure-to-Protect-final.pdf> accessed 28 August 2020.

[12] Ibid.

[13] National Audit Office, 'Mental Health in Prisons: Report by the Comptroller and Auditor General', June 2017 <https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf> accessed 28 August 2020.

noted that in 2016, in over 500 cases investigated between 2012 and 2014, 70% of those who died by suicide had mental health needs at the time of their death.

25. The high occurrence of individuals with mental health needs within the prison population demonstrates how pressing an issue mental health treatment and the prevention of suicide and self-harm is within the prison estate. Further insight could be gathered by examining the difference, if there is one, between the number of deaths of those detained in IRCs and foreign national offenders detained in prison under immigration powers.

26. For those with pre-existing or prior needs, alternatives to detention should be prioritised. The Home Office policy contained within the Enforcement Instructions and Guidelines states that *"wherever possible, alternatives to detention are used"*, especially for those with mental health requirements. Progress has been made in minimising the use of immigration detention and exploring alternatives to detention through a presumption of granting immigration bail (the vast majority of individuals with no status in the UK live in the community).[14] However, this work to divert as many as possible from detention should be prioritised.

Learning from: alternatives to custody

27. There is precedent within the UK for providing alternatives to detention for the immigration population. Detention for children has been significantly reduced after a number of organisations successfully campaigned for its use for immigration purposes to be eradicated.[15] The Immigration Act 2014 banned the detention of unaccompanied children for more than a 24-hour period at any one time.

28. NHS England and NHS Improvement's Liaison and Diversion services place clinical staff at police stations and courts to assess and refer those with mental health needs, substance misuse or those known to be at risk of self-harm to the right sort of treatment and support that can help. Information can then be shared to inform sentencing and disposal decisions. In some instances, these individuals can be diverted from detention altogether.

<u>The links between self-harm and suicide</u>

29. Although self-harm is an important indicator of distress within an individual, it cannot be solely relied upon as the only potential indicator of suicide risk.

Learning from: suicide in the community

30. In 2018, the National Confidential Inquiry into Suicide and Safety in Mental Health found that out of all the suicides that occurred within the general population, only 29% of the individuals had a recent (three months prior to their death) history of self-harm.[16]

[14] Voluntary returns are also encouraged as a preference.
[15] UK Visas and Immigration, 'Chapters 46 to 62: detention and removals' <https://www.gov.uk/government/publications/chapters-46-to-62-detention-and-removals> accessed 18 June 2020.
[16] National Confidential Inquiry into Suicide and Safety in Mental Health, 'Annual report 2018: England, Northern Ireland, Scotland and Wales' <https://sites.manchester.ac.uk/ncish/reports/annual-report-2018-england-northern-ireland-scotland-and-wales/> accessed 4 February 2020.

31. This insight demonstrates that, while important, staff should not rely solely on a history of self-harm to predict suicide risk. Furthermore, it should be recognised that being placed in detention alone can make an individual vulnerable even if they do not display signs of vulnerability. This should be reflected in the suicide prevention training provided.

Uncertainty and hopelessness

32. In March 2015, the All Party Parliamentary Group (APPG) on Refugees and the APPG on Migration published a joint inquiry examining the use of immigration detention in the United Kingdom.[17] This cross-party report heard evidence from over 200 individuals and organisations. It drew attention to the uncertainty felt by detainees and how, while they may feel physically safe in their environment, the uncertainty around a detainee's case can make them particularly vulnerable. One person said:

> *"All these people here, and no one knows how long they will be there. Some lose hope, and they try to kill themselves. Some try burning themselves with whatever they can get. Some try hanging themselves in the shower. They think it's the only way out. I've seen this with my own eyes. Detention is a way to destroy people: they do not kill you directly, but instead you kill yourself."*[18]

33. Feelings of hopelessness are considered to be one of the most prominent cognitive factors associated with suicidality overall.[19] Similarly, uncertainty has also been found to have a negative impact on the mental health of detainees, who may hold negative beliefs about their future due to their personal circumstances.[20] This could be because they do not have a definite decision in relation to their case (as many detainees are waiting to hear the decision of the appeal cases).[21]

34. This may be particularly prevalent for Foreign National Offenders (FNOs), a term applied to anyone in prison who is either remanded on, or convicted of, criminal charges or breach of immigration laws, and who does not have an absolute legal right to live or remain in the UK. Due to their interaction with both the criminal justice system and the immigration system, foreign national offenders can face challenges over and above their national counterparts. Issues around resettlement and sentence progression can affect their mental health, while issues around accessing relevant information could cause additional stresses to already vulnerable individuals.[22]

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[17] All Party Parliamentary Group on Refugees & the All Party Parliamentary Group on Migration, ' The Report of the Inquiry into the Use of Immigration Detention in the United Kingdom' <https://detentioninquiry.files.wordpress.com/2015/03/immigration-detention-inquiry-report.pdf> accessed 18 June 2020

[18] Ibid.

[19] Helen Christensen, Phillip Batterham, Andrea Soubelet, Andrew Mackinnon, 'A test of the interpersonal theory of suicide in a large community-based cohort' (2013) 144(3) Journal of Affective Disorders.

[20] Stephen Shaw, 'Review into the Welfare in Detention of Vulnerable Persons. A report to the Home Office' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf> accessed 18 June 2020.

[21] Katy Robjant, Rita Hassan, Cornelius Katona 'Mental health implications of detaining asylum seekers: systematic review' (2009) 194 British Journal of Psychiatry. See also Stephan Shaw report

[22] Prison Reform Trust, 'Forgotten Prisoners – The Plight of Foreign National Prisoners in England and Wales' <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Forgotten%20prisoners%20-%20the%20plight%20of%20foreign%20national%20prisoners%20in%20england%20and%20wales.pdf> accessed 9th July 2020

Learning from: groups within the prison population

35. Research has found high levels of self-harm among individuals still serving imprisonment for public protection (IPP) sentences. Rates of self-harm among this cohort of prisoner is high. In particular, the rate of self-harm among women still serving an IPP sentence appears to be significantly greater than that in the women's prison population as a whole - which is already considerably higher than that in the general female population.[23]

36. In addition, the uncertainty experienced by people held on remand is thought to increase the risk of self-harm and suicide prevalent within this section of the prison population.[24]

37. Though some similarities are shared between detainees and IPP prisoners due to feelings of uncertainty they might experience, it would be difficult to draw definite conclusions regarding detainees based on the IPP prisoner population alone. Indeed, there are a several groups from where comparisons can be made, for example, prisoners who are on remand, prisoners who currently serving life sentences and even patients who are held under the Mental Health Act. The IAP therefore does not recommend drawing comparisons from the IPP population only but rather encourages greater research into the impact of indeterminate terms.

38. The availability of clear information for detainees should be prioritised at all times. This should be tailored to suit the requirements demanded by the unique demographics and experiences of IRC populations. Support should also be provided by enabling family contact where possible, which should be facilitated through accompanying related staff training.

Trauma

39. Some of the individuals within the IRC population - in a similar way to prisoners - may have had, on average, more traumatic experiences than individuals within the community. In 2018, a study found that 20.8% of detainees presented symptoms of Post-Traumatic Stress Disorder (PTSD)[25] compared to 3.7% for men and 5.1% for females within the community, demonstrating greater vulnerability.[26] Furthermore, it found that 52.5% of detainees suffered from anxiety and depression, compared to 25% of prisoners (23% of men in prison and 49% of women) and 15% of the general population.[27]

[23] Independent Advisory Panel of Deaths in Custody, 'Indeterminate sentences for public protection (IPPs): preventing self-harm and deaths in custody' <https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ec5081628025026638c805a/1589970970941/IPP+briefing+paper+for+Ministers+FINAL.pdf> accessed 20 June 2020

[24] Jenny Shaw, Denise Baker, Isabelle M Hunt, Anne Moloney & Louis Appleby, 'Suicide by prisoners. National clinical survey' (2004) 184 British Journal of Psychiatry.

[25] Sen P, et al, 'Mental health morbidity among people subject to immigration detention in the UK: a feasibility study' (2018) 27(6) Epidemiol Psychiatr Sci.

[26] House of Commons, 'Mental health statistics for England: prevalence, services and funding in England' <https://commonslibrary.parliament.uk/research-briefings/sn06988/> accessed 20 July 2020

[27] Ibid.

40. Research shows that this trauma, if not properly addressed, is likely to have an adverse effect on a detainee's mental health.[28] To build an understanding of this, work should be progressed, potentially through the Ministerial Board on Deaths in Custody, to collate, review and share learning and best practice on the impact of childhood trauma with the aim of developing better informed practice to reduce the risk of suicide and self-harm.

Population diversity

Learning from: suicide strategies in the community

41. Guidelines produced by the National Institute for Health and Care Excellence recommend that suicide strategies should take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high risk of suicide.[29]

42. The multiple nationalities present in IRCs might mean that pressures such as stress and anxiety might present themselves in ways that might not be obvious or consistent with typical understandings of what stress and anxiety is.[30] Research shows that one major challenge facing mental health workers is understanding how different cultural groups communicate psychological distress. Approaches to mental health have often been developed in high-income countries and may deploy unfamiliar approaches to those from different cultures.[31] By misunderstanding them or not understanding at all, any suicide prevention methods will not be as robust as they could be.[32]

43. The translation services available in the lawyer's room at Colnbrook IRC enabled detainees to speak to their lawyers. This service should be extended to all members of staff to allow them to communicate adequately, for example through the use of mobile translation technology (which is currently being considered and rolled out).

Summary – principles for a prevention of deaths strategy:

- Prioritise alternatives to detention for those with pre-existing or significant mental health needs.
- Carry out further research comparing remand, IPP prisoners and others serving indeterminate terms with those detained in IRCs to further understand the impact of uncertainty and hopelessness on detainees.

[28] Centre for Mental Health, 'Immigration Removal Centres in England. A mental health needs analysis' <https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/immigration_removal.pdf> accessed on 20 July 2020

[29] National Institute for Health and Care Excellence, 'Preventing suicide in community and custodial settings' <https://www.nice.org.uk/guidance/ng105> accessed 18 June 2020.

[30] Soumia Cheref et al, 'Suicidal Ideation Among Racial/Ethnic Minorities: Moderating Effects of Rumination and Depressive Symptoms' (2014) 21 (1) Cultural Diversity and Ethnic Minority Psychology.

[31] Derek Summerfield, 'Asylum-seekers, refugees and mental health services in the UK' (2001) 25 Psychiatric Bulletin; Sen P, 'The mental health needs of asylum seekers and refugees - challenges and solutions' 2016 13(2) BJPsych International.

[32] Sen P, 'The mental health needs of asylum seekers and refugees - challenges and solutions' 2016 13(2) BJPsych International.

- Review and share learning and best practice on the impact of childhood and later trauma with aim of using it to reduce the risk of suicide and self-harm.

- Develop an increased understanding of the impact of cultural differences on the effectiveness of suicide prevention strategies.

- Ensure clear communication with detainees through information that is tailored to suit their unique needs and circumstances. Facilitate family contact where possible to provide support and mitigate feelings of hopelessness and uncertainty.

Review of current immigration detention policy

44. This section summarises existing relevant policies concerning IRCs and draws on evidence to assess their success and suitability.[33] Policies determining outcomes for those detained by the state should be published and easily accessible.

Population size

45. Home Office data shows that at the end of June 2019 there were 22% fewer individuals in detention than in June 2018, while the estate is also almost 40% smaller than it was four years ago. It is worth examining this decrease further (as well as the impact of the population decline prompted by the necessary response to the 2020 COVID-19 outbreak), including its effect on detainee self-harm levels (including numbers on ACDTs) and wider wellbeing indicators. This could include self-reporting on detainee views on their own safety and wellbeing, as well as their thoughts on contact with staff and access to information.

Detention of at risk individuals

46. Government has long committed to vulnerable people not being detained .[34] The *Management of Adults at Risk in Immigration Detention* policy, introduced in 2017 as a result of the Stephen Shaw review to ensure greater attention was paid to vulnerability, widened the definition of vulnerability in this context to those with learning difficulties, those suffering from PTSD, victims of sexual or gender-based violence, and transgender individuals.[35] If an individual is considered to have experienced a traumatic event such as trafficking, torture and/or sexual violence, then they are likely to be considered an 'at risk' adult and detention should be avoided where possible. However, these experiences have to be weighed up against other considerations – such as an individual's 'risk' to the public.

47. HM Inspectorate of Prison's 2017-18 annual report found that the Home Office's *Adults at Risk* policy is not working effectively – evidenced by the fact that vulnerable detainees are still being detained for long periods of time. The report highlighted cases of individuals still being placed in detention even when there was evidence of torture accepted (which the Home Office views as making a detainee vulnerable). Other examples included a blind detainee on an ACDT (self-harm monitoring) who was detained for over a year."[36] In a report on the Adults at Risk Policy, the Chief Inspector of Borders and Immigration also highlighted concerns about the consistency of the Home Office's understanding of vulnerability.[37]

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[33] Home Office, 'Factsheet: Detention' <https://homeofficemedia.blog.gov.uk/2019/03/21/fact-sheet-detention/> accessed 20 July.
[34] See, for example, Joint Committee on Human Rights in 2018 < https://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/inquiries/parliament-2017/inquiry10/publications/> accessed 28 August 2020.
[35] Home Office, Management of Adults at Risk in Immigration Detention < https://www.gov.uk/government/publications/management-of-adults-at-risk-in-immigration-detention> accessed 18 June 2020.
[36] HM Chief Inspector of Prisons for England and Wales, 'Annual Report 2017-18' < https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/07/6.4472_HMI-Prisons_AR-2017-18_Content_A4_Final_WEB.pdf> accessed 18 June 2020.
[37] Independent Chief Inspector of Borders and Immigration, 'Annual inspection of 'Adults at Risk in Immigration Detention' (2018–19) November 2018 – May 2019' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/8

Identifying risk among those who are detained

48. The inquest into the death of Prince Kwabena Fosu, who died of hypothermia, dehydration and malnourishment, identified key areas where measures to protect vulnerable detainees and then remove them from detention had failed. Prince Fosu's inquest found that the training, knowledge and awareness of detention officers and management around mental health was *"inadequate and unsatisfactory"* and that doctors in the establishment were not aware of key policies. Steps have since been taken to address this issue, including in the form of a recently published Detention Service Order providing staff with guidance on mental capacity.

49. The *Adults at Risk* policy sets out procedures to ensure that all relevant staff and parties are aware of and up to date on a detainee's health and welfare needs prior to their arrival. It also outlines how transfers between centres must be kept to a minimum and that medical records, open ACDTs, and prison files should be shared between IRCs.

50. The Assessment Care in Detention and Teamwork (ACDT) is a self-harm reduction management plan within the immigration estate which aims to provide a holistic approach to suicide prevention and brings existing policy in line with similar changes implemented by the Ministry of Justice. Used effectively, it should alert staff to risks among those who are detained (though should not be the only tool used to assess risk, as discussed in the previous section).

51. However, there are cases where ACDT has not proved effective in identifying risk, for example in the case of Mr Siman-Tov, who died in Colnbrook in 2016 despite constant supervision by custody officers through ACDT. A recent study found that only 30% of detainees interviewed who indicated that they had had thoughts of ending their life were also on an ACDT while in the centre they were currently in, while 47% were not sure if they had been on an ACDT or not.[38]

52. In addition, staff have identified issues with the current iteration of the policy, as highlighted by the IAP's visit to Colnbrook IRC. Staff described ACDT as 'not user friendly' and impractical, and also expressed frustration at the fact that ACDT does not appear to attract the same degree of focus as its equivalent (Assessment, Care in Custody and Teamwork, or ACCT) within the prison service and that the policy did not sufficiently recognise the differences between population needs within a prison and an IRC. Staff must also be trained by prison staff and in prison-run training facilities, and there have been incidents of limited availability in particular institutions.

Learning from: ACCT in prisons

53. The IAP's *Keeping Safe* report highlighted issues with the current ACCT process for identifying and supporting prisoners at risk of hurting themselves, and the need for humane treatment.[39] At worst it was seen as a box ticking exercise.

81648/Annual_inspection_of_Adults_at_RIsk_in_Immigration_Detention__2018-29_.pdf> accessed 28 August 2020.

[38] Mary Bosworth and Alice Gerlach, 'Quality of Life in Detention', March 2020 <https://www.law.ox.ac.uk/sites/files/oxlaw/mqld_2019_report_for_publication_16.03.20.pdf> accessed 28 August 2020.

[39] IAP, Keeping Safe.

54. A review of ACCT was undertaken in 2015, which found that the system was fit for purpose, but that there were problems with compliance with the policy and procedures, and an over-emphasis on process over individualised support. HMPPS has been working closely with NHS England, Public Health England, HMIP, PPO, IAP and trade unions to revise ACCT to improve its efficacy.

55. HMPPS and MoJ are currently piloting and evaluating changes to the ACCT case management system, improving the focus on individual needs and effective multi-disciplinary working, including engagement of healthcare and family members where possible. The changes will be rolled-out across the estate in due course.

56. Staff and funding resource should be dedicated to the development of the ACDT policy, delivered in collaboration with the prison service and learning lessons from the evolution of the ACCT policy. The IAP welcomes indications that the Home Office is currently working with HMPPS to progress the development of both policies.

Healthcare

57. Previous deaths have highlighted a number of missed opportunities or the failure to diagnose deteriorating physical health. For example, the inquest into the 2016 death of Bai Bai Ahmed Kabia, who died from a brain haemorrhage, identified missed opportunities for ill health to be diagnosed and treated.[40] Other inquests, such as that for Carlington Spencer, who died in 2017, demonstrate instances of 'confirmatory bias' where healthcare staff misattributed medical issues to drug use.[41]

58. Healthcare professionals working in IRCs face unique challenges, such as high rates of mental health problems, specific vulnerabilities as a result of a past traumatic experiences, and the complex needs of individuals. The difficulty is often amplified by the fact that individuals in removal centres are detained as a result of being illegally in the UK, and therefore will have been restricted from accessing a number of services, including healthcare. Screening practices must take this context into consideration.

59. NHS England took over the commissioning of healthcare services within IRCs in England in 2014. Research shows that private companies previously responsible had collected differing levels of data on detainees upon their arrival. This has previously made it difficult to obtain a true picture of the detainee's health needs.[42]

60. The British Medical Association reported that many individuals did not understand the questions that were being asked of them during screening processes, another key issue when detainees are required to self-report any healthcare concerns.[43] This suggests that

[40] Death of immigration detainee Bai Bai Ahmed Kabia could have been prevented, inquest concludes' < https://www.inquest.org.uk/ahmed-kabia-inquest-close>.
[41] Jury highlight Morton Hall staff failures as inquest concludes on death of immigration detainee Carlington Spencer < https://www.inquest.org.uk/carlington-spencer-closes>.
[42] British Medical Association, 'Locked up, locked out: health and human rights in immigration detention' <https://www.bma.org.uk/media/1862/bma-locked-up-locked-out-immigration-detention-report-2017.pdf> accessed 28 February 2020.
[43] ibid

the information IRCs collect on arrival might not be as accurate as first assumed, with potential detrimental healthcare implications.

61. The lessons learned exercise attended by IAP member John Wadham raised a question as to why no assessment was made, or indication provided, as to whether the deceased's healthcare requests were urgent. Guidance should be provided to staff to encourage them to enquire about the urgency of the matter leading to a detainee requesting a healthcare appointment.

Learning from: secure health settings

62. Research by the Care Quality Commission highlights the importance of listening to a patient when deciding their care. It found that involving a patient in their treatment plan helped to alleviate the patient's stress and anxiety.[44] This would only be successful if detainees understand what is going on and again highlights the importance utilising good translation services.

Support for detainees

63. Home Office policy sets out steps that should be taken to support staff and other detainees following a death in detention. This includes the opportunity for face to face meetings, chaplaincy team support, healthcare team support, and Samaritans or bereavement help lines. Suppliers must also ensure that a death is communicated promptly and sensitively to other detainees in the centre and that they are offered subsequent support.

Learning from: Samaritans in prisons

64. Both prisoners and prison staff can access Samaritans services in a number of ways:
    a. The Listener scheme which allows prisoners, trained and supported by the local branch of the Samaritans, to offer confidential peer support to those who might be struggling to cope, or those who are feeling worried and/or frightened.
    b. Access to a Samaritan's helpline free of charge, or the option for prisoners to write to Samaritans should they prefer (via a freepost service with confidential access).
    c. If there are no prison Listener scheme's available, volunteers from the local Samaritans branch may visit the prison to offer face to face support.
    d. Samaritans also offer a service to prison staff. These have been proven to play a valuable role in the times that follow a suicide or self-harm incident.

65. The prison service is improving access to support for people in prisons following self-inflicted deaths, including clusters. HMPPS has provided grant funding to the Samaritans to develop and pilot a 'postvention' support service.

66. While the Samaritans are present in IRCs, funding for this resource should be enhanced to provide the fullest possible support for this vulnerable population.

[44] Care Quality Commission, 'Monitoring the Mental Health Act in 2018/19' <'https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf> accessed on 18 June 2020.

Learning lessons

67. Under Article 2, there is an obligation on the state to conduct full, open and transparent investigation into deaths where the person is detained. These should be independent, publicly accessible and facilitate the involvement of the family of the person who has died.

68. The PPO has access to investigate all deaths that occur within an IRC. However, they do not currently have any legal power to compel staff or detainees to speak with the PPO or to give evidence or to hold hearings in public, which has previously made investigating a death or allegations of ill-treatment difficult.[45] The PPO are currently in the process of seeking statutory powers which would allow them to thoroughly investigate any death within an IRC.[46]

69. The Home Office has an obligation to respond to the coroner's Prevention of Future Death report (PFD) within 56 days of receipt – either setting out an action plan to implement the coroner's recommendations or to explain why they are not being taken forward. However, changes made as a result, for example to the coroner's critical report in response to Branko Zdranvkovic's self-inflicted death, can appear limited.[47]

70. The concerns and recommendations shared by the coroner are an invaluable source to help prevent a death from occurring which should be utilised by contractors running IRCs. During the roundtable discussion with staff at Colnbrook IRC, staff set out how learning is shared with members of staff via newsletters and bulletins, with the expectation that staff will read and inform themselves of any changes. Senior members of staff from the differing centres meet a few times a year to discuss and share best practice. These are largely positive practises, though present a risk of organisations rationalising effective learning as simply a function of motivation and access – essentially assuming that effective learning will result from giving people the opportunity to learn (e.g. through reviews or training). A more formal mechanism should be put in place to ensure that best practice is regularly shared between centre providers and with members of staff.

71. Lessons learned exercises should continue to invite independent input. Participants at the meeting attended by the IAP commented that that the presence of an independent person helped them to be more reflective. The involvement of an independent facilitator should be formalised.

72. The Home Office should also develop methods of providing resources and feedback to bereaved families on actions taken and ensure these are subject to a regular review.

Inquests

73. Research by the charity INQUEST shows that it is not uncommon for the deceased to have no family representatives present at inquests, in contrast to the government

[45] See the Brook House case, R (MA & BB) v Secretary of State for the Home Department, High Court, 14 June 2016.
[46] Strengthening the Independent Scrutiny Bodies through Legislation, Ministry of Justice, August 2020.
[47] Stephen Nicholls, Assistant Coroner, 'Report to prevent future deaths: Branko Zdranvkovic' <https://www.judiciary.uk/wp-content/uploads/2019/05/Branko-Zdravkovic-2019-0047_Redacted.pdf> accessed 18 June 2020.

institution (in this case, the Home Office) which often has significant legal representation. There is a risk that this undermines the purpose of inquests: to identify systemic trends with a wide scope and provide appropriate scrutiny. The Home Office should press the Ministry of Justice to permit this approach to be changed, with improvements made to information provided to bereaved families, including sources of specialist advice and support.

Summary – principles for a prevention of deaths strategy

- Work with the prison service to review and update ACDT within detention centres.
- Carry out further research to examine the impact of decreases to the immigration population, both in recent years and as part of the response to the COVID-19 pandemic, on self-harm rates and wider wellbeing indicators.
- Provide guidance to staff to enquire about the urgency of a matter which leads to a detainee requesting a healthcare appointment.
- Review healthcare screening processes to account for language barriers and the likelihood of limited prior interaction with healthcare systems and ensure that processes are understood and the detainee can participate.
- Increase resources for Samaritan and listeners within IRCs.
- Formalise mechanisms for sharing lessons learned across IRCs following a death and the involvement of independent scrutiny at lessons learned exercises.
- Share regular updates of good practice with the different service providers encouraging them to share good practice with each centre. Good practice should be disseminated via regular newsletters or regular meetings with senior management of each centre. Devise formal ways of checking that learning has been embedded.
- Work with the Ministry of Justice to allow non-relatives and relevant organisations to apply to attend inquests where it is not possible for family members to attend. Deliver improvements to information provided to bereaved families, including sources of specialist advice and support.
- Develop method of providing resources and feedback to bereaved families on actions taken and ensure these are subject to a regular review.

Themes and patterns from previous deaths

74. The Home Office provided the IAP with information on the deaths in custody within the immigration estate. The documents provided included PPO investigation reports and PFDs from coroners. This was supplemented by statistical information and summaries of the deaths provided by the Home Office. The IAP was also given information on 'near-miss' cases of individuals who attempted suicide at an IRC that have occurred in the last two years. Deaths in the immigration estate were investigated by the PPO and coroner and, in many of them, recommendations were made to try to prevent further deaths. Additional context on wider themes is discussed below.

Staff error

75. In many of the cases, some form of staff error featured in the lead-up to a death. The inquest into the death of Marcin Gwozdzinski, for example, highlighted the missing of *"significant warning signs"* and inadequate risk assessments by untrained staff.[48]

76. Several of the errors related to staff making flawed decisions under pressure – such as the incorrect use of emergency procedures or application of the wrong equipment. The coroner and PPO have made many recommendations to improve emergency protocols and ensure all staff are aware of them. Yet they will not necessarily, in themselves, stop another member of staff in the future making a flawed decision under pressure.

77. Gehlbach & Artino found that the use of checklist and other cognitive aids in high stress, time critical medical situations reduced the number of mistakes medical staff made and increased the level of care received.[49] This would have been helpful in the case of Bai Bai Kabia where the use of incorrect emergency codes led to a delay in the ambulance being allowed into the IRC. In future situations a delay of medical care could make important differences.

78. Staff mistakes again suggest the need for effective learning. Focussed, objective discussions are needed to bring out the premises, inferences and conclusions that have driven behaviour, if the organisations are determined to change behaviour in the long-term. In order to facilitate change, a culture of learning should be present, where staff are actively encouraged to learn lessons from past mistakes.

79. The Ministerial Board on Deaths in Custody has previously scoped work to explore the collation, review and sharing of learning and best practice on how different organisations train staff, particularly on suicide and self-harm prevention. This work should be carried forward as part of the revised Board workplan.

Information sharing

80. A significant, systemic factor in some of the deaths under consideration featured some form of breakdown of information sharing – either within or between organisations. For example, Tarek Chowdhury died in December 2017 following an attack from a violent

[48] INQUEST, 'Jury finds 'systemic failures' at Heathrow IRC contributed to death of immigration detainee Marcin Gwozdzinski', June 2019 < https://www.inquest.org.uk/marcin-gwozdzinski-conclusion>.
[49] Hunter Gehlbach and Anthony R Artino, 'The Survey Checklist (Manifesto)' 2017 93(3) Academic Medicine

detainee. This individual was known to be violent within the prison service, though this information was not passed onto staff at the IRC. This was also the case in relation to the death of Tome Kirungi. It was known that Mr Kirungi had got into debt during his time in prison. This again occurred when he was moved to an IRC, where an individual to whom he owed money also later arrived – a factor thought to be a key cause behind his suicide. The death of Mr Kirungi may have been avoided if Immigration Enforcement were aware of information known to the prison service.

81. There is evidence showing that information is not accurately shared between hospitals and Immigration Enforcement. This became clear in the case of Amir Siman-Tov, where information about Mr Siman-Tov was faxed to the removal centre but never received. After being hospitalised following an attempted overdose, no clear discharge instructions were given to immigration staff. The PPO found that a lack of a care management plan and direct clinical oversight led to his death.

82. Information sharing between departments, agencies and providers must be improved about important decisions shared with detainees. One case considered by the IAP showed that an individual was refused bail and tried to hang himself as a result. A system that logs and tracks important dates and decisions that could be considered a 'trigger point' for detainees should be introduced.

Time of death

Learning from: prisons

83. Within the prison service, extra measures are taken when a prisoner is first admitted, as evidence shows that risk is heightened during the first three months of a sentence. The prison service also tracks dates that might be important to prisoners such as birthdays, anniversaries of crime committed and any court or sentencing dates.

84. The IAP is not aware of any research into trends as at to what stage deaths or near miss incidents occur during an individual's time within an IRC. Though similar to prisoners in the sense that a detainee can be considered to be most vulnerable when they first arrive at a detention centre, risk of suicide also may increase as they approach the time they are due to be deported. Other cases suggest that deaths occur as a result of the extended length of a time held within an IRC. The inquest into Mr Gwozdzinski, for example, noted that a *"prolonged period of detention"* (9 months) was a possible factor of death.[50] Research into this area should be carried out and any patterns identified.

Summary – priorities for a prevention of deaths strategy

- Introduce the use of a checklist, or other structural tool, that can be used by staff members during times of emergency to support informed response and treatment.

- Improve information sharing between prison, other agencies and immigration removal centres. Key information (such as any vulnerabilities, history of violence, any mental

[50] Inquest, 'Jury finds 'systemic failures' at Heathrow IRC contributed to death of immigration detainee Marcin Gwozdzinski' <https://www.inquest.org.uk/marcin-gwozdzinski-conclusion> accessed 20 July 2020

health or clinical concerns) about the individual should be shared ahead of their arrival so that the immigration centre has adequate time to plan and prepare.

- Develop and introduce a system within IRCs that tracks any important dates or decisions that might be of importance to the detainee, such as days leading up to deportation, around trials and / or appeals.

Conclusion: Priorities for a prevention of deaths strategy

Key conclusions

85. Comprehensive research conducted by academics, NGOs, select committees and inspectorates demonstrates that immigration detention harms the mental health of detainees. Those with previous trauma or mental health concerns are at particular risk. The safeguards to ensure that vulnerable people are protected and ultimately not detained occasionally fail.

86. Evidence assessing the cause of previous deaths also highlights instances of basic healthcare failings, where an inability to address signs of physical and mental health deterioration have resulted in fatal consequences.

Strategy principles

87. The IAP proposes that the following principles are used to shape a Home Office IRC prevention of deaths strategy. A strategy should:

    a. **Have clear leadership acceptance and ownership, including clear ministerial oversight.** The National Suicide Prevention Strategy reports regularly to the National Suicide Prevention Strategy Advisory Group (NSPSAG), chaired by the Suicide Prevention Minister. A similar process of accountability should be introduced to support the delivery of this strategy.
    b. **Have a clear path for implementation.** A timeline setting out deliverables should be published and updated on with full transparency and opportunities for external scrutiny.
    c. **Have clear governance, accountability and expert insight.** This should include establishing a steering group comprised of external independent experts.
    d. **Be cross cutting, and learn from other strategies.** This paper sets out examples of methods that other custodial settings aim to reduce deaths. They should be actively involved in supporting the development and delivery of a strategy, including through the mechanism of the Ministerial Board on Deaths in Custody. This should not, however, come at the expense of work to understand the unique circumstances and characteristics of IRCs and their population.
    e. **Have a clear target.** To address suicide prevention in mental health settings, the Secretary of State for Health and Social Care launched a zero-suicide ambition across the NHS in January 2018, starting with mental health inpatients but looking to expand to include all mental health patients. Immigration Enforcement should aim for no suicides and no avoidable ‘natural’ deaths going forward.

88. Suggested specific objectives for a strategy, and the deliverables that would ensure they are met, are outlined below.

	Target	Priority actions	Lead
1	**Transform the transparency of policy, data and other information around deaths in the immigration estate to improve accountability and lessons learned.**	1. Improve the transparency of data in relation to deaths in detention by improving Home Office website signposting and through publication of a quarterly statistical report. Provide disaggregated data covering ethnicity, age, location, possible risk groups, type of death *(in progress).*	Home Office and IRC providers, IAP
		2. To improve transparency and improve learning, expand the definition of a 'death' in an IRC, for example by collecting and publishing details of detainees who die in prison while under immigration powers and those who die shortly after leaving detention *(in progress)*.	Home Office, HMPPS
		3. Introduce reporting to mirror that of HMPPS to provide notification of deaths to key external stakeholders.	Home Office, HMPPS
2	**Dedicate resource and focus on building a greater understanding of those at risk and scope for support from family and friends.**	4. Develop an increased understanding of the impact of cultural differences on the effectiveness of suicide prevention strategies.	Home Office
		5. Improve, expand and utilise translation services. Explore ways for all staff to have access to interpretation services, for example through mobile devices *(in progress).*	Home Office
		6. Improve information sharing between prison and immigration removal centres. Key information (such as any vulnerabilities, history of violence, any mental health or clinical concerns) about the individual should be shared ahead of their arrival so that the immigration centre has adequate time to plan and prepare.	Home Office, IRC providers, HMPPS
		7. Develop and introduce a system with immigration centres that tracks any important dates or decisions that might be of importance to the detainee such as days leading up to deportation, around trials and / or appeals.	Home Office with possible suggestions from HMPPS
		8. Review and share learning and best practice on childhood and later trauma with aim of using it to prevent suicide and self-harm.	Home Office, IAP, Ministerial Board on Deaths in Custody

		9. Review and sharing of learning and best practice on how different organisations train staff, particularly on suicide and self-harm prevention.	Home Office, IAP, Ministerial Board on Deaths in Custody
		10. Ensure clear communication with detainees through information that is tailored to suit their unique needs and circumstances. Facilitate family contact where possible to provide support and mitigate feelings of hopelessness and uncertainty.	Home Office
3	**Reconsider the immigration population in the context of the impact of detention on the mental health of detainees.**	11. Carry out further research to examine the impact of decreases to the immigration population, both in recent years and as part of the response to the Covid-19 pandemic, on self-harm rates and wider wellbeing indicators.	Home Office
		12. Prioritise alternatives to detention for those with pre-existing or significant mental health needs *(in progress)*.	Home Office
		13. Carry out further research comparing remand, IPP prisoners and others serving indeterminate terms with those detained in IRCs to further understand the impact of uncertainty and hopelessness on detainees.	Home Office, IAP, Ministerial Board
		14. Increase resources for Samaritans and listeners within IRCs.	Home Office
4	**Take steps to ensure adequate healthcare provision to suit the needs and circumstances of the immigration population.**	15. Ensure that vital information is shared between hospitals and immigration removal centres.	Home Office, IRC providers, healthcare providers, NHS E/I
		16. Provide guidance to staff to enquire about the urgency of a matter which leads to a detainee requesting a healthcare appointment.	Home Office, IRC providers, NHS E/I
		17. Review healthcare screening processes to account for language barriers and the likelihood of limited prior interaction with healthcare systems and ensure that processes are understood and the detainee can participate.	Home Office, IRC providers, healthcare providers, NHS E/I

5	**Provide staff with appropriate training, tools and supervision to support detainees and identify signs of physical and mental health risk.**	18. Work with HMPPS to update ACDT within removal centres *(in progress)*. 19. Develop and roll out cultural awareness training for staff to increase understanding of the different ways in which detainees might express pain or anxiety. 20. Introduce the use of a checklist system or other cognitive aid that can be used by staff members during times of emergency to aid them to treat an individual humanely and effectively.	HMPPS, Home Office Home Office with advice from IAP Home Office with advice from IAP
6	**Improve learning processes and ensure public, independent, transparent investigation.**	21. Formalise mechanisms for sharing lessons learned across IRCs following a death and the involvement of independent scrutiny and facilitation at lessons learned exercises. 22. Share regular updates of good practice with the different service providers encouraging them to share good practice with each centre. Good practice should be disseminated via regular newsletters or regular meetings with senior management of each centre. Devise formal ways of checking that learning has been embedded. 23. Work with the Ministry of Justice to allow non-relatives and relevant organisations to apply to attend inquests where it is not possible for family members to attend. Deliver improvements to information provided to bereaved families, including sources of specialist advice and support. 24. Develop method of providing resources and feedback to bereaved families on actions taken and ensure these are subject to a regular review *(in progress)*.	Home Office with IAP Home Office in conjunction with service providers Home Office in collaboration with Ministry of Justice with relevant NGOs Home Office