AVID Annual General Meeting 14 May 2014

I am very pleased to be able to speak to you tonight about my work as the Prisons and Probation Ombudsman and my investigations into immigration removal centres.

I was asked to look at my office's investigations into fatal incidents in IRCs and our recent learning lessons bulletin, but, in case some of you are unfamiliar with my office, I will first say something about myself and my role.

Background

I have been Ombudsman since the end of 2011 and before that I was Deputy Chief Inspector of Prisons for 9 years. In the Inspectorate, among other things, I established the methodology and programme of inspection for immigration removal centres and short-term holding facilities. So I have some knowledge of the independent scrutiny of IRCs.

The post of Ombudsman was established in 1994 following Lord Justice Woolf's report into prison disturbances. He recommended the creation of an external independent mechanism for prisoners unhappy with the internal complaints process. The office took on complaints from immigration detainees in 2006.

But before that, in 2004, the role was greatly expanded to take on the investigation of all deaths in prisons, young offender facilities, probation approved premises, IRCs and those under immigration managed escort. This was partly a response to concern about the UK's compliance with Article 2 of the European Convention of Human Rights on the right to life which requires independent investigation of all deaths in state custody.

In essence, my investigations, together with the Coroner's inquest, combine to meet the state's obligation under Article 2.

The office is wholly independent of the services I investigate – be it the National Offender Management Service or the Home Office and their various delivery arms and contractors. My powers lack a statutory framework, but I do have written terms of reference to ensure I can conduct my investigations without fear or favour.

The terms of reference set the following aims for fatal incident investigations:

- To establish the circumstances and events surrounding the death
- To examine whether any change to operational policy or practice would help prevent recurrence
- In conjunction with the NHS, to examine relevant health care issues
- To provide explanation and insight for bereaved relatives
- To assist the Coroner's inquest to bring the full facts to light and identify any failings, commendable action or learning

Our investigations are usually assisted by a clinical reviewer commissioned by NHS England to assess the quality of healthcare received by the deceased.

An investigation report is produced, proportionate in detail and analysis to the learning that can be obtained and, in every case, I write an Ombudsman's introduction.

We have our own family liaison officers and will use interpreters and translators to ensure family involvement in the investigation process - wherever they may be in the world. Our draft reports are shared with the bereaved family, the investigated body and the Coroner. A final anonymised report is published on our web-site.

The timetable for producing a draft investigation report is 20 weeks for a natural cause death and 26 weeks for a self-inflicted death or homicide. In 2013-14, we met this target in 92% of cases (a huge improvement on when I arrived in 2011, when we missed the target in 79% of cases).

We make recommendations as we see fit and those we investigate must produce an implementation action plan. We now work closely with my old colleagues at the Prisons Inspectorate who inspect progress against our recommendations.

Learning lessons bulletin

Since my appointment - apart from being faced like any public sector body with having to do much more with much less - I have made a particular effort to increase our thematic work.

In other words, I have asked my staff to look beyond the learning in individual cases to identify the lessons that should be learned across the board, so that we contribute more generally to increasing safety and fairness in custody.

I recently published our first learning lessons bulletin into the immigration detention estate, and will look at this in some detail. The bulletin looked at both complaints from detainees and the mercifully small number of fatal incidents in IRCs.

Complaints

While my focus tonight is on fatal incidents, our complaints work also merits a few words.

Immigration detainees make few complaints to my office – only around 2% (110) of the 5000 cases we receive a year. Detainee complaints are broadly similar to those of prisoners, but they, of course, are administrative detainees and their conditions and treatment should be commensurate with that civil status.

For this reason - and also because of concern that few detainees use my office - I have set up a dedicated team to investigate complaints from IRCs and to identify any specific learning. While there have been some serious complaints of assault, bullying and racism in IRCs, the most common complaint – as with prisoners – is about property.

So the recent bulletin also looks at property complaints and illustrates that there is considerable scope to improve the management of detainee property - the loss or damage of which can be acutely felt. Such improvement would not only benefit detainees, but also save staff resources and cost to the public purse for compensation.

Interestingly, while Prison Service management of prisoner property can be poor, it is at least covered by detailed policies. I do not understand why there has not been more learning from these sources across IRCs, particularly as some are run by the Prison Service. Accordingly, the bulletin calls on the Home Office and its contractors to improve matters.

Fatal incidents

Turning now to the bulletin's review of fatal incident investigations: in 2013-14, my office began 239 investigations into deaths in custody – a 25% increase on the year before. Of these, 2 were immigration detainees.

Most deaths - including apparently those of the two immigration detainees, were from natural causes – although last year saw a deeply troubling 64% increase in self-inflicted deaths in prison.

In the 10 years since my office began investigating deaths in custody, we have investigated nearly 2000 (1984) deaths – a startling figure, the population of a small town. In the same period, we have completed 15 fatal incident investigations in IRCs – a small proportion, but obviously the figure can never be small enough and the personal tragedies involved cannot be underestimated.

Of these 15 deaths, 7 were from natural causes, 7 were self-inflicted and one was the death of a man while being removed under escort on an aeroplane and which an inquest jury found to be a case of unlawful killing. A further four cases are currently under investigation or are suspended because of police inquiries.

Drawing thematic learning from this relatively small, diverse, but nonetheless tragic sample over a ten year period is not easy. However, one rather surprising issue recurs: in 8 of the 15 deaths we had concerns about the IRC's emergency response.

Emergency response

The point may be obvious, but a fast and efficient emergency response can mean the difference between life and death. It is crucial that those responding

to a medical emergency have the training, equipment and systems in place to enable an effective reaction to the situation.

It is, therefore, a huge concern that recommendations about this issue recur in our investigations. This lack of progress is unacceptable.

There are two aspects of improvement that we have frequently had to highlight:

- First, the lack of clear and effective systems to ensure that the nature of an emergency is correctly communicated

- and, second, that healthcare and detention staff working in IRCs are sometimes insufficiently trained and equipped to deal with emergency incidents.

The bulletin provides some troubling case studies of the consequences of not having proper procedures in place for responding to medical emergencies. Time is short, so I will only describe the case of Mr B:

Mr B was found hanging in the shower of an IRC. The detention officer who found him shouted for another officer to radio for a medical response team. He was about to start cardiopulmonary resuscitation (CPR) when two nurses arrived. The nurses had brought emergency equipment, but one of them had to go back to the healthcare centre to get some oxygen. The nurses placed Mr B in the recovery position, but did not perform CPR or administer oxygen.

A detention officer called for an ambulance and the emergency services asked whether the IRC had a defibrillator on site. The officer asked one of the nurses to bring the defibrillator. The nurse attached it to Mr B, but still neither nurse performed CPR and they seemed unsure what to do. An ambulance arrived and the paramedics pronounced Mr B dead.

The investigation found that no emergency code had been used to communicate the nature of the emergency which nurses would have found helpful.

We recommended that Home Office Immigration Enforcement should ensure that an emergency code system is introduced to notify responding staff about the nature of an emergency.

We also recommended that there should be sufficiently trained healthcare and other staff on duty in the IRC at all times who are competent to administer CPR.

That the same issues continue to emerge is as inexplicable as it is reprehensible and it is difficult to understand why Home Office Immigration Enforcement has not already instructed IRCs to learn the important and potentially life saving lessons from our investigations.

The recent bulletin puts these lessons simply:

Lesson 1 - Every IRC should implement a simple emergency code system to communicate the nature of the emergency, and managers should ensure it is understood and used by all staff.

Lesson 2 – Every IRC should be equipped with working emergency medical equipment.

Lesson 3 – All IRCs should have sufficiently trained healthcare and\or discipline staff on duty at all times, who are able to administer CPR.

Lesson 4 – In line with NHS ambulance service guidance, staff should immediately call an ambulance when a detainee presents with any of the following; chest pain, difficulty breathing, unconsciousness, severe blood loss, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected stroke.

These are simple yet potentially life saving lessons and you may want to ask staff in the IRCs you visit whether these lessons have now been learned and what emergency procedures they have in place.

As I say, I find the lack of a standardised approach to emergencies in IRCs inexplicable, particularly as it contrasts with the general position in prisons

Thus to date, Home Office Immigration Enforcement has not issued a specific Detention Service Order about emergency response and, while its operating manual sets out what control room staff should do in the event of an emergency, it does not make clear what is expected of healthcare or detention staff in the event of finding a detainee in a critical state.

By contrast – and despite not being immune from criticism themselves - the Prison Service published a Medical Emergency Instruction in 2013[1] which addresses emergency responses in the light of findings from my investigations – and from which the whole immigration detention estate would do well to learn.

Interestingly, the three IRCs run by the Prison Service are governed by Prison Service Instructions rather than DSOs. We have only investigated one death in a Prison Service run IRC, but healthcare and discipline staff were both commended for the way in which they managed the emergency response and administered first aid.

I recently drew this contrast to the attention of the new Home Office Director of Immigration Enforcement and I expect her to ensure her contractors learn the lessons of our investigations.

[1] Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes

Conclusion

Let me conclude this quick review of my office's independent investigation of complaints and, more particularly, fatal incidents in IRCs with a couple of aspirations.

First, I very much hope that demand for my mournful services relating to fatal incidents in IRCs continues to remain low.

Second, in order to meet this aspiration, I hope that the learning from my individual investigations and thematic reports is used to support improved safety and fairness in IRCs – and that this learning is more expeditiously implemented than has been the case to date.

Finally, I hope this talk has been of some interest and I would welcome any questions you may have.