[redacted]
National Chair
Independent Monitoring Boards
Post Point 2, Third Floor
10 South Colonnade
Canary Wharf
London
E14 4PH

Email: [redacted]

27th August 2020

Chinyere Inyama
Senior Coroner – West London Coroners Court

(Via email to: [redacted] & [redacted]

Dear Sir,

Re: Inquest touching the death of Prince Kwabena Fosu – Prevention of Future Deaths report

I write in response to your report pursuant to reg.28 of the Coroners (Investigations) Regulations 2013 following the inquest touching upon the death of Prince Kwabena Fosu.

During the inquest, you heard evidence from two former members of the Harmondsworth Independent Monitoring Board and from [redacted], a member of the Management Board of the Independent Monitoring Boards. In her evidence, Mrs [redacted] explained the developments at the Harmondsworth IMB and IMBs more generally since Mr Fosu's death in 2012. Following the conclusion of the inquest you made a report pursuant to reg.28. You identified two matters of concern, one of which was directed to the IMB. I write in respect of that concern.

As explained at the inquest, the IMB welcomes the opportunity to learn from the circumstances of Mr Fosu's death. As an organisation which monitors the conditions in which detainees are held in Immigration Removal Centres, the IMB recognises that where there are opportunities to improve its own processes, these should be acted upon. In your report, you state:

> "The current practise remains to refer concerns around detainees only to the Home Office contract monitor. I see no good reason not to, in addition and simultaneously, report concerns to the healthcare managers at the IRC. In recording this concern, I have in mind the jury's determinations and findings in the record of inquest which highlight ineffective joint working across all agencies. Simultaneous reporting of issues would lessen the prospect of a healthcare related issue slipping through the net and not being addressed."

Before addressing the steps taken since receipt of your report, it may be of assistance to set out some background. In doing so, I do not repeat the evidence contained in Mrs [redacted]'s statement

or those parts of her oral evidence which concerned matters not directly relevant to the above concern.

Background

In her evidence, Mrs [redacted] explained that as at February 2020 there was no formal instruction to IMB members as to whom they should raise concerns about a detainee, other than to the Contract Manager and in some instances the Secretary of State directly. This reflects the Detention Centre Rules 2001 (which is the relevant legislative framework) which provide *inter alia* that:

a. The IMB "shall direct the attention of the manager to any matter which calls for his attention, and shall report to the Secretary of State any matter which they consider expedient to report" (r.61(3));
b. The IMB "shall inform the Secretary of State immediately of any abuse which comes to their knowledge"; (r.61(4));
c. The IMB "shall being to the attention of the Secretary of State any aspect of the process of consideration of the immigration status of any detainee that causes them concern insofar as it affects that detainee's continued detention" (r.61(5)); and
d. The IMB is required to make an annual report to the Secretary of State (r.64(1)).

Notwithstanding that framework, Mrs [redacted]'s evidence was that IMB members are encouraged to identify who within an IRC is the most appropriate person to whom a concern may be raised. IMB members are taught to engage constructively with the most appropriate people. Further, as Mrs [redacted] explained, in her experience the Contract Manager would be the 'first port of call' in serious and complex cases like that of Mr Fosu, but that she had personal experience of raising concerns directly with members of healthcare staff.

Whilst we recognise that there is no evidence that IMB members directly raised Mr Fosu's case with healthcare staff, it is noteworthy that it was an IMB member who raised concerns with the Centre Manager (including that she felt Mr Fosu looked vulnerable and asked whether he had had a mental health assessment) and as a result Mr Fosu's case was discussed at the multi-disciplinary meeting the following morning.

Reply

As an immediate response to the inquest, 20 IMB members from IMBs across all six Immigration Removal Centres attended a workshop at a Study Day on 7th March 2020, entitled "Monitoring Separation and Adults and Risk", which worked through the appropriate responses for raising concerns. The case study concerned a fictionalised detainee, but whose experiences were based very closely on those of Mr Fosu. I enclose a copy of the slides used during this session. You may wish to note in particular:

- Delegates were told that the case study was based on a real case.

- Delegates were challenged on whether their monitoring had been taking place in 'silos'.
- Delegates were encouraged to ask questions of Centre and Healthcare staff: they were told to look for and interrogate information contained in documents such as PERs or ACDTs.
- Rule 42 of the Detention Centre Rules 2001 (and its importance) was discussed.
- Delegates were asked how they could challenge or probe statements made by staff in the CSU. They were reminded of the types of information that they should consult and that they should not take statements made by staff at face value.

Delegates were told that the workshop was intended to be a starting point for their thinking: they should return to their individual Boards and begin a conversation with their fellow members about the issues raised. This session has since been adapted for use within other more general training sessions.

In addition to this specific training, an external review was commissioned to review IMB training more generally. Informed by that review, and reflecting on the issues that arose during Mr Fosu's inquest, the Management Board identified a need for three additional areas where specific training for members in IRCs was required, *viz.*:

a. Mental health awareness;
b. Monitoring the separation of adults at risk; and
c. Raising concerns and preventing abuse.

At a meeting of the Management Board in July 2020, the Board approved a requirement that all members of IMBs at IRCs should complete all three elements of the above training. Where relevant, members of IMBs at Short-Term Holding Facilities will also be required to complete the mental health awareness and raising concerns modules. In due course, this training is likely to be rolled out to all parts of the IMB, i.e. including IMBs within prisons.

The training sessions, which we anticipate running on three occasions in September 2020, will be for two-hours. The training will consist of a presentation with a series of training segments and will be supported with multimedia such as video content (the 'presentation element'). Each presentation may have a live introduction, and all will have a live Q&A / discussion after the presentation element.

The first module of training specifically focusses on mental health awareness. Working with the Centre for Mental Health (www.centreformentalhealth.org.uk) a training programme has been agreed. Its aims and learning outcomes are:

"On completion of the training, members will:

- Have an enhanced understanding of mental health problems and associated vulnerabilities
- Know how to recognise signs indicating poor mental wellbeing

- Have an overview of what effective mental health provision and support for detainees should look like
- Understand key points on monitoring the impact of IRC/STHF provision on mental health and wellbeing of people in detention and how to escalate any concerns"

The training will be delivered by Dr [redacted] who has worked in the mental health field for nearly 40 years and was a psychiatric nurse. He has worked in a variety of settings, including CAMHS, community, acute inpatient, high secure. For the last fifteen years he has led the Centre for Mental Health work in Criminal Justice and has worked on projects covering: prisons, secure care services, policing, liaison & diversion, resettlement, probation, immigration removal and gangs, as well as internationally.

The second module specifically covers the monitoring in separation units, particularly in relation to adults at risk. This training will cover:

- Identifying factors which may indicate that a detainee in separation is at particular risk;
- Analysing how to broaden and deepen the monitoring of adults at risk in separation;
- Exploring techniques for questioning challenging and escalating concerns; and
- Identifying and taking forward actions for individual members and for boards' monitoring in these areas.

The third session focuses on how to raise concerns about potential abuse. This training will cover:

- The IMB's role in responding to allegations of abuse made by detainees and how this relates to formal establishment processes;
- Identifying how to respond to allegations of abuse made by detainees against members of staff;
- Identifying how to respond to allegations of abuse made by detainees against other detainees; and
- Exploring the monitoring and follow-up activities that Boards should undertake in response to allegations or concerns about abuse.

Though the COVID-19 pandemic has delayed matters a little, this training will commence in September 2020. We anticipate that all training of the current 91 IMB members in the immigration detention estate should be completed by the end of 2020 although there may be some sessions thereafter to ensure that everyone has participated. The Management Board also determined that these three elements of training will be required for all future IMB members in the immigration detention estate, both when they first become members and thereafter with refresher training on at least a three year cycle to coordinate with the current triennial appointment structure for members.

Conclusion

The above are specific steps which the IMB have taken in response to Mr Fosu's death and in light of the matters which emerged during the inquest. More specifically, I hope the above provides some reassurance that the IMB have taken steps in light of the concerns which you have identified.

Yours faithfully,

[redacted] **– National Chair, Independent Monitoring Boards**