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Dear Stuart

INQUEST INTO THE DEATH OF RUBEL AHMED – REGULATION 28 REPORT

Thank you for your regulation 28 report to prevent future deaths of 5 August 2015 addressed to the Home Office and the Ministry of Justice, following the inquest into the death of Rubel Ahmed who died on 6 September 2014 at Morton Hall immigration removal centre (IRC). You identify the following five matters of concern:

- The locking of some detainees in their rooms overnight;
- Detention awareness training;
- Staff awareness of changes in detainees' circumstances including removal directions;
- Personal officer detail; and
- Use of electrical items in rooms.

Any death in detention is deeply regrettable, and I am grateful to you for your report. I am replying on behalf of both Departments, as the Home Office Minister for Immigration.

We understand your concerns about the practice of locking some detainees in their rooms overnight and acknowledge that a similar recommendation was accepted in

principle following an inspection of the centre by Her Majesty's Chief Inspector of Prisons (HMCIP) in 2013. Windsor Unit, where Mr Ahmed was accommodated, was originally designed, fitted and approved for use as a custodial building in which prisoners were locked in their rooms overnight. In order to operate a new regime in which rooms in Windsor Unit remain unlocked overnight, major changes to the fire safety measures are required to ensure detainee and staff safety and compliance with Crown Premises Inspectorate Group requirements. There is ongoing work to establish the costs of these measures.

However, since the HMCIP inspection there has been a significant change in the profile of the detainee population at Morton Hall, with a large increase in ex foreign national offenders, often with complex needs. As a result the availability of more secure accommodation, including Windsor Unit, is necessary to house any detainees whose risk assessment makes them unsuitable to be held in more open conditions.

We agree that it is important that all staff working in an IRC have a broad understanding of the needs of detainees. There is a comprehensive Detention Awareness training package in place for all staff at Morton Hall IRC and work is underway to implement a programme of regular refresher training.

There is a robust safer detention system in place across the detention estate to identify and manage detainees who are at risk of self-harm or suicide, which includes Assessment, Care in Detention and Teamwork (ACDT) and Vulnerable Adult Care Plans. The large majority of detainees who are monitored on an ACDT are assessed as vulnerable as a result of their concerns about being deported or because of a change in circumstances. This is kept under review.

Staff at Morton Hall IRC are aware that the service of removal directions can be a significant event for a detainee and provide individual support if there are signs or indications that the detainee is at risk. Mr Ahmed had received his removal directions six days prior to his death and there were no indications that he was at risk of self harm or suicide, which would have resulted in extra care and support.

At Morton Hall all staff operate on the basis that every contact matters: every interaction between a member of staff and a detainee contributes to they effective management and care, and positive engagement is not limited to a relationship with a single personal officer. Welfare services are provided by specialist staff from Children's Links, and each detainee has a welfare booklet opened during induction which is regularly reviewed and updated during their stay at Morton Hall. Again, I must stress that in the case of Mr Ahmed there were no indications prior to his death that he was at risk of self-harm or suicide.

The use of electrical items in rooms has also been reviewed by officials at the National Offender Management Service. The electric leads on the kettles at Morton Hall are standard issue for the type of kettle in use in custodial settings as are all other electrical items in rooms at Morton Hall such as TVs and DVD players. Shortening electrical leads would unfortunately not eliminate the risk of self-harm or suicide. Instead, when a detainee presents a risk of self-harm or suicide, he will continue to be managed and monitored on an ACDT document and any necessary

steps to reduce risk (including limiting access to items that could be used in acts of self-harm) will be taken, as is the existing policy.

I would like to thank you for raising these important issues and hope that this response addresses your concerns. A copy goes to Andrew Selous MP, Parliamentary Under Secretary of State for Prisons, Probation, Rehabilitation and Sentencing at the Ministry of Justice.

p.p. **Rt Hon James Brokenshire**