Short thematic report by HM Inspectorate of Prisons

A review of short-term holding facility inspections

2011–2015

March 2016

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Printed and published by:
Her Majesty's Inspectorate of Prisons
Victory House
6th floor
30–34 Kingsway
London
WC2B 6EX
England

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Acknowledgements

This report was written by Beverley Alden (Inspector) with assistance from Hindpal Singh Bhui (Team Leader).

Introduction

This review briefly summarises key themes from the 40 short-term holding facility (STHF) inspection reports published in the five years to March 2016 (see Appendix I). The purpose of this review is to consider the degree of progress that had been made and to highlight both points of concern and positive practices that could be replicated more widely. The report also quotes a number of illustrative cases to promote understanding of the experiences of detainees held in these environments. For most detainees, STHFs are their first experience of detention and many are likely to be anxious and stressed about what will happen to them next.

The last review of STHFs was published in 2010 and noted significantly improved treatment of and conditions for detainees held in STHFs over the preceding six years. Physical conditions had been upgraded in many STHFs and staff were largely respectful and decent. Such findings have largely been replicated in the current review, which shows that, on the whole, standards have been at least maintained, and most detainees are held safely and in conditions that are appropriate for short periods of detention.

However, some facilities were not fit for purpose, and some key concerns identified in the last review have not been resolved. These include the co-location of unrelated men, women and families, excessively long detention of both adults and children in facilities that are only designed to hold people for a few hours, poor use of telephone interpretation and lack of access to the open air. Safeguarding adults policies and links with the local authority were also generally lacking and, despite some better recent findings, detention staff usually had insufficient knowledge of trafficking risks and procedures.

STHF reports will in future focus more strongly on these and other key recurring areas of concern.

Peter Clarke April 2016
HM Chief Inspector of Prisons

Section 1. Background to the report

1.1 HM Inspectorate of Prisons has been inspecting short-term holding facilities (STHFs) since 2004, although these inspections were only placed on a statutory footing in 2006 by Section 46 of the Immigration, Asylum and Nationality Act. At the time of writing there are 37 STHFs,[1] which are normally located at ports of entry or at immigration reporting centres. People are normally held in them for two main reasons: during investigations by immigration officers after arrival in the UK, or as a staging post before removal. They may also hold people awaiting transportation to a longer-term place of detention. Most STHFs are designed to hold people for just a few hours. There are three residential facilities that can hold detainees for five days before their transfer or release, or seven days if removal directions have been set.[2] There are also three STHFs in France that are run by UK detention staff under juxtaposed controls. These facilities are inspected jointly by HM Inspectorate of Prisons and the Contrôleur Général des Lieux de Privation de Liberté, which is the French National Preventive Mechanism. Most STHFs hold men and women, and some also hold children and families. All inspections of STHFs are unannounced.

1.2 The Home Office awarded the contract to manage STHFs to Reliance in May 2011 and the contract was subsequently transferred again to Tascor, which currently runs most of the UK's STHFs. The exceptions are Dunkirk and the part-time facilities at Bristol and Cardiff airports, which are all managed by Border Force, and the Longport Freight Shed, which is managed by Home Office Immigration Enforcement staff. In 2012, the residential facility at Colnbrook IRC was re-designated as an induction unit and is no longer run as an STHF.

1.3 The Home Office has not, at time of writing, published STHF rules. Draft rules have been issued on a number of occasions and were most recently circulated for consultation in February 2016.

[1] This figure is from the end of May 2016. The number of these facilities fluctuates. Some are opened only according to need, others have been used as overflow or temporary facilities and some may not be used again (Longport and Frontier House). Not all are managed by Tascor or Immigration Enforcement (e.g. Dunkerque).

[2] The residential facilities are Pennine House, Larne House and a male facility located in Yarl's Wood immigration removal centre. The Yarl's Wood STHF for male detainees is inspected alongside the larger immigration removal centre and there are no separate reports on this facility.

Section 2. Summary and key findings

Safety

2.1 With a few exceptions, escort vans were generally clean and fit for purpose, but some detainees were still moved too frequently between places of detention. The Home Office had responded to findings that detainees were arriving at holding rooms excessively early for their flights and had imposed a rule that detainees should not arrive at airports more than five hours before departure. Person escort records (PERs), used to assist safe transfer to and from different detention facilities, were usually completed reasonably well by escort staff. At a significant number of inspections, we found use of handcuffs during escort without adequate risk assessment or obvious need.

2.2 On arrival, searching was usually respectful but sometimes carried out in view of others. Booking-in processes, which usually involved sensitive and personal questions, were not always confidential or sufficiently robust in assessing welfare needs. Interpretation was under-used. Access to telephones, and therefore to vital contact with families and lawyers, was usually good.

2.3 As we found before, recorded instances of bullying in short-term holding facilities (STHFs) were rare. The design of most holding rooms allowed for good staff observation and they were generally aware of the potential for bullying or unwanted attention. However, at a significant number of facilities women could not be, or were not, held separately from unrelated adult men, increasing the risks of inappropriate attention or intimidation; some had felt extremely insecure as a result.

2.4 Self-harm incidents were rare, and where they had occurred staff had managed them appropriately. There had been no self-inflicted deaths in the period encompassed by this report. We saw some disproportionate measures, such as the removal of watches and belts from detainees irrespective of the individual risks they posed. Not all detention staff managing detainees on an ACDT (assessment, care in detention and teamwork – the case management for detainees at risk of suicide or self harm) understood the process and many had had no recent training in prevention of self harm or suicide. As noted in our previous review, not all detainee custody officers (DCOs) carried anti-ligature knives, although the frequency with which we found this had decreased significantly. At some locations, detainees were looked after by Border Force or Immigration Enforcement staff who had not received appropriate detention training.

2.5 Throughout 2013 and 2014, findings relating to safeguarding adults had been consistently poor. Policies and links with local authorities were lacking, staff were not trained and lacked knowledge of trafficking indicators and the National Referral Mechanism. However by 2015, some of these areas were showing distinct improvement.

2.6 The number of children detained in STHFs varied very significantly, from two in the previous three months at Glasgow Airport (2011) to several hundreds at Dover Seaport (2015). Most families with children and unaccompanied minors were detained at ports following attempted entry into the UK. All DCOs had undertaken some safeguarding children training and most staff were familiar with the need for care planning. Some facilities did not hold unaccompanied children and families separately from unrelated adults, which raised potential safeguarding issues. DCOs were generally unfamiliar with the Tascor child protection policy.

2.7 Specialist immigration teams had been developed to deal with children and young people and were responsible for interviewing them and progressing their cases. These staff normally had a good level of training. Social workers or other appropriate adults were called upon to support children while they were being interviewed, but in some areas there were not enough of them to meet the need. Social services were often called to assess the age of detainees if it was in doubt, but a Merton compliant age assessment was not routinely completed. Despite very good links with local social services teams at some STHFs, many of the children detained had been held for substantial periods of time in unsuitable conditions.

2.8 Use of force was rare. Where it had been used, it appeared to have been proportionate and used as a last resort. Reporting of incidents had improved and provided assurance of reasonable accountability. During inspections undertaken earlier in the review period, we found DCOs received regular training in control and restraint (C&R) techniques. We saw some good examples of de-escalation in incident reports. In 2014–15, DCOs undertook the HOMES (Home Office Manual in Escorting Safely) training, which was considered to be more applicable to their working environment. As noted in the previous report, detainees resisting removal were appropriately booked for a later removal or overseas escorts were arranged in order to avoid escalation of violence and consequent risk of harm to detainees and staff.

2.9 Detainees were normally held with the necessary legal authority to detain (IS91) and given written reasons for detention (IS91R), although they were still always in English only. However, at the secondary search area at Becket House (2015) the legality of detention was at least questionable, and at Longport (2015), we were concerned that Home Office staff did not seem to recognise that people were detained; this was despite them being in possession of legal detention authorities and unable to leave.

2.10 The number of detainees held varied significantly across the facilities we inspected from 30 at London City Airport (2015) in the previous three months, to 650 at Gatwick Airport South (2013) and nearly 3,000 at Dover Seaport in October 2015. Most people were held for only a few hours but in a large number of facilities we found some who were held for over 24 hours in conditions that were unsuitable for such long periods of detention.

Respect

2.11 The size and quality of accommodation varied and some facilities needed refurbishment. Many were cramped and the lack of natural light in most facilities was a major concern for people held for longer periods. Non-residential holding rooms did not have adequate sleeping facilities and most had inadequate washing facilities (the new facility at Heathrow Terminal 2 was the exception). The quality of accommodation at a small number of facilities was very poor and some failed to meet basic standards of hygiene and decency.

2.12 Facilities were often not designed to hold men, women and children separately. Married couples in the residential facilities were not permitted to share a room.[3] Most holding rooms had separate toilets for men and women, although they were not always adequately screened and not all had seats. Toiletry packs and a small stock of clothing was available in many facilities. Copies of a basic Tascor information booklet were usually freely available in a wide range of languages.

2.13 There was no dedicated health care provision on site in the non-residential facilities, but staff could call a medical triage telephone line for advice, or the emergency services if necessary. The three residential facilities had a 24-hour healthcare presence.

[3] The Home Office has subsequently informed us that married couples are now allowed to share rooms at the residential facilities.

2.14 As in the last review, we found that staff were generally polite and courteous towards detainees, and often demonstrated a good understanding of how to care for detainees decently. However, there was very limited use of interpretation despite obvious need.

2.15 We found no evidence of racial or religious discrimination and most facilities had appropriate religious items to help detainees to practise their religions. The size and layout of holding rooms meant they were often unsuitable for wheelchair users or others with significantly reduced mobility. We saw few people detained with obvious identified disabilities and DCOs opened care plans for such detainees when they were detained, but there was little understanding of disabilities that were not immediately visible.

2.16 The number of complaints was low but we had concerns about the quality and robustness of the small number of responses to complaints we saw. A few STHFs did not have freely available complaints forms, and not all complaints boxes were secure or emptied on a daily basis. Notices promoting the Independent Monitoring Board (IMB) were displayed in some holding rooms, but not all STHFs had an IMB.

2.17 With some notable exceptions (Bristol and Cardiff airports, 2015 and Longport Freight Shed, 2015), catering arrangements were adequate, including for those with special dietary needs.

Activities

2.18 The activities available in many STHFs were suitable for short periods of detention. Most STHFs provided reading materials to detainees, although they were often out of date and/or in English only. Most STHFs had a television, some had portable DVD players and films. Activities for children were available at some locations and were generally adequate for brief stays.

2.19 An ongoing concern was that STHFs did not permit access to the open air even when detainees were held for unreasonably long periods. At two residential facilities, access to outside areas was tightly restricted. Detainees in the male STHF at Yarl's Wood were the only ones with good outdoor access.

Preparation for removal and release

2.20 Detainees held in STHFs were removed or released to a range of destinations, including to other places of detention and straight to flights. Those in non-residential facilities could not receive visitors and those in residential facilities could receive a limited number. While many of the holding facilities were able to provide clothing for detainees, not all clothing was suitable for the climate in destination countries. At several facilities, detainees could have property brought in by family or friends, but this was not the case everywhere.

2.21 A praiseworthy innovation at Dover Seaport (2015) was the 'Atrium', a large and well equipped area where detainees released from the nearby STHF received support from third sector organisations. Detainees were moved there to wait for transport to their accommodation once they had been granted temporary admission into the UK. A worker from Migrant Help assisted adults and a Refugee Council worker with considerable experience of working with unaccompanied minors provided support for unaccompanied children.

2.22 Detainees were not permitted access to the internet, including email, social networks and Skype, at non-residential facilities. This is a longstanding and disproportionate restriction for a detainee population. Internet access was permitted in the residential facilities but a wide

range of legal, information and recreational websites were blocked. Detainees could not always download translated PDF documents or access country of origin information reports.

2.23 For those being transferred into further detention, several facilities provided detainees with details of the relevant immigration removal centre, but detainees were often ill informed on what would happen to them next.

2.24 No support or funds were available to those released into France, including potentially vulnerable detainees, to enable them to safely reach their destination. In the UK, some funds were available but payment was not guaranteed and detainees who required it were not always made aware of it.

Section 3. Safety

Escort vehicles and transfers

3.1 Escort vehicles we saw were generally clean, decent, and fitted with integral CCTV with audio. However, at Dunkerque (2014) the escort vehicle provided by private contractor Eamus Cork Solutions was caged, dirty and littered with cigarette butts. None of the vehicles used in the UK had cages. Unrelated men and women were almost never transported in the same vehicle, a rare exception being at Portsmouth International Port (2013).

3.2 We continued to find too many examples of detainees being subject to frequent moves between places of detention. One detainee had been in five places of detention in five weeks (Cayley House, 2012). At Pennine House, a detainee had been moved 10 times in just over two months, including three moves between Dungavel Immigration Removal Centre (IRC) and Pennine House and back to Dungavel. Again at Pennine House (2011), a pregnant detainee had collapsed in the centre during the course of moves over several days from Northern Ireland via Scotland to Yarl's Wood IRC.

3.3 Escorts often telephoned ahead to the facility to indicate planned arrival times. This was helpful, but there were some examples of excessive delays, either to pick up times or journey times. For example, one detainee had made a substantiated complaint in July 2011, saying:

'I was awoken at 7am to be told I was leaving for Brook House in one hour. I am still here now. The time is 8pm. I have asked people through the day why I have not been moved, but they could not give me an answer.' (Pennine House, 2011)

3.4 In another example, a 63-year-old detainee whose behaviour was indicative of mental illness had spent over two hours in an escort van being transported to an immigration removal centre from the airport right next to it (Heathrow Terminal 1, 2014).

3.5 At Bristol and Cardiff airports (2014) Border Force staff told us that it took a long time for Tascor staff to arrive at the airports to escort detainees onwards, and that many had to wait in the passport control areas for several hours. We were told of one case at Cardiff of a Malaysian national who had been refused entry at 4.40pm; Border Force had advised Tascor of his detention and requested an escort. The man had been held in the control area until just after 10pm, when Tascor had called to say that they would not be coming as they had no team available. As a result, Border Force had granted the man temporary admission late at night.

3.6 Detainees were sometimes transported overnight for an early morning flight, but other detainees were often transported with them to airport holding rooms, even if they were on a much later flight. These unnecessary overnight moves were tiring, disorientating and not justifiable:

3.7 At Gatwick Airport South (2013), the reasons for detainees arriving more than five hours before their flight were recorded in a log, but they were administrative or logistical rather than reflecting the detainees' interests. For example, in one case the recorded reason was 'for officers to finish within working hours'.

3.8 However, by the time of the inspection of Cayley House in 2014, the Home Office had directed that detainees should not arrive at the facility more than five hours before their flight was due to leave. This avoided the exhausting long pre-flight detentions that we had seen at the previous inspection in 2012.

3.9 Person escort records (PERs), intended to promote safe transfer to and from different detention facilities, were usually completed reasonably well by escort staff, but some lacked detail or properly completed risk sections that could have compromised detainee safety (Loughborough, 2013; Portsmouth International Port, 2013). For example, we observed an escort where a detainee's PER noted 'suicide attempts' but there was no further elaboration. On his 'airline risk assessment' (completed by the Home Office for each flight and passed on to the cabin crew by escort staff to provide relevant risk information), the question 'is there a known risk of self-harm?' and been answered as 'no'. The overall risk assessment process in this case had been poor, and potentially important information was not passed on to airline staff, or even noticed until pointed out by inspectors (Cayley House, 2014).

3.10 At a significant number of facilities, detainees were routinely handcuffed during escort, irrespective of the individual risks they posed. This included when passing through public areas, although we saw examples of DCOs doing their best to cover handcuffs with their jackets to preserve dignity (Luton Airport, 2013). At some locations, such as Manchester Airport (2013), staff told us that they would use handcuffs in virtually all cases as it was a requirement of airport security. In addition, some escorting staff routinely wore high visibility clothing when transferring detainees to departure gates at airports, unnecessarily drawing attention to detainees (Heathrow Terminals 3, 4 and 5, 2015; Cayley House; 2014).

3.11 We accompanied several detainees with in-country escorts who went with them to their flights and waited until the flight had left, but did not board. In some of these cases, inefficient practices had a significant negative impact on detainees. For example, a Brazilian man who had arrived from Portugal had been detained from his flight and held at the Heathrow Terminal 1 holding room overnight. This short-term holding facility (STHF) has no sleeping facilities. He was due to return to Portugal the next day, after 18 hours in detention. He had no objections to his treatment and accepted the Border Force decision not to allow him entry. Staff were friendly, assisted him with his luggage and escorted him through public areas reasonably discreetly. However, after boarding the plane, he was told to leave by the captain because escort staff had not brought with them a copy of his risk assessment. The man was returned to detention until another flight could be booked. The risk assessment recorded no risks (Cayley House, 2012).

Arrival

3.12 Searching at STHFs was usually respectful. However, some detainees were searched too often for no apparent purpose (Eaton House, 2011; Becket House, 2015) and some facilities did not have a designated searching area, which meant that detainees were searched in sight of others (London City Airport, 2015; Pennine House, 2013). Cayley House had a room for searching detainees, but this was still a problem:

The curtain for the room where searching took place was not closed, and so detainees were searched in view of other detainees; we saw a male detainee at the reception desk watching a female detainee being searched. (Cayley House, 2014)

3.13 At a number of locations, we were told there was no guarantee a female member of staff would be on duty (Heathrow Terminal 1, 2011; Stansted, 2013), which was inappropriate when receiving and searching female detainees. During some inspections we found only male staff on duty (Portsmouth International Port, 2013; London City Airport, 2013), although

staff took a pragmatic approach and searched female detainees with a wand only. In more recent inspections during 2015 this had improved. While there remained no guarantee of there being male and female staff available, we were told it was more likely to be the case.

3.14 We saw some good examples of detainees being dealt with sensitively on arrival and staff making efforts to put them at their ease (Larne House, 2011) although not all initial interviews adequately assessed detainee welfare (Cayley House, 2014). At some locations, detainees were booked in at a reception desk located within hearing of other staff and detainees. In such cases the process, which usually incorporated personal and sensitive questions, for example, questions about risk of self-harm, potentially inhibited some detainees from disclosing important information (Larne House, 2011; Becket House, 2015). Professional interpretation was not always used when necessary:

The detainee custody officers (DCOs) failed to use telephone interpretation when inducting the detainees, which raised concerns about the reception, supervision and care of other detainees who did not speak English. The DCOs tried to establish rapport and communicate through gestures, but this was clearly inadequate. (Stansted, 2013)

Interviews were largely conducted in English. Telephone interpretation had not been used in the previous three months, despite some obvious cases of need. (Portsmouth International Port, 2013)

3.15 Although not commonly found, some practices were too risk averse. For example, detainees were not allowed to take coins for use in the payphone into the holding room at Waterside Court (2011), which we were told was to prevent self-harm. If detainees wanted to make a telephone call, staff normally let them use the office telephone but would occasionally put the detainee's coins into the payphone on their behalf. This was routine practice which, at best, severely overestimated risk, and was obviously not based on individual risk assessment.

3.16 Access to phones was generally good. At many, but not all facilities (for example, Cayley House, 2014), detainees were offered a free phone call on arrival. There was usually a payphone in holding rooms that could receive incoming calls. At all locations, detainees were not permitted to retain mobile phones with cameras or internet access, but staff usually loaned detainees a suitable mobile which could be taken into the holding room and enabled them to readily contact family, friends and legal representatives. However, at more recent inspections at Heathrow, mobile phones had not been consistently provided, thereby inappropriately restricting detainees' ability to communicate (Heathrow Terminal 2, 2014; Cayley House, 2014; Heathrow Terminals 3, 4 and 5, 2015).

Bullying and personal safety

3.17 As we have found before, recorded instances of bullying in STHFs were rare. Staff were generally aware of the potential for bullying or unwanted attention, and managed it reasonably well when necessary. A detainee information booklet in different languages clearly warned against bullying and Tascor had an anti-bullying and harassment policy, although not all staff were aware of it or had received recent relevant training.

3.18 In most facilities staff had a good view of the holding rooms and detainees were easily able to attract their attention. In others, poor sight lines were mitigated by CCTV to cover any areas out of sight of the supervising staff, although some rooms with evident blind spots did not have cameras (for example, Eaton House, 2011). At Coquelles Freight holding room supervision of detainees was poor; there was no CCTV, detainees could not be constantly monitored and call bells did not work so detainees could not easily ask for help in an emergency.

3.19 We remained concerned that at a significant number of facilities women could not be, or were not, held separately from unrelated adult men. This was potentially intimidating for women, particularly given the backgrounds of those who may have experienced victimisation, sexual violence and trafficking. At Sandford House (2012), a female detainee had been held for over nine hours with up to five male detainees. Some non-residential holding rooms at which children were no longer detained used designated family rooms to accommodate women (for example, Drumkeen House, 2011). Lack of separation was also an issue at some residential facilities:

If a large number (of women) were held at one time, they were accommodated on a corridor with rooms holding men. Otherwise, they were grouped together in three rooms on one corridor. However, this corridor could not be locked off because of fire regulations and male detainees could walk through the area to get to the dining room. (Larne House, 2011)

They (women) slept in dedicated rooms at the end of the corridor but…could not lock their doors. We were told that in the past one woman had barricaded herself into her room because she did not feel safe. (Pennine House, 2013)

3.20 At Longport Freight Shed, women and children were prioritised for transfer to the Dover Seaport holding centre, but nonetheless many were accommodated overnight in degrading conditions and where safeguarding risks were very considerable. At Dover Seaport itself, a woman who was a suspected victim of trafficking was placed in the small family room. However, the only toilet was across the main holding room which was crowded with men and boys.

3.21 Staff generally demonstrated a readiness to challenge bullying behaviour and described taking a pragmatic approach towards managing potential safety issues, for example allowing a female detainee to sit in the office with staff so that she could sit separately from a group of male detainees (Heathrow Terminal 1, 2011). On rare occasions at Coquelles Tourist holding room (2012) staff said they had detected tensions between people smugglers and the people they were transporting when both were held in the same room. At such times we were told that staff remained in the holding room with them. At Festival Court (2011) detainees who posed a risk to others were locked in an adjacent immigration interview room. However the room lacked a toilet, telephone or television and we were not assured that governance or security arrangements around this informal separation were robust.

Self-harm and suicide prevention

3.22 Self-harm incidents at facilities were rare, and there had been no self-inflicted deaths in the five-year period encompassed by this report. In general, the small amount of actual self-harm appeared to be well managed. For example, during an inspection of Cayley House (2014), we reviewed the documentation on a serious self-harm incident when a detainee had headbutted a piece of furniture. Staff took swift and appropriate action to prevent the detainee from harming himself further (see use of force section).

3.23 DCOs received self-harm and suicide prevention training during their initial training course, although most had not received refresher training thereafter. They had all had first aid training. Where staff other than Tascor DCOs managed facilities, awareness and management of self-harm risks was relatively poor. At Bristol and Cardiff airports, Border Force staff had not received specific training in suicide and self-harm prevention. No specific risk assessment was undertaken on detention, beyond limited information in the IS91 form, when one was completed. At Becket House (2015) the security guard in the secondary search area had not been trained in self-harm prevention or first aid, was not aware of any suicide prevention procedures and did not carry an anti-ligature knife. At Dunkerque (2014),

authorised search officers (who staffed the facility) were not aware of any self-harm prevention procedures. Not all staff, including Tascor DCOs, carried a ligature knife, which could have led to critical delays in emergency situations.

3.24 DCOs opened a suicide and self-harm warning form if a detainee harmed or threatened to harm themselves; staff were familiar and confident with the form, although it was not necessarily a recognised document at IRCs. The assessment, care in detention and teamwork (ACDT) system, the case management approach for detainees at risk of suicide or self-harm used at all IRCs, was not always adequately understood in STHFs, even when used. For example, at Dover Seaport (2015) staff had cared for six detainees through the ACDT system in the six months before the inspection, but documentation suggested little understanding of the how the process was intended to protect detainees. For example, in one case it specified that a detainee placed on 'constant supervision' should have hourly welfare checks. At Pennine House residential facility (2013), staff used the tools provided by ACDT more proficiently. At least 11 detainees had been cared for through the ACDT system in 2012, and two in 2013. From the records available, it appeared staff had behaved proportionately and appropriately to reduce and manage the risks in these cases.

3.25 On occasion, we saw disproportionate measures such as the removal of watches and belts from detainees, irrespective of the individual risks they posed (for example, Becket House, 2015). At Larne House (2013) detainees were not allowed to keep their shaving kit and were only given a razor if they could convince staff that they were not a risk to themselves or others. They could then only use the razor under the supervision of a detention custody officer. Such practices did not appear to be motivated primarily by a desire to provide appropriate and proportionate care for detainees.

Safeguarding (protection of adults at risk)

3.26 In 2013, HMIP began inspecting safeguarding measures which protected adults at risk. Throughout 2013 and 2014, findings were consistently poor: policies for safeguarding adults had not been developed, and links with and referral pathways to local authorities regarding detainees with social care needs were undeveloped. In some locations staff said they would open a care plan for detainees with a disability, but staff, particularly DCOs, lacked training and knowledge in trafficking indicators and the National Referral Mechanism.

DCOs were not aware of the National Referral Mechanism (NRM) to report suspected victims of trafficking or trafficking indicators, and said these matters were Border Force's responsibility…Tascor did not attend the regular meetings between Border Force and Hillingdon social services…which could have expanded DCOs' learning opportunities. (Heathrow Terminal 3, 2015)

There was no policy for safeguarding adults at risk or procedures for identifying detainees who may need to be placed in the care of social services. Furthermore, there were no links with adult social services. Care plans were only used for children. There was very basic awareness of trafficking and Crimestoppers posters on trafficking were displayed in the holding rooms. Adult victims of trafficking could be referred to the national referral mechanism by Border Force officers. (Gatwick North, 2013)

3.27 In 2015 there were some improvements. For example, at Heathrow Airport (Terminals 3, 4 and 5) Border Force had an onsite safeguarding and trafficking (SAT) team which, in addition to dealing with children's cases, was responsible for suspected victims of trafficking, both adults and children. The Border Force was considering expanding the remit of the SAT team to cover all vulnerable adults. At Terminal 5, immigration officers were reminded of intelligence-led anti-trafficking operations.

Safeguarding children

3.28 The number of children held in short-term detention varied significantly from facility to facility. For example, at Glasgow Airport (2011), two 17-year-olds were the only children held in the previous three months, while at Heathrow Terminal 4 (2015) 67 children were held in the previous three months, including 12 unaccompanied minors; the longest detention of a child at Terminal 4 was for just over 19 hours. Meanwhile, at Dover Seaport (2015), during a substantial rise in the number of people coming through the Channel Tunnel, 370 unaccompanied children were detained in one three-month period, 36% of whom were 15 years old or younger. Some were held for very long periods in unsuitable conditions:

Children were routinely detained for excessive periods of time, often overnight and with inadequate supervision. Accompanied children were held for an average of 16 hours, with the longest detention being 40 hours. Unaccompanied children were held for an average of 12 hours and 19 minutes, with the longest detention being 58 hours and 20 minutes. The facility could not safely accommodate children in these numbers and for this length of time. (Dover Seaport, 2015)

3.29 At Heathrow there were specialist immigration teams to deal with children and young people, responsible for interviewing children and progressing their cases, although it could not be guaranteed that a member of these teams was on duty at all times. Not all staff had received background checks from the Disclosure and Barring Service (Stansted Airport, 2013). While there were exceptions (Stansted Airport, 2013), Home Office staff were usually appropriately trained; for example, at Heathrow Terminal 5 (2015) team members who interviewed children were required to have attended a four-day safeguarding course. At the same inspection, we saw fortnightly pan-Heathrow case conference meetings, attended by immigration officers from each terminal and Hillingdon social services, which provided an opportunity to share learning and discuss operational issues. We saw some good examples of active safeguarding work with children.

3.30 Family returns were also managed by designated immigration teams. For example, at Festival Court (2011) the family returns team was working with 13 families, all at various stages of the Home Office family returns process.[4]

3.31 Social workers or other appropriate adults were called upon to support children while they were being interviewed. At Heathrow Terminals 3, 4 and 5 (2015), a list of appropriate adults had been drawn up by Border Force. These volunteers had a familiarisation briefing, but no formal training for their role. There were not enough responsible adults, although Border Force had recruited more volunteers who were awaiting security clearance. Border Force case records indicated that some unaccompanied children had been fingerprinted, interviewed and detained without a responsible adult. A 14-year-old boy was screened without a responsible adult because there was no-one available.

3.32 DCOs were not generally familiar with the Tascor child protection policy but had usually undertaken safeguarding training. Not all had received refresher training. Despite this most were familiar with the need for care planning and a care plan was opened for unaccompanied children entering the holding room, and latterly for accompanied children too. The aim of care plans was to ensure the needs of the child were met and welfare issues addressed. The quality of care plans varied. Some DCOs and immigration staff, including members of the specialist children and young people's teams, were not sufficiently aware of trafficking

[4] Home Office Enforcement Instructions and Guidance (2016) Chapter 45, Families and children, section b: Family returns process operational guidance. London: Home Office. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497901/Ch45_b__noSeps_EXT_v5_20160127.pdf

indicators and the National Referral Mechanism. In contrast, trafficking training had been delivered to all Border Force staff at Bristol Airport, and was upcoming for those in Cardiff Airport, and staff we spoke to were well sighted on trafficking indicators (Bristol and Cardiff airports, 2014).

3.33 Some facilities were not able to hold unaccompanied minors and families separately from unrelated adults, which presented potential safeguarding issues. Others had family rooms, some of which were well equipped, although they tended to be small and could hold only a few people comfortably. We saw instances of minors being held with unrelated adults, including at Dover (2015) when at one point in the inspection, 20 adult detainees and 19 unaccompanied children, including one girl, were detained at the same time. All the boys were held in the main holding room with adults.

3.34 Social services were often called to assess the age of detainees if it was in doubt, although at London City Airport (2013) it was evident that some Border Force staff were unaware of the process for managing such cases, and had not heard of a Merton compliant age assessment. Home Office policy still allowed for a chief immigration officer to assess a detainee as an adult if they looked significantly over the age of 18, without the opinion of a qualified social worker, which was inappropriate.

3.35 At some centres there were very good links with local social services teams; this was the case at Dover Seaport but many of these children had been held for substantial periods of time in degrading and potentially unsafe conditions at Longport Freight Shed before arrival at Dover. During our inspection, 10 children were held at Longport and the child held for longest in the previous month was detained for more than 21 hours. We saw other examples of inappropriate management of minors:

DCOs and Border Force staff told us about an unaccompanied detainee, who it was agreed was a minor, who had been held at the facility around 18 months previously. He was not released into the care of social services, and instead was transferred elsewhere into further detention on the direction of a senior immigration manager. This was due to a perceived abscond risk, but was inappropriate. (London City Airport, 2015)

A European Union national child was detained without the necessary authority (IS91.)[5] *The father was a non-EU national who had lived in the UK and was returning following a visit to his country of origin. The immigration officer brought the father and child to the holding room with only authority to detain the father. The DCO rightly challenged the officer and said she was unable to detain the child without the IS91. The immigration officer told the DCO to book the child in as a visitor, which her line manager agreed to.* (Heathrow Terminal 4, 2011)

3.36 It took too long to transfer asylum-seeking families with children from some holding rooms to their initial accommodation. For example, one family with two children were detained for seven hours and 45 minutes, released at 3.15am for 10 hours and re-detained for a further 15 hours. The family was finally released at 4.10am after spending 22 hours and 45 minutes in detention. Another asylum-seeking family with three children was held for 21 hours and 15 minutes before they were taken to initial accommodation (Heathrow Terminal 1, 2011).

[5] Border Force officers have no power to detain EU nationals where there are no concerns, and therefore issuing an IS91 would in any event have been inappropriate and unlawful.

Use of force

3.37 Use of force was low across the short-term detention estate. Where it had been used, there was usually evidence to show that it was proportionate and used as a last resort following attempts at de-escalation. When it was used, force was often to prevent self-harm, reflecting the high levels of distress of some detainees. In one case at Becket House (2015), restraints were used on a detainee who had self-harmed. Documentation suggested that in all the circumstances, the action taken was justified:

Incident reports showed that staff had to use force to prevent him from banging his head against a wall. A struggle ensued and the detainee was put in handcuffs. The documentation assured us that the force was necessary and used proportionately. (Becket House, 2015)

3.38 In Sheffield Vulcan House (2012), we similarly found that force was used proportionately and for the minimum time that was reasonable in the case of a man who harmed himself and then lashed out at staff:

The detainee started shouting and banging himself against the wall…DCOs attempted to restrain the detainee who bit himself and attempted to bite an officer. The detainee was placed in handcuffs but continued to try to bite staff. DCOs talked to the detainee in an attempt to de-escalate the situation. (Sheffield Vulcan House, 2012)

3.39 When detainees were taken from airport holding rooms to a flight and a detainee refused to board, the removal was cancelled and the detainee taken to an IRC. The removal was re-scheduled with specially trained overseas escorts, and this policy helped to minimise the risk of violence and ensure that force was used as a last resort. Not all detainees were seen by a medic following use of force. For example, at Cayley House in 2014 one report recorded how a detainee complained about 'the wrist of his right hand' following the use of force, and the DCO recorded: 'examined his mobility in the wrist, finger seems to be all okay so it was decided not to call the paramedics.'

3.40 The quality of incident reports and their oversight by managers was reasonable although the reports were not always used appropriately. At Pennine House (2013) incident reports were completed when removal directions were served on detainees and managers told us they were a way of providing evidence of removal directions having been served on time. This practice undermined the system for reporting concerns, and meaningful trends were obscured by the mass of routine information.

3.41 In earlier inspections, DCOs received training in control and restraint (C&R) techniques as part of their initial training, and also received regular annual refresher training. However, there were not always the requisite three officers present to carry out C&R. In these circumstances staff told us they would rely on their de-escalation skills, and we saw some good examples of this in incident reports.

3.42 In 2014–15, DCOs undertook the HOMES (Home Office Manual in Escorting Safely) training, which we were told was more applicable and appropriate to their working environment. HOMES techniques included the use of nylon waist and leg restraints, and these were stored at some holding rooms we inspected during 2015 (Heathrow Terminals 3, 4 and 5).

3.43 At Heathrow Terminal 5 (2015) force had been used twice in the previous 12 months: once in the holding room and once at a gate in the terminal. In the holding room incident the detainee was non-compliant and had repeatedly threatened to attack staff. Rigid handcuffs, which DCOs now carried instead of chain cuffs, were used to restrain the detainee followed by use of a nylon waist restraint belt. In both instances, the documentation assured us that there had been good efforts to de-escalate, and force was used proportionately and as a last resort. However Border Force officers carried extendable batons, which was disproportionate.

Legal rights

3.44 Detainees were normally held with the necessary authority to detain (IS91). We were told that some immigration enforcement officers occasionally asked DCOs to hold detainees without the written authority (Eaton House, 2011), although DCOs generally said they would refuse to accept a detainee without one. There were some exceptions; at Heathrow Terminal 1 (2011) DCOs reported that they occasionally agreed to hold a detainee without an IS91 on condition that 'the IS91 was issued within 10 minutes'. This could have been unlawful. The legitimacy of holding people in the secondary search area at Becket House was at best unclear, at worst also unlawful. Immigration enforcement officers did not issue any written authority to detain before holding people in the area. The Home Office security guard logged detainees' names and nationality together with the time they entered and left the area.

3.45 At Longport (2015), while detainees were given detention documentation, the normal mechanisms of oversight and accountability that should apply to any form of detention were lacking:

We were concerned that on various occasions Home Office staff told us that they did not consider Longport to be a place of detention. This was despite detainees being in possession of legal authority to detain documentation and obviously being unable to leave. (Longport, 2015)

3.46 The information recorded in IS91s was usually accurate, although in too many cases the risk section was not adequately completed. Detainees were normally given written reasons for detention (IS91R), although they were always in English only. At Eaton House (2011) two of the four detainees we spoke to could not read English although the contents of the IS91R had been explained by an immigration officer through an interpreter. However, immigration officers did not always use interpreters when necessary. A detainee who had been refused entry but was to be granted temporary admission for three days was confused as to whether he had an in-country right of appeal or not. He requested to speak to the immigration officer with an interpreter. No interpreter was called and the immigration officer spoke to the detainee in English, which he struggled to understand (Heathrow Terminal 3, 2011). In some cases, the IS91R was not issued until after a screening interview had been undertaken by immigration officers, which could take place many hours after they were initially detained (Dover Seaport, 2013).

3.47 Helpful information was displayed in some holding rooms, such as details of the Civil Legal Advice Line, which signposted detainees to legal aid immigration lawyers (Becket House, 2015; London City Airport, 2015), but information at other centres was out-of-date and/or unavailable in languages other than English:

An out-of-date poster gave a Legal Aid Agency contact number for detainees wishing to be put in touch with a representative, but this would have been of little practical use to detainees who did not speak English. (Heathrow Terminals 3, 4 and 5, 2015)

3.48 A notice promoting the Legal Service Commission's Community Legal Advice line at French holding rooms was irrelevant to detainees who would not be continuing their journeys to the UK (Calais and Coquelles, 2012).

3.49 Fax machines were not always freely available for detainees to send documentation to legal representatives; in some cases DCOs said they would send papers on detainees' behalf but in other cases permission was required from immigration officers before detainees could use the fax machine, which was an unnecessary restriction on detainees' ability to send documents to their solicitors (Cayley House, 2014). Detainees in non-residential facilities were not able to email legal representatives, and not all were able to easily access a telephone (see arrival section). At most facilities legal visits were not permitted.

3.50 At residential facilities, we saw DCOs faxing documents from the staff office, on behalf of detainees, and giving them confirmation receipts (Larne House, 2011; Pennine House, 2013), and detainees could receive visits from legal representatives. Larne House, Pennine House and the STHF for male detainees in Yarl's Wood (2015), were the only locations where detainees could use the internet to seek legal information and advice. However, at Larne House and Pennine House, many legal websites were inappropriately blocked. At the latter, these included the Detention Advice Service, Refugee Council and the United Nations High Commissioner for Refugees.

Casework

3.51 The number of detainees held, and the time they were held for, varied significantly across the facilities we inspected. For example, at Festival Court (2011) in the three months prior to our inspection, 34 detainees had been held. The average length of stay was two hours and 11 minutes. The longest period of detention was five hours and 10 minutes. Similarly, at London City Airport (2015) 30 detainees had been held in the previous three months, for on average, under six hours.

3.52 In contrast, in the three months before our inspection of Gatwick Airport South (2013), 366 men, 232 women and 52 children had been held. On average, they were held for seven hours and four minutes. Ten detainees were held for between 18 and 24 hours and two were held for more than 24 hours. The longest period of detention was 24 hours and 20 minutes.

3.53 At Dover Seaport, there had been a 126% increase in detentions during 2015. In the first nine months of 2014, there were 2,118 detentions; in 2015, the figure had increased to 4,785. Between July and September 2015 alone, there had been 2,781 detentions at Dover. The average length of detention was 18 hours and 18 minutes. The longest period of detention was 66 hours and 25 minutes. During the inspection we saw one detainee who had arrived at 10:45pm on 29 September, and was still there at 1:05pm on 1 October, nearly 40 hours later.

3.54 At the facilities run by UK staff in France under the aegis of juxtaposed immigration controls, processes were different to those applied in the UK. For example, at Coquelles Freight holding room (2012) the 16 detainees held in the facility had been arrested after trying to enter the UK clandestinely in a lorry. There had been 250 other arrests by UKBF and these people (including 13 children) had been handed directly to the Police Aux Frontieres (PAF). UKBF did not fingerprint or record detainees' details on their casework information database. After being handed to PAF, there were four outcomes for detainees; they could stay in France if they had leave to remain, claim asylum, apply for assisted voluntary return or be forcibly removed. In the previous year the holding room had rarely been used and most detainees had been passed to PAF by the contractor without entering the facility.

3.55 Detention was not always kept to a minimum. For example, there were delays in transferring asylum seekers into initial accommodation at Heathrow Terminal 2 (2014); shortly before our inspection, a 66-year-old female detainee claiming asylum on arrival was held for 26 hours before transfer into asylum initial accommodation. At London City Airport (2015) some detainees were removed from and returned to the facility in short spaces of time to facilitate interviews with Border Force officers, which resulted in cumulatively long periods of detention. For example, a detainee was detained at 9.25pm, transferred to Colnbrook IRC at 1am, returned to the holding room at 9.30am the same day, transferred back to Colnbrook IRC at 10.15pm that night, and then returned again to the holding room at 11.05am, two days later. She was granted temporary admission into the UK at 7.20pm that evening, having been detained in the facility for a cumulative total of 24 hours and 35 minutes (London City Airport 2015).

Section 4. Respect

Accommodation

4.1 Most non-residential holding rooms were suitable for short stays, but detention for 12 hours or longer was not uncommon (see casework section). The lack of natural light in many facilities was especially problematic for people held for long periods. Less busy holding rooms at immigration reporting centres and smaller airports tended to be minimally furnished. Some were only opened on an ad hoc basis when needed. Levels of cleanliness were variable and some facilities were in need of refurbishment (Gatwick Airport North, 2013). However, improvements had been made at some facilities since previous inspections, including Electric House (2012) and London City Airport (2013), where additional rooms had been added.

4.2 Holding rooms at larger airports were usually in use 24 hours a day, seven days a week. Detainees were frequently held overnight or after long flights. At Manchester Airport (2013), in addition to fixed chairs, the holding room had a hard reclining chair and a large bean bag, and although pillows and blankets were provided, there was nowhere for people staying overnight to sleep. Even the new holding room at Heathrow Terminal 2 was not suitable for overnight stays, although it was welcome that it now had a much needed shower for detainees who were often held there after long journeys (Heathrow Terminal 2, 2015).

4.3 The accommodation at a small number of facilities was poor and some fundamentally lacked decency:

On very rare occasions, when a large number of detainees arrived at the same time, they were accommodated in a separate room known as the 'customs shed' … [which] *was not fit for use as a holding room.* (Portsmouth International Port, 2013)

Despite staff efforts to make them more presentable, the three holding rooms were some of the worst we have seen and were not fit for purpose…In the corner of each room was a squat toilet with three-quarter length screening, each of which was dirty and smelly despite not having been used for some time. (Coquelles Freight, 2012)

Men, women and children were all held together…Detainees were given blankets and slept on a concrete floor. These blankets were not washed before being handed over to other detainees, increasing the risk of the spread of disease. Many slept in the lorry bay bordered by plastic road traffic barriers. (Longport Freight Shed, 2015)

4.4 At both Lane House and Pennine House, couples were not permitted to share a room, including married couples. Most holding rooms usually had separate toilets for men and women, although these were not always adequately screened to provide sufficient privacy in mixed holding rooms (Sandford House, 2012; Vulcan House, 2012; Drumkeen House, 2013). Toilets did not always have seats. Toiletry packs and a small stock of clothing was available in many facilities, although detainees were not always made aware of this (Becket House, 2015). Copies of a basic Tascor information booklet were usually freely available in a wide range of languages.

4.5 With the exception of the residential facilities, there was no dedicated health care provision on site at short-term holding facilities (STHFs). Detention staff could call a medical triage telephone line for advice, or the emergency services if necessary. At Sandford House (2012) a pregnant woman complained of feeling unwell so paramedics were called and arrived five

minutes later. The woman was quickly moved to hospital for an assessment before going on to further detention.

Positive relationships

4.6 A common finding during our inspection of holding facilities was that staff were polite and courteous towards detainees:

Without exception, staff had a positive attitude and related well to detainees. All the detainees we spoke to said they had been well treated by detention staff, and many said that staff had been very helpful. We saw staff spending considerable time talking to detainees when they came into the facility. (Heathrow Terminal 3, 2011)

Staff were visible throughout the accommodation areas, and spent significant periods in the association area talking to detainees. Detainees spoke very positively to us about the care they received. (Larne House, 2013)

Overall, facility staff were courteous to detainees, empathised with their situation and tried to reassure them. We observed one detainee being escorted to a flight accompanied by a DCO who reassured her throughout her journey to the aircraft. Staff regularly spoke to and tried to reassure detainees in the holding room. (Gatwick South, 2013)

4.7 Staff often demonstrated a good understanding of how to care for detainees decently and showed flexibility in dealing with individuals. For example, at Stansted (2013) DCOs felt strongly that it was preferable to have the holding room door open so that they could better communicate with, supervise and care for detainees.

4.8 However, interpretation was not always used where necessary to communicate and we still found instances where staff were brusque. For example, at Cayley House (2012) we saw an officer chastising a polite detainee who simply wanted help to contact his solicitor, and staff did not sit in the holding rooms to talk to detainees or actively engage with them. This had not changed when we inspected the facility again in 2014. In addition, staff were not always sufficiently proactive; at Pennine House (2013) it was well known that many important internet sites were blocked but staff had not taken any action to deal with the issue.

4.9 At Becket House (2015) we saw some helpful and reassuring treatment of detainees by immigration enforcement staff. At Bristol and Cardiff airports (2015), as the holding rooms were rarely used, Border Force officers were responsible for caring for detainees when they were held in the passport control area. However, they had not received specific training in detention, such as in suicide and self-harm prevention, or control and restraint. We found the same situation at Longport (2015), which was managed by immigration enforcement staff.

Equality and Diversity

4.10 Detainee custody officers (DCOs) received equality training as part of their initial induction, but generally had not undertaken any subsequent refresher training. At some locations, including Coquelles Tourist holding room (2012), DCOs were not aware of the requirements of the Equality Act 2010. Despite this, some staff demonstrated a good understanding of cultural differences and potential issues and we found little evidence of discrimination. There was a diversity policy available in 16 languages.

4.11 Copies of the Bible and the Qur'an were usually available either in holding rooms or on request, together with prayer mats and in some cases a compass. Staff we spoke to were generally familiar with the requirements of Ramadan and information about a number of other key dates on the religious calendar were often posted on staff notice boards. With the exception of Larne House (2013), STHFs did not have designated prayer rooms. At Pennine House (2013) the airport chaplain visited the facility and could be contacted on request.

4.12 DCOs opened care plans for detainees with disabilities and these were sent to a central manager for monitoring. It was evident that some DCOs perceived disability predominantly in terms of mobility issues (Waterside Court, 2011; Calais Tourist, 2012). The size and layout of holding rooms meant they were often unsuitable for wheelchair users or others with significantly reduced mobility. While the new holding room at Heathrow Terminal 5 had an adapted toilet with grab handles, a low sink and an alarm, other locations, such as London City Airport had no adapted facilities. At Eaton House (2011) detainees requiring them could be accompanied from the holding room to use the adapted facilities in the reporting centre.

4.13 At a significant number of holding rooms provision for non-English speakers was poor; the use of telephone interpretation by DCOs was generally insufficient and staff often used hand gestures instead, which was inappropriate:

Although there had been over 850 detentions in the previous three months, the telephone interpreting service had only been used on 16 occasions. One of the two detainees held during our inspection could not speak English, but instead of using professional interpreters, a DCO used Google Translate via his mobile phone. (Heathrow Terminal 5, 2015)

Records kept by Reliance showed that telephone interpretation was not used by DCOs in the three months before our inspection despite over 200 detainees passing through the facility. (Electric House, 2012)

Tascor logs showed low usage of the telephone interpreting service for the number of detainees held in the facility. During the three months before our inspection when 462 detainees had been held, telephone interpretation had only been used 18 times. (Stansted, 2013)

Complaints

4.14 The number of complaints submitted by detainees was generally very low. Given the short periods that most detainees spent in detention this was not surprising, and detainees generally expressed very few concerns to us about detention staff. However, in some cases it was not made easy or obvious how to complain:

Complaint forms were not available in the holding room. Detainees wishing to complain were expected to raise their concerns with Border Force staff, who would then give detainees a complaint form. The lack of freely available forms and of a secure complaints box might have inhibited detainees from complaining. (Dunkerque 2014)

4.15 Dunkerque was not run by Tascor, but a small number of holding rooms that were, did not have freely available complaints forms and some complaints boxes were not secure or not emptied each day. At Calais and Coquelles Tourist (2012), complaints boxes could be opened without a key. At Drumkeen House (2013) we submitted a test complaint form asking the Home Office to telephone us but no response had been received three weeks later. During our inspection of London City Airport (2013), staff were unable to locate the key to the complaints box, and at Becket House (2015) staff could not remember the last time complaints boxes had been emptied. These factors gave little assurance that detainees

were provided with the protection of a properly functioning system which provided the swift resolution that was so essential for people who might not be in the country for long.

4.16 We had concerns about the quality of responses to complaints we saw. At Pennine House (2013), detainees had submitted 37 complaints in the previous 12 months. A number of them were substantiated but action was not always taken to resolve the issues raised: for example, two complaints related to insufficient internet access, which was still poor. At Heathrow Terminal 4 (2015), three detainees had submitted complaints in the previous 12 months. One detainee complained that she was not able to shower and the investigation found that she was not taken to Cayley House for a shower, yet the complaint was recorded as unsubstantiated. Another detainee held with his son for more than 24 hours complained about the inadequate sleeping facilities, overcrowding and temperature of the room, which were all legitimate grievances for detainees held for such a long time, yet this complaint was also found to be unsubstantiated. The third complaint was about a long wait and the poor conditions; although the investigations described the situation as 'regrettable' it went on to find the complaint unsubstantiated. In these three cases, there was no evidence that the investigator had attempted to contact the detainees to explore their complaints. In one complaint response we saw:

The detainee was very positive about staff but concerned that they had revealed his medical condition to other detainees through indiscreet talk. The investigation report was extensive but appeared focused on exonerating staff rather than establishing the facts. It led to no further action, when it would have been appropriate at least to issue a reminder to staff about the importance of medical confidentiality. Larne House (2013)

4.17 More positively, at Glasgow Airport (2011), complaint forms were available in English and 14 other languages in the holding room, along with pens and a complaints box. Detainees were able to raise a complaint without being monitored by staff and the complaints box was routinely emptied by the duty chief immigration officer. At Heathrow Terminals 1 and 2 (2014) we received a response to our test complaint the next day.

4.18 We saw notices promoting the Independent Monitoring Board (IMB) displayed in some holding rooms, although details of how to contact them were not always included. IMBs have not yet been appointed for all STHFs.

Catering

4.19 Catering arrangements were basic but adequate at most facilities, including for those with special dietary needs. Microwave meals were usually available, including vegetarian and halal options, either as long life ambient meals or as frozen meals. Hot and cold drinks and snacks were generally provided, although the latter did not always include healthy options such as fruit. Baby food was available in some holding rooms, while at others staff said they would buy it as and when needed.

4.20 Pictures of the meals were displayed for non-English speakers at some locations, for example, Portsmouth International Port (2013). At Larne House (2013) the names of meals had been translated into a good range of languages and staff kept a record of if and when detainees ate.

4.21 However, at Bristol and Cardiff airports (2014) no food or drinks for detainees were held at either site, despite detainees often being held in passport control for long periods. Border Force staff did not hold petty cash and told us they sometimes paid for food for detainees themselves. At Dunkerque (2014) food provision was poor:

Despite the fact that some detainees may have had long and difficult journeys in the back of lorries, only crisps and snack bars were available, with no hot food or sandwiches. Other than a water fountain, detainees were not offered drinks.

4.22 At Longport Freight Shed (2015), as inspectors walked to the back of the shed, a number of detainees pointed to their open mouths to indicate they were hungry. No detainee we spoke to had been offered a hot drink or food despite some not having eaten for many hours. They asked us when they were going to be given some hot food.

Section 5. Activities

5.1 Short-term holding facilities (STHFs) are by definition not designed to hold people for lengthy periods. The activities available in many STHFs were accordingly suitable for short stays. Most STHFs provided newspapers, magazines or other reading material to detainees, although these were often out of date and/or in English only. Most also had a television, although not always a working set (Lunar House, 2012; Loughborough, 2013; London City Airport, 2015). Portable DVD players and films were available in some facilities, and a small number had games.

5.2 Some activities for children were available: at Heathrow Terminal 4 (2011) children were given an activity pack on arrival and toys and books in the family room were suitable for the under-fives. However, there was nothing for older children. Children's toys, books and DVDs were available in the family holding rooms at both Gatwick North and Gatwick South (2013), and at Heathrow T3 (2015) there was a wall-mounted screen with a games console.

5.3 A problem at almost every STHF was the lack of access to the open air. Most did not allow it at all. At Larne House, access to the caged outside area was tightly restricted. At Portsmouth International Port, staff told us that they took smokers outside for a cigarette but this was in handcuffs. The residential facility at Pennine House was an exception, although the outside areas were not ideal:

There were two small outside areas, one for fresh air and the other for smoking… and detainees had to be accompanied by a staff member if they wished to use them. The two areas were identical and offered insufficient space for outside exercise. They were boxed off by steel caging creating a particularly unwelcoming environment. (Pennine House, 2013)

5.4 The best access was at Yarl's Wood (2015), where male detainees could go outside regularly, and also use gym equipment and outdoor sports facilities.

Section 6. Preparation for removal and release

6.1 Detainees held in short-term holding facilities (STHFs) were removed or released to a range of destinations. For example, during the three months before our inspection in 2011, the destinations for those leaving Eaton House were Harmondsworth 28%, Colnbrook 27%, Yarl's Wood 21%, Tinsley House 8%, temporary admission 8%, Brook House 5%, with 3% taken to hospital or a police station. Cayley House removals unit was an exception and people were usually held there before being removed to a flight back to their country of origin. Similarly, the Yarl's Wood STHF for men mostly held men who were found in lorries or found disembarking from them. These men were normally processed and then released on immigration bail.

6.2 Detainees in non-residential facilities could not receive visitors, often because holding rooms were located airside at airports and security requirements made this difficult. For those only spending short periods in these facilities this was not unreasonable but see also the casework section. The only facilities where detainees could receive visitors were the residential facilities at Pennine House, Larne House and Yarl's Wood. At Pennine House, daily visits sessions were welcome, although the small and unwelcoming visits room could only accommodate one detainee and their visitors at a time. Detainees also received visits from the Manchester Immigration Detainee Support Team (MIDST), which had a long involvement with the centre.

6.3 At several facilities, detainees could have property brought in by family or friends. While many of the holding rooms were able to provide clothing for detainees, it was not always suitable for those being removed back to a country with a cold climate. At the residential STHFs, detainees leaving the facility were seen by a nurse before discharge.

6.4 A praiseworthy innovation at Dover Seaport (2015) was the 'Atrium', a large and well equipped area where detainees released from the nearby STHF received support from third sector organisations. Detainees were moved there to wait for transport to their accommodation once they had been granted temporary admission into the UK. This reduced the time they spent in the holding room. A worker from Migrant Help assisted adults and a separate area in the Atrium provided welcoming facilities and recreational activities specifically for children and young people. A Refugee Council worker with considerable experience of working with unaccompanied minors was based in this area, and some Refugee Council staff had useful language skills, for example one was an Arabic speaker.

6.5 Detainees were usually not permitted access to the internet, including email, social networks and Skype. This was a disproportionate restriction for a detainee population. Subject to staff availability at Heathrow Terminals 3, 4 and 5 (2015), detainees could log on to the internet in the staff office for short periods to check flight and ticket details, but not for general web-browsing. At Pennine House residential STHF, there were internet enabled computers in the association room. While detainees had easy access to the internet, we were surprised to find that a wide range of useful information and recreational websites were blocked. Detainees with a Yahoo email account could receive and send emails but other common online email accounts were blocked. Detainees could not download translated PDF documents and they could not access country of origin information reports. Staff were unclear about who was responsible for blocking websites and how to request that specific sites be unblocked (Pennine House, 2013).

6.6 For those being transferred into further detention, several facilities gave a small credit card sized information card to detainees with details on it of the relevant immigration removal centre. However, at Coquelles Tourist (2012) staff told us they explained to detainees that they would be transferred to the custody of the Police Aux Frontieres (PAF) but they knew little about the procedures beyond that point. In reality, most detainees were released by PAF if they had legal status in France.

6.7 No support or funds were available to those released into France, including potentially vulnerable detainees. We spoke to a young detainee in Calais Tourist (2012) who was being released by the PAF at night with very little money and no travel tickets. We were told that there was no emergency welfare fund or release planning. At our inspection of Cayley House (2015) we found a process was in place for destitute payments to enable detainees to safely reach their final destination, and escorts referred such cases to the Detainee Escorting and Population Management Unit (DEPMU) for consideration. However, payment was not guaranteed and detainees who required it were not made aware of it. We spoke to two detainees who said the destination airport in their country of origin was nearly 300km away from where they would be living – one had only £5 and the other only £10 to make this journey.

Section 7. Appendix I

List of reports

Becket House STHF	6 January 2015
Bristol and Cardiff STHFs	14 October 2014
Capital Building STHF	2 May 2012
Cayley House STHF	9–10 July 2012
Cayley House STHF	1 October 2014
Coquelles/Calais STHF	6–7 November 2012
Longport freight shed, Dover Seaport and Frontier House	7 September, 1–2 and 5–6 October 2015
Drumkeen House STHF	2 November 2011
Drumkeen House STHF	19 November 2013
Dunkerque STHF	28 January 2014
Eaton House STHF	8 August 2011
Electric House STHF	7 June 2012
Festival Court STHF	6 September 2011
Gatwick North STHF	16–17 July 2013
Gatwick South STHF	17–18 July 2013
Glasgow Airport STHF	7 September 2011
Heathrow T1 STHF	11 April 2011
Heathrow T1 STHF	30 September 2014
Heathrow T2 STHF	30 September 2014
Heathrow T3 STHF	3 March 2011
Heathrow T3 STHF	13 May 2015
Heathrow T4 STHF	3 March 2011
Heathrow T4 STHF	13 May 2015
Heathrow T5 STHF	12 May 2015
Larne House STHF	1–2 Nov 2011
Larne House STHF	18 November 2013
London City Airport STHF	22 February 2013
London City Airport STHF	11 February 2015
Loughborough STHF	28 August 2013
Lunar House STHF	7 June 2012
Luton Airport STHF	9 December 2013
Manchester Airport STHF	13–14 May 2013
Pennine House STHF	4–5 October 2011
Pennine House STHF	13–14 May 2013
Portsmouth STHF	27 August 2013
Sandford House STHF	17 September 2012
Stansted STHF	10 December 2013
STHF Review	2004–2010
Vulcan House STHF	29 May 2012
Waterside Court STHF	7 October 2011