



Report on an unannounced
inspection of

Colnbrook Immigration Removal Centre

by HM Chief Inspector of Prisons

28 February – 18 March 2022



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Introduction

This Mitie Care and Custody run immigration removal centre next to Heathrow Airport held 184 detainees at the time of our inspection. Almost all spent less than a month in the centre before they were either released into the community or deported.

The building is prison-like in its design apart from the women's unit which has been decorated and furnished to give it a more homely feel. More could have been done to improve the environment on the men's wings, which was drab and grey. Accommodation is, however, of a reasonable standard with detainees housed in rooms that are mostly in good condition and are clean and graffiti-free. Pool tables and board games are provided to relieve some of the boredom.

There were other activities on offer such as music, cake decorating or the library, although apart from going to the gym, most chose to stay on the wing or in their rooms. The centre had also set up an additional mobile cultural kitchen to provide meals on the units, which provided a welcome break from the adequate but institutional food.

Uncertainty about their future was the most common cause of frustration for detainees so it was disappointing that the Home Office's Detention Engagement Team (DET), that was supposed to answer questions and provide support, was functioning so poorly. Low staffing levels and a lack of ambition from leaders meant that there was almost no face-to-face interaction, while the team's telephones often rung unanswered.

Health services were generally of a good standard and there was good support for those who were most distressed, but it was disappointing that there was less provision for those with lower-level mental health issues who needed support before things reached crisis point.

Given how many detainees were quickly released into the community, there is a question about why they had been placed in the centre in the first place. Furthermore, some distressed detainees who should have been released earlier as a result of physical and mental health problems were not served well by inadequate assessments in Rule 35 reports. A shortage of suitable accommodation meant that others continued to be detained even after being granted conditional bail.

When staff members came out of their offices in which they seem to spend much of their day, they were usually friendly and got on well with detainees, but relationships are somewhat transactional and leaders need to do more to encourage more meaningful interaction.

Overall, the centre was well led by an experienced team who generally provided good oversight of this reasonably safe and decently run centre. The centre had been let down by Home Office services that failed to communicate adequately with detainees or act with enough urgency, meaning that some cases dragged on unnecessarily to the detriment of detainees.

Charlie Taylor

HM Chief Inspector of Prisons

April 2022

About Colnbrook

Task of the establishment

To detain men and women subject to immigration control. During most of the COVID-19 the pandemic, the centre was being used as a reverse cohort unit (RCU, see Glossary) to quarantine arrivals for a short period. They were then release or transferred, usually to the neighbouring Harmondsworth IRC.

Certified normal accommodation and operational capacity (see Glossary)

Detainees held at the time of inspection: 184

Baseline certified normal capacity: 312 men, 18 women

In-use certified normal capacity: 330

Operational capacity: 330

Population of the centre

- As Colnbrook was being used as an RCU for the immigration estate, 97% of detainees had been there for less than a month.
- In the previous six months, 52% of detainees leaving the centre had been released into the community.
- 105 Rule 35 reports (see Glossary) had been submitted in the previous six months, leading to release in 34% of cases.

Name of contractor

Care and Custody (Mitie Group)

Escort provider: Care and Custody – Escorting Services

Health service provider: Central and North West London NHS Foundation Trust

Learning and skills providers: Open College Network; Oxford Cambridge and RSA (OCR)

Location

Harmondsworth, West Drayton

Brief history

Colnbrook IRC opened in 2004. It was managed by Serco until 1 September 2014 when Mitie Care and Custody took over the operation of both Colnbrook and Harmondsworth IRCs.

Short description of residential units

Alpha, Bravo, Charlie, Induction and Echo units hold men in shared rooms over three landings.

Sahara unit has 18 beds for women.

The care and separation unit has 16 beds.

The care suite has six beds for detainees considered to be in crisis and requiring time out from the normal regime.

Name of centre manager and date in post

Paul Rennie, March 2018

Independent Monitoring Board chair

Karina Kielbinska

Date of last inspection

19 November – 7 December 2018

Section 1 Summary of key findings

- 1.1 We last inspected Colnbrook in 2018 and made 36 recommendations, three of which were about areas of key concern. The centre contractor and Home Office fully accepted 24 of the recommendations and partially (or subject to resources) accepted 10. They rejected two of the recommendations.
- 1.2 Section 7 contains a full list of recommendations made at the last full inspection and the progress against them.

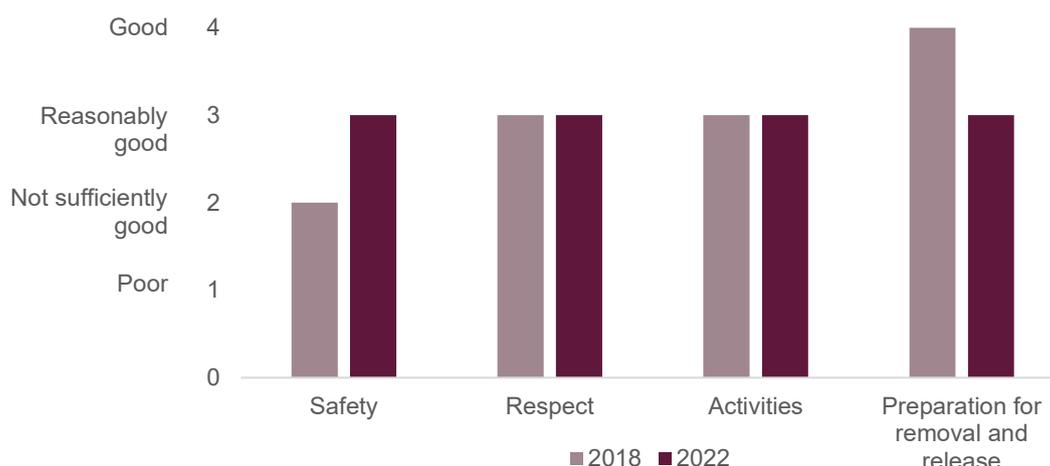
Progress on key concerns and recommendations

- 1.3 Our last inspection of Colnbrook took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for detainees at the time. Although we recognise that the challenges of keeping detainees safe during COVID-19 will have changed the focus for many leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.
- 1.4 At our last full inspection, we made one recommendation about a key concern in the area of safety. At this inspection we found that this recommendation had not been achieved.
- 1.5 We made two recommendations about key concerns in the area of respect. At this inspection we found that both those recommendations had not been achieved.

Outcomes for detainees

- 1.6 We assess outcomes for detainees against four healthy establishment tests (see Appendix I for more information about the tests). At this inspection of Colnbrook, we found that outcomes for detainees had stayed the same in two healthy establishment areas, improved in one and declined in one.
- 1.7 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the IRC's recovery from COVID-19.

Figure 1: Colnbrook Immigration Removal Centre healthy establishment outcomes 2018 and 2022



Safety

At the last inspection of Colnbrook in 2018 we found that outcomes for detainees were not sufficiently good against this healthy establishment test.

At this inspection we found that outcomes for detainees were now reasonably good.

- 1.8 During most of the COVID-19 the pandemic, Colnbrook had been a reverse cohort unit (see Glossary) for detainees who were then either released or transferred, usually to the neighbouring Harmondsworth IRC. This had resulted in reduced numbers received and held, amounting to about 56% of capacity, and a faster throughput at the centre.
- 1.9 About a third of detainees arrived at the centre overnight and many then waited outside reception for several hours. Not all arrivals were given a private interview and the interviews did not focus enough on detainee safety. First night accommodation had improved since our last inspection, but induction was inadequate.
- 1.10 Data on vulnerabilities was now shared between the centre and the Home Office, but adults at risk in detention (see Glossary) had not been recorded accurately in some cases, which meant that the correct level of support may not have been provided. The centre’s vulnerable adult care planning was good and indicated that detainees were supported well.
- 1.11 In the previous six months, about a third of detainees had been released following a Rule 35 report (see Glossary), more than at our last inspection. However, very few reports related to health concerns or suicide risk and those in our sample contained little detail. In most cases we reviewed where the Home Office accepted that there was evidence of torture, detention was nevertheless maintained.

- 1.12 There was a well-advertised whistleblowing service for staff to report concerns about mistreatment of detainees, but it had not been used in the previous six months. In our staff survey, most said they knew how to raise concerns, but a few said they would not report these, citing factors such as fear of repercussions or lack of confidentiality.
- 1.13 In our survey, a quarter of detainees said they had felt suicidal while in the centre. There had been 41 self-harm incidents in the previous six months. Two incidents were serious and had been suitably investigated. There had been no deaths in Colnbrook since the last inspection. Assessment, care in detention and teamwork (ACDT) case management to support detainees in crisis was generally used well.
- 1.14 In our survey, a third of detainees said they currently felt unsafe in the centre. In our interviews, detainees cited factors such as fear of removal and the uncertainty associated with their immigration case as the main reasons for this. None of the detainees we interviewed reported feeling unsafe from staff at Colnbrook. Violence was infrequent and usually low level. The number of assaults on detainees and staff had reduced since our last inspection and none were serious. All incidents were investigated.
- 1.15 The centre resembled a prison and detainees were still locked in their cells inappropriately overnight and for a daily roll check. There had been improvements in other aspects of security. There was now very little evidence of drug use, detainees were only handcuffed during external escorts following individual risk assessment and cell searches were based on intelligence.
- 1.16 Use of force incidents were usually low level. Governance and quality assurance of incidents were generally robust. The centre now had a stock of body-worn cameras and staff had worn them in every incident that we reviewed, providing a good record of events.
- 1.17 The use of separation had reduced, but the decision to separate detainees was not always properly justified in the documentation. The separation unit had held some challenging, long-term detainees, one of whom had significant mental health problems and should not have been in immigration detention.
- 1.18 The vast majority of detainees spent less than a month in Colnbrook, but the average cumulative length of detention was about 38 days per detainee and one man had been detained for over 1,000 days. Some people had been held for lengthy periods despite barriers to removal and repeated recommendations for release from the Home Office's case progression panel. The Home Office detention engagement team (DET, see Glossary) was providing an inadequate service, and many detainees told us they found it difficult to obtain an update on their case. Most detainees had reasonable access to legal visits and surgeries.

Respect

At the last inspection of Colnbrook in 2018 we found that outcomes for detainees were reasonably good against this healthy establishment test.

At this inspection we found that outcomes for detainees remained reasonably good.

- 1.19 In our survey and interviews, most detainees reported respectful treatment from staff. There had been a major investment in restorative practice to manage conflicts and disagreements, with some emerging evidence of its value.
- 1.20 Many operational staff described low morale at work; turnover of staff was high and a minority commented that the centre did not support a learning culture. We found no evidence that this was yet affecting detainee outcomes.
- 1.21 Much of the accommodation had been refurbished and the centre was clean. However, except for the women's unit, it remained prison-like and austere. Poor ventilation in the rooms was a longstanding and as-yet unresolved problem. Toilet screening was insufficient and some mattresses were not in an acceptable condition. The environment for detained women had improved and was comfortable and welcoming.
- 1.22 Detainees had few structured opportunities to provide feedback about their experiences at the centre. Consultation with detainees had stopped during the pandemic and there were currently no peer representatives. In our survey, most detainees who had complained said their concerns had been dealt with fairly, and we saw some good investigations.
- 1.23 In our survey, more than half of detainees said that the quality of food was good. There were limited options for detainees to cook for themselves, but the global kitchen, where they could cook food from their own culture, continued to be popular and had adapted to pandemic restrictions with mobile equipment to allow cooking on the wings. The centre shop had recently reopened and held a good stock of items.
- 1.24 Equality work was led and delivered energetically, with emphasis on support for individual detainees with protected characteristics (see Glossary). More systemic work, such as detainee forums and equality representatives, had yet to be re-established. Professional telephone interpreting was used regularly for detainees with little or no English, although not always when needed. A fifth of those responding to our survey said they were gay, bisexual or other sexuality, but few had been identified by the centre. A constructive and individualised approach was taken to the care of transgender people.
- 1.25 A strong and experienced chaplaincy had maintained opportunities for worship alongside individual support during the pandemic. The faith

area was a welcoming and attractive environment with good provision for most faiths.

- 1.26 Detainees were more positive about the quality of health care than at the previous inspection and provision was reasonably good. However, there was a high number of staff vacancies, especially in the mental health team. Detainees with lower level mental health needs did not have enough support.

Activities

At the last inspection of Colnbrook in 2018 we found that outcomes for detainees were reasonably good against this healthy establishment test.

At this inspection we found that outcomes for detainees remained reasonably good.

- 1.27 COVID-19 restrictions had limited detainee movement around the centre, but they had access to some activities each day. The Sahara unit also offered a reasonably good range of activities, although women had less freedom of movement. The recreational facilities on the wings were much better than at the last inspection.
- 1.28 There was a reasonable range of learning activities, good resources for education and generally good teaching, but few detainees attended classes. There were a few basic jobs on offer, mostly cleaning, but most workplaces were not filled. The activities were not well enough promoted.
- 1.29 The library was an attractive, well-used and welcoming space, with comfortable sofas and tables, but the stock of foreign language books was too small. Nearly all the men could visit it at least three times a week. Women detainees had a small book stock on the Sahara unit and could order books for officers to collect from the library.
- 1.30 Fitness facilities were good and included well-equipped rooms for weight training and cardiovascular work, and a good-sized sports hall. Staff were suitably qualified. Detainees had reasonably good access and induction leaflets were available in 20 languages, but the gym induction did not make sure that all detainees were properly informed about safe use of the equipment. Women in the Sahara unit were offered a daily gym session off the unit. Very few attended, but most women in our survey said they had enough to do to fill their time.

Preparation for removal and release

At the last inspection of Colnbrook in 2018 we found that outcomes for detainees were good against this healthy establishment test.

At this inspection we found that outcomes for detainees were now reasonably good.

- 1.31 Most new arrivals were seen by the experienced and competent welfare team. Community support organisations had maintained email and phone contact with detainees through the pandemic and were now attending the centre again. The biggest reported concern for the welfare team was the difficulty of obtaining information from the Home Office DET.
- 1.32 All detainees had good access to visits. The visits area had been considerably improved in both the general environment and the children's play facilities. Visiting groups were now able to support the more isolated detainees, but the centre was not active in identifying such individuals.
- 1.33 All detainees had good access to mobile phones and most could use the internet and send email easily. The computer for video calls was poorly located in a noisy communal area and take-up was low. Detainees could easily use a fax machine, but there were some delays in the receipt of their mail and property.
- 1.34 The welfare team saw detainees routinely before they left the centre to address potential outstanding needs. Individual strategy meetings were convened in complex cases, usually where it was considered that detainees might resist removal.
- 1.35 The DET was not convening multidisciplinary meetings to support vulnerable detainees being released. The Hibiscus charity (see Glossary) could assist detainees to reach their destinations and provided other resettlement support. Some detainees were released homeless, but there were no reliable data on this.

Key concerns and recommendations

- 1.36 Key concerns and recommendations identify the issues of most importance to improving outcomes for detainees and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of detainees.
- 1.37 During this inspection we identified some areas of key concern and have made a small number of recommendations for the IRC to address those concerns.
- 1.38 Key concern: The reception and induction of new arrivals were weak; they waited up to five hours in vans outside reception and it could take a further two-and-a-half hours to process them before they were taken to their first night accommodation. Most arrivals were not offered a private interview, and interviews were insufficiently focused on safety. The induction process was ineffective.

Recommendation: New arrivals should be received promptly into the centre and reception processes, including interviews with detainees, should promote disclosure of vulnerabilities. Detainees should receive an induction that informs them of how to access all key activities and services in the centre, supported by written

information that they can understand.

(To the centre manager and the Home Office)

- 1.39 Key concern: Rule 35 reports lacked detail and did not always provide an adequate assessment of the impact of continued detention on a detainee's physical and mental health.

Recommendation: Rule 35 reports should provide a clear and detailed assessment of the detainee's injuries and a comprehensive assessment of the impact of continued detention on their physical and mental health.

(To the health care provider and the Home Office)

- 1.40 Key concern: The Home Office detention engagement team had not been engaging routinely with detainees face to face, and many detainees faced difficulties contacting them by telephone.

Recommendation: The detention engagement team should resume face-to-face contact with detainees as a priority and make sure that all detainees can telephone their engagement worker easily.

(To the Home Office)

- 1.41 Key concern: Some detainees who were due to be removed on charter flights were located on Echo Unit as part of the centre's approach to preventing the spread of COVID-19. This resulted in limited access to the internet to communicate with their legal representatives at a critical time.

Recommendation: All detainees should be able to communicate freely with their legal representatives at all times, including prompt access to emails.

(To the centre manager)

- 1.42 Key concern: Poor ventilation remained a problem and the shower facilities were in a poor condition. Showers and toilets remained inadequately screened and some mattresses were not fit for purpose. Despite some work to the outside exercise areas, they remained bleak and prison-like, with few or no facilities to encourage outdoor exercise.

Recommendation: The environment should be improved through well-ventilated residential units that are kept in good repair, showers and toilets that are properly screened, and well-equipped and more welcoming exercise yards.

(To the centre manager and the Home Office)

- 1.43 Key concern: During the pandemic, equality, diversity and inclusion work had focused on identifying individuals with protected characteristics who might need support, and the networks of staff equality liaison officers and detainee equality representatives had fallen into disuse. Colnbrook did not yet have a sound structure for meeting the requirements of equality, diversity and inclusion as it returned to its role as a regular IRC.

Recommendation: The centre should address issues of equality, diversity and inclusion comprehensively, supported by sufficient staff to make sure that monitoring, analysis, provision and support are consistent for all protected characteristics, and that the detainee voice is heard and acted on.

(To the centre manager)

Notable positive practice

- 1.44 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.
- 1.45 Inspectors found six examples of notable positive practice during this inspection.
- 1.46 The centre's staff training package covering vulnerable adult care plans was of a high quality and provided useful guidance to staff. (See paragraph 2.11.)
- 1.47 An 'emotional support' dog to support detainees in crisis was available on most weekdays. We observed the dog having an immediate positive effect on a detainee on constant supervision who had not been engaging with staff. (See paragraph 2.22.)
- 1.48 The centre had produced a useful desktop guide for staff that contained a range of helpful information, including how to complete use of force documents. (See paragraph 2.40.)
- 1.49 The investment in restorative practices and promoting a positive culture for staff and detainees was proving valuable. (See paragraph 3.2.)
- 1.50 The staff of the 'global kitchen' had adapted to pandemic restrictions by purchasing and using mobile catering equipment to enable celebration of cultural events and popular world foods on the wings. (See paragraph 3.13.)
- 1.51 New play facilities for children had been installed in the visits area and were already well used, including a soft play area and an arcade-style games machine, as well as a new playframe designed for children to use safely without supervision by a play leader. (See paragraph 5.7.)

Section 2 Safety

Detainees are held in safety and with due regard to the insecurity of their position.

Arrival and early days in detention

Expected outcomes: Detainees travelling to and arriving at the centre are treated with respect and care. Risks are identified and acted on. Detainees are supported on their first night. Induction is comprehensive.

- 2.1 In our survey, 83% of detainees said they were treated well by escort staff on their journey to the centre. Escort vans were clean and in good condition, but carried no food except crisps and biscuits, despite some long journeys. As at our previous inspection, over a third of detainees arrived overnight between 11pm and 7am. Some detainees were held for several hours in reporting centre holding rooms or police stations before their escort to Colnbrook. In one case, a detainee held in a police station on immigration powers from 8pm only arrived at Colnbrook at 3.30am the following night, over 27 hours later.
- 2.2 The centre had received an average of 49 new detainees a week in the previous six months, which was similar to the previous inspection. Home Office COVID-19 instructions stipulated that no more than six detainees should be held in the reception and its holding rooms, even though these areas were spacious and social distancing was not enforced elsewhere in the centre. This resulted in detainees being held far too long in vans outside reception; on one busy day, we saw waits of between two-and-a-half and five hours. Detainees then spent about a further two-and-a-half hours in reception before they were taken to their first night accommodation. See key concern and recommendation 1.38.) However, 89% of detainees in our survey said they were treated well while in reception, and we saw staff who were welcoming and friendly.
- 2.3 In our survey, 89% of detainees said they were searched in reception in a respectful way. Women were searched by a female officer. We interviewed two detainees who had been taken to wings wearing electronic tags. We were told this was an oversight and the centre introduced measures during the inspection to make sure this did not happen again. After initial processing, detainees were held in a large waiting room, with comfortable sofas, TV and a telephone for their use, including for overseas calls.
- 2.4 When they first arrived, 50% of detainees said they had problems with feeling depressed and 29% with their mental health. Information was not always sent in advance about detainees' medical needs, vulnerability and disability, particularly for those arriving from a police station or from crossing the Channel in small boats. Not all detainees

were offered a private interview on arrival. There was insufficient focus on detainee safety in the reception interview and professional telephone interpreting was not always used with those with little English. (See key concern and recommendation 1.38.)

- 2.5 First night accommodation was reasonably clean and in much better condition than at our previous inspection. Staff gave adequate attention to the safety of detainees on their first night, with regular documented checks.
- 2.6 The induction process, consisting of two very short contacts with staff and the provision of some written material, was inadequate. (See key concern and recommendation 1.38.)

Safeguarding

Expected outcomes: The centre promotes the welfare of all detainees and protects them from all kinds of harm and neglect. The centre provides a safe environment which reduces the risk of self-harm and suicide. Detainees at risk of self-harm or suicide are identified at an early stage and given the necessary care and support.

Safeguarding of vulnerable adults

- 2.7 The local safeguarding policy was comprehensive and tailored to the detention setting. All staff had received safeguarding training and several managers had completed more advanced training, including dealing with human trafficking, modern slavery and gender-based violence. Links with Hillingdon Safeguarding Adults Board had improved since the last inspection, although meetings had been irregular during the pandemic.
- 2.8 The weekly vulnerable persons review meeting was well attended, including by health care staff and Home Office caseworkers. The meetings were suitably focused on adults at risk (see Glossary), as well as detainees with complex cases or care needs. However, they were mainly concerned with case progression rather than monitoring vulnerabilities, and the minutes did not always demonstrate discussion of the care that detainees were receiving.
- 2.9 Operational staff had variable knowledge of the adults at risk policy and the National Referral Mechanism (NRM, see Glossary). However, all of the staff we spoke to said that they would refer any concerns about vulnerable detainees to their manager or the Home Office.
- 2.10 Arrangements to share data about vulnerabilities between the centre and the Home Office had improved, and records of adults at risk were now consolidated weekly. However, in some documents we found that the level of risk for detainees with serious vulnerabilities had been recorded inaccurately. For example, a man sectioned under the Mental Health Act was recorded at a lower level risk in Home Office and centre documentation than on his online records; this meant that his case may

not have been considered correctly by the Home Office and he may not have been given the necessary support. Where detainees were identified by the Home Office as level 3 (high) adults at risk, those in our case sample were not held for long periods and detention had been authorised and reviewed appropriately.

- 2.11 Vulnerable adult care plans (VACPs) were of a good quality. In the sample of VACPs we reviewed, detainees with vulnerabilities – such as older detainees and pregnant women – were identified and cared for appropriately, and all plans had care maps and observations completed. The centre’s staff training package on VACPs was of a high quality and had been shared across the detention estate. We saw vulnerable detainees being given good care, particularly in the care suite for those with more complex needs.
- 2.12 Home Office data for the previous six months showed that 34% of detainees were released following a Rule 35 report (see Glossary), which was much higher than the 16% at our previous inspection. However, Rule 35 reports were not always submitted in relevant cases. Of the 105 Rule 35 reports submitted in the previous six months, only four related to health concerns or suicide risk; the remaining 101 all concerned claims of torture.
- 2.13 We reviewed in detail 10 Rule 35 reports and their responses. All related to torture, although in one case a second report was submitted on a detainee relating to suicidal thoughts. As at our previous inspection, most reports were not detailed enough; all provided a judgement on the consistency of injuries with the alleged method of torture, but the reasoning was brief and unclear. Only one report clearly explored the likely impact of further detention. Although nine of the reports contained claims of psychological trauma, such as low mood, insomnia, depression, anxiety and flashbacks, evaluation of the trauma was vague and limited, and none assessed whether a detainee was suffering from post-traumatic stress disorder (see paragraph 3.44). (See key concern and recommendation 1.39.)
- 2.14 In nine of the cases we reviewed, responses from the Home Office were prompt and torture was accepted in eight cases. One detainee was identified as a level 3 adult at risk and their release was agreed. Detention was maintained in eight cases on the grounds that immigration or public protection factors outweighed the presumption to release. In one case, the detainee had been granted bail before there had been a response to the Rule 35 report.
- 2.15 For women in the Sahara unit, casework progression was prompt and women were rarely held at Colnbrook for more than a few days. The female staff who worked on the unit supported and engaged well with the women. One pregnant woman had been held in the centre during the previous six months for an appropriately short period, and the records indicated a good level of care.
- 2.16 There was a well-advertised whistleblowing procedure, but it had not been used in the previous six months. Our confidential staff survey

suggested that staff knew how to raise concerns about mistreatment of detainees and most said that they would do so if necessary. A small number said they would not raise concerns if they had them, citing fear of repercussions and/or lack of confidentiality.

Recommendations

- 2.17 The Home Office should ensure that all information shared about adults at risk is accurate.**
- 2.18 Leaders should investigate and address the reasons for some staff being unwilling to raise whistleblowing concerns.**

Self-harm and suicide prevention

- 2.19 In our survey, a quarter of detainees said they had felt suicidal at some point in the centre. There had been 41 incidents of self-harm in the six months to the end of February 2022. Two incidents had been serious and there had been appropriate investigations to learn lessons from these. There were insufficient safeguards against the detention of detainees with suicidal thoughts. Although risk information was communicated through the Home Office's risk assessment process, Rule 35 reports were seldom prepared when necessary (see paragraph 2.12). In the previous six months, 14 detainees had been placed on constant watch because they were considered to be at imminent risk of self-harm.
- 2.20 There had been no deaths of any kind in Colnbrook since the last inspection. In January 2019, the Prisons and Probation Ombudsman (PPO) had finalised its investigation into a homicide at the centre in 2016. Most PPO recommendations had been achieved, but one that entailed the Home Office ensuring that risk information was communicated to centres receiving new detainees was outstanding.
- 2.21 In the previous six months, 86 assessment, care in detention and teamwork (ACDT) case management forms for detainees at risk of suicide or self-harm had been opened, fewer than at the previous inspection when the population had been larger. While records showed several common triggers to self-harm, most incidents were linked to frustrations about detention and the detainee's immigration status. The ACDT process generally supported detainees well. Although there was insufficient attendance by mental health and Home Office staff at case reviews, we saw some detailed risk planning, particularly for the more vulnerable detainees. However, care planning was limited, with insufficient attention to the need to keep detainees occupied and encourage family contact.
- 2.22 In our survey, 78% of detainees said they had felt depressed while at the centre. Acute staffing shortages in the integrated mental health team had reduced capacity to offer psychological interventions to the large number of detainees with lower-level mental health needs. There had been no psychologist in the centre since August 2021 (see paragraph 3.49). However, there was some good provision to support

detainees in crisis, including the care suite and therapeutic video presentations. An 'emotional support' dog was available to detainees on most weekdays. We observed the dog having an immediate positive effect on a detainee on constant supervision, who had not been engaging with staff. We observed some very good care of detainees in the care suite.

- 2.23 In the previous six months, 76 detainees had refused food and fluids. Most were involved in two protests lasting less than 24 hours. Food and fluid refusal logs did not show evidence of suitable monitoring and support for detainees who were refusing food. Most of those we saw had not had a case review, including one detainee noted to have refused food and fluids for five days. Logs focused on monitoring whether detainees were taking food and fluids and did not record any engagement with the detainee about their welfare, or the reasons for their refusal.
- 2.24 There was inconsistent attendance at the monthly safer detention committee meeting. Minutes of meetings were brief. There was little documented discussion on the data presented, and no discussion of the two serious self-harm incidents (see also paragraph 2.8).

Safeguarding children

Expected outcomes: The centre promotes the welfare of children and protects them from all kind of harm and neglect.

- 2.25 No children had been held in the centre in the previous 12 months and there had been no age-dispute cases. The centre had a comprehensive child safeguarding policy, which included guidance for staff on caring for children and managing any individuals who posed a risk to them, and staff had received appropriate training. The centre had the necessary links with the local authority for managing any cases involving children.

Personal safety

Expected outcomes: Everyone is and feels safe. The centre promotes positive behaviour and protects detainees from bullying and victimisation. Security measures and the use of force are proportionate to the need to keep detainees safe.

- 2.26 In our survey, 33% of detainees said they currently felt unsafe in the centre; the response was more negative from those with a disability (63% against 19% for those without a disability) and those with a mental health problem (55% against 21%). In our confidential interviews and during inspection, most detainees told us that they felt safe in the centre and that their safety concerns stemmed largely from their fear of removal from the country and their immigration case. No detainees reported feeling unsafe from staff. In our staff survey, some

said they had witnessed staff behaving inappropriately towards detainees, citing examples such as dismissive behaviour. The inability to contact the Home Office Detention Engagement Team (DET) was also an issue (see paragraph 2.48).

- 2.27 There had been 11 assaults on detainees by other detainees and three assaults on staff in the previous six months, which was lower than at our last inspection; all were relatively minor. In our detainee interviews, we were told that violence was very rare, but when it did occur staff responded quickly and professionally.
- 2.28 In the previous six months, three detainees had been monitored for antisocial or violent behaviour. The anti-bullying and violence reduction policies were reasonable. All alleged incidents were investigated and in several of those we reviewed restorative practice sessions had been used to mediate successfully.
- 2.29 The safer community team met monthly and although much useful data were produced, there was a lack of analysis or focus on issues relating to bullying and victimisation.
- 2.30 All detainees were on the enhanced level of the centre's two-tier rewards scheme. Although they welcomed the opportunity to obtain rewards via the scheme, many told us that it was used punitively by staff who would issue warnings for minor infringements, such as not wanting to share a room with another detainee. Following the inspection, we were informed that the scheme had been withdrawn.

Security and freedom of movement

Expected outcomes: Detainees feel secure. They have a relaxed regime with as much freedom of movement as is consistent with the need to maintain a safe and well-ordered community.

- 2.31 The centre resembled a prison and most rooms were like cells. As at the previous inspection, with the exception of the women's unit, detainees were locked in their cells overnight from 9pm until 8am, Monday to Friday, and 9pm until 8.30am at the weekend. They were also locked in their cells for an hour over the lunch period. Detainees' ability to move freely around the centre was further restricted to designated periods during the day. They had around eight to 10 hours a day free movement.
- 2.32 During the previous six months, 217 security information reports had been submitted, which was less than at the last inspection. Managers were aware of this decrease and were planning to promote greater staff use of the intelligence report processes. The security information reports that we examined had been analysed and processed quickly, with intelligence communicated to other areas of the centre.
- 2.33 The monthly security committee meeting identified key threats and risks and considered useful information, leading to some actions.

However, there was no overarching security strategy, minutes did not show any meaningful analysis and actions sometimes dropped off the agenda without resolution.

- 2.34 Detainees were only strip searched based on intelligence and the reasons for each search were documented. Six detainees had been strip searched in the previous six months, but none in the last four months. Each search was defensible on the grounds of safety and security. In the sample of documents we reviewed, handcuffing of detainees during external escorts was now based on an individual risk assessment and subject to rigorous scrutiny by managers.
- 2.35 In our survey, only 2% of detainees said that it was easy to get drugs in the centre and in our confidential interviews most told us that it was either hard to get them or that they had no knowledge of drugs in the centre. Searching records showed that in the previous six months there had been seven alcohol finds and five drug finds, which was low and suggested little availability of illicit substances. An itemiser drug-detecting machine was used well to check incoming mail and several illicit substances had been intercepted.
- 2.36 All cell searches were based only on intelligence, which was good. There were regular checks and searches of the perimeter, communal areas and activities.
- 2.37 Corruption prevention work was good. Senior managers investigated allegations of inappropriate conduct and took the necessary action.

Use of force and single separation

Expected outcomes: Force is only used as a last resort and for legitimate reasons. Detainees are placed in the separation unit on proper authority, for security and safety reasons only, and are held in the unit for the shortest possible period.

- 2.38 Force had been used 34 times in the previous six months, compared with 76 at the previous inspection when the population had been higher; this still represented a proportionate reduction in the use of force. Handcuffs had been used in 11 of these incidents. Incidents were usually low level, often involving guiding holds. Staff used body-worn cameras well and had turned them on in all the incidents we reviewed.
- 2.39 Governance and quality assurance for use of force were generally good. A use of force instructor reviewed all incidents, scrutinising the documentation and video footage, including all body-worn camera footage. In the sample of use of force forms that we examined, all but one indicated that force was used proportionately and as a last resort. In the case where it was not, managers had identified the concern through their review of paperwork and dealt with it robustly. In the video footage we reviewed, while staff mostly dealt with detainees compassionately and used de-escalation techniques, we identified one

incident where some staff used inappropriate techniques, which, despite being scrutinised, had not been picked up. We reported this to the centre manager and were advised that this would be fully investigated. An independent expert also reviewed a random number of incidents and those that the centre highlighted as a concern.

- 2.40 A useful desktop guide to using force in an accountable way had been produced by the centre. It contained a range of helpful information for staff, including how to complete use of force paperwork.
- 2.41 During the previous six months, separation had been used 49 times, which was proportionately lower than at the previous inspection. In the cases that we examined, the centre's decision to separate detainees was not always properly justified. There were procedures for the authorisation of continued separation by Home Office staff, and they visited the unit every day to speak to detainees and assess their welfare, but in one case we reviewed the continued use of separation was not justified. Over 95% of these cases fell under detention centre Rule 40 (in the interests of safety and security). Rule 42 (separation for violent and refractory detainees) had been used three times in the same period.
- 2.42 The average time in separation under Rule 40 was high at just under 58 hours and under Rule 42 was just under 90 hours. Twenty-three detainees had been separated for more than a day and the longest for almost 24 days. However, in the previous six months, the unit had held two challenging, long-term detainees who were difficult to manage; one had major mental health problems and should not have been in immigration detention. These two detainees spent a lengthy time on the unit and, excluding them, the average time in separation was much lower, although still significant at 33.38 hours under Rule 40 and 14.65 under Rule 42.
- 2.43 Cells in the separation unit remained austere. There was no difference between those for detainees held under Rule 40 and those held under Rule 42. One detainee was in the separation unit during the inspection and had access to a radio but had not been located in the one cell that had a television.

Recommendation

- 2.44 **All use of separation should be proportionate and fully justified.**

Legal rights

Expected outcomes: Detainees are fully aware of and understand their detention, following their arrival at the centre and on release. Detainees are supported by the centre staff to freely exercise their legal rights.

- 2.45 At the time of our inspection, almost all detainees (97%) were held in Colnbrook for less than a month. However, the average cumulative length of detention including time held both at Colnbrook and other

centres was 38.3 days, and the longest cumulative detention period was over 1,000 days, which was unacceptably long. The Home Office had made little progress in obtaining an emergency travel document (ETD) for this detainee since 2019.

- 2.46 We looked at the cases of four detainees who had been held for longer than four months. They usually received monthly detention reviews, but in each case there were barriers that meant imminent removal was not a possibility, predominantly because of long waits for ETDs. A lack of suitable bail accommodation was also preventing release in several cases. The remaining sample of casework involved shorter periods of detention and had been better managed. Cases had been authorised and reviewed appropriately, and arrangements for removal or transfer were made.
- 2.47 All the women currently detained had been held for less than two weeks, and most for under a week. Both of the two women's cases in our sample were progressed promptly.
- 2.48 The Home Office detention engagement team (DET) was understaffed and had had limited face-to-face engagement with detainees during the pandemic. Efforts to address staff shortages were ongoing at the time of our inspection, but had not yet come to fruition. Many detainees also told us that they struggled to contact the DET by phone to get an update on their immigration case. In our survey, just 17% of detainees said it was easy to see Home Office staff and 30% that the Home Office was keeping them updated on their case. In our interviews with detainees, the lack of access to the Home Office and uncertainty about what was happening with their immigration case was a common concern and a major factor contributing to feelings of unsafety. Mitie staff had sometimes served immigration papers because of the lack of DET staff and were also frustrated at the difficulty in obtaining information from the Home Office for detainees. (See key concern and recommendation 1.40.)
- 2.49 Legal visits could take place either in person or by video link, and legal advice surgeries took place several times a week and had adequate capacity. However, in our survey, only 54% of detainees said that they had been given information in a language they could understand about how to see immigration staff and get legal advice in their first two days at the centre, and some told us they were unsure about how to contact a legal representative.
- 2.50 Some detainees who had been held on Echo Unit before chartered removal flights had had limited access to computers to email their legal representatives ahead of their planned removal. These detainees were only permitted to use computers for limited periods at specific times of the day, and some of those who we interviewed told us that this had caused them significant stress. (See key concern and recommendation 1.41.)

Recommendation

- 2.51 **The Home Office should make sure that detention is not prolonged unnecessarily when there is little prospect of a detainee's removal within a reasonable timescale.**

Section 3 Respect

Detainees are treated with respect for their human dignity and the circumstances of their detention.

Staff-detainee relationships

Expected outcomes: Detainees are treated with respect by all staff, with proper regard for the uncertainty of their situation and their cultural backgrounds.

- 3.1 In our survey, 87% of detainees said staff treated them with respect and most of those who we interviewed were positive about staff. There was no longer a personal officer scheme because the fast turnover of detainees made it difficult to develop relationships with individual detainees, but staff were now responsible for offering support and advice to each individual and contacts were briefly summarised on individual records. We saw mostly positive interactions between staff and detainees, although staff usually congregated in offices instead of mixing with detainees.
- 3.2 We saw some examples of staff not challenging low-level poor behaviour by detainees, for example smoking in a classroom, which was raised by some interviewed detainees as a concern. Since our last inspection, there had been major investment in restorative practices training for staff to improve communication and reduce the potential for conflicts, and a few staff in our survey commented positively on the value of the skills they had gained. A team of 13 staff facilitated restorative practice meetings for staff and detainees and quality assurance was supported by an external agency. There had been 49 meetings in the previous 12 months.
- 3.3 In our staff survey, most operational staff who responded, and many of those we spoke to around the centre, said that staff well-being was poorly supported and they often described low morale at work. A minority of staff commented that the centre did not support a learning culture, rather adopting an excessively disciplinary approach to staff mistakes. However, we found no evidence that this was currently affecting their interactions with detainees.

Recommendation

- 3.4 **Officers should be visible in units and interact regularly and positively with individual detainees to help support them during their detention.** (Repeated recommendation 2.4)

Daily life

Expected outcomes: Detainees live in a clean and decent environment suitable for immigration detainees. Detainees are aware of the rules and routines of the centre. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair. Food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

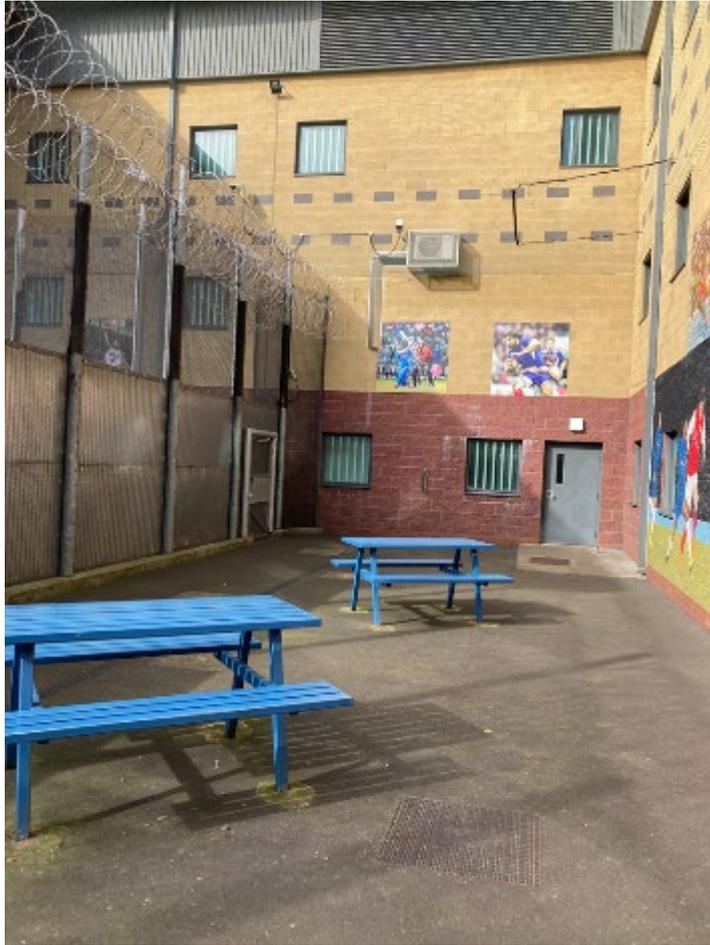
Living conditions

- 3.5 Most of the centre had been refurbished, and the standard of accommodation had improved, but the prison-like design remained inappropriate for a detainee population. The Sahara women's unit was better designed and much more comfortable (see paragraph 3.18). In our survey, 87% of detainees said the communal areas on units were normally clean. There were some vacancies in detainee wing cleaning jobs, but there was also a dedicated staff cleaning team to help maintain a focus on keeping the centre clean.
- 3.6 Ventilation remained a problem and the temperature fluctuated between being too hot or too cold in detainees' rooms. Windows could not be opened, which made this worse. Toilets continued to be inadequately screened and some cells had mattresses that were not suitable, being too small or too large for the bed frames. Several showers remained in a poor condition and there was a problem with flies around showers on two units. Some of the showers were cold and privacy was not sufficient. The centre was planning refurbishments on the units. (See key concern and recommendation 1.42.)



Alpha unit mattress

- 3.7 Murals had been painted on the exercise yards since the last inspection, but the yards remained bare. Picnic benches were available, but provided limited seating. (See key concern and recommendation 1.42.) The women's outdoor area was far more attractive and welcoming (see paragraph 4.4).



C wing yard

- 3.8 In our survey, 62% of detainees said they could get enough clean, suitable clothes for the week. The stock of clothes was low during our inspection and the centre said it shared these with the neighbouring IRC to make sure there was enough supply. Detainees could have clothes sent in, although these were quarantined for 72 hours under COVID guidelines before they could be issued. We saw a detainee wearing a prison-issued vest, which was inappropriate to wear in an IRC.

Detainee consultation, applications and redress

- 3.9 Consultation with detainees had stopped during the pandemic and there were currently no peer representatives, although there were plans to recommence this soon. There was limited opportunity for feedback in most of the centre. There was a feedback book in the main kitchen servery, but not all units had access to it. A feedback and suggestion book for the shop was also available.
- 3.10 In the detainee survey, only 35% said they knew how to make a complaint. Complaint boxes were not situated on all the units, and detainees could not always access the boxes on the activities corridor. Several staff said detainees could give them the complaint form to submit, failing to understand the problem with lack of confidentiality

with this process. Complaints forms were freely available on the units in a range of languages.

- 3.11 Of the small number in our survey who said they had made a complaint, 67% said they had been dealt with fairly compared with 15% at the previous inspection. There was evidence of good investigations into complaints, which covered a range of topics including missing property, errors in payment, food and minor misconduct by staff. Home Office staff collected the complaints daily and distributed those related to issues in the centre to Mitie. These were well managed, with prompt and reasonable responses to detainees.

Residential services

- 3.12 The quantity and quality of food we saw were adequate with a hot option available at the lunch and evening meal. In our survey, 54% of detainees said the quality of food was good. Kitchen staff worked well with health care staff on health-related catering needs for detainees where required.
- 3.13 Many detainees still had complaints about the food and there were limited options to cook for themselves. They had good access to hot water and a microwave on the units, but the toasters were locked away after breakfast. The 'global kitchen', where detainees could work in groups to cook food from their own culture, continued to be popular. The number of detainees who could attend at a time had been reduced during the pandemic, but it was positive that managers had purchased mobile cooking equipment, enabling staff to offer occasional 'pop-up' food sessions on the units. These had included offering pancakes on Shrove Tuesday and burgers on 4 July and were popular with detainees.
- 3.14 The centre shop had recently reopened and there was a variety of products and a good stock. Staff had access to the centre shop and had been able to deliver goods to detainees throughout the pandemic when they were unable to access it for themselves, which was good practice.



Shop

Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality and diversity, underpinned by processes to identify and address any inequality or discrimination. The distinct needs of detainees with protected and any other minority characteristics (see Glossary) are recognised and addressed. Detainees are able to practise their religion. The multi-faith team plays a full part in centre life and contributes to detainees' overall care and support.

Strategic management

- 3.15 Equality, diversity and inclusion (EDI) work was led by an experienced manager and delivered with the help of an EDI officer across the two Heathrow IRC sites. During the pandemic, their work had focused on identifying individuals who might need support in relation to protected characteristics. Some meetings with protected groups had recently taken place, but generally with small numbers.
- 3.16 Much of the more systemic EDI work had been suspended during the pandemic. Networks of staff liaison officers and detainee representatives had fallen into abeyance and finding representatives was a problem when detainees stayed for a short time at Colnbrook. Well-presented monthly EDI reports provided useful data, but there was insufficient analysis and action planning to ensure a rigorous approach to EDI issues. (See key concern and recommendation 1.43.)

- 3.17 Where there was evidence that a reported incident may have involved discriminatory behaviour, and when any complaint was submitted that alleged discrimination, the matter was referred to the EDI manager and investigated properly.

Protected characteristics (see Glossary)

- 3.18 The Sahara unit for detained women had been improved, with more comfortable furnishings, a more relaxed environment and a range of materials for crafts and activities, which were popular with many detainees. They were given good support by staff, although some aspects of off-unit regime remained limited (see paragraphs 4.4 and 4.6). A woman discovered to be at an early stage in pregnancy was well supported and released quickly.
- 3.19 Telephone interpreting was used daily, but not at some key points, such as the serving of official immigration papers. Detainees did not always have ready access to written information in translation, for example in the reception area, although there was a good display of translated material in the health care department. The ability of many staff to interpret in a range of languages was a strength, but this operated informally with no organised system for maximising this knowledge.
- 3.20 Special events, such as cultural festivals, national days and religious occasions, had continued to give a positive focus on diversity, COVID restrictions permitting. The global kitchen (see paragraph 3.13) had further extended its imaginative work celebrating diverse cultures and special days.
- 3.21 There was good ad hoc provision for detainees with disabilities who needed specific practical equipment. Nevertheless, in our survey 77% of those declaring a disability said that they had felt unsafe in the centre and 63%, against only 19% of those without a disability, that they currently felt unsafe. (See key concern and recommendation 1.43.)
- 3.22 Although 20% of detainees responding to our survey said they were gay, bisexual or other sexual orientation, centre staff knew few in these groups or gave them support. There had been a constructive and individualised approach to the care of transgender people.

Recommendation

- 3.23 **The centre should use an organised system of staff interpreters to assist detainees who have little or no English, and should use a professional interpreting service whenever full confidentiality is required.**

Faith and religion

- 3.24 A strong and experienced chaplaincy had maintained opportunities for worship and learning alongside individual support during the pandemic, even though the team of volunteers had reduced considerably. Links

with community faith groups had been weakened by the impact of COVID-19.

- 3.25 The faith area had developed further as an attractive environment, with colourful décor and a welcoming atmosphere. There was good provision for the most common faiths, although Hindu and Sikh detainees had to share one space, and there was limited provision for washing by Muslim worshippers.
- 3.26 Chaplains took a full part in facilitating the celebration of festivals and special days that could help to mitigate the effects of detention, celebrating the diversity and dignity of all the traditions represented in the centre. The team had been present throughout the last two years giving valuable pastoral support and had expanded the practical help offered to those preparing to leave the centre, with coats, bags and a variety of donated new clothing.

Health services

Expected outcomes: Health services assess and meet detainees' health needs while in detention and promote continuity of health and social care on release. Health services recognise the specific needs of detainees as displaced persons who may have experienced trauma. The standard of health service provided is equivalent to that which people expect to receive elsewhere in the community.

- 3.27 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) (see Glossary) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found there were no breaches of the relevant regulations.

Governance arrangements

- 3.28 Health services were commissioned by NHS England and NHS Improvement and delivered by Central and North West London NHS Foundation Trust (CNWL) at the time of inspection. Following retendering for the health contract, services were due to be delivered by Practice Plus Group from 1 April 2022 with services informed by a recent health needs analysis.
- 3.29 Although there had been no recent contract meetings due to the retendering process, CNWL had continued governance meetings and the monitoring of performance data. We did not see much evidence that governance minutes were shared with patient-facing health staff, and this had been identified as an area for improvement by the head of health care. Local delivery board meetings had continued, but while there was representation from Mitie Care and Custody and the Home Office, meetings were not always quorate and the minutes did not give a clear indication of what was discussed. COVID-19 outbreaks had been managed well in partnership with the custody providers and the regional health security lead.

- 3.30 All untoward incidents continued to be reported, CNWL shared information for lessons to be learned and local issues were raised at staff meetings. There were few detainee complaints about health services; responses to those made were clear and addressed the issue.
- 3.31 Staff vacancies were very high, averaging 38% across the team and up to 69% in the mental health team. Recruitment to vacancies had been frozen during the retendering process. The lack of health staff had been somewhat offset by the lower detainee numbers and fall in reception of people from Channel boat crossings during the winter. There was consistent provision of staff training and supervision, and clinical supervision was managed by prioritising monthly reflective practice sessions between clinicians, which was good.
- 3.32 The staff profile included a full-time health care detainee engagement coordinator post across both sites, but this role was mostly redeployed to support the health administrative team. A friends and family survey about health care had been undertaken and comments were acted on and shared with all health staff through email. The health induction pack previously issued to all new arrivals with much useful information in several languages was no longer available due to staffing pressures and was a missed opportunity to inform detainees about the health services available in the centre.
- 3.33 In our survey, 73% said the quality of health services was good. In our interviews, most detainees said that their health needs were being met and we received some very positive feedback on the care received. However, some detainees complained about the length of time it took to see GPs and some said they were addressed abruptly or rudely.
- 3.34 The health centre was clean and all equipment was regularly serviced. There had been recent handwashing and infection prevention and control audits; the July 2021 audit scored within an acceptable range.
- 3.35 Professional telephone and in-person interpreting services were available to health staff and regularly used, although some staff told us that waits to access an interpreter could be longer than the booked health appointment.
- 3.36 All permanent clinical staff were trained in intermediate life support in line with Prisons and Probation Ombudsman recommendations following a death at the centre (see paragraph 2.20). Custody and health staff checked the automated external defibrillators, which were available throughout the centre. The health teams also had three well-equipped, but heavy, resuscitation bags for use in emergencies.
- 3.37 All health teams used a single patient record on the SystmOne clinical information system. The records were mostly good, but some were not clear enough about whether an appointment had been face to face or if a missed GP telephone consultation was classed as a 'non-attendance'.

- 3.38 There was a local health promotion strategy and outbreak control policy. Detainees were offered COVID-19 lateral flow tests on arrival and again after five days, and any testing positive were isolated in a designated unit.
- 3.39 There was a range of health promotion material in several languages in racks in the health centre, and some had also recently been displayed near the shop, but there was very little information on the units; this was a problem where detainees were COVID isolated for their entire stay.
- 3.40 A trained primary care nurse delivered a sexual health service promptly and a specialist genitourinary medicine service was provided by the local Northwick Park Hospital.

Primary care and inpatient services

- 3.41 Nursing staff carried out a full health care screen of all new arrivals and made referrals to the GP and other health services as required. Detainees received no secondary health screens, which risked missing opportunities to address further health issues.
- 3.42 The health service was staffed over 24 hours, with two nurses providing overnight cover, extended to include a health care assistant if a large number of new arrivals were expected. Arrivals requesting to see a GP were seen within 24 hours.
- 3.43 Detainees could request most health appointments through the electronic detainee messaging system and most had a quick response. Waiting times for primary care services were short with GP appointments available within 24 to 48 hours following a nurse triage. Nurse triage appointments were usually available on the same day or next, and detainees could also go to this clinic on a walk-in basis. We observed caring and compassionate health staff interactions with detainees. Other primary care services available included phlebotomy, an optician and vaccination clinics, although routine vaccines had been reduced during the focus on delivering COVID-19 vaccines.
- 3.44 Four detainees were awaiting a Rule 35 assessment (see Glossary and paragraphs 2.12-14). Most of these highly sensitive disclosures of torture had not been identified until after the initial reception screening, even though detainees were prompted on arrival. Rule 35(3) assessments were undertaken face to face by the GPs but lacked detail and a clear conclusion on the impact of continued detention. We were told that GP training in this area was due in the next month.
- 3.45 Detainees with long-term conditions, such as asthma or diabetes, were assessed promptly by skilled nurses with support from GPs. Care plans were drawn up soon after arrival and required checks, such as blood tests, were carried out as soon as practicable.
- 3.46 Detainees were given medication, where required, to take out on their release or transfer. On some occasions, health staff had not been

provided with sufficient notice to arrange medication or transfer of care and treatment.

- 3.47 Hospital appointments were managed well, and few were cancelled due to the lack of escorting officers. However, only two outside appointments a day were available for both Colnbrook and Harmondsworth, and routine appointments were cancelled when there were any A&E attendances. Administrative teams contacted detainees directly if they were given an appointment following their transfer or release. The Home Office was notified of all detainees referred to a secondary care appointment to inform them of a change in their circumstance.

Mental health

- 3.48 An integrated mental health team delivered a stepped care model for detainees with mental health and substance misuse needs. There were staff shortages in the team with a 69% vacancy rate across both sites, which prevented a comprehensive service delivery. The small number of detainees with severe and enduring mental ill health and in acute crisis were managed well with clear care planning and assessment, care in detention and teamwork (ACDT) case management support. Mental health staff attended most of the ACDT initial reviews but did not have the capacity to attend all of them; they made considerable efforts to provide an update for those under their care. Nurse care coordinators undertook full assessments, which included risk assessments, and, where required, made referrals to the psychiatrist. There had been one transfer under the Mental Health Act in the previous six months; it took place within 11 days, which was within the guidelines.
- 3.49 The senior mental health nurses who were providing secondary care were also delivering lower-level interventions to cover some of the staff shortages. No psychologist had been available since August 2021 for those requiring trauma-informed psychological interventions. Detainees with identified treatment needs for trauma were given an in-cell work pack to help them manage their symptoms.
- 3.50 There was a daily allocation and referrals meeting to prioritise work and allocate referrals. There were only two psychosocial well-being staff delivering low-level mental health and substance misuse interventions for both the Colnbrook and Harmondsworth sites, which was completely inadequate. In our survey, 82% of women and 78% of men said they had felt depressed while at the centre and most could have benefited from some brief but meaningful coping interventions while at Colnbrook. A weekly multidisciplinary team meeting led by the psychiatrist discussed complex cases.
- 3.51 The good practice that we had noted on the previous inspection, such as the routine identification to the Home Office of those suffering with post-traumatic stress disorder and the football team events to build resilience and strengths, had ceased due to staff shortages and COVID restrictions. However, we saw a therapy dog used with positive

outcomes for the most distressed (see paragraph 2.22). The well-being drop-in clinics had also stopped due to COVID restrictions.

- 3.52 There had been no mental health awareness training for staff during the pandemic and this had not restarted, which was an additional shortcoming in terms of detainee support.

Recommendations

- 3.53 **Psychological interventions should be offered to meet the needs of detainees.**
- 3.54 **Detention staff should be trained in mental health awareness to promote trauma-informed custodial care.**

Substance misuse treatment

- 3.55 Clinical staff were unaware of a substance misuse strategy, although data were discussed at the security meeting. Following the inspection, we were sent a substance misuse policy updated in February 2022.
- 3.56 One detainee was on opiate substitution medication and was issued with this in line with NHS good practice. Screening of new arrivals included an alcohol audit and withdrawal scores for substance use, with urine testing if detainees required or demonstrated withdrawal symptoms. Those who needed overnight observations were transferred to Harmondsworth inpatient unit. The CNWL policy indicated that it was compliant with national prescribing guidance, but it was unclear if opiate maintenance was an option; we were told that all new arrivals requiring opiate substitution medication had a reduction plan to facilitate those facing removal out of the country.
- 3.57 The GP initiated prescribing of opiate substitution medication for new arrivals and subsequent assessments were undertaken by the non-medical prescriber. Most assessments were jointly undertaken by the clinical and psychosocial team and detainees were seen at days five and 28, although most had been released or transferred by this latter point.

Medicines optimisation and pharmacy services

- 3.58 St Charles Hospital dispensed medicines to the IRC on every weekday. There was an appropriate range of medicines in the onsite out-of-hours cupboard if a detainee required medication urgently over the weekend. If a medicine was not available on site, a prescription could be taken to a local pharmacy.
- 3.59 The lead pharmacist provided strong oversight and also saw detainees to review their medicines if required. Medicines reconciliation was generally completed for new arrivals within 24 hours. All detainees had a risk assessment to determine whether they could keep their medicines in possession safely. A local formulary outlined those medicines which could not be given in possession.

- 3.60 Nurses administered medicines competently three times a day and included a period for controlled drugs. They followed up any patients who had not collected their medication. A detention officer was present during medicines administration to manage queues and ensure privacy for detainees.
- 3.61 Nurses were able to provide detainees with a suitable range of over-the-counter medicines, including pain relief, without a prescription. If a detainee required pain relief on two or more occasions, they were referred to the GP to discuss ongoing pain management.
- 3.62 Staff had access to a range of medicines information in several languages, which could be printed and given to patients to aid their understanding of the medicines they were prescribed.
- 3.63 A medicines optimisation group met occasionally and the lead pharmacist monitored patterns in prescribing generally, as well as looking at the prescribing of medicines that could be traded by detainees. The pharmacy room was tidy and well organised, with robust stock control procedures and daily checks of storage temperatures.

Oral health

- 3.64 Smile Dental Care had been awarded the contract to provide dental services six months before the inspection and provided the NHS range of treatments. The service was responsive with short waiting times for routine and urgent care. The dentist carried out telephone triage initially to determine the urgency of need.
- 3.65 Detainees were given oral health advice during appointments and telephone triage calls. The dentist could prescribe pain relief and antibiotics as required. Dental staff were supported with supervision, appraisal and a comprehensive package of training.
- 3.66 The dental suite was clean and well maintained and staff followed appropriate infection control and decontamination processes. The provider was responsible for ensuring that equipment was serviced and maintained, and routine servicing was scheduled for the following week.

Section 4 Activities

The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.

Access to activities

- 4.1 The centre offered approximately 50 education places and 76 job opportunities, which was considerably lower than the number of detainees. However, participation rates were low and most of these places were not used. Detainees only stayed a short time in the centre, so many did not feel the need to take up work or education. Although only 39% of detainees in our survey said they had enough to do in the centre, there were no waiting lists for activities.
- 4.2 In response to COVID restrictions, managers had devised a system that allowed all detainees to access some activities each day, while maintaining separation between the residential units. New arrivals were restricted to their residential units during the day but could attend evening activities. Once they had been at the centre for 10 days, detainees had good access to most activities, including the gym, in either the morning or afternoon.
- 4.3 The centre gathered good quality data on attendance at activities by scanning detainees' ID cards at each activity session. The data showed that in February 2022 there were 2,853 attendances, most (83%) being visits to the gym, library and internet suite. Only 12% were in education classes.
- 4.4 Detainees could use the outside yards for most of the day, although most were prison-like, unattractive and with few or no facilities to encourage outdoor exercise. (See key concern and recommendation 1.42.) The exception was the garden for women detainees, which had attractive planting and sculpture features. However, women could not freely use this as staff had to be available to escort them outside.
- 4.5 Recreational facilities on the residential units were much better than at the last inspection. They included table tennis, pool, table football, computer games and TV sports channels. New exercise bikes and rowing machines were about to be installed on the units.



Table tennis

- 4.6 The Sahara women's unit offered a reasonably good range of activities, including exercise machines, yoga sessions, computer games, dance competitions, and art and craft projects. Although very few women were employed or attending education, in our survey 78% said they had enough to do to fill their time at the centre.
- 4.7 The centre had not done enough to promote attendance at activities. Many detainees had poor English, but attendance at English classes was very low – involving an average of around four a day. Staff visited wings to encourage attendance but did not adjust course content to suit the groups in the centre. Communication failures on the units sometimes meant that officers did not inform detainees that they could go to classes.
- 4.8 Detainees had good access to the internet, with 15 computers in the IT room providing this. Machines were fast and worked well, and there were keyboards for Arabic and Chinese users and equipment to enable disabled people to use them. The room was generally busy, but with the current population there was enough capacity and no queues.
- 4.9 Managers had improved quality monitoring of activities to support improvement, but observations of teaching were suspended during the pandemic. Peer reviews of teaching had continued and some provided useful feedback to teachers. However, some staff needed more support to carry this out effectively. There had been no recent staff development for teachers, but managers had commissioned an advanced level teacher development programme to be offered later in the year.

Education and work

- 4.10 There was a reasonably good range of learning activities. The classes offered were similar to those in 2018, but teachers placed less emphasis on accreditation because of the short time that detainees spent at Colnbrook. In classes such as art, music and cake decoration, teachers organised individual learning activities with an emphasis on therapeutic activity, rather than structured learning programmes. This was appropriate considering the centre's role as a reverse cohort unit (see Glossary).
- 4.11 Education facilities were good. The barber shop, global kitchen and music rooms were attractive and well equipped. The art room displayed a wide range of work, creating a stimulating and attractive environment that detainees found beneficial. Courses in sugar craft and floristry were popular with detainees. Classroom resources were reasonably good. In English classes, learners could use language teaching programmes on computers. In ICT, the teacher had developed a good range of worksheets, well suited to learners with little English.
- 4.12 Education classes were very small, which made it difficult for teachers to develop group learning activities. In English language classes, most individuals used workbooks with one-to-one assistance from the teacher. Most learners stayed for only a short time, but the small number who took advantage of this tuition made good progress. English language learners had achieved 11 certificates in the month of the inspection and ICT learners had achieved 20.
- 4.13 Teaching was generally good. Teachers were very experienced, enabling them to assess learners' prior knowledge quickly and devise suitable individual learning plans. In craft subjects, teachers demonstrated an excellent rapport with learners and encouraged them to relax and talk about their feelings while carrying out the task.
- 4.14 Detainees' progress was recorded briefly but carefully on their learning plans. These records were passed on if detainees moved to the Harmondsworth IRC. Teachers at the two centres worked well together and some taught at both. This continuity of education provision across the two sites enabled many detainees to achieve certificates at Harmondsworth for work begun at Colnbrook.
- 4.15 The range of paid jobs was limited – most were cleaners or kitchen and servery workers. Jobs such as orderlies and Buddies were not being filled, due to COVID restrictions. This left 54 paid workplaces, but most detainees were not interested in the available work and only 17 were employed. Detainees who applied for work were still vetted by the Home Office and in the previous six months 28 had been refused permission to work because of their non-compliance with the Home Office. During our inspection, there were no detainees whose applications for work had been rejected.
- 4.16 Employed detainees who we spoke to were pleased to be working and had no complaints about their jobs. They received a short induction and

were issued with suitable protective clothing. However, the work offered only minimal training and no recognition of the skills gained.

Recommendation

- 4.17 **Managers should investigate the reasons for poor take-up of education courses, and devise plans to make them more attractive to detainees and increase enrolments.**

Library provision

- 4.18 The library was an attractive and welcoming space, with comfortable sofas and tables as well as two computer workstations, one of which could be used for Skype video-messaging calls. It was open all day and every evening, seven days a week and was well used by detainees. In February 2022, detainees made almost 600 visits to the library. Nearly all male detainees could attend at least three times a week and most could visit at some time every day. There was a small book stock on the Sahara unit for women detainees, and they could order books for officers to collect from the library.
- 4.19 Most books were in English, for which demand was low. The number of foreign texts was much more limited, although it included those in 28 languages. Staff had found it difficult to get books in Albanian, which was spoken by many of the current detainees. In our survey, only around a third of detainees said the library had appropriate materials to meet their needs.
- 4.20 Reference material included a range of foreign-language-to-English dictionaries and books on immigration law that were reasonably up to date. A small number of e-book readers were available for loan. There was a large stock of films on DVD, which were the most popular item borrowed.
- 4.21 Library staff were helpful and friendly, although some lacked professional knowledge of library work. The library provided a range of newspapers and magazines, including some in foreign languages, and recreational materials such as puzzles and colouring books. Regular competitions held in the library included chess, draughts and backgammon.

Fitness provision

- 4.22 Detainees had reasonably good access to the gym. New arrivals could use it for two or three evenings a week. After the 10-day isolation period, they could attend for up to three hours a day. Data for January 2022 recorded over 900 attendances, more than any other centre activity. However, in our survey only 35% of detainees said they could go to the gym as often as they wanted.
- 4.23 Fitness facilities were good. The centre had well-equipped rooms for weight training and cardiovascular work, and a good-sized sports hall. Staff were qualified appropriately.

- 4.24 All detainees had an induction before using the sports facilities, which was recorded on the ID cards they used to visit the gym. Induction leaflets were available in 20 languages, which was good. However, the induction tour provided by staff was very brief and, while adequate for most detainees who only wanted to use the sports hall, it did not make sure that they were safe to use the weights and fitness machines.
- 4.25 Gym staff had produced leaflets giving details of workout regimes and offered personal training plans when requested. Links between the gym and health care were undeveloped. Gym staff did not receive referrals from health care or details of health conditions that might affect a detainee's exercise regime.
- 4.26 Women in the Sahara unit could use the gym every lunchtime when the men were locked up, but very few did so. They could use exercise cycles and a cross-country ski machine on the Sahara unit, and attend a weekly yoga session.

Recommendation

- 4.27 **PE staff should make sure that only detainees who have been fully inducted into the use of fitness equipment are allowed to use it.**

Section 5 Preparation for removal and release

Detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their destination country and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.

Welfare

Expected outcomes: Detainees are supported by welfare services during their time in detention and prepared for release, transfer or removal before leaving detention.

- 5.1 The welfare officers visited new arrivals on the residential units with a pack containing useful information that was available in the most common languages spoken. Staff checked the detainee's case records for their first language. However, this was not reliable since many records did not identify the language. The handover of the pack was generally very brief, because of time pressures on welfare staff (see paragraph 2.6).
- 5.2 The welfare team saw all detainees receiving removal directions to establish their care needs and their attitude to removal. This was useful to the Home Office in signalling any likely problems with removal, but also helped with the care and support of the individual.
- 5.3 The members of the welfare team were experienced and committed, and had the confidence of detainees to whom we spoke. The detainee peer workers in the welfare department had not yet resumed their work, which was suspended when the pandemic started.
- 5.4 Support organisations such as Detention Action, the Jesuit Refugee Service and Bail for Immigration Detainees were now starting to come into the centre again after the period of restrictions, during which they had maintained email and phone contact with detainees. Hibiscus (see Glossary) provided useful practical support for detainees and was currently on site for three days a week.
- 5.5 The welfare team reported that its biggest concern was the difficulty, for both themselves and detainees, of communicating with the Home Office detention engagement team. The welfare officers did what they could to assist detainees and were sometimes also used as intermediaries, for example to serve Home Office documents when this had to be done out of office hours.

Visits and family contact

Expected outcomes: Detainees can easily maintain contact with their families and the outside world. Visits take place in a clean, respectful and safe environment.

- 5.6 Visits had been facilitated whenever the COVID-19 restrictions permitted and Skype video calls had been available throughout the period, although with limited take-up (see paragraph 5.12). Detained men could have daily visits of up to two and a half hours and women could receive visits by arrangement. Voluntary groups were now able to visit those who did not otherwise receive visits, but the centre did not actively identify such people and suggest that they could see a volunteer visitor.
- 5.7 The visits area had been considerably improved. There was better flooring, attractive murals and new play facilities that were already being well used, such as a soft play area and an arcade-style games machine, as well as a new playframe designed for children to use safely without supervision by a play leader. There were three vending machines for refreshments and detainees could also bring along snacks bought from the centre shop.
- 5.8 Measures to maintain safety in visits, such as rub-down searching, were proportionate, and detainees could have as much physical contact with their partners and families as is normal in social settings.
- 5.9 The visitors' centre outside the gate provided a welcome and information for visitors. However, apart from speaking to staff or phoning the main centre switchboard, there was no way for a visitor to communicate concerns about an individual or make suggestions about the visits process, as there was no dedicated telephone line for this or feedback materials.



Visits hall (top) which contained soft play (bottom)

Recommendations

- 5.10 **The centre should identify detainees who do not receive a visit. They should be supported to ensure they are not at an increased risk of isolation and heightened vulnerability, and referrals made to support organisations as necessary.** (Repeated recommendation 4.19)
- 5.11 **Visitors should be able to contact the centre easily and discreetly to report concerns about the safety or well-being of a detainee, and to record suggestion or views arising from their visit.**

Communications

Expected outcomes: Detainees can maintain contact with the outside world regularly using a full range of communications media.

- 5.12 Video calling through Skype had been made available for detainees since our last inspection, but the uptake was low and it had been used only 27 times in the last six months. The computer used for video calls was in a noisy communal area that was unsuitable for making private calls. Access to the service was not well advertised to detainees, although the uptake for legal calls was much greater and these took place in a quiet booth. Other, less dated, social media, to which detainees did not have access, were now used much more often in the community and both staff and detainees suggested that they were more likely to be used in the centre.
- 5.13 Detainees had access to one fax machine, which was well used, and staff in the welfare office helped those who wanted to use this. The team was due to recruit a welfare Buddy to support staff in managing the demand. When detainees were in isolation and unable to use the fax machine, staff on the units would do this for them. The fax machine for receiving mail was now in the communications room, where staff monitored it throughout the day. Correspondence by fax was delivered to detainees four times a day, which was good.
- 5.14 In our survey, 27% of detainees said they had problems sending or receiving mail, and several told us that legal letters get lost or were not delivered on time. The post room was staffed Monday-Friday and Saturday mail often went unattended.
- 5.15 Most detainees had reasonable access to the internet and email. Although computers in the internet room (see paragraph 4.8) and library had good capacity, only 30% of detainees in our survey said they were easy to access. Women had access to computers on their unit and they were free to use them during the core day. During our inspection, Echo unit was being used for detainees who had tested positive for COVID, and it had been recently used for those due for removal on a charter flight, and their access to the internet and email was limited and only available at the discretion of staff, usually when other units were not using the room.

- 5.16 Detainees could send one free letter a week. Although new arrivals were not allowed to keep their own personal mobile phone if it had a camera or recording equipment, the centre issued them with a mobile phone. Top-up cards could be bought from the shop and the centre monitored international call rates to get the best deals. During the pandemic, the Home Office had authorised an additional £5 credit on top of what detainees were already issued on their arrival, but this was stopped when social visits restarted.

Recommendations

- 5.17 **Detainees should be made aware that they can use video calling, and other social networking sites should be made available.**
- 5.18 **Post should be monitored and delivered to detainees on all days of the week it is received.**

Leaving the centre

Expected outcomes: Detainees leaving detention are prepared for their release, transfer or removal. Detainees are treated sensitively and humanely and are able to retain or recover their property.

- 5.19 In the previous six months, 52% of detainees leaving the centre had been released into the community, suggesting that many should not have been detained in the first place.
- 5.20 The welfare team routinely saw detainees being removed from the UK before they left the centre to address potential outstanding needs. Hibiscus could assist detainees to reach their destinations and provided other resettlement support, although staff told us that those challenging their removal often declined assistance.
- 5.21 Some detainees were still placed on a reserve list for removal. This was not voluntary, but they were told in advance that they might not fly. Some detainees were returning to destitution, or with small funds, but Home Office destitution grants to help with onward travel were only assessed during the flight and not in advance, which might have helped reduced detainee anxiety.
- 5.22 We were told that the Home Office convened individual strategy meetings to plan for removal in 'complex cases', usually where it was considered that detainees might resist removal. However, despite several requests, the Home Office was unable to produce minutes of any such meetings.
- 5.23 There continued to be delays in releasing detainees due to the unavailability of bail accommodation (see paragraph 2.46). We were told that detainees granted bail were routinely tagged for electronic monitoring, but there were no reliable records of how many had been subject to monitoring. Contractors had 72 hours to apply tags before detainees were released, which was an excessive period of time to

continue detention after the granting of bail. The Home Office was unable to tell us how long in practice it took contractors to fit electronic tags.

- 5.24 DET was not convening multidisciplinary meetings to coordinate the safe release of particularly vulnerable detainees, despite this being a requirement of Home Office policy. Last-minute releases created some risks for more vulnerable detainees who did not have adequate continuity of care (see paragraph 3.46).
- 5.25 Detainees released into the UK were given a summary of their medical records and up to a month's supply of medication. They were provided with travel warrants and staff ensured they could reach local train stations, by a free bus service or taxi.
- 5.26 Some detainees were released homeless and, under Home Office policy, were prohibited from working. The Home Office kept no reliable data on homeless releases, although Mitie records suggested there could have been nine in the previous year. The centre gave these detainees a sleeping bag and, where needed, a spare set of clothing.

Recommendations

- 5.27 **The Home Office should convene multidisciplinary meetings to plan for the removal and release of more vulnerable detainees to make sure their welfare is promoted and suitable arrangements are in place, as needed, for their travel, reception and continuity of care.**
- 5.28 **The Home Office should gather data on the use of electronic monitoring and provide effective oversight of the process of fitting tags.**

Section 6 Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

- 6.1 Key concern 1.38: The reception and induction of new arrivals were weak; they waited up to five hours in vans outside reception and it could take a further two-and-a-half hours to process them before they were taken to their first night accommodation. Most arrivals were not offered a private interview, and interviews were insufficiently focused on safety. The induction process was ineffective.

Recommendation: New arrivals should be received promptly into the centre and reception processes, including interviews with detainees, should promote disclosure of vulnerabilities. Detainees should receive an induction that informs them of how to access all key activities and services in the centre, supported by written information that they can understand.

(To the centre manager and the Home Office)

- 6.2 Key concern 1.39: Rule 35 reports lacked detail and did not always provide an adequate assessment of the impact of continued detention on a detainee's physical and mental health.

Recommendation: Rule 35 reports should provide a clear and detailed assessment of the detainee's injuries and a comprehensive assessment of the impact of continued detention on their physical and mental health.

(To the health care provider and the Home Office)

- 6.3 Key concern 1.40: The Home Office detention engagement team had not been engaging routinely with detainees face to face, and many detainees faced difficulties contacting them by telephone.

Recommendation: The detention engagement team should resume face-to-face contact with detainees as a priority and make sure that all detainees can telephone their engagement worker easily.

(To the Home Office)

- 6.4 Key concern 1.41: Some detainees who were due to be removed on charter flights were located on Echo Unit as part of the centre's approach to preventing the spread of COVID-19. This resulted in limited access to the internet to communicate with their legal representatives at a critical time.

Recommendation: All detainees should be able to communicate freely with their legal representatives at all times, including

prompt access to emails.

(To the centre manager)

- 6.5 Key concern 1.42: Poor ventilation remained a problem and the shower facilities were in a poor condition. Showers and toilets remained inadequately screened and some mattresses were not fit for purpose. Despite some work to the outside exercise areas, they remained bleak and prison-like, with few or no facilities to encourage outdoor exercise.

Recommendation: The environment should be improved through well-ventilated residential units that are kept in good repair, showers and toilets that are properly screened, and well-equipped and more welcoming exercise yards.

(To the centre manager and the Home Office)

- 6.6 Key concern 1.43: During the pandemic, equality, diversity and inclusion work had focused on identifying individuals with protected characteristics who might need support, and the networks of staff equality liaison officers and detainee equality representatives had fallen into disuse. Colnbrook did not yet have a sound structure for meeting the requirements of equality, diversity and inclusion as it returned to its role as a regular IRC.

Recommendation: The centre should address issues of equality, diversity and inclusion comprehensively, supported by sufficient staff to make sure that monitoring, analysis, provision and support are consistent for all protected characteristics, and that the detainee voice is heard and acted on.

(To the centre manager)

Recommendations

- 6.7 Recommendation 2.17: The Home Office should ensure that all information shared about adults at risk is accurate.
(To the centre manager and the Home Office)
- 6.8 Recommendation 2.18: Leaders should investigate and address the reasons for some staff being unwilling to raise whistleblowing concerns.
(To the centre manager)
- 6.9 Recommendation 2.44: All use of separation should be proportionate and fully justified.
(To the centre manager and the Home Office)
- 6.10 Recommendation 2.51: The Home Office should make sure that detention is not prolonged unnecessarily when there is little prospect of a detainee's removal within a reasonable timescale.
(To the Home Office)
- 6.11 Recommendation 3.4: Officers should be visible in units and interact regularly and positively with individual detainees to help support them

- during their detention. (Repeated recommendation 2.4)
(To the centre manager)
- 6.12 Recommendation 3.23: The centre should use an organised system of staff interpreters to assist detainees who have little or no English, and should use a professional interpreting service whenever full confidentiality is required.
(To the centre manager)
- 6.13 Recommendation 3.53: Psychological interventions should be offered to meet the needs of detainees.
(To the health care provider and the Home Office)
- 6.14 Recommendation 3.54: Detention staff should be trained in mental health awareness to promote trauma-informed custodial care.
(To the centre manager)
- 6.15 Recommendation 4.17: Managers should investigate the reasons for poor take-up of education courses, and devise plans to make them more attractive to detainees and increase enrolments.
(To the centre manager)
- 6.16 Recommendation 4.27: PE staff should make sure that only detainees who have been fully inducted into the use of fitness equipment are allowed to use it.
(To the centre manager)
- 6.17 Recommendation 5.10: The centre should identify detainees who do not receive a visit. They should be supported to ensure they are not at an increased risk of isolation and heightened vulnerability, and referrals made to support organisations as necessary. (Repeated recommendation 4.19)
(To the centre manager)
- 6.18 Recommendation 5.11: Visitors should be able to contact the centre easily and discreetly to report concerns about the safety or well-being of a detainee, and to record suggestion or views arising from their visit.
(To the centre manager)
- 6.19 Recommendation 5.17: Detainees should be made aware that they can use video calling, and other social networking sites should be made available.
(To the centre manager and the Home Office)
- 6.20 Recommendation 5.18: Post should be monitored and delivered to detainees on all days of the week it is received.
(To the centre manager)
- 6.21 Recommendation 5.27: The Home Office should convene multidisciplinary meetings to plan for the removal and release of more vulnerable detainees to make sure their welfare is promoted and suitable arrangements are in place, as needed, for their travel, reception and continuity of care.
(To the Home Office)

6.22 Recommendation 5.28: The Home Office should gather data on the use of electronic monitoring and provide effective oversight of the process of fitting tags.
(To the Home Office)

Section 7 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy establishment. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Safety

Detainees are held in safety and with due regard to the insecurity of their position.

At the last inspection, in 2018, initial risk assessment and induction processes were not sufficiently thorough. Levels of violence were low and the centre had a calm atmosphere. Self-harm had increased substantially. Support for those on ACDT was generally good. The environment remained prison-like and unsuitable for a detainee population. Detainees spent long periods unnecessarily locked in rooms. Procedural security was reasonable overall. While availability of drugs was being addressed, there was no coordinated drug strategy. Vulnerable adults were not sufficiently well identified. Rule 35 was rarely used for cases that did not involve torture, and most of those with evidence of experience of torture had detention maintained. Use of force was proportionate in the cases we saw, but there was very little video- recording of incidents. Governance was generally good. Separation had been used for people with serious mental health problems who should not have been in detention. There were still too many instances of prolonged detention, including cases where detainees were granted bail but were not released because of a lack of accommodation. There were sufficient legal advice surgeries but there was evidence of questionable levels of service by some solicitors' firms. Outcomes for detainees were not sufficiently good against this healthy establishment test.

Key recommendation

The centre should monitor Rule 35 reports to ensure they are submitted when necessary. Psychiatrists should be able to submit Rule 35 reports concerning the mental health of detainees. Reports should contain sufficient detail to inform a proper assessment of the vulnerability of the detainee. Home Office responses should be timely. Where evidence of torture is accepted, detention should only be maintained in exceptional circumstances. (S36)

Not achieved

Recommendations

Newly arrived detainees should have a private interview with a member of the centre staff, who should give them adequate information in their own language about services and support available. (1.6)

Not achieved

Every detainee should spend their first night in a cell which is in a decent condition. (1.7)

Achieved

Every detainee should gain an understanding during induction of how to feel safe and how to access all key activities and services in the centre, supported by written information which they can understand. (1.8)

Not achieved

The Home Office should ensure that the centre has an up-to-date record of adults at risk, so that targeted support can be provided. (1.22)

Partially achieved

All detainees whose age is in dispute should have a multidisciplinary care plan and prompt, thorough assessments, which ensure that children are identified and released from detention. (1.32)

No longer relevant

All allegations of antisocial behaviour or violence should be fully investigated and acted on accordingly. Detainee custody officers should understand and apply the centre's violence reduction and anti-bullying policies. (1.37)

Achieved

Detainees should not be routinely handcuffed during escorts or hospital appointments. Restraints should be applied only if a risk assessment indicates a specific risk of escape or to the safety of the public, staff or other detainees. (1.45)

Achieved

There should be a coordinated, centre-wide approach to substance supply and reduction, with regularly monitored action plans, and forums for systematic discussion of substance use. (1.46)

Achieved

All planned use of force incidents should be video recorded and body-worn cameras routinely turned on during spontaneous incidents. (1.53)

Achieved

All detainees at the Legal Aid Agency advice surgeries should be given enough time to explain their circumstances and receive advice over the full allocated half-hour interview. (1.65, repeated recommendation 1.56)

Achieved

There should be a strict time limit on the length of detention and caseworkers should act with diligence and expedition. (1.66, repeated recommendation 1.62)

Partially achieved

Respect

Detainees are treated with respect for their human dignity and the circumstances of their detention.

At the last inspection, in 2018, detainees were very positive about the way they were treated by staff. The accommodation was in a generally grubby condition. Equality and diversity work was underdeveloped but improving. Professional interpreting was underused. Faith provision was reasonable. Complaints were managed well. Detainees were critical of the quality of food, which lacked variety. The cultural kitchen was a very good resource. Health care provision had improved and was reasonably good overall. However, there were some shortcomings in governance and provision for those with low-level mental health needs. Outcomes for detainees were reasonably good against this healthy establishment test.

Key recommendations

The living environment for all detainees should be more open and security restrictions should be proportionate to the risks presented. Detainees should not be locked in their cells. (S37)

Not achieved

Residential units should be kept clean, in good repair and well ventilated. Rooms should be sufficiently furnished to allow for storage and security of possessions and all showers and toilets should be properly screened. (S38)

Not achieved

Recommendations

Officers should be visible in units and interact regularly and positively with individual detainees to help support them during their detention. (2.4, repeated recommendation 2.14)

Not achieved (recommendation repeated, 3.4)

The centre should ensure that exercise yards offer a welcoming environment. (2.9, repeated recommendation 2.6)

Not achieved

Women should have access to sufficient suitable activities both on and off the unit. (2.10)

Partially achieved

Food should provide a healthy, balanced diet and all diets should be catered for. (2.17)

Not achieved

A regular cycle of equality meetings, with data analysis and progress reports relating to all protected characteristics, should lead to measurable improvements in outcomes for detainees. (2.20)

Not achieved

All detainees' protected characteristics should be systematically identified on arrival and support offered where necessary. (2.26)

Not achieved

Interpreting should be used on all occasions where confidentiality is required, or where no alternative is available, to ensure that detainees understand information they are being given and can express themselves. (2.27)

Partially achieved

Health care staff should have regular recorded clinical and managerial supervision. (2.45)

Achieved

Health information, including health promotion material, should be available in a range of languages and visible signs should promote the availability of translated material. (2.46)

Achieved

The use of professional telephone interpretation should be used more consistently and detainees should not be used as interpreters in confidential health appointments. (2.47)

Achieved

The automated external defibrillators (AEDs) available to centre staff should be regularly checked via a robust monitoring system and all staff on duty should know the location of the nearest AED. (2.48)

Achieved

The range and frequency of interventions for detainees with mild to moderate needs should be increased. (2.64)

Not achieved

Detainees who are experiencing severe and acute mental illness should not be in immigration detention. (2.65)

Not achieved

Activities

The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.

At the last inspection, in 2018, there was an improved range of activities, management of activities had improved and detainees had good access when unlocked. Most detainees could work and attend education or vocational training, and there were no waiting lists. However, a large number were prevented from working by the Home Office. Fewer than half the detainees in our survey said they could fill their time. The library provided a good service. Fitness provision was good. Outcomes for detainees were reasonably good against this healthy establishment test.

Recommendations

Activities inductions should ensure that all detainees are aware of the activities available and how they might help them. (3.10)

Not achieved

The Home Office should not prevent detainees from working. (3.11, repeated recommendation 3.16)

Achieved

Managers should effectively monitor the quality of provision and undertake a self-assessment to inform future improvement plans. (3.12)

Not achieved

Preparation for removal and release

Detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their country of origin and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.

At the last inspection, in 2018, welfare support remained a strength of the centre. There was excellent involvement of NGOs (non-governmental organisations). Visits provision was generally good. Detainees had good access to phones. Detainees could easily use the internet but not social media or video-calling. There was no systematic pre-discharge assessment, although Hibiscus provided useful support for detainees. Outcomes for detainees were good against this healthy establishment test.

Recommendations

There should be sufficient staff oversight of the tasks undertaken by detainees employed in the welfare office, particularly regarding the completion of forms for other detainees. (4.9)

Achieved

The centre should identify detainees who do not receive a visit. They should be supported to ensure they are not at an increased risk of isolation and heightened vulnerability, and referrals made to support organisations as necessary. (4.19)

Not achieved (recommendation repeated, 5.10)

Detainees should be routinely seen on arrival and before discharge to ensure that welfare matters are identified and addressed. (4.33)

Partially achieved

Detainees should have access to Skype and social networking sites unless an individual risk assessment determines that this is inappropriate. (4.25, repeated recommendation 4.18)

Partially achieved

Complex removal meetings should focus on detainees with vulnerabilities and their resettlement needs, as well as detainees who might prove refractory.
(4.34)

Not achieved

The process of having involuntary 'reserves' for chartered flights should cease.
(4.35)

Not achieved

Appendix I About our inspections and reports

Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For immigration removal centres the tests are:

Safety

Detainees are held in safety and with due regard to the insecurity of their position.

Respect

Detainees are treated with respect for their human dignity and the circumstances of their detention.

Activities

The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.

Preparation for removal and release

Detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their destination country and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.

Under each test, we make an assessment of outcomes for detainees and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the Home Office.

Outcomes for detainees are good.

There is no evidence that outcomes for detainees are being adversely affected in any significant areas.

Outcomes for detainees are reasonably good.

There is evidence of adverse outcomes for detainees in only a

small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for detainees are not sufficiently good.

There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for detainees are poor.

There is evidence that the outcomes for detainees are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for detainees. Immediate remedial action is required.

The tests for immigration detention facilities take into account the specific circumstances applying to detainees, and the fact that they are not being held for committing a criminal offence and their detention may not have been as a result of a judicial process. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees: in a relaxed regime; with as much freedom of movement and association as possible consistent with maintaining a safe and secure environment; to encourage and assist detainees to make the most productive use of their time; and respecting in particular their dignity and the right to individual expression.

The statutory instrument also states that due recognition will be given at immigration removal centres to the need for awareness of the particular anxieties to which detainees may be subject, and the sensitivity that this will require, especially when handling issues of cultural diversity.

Our assessments might result in one of the following:

Key concerns and recommendations: identify the issues of most importance to improving outcomes for detainees and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

Recommendations: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

Examples of notable positive practice: innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Five key sources of evidence are used by inspectors: observation; detainee and staff surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

This report

This report provides a summary of our inspection findings against the four healthy establishment tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees* (Version 4, 2018) (available on our website at <https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/immigration-detention-expectations/>). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 6 lists all recommendations made in the report. Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of detainees and a detailed description of the survey methodology can be found on our website (see Appendix II: Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief inspector
Hindpal Singh Bhui	Team leader
Deri Hughes-Roberts	Inspector
Martin Kettle	Inspector
Rebecca Mavin	Inspector
Steve Oliver-Watts	Inspector
Tamara Pattinson	Inspector
Chelsey Pattison	Inspector
Elenor Ben-Ari	Researcher
Charlotte Betts	Researcher
Rachel Duncan	Researcher
Rahul Jalil	Researcher
Tania Osborne	Lead health and social care inspector
Dee Angwin	Care Quality Commission inspector
Matthew Tedstone	Care Quality Commission inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: <http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/>

Care Quality Commission (CQC)

CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: <http://www.cqc.org.uk>

Certified normal accommodation (CNA) and operational capacity

Baseline CNA is the sum total of all certified accommodation in an establishment except rooms in segregation units, health care rooms or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged rooms, rooms affected by building works, and rooms taken out of use due to staff shortages. Operational capacity is the total number of detainees that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Detention engagement team (DET)

Home Office team responsible for engaging with detainees to update them on progress on their case while detained.

Hibiscus

British charity working with Black, minority and migrant women and families at the intersection of the immigration and criminal justice systems.

National referral mechanism (NRM)

A framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

Protected characteristics

The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Protection of adults at risk

Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Reverse cohort unit (RCU)

Unit holding new arrivals in quarantine.

Rule 35

Of Detention Centre Rules, requires notification to Home Office Immigration and Enforcement if a detainee's health is likely to be injuriously affected by detention, including if they may have been the victim of torture.

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the establishment). For this report, these are:

Detainee population profile

We request a population profile from each centre as part of the information we gather during our inspection. We have published this breakdown on our website.

Detainee survey methodology and results

A representative survey of detainees is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Survey of centre staff

Staff from the centre are invited to complete a staff survey. The results are published alongside the report on our website.

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