Report on the unannounced inspection of the non-residential short-term holding facility at:

Cayley House

10–12 May 2010

by HM Chief Inspector of Prisons

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Contents

Overview 4

The healthy custodial establishment 5

Section 1:

- Escorts, vans and transfers 8
- Arrival and accommodation 9
- Positive relationships 11
- Legal rights 12
- Casework 13
- Duty of care 14
- Childcare and child protection 15
- Diversity 16
- Activities 17
- Facility rules 17
- Complaints 19
- Services 19
- Preparation for release 20

Section 2: Summary of recommendations 21

Overview

The UK Border Agency has six short-term holding facilities at Heathrow Airport, one at each of the five terminals[1] and a newly built non-residential removals holding facility, Cayley House.

Cayley House replaced the removals facility at Queen's Building in 2009. Group 4 Securicor (G4S) was contracted to manage the area, which was located next to Terminal 3 but inaccessible from inside the terminal. It received people who were due to be removed from Heathrow Airport from other places of detention around the country. It was open 24 hours a day and allowed for separation of men, women and families. Overall, the physical conditions in Cayley House were a marked improvement on those at Queen's Building. Some sensible policy changes had also been implemented since the previous inspection, most notably in relation to use of force, which had reduced considerably.

Three detainee custody managers were based in the main office: one was in charge of liaison with flight staff, one managed the detainees at Cayley House and kept the computer system up to date and one coordinated escort teams. An Independent Monitoring Board provided regular oversight but supervisory visits by UK Border Agency (UKBA) staff were not routine. Over 3,000 people had passed through the facility between January and April 2010, most (95%) for less than eight hours. About a fifth of detainees were women[2] and 57 children had been detained, on average for 2.8 hours. In addition to day-to-day contact with detainees, inspectors carried out structured interviews with 10 detainees at the facility.

Cayley House Short-Term Holding Facility
Inspected: 10–12 May 2010
Last inspected: Never previously inspected

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[1] At the time of inspection, the whole of Terminal 2 was closed for refurbishment.
[2] It was not possible to establish from the provided figures the exact number of women passing through the holding area.

The healthy custodial establishment

HE.1 The concept of a healthy prison was introduced in our thematic review *Suicide is Everyone's Concern* (1999). The healthy prison criteria have been modified to fit the inspection of short-term holding facilities, both residential and non-residential. The criteria for short-term holding facilities 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 – detainees are able to be occupied while they are in detention

Preparation for release – detainees are able to keep in contact with the outside world and are prepared for their release, transfer or removal.

HE.2 Inspectors kept fully in mind that although these were custodial facilities, detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes.

Safety

HE.3 Detainees generally reported positively about staff conduct during escorts. Most vehicles had cages, but some new, more spacious and uncaged vehicles were also used. A 'rapid response' overseas escort team had recently been located at the facility to facilitate swift repeat attempts to remove detainees who had initially refused to travel. The observed removal escorts were generally handled appropriately, but in one case overseas staff lacked sensitivity to a detainee's embarrassment when on the aircraft. Use of handcuffs during escort was rare, and in line with appropriate risk assessment. There was a sensible, harm reduction approach to removals: rather than attempting to use force and escalating situations, removals were simply rescheduled or overseas escorts booked.

HE.4 Not all detainees were offered free telephone calls on arrival. Searching was generally appropriate, but we saw some insensitive searching practice. Use of force was low and had reduced, particularly since the change of policy on removals. Incident reports showed appropriate attempts at de-escalation. Documentation was generally completed appropriately, although medical assessment did not always take place after use of force. We observed a use of force on a disturbed detainee during the inspection, which was not managed effectively.

HE.5 There had been no reports of bullying or intimidation among detainees. The separation room was used infrequently and mainly for the few people who had self-harmed. Staff did not routinely carry anti-ligature knives and had not received assessment, care in detention and teamwork (ACDT) training.

HE.6 The Independent Monitoring Board provided regular oversight of the facility. There was no routine and recorded supervision of the holding area by UK Border Agency

(UKBA) staff. Inspected IS91 authority to detain forms were completed appropriately. Most detainees understood their situations. Valid legal advice telephone numbers were displayed in the holding rooms, but were of little use to detainees who could not speak English and there was no advice line using interpretation.

HE.7 G4S had a national and some local children's champions. The UKBA child protection coordinator was knowledgeable and had links with the local safeguarding children board. There were no children's team immigration staff in the UKBA removals facilitation unit. UKBA staff had a basic level of child protection training, but no such training was available for G4S staff.

Respect

HE.8 Overall physical conditions were reasonably good. Three separate holding rooms had been built, allowing for separation of women, men and families. The rooms were clean and had sufficient space. The doors were appropriately left unlocked so that detainees could walk around the facility and easily access the toilets and showers.

HE.9 Detainees were positive about staff treatment. Telephone interpretation was used regularly, although not in all cases where it would have been helpful. We observed some good staff–detainee interactions, and staff sat in the holding rooms with detainees. However, overall staff numbers were not well managed and there were often more staff than detainees in the holding rooms, disturbing detainees trying to rest. A large number of staff also congregated in the booking-in area, sometimes causing tension and, in at least one case, unprofessional conduct between staff.

HE.10 Secure complaints boxes were available, with complaint forms in a variety of languages. However, they were not opened daily by UKBA staff. One complaint being dealt with by G4S had not been resolved, more than seven months after it had been submitted.

HE.11 There was a variety of translated information in the holding rooms. A range of religious books was available in different languages, as well as prayer mats and compasses. Male detainees could use a separate room for quiet contemplation or prayer. Telephone numbers for airport chaplaincy staff were posted in the holding rooms. Some detainees with disabilities had been held in the facility. A form was completed for each such case and sent to G4S's national disability officer. There were no obvious adjustments for detainees with disabilities coming through the facility.

HE.12 A reasonable range of hot meals was available, but they were in the form of unappealing ambient meals. A range of sandwiches and snacks was provided, including fresh fruit, and hot and cold drinks were freely available.

Activities

HE.13 Newspapers and some books were provided in different languages. A number of books were suitable for children. DVDs were freely available in the family holding room. There was no smoking area and no access to fresh air.

Preparation for release

HE.14 There was little focused preparation for release or removal. There was no supply of clothes for issue to detainees being removed. Visits were not allowed. Detainees had good access to telephones. They could borrow them from staff if their own telephones had camera or recording capabilities. There was a range of cards containing information about immigration removal centres for those being transferred to further detention. There was no internet or email access.

Section 1

Escort vans and transfers

Expected outcomes:
Detainees under escort are treated courteously, provided with refreshment and comfort breaks, and transported safely

1.1 There was little evidence of frequent moves around the immigration detention estate. However, one Vietnamese detainee had within two months been moved on six separate occasions between immigration removal centres (IRCs) before coming to Cayley House; this sequence had included a failed removal.

1.2 Escort staff were polite and courteous to detainees. Overseas escort staff made positive and continuous attempts – successfully, in the cases which we observed – to converse with the detainees in their charge, before and during departure from Cayley House, to ascertain any problems and deal with them early. In one case, the escorting staff behaved on the aircraft with insufficient discretion and drew attention to the detainee while other passengers were taking their seats.

1.3 There was no evidence of detainees being held in vans for unreasonable lengths of time. The new facilities at Cayley House enabled detainees to disembark from the van in a secure location and proceed straight to the reception desk. Most journeys were short, and there was evidence of refreshment and comfort breaks having been offered.

1.4 In one case, a Brazilian couple, who had overstayed their tourist visas in order to look after the wife's seriously ill mother, were held in separate cells in a police station before coming to Cayley House. They had not communicated at all until they were reunited the following afternoon at Cayley House, more than 24 hours after their arrest. In the intervening period, she had been detained at Yarl's Wood IRC, and he at Campsfield House IRC.

1.5 There were suitable vehicles for families, children and those with disabilities; these were spacious and did not have obtrusive internal cages. Male and female detainees were transported separately, unless they were related to each other. Most escort vehicles were in a reasonable condition, although most had internal cages. However, the vehicles used for transit within the airport were in poorer repair. Some detainees (many of whom had no previous experience of any form of detention) said that they felt degraded to be placed in cages for short transit journeys within the airport. Since all such moves remain within the secure envelope of the airside section of the airport, the need for such vehicles was unclear, other than in a case of exceptional risk.

1.6 Escort staff ensured that detainees received an adequate meal and drink at meal times. On one occasion, we observed staff buying food for a detainee in a terminal, since none was carried on the internal transit vans.

1.7 Information on needs and risks associated with individual detainees was passed between places of detention with reasonable reliability. In most IS91 (authority to detain) forms, the risk assessment section was completed with a 'no risks known' entry, which gave assurance that the matter had been considered. However, this was not always the case. (see 1.39) Escort providers notified the destination establishment in cases of transfer to an IRC.

1.8 At one point, a detainee in Cayley House wanted to take some pills used to treat a serious illness. The pill box he produced did not bear his name and staff were therefore concerned about allowing him to take them. They expended considerable effort to check, using the telephone medical advice line, consulting with a doctor in the airport and using other means to gather information, before giving them to him.

1.9 Physical restraint had not been used in recent months by holding room staff in order to effect removal; a policy had been introduced for avoiding such use of force (see section on facility rules). The only occasions of serious use of force in the course of an escort had been reactive, when a detainee had been physically violent or recalcitrant; on rare occasions, minimal physical contact, a hand under the arm, was used. Use of handcuffs during escort was uncommon, and was backed in each case by individual risk assessment. A new 'rapid response' overseas escort team had been located in Cayley House to remove detainees who had initially refused to travel, using force if necessary (see section on facility rules).

Recommendations

1.10 **Detainees should not be subject to unnecessarily frequent moves between places of detention.**

1.11 **Couples transferred and located apart from each other should be enabled to communicate with one another, unless relevant risk information justifies prevention of contact.**

1.12 **Vehicles with internal cages should not be used for journeys within the airport unless clearly justified by individual risk assessment.**

1.13 **There should be clear protocols, well understood by staff, for the handling of medication brought into the facility by detainees.**

Arrival and accommodation

Expected outcomes:
Detainees taken into custody are treated with respect, have the correct documentation, and are held in safe and decent conditions. Family accommodation is suitable.

1.14 Cayley House comprised a reception area, staff offices, a staff room, a kitchen and three holding rooms, which were clean and had sufficient space. Of these, one was designated for families, a second for women or couples and a third for men. There were also separate toilet and shower facilities for men and women.

1.15 The reception area had a desk, where detainees were booked in. A separate room opposite the desk was designated as a close supervision room but was used most frequently as a waiting area. Next to that was a search area, which was screened from the corridor by a curtain; it doubled as a locker room for staff.

1.16 The largest holding room was used for male detainees. It contained two fixed tables, each with four seats, and a further 16 seats arranged around the edge and across the middle of the room. In the centre of the room was one lounger-type chair. At one end of the room there was a large flat-screen television. The room also contained a pay telephone, a drinks vending machine and a bookcase. Off this room was a small area described as a quiet area, with two lounger-type chairs.

1.17 The second room, used primarily by women and couples, was smaller and contained two fixed tables, each with four chairs, 10 other seats arranged around the edge of the room and one lounger-type chair. The room was also equipped with a pay telephone, a drinks vending machine, a bookcase and a flat-screen television.

1.18 The family room contained a fixed table with four chairs, one lounger-type chair and an additional three chairs in one corner of the room. There was also a highchair for young children and a travel cot. This room also had a pay telephone, bookcase and a television but did not have a drinks machine. None of the rooms had windows; ventilation and heating were provided by an air-conditioning system. The temperature in each of the rooms could be adjusted independently, on a control panel situated in the corridor outside each room.

1.19 On arrival, the officer at the reception desk checked the detainee's identity and the IS91. All detainees held at the time of the inspection had a completed IS91 form. Detainees were asked if they knew why they were at Cayley House. If they were booked on a flight, the officer confirmed the details to them and told them when they would be leaving the centre to travel to their departure gate. The area in front of the reception desk was cramped; it was frequently filled with detainees and staff arriving and leaving. This made it impossible to speak to the detainee in private and increased the tensions both between staff and detainees and among staff.

1.20 Detainees were allowed to retain their money. The pay telephones in the holding rooms could be used for incoming or outgoing calls but did not have privacy hoods. We were told that detainees without means were given a free call from the staff telephone in reception, but this telephone was only able to call numbers within the UK. All their other property was sealed and stored in a locked store room.

1.21 After the booking-in procedure was completed, detainees were given a rub-down search by an officer of the same gender. The area became crowded on occasions during the inspection, making it difficult to search detainees sensitively. We noted examples of women being searched in a confined space in the presence of a group of unrelated male detainees, to the clear discomfort of all of them.

1.22 Once they had been searched, detainees were given a brief tour of the facilities, offered a meal and a drink and shown how to help themselves to additional drinks from the vending machines; these were free and offered a range of hot and cold drinks. Detainees were given a copy of the G4S booklet on detention in a holding room, which contained information in 11 languages.

1.23 The men's and women's toilet facilities each had a shower area and a baby change facility. In the showers there was a supply of clean towels and a selection of toiletries, including hygiene packs and a pair of socks. The baby change areas were stocked with a range of nappies in different sizes and also baby wipes. At the time of the inspection, the shower in the men's area was out of order. Officers had arranged for male detainees to use the women's showers when they were available. Apart from the socks supplied in the hygiene packs, there was no stock of clean clothing for detainees who required a change of clothes.

1.24 Detainees were supervised by staff at all times, with at least one officer based in each of the holding rooms. The doors of the room were not locked and detainees could move around freely and summon assistance if necessary.

1.25 Some detainees were held in Cayley House for long periods and overnight. Although a number of lounger-type chairs were available, enabling detainees to rest, they could not sleep on them

comfortably. These chairs were situated in the middle of the holding rooms, where detainees were constantly disturbed. In each of the holding rooms there was a sign, in different languages, advertising the availability of blankets and pillows; there was an adequate supply of fresh pillow cases and blankets.

1.26 There were no health services staff on site. If detainees had medication with them that they needed to take, staff could contact a telephone medical advice line and triage service provided by G4S Forensic and Medical Services to obtain advice about whether the detainee should be given access to medication. In an emergency, officers contacted paramedic services based at the airport via the 999 emergency service telephone number.

Recommendations

1.27 **Detainees should be booked in or discharged from the holding room one at a time, and staff not dealing with the detainee should not be in the reception area.**

1.28 **Pay telephones should have privacy hoods, to enable detainees to make calls in private.**

1.29 **Detainees should be searched sensitively, and not in the presence of detainees of the opposite sex.**

1.30 **The holding room should have a stock of clean clothing, including underwear, for men and women in a range of sizes.**

1.31 **Detainees should not be held for substantial periods or overnight without adequate sleeping facilities.**

1.32 **Detainees held for more than 24 hours should receive a health screening.**

Positive relationships

Expected outcomes:
Those detained are treated respectfully by all staff, who have proper regard for the uncertainty of their situation and their personal circumstances.

1.33 Detainees reported positively on treatment by staff, and nearly all of those who completed our structured interviews said that staff had treated them with respect. Staff usually sat in the holding rooms with detainees and we observed some positive interactions.

1.34 Staff were aware of how to access the telephone interpreting service and had used it on 40 occasions between January and April 2010. Some staff also spoke different languages and made use of this ability to communicate with detainees. We observed some brusque behaviour towards detainees, including a member of staff abruptly and rudely telling a detainee that smoking was not allowed.

1.35 Overall, staff numbers in the facility were not always well managed. There were often more staff than detainees in the rooms, especially the women's room, where most staff went to use the hot drinks machine or simply to take breaks or watch television. This disturbed detainees trying to rest; during the inspection, we saw eight staff and one female detainee in the women's holding room. The latter eventually left and went to the adjacent family room. We also saw a large number of staff regularly congregated in the booking-in area, sometimes creating confusion and tension, and in one case we heard racist comments: two members of staff started to argue with each other about where to place incoming detainees. One officer said to

the other, who was Asian, 'Should I explain that to you in Indian?', causing the Asian officer to become visibly upset and assert that he was British. This matter was being investigated by managers. (see recommendation 1.77)

Recommendations

1.36 **Staff should address detainees and each other with respect at all times.**

1.37 **Staff numbers in the reception area and in other parts of the facility should be controlled effectively by managers.**

1.38 **Staff in the holding rooms should engage with detainees or sit with them, but not use the rooms for breaks or discussions with other staff who have no role in caring for detainees.**

Legal rights

Expected outcomes:
Detainees are able to obtain expert legal advice and representation from within the facility. They can understand and retain legal documents. They can communicate with legal representatives without difficulty to progress their cases efficiently.

1.39 Detainees were allowed to retain their IS91R (reasons for detention) forms. Most detainees we spoke to said that they understood their situation. Custody staff appropriately retained the original authority to detain (IS91) form at the reception desk while detainees were held at the facility. IS91s were generally fully completed. Officers said that they would never accept a detainee if an IS91 had not been issued. The IS91 risk assessment had a series of tick boxes. Where there were no risk factors, there was no option to indicate that an assessment had been made. Staff then made the effort to write 'no needs known' but this was not always done. (see 1.7) It was therefore not clear from the IS91 whether the detaining officer had omitted to carry out the risk assessment or considered there to be no risk.

1.40 Notices promoting legal advice agencies were posted in the facility. Telephone numbers for Immigration Advisory Service and Refugee and Migrant Justice were posted beside the pay telephones. These numbers were of little use to those who could not speak English. Details of the Community Legal Advice helpline and other local immigration advisers were not displayed. As the facility was located airside, it was not possible for detainees to receive visits from legal representatives. There was no information in the facility about bail rights.

1.41 Detainees were able to contact their legal representatives by telephone, although the pay telephones did not have privacy hoods (see section on arrival and accommodation). Pens and paper were available beside the telephones. In one case, a detainee with no money or credit on his mobile telephone was allowed by a DCO to use a mobile telephone. However, the officer asked the detainee for the solicitor's number and entered it into the telephone, and stood next to him throughout the telephone conversation, hurrying him to finish so that he could be transported from the facility. Detainees did not have access to the internet, email or fax machines (see section on preparation for release).

Recommendations

1.42 **The IS91 should confirm that a risk assessment has been conducted even when no risk factors have been identified.**

1.43 **The UK Border Agency (UKBA) should negotiate with the Legal Services Commission to offer telephone advice to detainees using an interpretation service similar to that used in its police station telephone immigration advice line.**

1.44 **Details of the Community Legal Advice line should be displayed in the holding room.**

Casework

Expected outcomes:
Detention is carried out on the basis of individual reasons that are clearly communicated.
Detention is for the minimum period necessary.

1.45 In the four months from the start of 2010, 3,245 people had passed through the facility. Most (95%) of them had been held for less than eight hours and none for 24 hours or more. However, 28 people had been held for more than 12 hours, and five for more than 18 hours. UKBA managers did not conduct regular visits to check on conditions and on the treatment of detainees. However, the Independent Monitoring Board made regular visits and exercised effective oversight of Cayley House.

1.46 The UKBA removals facilitation unit (RFU), based at Terminal 3, was responsible for maximising the number of successful removals by liaising with airlines, G4S, case owners and detainees to resolve any issues which threatened a successful removal. Most detainees had exhausted their appeal rights and were facing imminent removal. Some had mounted last-minute judicial reviews of the decision to remove. The RFU comprised approximately 30 staff, including one immigration inspector and five chief immigration officers.

1.47 The RFU also administered the Facilitated Returns Scheme (FRS) discharge grant as appropriate. RFU staff told us that many detainees were concerned about why they were not receiving the discharge money they expected through the FRS. We witnessed staff from the RFU attending the facility and were told that detainees could request to see a member of the team.

1.48 The RFU also tracked and monitored cases where the detainee had left the UK but had been refused entry to the destination country and returned to the UK. There were approximately 50 such 'bounce back' cases a year. An interview room in the facility was used by UKBA staff to interview detainees. It contained four chairs, a desk and a conference telephone for use with telephone interpreters. The chairs were chained to the floor, which was disrespectful to, and uncomfortable for, detainees, and not a proportionate response to presenting risks.

1.49 Telephone interpreting did not appear to have been used by UKBA staff on all appropriate occasions. Records showed that a Chinese man had been interviewed by an immigration officer, who had 'requested detainee to explain himself in English…as he had been living in the UK for seven years … should be able to speak a bit of English'. The detainee, whose ability to speak English was not obvious, had become agitated and banged his head on the cable ducting. He had then been restrained with his arms in locks, still trying to bang his head. A DCO with a limited knowledge of Mandarin had then spoken to him in that language, asking him whether he wished to see a doctor; he had declined. From the summary written record that was available, it appeared that the use of telephone or other interpretation at an early stage might have secured a better outcome.

Recommendations

1.50 **A UKBA manager should visit Cayley House daily to check conditions and the treatment of detainees; these visits and any issues arising should be recorded.**

1.51 **UKBA should ensure the efficient administration of Facilitated Returns Scheme discharge money.**

1.52 **The chairs in the interview room should not be chained to the floor.**

1.53 **Telephone interpreting should be used by UKBA staff whenever appropriate, especially where there is evidence of emotional or behavioural difficulties.**

Duty of care

Expected outcomes:
The centre exercises a duty of care to protect detainees from risk of harm.

Bullying

1.54 There had been no reports of bullying or intimidation among detainees and staff could not recall any incidents of bullying. Detainees we spoke to said that they felt safe in the facility. Officers had not received bullying or victimisation refresher training. Men and women were held separately and all areas of the facility were monitored by closed-circuit television. Staffing levels were high and staff were always present in or around the holding rooms.

Suicide and self-harm

1.55 In the six months before the inspection, five detainees had self-harmed or threatened self-harm. Four had banged their heads on desks or walls, and one had both done this and slapped himself in the face. Two of this group were Chinese and two Vietnamese; there was no obvious explanation for detainees of these nationalities behaving in this way. The fifth detainee, from Congo, had threatened to kill himself. Incident reports had been completed appropriately on each of these detainees.

1.56 All five of these detainees had been placed in the close supervision room. The room contained a row of chairs fixed to the floor and was located immediately by the front entrance. A document titled *Use of Cayley House Close Supervision Room* set out the procedure for use of the room. Authorisation had to be given by a detainee custody manager or higher grade before a detainee could be placed in the room. Use of the room could last no longer than four hours without authorisation from a UKBA duty manager at the Detainee Escorting and Population Management Unit. An observation log had to be completed for every use of the room.

1.57 In one case we examined, staff had spoken to the detainee using an interpreter and the log had been regularly updated with appropriate observations. He had been held in the close supervision room for a total of four hours 25 minutes but no authority from the UKBA had been sought in order to exceed the initial four hours (see section on facility rules). The detainee had eventually been escorted from the facility to Colnbrook IRC.

1.58 Assessment, care in detention and teamwork (ACDT) booklets had not been opened for the five detainees. Staff had not received training in ACDT and their knowledge of the system was therefore limited. One member of staff had no knowledge at all of ACDT documents, while

another said that if a detainee arrived on an open ACDT document he would continue to make observation entries. No staff we spoke to knew how to open an ACDT document. A useful pocket guide for staff, entitled *Caring for Detainees,* was given to all staff and additional copies were available on reception.

1.59 Officers did not carry anti-ligature knives. There were three anti-ligature knives located in the facility; one each in the managers' office, the staff kitchen and the locked store cupboard. The need to fetch the knives could have caused delay in the event of an emergency. All the detainee custody officers (DCOs) on duty at the time of the inspection carried pouches containing resuscitation aids and instructions for their use.

Recommendations

1.60 **Staff should receive anti-bullying and self-harm and suicide prevention training.**

1.61 **Staff should be trained on the care planning system, assessment, care in detention and teamwork (ACDT), and booklets should be opened at the facility when necessary.**

1.62 **Staff should routinely carry anti-ligature knives.**

Good practice

1.63 *Detainee custody officers carried vent-aid resuscitation aids, which incorporated instructions for use and basic resuscitation guidance.*

Childcare and child protection

Expected outcomes:
Children are detained only in exceptional circumstances and for the minimum time.. Children's rights and needs for care and protection are respected and met in full.

1.64 G4S kept records of all children detained at the facility. Local managers were able to monitor the number of children detained, their age and the duration of the detention. In the previous four months, 57 children had been detained for an average of 2.8 hours. The longest stay was for almost 18 hours but all the rest were for less than 10 hours. All of the children had been accompanied by adults.

1.65 There was a national G4S children's champion who was known to staff, and some local staff had also been designated as children's champions. The local UKBA child protection coordinator was well informed and maintained links with the local safeguarding children board. The RFU at Heathrow covered most cases going through Cayley House; there were no children's team immigration staff in this unit.

1.66 UKBA staff had all received basic training in child protection, via the 'Keeping Children Safe' e-learning package; children's team staff at the airport had received a higher level of training, incorporating both e-learning and workshop sessions. Not all UKBA staff in contact with children were Criminal Records Bureau (CRB) checked to enhanced level. All G4S officers were CRB checked to enhanced level, but they had not received any specific training on safeguarding children.

1.67 If an unaccompanied child was held at the facility, a children's care plan would be completed, identifying who would act as a primary carer. The care plan would then be forwarded to the

G4S children's champion and held in their central office in order to monitor trends. A copy of G4S's child protection policy was available in the supervisor's office. A brief reminder was also available in the pocket guide for detention staff, *Caring for Detainees*.

1.68 Rub-down searches were not administered to children unless justified by specific intelligence; normal practice was to use a metal-detecting wand. A wand was available for use with children which did not generate an audible alert – this was helpful to avoid causing alarm to children.

1.69 Children were kept with their parents in the family room, which had colourful murals and posters on the walls. The room contained a cot, a highchair and children's toys. Fresh fruit, crisps and jars of baby food were available. The women's toilet contained a baby changing trolley, wipes, nappies and bags for disposing of nappies. The men's toilet contained a baby change facility but no nappies. Children's activity packs and books in different languages were available. DVDs were freely available in the family holding room. Car seats of various sizes were used to escort small children and babies.

Recommendations

1.70 **All UKBA staff coming into contact with children should be subject to enhanced Criminal Records Bureau checks.**

1.71 **Some removals facilitation unit staff should receive a higher level of child protection training.**

1.72 **Detainee custody officers should receive child protection training.**

Diversity

Expected outcomes:
There is understanding of the diverse backgrounds of detainees and different cultural norms. Detainees are not discriminated against on the basis of their race, nationality, gender, religion, disability or sexual orientation, and there is positive promotion and understanding of diversity.

1.73 There was a range of translated information in each of the holding rooms. This included the standard G4S booklet that provided basic information about detention, a 'respecting diversity and equal treatment of detainees' G4S policy statement, suggestion forms and legal information from the Office of the Immigration Services Commissioner. Up-to-date newspapers were also provided in a range of languages.

1.74 Religious texts included Bibles in Spanish and English, and Qur'ans in Arabic and English. Prayer mats and compasses were also provided in the main holding rooms. Detainees could use a separate room, adjacent to the busier male holding room, for contemplation or prayer, and this room contained further religious texts and prayer mats. Telephone numbers for ministers in the Heathrow Airport chaplaincy team and for community religious contacts were posted by the telephones in the holding rooms. All the detainees who completed our structured interviews said that their religious beliefs were respected.

1.75 Staff had been given some race relations and diversity training as part of their initial training course but had not received any refresher training. They were unaware of any equality impact assessments having been done.

1.76 Only two people had been identified as having disabilities in the previous 12 months. Officers completed a short questionnaire for each person so identified and were required to state if

anything needed to be done to overcome problems relating to disability. The completed form was then sent to the G4S central disability liaison officer. One of the forms we saw related to a detainee with mental health issues and the other described a detainee with hearing and speech difficulties. There were no obvious adjustments for detainees with disabilities coming through Cayley House, and staff said that they would not be able to accommodate anyone with serious mobility problems. Staff could not remember any such detainees coming through the facility.

Recommendation

1.77 **Staff should receive routine refresher training in all aspects of diversity policy and procedures.**

Activities

Expected outcomes:
The facility encourages activities to preserve and promote the mental and physical well being of detainees.

1.78 There was no access to exercise in the fresh air or to a smoking area. Each of the three holding rooms had a flat-screen television, with a range of terrestrial and satellite channels. Bookcases in all three holding rooms were adequately stocked with a range of books, magazines and newspapers in different languages (see also sections on diversity, and childcare and child protection).

Recommendation

1.79 **Detainees held for several hours should have access to exercise in the fresh air.**

Facility rules

Expected outcomes:
Detainees are able to feel secure in a predictable and ordered environment.

1.80 Expectations of behaviour by both staff and detainees were set out with reasonable clarity. The security of the holding rooms was sufficient, without any unnecessary layers of security within the facility. Strip-searching had never been used at Cayley House.

1.81 There were clear protocols and instructions for occasions when the close supervision room was used for formal separation. It was used for this purpose infrequently, and much less often than the equivalent rooms in Queen's Building. There had been only one recorded incident in the previous 10 months when a detainee had been placed there simply to prevent him or her from influencing others, which had been a common reason for use of the Queen's Building separation rooms. The room was rarely locked when occupied. It was used on one occasion during the inspection, when a detainee showing marked signs of confusion and disturbance was placed there while staff attempted to calm him down. These attempts were not well managed or coordinated; a considerable number of staff entered and left the room throughout the incident, different people spoke to him in rapid succession, and staff were too close to him, despite there being no evidence of a risk of actual harm to himself or others and his obvious desire for space.

1.82 The average length of stay in the close supervision room over the preceding 10 months had been 91 minutes. On one occasion, the duration had exceeded four hours; there was no evidence that continued location in this room beyond four hours had been authorised by a UKBA manager, as required. This had occurred three weeks after a new form had been introduced for authorisation and recording of use of this room; the new form did not, as the previous form had done, contain a box for the UKBA to record renewal of authorisation after each four-hour period.

1.83 Of 16 recorded uses of the room in the 10 months before the inspection, 10 detainees had been placed there because they were being, or had recently been, actively violent or disruptive. On 11 of the occasions, force had been used. In two of these 11 cases, a health services professional had made an assessment of the detainee afterwards. In six cases this had not been done, and in three cases (all before the introduction of new forms which asked for this information) it had not been recorded. Managers explained the absence of a medical assessment on the grounds that detainees frequently refused treatment; secondly, that all staff were first-aid trained and could make an assessment as to whether there was a threat to life; and, thirdly, that the only access to professional advice was by calling an ambulance, and NHS managers objected to such calls when there was not a current medical emergency. Most uses of force in 2010 had been to monitor and support detainees who were at risk of self-harm, or who were actively harming themselves (see section on self-harm).

1.84 All uses of control and restraint techniques by Cayley House staff had been reactive, containing and limiting damage from aggressive, recalcitrant or self-harming behaviour by detainees. The accounts in incident reports reworded that excessive force had not been used and that staff had de-escalated situations as swiftly as possible. Following a change of policy, staff had ceased to use force on detainees in order to make them board escort vans for removal, focusing instead on developing interpersonal skills of motivation and persuasion.

1.85 The rapid response team, comprising staff from the separate overseas escorts team, was located in Cayley House to facilitate swift repeat attempts to remove detainees who had initially refused to travel. This system had been in place for only two weeks at the time of the inspection, and the team had not used force on any detainee during that period. At the time of the inspection, there had been a reduction in the use of force in Cayley House: the monthly average had fallen from 10 in the first quarter of 2009/10 to three in each of the last two quarters. The recording of uses of force was thorough, and all incidents were assessed by senior managers after the event.

1.86 In March 2010, an Ecuadorian detainee had become disruptive when about to board the aircraft. Embarkation had been cancelled but staff still held him in locks because he was not complying with their instructions. In the escort vehicle, one officer sat on either side of the detainee, holding him in wrist locks until arrival at Cayley House. This use of pain compliance techniques in a moving vehicle carries some clear risks of injury.

Recommendations

1.87 **Managers should train staff in procedures to support clear and coordinated management of incidents.**

1.88 **A UKBA manager should record renewed authorisation of location in the close supervision room after each period of four hours.**

1.89 **Detainees subject to control and restraint procedures should be seen by a health services practitioner as soon as possible after restraint is removed.**

1.90 **Pain compliance techniques should not be used in moving vehicles.**

Good practice

1.91 *Cayley House staff no longer used force to make detainees board escort vans for removal, but focused on developing interpersonal skills of motivation and persuasion.*

Complaints

Expected outcomes:
There is a published complaints procedure; compliant forms are freely available.

1.92 There was a secure complaints box in each of the holding rooms. Information about complaints was posted on the walls and complaint forms were provided in accessible folders, in 11 languages. However, the complaints boxes were not opened every day, as UKBA staff did not conduct routine supervisory visits to the facility.

1.93 Five written complaints relating to G4S staff had been recorded in the first four months of 2010 and in two cases the subsequent investigation had been completed. Relevant parties had been interviewed and each complaint investigated by a manager at the facility. One of the completed complaints related to a detainee not being able to sleep because of the lack of eye masks and the other referred to 'unhelpful' behaviour by escorts. The first complaint had been upheld and the other found to be unjustified. The other three complaints had yet to be resolved. One of these, recorded as being about 'communication issues', referred to an incident that had taken place at the beginning of October 2009. There was no locally available data on complaints against UKBA.

Recommendations

1.94 **All complaints should be investigated, and the investigations completed promptly.**

1.95 **Information about complaints against UKBA staff should be available locally.**

Services

Expected outcomes:
Services available to detainees allow them to live in a decent environment in which their normal everyday needs are met freely and without discrimination.

1.96 The kitchen area was clean and tidy. It contained a range of ambient microwave meals for a variety of diets, including vegetarian, vegan and halal options. However, these long-life meals were unappetising. There was no freezer to store more appealing meals. A pictorial menu for the meals indicated which were suitable for special diets. There was also a selection of sandwiches and microwave kosher meals. Detainees were offered a meal on arrival and at meal times and were told that they could request food at any time during their stay.

1.97 In each of the three holding rooms there was a tray stocked with snacks, including crisps, cereal bars and fresh fruit. Detainees were told to help themselves whenever they wished.

1.98 A variety of female sanitary products and a sanitary disposal bin were available in the women's toilet area.

Recommendation

1.99 **Ambient meals should be replaced with a range of frozen meals.**

Good practice

1.100 *Detainees had free access to fruit, snacks and drinks.*

Preparation for release

Expected outcomes:
Detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, are given adequate notice of their release, transfer or removal, and are able to recover property. Families with children and others with special needs are not detained without items essential to their welfare.

1.101 No visitors were permitted. A few weeks before the inspection, during a busy period at Cayley House, a detainee had picked up the wrong suitcase and taken it with him. This had been discovered when a female detainee subsequently found that the similar case remaining at the facility was not hers.

1.102 Detainees were allowed to keep their mobile telephones with them, provided that they were not equipped with a camera or internet access. If their telephones were unsuitable, they were offered a dummy mobile telephone which they could use with their own SIM card. Detainees did not have access to faxing, the internet or to email.

1.103 No clothing was available for issue to detainees who might need it for onward travel. By chance, recently, a coat which had been left behind had been given to a Polish detainee returning to very cold conditions in his home country; but, normally, clothes left behind were discarded on health grounds.

1.104 Small information cards giving details of the relevant IRCs were handed to all those being transferred. We saw an Eritrean detainee about to be transferred to Brook House, who understood nothing of what was said to him about his transfer, being shown a card which meant nothing to him, but no attempt was made to access interpreting services.

Recommendations

1.105 **Detainees should be able to receive visits.**

1.106 **There should be a clear and auditable system to control and track each item of property.**

1.107 **Detainees should have access to the internet, email and fax machines.**

1.108 **Suitable clothing should be available for issue to detainees needing it for onward journeys.**

1.109 **Interpretation should be used to inform detainees about what is happening next.**

Section 2: Recommendations and good practice

Recommendations — To the UK Border Agency

2.1 The IS91 should confirm that a risk assessment has been conducted even when no risk factors have been identified. (1.42, see paragraph 1.39)

2.2 The UK Border Agency (UKBA) should negotiate with the Legal Services Commission to offer telephone advice to detainees using an interpretation service similar to that used in its police station telephone immigration advice line. (1.43, see paragraph 1.40)

2.3 A UKBA manager should visit Cayley House daily to check conditions and the treatment of detainees; these visits and any issues arising should be recorded. (1.50, see paragraph 1.45)

2.4 UKBA should ensure the efficient administration of Facilitated Returns Scheme discharge money. (1.51, see paragraph 1.47)

2.5 The chairs in the interview room should not be chained to the floor. (1.52, see paragraph 1.48)

2.6 Telephone interpreting should be used by UKBA staff whenever appropriate, especially where there is evidence of emotional or behavioural difficulties. (1.53, see paragraph 1.49)

2.7 All UKBA staff coming into contact with children should be subject to enhanced Criminal Records Bureau checks. (1.70, see paragraph 1.66)

2.8 Some removals facilitation unit staff should receive a higher level of child protection training. (1.71, see paragraph 1.66)

2.9 A UKBA manager should record renewed authorisation of location in the close supervision room after each period of four hours. (1.88, see paragraph 1.82)

2.10 Information about complaints against UKBA staff should be available locally. (1.95, see paragraph 1.93)

Recommendations — To the UK Border Agency and Group 4 Securicor

2.11 Detainees should not be subject to unnecessarily frequent moves between places of detention. (1.10, see paragraph 1.1)

2.12 Detainees should not be held for substantial periods or overnight without adequate sleeping facilities. (1.31, see paragraph 1.25)

2.13 Detainees held for several hours should have access to exercise in the fresh air. (1.79, see paragraph 1.78)

2.14 All complaints should be investigated, and the investigations completed promptly. (1.94, see paragraph 1.93)

2.15 Detainees should have access to the internet, email and fax machines. (1.107, see paragraph 1.93)

Recommendations To Group 4 Securicor

2.16 Couples transferred and located apart from each other should be enabled to communicate with one another, unless relevant risk information justifies prevention of contact. (1.11, see paragraph 1.4)

2.17 Vehicles with internal cages should not be used for journeys within the airport unless clearly justified by individual risk assessment. (1.12, see paragraph 1.5)

2.18 There should be clear protocols, well understood by staff, for the handling of medication brought into the facility by detainees. (1.13, see paragraph 1.8)

2.19 Detainees should be booked in or discharged from the holding room one at a time, and staff not dealing with the detainee should not be in the reception area. (1.27, see paragraph 1.19)

2.20 Pay telephones should have privacy hoods, to enable detainees to make calls in private. (1.28, see paragraph 1.20)

2.21 Detainees should be searched sensitively, and not in the presence of detainees of the opposite sex. (1.29, see paragraph 1.21)

2.22 The holding room should have a stock of clean clothing, including underwear, for men and women in a range of sizes. (1.30, see paragraph 1.23)

2.23 Detainees held for more than 24 hours should receive a health screening. (1.32, see paragraph 1.26)

2.24 Staff should address detainees and each other with respect at all times. (1.36, see paragraph 1.34)

2.25 Staff numbers in the reception area and in other parts of the facility should be controlled effectively by managers. (1.37, see paragraph 1.35)

2.26 Staff in the holding rooms should engage with detainees or sit with them, but not use the rooms for breaks or discussions with other staff who have no role in caring for detainees. (1.38, see paragraph 1.35)

2.27 Details of the Community Legal Advice line should be displayed in the holding room. (1.44, see paragraph 1.40)

2.28 Staff should receive anti-bullying and self-harm and suicide prevention training. (1.60, see paragraph 1.54)

2.29 Staff should be trained on the care planning system, assessment, care in detention and teamwork (ACDT), and booklets should be opened at the facility when necessary. (1.61, see paragraph 1.58)

2.30 Staff should routinely carry anti-ligature knives. (1.62, see paragraph 1.59)

2.31 Detainee custody officers should receive child protection training. (1.72, see paragraph 1.66)

2.32 Staff should receive routine refresher training in all aspects of diversity policy and procedures. (1.77, see paragraph 1.75)

2.33 Managers should train staff in procedures to support clear and coordinated management of incidents. (1.87, see paragraph 1.81)

2.34 Detainees subject to control and restraint procedures should be seen by a health services practitioner as soon as possible after restraint is removed. (1.89, see paragraph 1.83)

2.35 Pain compliance techniques should not be used in moving vehicles. (1.90, see paragraph 1.86)

2.36 Ambient meals should be replaced with a range of frozen meals. (1.99, see paragraph 1.96)

2.37 Detainees should be able to receive visits. (1.105, see paragraph 1.101)

2.38 There should be a clear and auditable system to control and track each item of property. (1.106, see paragraph 1.101)

2.39 Suitable clothing should be available for issue to detainees needing it for onward journeys. (1.108, see paragraph 1.103)

2.40 Interpretation should be used to inform detainees about what is happening next. (1.109, see paragraph 1.104)

Examples of good practice

2.41 Detainee custody officers carried vent-aid resuscitation aids, which incorporated instructions for use and basic resuscitation guidance. (1.63, see paragraph 1.59)

2.42 Cayley House staff no longer used force to make detainees board escort vans for removal, but focused on developing interpersonal skills of motivation and persuasion. (1.91, see paragraph 1.84)

2.43 Detainees had free access to fruit, snacks and drinks. (1.100, see paragraph 1.97)