Report on an unannounced short follow-up inspection of

Oakington Immigration Reception Centre

2 - 5 August 2010

by HM Chief Inspector of Prisons

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Introduction

Previous inspections of Oakington have expressed concern about the negative impact, on both detainees and staff, of the uncertainty that for some years has hung over the centre's future. It is perhaps ironic that, during the course of this unannounced follow-up inspection, senior officials from the UK Border Agency arrived to announce definitively that the centre would close in November 2010. Accordingly, this is Oakington's valedictory inspection report and it therefore makes no recommendations for the future.

Some aspects of safety at the centre had improved since our last visit: increased perimeter security and better use of intelligence had reduced the number of escapes, work to prevent self-harm had improved, use of force remained low and most detainees spoken to reported feeling safe. However, these improvements were tempered by the poor dormitory accommodation, which remained hard to supervise and where bullying was an ever-present risk. We were also concerned that separation was overused and, despite the efforts of on-site immigration staff, many detainees were frustrated by the uncertainty surrounding their immigration status.

The lack of investment in infrastructure at the centre meant that the quality of the living accommodation remained poor. Staff-detainee relationships varied and were not supported by a personal officer scheme. Work on diversity remained underdeveloped and too little use was made of translation services. Health care provided a satisfactory service but there was little mental health provision.

Since the last inspection, there had been a considerable increase in the quantity and quality of activities, including better education opportunities and an increase in paid work. Staff worked hard to provide welfare support, but they were not trained and there were no structured arrangements to prepare detainees for release or removal. Visits arrangements were satisfactory.

Oakington is scheduled to close at around the time this report is published. The mixed findings from the inspection in many ways reflect the uncertainty that for so long has hung over the centre and hampered the prospects for investment and improvement. However, it is also important to note that we record a number of areas where we commend the positive and committed work of staff and managers.

Nick Hardwick
HM Chief Inspector of Prisons

September 2010

Fact page

Task of the establishment
The detention, care and welfare of single male detainees on behalf of the UK Border Agency. Two UKBA teams operate at the site independently of each other. The screening unit and satellite casework management unit screens asylum seekers who clandestinely enter the UK and are picked up in the Midlands and Eastern regions. The contact management team handle cases where removal is imminent.

Location
Longstanton, Cambridgeshire

Contractor
G4S

Number held
385

Certified normal accommodation (CNA)
408

Operational capacity
408

Escort provider
G4S

Last inspection
June 2008

Brief history

The centre opened in March 2000, originally for three years with four six-month extensions. The original role was to accommodate fast-track cases, including single males, single females and families. The current role is to accommodate single male detainees. During our inspection, UKBA announced the closure of the centre by November 2010.

Description of the residential units

The site was formally used by the RAF and the buildings were used as barracks. There are five residential units containing dormitory bedrooms which house up to 12 single males. There are some single rooms in each house block, used for detainees with medical needs.

Section 1: Healthy establishment assessment

Introduction

HE.1 The concept of a healthy prison was introduced in our thematic review *Suicide is Everyone's Concern* (1999). The healthy prison criteria, upon which inspections base the four tests of a healthy establishment, have been modified to fit the inspection of removal centres. The criteria for removal centres are:

Safety	detainees, even the most vulnerable, are held safely
Respect	detainees are treated with respect for their human dignity
Purposeful activity	detainees are able, and expected, to engage in activity that is likely to benefit them
Preparation for release	detainees are prepared for their release into the community and helped to reduce the likelihood of reoffending.

HE.2 Under each test, we make an assessment of outcomes for detainees and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the United Kingdom Border Agency.

- outcomes for detainees are good against this healthy establishment test.
There is no evidence that outcomes for detainees are being adversely affected in any significant areas.

- outcomes for detainees are reasonably good against this healthy establishment test.
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 against this healthy establishment test.
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 against this healthy establishment test.
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.

HE.3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections

are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy establishment summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy establishment assessment held by the Inspectorate on all establishments but only published since early 2004.

Safety

HE.4 At the last inspection in 2008, we judged that Oakington was not performing sufficiently well against this healthy establishment test. Of the 41 recommendations in this area, 19 had been achieved, six partially achieved and 16 were not achieved.

HE.5 Detainees reported long journeys to the centre. In general they were provided with food and drink and comfort stops were allowed, although some detainees said that no such provision had been made. The majority of detainees still arrived at night, although the centre had taken steps to reduce the number.

HE.6 The reception area was quite large, but afforded little privacy. Health care interviews were conducted without complete privacy. Detainees reported that they were in reception for up to two hours. Interpretation was not used, other than by health care staff, and then not in all cases where it was needed. Reception staff relied on other detainees with a command of English, and on signs and gestures. The information pack was available in six languages other than English.

HE.7 A brief induction was conducted by the advice and support officer, who provided information about services and showed detainees the facilities.

HE.8 Perimeter security had been strengthened and the number of escapes had greatly reduced. The small security department operated effective systems to process and analyse the information they received from staff. Security procedures were generally proportionate, but we found examples of unduly restrictive procedures such as routine handcuffing on escorts and forbidding items such as CDs and shaving equipment.

HE.9 The number of incidents involving use of force was not excessive. Records which we examined were not always completed correctly, but demonstrated that force was used only as a last resort. There was evidence that de-escalation was used effectively and encouraged by managers. Planned interventions were video recorded, and governance arrangements by senior managers were adequate.

HE.10 There was a high level of use of single separation, principally because of late escorted flights, but also owing to 'unacceptable behaviour'. Records did not demonstrate that this was always justified. The environment in the separation accommodation was poor. Cells were stark and poorly equipped. Corridors were reasonably clean, but toilets were dirty and some showers were in a poor state of repair. Engagement between staff and separated detainees was good, but there was a need for better formal care planning and for a constructive regime, particularly for longer stays.

HE.11 UKBA staff were aware of child protection issues, but there were weaknesses in the mechanisms for identifying minors. Age-disputed cases were referred to Cambridgeshire social services, who responded promptly. Age assessment reports by social services were brief and repetitive, and were not compliant with legal requirements. Children assessed as aged under 18 slept in the Rule 40 separation accommodation, but associated in the communal area until they were collected by social services; neither of these arrangements was satisfactory.

HE.12 The suicide prevention policy was sound and the quality of entries in formal records was generally good. Most records demonstrated understanding of the individual circumstances and feelings of detainees. Case management had improved since the previous inspection and the quality of individual care plans was above average. Attendance at safer custody meetings by key representatives such as health care staff was often poor. There were effective monitoring arrangements to ensure that detainees were cared for during periods of increased stress and risk. There was still no peer support system, nor direct line telephones to the Samaritans, and the continuing use of the Rule 40 separation accommodation for detainees in crisis was inappropriate.

HE.13 The number of reported violent incidents was low and detainees said that, on the whole, they felt safe at Oakington. There was some evidence that not all incidents were reported and that the many opportunities for bullying across the site were not fully recognised by staff. The supervision of dormitories and some communal areas was weak. The monthly safer custody meeting was poorly attended, particularly by senior managers, and concentrated on self-harm and suicide prevention, but not on violence reduction. There was little evidence of formal support for victims, other than close monitoring or removal from the house block.

HE.14 The Immigration Advisory Service saw as many detainees as possible, including those who already had a solicitor; but they did not have the capacity to see all detainees. The country of origin reports in the library were out of date and many were not accessible on the internet. Legal text books were kept under the assistant's desk in the library and were not advertised. Many helpful websites were unnecessarily blocked. Detainees were able to contact their lawyers easily by telephone, fax and email.

HE.15 The on-site contact management team had insufficient staff to induct every new detainee or to progress cases expeditiously. The on-site screening unit and satellite casework management unit did not help the contact management team to progress cases. The UK Border Agency (UKBA) said it was unable to monitor the cumulative length of detention in a succession of locations.

HE.16 On the basis of this short follow-up inspection, we judged that outcomes for detainees were still not sufficiently good at Oakington against this healthy establishment test.

Respect

HE.17 At the last inspection in 2008, we judged that Oakington was not performing sufficiently well against this healthy establishment test. Of the 52 recommendations in this area, 18 had been achieved, nine partially achieved and 25 were not achieved.

HE.18 The dormitory accommodation continued to present problems for detainees who felt disorientated and uncomfortable sharing with up to 11 others. The rules and routines, such as compulsory rising times, were resented as demeaning. Showers and toilets were unhygienic with peeling and cracking surfaces to floors, walls and ceilings. Sufficient clothing was available for issue and laundry arrangements were adequate.

HE.19 Monthly consultation meetings were promoted, but no detainees had attended in the previous four months.

HE.20 Staff in the accommodation blocks interacted well with detainees who sought them out, but some staff did not engage spontaneously with detainees, particularly in groups. There was no personal officer scheme and most staff only knew the names of a few detainees. Wing files contained no records of the mood of detainees or interactions with them. The tannoy continued to be an intrusive and ineffective form of communication.

HE.21 The diversity strategy was underdeveloped. Safer custody and race relations meetings were poorly attended and did not address the diversity needs of the population. The monitoring of complaints and access to paid employment and activities in respect of diversity was poor.

HE.22 The chaplains were very active, visiting detainees identified as vulnerable every day. They coordinated an impressive network of external contacts to provide material support. The Muslim prayer room had good facilities, but was too small for the number attending. There was no faith leader for the nine Buddhist detainees, nor for the two Falun Gong detainees.

HE.23 Although the rewards scheme was applied with reasonable consistency and fairness, sanctions such as restriction of access to paid work and educational activities were inappropriate. All detainees were on the enhanced level at the time of the inspection.

HE.24 Complaints were responded to by G4S in a polite and timely manner, but detainees in groups said that they had little faith in the complaints procedure. There was only one complaints box in the centre, with forms available beside it in various languages. There were no notices explaining how detainees could complain, although they were given written information on arrival.

HE.25 Primary health care services were generally good. Uncertainty about the future of the centre had affected recruitment and retention, and this had compromised speedy access to initial nurse and GP appointments. Governance was satisfactory and health promotion initiatives were in place. There was inadequate use of interpretation. Access to the dentist had improved and waiting times for the optician had reduced significantly. Nurse cover at night was inadequate for the number of new arrivals. Mental health services were almost non-existent. There was no registered mental health nurse in post and no counselling for this vulnerable population.

HE.26 There was a reasonably varied choice of food, although detainees complained of a monotonous diet. Efforts were made to ensure that religious needs were respected. Detainees could buy food and drink from vending machines. The shop had a good range of stock, suited to the population. There was no formal catalogue ordering system, although shop staff were willing to process orders from a catalogue on request.

HE.27 On the basis of this short follow-up inspection, we judged that outcomes for detainees were still not sufficiently good at Oakington against this healthy establishment test.

Activities

HE.28 At the last inspection in 2008, we judged that Oakington was performing reasonably well against this healthy establishment test. Of the 11 recommendations in this area, nine had been achieved, one partially achieved and one was not achieved.

HE.29 The range of activities had been extended since the previous inspection. There was freedom of movement around the site for about 15 hours each day. There was adequate internet access.

HE.30 Opportunities for paid work had increased since the previous inspection. Seventy-nine detainees were employed with 46 vacancies, providing jobs for about a quarter of the population. Jobs were well advertised in accommodation blocks through posters using text and pictorial images to explain the job requirements. Rates of pay were equitable. Special jobs were created to meet detainees' needs, for example, over the period of Ramadan, 20 new kitchen jobs had been created to provide Muslim detainees with food after sunset.

HE.31 The quality of education was good and classes were well attended. The standard of teaching and learning was good and staff delivered interesting and enjoyable classes which accommodated a wide range of abilities.

HE.32 The well-managed study centre was very popular with detainees. Learners undertook a range of activities in information technology and English language development, using well developed learning materials to work at their own pace. ESOL (English for speakers of other languages) courses from entry 3 to level 1 were provided during the day and in the evening. Classes were well planned and used a wide range of stimulating methods to develop learners' skills.

HE.33 Individual coaching in art developed learners' skills particularly well. The standard of work was high and many examples were displayed around the activities centre. Mentors were used to support learning activities in art.

HE.34 The recently extended library provided a valuable service, loaning games and sports equipment as well as books, newspapers and DVDs. Health and job promotion events were held in the library. There was an over-reliance on the donation of books to extend the stock, with no annual budget to renew books. There was no catalogue of stock.

HE.35 The gymnasium had been relocated to the ground floor of the amenities building. Equipment had been enhanced since the previous inspection and provided an appropriate range to meet the needs of detainees. The facility was open seven days a week and in the evenings. On occasions, staff shortages caused the closure of the gym in the evening.

HE.36 Team games such as football and cricket were played in an outdoor area and there was equipment for other games popular with detainees.

HE.37 On the basis of this short follow-up inspection, we judged that outcomes for detainees were still reasonably good at Oakington against this healthy establishment test.

Preparation for release

HE.38 At the last inspection in 2008, we judged that Oakington was not performing sufficiently well against this healthy establishment test. Of the seven recommendations in this area, two had been achieved, two partially achieved and three were not achieved.

HE.39 The advice and support service was provided by dedicated staff on each shift. They had not been formally trained, but had acquired skills through contacts and experience. The advice and support office was not open consistently, because of a lack of discrete funding.

HE.40 Three social visits sessions were available every day. Visitors told us that booking by telephone and email was straightforward and they were treated respectfully by staff. The visits area was small and cramped. Limited refreshments were available from vending machines. There was no children's play area.

HE.41 There were sufficient telephones in the house blocks. Fax machines were available in the library and the advice and support office, although detainees said that delivery of incoming faxes was frequently slow.

HE.42 Detainees were given adequate notice of removal, but were not told about transfers until their transport was imminent. There were no structured arrangements for preparing detainees for release, transfer or removal.

HE.43 On the basis of this short follow-up inspection, we judged that outcomes for detainees were still not sufficiently good at Oakington against this healthy establishment test.

Section 2: Progress since the last report

The paragraph reference number at the end of each recommendation below refers to its location in the previous inspection report.

Main recommendations (from the previous report)

To the chief executive, UK Border Agency (UKBA)

2.1 There should be sufficient, suitably trained and competent UKBA staff on site to engage effectively with detainees' needs for explanation and progress. (HE32)

Not achieved. There were insufficient UK Border Agency (UKBA) staff of an appropriate grade to engage effectively with detainees' needs for explanation and progress. UKBA had two teams at the centre, the contact management team and the screening unit and satellite casework management unit. Cooperation between the two was poor (see paragraph 2.16).

To the centre manager

2.2 Managers should issue guidance describing clearly the role and responsibilities of all staff in supporting detainees. This should be monitored through record keeping and direct observation and the outcomes disseminated regularly to staff. (HE31)

Partially achieved. Role briefs had been issued, describing the full range of duties for accommodation unit staff, including supporting detainees. There was no evidence of records being kept or information analysed and disseminated, nor of detainee surveys to test perceptions of the behaviour and attitudes of staff. Managers, whose numbers had been depleted by recent departures, were often not present in the secure area monitoring relationships with detainees.

2.3 The DDU should not be used to hold detainees in crisis. (HE33)

Not achieved. The detainee departure unit (DDU) remained an inappropriate location to care for detainees in crisis. Constant observations had been used 12 times from January to July 2010. Conditions remained stark and dreary and there was no structured regime for detainees.

2.4 Interpreting services should be used when required to communicate with detainees in order to complete assessments, in particular health care assessments, and convey general information about life in the centre, as well as personal information about their care and immigration status. (HE34)

Not achieved. The use of interpreting services by G4S staff was very limited. Detention custody officers had to seek permission from their shift manager before using a telephone interpreter. Reception staff advised us that they never used interpretation and interpreters were not used in health care assessments. UKBA only had access to one telephone in the interview block.

2.5 The centre should ensure that there is sufficient welfare provision, with suitable training, expertise and resources, able to address the needs of the complex population. (HE35)

Partially achieved. There were advice and support staff in each shift group with offices adjacent to the restaurant and in the induction accommodation unit. The staff had not received formal training in welfare services, but had developed a degree of expertise from experience and networking with other centres. The centre was not funded to provide a welfare service. Staff working in the advice and support office were often called away to other duties, necessitating the closure of the office. In June 2010, the service had been suspended on six days. When it was properly staffed, the office was open up to five hours a day, seven days a week.

2.6 UKBA should determine the future of Oakington as soon as possible and ensure that, while it remains open, the necessary improvements can be carried out and appropriate services provided for the needs of the population. (HE36)

Not achieved. At the previous inspection in 2008, it was noted that the 'ever-present threat of imminent closure' had been hanging over the centre for four years. That threat had continued and there had been a lack of investment in the physical fabric, particularly the accommodation blocks. Only cosmetic refurbishments had taken place.

2.7 UKBA casework resource should be increased and there should be sufficient expertise in the workforce to ensure that the complex needs of the detainee population are fully met. (HE37)

Not achieved. The onsite contact management team did not have sufficient staff to induct all detainees and did not receive assistance from the screening unit (see paragraph 2.1). The complex needs of the detainee population were not fully met.

2.8 There should be sufficient structured activity for all detainees to have access to purposeful activity for the majority of the day. (HE38)

Achieved. There was a sufficient range of activities. The fitness suite was open seven days a week with sessions during the day and in the evenings. The number of classes in education remained similar to the previous inspection, but the range had been extended. Recreational activities took place seven days a week, but some evening provision was occasionally cancelled through staff shortages.

2.9 Managers should keep accurate records of the length of time that detainees have spent at the centre, and inform UKBA of all cases where this exceeds a month. (HE39)

Achieved. Records were kept of the length of time detainees had been held at the centre.

2.10 There should be comprehensive monitoring and analysis of the use of force, the use of rules 40 and 42, and strip searching, and this should be overseen by the safer detention committee. (HE40)

Partially achieved. A good range of information on the use of force and segregation was provided to the safer detention committee. This covered the nature and location of incidents and the ethnicity of detainees segregated under rules 40 and 42. However, this information was not being used effectively (see section on use of force and single separation).

Other recommendations

To the chief executive, UKBA

Arrival in detention

2.11 Transfer between places of detention in the middle of the night should be avoided wherever possible. (1.5)

Partially achieved. Detainees were routinely transferred in and out of the centre during the night. Movements were determined by the schedule of escort services rather than the needs of detainees. Reception operated two 12-hour shifts starting at 7pm. The log for the three days prior to the inspection showed that 21 detainees had been received during the day and 51 during the night, of whom 45 had arrived after 10 pm. During the same period, 25 detainees had been transferred out during the day shift and 23 during the night. An assurance had been received from UKBA that the number of detainees transferred in after 10pm would be limited to 15 per night and some progress had been made towards this target.

2.12 Removal centres should ensure that all relevant information about the detainee accompanies them when they are transferred to another centre. (1.6)

Achieved. In a sample of files that we examined, relevant information was included from the previous centre, including history sheets and property records. Prison files were reliably passed to the centre and lodged in security.

2.13 Immigration detainees should not be lodged for days in police stations. (1.7)

Achieved. In a sample of 10 files, the longest period a detainee had been held in police cells was less than two days and seven were less than 24 hours. Detainees we spoke to in groups reported that they were held for short periods in police cells.

2.14 When immigration detainees are lodged in police custody suites, custody records, including any property information, should accompany them on transfer. (1.8)

Partially achieved. There were records of police custody in six of the 10 files examined. These varied in quality and detail from full history sheets and risk assessments to bare property lists.

Immigration casework

2.15 UKBA staff should use professional interpreters to explain the content and the implications of important documents, such as removal directions or threats to prosecute. (3.16)

Not achieved. We observed a detainee being served with removal directions who could not speak English. The UKBA member of staff quickly arranged for a telephone interpreter. Other UKBA staff told us: 'We don't use [interpreters] unless we have to… Often we use other detainees for interpreting. We're now paying detainees to act as interpreters. We use them for any sort of interview. It's not always ideal.' Only one interview room was equipped with a telephone.

Additional information

2.16 The contact management team comprised one higher executive officer (HEO), one executive officer (EO) and 5.2 administrative officers (AOs) who acted as contact officers. None of the team was employed on permanent contracts. All were either on fixed-term contracts or were agency staff. The team had an unfilled vacancy for an executive officer. Recruitment had been hampered by the impending closure of the centre and lengthy security checks, and a recruitment ban had recently been introduced. The team were unable to induct every new arrival and some detainees were not advised of their appeal and bail rights. The team also had to cancel some bio-data interviews and interviews with high commissions for travel documents, which caused delays for compliant detainees. The contact management team received little support from the local immigration team or the Criminal Casework Directorate. There were no cumulative records of detention if a detainee had been held in more than one IRC.

2.17 The screening unit had better resources. The team comprised a senior executive officer, six HEOs, eight EOs and 2.5 AOs. Their role was to screen all clandestine arrivals in the Midlands and East of England. These were asylum seekers who had entered the UK illegally, had been dropped off from a lorry, held in a police station and taken to Oakington to undergo the screening process. After three to four days at the centre, they were typically routed into the new asylum model, detained fast track or the third country unit. The team also conducted screening interviews at Yarls Wood immigration removal centre (IRC) for clandestine female entrants, and progressed prison cases in the region. The team did not work on detainee escorting and population management unit (DEPMU) cases at Oakington. Despite their expertise and capacity, the screening unit had been instructed not to progress cases that were out of region.

Childcare and child protection

2.18 UKBA should monitor age dispute outcomes to ensure that UKBA staff in all areas observe their policy that young people who could be minors are not detained. (4.32)

Partially achieved. Age dispute outcomes were monitored by the contact management team who kept a central record of referrals made to Cambridgeshire social services. However, there was a risk that minors could still be detained (see section on childcare and child protection addressed to the centre manager).

To the chief executive, UKBA, and the centre manager

Complaints

2.19 UKBA and the centre manager should examine the relatively low use of the complaints system and find ways of increasing detainees' confidence in using it. (8.39)

Not achieved. We could find no evidence that the centre manager had examined the low use of the complaints system and taken steps to increase detainees' confidence in using it. In our groups, detainees reported little understanding of how to make a complaint and even less faith in the system. One detainee had made a complaint on 7 June 2010, but had not received a response by the time we spoke to him on 2 August. There was only one complaints box in the centre located next to the advice and support office. Complaint forms were available in a variety of languages. The complaints procedure stated that the box should be emptied every

day, but a complaint had not been collected the day after it had been placed in the box by inspectors. No notices were displayed explaining the complaints procedure, although information was provided to detainees at reception.

To the centre manager

Arrival in detention

2.20 Detainees under escort should be offered comfort breaks if their journey exceeds two and a half hours. (1.4)

Partially achieved. Some detainees we spoke to in groups who had arrived during the inspection had been allowed comfort breaks during their journey to the centre. They were escorted off the transport in handcuffs to use facilities. Others reported that they had not been allowed toilet breaks during long journeys.

2.21 Detainees spending their first night in custody should be introduced to night staff who offer appropriate support and regularly check on their well-being throughout the night. (1.16)

Achieved. Night staff on the induction house block were informed of new detainees. During our night visit, we observed staff visiting new arrivals and checking on their welfare.

Additional information

2.22 Detainees reported that escort staff were generally respectful. Most detainees had been provided with refreshments during their journey. In our groups, detainees reported long journey times involving several stops to pick up and drop off detainees. Vans were clean and safe. Detainees transferred between establishments were not given information about where they were going and received little notice of their move. Escort providers contacted the centre at least one hour before arrival with information about the number and estimated time of arrival of detainees to allow reception staff to prepare.

2.23 Detainees disembarked promptly into a large holding area in reception. Reception procedures took place at an open desk and a health care interview was held in a separate room adjacent to the waiting area with the door left open. Interpretation services were not used by reception staff; they relied on detainees who spoke English to interpret for others, or used hand gestures. Interpreting services had been used in health care interviews. Detainees were offered sandwiches and drinks in reception. They were allowed a free telephone call.

2.24 Some detainees told us that they had spent up to four hours in reception before moving to the induction accommodation unit. Staff told us that when detainees were received, they were moved as quickly as possible, but if arriving in a large group they could wait for up to two hours.

2.25 All newly arrived detainees were accommodated in a dedicated induction accommodation unit. When they arrived, they were provided with a change of clothing if required, a toiletries pack, drinks and an information pack which contained useful details about the centre and was available in seven languages. There were no Listeners or detainee mentors to provide support and advice to new arrivals. Interpreting services were rarely used. All detainees went into

shared accommodation and staff tried to ensure that they were in the same dormitory as somebody they knew.

2.26 The day after arrival detainees were seen by the support and advice staff who provided information and a tour of the centre, which took half a day. There were no allocated slots in the timetable for gym, library, education or chaplaincy induction sessions. Detainees were informed of these services and left to make contact themselves. In our groups, detainees reported that they did not find the induction useful.

Residential units

2.27 Worn carpets in the dormitories should be replaced. (2.12)

Partially achieved. Some dormitory carpets had been replaced, together with some flooring in the passages and communal areas in the accommodation blocks. The carpets in several dormitories were dirty and stained.

2.28 The dormitories should be adequately ventilated. (2.13)

Not achieved. No alteration had been made to the bars which limited the extent to which the windows could be opened.

2.29 More effort should be made to obtain the active participation of detainees in open forum meetings. (2.14)

Partially achieved. Staff had tried to encourage attendance by engaging with prominent members of nationality groups among detainees. Notices were displayed, but only in English. There had been reasonable attendance previously, but no detainees had attended during the four months preceding the inspection. A more systematic approach was needed to sustain attendance.

Additional information

2.30 The accommodation consisted principally of dormitories of 12 people, which was not appropriate. Detainees were roused by the tannoy at 7am and required to be out of the dormitory by a certain time, although staff interpreted this differently, to enable cleaning to take place.

2.31 There was poor attendance by managers at the forum meetings. The centre manager and the catering manager usually attended, but very few others. This did not lend credibility to the meetings, as this was the centre's only consultation forum apart from occasional ad hoc meetings with specific nationality groups.

2.32 Staff should assist detainees to organise the laundry arrangements to ensure that clothing does not go missing. (2.15)

Achieved. There were two laundry rooms in each accommodation unit, one staffed by a detainee worker and the other available for the free use of detainees. This mixed economy worked well and there were no complaints about clothing going missing.

2.33 Detainees should be allowed items in possession unless there is clear evidence of a risk. (2.16)

Not achieved. A number of items permitted in other centres were forbidden, such as toiletries, on the basis of risk of concealment of weapons or drugs. Such risks were likely to be very low with this population and therefore the ban was disproportionate. Detainees were not allowed to buy certain food items from the shop or remove them from the dining hall on the grounds that dormitory accommodation was inappropriate for perishable foods. These restrictions appeared petty and unnecessary to detainees.

2.34 A reliable system should be introduced which ensures that bedding is changed weekly. (2.17)

Achieved. Bedding was changed weekly for all detainees.

2.35 Showers should be refurbished and well maintained. Shower curtains and mats should be maintained in a clean condition and replaced regularly. (2.18)

Not achieved. Although some showers had recently been refurbished, and a renewal programme was in progress during the inspection, this was largely limited to the tiling of shower cubicles. The environment in many of the washing areas was very poor, with cracking and peeling surfaces on walls, ceilings and pipes, and floors in poor condition. We were informed that shower curtains and mats were replaced regularly, but many of them were in poor condition.

Additional information

2.36 A good supply of second-hand clothes was available in the induction block for issue to those arriving without sufficient clothing. These clothes were kept clean and were well used, complementing the standard issue clothing which some detainees regarded as institutional and demeaning. The chaplaincy supported this by sourcing good quality clothing.

Staff-detainee relationships

2.37 The tannoy system should be replaced by a pager system without delay. (2.24)

Not achieved. The intrusive and peremptory tannoy system remained, even though it was ineffective because it operated separately in each accommodation block, and detainees were usually elsewhere during the day. Although staff increasingly contacted detainees on their mobile phones, the tannoy was still very frequently used.

2.38 Staff should address detainees by their preferred name. (2.25)

Partially achieved. Managers had issued guidance, which they reinforced in practice, instructing staff to address detainees by name. However, there was little evidence of staff making an effort to learn names other than those of detainees who had been at the centre for some weeks.

2.39 Managers should investigate the reasons for the significant decline in relationships between staff and detainees. The results should be used to inform a strategy to improve and maintain relationships. (2.26)

Not achieved. Managers had rejected this recommendation and did not accept that there had been such a decline, other than as the temporary effect of a large recruitment exercise at the

time of the previous inspection. There had not, therefore, been an investigation or an improvement strategy.

Additional information

2.40 Our observations showed a very mixed picture in staff/detainee relationships. A number of staff, especially in the induction block, actively engaged with detainees, particularly if their mood appeared low or uncertain. Others detached themselves from detainees, adopting a supervisory role. This was noticeable where detainees gathered in large numbers, for example in the dining hall where staff were present but scarcely engaged with detainees at all. On the whole, staff were polite and helpful when approached by detainees, but did not take the initiative to open conversations with them.

2.41 There was no personal officer scheme. Individual records maintained in the accommodation blocks contained only brief accounts of events such as appointments and interviews, and occasionally the issue of warnings. There was no description of detainees' mood or record of conversations.

Legal rights

2.42 The library should stock sufficient, up-to-date legal reference materials to meet the needs of the population. (3.7)

Not achieved. The library contained a few legal text books, but they were difficult to access under the library assistant's counter and there were no notices advising detainees of their existence. The country of origin reports were years out of date, some dating back to 2004. The Bail for Immigration Detainees notebook was available in a number of languages.

2.43 Legal interview rooms should be equipped with conference telephones to permit access to a telephone interpreting service. If it is necessary to conduct a legal visit in the DDU, the visit should be private. (3.8)

Not achieved. Legal interview rooms were not equipped with telephones. Custody staff were sometimes within sight and hearing in the DDU when detainees met their legal representatives.

Additional information

2.44 Detainees were given a bail application form during their induction interview with the UKBA contact management team (although not all detainees had induction interviews - see paragraph 2.7). Bail application forms were not freely available throughout the centre apart from the advice and support office, which was frequently closed during the inspection. This could have inhibited detainees' ability to make repeat bail applications.

2.45 There was information in the advice and support office on how to complain to the Office of the Immigration Services Commissioner about the Immigration Advisory Service (IAS). There was no information in the centre on the Legal Complaints Service which dealt with complaints about solicitors. The IAS had offices on site. They received notification of every detainee arriving at the centre, but lacked the capacity to see all of them.

2.46 There was good access to the internet suite, but many websites containing legal and country of origin information were inaccessible and management had blocked access to the BBC News

website. Detainees were unable to open documents in Word format which prevented them from receiving letters and witness statements from their solicitors. Custody officers staffing the internet suite were unable to override the software to unblock websites.

Immigration casework

2.47 Reasons and reviews of detention should be issued in writing in a language which the detainee understands. (3.15)

Not achieved. Reasons and reviews of detention were issued in English. UKBA staff reported that they arranged for them to be translated where necessary.

2.48 A central folder of rule 35 letters and responses should be maintained, to enable monitoring of content, reaction and follow up. (3.17)

Achieved. The UKBA contact management team kept a central folder of all rule 35 reports. The quality of rule 35 reports from the health care managers was good. In one case a rule 35 report had contributed to the decision to grant temporary admission.

2.49 When detainees are threatened with prosecution and a custodial sentence for not cooperating with the removal process, there should be appropriate legal safeguards, including access to specialist legal advice, in line with Police and Criminal Evidence Act Codes of Practice. (3.18)

Achieved. UKBA informed us that, when an arrest was made under section 35 of the Asylum and Immigration (Treatment of claimants) Act 2004, detainees were given access to free independent legal advice at the police station as required under the Police and Criminal Evidence Act.

Bullying

2.50 Efforts should be made to encourage and assist detainees to attend safer detention meetings. (4.16)

Not achieved. The safer custody manager told us that notices inviting detainees to attend the monthly safer detention meetings had been published and meetings were announced on the public address system on the day that they were held. However, detainees we spoke to said that they were not aware of the meetings and minutes showed that they did not attend.

2.51 Monitoring information provided to the safer detention committee should include the nationality of perpetrators and victims, and other acts of violence. (4.17)

Achieved. The safer custody manager produced a monthly report which contained information on reported violent incidents, including their nature and the nationality of victims and perpetrators of bullying.

2.52 A local bullying survey should be conducted as a priority and its findings used to inform local policy. Subsequent surveys should take place every two years. (4.18)

Partially achieved. Although a detainee survey had reportedly been conducted in 2008, there was no evidence that it had been used to inform a violence reduction strategy or to review anti-bullying procedures. Detainees and staff said that there had been no meaningful consultation.

2.53 Detainees should be consulted on safer detention matters at least monthly. (4.19)

Not achieved. There was still no effective consultation with detainees on violence reduction and bullying. The monthly open forum for detainees was frequently cancelled because of non-attendance. Safer detention had not been raised by staff or detainees in the meetings that had taken place in the 12 months prior to our inspection.

2.54 Incidents of stolen property should be investigated as potential bullying incidents. (4.20)

Not achieved. Incidents of stolen property were still reported to the security department on a locally devised form, but were not passed to the safer detention manager to investigate as potential bullying.

2.55 Information about safer detention should be included in the reception pack issued to all new arrivals. (4.21)

Partially achieved. Information about the anti-bullying strategy was included in the welcome pack issued to all detainees, but there was no further information in the accommodation units, nor advice on how to get support. There were no anti-bullying posters on display.

Additional information

2.56 Procedures to deal with bullying and levels of violence had generally not improved since the previous inspection. An anti-bullying policy had been produced in 2008, but there was no evidence that it had been informed by an analysis of the pattern of violence in the centre. Copies of the policy were not kept on accommodation units and many detainees we spoke to were not aware of its content.

2.57 A nominated safer detention manager had been appointed to monitor, review and supervise the implementation of the anti-bullying strategy and to lead at the monthly combined safer detention and race relations meetings. She was also responsible for race equality, diversity and suicide and self-harm prevention. This range of responsibilities allowed insufficient time to oversee procedures, offer guidance and training to residential staff and ensure that monitoring arrangements were effective.

2.58 A multidisciplinary safer detention committee had been appointed to monitor, review and supervise the implementation of the violence reduction strategy. The committee met monthly and also managed and monitored the suicide prevention, race equality and diversity policies. Meetings were usually chaired by the safer detention manager, with little support from managers in key areas in the centre, such as security and the residential units. Meetings were generally poorly attended and representation from senior managers was particularly poor. Meetings focused on self-harm, suicide prevention and race equality issues, but did not give appropriate emphasis to violence reduction. The safer detention manager provided relevant information on the number of reported incidents, but, although there was some analysis of wider trends, it was not used effectively to drive strategy.

2.59 From January 2010 until the inspection, there had been 38 recorded violent incidents. Given the nature and size of the establishment, this figure was not excessive. Although most detainees we spoke to said that they felt reasonably safe, we were not confident that the many opportunities for bullying across the site were fully recognised by staff. We observed weak supervision on all accommodation units, particularly the dormitories. Unexplained injuries to detainees recorded on accident forms were not regularly examined.

Suicide and self-harm

2.60 Monitoring data provided to the safer detention committee should include the nationality of self harmers and those on open ACDT documents. (4.22)

Achieved. The safer custody committee used historical information provided by the safer detention manager, including the nature of offence, the timing, nationality and ethnicity of self-harmers, to help identify trends and patterns of behaviour. These were being used to develop the strategy.

2.61 The quality of assessor reports, care maps and case reviews should be closely monitored and regular quality reports should be provided to the safer detention committee to ensure a good and more consistent standard. (4.23)

Achieved. The safer custody manager conducted regular quality checks on all ACDT (assessment, care in detention and teamwork) documents. The quality of documentation was very good. Initial assessments were realistic and involved proper consultation with the detainee. Case management arrangements through the safer detention manager were effective and the quality of individual care plans was better than at other IRCs. Detailed support plans prepared in consultation with the detainee identified specific needs and apportioned responsibilities to a nominated member of staff. The progress of plans was reviewed at pre-determined times in agreement with the detainee.

2.62 Staff monitoring detainees at night should ensure that checks are not so regular that they are predictable. (4.24)

Achieved. Documentation showed that observations and checks made during the night were consistent, but not too predictable.

2.63 Interpreting services should always be used for assessments and case reviews when required. (4.25)

Achieved. There were protocols to allow the use of interpreting services (language line) during assessments and case reviews. Services had been used at least six times from January to July 2010.

2.64 Care maps should be routinely reviewed during case reviews. (4.26)

Achieved. Care maps were reviewed at all subsequent case reviews, and required actions were carried over. Planned actions were realistic and always followed through at reviews.

2.65 A peer supporter scheme should be developed. (4.27)

Not achieved. There was still no peer support scheme in place.

2.66 Samaritans telephones should be provided. (4.28)

Not achieved. Detainees had no access to Samaritans telephones.

Additional information

2.67 There had been a death at the centre in April 2010. The case had been fully considered by the safer custody committee and interim action plans drawn up pending the completion of full investigations by the Prisons and Probation Ombudsman.

2.68 Since the previous inspection, a revised suicide and self-harm policy had been published based on an examination of local practices. Its content was comprehensive and copies were found on all residential units and communal areas throughout the centre. Strategic protocols described in the policy were the responsibility of a senior manager acting as the safer detention manager (see section on bullying). She was responsible for ensuring that procedures for managing detainees at risk of self-harm were properly implemented, and acted as a central point for advice and guidance for staff.

2.69 A high priority had been given to suicide and self-harm prevention at the safer detention team meetings. Minutes we examined reflected a consistent standard of debate about self-harm issues despite poor attendance.

2.70 There were three open ACDT documents at the time of the inspection. The quality of entries was generally very good and demonstrated a full understanding of the detainee's individual circumstances and feelings. The ACDT scheme continued to be supplemented by raised awareness support plans (RASP). Staff were encouraged to open a RASP for up to 48 hours for any detainee appearing vulnerable or at times of particular risk, such as notification of deportation. The quality of entries was good and demonstrated that the needs of detainees at risk were given priority.

Childcare and child protection

2.71 There should be robust mechanisms to identify on arrival all young people who might be minors and refer them for assessment, legal advice and appropriate care without delay. (4.33)

Partially achieved. UKBA, G4S and IAS staff were aware of the potential for minors to be held at the centre and told us that they were committed to identifying, safeguarding and transferring minors. Despite these good intentions, there were weaknesses in the procedures for identifying, assessing and caring for minors. Oakington acted as a screening unit for all male clandestine entrants in the UKBA regions of Midlands and East of England. The objective of the screening interview was to establish the person's identity and gather information needed for routing. As interpreters were not used in reception and there was insufficient capacity to see all detainees on arrival, the screening interview was potentially the first opportunity for detainees to declare that they were a minor, by which time they could have been in detention for a number of days. If a child's stated age was not accepted by UKBA, an age assessment was sought from Cambridge social services. The quality of the social services reports was poor: only a few lines were devoted to the conclusions and reasons given and they were not compliant with the Merton judgement which set out the standards for such reports. The assessments were not conducted by two social workers registered with the General Social Care Council.

2.72 There was inadequate provision for the care of detainees found to be minors. Children slept in the Rule 40 separation accommodation where the environment was stark and poorly equipped and the toilets and showers were dirty (see the section on use of force and single separation).

At 7.30am on the day following arrival, the child was escorted to the secure compound to associate with the 400 adult detainees and remained there until 10pm. Both environments were unsatisfactory for the care of minors.

2.73 Detainees claiming to be minors who had yet to be assessed by social services were placed on a RASP. We reviewed one case of a 14-year old child who staff had recorded was very tearful and afraid of the other detainees. The RASP required staff to check on the child regularly, but he remained on normal location until he was released.

Diversity

2.74 The race relations committee meetings should be chaired by the centre manager or deputy manager, who should monitor attendance by the designated membership and take steps to ensure attendance. (4.43)

Not achieved. The race relations committee meetings were combined with the safer detention meetings. They were chaired by the safer detention manager and were poorly attended. In July 2010, 35 people had been invited to the meeting, but only three had attended, one of whom was a member of the Independent Monitoring Board. The minutes showed that diversity issues were not given prominence.

2.75 There should be consultation with detainees to encourage and facilitate their attendance at race relations committee meetings. The race relations committee should investigate concerns identified through their monitoring arrangements and take corrective action. Monitoring information should be available to all staff and detainees. (4.44)

Not achieved. Notices were displayed around the centre encouraging detainees to attend the monthly race relations and safer detention meetings, but no detainees had attended the previous three meetings. This contrasted with each of our groups which were attended by up to 30 detainees.

2.76 Assessments should be made of all facilities to ensure that disabled detainees have equality of access, and a disability equality scheme should be introduced. (4.45)

Partially achieved. All detainees were assessed on arrival to determine their needs and suitability for detention at the centre. We found no evidence of the introduction of a disability equality scheme.

2.77 Assessments should be made of all locally implemented policies to determine their impact on detainees with disabilities and people of different nationalities and cultures in the centre. (4.46)

Not achieved. We found no evidence of the assessment of locally implemented policies to determine their impact on detainees with disabilities and people of different nationalities or cultures.

2.78 The race relations committee should broaden its remit to ensure adequate coverage of diversity issues relating to disability and sexuality. (4.47)

Not achieved. The race relations and safer detention meetings did not address disability or sexuality issues. The centre did not monitor detainees' sexual orientation.

2.79 Access to activities and paid work should be monitored by the race relations committee. (4.48)

Partially achieved. The regime manager produced a monthly report of participation in activities and jobs by ethnicity. At the time of the inspection, there were 46 vacancies. Access to activities and paid work was not monitored by the race relations committee.

2.80 The centre should provide for the needs of detainees and visitors to at least the level required by the Disability Discrimination Act 2005. (4.49)

Partially achieved. All accommodation units were accessible by ramp. Education classrooms and the internet suite were located on the first floor and were inaccessible by wheelchair. Only one of the accommodation units had a toilet for disabled people and it was being used as a staff toilet.

2.81 Notices containing information about daily life at the establishment should be translated into an appropriate range of languages, so that the information is accessible to all detainees. (4.50)

Not achieved. Notices about daily life at the centre had not been translated into different languages. The safer detention manager was unaware if the centre had a budget for translating material.

2.82 Assistant race relations officers should act as diversity 'champions' on their accommodation blocks and consult with detainees regularly on matters of race, nationality, culture and religion. They should support detainee representatives at race relations committee meetings and report back to detainees on the accommodation blocks. (4.51)

Partially achieved. There were 21 assistant race relation liaison officers, all of whom had undergone a day's race relations training. Their photographs were displayed around the centre.

2.83 Regular events involving members of local minority groups should be held to celebrate cultural diversity. (4.52)

Partially achieved. Events were held to celebrate cultural diversity, but there was no involvement by local minority groups. At the time of the inspection, preparations were being made for Ramadan. The centre had previously celebrated Christmas, Divali, Chinese New Year and Hanukah.

Additional information

2.84 The centre did not keep personal emergency evacuation plans for disabled detainees who might have required assistance in an emergency. There were no regular consultation groups arranged by nationality, although a meeting had recently been held with Chinese detainees using an interpreter.

Faith

2.85 Warm water should be available in the washing facilities attached to the Muslim prayer room. (4.58)

Achieved. Warm water had been plumbed in to the washing facilities during 2009.

2.86 The religious affairs team should have adequate office space to work effectively, including room for private interviews. (4.59)

Not achieved. The religious affairs team had an office which was too small to accommodate them and provide individual space for their work. There was no dedicated private interview room. The religious affairs team had to use education rooms when they were not occupied.

2.87 The Muslim prayer room should be of adequate size for the population. (4.60)

Not achieved. At the time of the inspection, there were 167 detainees who identified themselves as Muslim. Approximately 80 to 90 attended daily prayers and 120 Friday prayers. The room used for Muslim prayers was not large enough to accommodate these numbers and there were only 40 prayer mats in place. The Muslim chaplain told us that some detainees had to go into the ablutions area during crowded sessions.

2.88 The current levels of pastoral support should be maintained to ensure that the needs of all detainees are met. (4.61)

Partially achieved. The levels of pastoral support had been under review at the time of the previous inspection, with the possibility that the hours available would be reduced. This had not happened and the hours remained the same. However, the centre had not been able to recruit a Buddhist leader and the level of pastoral support had reduced. There was no provision for two detainees who had declared their religion as Falun Gong.

Additional information

2.89 Apart from Buddhist prayers, a full range of appropriate opportunities to worship were provided for the centre population. The religious affairs team were well supported by the religious affairs manager who handled sensitively issues such as competing demands for chapel time.

2.90 Bibles were available in a range of languages through the Bible Society and copies of the Qur'an were freely available. A range of religious classes were held including Qur'an and Bible study and baptism preparation.

2.91 The religious affairs team were well integrated in the centre and provided pastoral support across faith boundaries. They saw detainees subject to RASP and ACDT supervision daily. They also provided welfare support for detainees, such as clothing and financial support, through their links with community-based Christian organisations. Links with Muslim organisations required further development. The Oakington visitors group told us that detainees appreciated the pastoral and practical welfare support they received from the religious affairs team.

Health services

2.92 The planned relocation of the health care centre should be expedited. (5.35)

Achieved. The health care centre was located on the second floor of block 21. The new facility provided a small waiting area, several consultation rooms and two treatment rooms. Despite a rather narrow connecting corridor, there was appropriate provision and a generally relaxed, positive feel to the area.

2.93 A full health needs assessment should be undertaken. (5.36)

Achieved. A health needs assessment had been commissioned by the primary care trust (PCT), NHS Cambridgeshire, in February 2009. Some of the recommendations in the report had been implemented, but some, for example a counselling service for detainees, required financial commitment which had not been forthcoming in view of the uncertain long-term future of the centre.

2.94 A professional interpreting service should be used for all health care consultations, including the initial reception health screen, for all detainees not able to communicate confidently in English. (5.37)

Partially achieved. Telephone interpretation was used for most consultations with detainees who could speak little English. One of the GPs was able to communicate in some Asian languages and dialects, for example Punjabi and Urdu, and had some command of Afghan languages such as Pashtu. Some detainees told us they could not always express themselves properly or understand fully.

2.95 If a detainee is registered with a GP or any relevant care agencies, they should be contacted at the beginning of detention, with the detainee's consent, to provide relevant information to ensure continuity of care (5.38)

Achieved. If a detainee had previously been registered with a UK GP or other health care provider, a special 'request for medical records' form was routinely sent to the provider after some investigative work by the health care administrator to identify the appropriate GP practice.

2.96 All health care consultations, including reception screening, should be conducted in private. (5.39)

Partially achieved. Reception screens were conducted with the door wide open, which we were told was for security reasons. The nurse said that she partially closed the door if the detainee showed signs of distress. All other health care consultations were conducted in private.

2.97 The frequency of optician sessions should be reviewed with a view to reducing the waiting times for this service to a more acceptable level. (5.40)

Partially achieved. The optician still attended once every two months. There were 17 detainees on the waiting list at the time of the inspection. We were told that the optician was due to attend the following week and would see up to eight of those on the list. The longest waiting time was approximately eight weeks, which was less than at the previous inspection. Detainees were able to buy reading glasses from the library.

2.98 All health services staff should receive resuscitation training at least annually and records of this should be maintained. (5.41)

Achieved. All nursing staff had received annual intermediate life support training which included use of the automated defibrillator. Records showed regular annual updates and identified staff due for refresher training.

2.99 Detainees should have direct access to advice from appropriately trained pharmacy staff and information about the benefits and risks of medicines and the self-administration of medication. (5.42)

Achieved. The lead pharmacist from Primecare visited the centre every two months. Detainees were made aware of these visits and could ask to see the pharmacist for advice and information. However, we were advised that this service was not used by detainees. Medicines administered by the nursing staff were not always accompanied by the appropriate patient information leaflet.

2.100 A medicines and therapeutics committee should be established. (5.43)

Achieved. A quarterly medicines and therapeutics committee was attended by the health care manager, the lead pharmacist, senior pharmacy representatives from the local PCT, and G4S security and regimes senior managers. There was no GP prescriber representation.

2.101 All nurses should receive clinical supervision and records of this should be maintained. (5.44)

Not achieved. There was a Primecare policy for clinical supervision, but only two nurses received clinical supervision. There appeared to be a view among nursing staff that informal peer support was sufficient for clinical practice.

2.102 A comprehensive accurate health care information leaflet which is accessible to all detainees should be given to detainees in reception. (5.45)

Partially achieved. A comprehensive patient information leaflet was available in the health care reception room. This was not given to detainees at reception screening because it was included in their welcome packs, but some detainees did not receive the welcome pack.

2.103 Detainees should be informed of forthcoming medical appointments. (5.46)

Achieved. Detainees were routinely advised of forthcoming external medical appointments unless a risk assessment prevented disclosure before the time of the appointment.

2.104 Detainees should be able to obtain barrier protection without charge and without asking a member of staff. (5.47)

Achieved. Condoms were freely available from the waiting area in health care and detainees did not have to ask a member of staff. They had been made available in the accommodation blocks, but this had ceased following inappropriate damage to condom supplies. Information in several different languages about sexually transmitted diseases was available in health care, the library and the reception health care room.

2.105 Patient information leaflets should be provided in a language that detainees can easily read. (5.48)

Achieved. There was a leaflet about health care services and how to access them in a wide range of languages. A selection of health promotion leaflets was available in several different languages from health care, the library and reception health care room. It was not clear to what extent detainees used these leaflets.

2.106 There should be a system which allows for medical complaints to be made in confidence. (5.49)

Partially achieved. Detainees could make confidential complaints using a closed Primecare system, but detainees were not aware of this and there were no notices in the house blocks to explain this. All health care complaints received through the G4S central system were channelled back to health care. There had been eight complaints during the previous year, one of which related to being taken to an external appointment in handcuffs. All other complaints had been dealt with and answered appropriately.

2.107 A counselling service should be available within the centre. (5.50)

Not achieved. The health care department recognised the lack of counselling as a significant issue for this vulnerable population. A bid for funding in 2009 to NHS Cambridgeshire had been unsuccessful. There was no registered mental health nurse, which compounded the effect of the lack of counselling, and there was little capacity in the nursing team to alleviate this gap.

Additional information

2.108 Detainees in our groups had a negative perception of access to and the quality of health care. We observed some caring and sensitive exchanges between nurses and detainees, and nurses tried hard to ensure that vulnerable detainees received appropriate and timely care.

2.109 The health care centre was struggling to deal with staff recruitment and retention due to the uncertain future of the centre and there had been a high turnover of staff in the previous year. Of a total nursing establishment of 11 (nine full-time and two part-time staff), there were four full-time registered general nurses (RGNs) and two part-time RGNs, including one on maternity leave. Two RGNs were awaiting security clearance to start and there were two vacancies, including the designated registered mental health nurse post. There was a full-time administrator post.

2.110 The health care manager was a registered mental nurse with special interest in the psychological consequences of torture. She had developed a package which was used to train health care staff in recognising and dealing with cases of reported torture. The manager was also an ACDT trainer and all the nursing staff had received ACDT training.

2.111 There was an established governance framework through the provider Primecare, including a wide-ranging company portfolio of clinical policies and protocols. High priority was given to health promotion and there was a wide range of leaflets and displays in health care and the library, some in different languages. Health care staff had identified the dates of national health promotion campaigns and had organised several successful health promotion days during the previous year. There had been 201 declarations of torture under Rule 35 by detainees to health care between January and July 2010, but the health care department had had confirmation of receipt and an update from UKBA on only a very small number.

2.112 Reception screening was conducted using a template questionnaire. If the detainee said he could understand and read English, he was encouraged to complete this himself. The approach to the screening was a little perfunctory and there was a risk that if detainees' command of English was poor, an important issue could be missed. There was one nurse on night duty between 8pm and 8am. On one occasion during the previous year, 48 new receptions had arrived during the night which was too many for one member of staff to handle in addition to responsibility for emergency response and screening of requests for pain relief.

2.113 There had been a death in detention in April 2010 which was being investigated by the Prisons and Probation Ombudsman. A learning from events report and an action plan had been generated by the health care manager within approximately three weeks of the event, which was commendable.

2.114 Detainees requested health care appointments through their house block detention custody officer, during a specified period in the morning, with some variation of timing between house blocks. The request was logged by the officers and taken to health care. Confirmed clinic appointments were collected by the officers at the end of the day and detainees were notified on the same day, using a slip with pictorial icons to denote day and time. All appointee names were posted on a board in the main waiting area below the health care centre in Block 21, which breached patient confidentiality.

2.115 The increased turnover of staff had reduced the capacity to deal with detainees' health needs and contributed to some detainees waiting up to three or four days to see a nurse for routine appointments. All requests for appointments were triaged by a nurse to ensure that access to the GP and the nurse was clinically appropriate and prioritised.

2.116 All detainees had their medication in possession unless a risk assessment indicated that this was inappropriate. There were supervised medication rounds three times a day from the health care pharmacy room, with the last round at 9.30pm before detainees were locked in to their house blocks. During the night and when the health care centre was closed, detainees could request soluble paracetamol for pain relief from their detention custody officers. A small supply of paracetamol was kept in locked boxes in the house blocks and the officers checked with the nurse on duty before giving the paracetamol and recording it in a log sheet. A review of the records in one house block showed regular access to pain relief by detainees across the 24-hour period.

2.117 Detainees were routinely told about external appointments unless a risk assessment indicated that this was not appropriate. All detainees were risk assessed for the use of handcuffs, but in practice they were asked to consent to handcuffs unless there was a clinical reason not to handcuff. We were told that detainees visiting the external genitourinary clinic at Addenbrooke's Hospital were handcuffed in the van and into the hospital and the handcuffs released while the escort remained outside the consulting room door.

2.118 There had been no mental health service since December 2009 owing to recruitment difficulties. We were told that there were good links with the local mental health trust and that the consultant psychiatrist visited if requested. We observed and heard of examples of many detainees who were distressed by their situation, with potentially more significant mental health issues going unrecognised.

Activities

2.119 Opportunities for voluntary or paid work should be further promoted and extended. (7.13)

Achieved. Work opportunities had been extended and met the needs of approximately a quarter of the population.

2.120 Wages for detainees undertaking work should be paid in cash, rather than vouchers. (7.14)

Achieved. Wages for employed activities were paid straight into the detainee's shop account. If detainees did not spend it in the shop during their time at the centre, they were given the balance in cash when they left.

2.121 There should be a wider range of structured purposeful activities and learning opportunities to suit the needs of the longer-stay and English-speaking detainees. This should include opportunities for accreditation. (7.15)

Achieved. Provision had been extended for English-speaking and longer-stay detainees. Higher level information technology (IT) courses had been added to the curriculum. Additional courses had been delivered in first aid, an introduction to business planning and an accredited health and safety course, but demand for these courses was limited.

2.122 The suitability of the book stock should be monitored against the detainee population profile. (7.16)

Partially achieved. An audit had been carried out on book stock and a new computer installed to catalogue books. However, this had not been completed and the range of current book stock could not be measured to ensure that it met population needs.

2.123 The fitness suite should be available to detainees during the evenings. (7.17)

Achieved. The opening times of the fitness suite had been extended to include evenings and weekends. However, the fitness suite was closed on occasions because of staffing issues.

2.124 Formal processes should be established to ensure that all detainees receive an effective induction to fitness equipment and that PE staff are informed of those detainees who are advised by health services staff not to participate in PE. (7.18)

Achieved. Induction sessions to the fitness suite were offered every weekday. Health care staff produced a report on any detainees who were unfit to participate in exercise and shared this with activities staff who ran the fitness suite.

2.125 PE staff should undertake updating and development training. (7.19)

Achieved. Activities staff had participated in training in the use of the fitness equipment in the gym in February 2010.

2.126 Visual displays should be better used to promote physical exercise. (7.20)

Achieved. Posters had been purchased and displayed in the gym showing how to use each exercise machine, and relevant anatomical diagrams were displayed.

2.127 The arts and crafts class should be located in a suitable classroom with appropriate equipment, storage and display space. (7.21)

Achieved. The art room had been relocated and facilities improved in March 2010. The room had better lighting, hot and cold running water and storage space for tools and equipment. Art and craft resources had been increased.

2.128 Arrangements for monitoring and improving the quality of the activity provision should be established. (7.22)

Achieved. A quality cycle had been implemented to review and improve the provision. A self-assessment report was produced annually, together with an improvement action plan. Some aspects of quality improvement, such as peer observation of teaching and learning and external observations, were behind schedule. Good use was made of learner feedback to inform and improve provision. This was particularly evident in art.

2.129 The range of foreign language newspapers should be extended to meet the needs of all detainees. (7.23)

Not achieved. The range of foreign language newspapers had decreased since the previous inspection. However, activities staff ordered specific foreign language newspapers to meet detainees' requests.

Additional information

2.130 The range of activities had been extended since the previous inspection. There was freedom of movement around the site for about 15 hours each day. Fourteen staff provided a range of activities during the day and in the evening. Working shift patterns had been revised to enable the amenities area to be staffed from 7am to 8pm. The area was permanently staffed when open and was very popular with detainees. A social area in the amenities building provided access to the fitness suite, the library and the shop. It was equipped with five pool tables, two electronic games machines and two table football games. Table tennis was available, but the room was being refurbished during the week of inspection. Booking systems ensured fair access to the games equipment. Evening activities included bingo. A computer room containing 20 computers with internet access was open during the day and evening seven days a week. However, detainees complained that a number of websites were blocked, for example, the BBC and Home Office websites. Each accommodation block had a television room, and a satellite television room in the amenities block showed a range of films and sporting events.

Work and learning and skills

2.131 Seventy-nine detainees were employed and there were 46 job vacancies, which together provided jobs for about a quarter of the population. Detainees worked for up to two hours each day earning a maximum of £15 a week. Jobs were well advertised in accommodation blocks through posters describing the job requirements with text and pictorial images. Rates of pay were equitable. Special short-term jobs had been created to meet detainees' needs. For example, over the period of Ramadan, 20 new kitchen jobs had been created to provide Muslim detainees with food after sunset. Detainees who acted as interpreters were paid on a needs basis.

2.132 The quality of education and the standard of teaching and learning were good. Classes were popular, well attended and delivered during the day and in the evening. Tutors planned carefully to provide interesting and enjoyable classes which met the wide range of detainees' abilities. The accommodation was clean and welcoming with attractive wall displays. Mentors were used to support learning activities in the study centre and in art.

2.133 The well managed study centre was very popular with detainees and operated to full capacity for the majority of the time. Learners undertook a range of basic, intermediate and advanced learning activities in IT and English language development. Learning materials were well developed and helped detainees to progress at their own pace. The purchase of laptops in addition to the computer stations had extended the use of English language interactive

learning programmes. English for speakers of other languages (ESOL) courses from entry 3 to level 1 were provided during the day and in the evening. Classes were well planned and used a wide range of stimulating activities to develop learners' skills.

2.134 In art classes, learners could develop their skills from basic to intermediate and advanced level in drawing, colour studies, painting, sculpture, print making and crafts. Individual coaching and support developed learners' skills particularly well. The standard of work was high. Examples of learners' work were displayed around the activities centre, improving the environment. Learners produced art work to celebrate a variety of cultural and religious festivals including Eid, Chinese New Year and Christmas. Learners' work had been entered for the Koestler Trust awards.

Library

2.135 The extended library facility provided a valuable service for detainees. In addition to book, DVD and newspaper loans, games, sports equipment, and bookings for hairdressing were also managed by activities staff in the library. A fax machine was well used by detainees. Two volunteer librarians supported library services. Health care and job promotion events were held in the library.

2.136 The range of fiction and non-fiction books, newspapers and periodicals was adequate, although there were still some gaps in the stock, particularly dictionaries in other languages. There was an over-reliance on donations of books to extend the book stock and there was no annual budget to renew books. A new system had recently been introduced to improve the monitoring of book loans and reduce the number of books lost.

Physical education

2.137 Since the previous inspection, the fitness suite had been relocated to the ground floor of the amenities building in a room adjacent to the amenities social area. There was additional equipment which adequately met the needs of the population. A booking system ensured fair access to the facilities. Induction took place daily in a regular one-hour time slot. Appropriate footwear was provided for detainees who did not possess their own.

2.138 An outdoor grassed area was used for football and cricket, which were sometimes refereed by activities staff. Other facilities included volley ball and pétanque courts and badminton. Monthly events included sports days.

Rules of the centre

2.139 Staffing levels and handcuffing arrangements for hospital escorts should be proportionate to the risks posed by the individual detainee. (8.29)

Not achieved. Arrangements for hospital escorts remained disproportionate. All detainees attending external hospital appointments were escorted by three officers. Although cursory risk assessments were conducted to determine handcuffing arrangements, all detainees attending hospital appointments were handcuffed (see section on health services).

2.140 Detainees' lockers should be secure and each should have its own unique key. (8.30)

Achieved. All detainees had their own large secure locker.

Additional information

2.141 The centre rules were explained in the welcome pack and the compact issued to new arrivals. Both had been translated into a wide range of languages. Although centre rules were usually applied consistently, as at the previous inspection property entering the centre was unduly restricted. New arrivals were not allowed to retain some basic items such as shaving equipment and music CDs (see also section on residential units).

2.142 There had been some heightening of perimeter security. The number of escapes had greatly reduced with six escapes from January to July 2010 compared to 14 during the same period in 2008.

2.143 There were effective systems for processing information and using intelligence to inform risk assessments. Important elements of dynamic security were well established: the flow of information between the residential units and the security department was effective. The large number of security incident reports, about 80 a month, were processed and categorised by a nominated security collator. Information was communicated to staff in all areas of the centre through monthly bulletins and published intelligence assessments.

2.144 Composition of the security committee was appropriate and it was well attended by representatives of relevant internal departments and external agencies. Intelligence was considered and monthly objectives set. In general, security procedures were proportionate and at the level necessary to ensure safe containment.

Rewards scheme

2.145 Detainees should be invited to attend review meetings following warnings that their reward level is to be reviewed. (8.31)

Not achieved. There had been no change since the previous inspection. Reviews were chaired by the safer detention manager and attended by the security department and the shift manager. Detainees did not attend these meetings and were informed of the decisions of the review in writing.

2.146 The rewards scheme should offer incentives and not include sanctions. Removal of the use of personal mobile telephones and access to work should not be used as a punishment. (8.32)

Not achieved. Sanctions, such as restriction of access to paid work and educational activities, continued to be applied.

Additional information

2.147 All newly arrived detainees were placed on the enhanced level of the rewards scheme and were entitled to use all the available facilities. Failure to follow the centre rules or disruptive behaviour remained grounds for demotion to the standard regime, although this was rare. At the time of the inspection, all detainees were on the enhanced level of the scheme.

2.148 On the whole, the rewards scheme was applied consistently across the centre and did not appear to disadvantage any specific group of detainees.

The use of force and single separation

2.149 Standards of cleanliness in the DDU television room should be improved and maintained at a good standard. (8.33)

Achieved. The television room was reasonably clean and well maintained. The general area was light and brightly decorated. Access for most detainees was good.

2.150 Detainees on rule 40 should be provided with written reasons for their separation and a copy of the regime in a language that they can understand. (8.34)

Not achieved. Detainees were given written reasons for their separation in English. Although we were told that arrangements could be made to provide written reasons and a copy of the regime in other languages, there was no evidence that this had happened.

2.151 Detainees on rules 40 and 42 should be provided with a predictable regime. (8.35)

Not achieved. There was no published or predictable regime for detainees held in segregation under rules 40 or 42.Those held on rule 40 were allowed to watch the television and use the exercise yard every day at the discretion of staff.

2.152 Multiple planned use of force incidents should not be recorded on the same videotape. Used tapes should be stored in tamper-proof evidence bags. (8.36)

Achieved. Planned use of force incidents were videotaped on separate tapes. Tapes were stored in tamper-proof evidence bags.

2.153 Detainees placed on rule 42 should be provided with written reasons and a copy of the regime in a language that they can understand. (8.37)

Not achieved. See paragraph 2.150 above.

2.154 Detainees should be removed from rule 42 at the earliest opportunity and this should be fully documented. (8.38)

Achieved. The number of detainees segregated under rule 42 was reasonably low at six from January to July 2010. The average stay was less than one hour and proper authorisation was given in all cases. Entries by staff in observation logs were generally good and showed that detainees were removed from rule 42 at the earliest opportunity.

Additional information

2.155 Given the size and nature of the population, the number of incidents involving the use of force was not excessive at 23 from January 2010 to date. Sufficient information on use of force and separation was provided to the safer detention committee, but it was not being used to inform policy or to influence strategy.

2.156 Statements from staff following spontaneous incidents demonstrated that intervention techniques were used properly and that de-escalation had been used to good effect. Although not all the use of force paperwork we examined was properly completed and there was little

evidence of consistent management checks, overarching governance arrangements by senior staff, particularly the deputy head of centre, were rigorous.

2.157 The use of segregation was high. From January to the end of July 2010, more than 400 detainees had been segregated under detention centre rule 40 (removal from association). Almost 300 of these had been segregated because of escorted flights between 10pm and 6am for detainees who had at some time refused to be removed from the centre. We were told that, to avoid the possible disruption of moving out of dormitories in the middle of the night, they were locked in cells in the DDU in the late afternoon to await collection by escorting staff. Up-to-date risk assessments had not been carried out in any of these cases. A further 116 detainees had been segregated because of what was described on authorisation forms as unacceptable behaviour. Although authority was given at the required level in all cases, we did not feel that the reasons for segregation were always justified. We found, for example, that all detainees involved in incidents involving the use of force were segregated for a short period of time regardless of the nature of the incident. There were also examples of the application of rule 40 for minor breaches of the centre rules.

2.158 Living conditions in the unit were mixed. Although most communal areas were clean and adequately maintained, cells were too small, poorly furnished, stark and unwelcoming. Toilets were dirty and showers were in a poor state of repair.

Complaints

2.159 Information about the nature of complaints dealt with by the professional standards department should be relayed to the centre, to enable analysis of any emerging patterns and trends. (8.40)

2.160 Partially achieved. The results of complaints dealt with by the professional standards unit (PSU) were not always forwarded to the centre. Centre staff reported having to chase the PSU for reports. In one case, the PSU had completed an investigation on 11 February 2010, but the investigation report was not forwarded to the centre's complaints co-ordinator until April 2010. This had caused delay in the implementation of the report's recommendations and unnecessary anxiety for the officers who were the subject of the complaint. In addition to individual reports and recommendations from the PSU, UKBA's detention services customer complaints unit sent a monthly log of all complaints received in relation to the centre. The log recorded timelines of the response, the nature of the complaint, the outcome and brief comments about the case. Complaints responded to by G4S were polite and timely, and addressed the issues raised.

Services

2.161 A full range of meat products, including halal and non-halal meat, should be available. (9.9)

Achieved. The menu contained lamb, chicken and pork dishes. Complaints from Chinese detainees had led to a consultation and an agreement that pork would be included. Pork was served from a serving area separate to the halal options to reflect the sensitivities of Muslim detainees.

2.162 More work should be done with detainees to identify the reasons for the high levels of dissatisfaction with the food, and action taken to address these issues. (9.10)

Achieved. Monthly food consultation meetings were open to detainees, but they did not attend consistently. The complaints book was reviewed at each meeting and we saw evidence of action taken in response to complaints. Meetings were held with specific groups of detainees about their cultural needs.

2.163 There should be designated utensils for the preparation and serving of halal food. (9.11)

Partially achieved. There were no separate utensils for the preparation and serving of halal food. The catering manager had discussed this with the Muslim chaplain who was satisfied that utensils were being cleaned sufficiently to be used for both halal and non-halal preparation and serving of food.

2.164 The range of products available in the shop should be increased to meet the needs of detainees. (9.12)

Achieved. The range of products available in the shop had increased since the previous inspection. There were cosmetic products for black and minority ethnic detainees and some new food products. The shop manager added items to the list in response to detainee requests and monitored how well they sold.

2.165 Detainees should have the opportunity to purchase items from catalogues. (9.13)

Partially achieved. There was no formal system for detainees to purchase items from catalogues because the shop provider was not contracted to provide the service. There were catalogues in the centre and, if detainees wished to obtain an item, shop staff tried to facilitate the purchase.

Additional information

2.166 Meals were served at appropriate times in a communal dining area: breakfast until 8.30am, lunch until 1.30pm and tea until 6.30pm. Detainees were provided with a biscuit and soup at teatime to provide a night-time snack. Detainees complained that they were not otherwise permitted to have food in residential areas, which made informal fasting impossible.

2.167 The menu was on a four-week cycle and met a wide range of dietary requirements. Food we tasted was palatable and well prepared. Two comments books were available in the dining hall and they were considered at the monthly catering committee meeting.

2.168 Kitchen staff were trained in hygiene and catering, but no detainees were employed in food preparation. Detainees were employed in the servery and received basic instruction in hygiene. All those working with food wore appropriate clothing.

2.169 The storage and preparation areas were of a good standard. The kitchen had received a five star award in a recent audit and their environmental health inspection was up to date. Space for keeping halal food separately was limited and compromises had had to be made with frozen food, but these had been approved by the Muslim chaplain.

2.170 The shop was open every morning from 8.45 to 11.45am and in the afternoon from 2.30 to 4.30pm. A range of 160 items was stocked and this was kept under review in response to detainee requests. Only a limited range of food items was available because there were no storage facilities for perishable items in the residential areas.

Preparation for release

2.171 Visitors should be able to purchase a range of refreshments during visits. (10.14)

Partially achieved. There were vending machines selling drinks, crisps and chocolate in the waiting area and the visits hall, but nothing more substantial was available.

2.172 Visits capacity should be increased in order to meet demand. (10.15)

Not achieved. There was still only space for eight detainees and their visitors. However, the visits room was not full during our inspection and visitors telephoning to book a visit were offered one the following day.

2.173 Problems associated with the visits booking line should be remedied. (10.16)

Partially achieved. Evidence was mixed on the booking of visits. When we telephoned the booking line, it was busy for an entire morning. The telephone in reception was not answered on two occasions, but was on the third. Visitors told us that they had been able to book easily by telephone or email. Those who had booked by telephone reported that staff were courteous and informative.

2.174 Detainees should be able to purchase mobile telephones and top-up cards from the shop. (10.17)

Partially achieved. Top-up cards for mobile telephones covering a wide range of networks were available for purchase. The shop also sold telephone cards which could be used on the house block telephones. Mobile phones were not available for purchase. The Oakington visitors group had been in discussion with the centre to set up the system used in other establishments for detainees to purchase mobile phones on arrival, but this had not been approved by the centre manager.

2.175 People being transferred or removed should not routinely be taken to the detainee departure unit. (10.18)

Not achieved. All detainees being transferred or removed were taken to the detainee departure unit, which was justified by the centre as avoiding disturbance of detainees in the dormitories. This did not explain why detainees who were being moved during the night were taken to the unit in the afternoon. We were told that they often waited several hours in the unit for transport.

2.176 People being transferred should receive adequate notice and explanation of where they are going, with the opportunity to contact someone to pass on the change of address. (10.19)

Not achieved. Detainees were not informed of an intended transfer until the centre was sure that transport was on the way. This usually gave less than two hours' notice. We saw the consequences of this when a legal representative travelled from Birmingham to visit a detainee who had moved that morning and volunteer visitors arrived to find that the person they were visiting had been transferred or removed. Information given to detainees about where they were going and why was inadequate.

Additional information

2.177 The advice and support staff were responsible for induction and explained the services available to detainees. These included locating property, liaison with families, advice on legal representation and referral to specialist advice services. Important welfare services were also provided by the religious affairs team, including recovering detainees' property, providing clothing and financial support.

2.178 Visits were available every day in three sessions. A bus operated from Cambridge station to bring visitors to the centre. Visitors were booked in and searched at a waiting area near the gate. Lockers were provided for their personal possessions which could not be taken in to the visits room. Staff ensured that searching was conducted in a manner which was sensitive to religious and cultural standards. Visitors told us that staff were welcoming and respectful. The visits hall was too small for the number of tables so there was little privacy for detainees and their visitors if the room was near capacity. There were no facilities for children except a limited number of toys.

2.179 The voluntary visitors' scheme was advertised around the centre on posters, and detainees were informed of the service by the religious affairs team. There was no information about the volunteer visitors in the printed induction information provided to detainees. We were told that the voluntary visitors group's conversations with detainees had been overheard by staff and reported to managers, which was unacceptable.

2.180 Detainees were allowed mobile phones with no camera facility. There were four telephones on each house block which accepted cash or cards and received incoming calls. There was an internet facility which detainees could use for email correspondence. There were fax machines for detainees' use in the library and the advice and support offices. Detainees were allowed as many free letters as they wished.

2.181 There was no pre-removal or transfer interview to check if the detainee's affairs were in order. We were told of examples of detainees who had not had the chance to recover all their property and of welfare staff who had been unaware of the transfer of a detainee with whom they were working.

2.182 A store of clothing was available in the DDU for those being removed without adequate clothing of their own. Detainees were provided with a bag for their belongings and holdalls were available for purchase in the centre shop.

Appendix I: Inspection team

Martin Kettle	Team leader
Colin Carroll	Inspector
Gordon Riach	Inspector
Andrew Rooke	Inspector
Nicola Rabjohns	Health services inspector
Sheila Willis	Ofsted inspector

Appendix II: Detainee population profile*

(i) Age	No. of men	%
Under 1 year	0	
1 to 6 years	0	
7 to 11 years	0	
12 to 16 years	0	
16 to 17 years	0	
18 years to 21 years	39	10
22 years to 29 years	154	40
30 years to 39 years	132	34
40 years to 49 years	51	13
50 years to 59 years	8	2
60 years to 69 years	1	1
70 or over	0	
Total	385	100

(ii) Nationality	No. of men	%
Afghanistan	28	
Albania	9	
Algeria	7	
Angola	0	
Bangladesh	31	
Bhutan	1	
Bolivia	1	
Brazil	4	
British Overseas Citizen	1	
Cameroon	2	
China	37	
Cote Dinore	0	
Congo	1	
Congo (Democratic Republic)	2	
Ecuador	1	
Egypt	2	
Eritrea	17	
Ethiopia	1	
France	1	
Gambia	2	
Guatemala	0	
Guinea	1	
Ghana	6	
India	32	
Indonesia	1	
Iraq	8	
Iran	6	

* Percentages have been rounded up and may not always total 100%.

Jamaica	3	
Kenya	3	
Kosovo	4	
Kyrgyzstan	1	
Lebanon	0	
Liberia	1	
Libya	2	
Macedonia	1	
Malaysia	4	
Mauritius	2	
Mexico	0	
Mongolia	1	
Morocco	1	
Namibia	0	
Nepal	1	
Niger	1	
Nigeria	35	
Pakistan	30	
Palestine	1	
Russia	1	
South Africa	1	
South Korea	0	
Sierra Leone	0	
Sri Lanka	22	
Senegal	1	
Somalia	4	
Sudan	15	
Tanzania	1	
Turkey	5	
Uganda	6	
Ukraine	2	
Vietnam	15	
Western Sahara	1	
Yugoslavia	1	
Yugoslavia (Former Republic)	1	
Zambia	1	
Total	370	100

(iii) Religion/belief	No. of men	%
Buddhist	8	
Roman Catholic	15	
Orthodox	1	
Other Christian religion	70	
Hindu	31	
Islam	3	
Muslim	167	
Sikh	15	
Agnostic/atheist	0	

Unknown	18	
Other (please state what):		
Falun Gong	2	
Lutheran	0	
None	33	
Pentecostal	1	
Rasta	0	
Jehovah's Witness	0	
Total	364	100

(iv) Length of time in detention in this centre	No. of men	%
Less than a week	99	
1 to 2 weeks	64	
2 to 4 weeks	55	
1 to 2 months	111	
2 to 4 months	30	
4 to 6 months	3	
6 to 8 months	3	
8 to 10 months	1	
More than 10 months (please note the longest length of time)	07/10/09	
Total	366	100

(v) Detainees' last location before detention in this centre	No. of men	%
Community	0	
Another IRC	44	
A short term holding facility (e.g. at a port or reporting centre)	188	
Police station	116	
Prison	4	
Total	352	100