Report on an unannounced short follow-up inspection of

Dungavel Immigration Removal Centre

30 September – 2 October 2008

by HM Chief Inspector of Prisons

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Contents

Introduction

Dungavel Immigration Removal Centre (IRC) has always received good inspection reports: indeed, at the last inspection, we described it as the best IRC we had inspected. Since that inspection, the centre has continued to hold children and women, as well as the majority male population. That male population is now more challenging and complex, as the proportion of ex-prisoners and their length of stay has increased considerably.

It is therefore commendable that Dungavel has not slipped back against any of our previous assessments. It continues to be an extremely respectful place, where good relationships between staff and detainees underpin a generally safe environment. A wide range of activities is available for detainees, now supplemented by controlled internet access and some opportunity for paid work. Welfare support, provided by a committed officer, is admirable, with exemplary efforts to resolve the chronic inability of the system to ensure that detainees can be reunited with their property.

There were, however, some issues that needed attention, some of which we raised at the time of the last inspection. Handcuffing of detainees outside the centre for court or medical appointments, despite alleged risk assessment, effectively remained routine. The approach of the UK Border Agency to assertions that detainees were unfit for detention was inadequate, and indeed centre staff needed more training to recognise signs of previous trauma. More assistance was needed to ensure that the centre could meet its responsibilities under diversity legislation.

Above all, the length of detention, and the changed population, appeared to have increased the number and seriousness of incidents and assaults. Though the centre was handling this well, it pointed to the increased insecurity and frustration of many of the detainees. On-site staff were making considerable efforts to follow up casework, and the centre had been proactive in trying to involve local legal advisers. The centre also needed to review activities, particularly work opportunities, to ensure that they provided sufficiently well for a longer-staying population.

The provision for children at Dungavel had continued to improve, and child protection arrangements would be enhanced by the proposed appointment of a social worker. However, the detention of children in itself is a cause for concern, and, in spite of efforts by centre staff, there was still little evidence that children's welfare was taken into account before a decision to detain, nor was it independently reviewed immediately after detention. Now that the UK has indicated it will remove the immigration reservation to the International Convention on the Rights of the Child, the whole of policy and practice on detention of children needs to be reviewed.

This is once again a good report on a centre that is still succeeding, within a more challenging environment, in providing safe, decent and positive conditions for the wide range of detainees it holds. Many of the issues we raise are matters for the UK Border Agency to address, though centre managers will need to remain alert to the consequences of a changing population. However, the positive approach of staff and the good relationships with detainees provide a good foundation for responding to those challenges.

Anne Owers — December 2008
HM Chief Inspector of Prisons

Fact page

Contractor
G4S

Task of the establishment
Detain single males, single females and families on behalf of the UK Border Agency.

Brief history
The centre became operational in 2001. G4S took over the contract from Serco in Sept 2006. The centre has expanded its operational capacity from 74 to 190 since 2001.

Certified normal accommodation
190 + two cots

Operational capacity
190 + two cots

Number held
171

Last full inspection
4-8 December 2006

Description of residential units
Main house - male accommodation: dormitory style
Main house - female accommodation: dormitory style
Hamilton House - male accommodation: single and double rooms
Loudoun House - male accommodation: two, three and four person rooms
Clyde House - family accommodation: two rooms

Section 1: Healthy establishment summary

Introduction

HE.1 All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison 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
Resettlement	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 UK Border Agency.

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

...performing reasonably well 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.

...not performing sufficiently well 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.

...performing poorly against this healthy prison 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 conclude 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, Dungavel was performing reasonably well in this healthy establishment test. At this inspection, 13 recommendations, including one main recommendation, were fully achieved, nine, including three main recommendations, were partially achieved and 12, including six main recommendations, were not achieved. We have made 12 further recommendations.

HE.5 Fewer detainees appeared to be subject to frequent and lengthy journeys around the detention estate, but some reported being moved with little notice, explanation or regard for personal circumstances. Those transferred from Northern Ireland described difficult journeys, including time in a police station and routine use of handcuffs on boarding and disembarking the ferry. It was not unusual for people to arrive late and tired, but they reported a friendly welcome on reception to Dungavel. The reception area remained cramped and was unsuitable for large numbers of detainees arriving at the same time, some of whom reported long waits there.

HE.6 The number of former prisoners had increased substantially, but this had not led to a noticeable change in the culture. Positive relationships still appeared to underpin dynamic security, although, unusually for Dungavel, there had been some serious assaults in recent months.

HE.7 Use of force paperwork was completed adequately. A recording of a planned removal showed one poorly managed incident, which had led to some training needs being identified by managers.

HE.8 The two temporary confinement cells were little used, but were stark and had no integral sanitation, making them particularly unsuitable for extended periods of separation. After a recent incident, two detainees had inappropriately been placed there for over 34 hours despite becoming compliant after a few hours. Removal from association was used appropriately, but the rooms were still unfurnished. Detainees received written reasons for separation in a language they could understand and were visited daily by representatives of various departments.

HE.9 The physical conditions and facilities for children remained good. Centre statistics suggested that children were detained in broadly similar numbers to those seen at the previous inspection. Over the previous year, seven children had been held for over a week without an independent welfare assessment being carried out. The quality of advance information relating to children and families had improved over the previous 18 months and had led to some instances of children not being admitted because it was clearly against their best interests.

HE.10 The recording of child protection cases had improved and information was now held in a central log. There were clear procedures for dealing with child protection referrals, but there had been a lack of continuity in the post of child protection coordinator. The proposed appointment of an on-site qualified social worker was likely to strengthen overall child protection arrangements.

HE.11 A safer detention committee oversaw both suicide and self-harm prevention and anti-bullying issues. Meetings were held monthly, but neither representatives from the UK Border Agency (UKBA) nor detainees attended regularly. There were few incidents of self-harm and the assessment, care in detention and teamwork (ACDT) system had been implemented since the last inspection. There were some poor entries in the documentation, but detainees appeared to receive a good level of support.

HE.12 There had been some tensions between detainees of different nationalities and these had been adequately managed. There was little evidence of bullying and no detainees had been subject to anti-bullying measures in the previous six months.

HE.13 The lack of competent specialist legal advisers across the detention estate was aggravated at Dungavel by the fact that detainees from England lost their advisers when they crossed the border. However, the centre had made considerable efforts to encourage Scottish lawyers to visit Dungavel and had improved facilities to encourage legal visits.

HE.14 Detainees at our group interviews expressed considerable frustration with prolonged detention. The average stay had increased significantly, particularly for the majority population of former prisoners, who now averaged 79 days in detention. Monthly detention reviews were usually sent, but their content was not always up to date or adequately explained by the caseholder. Rule 35 letters were now copied to detainees, but caseholder responses remained variable, not all received a response and responses often failed to address the central issue of fitness to detain. However, on-site staff diligently followed up casework and put in place quality checks.

HE.15 On the basis of this short follow-up inspection, Dungavel was still performing reasonably well against this healthy establishment test.

Respect

HE.16 At the last inspection, Dungavel was performing well in this healthy establishment test. At this inspection, 20 recommendations were fully achieved, four were partially achieved and seven were not achieved. We have made 10 further recommendations.

HE.17 The standard of accommodation was good and living areas remained clean and tidy. All residential areas were well decorated and furnished, with particular improvements made to the living conditions for women. Better management of the smoking rooms and improved ventilation in some areas had helped to ensure better air quality in the units. An attractive café had been created next to the centre shop.

HE.18 Staff continued to treat detainees with respect. Although detainees were frustrated and anxious as a result of lengthy periods of detention, staff-detainee relationships generally appeared good. However, insufficient efforts were made to communicate with detainees who spoke little or no English.

HE.19 Race relations meetings were a useful forum for exchanging information with detainees, who reported few concerns about racism or diversity issues. However, the meetings still did not provide adequate strategic oversight. Monitoring remained limited and diversity impact assessments were incomplete and lacking in evidence and information. Few racist incident reports were submitted, but interview statements were now taken during investigations. There was still no broader diversity policy that included consideration of the specific needs of women and people with disabilities.

HE.20 Faith provision remained good, although visiting chaplains were inappropriately prevented from visiting detainees in parts of the centre outside the multi-faith areas.

HE.21 Nearly all detainees were on the enhanced level of the incentives and earned privileges scheme, but some changes were needed to the policy to ensure that it reflected and guided practice. Some sanctions relating to telephone and email access had the potential to restrict contact with family or legal advisers, although in practice staff appeared to take a flexible approach, with due regard to the need for detainees to maintain communication. Multi-lingual complaint forms were freely available.

HE.22 The standard of food was reasonable and access to the much appreciated cultural kitchen had been extended. Women were offered a dedicated slot and could also dine in their own unit. The range of products in the shop had been significantly extended and now included tins. A number of goods were sold at supermarket prices.

HE.23 There had been no health needs assessment, but healthcare provision was generally good. Healthcare staff made appropriate use of professional telephone and face-to-face interpreters. Most detainees taking regular medication had it in their possession. There was little evidence of substance use, but symptomatic relief was available to assist detoxification, as was maintenance prescribing once prescriptions had been verified. Individual risk assessments were now undertaken before medical visits outside the centre, but use of handcuffs still appeared to be high, requiring careful monitoring and further examination by managers.

HE.24 On the basis of this short follow-up inspection, Dungavel was still performing well against this healthy establishment test.

Activities

HE.25 At the last inspection, Dungavel was performing reasonably well in this healthy establishment test. At this inspection, the single recommendation was achieved. We have made one further recommendation.

HE.26 A good range of recreational activities was available. Detainees had good supervised access to the internet and email through 20 computers in the learning resource centre, a positive and much appreciated development. A further two computers were also available in the visits area.

HE.27 There were 16 work places and funding for a further seven places had just been agreed.

HE.28 The learning resource centre remained an attractive, welcoming and well used facility. A full-time English teacher provided individual tuition to meet the needs of detainees at different levels and Dungavel had just become an approved centre for the delivery of certificated literacy and numeracy courses. Arts and crafts provision remained good and the quality of detainees' work was reflected in the high number of Koestler Trust awards obtained.

HE.29 The gym was small, but had a good range of equipment. It was well used and offered dedicated time for female detainees. A new all-weather sports pitch was well used and an ongoing football tournament was particularly appreciated by detainees.

HE.30 On the basis of this short follow-up inspection, Dungavel was still performing reasonably well against this healthy establishment test.

Preparation for release

HE.31 At the last inspection, Dungavel was performing reasonably well in this healthy establishment test. At this inspection, three recommendations, including one main recommendation, were fully achieved and one recommendation was partially achieved.

HE.32 The welfare officer continued to provide valuable and appreciated support to detainees with problems, including after they left Dungavel. In some cases, this continued even when they had been removed from the country. About two-thirds of his cases related to problems detainees had with obtaining their property.

HE.33 Detainees could borrow mobile telephones for the duration of their stay. The internet suite was open seven days a week and allowed detainees to maintain contact with families by email and to obtain information about home countries. Meals were now offered to visitors.

HE.34 On the basis of this short follow-up inspection, Dungavel was still performing reasonably well 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

To the Director General, IND (now the Chief Executive, UK Border Agency)

2.1 Detainees should not be subjected to excessive moves around the detention estate. (HE.40)
Partially achieved. There was not the same frequency of movement as previously. In some cases, transport from Dungavel in Scotland to an immigration removal centre (IRC) near London and back again within a couple of days was explicable, even though uncomfortable for the detainee. Many detainees still said they had been given notice only on the day of the transfer with no reason given. This included a group of new arrivals from Yarl's Wood IRC in Bedfordshire who had relatives, friends and legal representatives in the south and were worried that the transfer to Scotland would make visits very difficult.

Further recommendation

2.2 Detainees should be given adequate notice of planned transfers.

2.3 Immigration detainees should not be held for protracted periods in police cells, which are unsuitable for overnight detention. (HE.41)
Not achieved. It was difficult to identify how many police station detainees passed through Dungavel over a period of time or the duration of detention. Most of those we came across were from Northern Ireland, where they were usually temporarily lodged in police cells as there was no immigration detention facility. Staff said the number arriving from Northern Ireland had reduced. Files included one detainee who had been held at more than one police station over a total of four days before arriving at Dungavel.
We repeat the recommendation.

2.4 Independent specialist legal advice should be available to all detainees at all places of detention from the time they are detained. (HE.42)
Not achieved. Detainees held in police stations continued to have difficulty getting specialist immigration legal advice. Duty solicitors practising criminal law usually knew little about immigration law and procedure. Detainees from England who had legal advisers often lost them when they were moved across the border to Dungavel as Scotland has different legal and legal aid systems from England and Wales or Northern Ireland (see also section on legal rights).
We repeat the recommendation.

2.5 The detention of children should be exceptional and for the shortest possible period, and the interests of the child should be fully considered and documented before detention is authorised. (HE 45)
Not achieved. Records showed that the number of children held and the length of time they remained in detention were little changed. Better quality advance information was now received, which allowed some marginal improvement (see section on childcare and child protection).
We repeat the recommendation.

2.6 Independent welfare checks should be carried out on all children detained for longer than seven days, and the results should be passed on to the immigration authorities immediately to inform reviews of detention. (HE 46)
Not achieved. Records indicated that in the previous 12 months, seven children had been held for over seven days. Independent welfare checks had not been carried out in any of these cases.
We repeat the recommendation.

2.7 IND officials responsible for reviewing continued detention of children should always take full account of independent assessment information. This should be recorded and, if detention is maintained, the reasoned review should be notified to those with parental responsibility. (HE.47)
Not achieved. Independent welfare assessments were not usually conducted at the initial stages of detention, which is when families with children passed through Dungavel (see paragraph 2.6).
We repeat the recommendation.

2.8 Detainee casework should be progressed speedily and information conveyed to detainees regularly and in good time. (HE.48)
Partially achieved. The Dungavel immigration team had established a good system to ensure detainees received reviews of detention, due at least monthly or following a change of circumstances. Dates of issue were noted prominently on the front of each file, making it easier to spot overdue reports. The team trawled through all files every month and chased up late reviews. As a result, few were missing. Dungavel immigration staff also made sure they automatically saw all detainees at least once a month and used a telephone interpreting service when necessary. Reviews were issued in English.

2.9 The team consisted of a manager, a deputy and 4.5 administrative officer posts. As well as seeing all new arrivals, usually within a day, they responded to inquiries. They served all documents, including monthly reviews, personally to ensure the recipients understood them. The content was often repetitive owing to limited change in circumstances and this led to some frustration. The population had changed since the last inspection, when the average stay was 18 days and a quarter of detainees were former prisoners. Now, more than two-thirds of detainees were former prisoners and detention was prolonged, often because they remained detained throughout legal proceedings relevant to their immigration status. The average stay for former prisoners was 79 days and for other detainees 23 days. Ten had been detained for more than a year.

2.10 Some long-term cases involved mental health issues. One man, already detained for 19 months, had been hospitalised part of the time. In the previous year, it had been suggested that he was not fit for detention in the IRC and doubts were raised about his fitness to fly. Anticipating his release, Dungavel healthcare and welfare staff had gone to considerable effort to set up accommodation and community mental healthcare support. However, following his return from hospital, the UK Border Agency (UKBA) issued release papers only to withdraw them. There was no reasoned explanation for this on the file and no explanation had been given to the detainee. Apart from the impact on the detainee, correct procedures had not been followed. His monthly review made no mention and we could not see a response to the detainee's own inquiry.
We repeat the recommendation.

2.11 Detainees should have access to email facilities and the internet. (HE.49)
Achieved. Twenty internet terminals had been installed in a room in the education corridor. A detailed user protocol was displayed. The room was supervised and staff offered help to those

who did not know how to set up an email account. The European community driving licence basic accredited programme was available. The facility was open every day from 9am to 9pm. People could book or simply turn up. Detainees collected any printed documents from a nearby room at fixed times during the day. Another two internet terminals were available for detainee use in the visits area. Non-internet computers were also provided in a separate room in the education department.

Main recommendations

To the centre manager

2.12 There should be a strategic approach to safety that covers anti-bullying and suicide and self-harm prevention, with one committee chaired by a senior manager. It should have representation from centre and IND staff, as well as detainees and should specifically address the impact on detainees of indefinite detention. (HE.43)
Partially achieved. A single Safe in Dungavel committee was responsible for suicide and self-harm and anti-bullying. It was chaired by the deputy director and met monthly, but attendance was usually limited to centre staff, managers and healthcare staff. Local UKBA staff were members, but had attended only one meeting to date in 2008. There was no system to identify and appoint detainee representatives to the committee and, although the policy stated that they would be invited to the meeting quarterly, they had been present only at the meeting in January 2008. There was no input from the Independent Monitoring Board or voluntary or community groups. The committee did not specifically address the impact of indefinite detention on detainees.

Further recommendations

2.13 Local UKBA representatives should attend the Safe in Dungavel committee meetings.

2.14 There should be a system to identify and appoint suitable detainee suicide and self-harm and anti-bullying representatives.

2.15 Membership of the Safe in Dungavel committee should be multidisciplinary.

2.16 Recommendations and action plans from self-inflicted death investigations should be monitored and periodically reviewed, to ensure that appropriate changes are made and sustained. (HE.44)
Achieved. The action plan arising from the investigation into the death of a detainee in 2004 had been completed and reviewed. The recommendations involving changes of procedures had been implemented and incorporated into director's rules, which were monitored.

Recommendations

To the Director General, IND (now the Chief Executive, UK Border Agency)

Arrival in detention

2.17 IND should make arrangements with the police to ensure that police custody records are attached to their detention authority record and their property sheets checked with them before they leave. (1.18)
Partially achieved. Reception staff said detainees arriving from police stations now usually had a police summary document with their property bag, although this was not always the case.
We repeat the recommendation.

2.18 Detainees under escort should be handcuffed only following individual risk assessment, which takes into account the views of health professionals, and which is subject to supervision and monitoring. (1.19)
Not achieved. Most non-medical escorts were undertaken by escort contractors rather than centre staff. Risk assessments were carried out and information was passed to escorts, including where relevant a letter from healthcare staff stating their concerns about a detainee being handcuffed. We were told that handcuffs were not applied to detainees leaving the centre when contractors used cellular vehicles. The centre did not record how many detainees were handcuffed on arrival at their destination. A video court had been set up in the centre to hear bail applications and fewer detainees now travelled to the hearing centre in Glasgow. A few still had to attend hearings and one detainee described being told on arrival at the court that he would have to be handcuffed. Escort staff had apologised, but he had been handcuffed between the vehicle and the waiting room, including through the car park and public areas of the building. Handcuffs had been reapplied after his hearing and removed only when he was back in the secure vehicle.
We repeat the recommendation.

Additional information

2.19 In the previous three months, 500 people had arrived and a similar number had left, including those going out for a medical or court appointment. Vans often arrived in the late afternoon and evening at the end of a long journey. We saw escort vehicles, each with a few passengers, arriving at the same time. The reception was too small to cope with these numbers, particularly as many detainees arrived from prisons with large bags of accumulated property. Staff interviewed each new arrival individually, but the large number of other detainees overspilling from the holding room, milling around the door and calling out questions made it difficult to maintain privacy when asking sensitive questions.

Further recommendation

2.20 New arrivals should be interviewed in private.

Legal rights

Additional information

2.21 Getting legal advice was one of the main issues brought to the Dungavel welfare officer by detainees (see repeated recommendation at paragraph 2.4). Some lost advisers on transfer; others no longer had money to pay them. From a sample of detainee account balances, 70% had less than £50 and 37% had less than £5. Some had just the 71 pence daily allowance granted by the centre. In response to demand, the centre had written letters to solicitors across Scotland seeking support for detainees. Efforts had also been made to make it easier for advisers and they could now spend the day at Dungavel, seeing more than one detainee and receiving a free cooked lunch from the kitchen. They could bring mobiles and laptops to keep in touch with their offices and get on with other work during the lunch break between legal visits. Solicitors we spoke to said centre staff were very helpful. The number of legal visits had increased significantly and, if maintained, the centre was likely to need to increase the number of legal visits cubicles. Currently, tables were allocated in the corners of the general visits hall. Legal visits were available seven days a week, but most advisers came on weekdays.

Casework

2.22 IND caseholders should review cases and respond in writing to concerns raised about fitness to detain under rule 35 of the Detention Centre Rules, and the healthcare department and the individual detainee should be notified. (4.8)
Partially achieved. Healthcare issued rule 35 notifications on a pro forma that included a note of any evidence observed or reported. With the detainee's consent, these were forwarded to on-site immigration staff for transmission to the external UKBA caseholder. The caseholder was then to review detention and respond within a few days, with a copy to the detainee and healthcare. Most of the 36 such notifications issued in the previous three months had been responded to, but often only after prompting by the on-site immigration team.

2.23 The on-site team also tried to improve the quality of responses, sometimes returning those that failed to address fitness to maintain detention. However, the overall level of understanding of the purpose of rule 35 among caseholders remained low and the reports of centre medical staff were not addressed. One response stated 'There is no evidence to substantiate your claim of torture', which ignored healthcare's description of scarring on the head, torso, thigh and leg, and justified detention on the basis of 'lack of candour regarding your actual journey to the UK', which had no obvious connection with the rule 35 question. In some, standard pro forma reasons from monthly detention reviews, such as lack of close ties to the UK, appeared to have been pasted in without focus on the purpose of rule 35, which is that detention can be damaging to health (see also paragraph 2.36).

Further recommendation

2.24 UKBA caseholders should review and respond to rule 35 letters in line with the purpose of that rule, addressing whether detention, particularly prolonged detention, could be injurious to mental or physical health in light of available evidence including medical opinion.

Preparation for release

2.25 IND caseholders should take individual detainees' circumstances, including the location of family and legal support, into account before they are moved. (10.15)
Partially achieved. Little account appeared to be taken of personal circumstances when people were transferred to Dungavel from another IRC. Detainees could make a reasoned application to transfer and were helped to do so by on-site immigration staff, who followed up such requests. Success was unlikely in the short term, because the immigration estate was close to capacity, but some people had eventually transferred when spaces became available.
We repeat the recommendation.

Recommendations

To the centre manager

Arrival in detention

2.26 All new arrivals should be offered a free telephone call in private. (1.20)
Achieved. Both the main and family receptions offered new arrivals a free telephone call to anywhere in the world. Detainees used a cordless telephone, which meant they could move away from the reception desk. Staff in the main reception sometimes allowed detainees to use the healthcare room if it was empty, which was more private. Detainees who could not make

the call on arrival, such as those who arrived late, were offered the call on the accommodation unit the next day.

Environment and relationships

2.27 All dormitory accommodation should have adequate space, ventilation and natural light for the number of occupants. (2.15)
Partially achieved. Some of the bedrooms remained cramped and not all had natural light. Ventilation had been improved and the bedrooms were not so stuffy.
We repeat the recommendation.

2.28 The accommodation for women should be upgraded so that it is suitable for long-stay individuals. (2.16)
Achieved. The facilities for women had improved considerably and were more comfortable. The bedrooms had been redecorated and equipped with good quality furniture.

2.29 Smoking rooms should be properly ventilated and smoke should not penetrate into living areas. (2.17)
Achieved. All smoking rooms were now properly ventilated and cigarette smoke no longer permeated the living areas.

2.30 The heating system in the main building should be modified so that the temperature can be regulated. (2.18)
Achieved. The heating system had been modified on 17 September.

2.31 Detainees should not be deprived of access to small electrical equipment because of delays in conducting electrical safety checks. (2.19)
Achieved. Detainees were allowed to keep small items of electrical equipment, and a log is kept in reception to ensure no unnecessary delays in portable appliance testing.

Additional information

2.32 Despite the constraints of an old building, best use was made of what was available and efforts were made to make further improvement. Plasma multi-channel televisions had been introduced, under-bed storage had been provided and there were leather couches and comfortable chairs in bedrooms.

Staff-detainee relationships

Additional information

2.33 The average stay had increased significantly and had been matched by increased levels of frustration. The behaviour of a few detainees had become more challenging, but staff remained positive and respectful, which in turn encouraged positive responses from detainees and minimised instability and disruption. However, more could have been done to communicate with detainees who spoke little or no English. A session facilitated by an interpreter had recently been convened with Chinese detainees following disagreements and tension between them and other groups, but such sessions were not routine.

Further recommendation

2.34 Group interviews assisted by professional interpreters should systematically be conducted with groups of detainees who speak little English to ensure that emerging concerns can be identified quickly and addressed.

Casework

2.35 Detainees should receive reasoned written reviews of their detention, at least monthly, in a language they understand, explaining fully any progress in their case. (4.7)
Partially achieved. See paragraph 2.8.

2.36 The centre should maintain a central log of communications issued under rule 35 of the Detention Centre Rules. (4.9)
Achieved. Healthcare kept a central folder of the letters issued and replies received from the UKBA caseholder, and put a copy on the detainee's file. The on-site immigration team kept a list of when letters were sent and received, and reminded the caseholder if no reply was received within a few days (see also paragraph 2.22).

Bullying and suicide and self-harm

2.37 There should be regular surveys of detainees' experiences and perceptions of safety, including an analysis of exit surveys. (5.26)
Partially achieved. The centre had conducted an exit survey and the findings had been considered, but no specific consultation had been completed.

Further recommendation

2.38 There should be regular surveys of detainees' experiences and perceptions of safety.

2.39 The counsellor or other appropriate staff should summarise the underlying reasons why detainees feel at risk and report this analysis to the at-risk strategy meeting to inform policy development. (5.27)
Not achieved. While counsellors attended at-risk meetings, the minutes indicated little discussion of detainee perceptions about safety either generally or in specific cases.
We repeat the recommendation.

2.40 Immigration staff should be invited to and attend all reviews of detainees at risk, and provide information about the progress of their immigration cases. (5.28)
Not achieved. The centre had introduced the assessment, care in detention and teamwork (ACDT) plan for the management of detainees at risk of self-harm or suicide. No detainees were on ACDTs and only three who had been on one were still at the centre, so only three documents were available for inspection. Immigration staff had not attended any of the reviews.
We repeat the recommendation.

2.41 Self-harm at-risk forms should accompany detainees whenever they are transferred from the centre. (5.29)
Achieved. Open ACDT plans accompanied detainees on transfer and were passed to escort staff. Closed ACDTs were placed on detainee records that also accompanied them on transfer.

2.42 When an at-risk form is closed following a detainee's release, staff should document the reason for closure and note the community support organisations to which information has been passed. (5.30)
Achieved. Although we were unable to examine any examples, there was a policy to ensure that healthcare staff contacted community support organisations, particularly GPs, when detainees on ACDTs were released.

2.43 A peer support scheme should be developed and evaluated. (5.31)
Not achieved. There was no formal peer support scheme. Staff occasionally used detainees to act as buddies for new arrivals or those they thought would benefit from additional support, but these buddies were not vetted by the security department and had not been trained. The reason given at our previous inspection was that detainees were not at Dungavel long enough to complete the training, but the length of stay had since increased substantially (see paragraph 2.9).
We repeat the recommendation.

2.44 An appropriate care suite should be provided to help monitor detainees at risk and this should replace use of the separation unit. In the meantime, the at-risk strategy meeting should monitor cases of detainees held there as a supportive measure. (5.32)
Not achieved. There was no care suite and detainees requiring high-level monitoring on an ACDT were still held in the separation unit. Such use of the separation unit was monitored by the Safe in Dungavel committee, but it remained an unsuitable environment for detainees at risk.
We repeat the recommendation.

2.45 The policy on managing detainees at risk of self-harm should be revised to include current good practice, such as the involvement of healthcare staff when detainees are issued with removal directions. (5.33)
Achieved. The procedure to be followed when a detainee was given removal directions was set out in a director's rule on the management of detainees at risk of self-harm or suicide. A protocol was also in place between on-site immigration staff and the healthcare provider, but was vague and, unlike the director's rule, did not ensure that all detainees served with removal directions were invited and encouraged to see a member of healthcare staff. Fortunately, staff followed the procedure set out in the director's rule rather than the protocol.

Further recommendation

2.46 The protocol for the assessment of detainees following removal directions should be revised to reflect the procedure set out in the director's rule.

2.47 Entries in open at-risk forms should show evidence that detainees have been spoken to, and managers should comment about the quality of entries. (5.34)
Achieved. ACDTs indicated that detainees generally received a good level of support. This was reflected in the assessments and reviews, although some entries in the ongoing record were of poor quality. Managers and the ACDT coordinator carried out regular quality checks and deficiencies were discussed at the Safe in Dungavel committee meetings. All three detainees who had previously been on an ACDT had been placed on one as a result of anxieties and acts of self-harm triggered by worries about their detention and possible removal. They said detainee custody officers and healthcare staff had been supportive, but that there was little they could do directly to resolve concerns about immigration status.

Additional information

2.48 Managers said levels of violence had increased since our last inspection. There had been 22 incidents involving 57 detainees to date in 2008 compared to 30 incidents involving 60 detainees in the whole of 2007. While the number of incidents had not increased significantly, the seriousness in terms of the numbers involved and injuries suffered by detainees and staff had increased. Forty of the detainees involved in 2008 were former prisoners and more detainees were held in the centre, but it was difficult to say with any certainty whether either factor was behind the increase. Some incidents had involved fights between groups of detainees of different nationalities, cultures and racial groups. Managers had identified these issues and had conducted focus groups and mediation in an effort to tackle them.

2.49 Despite the increased level of violence, there was no evidence that bullying was a significant problem. Detainees did not report concerns about bullying and no detainee had been placed on anti-bullying measures in the previous six months. A safer detention committee, Safe in Dungavel, was responsible for strategy, policy and monitoring of self-harm and bullying issues, but did not cover the wider issues of violence in the centre characterised by fights and assaults.

Further recommendations

2.50 The centre should analyse the causes of the increased incidence of fights and assaults.

2.51 The Safe in Dungavel committee should include violence reduction as part of its aims and strategy.

Childcare and child protection

2.52 Detailed records should be maintained on all cases raising child protection issues, and these records should be kept on site. (5.50)
Achieved. Child protection report forms were maintained on all cases and were kept securely on site.

2.53 A child protection log should be maintained. (5.51)
Achieved. A log had been set up and contained an up-to-date record of all cases.

2.54 There should be an integrated planning and review system to deal with complex child protection cases. (5.52)
Not achieved. Although difficult cases were dealt with well on a one-off basis, there was still no formal procedure to ensure this was standardised.
We repeat the recommendation.

Additional information

2.55 The conditions and facilities for children and families remained good. The family unit was clean and well equipped and it was better decorated and furnished. Similar numbers of children were held as at the time of the last inspection. The number of rooms for children and families had recently been reduced from five to two, increasing the spaces available for single men. It was too early to determine whether this was resulting in fewer children being admitted.

2.56 The quality of advance information about children and families had improved over the previous 18 months. In at least two cases, this had helped prevent admission of children when it was clearly against their best interests.

2.57 There were clear procedures for dealing with child protection referrals, but there had been a lack of continuity caused by the child protection coordinator post recently being held by different people. Funding to introduce an on-site social worker had been secured and negotiations about the best working arrangements were under way with the local authority.

Further recommendation

2.58 There should be continuity in the post of child protection coordinator.

Diversity

2.59 Race relations meetings should provide effective strategic oversight of race relations in the centre. All action points should be followed up and outcomes recorded and reviewed. (5.62)
Not achieved. Race relations meetings continued to provide a useful forum for exchange of information between staff and detainees. However, the minutes did not clearly record action points, nor was it clear that they were subsequently followed up. There was a lack of strategic consideration of overarching issues, such as the implications of nationality and ethnic monitoring. While race relations were not raised as a concern by detainees, the changing population demanded a more systematic approach to the management of this area to ensure that emerging concerns or tensions were identified and addressed.
We repeat the recommendation.

2.60 There should be more systematic ethnic and nationality monitoring, and the results of this should be routinely considered at race relations meetings. (5.63)
Not achieved. No additional areas were being monitored and, apart from a basic description of the nationalities represented in the centre, there was little discussion of monitoring at race relations meetings.
We repeat the recommendation.

2.61 There should be detailed records of interviews related to racist incidents. (5.64)
Achieved. There had been no recorded racist incidents in the year to date. Records of interviews had been completed for each of the incidents recorded in 2007.

2.62 Translated material should be quality checked before distribution. (5.65)
Achieved. Recent notices had been translated by a professional translation company rather than using unreliable computer translation programmes.

2.63 Diversity impact assessments should be completed. (5.66)
Partially achieved. A number of diversity assessments had been carried out, but all those we looked at were incomplete, superficial and lacked evidence and information on which to base reliable conclusions. The lack of adequate monitoring information or properly evidenced consultations undermined the process. For example, conclusions about access to the gym were drawn simply from visual evidence during a particular period, and the rewards policy was considered adequate simply because no complaints had been made. Centre staff lacked knowledge and confidence in how to complete these assessments and needed guidance and support.

Further recommendation

2.64 Diversity impact assessments should be reviewed and completed appropriately. The centre should be provided with advice and guidance from the UKBA, the responsible public authority under the legislation.

2.65 There should be a broader diversity policy that addresses the specific needs of all detainees, including women and people with disabilities. (5.6)
Not achieved. There was no wider diversity policy that included consideration of a range of diversity issues.
We repeat the recommendation.

Additional information

2.66 The multilingual religious and cultural affairs manager and the race relations liaison officer, who was also the welfare officer, continued to provide a high standard of individual support and care to detainees. Both were well known and well regarded.

2.67 None of the detainees during the inspection had an identified disability. There were 10 women and they felt their needs were well met. Specifically, the women's accommodation was of a good standard, they could take meals in their unit if they wanted and had protected time slots for the gym.

Faith

Additional information

2.68 Detainees were positive about faith provision. A range of chaplains continued to attend the centre, but the visiting chaplains were not allowed to visit detainees on units or in other communal areas. This limited their visibility and their ability to provide pastoral care, as access to them was only in the main house and specifically in the multi-faith area.

Further recommendation

2.69 Visiting chaplains should be able to visit detainees in all parts of the centre.

Health services

2.70 There should be a health needs assessment of detainees at Dungavel, which should be updated annually. (6.30)
Not achieved. The need for a health needs assessment had been discussed at a meeting between the local health board and the centre, but one had not been undertaken. The fact that all clinical records were in hard copy only owing to a lack of information technology made it difficult to gather information.
We repeat the recommendation.

2.71 Detainees should not be located in the observation room in the healthcare department. (6.31)

Achieved. The bed had been removed from the observation room and the space was used as an additional healthcare office.

2.72 Notices about health services and health promotion literature should be displayed in a variety of languages. (6.32)
Achieved. Notices about health services and health promotion literature were available in an appropriate range of languages in the healthcare waiting area. The induction booklet, which was available in a number of languages, also included information on health services and how to access them.

2.73 Detainees should have easy access to a GP of the same gender, and there should be notices in a variety of languages informing them of this option. (6.33)
Achieved. Detainees could ask to see a GP of the same gender. Information to this effect was displayed in the healthcare waiting area and consultation rooms in an appropriate range of languages.

2.74 Triage algorithms should be developed to ensure consistency of advice and treatment to all detainees. (6.34)
Achieved. Triage algorithms had been developed and were available in the clinical room where triage took place.

2.75 All staff should have at least annual resuscitation and defibrillation training. (6.35)
Achieved. Clinical staff had received resuscitation and defibrillation training, which had been renewed within the previous 12 months. Detailed training records and plans were maintained by the healthcare manager.

2.76 Healthcare staff should receive appropriate training in working with people who have experienced torture and trauma. (6.36)
Not achieved. Health staff had not received appropriate training in working with people who had experienced torture and trauma. We were told this was because it had not been possible to identify appropriate training, but attempts were being made to rectify this. An information file including information on this subject had been compiled for staff reference purposes.
We repeat the recommendation.

2.77 All clinical staff should have access to clinical supervision. (6.37)
Partially achieved. The registered mental health nurses received regular external clinical supervision and records of this were maintained. There were no clinical supervision arrangements for other nursing staff, although they met together informally and regularly to discuss their practice. The counsellors received regular supervision.
We repeat the recommendation.

2.78 Detainees should be allowed to have medication in possession following a formal risk assessment. (6.38)
Achieved. Around 60% of detainees receiving prescribed medication had it in their own possession. There was a policy for this and risk assessments were carried out.

2.79 Detainees should be able to consult a pharmacist. (6.39)
Not achieved. The pharmacy provider was based in Birmingham and any medication needed urgently was obtained from a local pharmacy. We were told that a pharmacist visited only about twice a year, so detainees did not have an opportunity to consult with one. Medicines and therapeutics committee meetings also had to be scheduled around the pharmacist's visits.
We repeat the recommendation.

Further recommendation

2.80 The centre should receive regular pharmacy support, including regular visits by a pharmacist.

2.81 Healthcare staff should put labels in appropriate languages on out-of-date medication withheld and returned, informing detainees that this may be out of date and should be checked. (6.40)
Achieved. Colour-coded stickers and leaflets in a range of languages identified any medication returned to a detainee with their property that was out of date or no longer part of their current prescription. Detainees who arrived with medication that was out of date or no longer current were asked if they would like healthcare staff to dispose of it for them.

2.82 Job descriptions for nurses should relate to their specific skills. (6.41)
Achieved. Appropriate job descriptions and documents outlining roles, accountabilities and performance standards were available for registered general nurses, registered mental health nurses and senior nurses.

2.83 There should be a clear policy on the use of handcuffs for detainees attending external medical appointments, including documented individual risk assessment. (6.42)
Partially achieved. There was a policy on the use of handcuffs for detainees attending external medical appointments, and individual risk assessments were conducted. The security risk assessment and healthcare assessment were recorded in separate places and the healthcare information was usually received through a telephone call between the security and healthcare departments. We were told that risk assessments were individualised, but there were occasions when detainees were required to be handcuffed unless there was a medical reason not to. These included when a detainee had been served a removal order or had been involved in a fight as instigator or victim.

2.84 The number of detainees handcuffed when attending external medical appointments appeared high, with 35 cuffed from a total of 51 healthcare escorts over a six month period. From one month's risk assessments for detainees attending external medical appointments, the only detainees not handcuffed were on crutches and the risk assessments stated that they would otherwise have been recommended to wear handcuffs. Staff and detainees also said that handcuffs were sometimes not removed during medical consultations.

Further recommendations

2.85 Handcuffing risk assessments for healthcare appointments should be fully individualised and handcuffs should be used for attendance at medical appointments only under exceptional circumstances.

2.86 Detainees should not be handcuffed during medical or dental examinations.

2.87 Detainees should not interpret for other detainees during healthcare consultations, and professional interpretation should be used. (6.43)
Achieved. Healthcare staff used telephone interpreting services for reception screening and other healthcare consultations as required. Professional face-to-face interpreters were used for more complex healthcare consultations, such as psychiatric assessments.

Additional information

2.88 We were told there was little need for substance use intervention and that this was not an area of concern raised at the detainee consultation meetings. The few drug finds were cannabis. Symptomatic relief was available if a detainee required detoxification and this would be given on the day of arrival, before a fuller review the following day. Detainees who had been receiving maintenance medication before arrival could continue this once the prescription had been verified. There had also been cases where detainees who had been receiving maintenance prescriptions before arrival had asked to be detoxed in preparation for their return to countries where they did not expect to be able to receive this.

Activities

2.89 The gym should offer dedicated time for female detainees. (7.24)
Achieved. Women had a dedicated time to use the gym between 6pm and 7pm every day and this time slot was being used by some women.

Additional information

2.90 The learning resource centre (LRC) remained an attractive, welcoming and well used facility. The activities manager produced a widely distributed activities booklet that was updated every week and was a useful way of keeping detainees informed of what was available. OCR (Oxford, Cambridge and Royal Society of Arts) literacy and numeracy courses were about to be introduced. A full-time English teacher provided materials and support for detainees at different levels. Arts and crafts teaching and provision remained good and the quality of work was reflected by the fact that detainees had recently won six Koestler Trust awards.

2.91 Detainees had access to 20 computers in a new internet café in the LRC and a further two terminals were available in the visits area for use by detainees and visitors. This much appreciated development allowed detainees to keep in touch with families by email and obtain information about home countries and legal cases. Inappropriate use led to short-term bans.

2.92 Sixteen detainees were in paid work, earning up to £15 a week. Funding for a further seven places had just been received. Detainees worked in the kitchen, as dormitory, litter and gym monitors, as decorators and some had provided teaching support. There had been no survey of the population to ensure that work places met demand, which was likely to increase with longer stays.

2.93 The gym was small, but had a good range of equipment and was well used. A new all-weather pitch was well used, particularly for a popular rolling football tournament. The range of recreational activities was good and a number of televisions and foreign language channels were provided.

Further recommendation

2.94 Periodic surveys of the detainee population should be carried out to ensure that work places meet demand.

Rules and management of the centre

2.95 One comprehensive set of rules should be compiled and provided to detainees in a range of languages. (8.27)
Achieved. Information about the centre, including details of rules and standards of behaviour, was included in an information book issued to detainees on arrival. The booklet was available in a range of languages. The rules of the centre were also explained during induction.

Security

2.96 Detainees should be allowed to have items in glass jars and to bring in open toiletries unless an individual risk assessment suggests otherwise. (8.28)
Partially achieved. Detainees could buy products in glass jars and tins from the shop. Detainees were not allowed to keep open toiletries, but this did not appear to be a significant issue as toiletries were provided to detainees who did not have their own.

2.97 Detainees should be able to move freely between the residential units and the activity areas. (8.29)
Achieved. Detainees had freedom of movement between residential and activities areas. Detainees and staff said this had proved successful, improving access to activities and giving staff more time to spend with detainees on the residential units. Free movement ceased when it became dark, but there were plans to extend it after dusk on a trial basis.

Rewards scheme

2.98 The incentives and earned privileges policy should reflect actual practice. (8.30)
Not achieved. The incentives and earned privileges policy appeared unchanged. It still stated that any detainee moved to the separation unit on rule 40 (removal from association) or 42 (temporary confinement) or involved in a serious incident would automatically be downgraded to standard level. It was unclear whether this was happening. The policy also stated that detainees on standard level were not allowed to use the internet or have a mobile telephone, although managers said the ban on the internet was not always applied. As at our previous inspection, few detainees were on standard level.

Further recommendations

2.99 Detainees moved to the separation unit under rule 40 or 42 should not automatically be downgraded to the standard level of the incentives and earned privileges scheme.

2.100 The incentives and earned privileges policy should set out the considerations that will determine whether the internet is banned.

Use of force

Additional information

2.101 Force had been used 10 times in the first eight months of 2008. The completed paperwork was satisfactory, with most officer reports giving a full account of the incident. The contributions

from healthcare staff were particularly good. The recording of one incident arising from the planned removal of a detainee showed that staff had little patience with the detainee, failed to communicate effectively and made no attempt at de-escalation once use of force had been instigated. Managers were aware of this incident and had identified some training needs.

Further recommendation

2.102 All staff should be trained in de-escalation techniques.

Single separation

2.103 Detainees placed on rule 40 or rule 42 of Detention Centre Rules should be given written reasons in a language they can understand. (8.31)
Achieved. All detainees placed on rule 40 or 42 were given written reasons in their own language or a language they could understand.

2.104 Detainees placed on rule 40 should have an avenue of appeal, and this should be explained to them in a language they can understand. (8.32)
Partially achieved. Detainees placed on rule 40 could appeal against the decision using the complaints system, but this was not explained to them.

Further recommendation

2.105 The notification that the detainee has been placed on rule 40 should include details of how to appeal the decision in a language the detainee can understand.

2.106 Rule 40 rooms should be fully furnished, and furniture removed only if necessary for good order and safety. (8.33)
Not achieved. The rule 40 rooms were clean and had en-suite toilet and shower facilities. They contained a bed, mattress and bedding, but no table, chair or storage. An association room on the unit was furnished with chairs and a television. Most detainees on rule 40 were unlocked during the day, allowing them to use this room to eat meals and watch television.
We repeat the recommendation.

2.107 Detainees held on rule 40 or 42 should receive all visits as required under Detention Centre Rules, and these should be recorded. (8.34)
Achieved. Individual records and the separation unit daily diary confirmed that detainees held in the separation unit received daily visits from the duty manager, shift manager and medical officer. A member of the Independent Monitoring Board also visited detainees on the unit every day.

2.108 A comprehensive central register of detainees resident in the unit should be kept, including those not held under rule 40 or 42, with a clear explanation of the reasons. (8.35)
Achieved. Three central registers were maintained on the unit: one for detainees held under rule 40, one for detainees held under rule 42 and one for those held for monitoring purposes under ACDT procedures. The registers recorded why each detainee had been located on the unit.

2.109 Information about how to make complaints should be fully explained to new arrivals, well publicised around the residential units, and available in a range of appropriate languages. (8.36)
Achieved. There were notice boards on every unit giving details of the complaints procedure in a number of languages. Complaints forms were also freely available in numerous languages.

2.110 Information about the work of the Independent Monitoring Board should be fully explained to detainees on induction, publicised around the centre, and available in a range of appropriate languages. (8.37)
Achieved. The information booklet given to new arrivals described the work of the Independent Monitoring Board. This information was reinforced during induction and there was further information on notice boards on the residential units and around the centre. All this information was available in a range of languages.

Additional information

2.111 Detainees held under rule 42 were located in one of two designated rooms also known as special accommodation. These were unfurnished apart from a low concrete plinth bed and mattress. They had no integral sanitation. The rooms were clean, but very stark with little natural light. Temporary confinement was not used frequently, but two detainees involved in an incident the previous weekend had been held in the special accommodation rooms for over 34 hours until their transfer to another centre. The rule 42 paperwork indicated that they had become compliant after a few hours. The log noted that they slept for periods and were allowed out of their rooms to use the toilet and have a cigarette.

Further recommendation

2.112 In accordance with rule 42 of the detention centre rules, detainees should not be held in special accommodation after they have ceased to be refractory or violent.

Services

2.113 There should be a designated dining area for women detainees. (9.13)
Achieved. Female detainees could now choose whether to eat communally with male detainees or on their own in the shared living area in the women's dormitory.

2.114 Women detainees should be offered regular sessions in the cultural kitchen. (9.14)
Achieved. Female detainees now had their own designated slot to use the cultural kitchen.

Additional information

2.115 The standard of food remained good. The range of products available from the shop had been extended and many were at supermarket prices. An attractive café had been created next to the centre shop.

Preparation for release

2.116 Adequate food should be available to visitors who stay for extended visits. (10.13)
Achieved. A hot meal from the centre kitchen was offered to visitors who were present at lunchtime or travelling some distance.

2.117 Detainees without means should be able to borrow mobile telephones from the centre for the duration of their stay. (10.14)
Achieved. Detainees were allowed to keep their own mobile telephones provided these did not have a camera or internet facility. Those who had to hand in their mobiles were allowed to keep the SIM card. Detainees without a mobile and with less than £20 could borrow one from the centre free of charge. The centre shop also sold mobile telephones.

Additional information

2.118 Dungavel's welfare officer met all new arrivals and recorded any problems, but did not necessarily record all the inquiries he encountered walking around the centre or when in his office on one of the units. Of 212 welfare problems recorded to date in 2008, two-thirds related to property. These included 77 about property left behind at prisons, of which 25 related to HMP Liverpool and 13 to HMP Altcourse. Seven related to money left at police stations. Finding legal advice was also a recurrent inquiry.

2.119 Inquiries continued after the detainee had left the centre, and the welfare officer had recovered and arranged onward transmission of missing money even after an individual had been removed from the country. Detainees were often detained without having the opportunity to recover clothing, documents or other essential property. Some did not have landlords or friends able to collect and deliver property. Some authorities were reluctant to allow third parties to collect and friends in insecure communities were sometimes reluctant to approach a removal centre. Over a period of years, the welfare officer had developed a network of contacts and volunteers, including church groups, prepared to help, although handling other people's property often involved volunteers putting themselves in difficult situations.

Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Main recommendations — To the UK Border Agency

3.1 Detainees should be given adequate notice of planned transfers. (2.2)

3.2 Immigration detainees should not be held for protracted periods in police cells, which are unsuitable for overnight detention. (2.3)

3.3 Independent specialist legal advice should be available to all detainees at all places of detention from the time they are detained. (2.4)

3.4 The detention of children should be exceptional and for the shortest possible period, and the interests of the child should be fully considered and documented before detention is authorised. (2.5)

3.5 Independent welfare checks should be carried out on all children detained for longer than seven days, and the results should be passed on to the immigration authorities immediately to inform reviews of detention. (2.6)

3.6 UKBA officials responsible for reviewing continued detention of children should always take full account of independent assessment information. This should be recorded and, if detention is maintained, the reasoned review should be notified to those with parental responsibility. (2.7)

3.7 Detainee casework should be progressed speedily and information conveyed to detainees regularly and in good time. (2.8)

Main recommendations — To the centre manager

3.8 Local UKBA representatives should attend the Safe in Dungavel committee meetings. (2.13)

3.9 There should be a system to identify and appoint suitable detainee suicide and self-harm and anti-bullying representatives. (2.14)

3.10 Membership of the Safe in Dungavel committee should be multidisciplinary. (2.15)

Recommendations — To the UK Border Agency

Arrival in detention

3.11 UKBA should make arrangements with the police to ensure that police custody records are attached to their detention authority record and their property sheets checked with them before they leave. (2.17)

3.12 Detainees under escort should be handcuffed only following individual risk assessment, which takes into account the views of health professionals, and which is subject to supervision and monitoring. (2.18)

3.13 New arrivals should be interviewed in private. (2.20)

Casework

3.14 UKBA caseholders should review and respond to rule 35 letters in line with the purpose of that rule, addressing whether detention, particularly prolonged detention, could be injurious to mental or physical health in light of available evidence including medical opinion. (2.24)

Preparation for release

3.15 UKBA caseholders should take individual detainees' circumstances, including the location of family and legal support, into account before they are moved. (2.25)

Recommendations

To the centre manager

Environment and relationships

3.16 All dormitory accommodation should have adequate space, ventilation and natural light for the number of occupants. (2.27)

Staff-detainee relationships

3.17 Group interviews assisted by professional interpreters should systematically be conducted with groups of detainees who speak little English to ensure that emerging concerns can be identified quickly and addressed. (2.34)

Bullying and suicide and self-harm

3.18 There should be regular surveys of detainees' experiences and perceptions of safety. (2.38)

3.19 The counsellor or other appropriate staff should summarise the underlying reasons why detainees feel at risk and report this analysis to the at-risk strategy meeting to inform policy development. (2.39)

3.20 Immigration staff should be invited to and attend all reviews of detainees at risk, and provide information about the progress of their immigration cases. (2.40)

3.21 A peer support scheme should be developed and evaluated. (2.43)

3.22 An appropriate care suite should be provided to help monitor detainees at risk and this should replace use of the separation unit. In the meantime, the at-risk strategy meeting should monitor cases of detainees held there as a supportive measure. (2.44)

3.23 The protocol for the assessment of detainees following removal directions should be revised to reflect the procedure set out in the director's rule. (2.46)

3.24 The centre should analyse the causes of the increased incidence of fights and assaults. (2.50)

3.25 The Safe in Dungavel committee should include violence reduction as part of its aims and strategy. (2.51)

Childcare and child protection

3.26 There should be an integrated planning and review system to deal with complex child protection cases. (2.54)

3.27 There should be continuity in the post of child protection coordinator. (2.58)

Diversity

3.28 Race relations meetings should provide effective strategic oversight of race relations in the centre. All action points should be followed up and outcomes recorded and reviewed. (2.59)

3.29 There should be more systematic ethnic and nationality monitoring, and the results of this should be routinely considered at race relations meetings. (2.60)

3.30 Diversity impact assessments should be reviewed and completed appropriately. The centre should be provided with advice and guidance from the UKBA, the responsible public authority under the legislation. (2.64)

3.31 There should be a broader diversity policy that addresses the specific needs of all detainees, including women and people with disabilities. (2.65)

Faith

3.32 Visiting chaplains should be able to visit detainees in all parts of the centre. (2.69)

Health services

3.33 There should be a health needs assessment of detainees at Dungavel, which should be updated annually. (2.70)

3.34 Healthcare staff should receive appropriate training in working with people who have experienced torture and trauma. (2.76)

3.35 All clinical staff should have access to clinical supervision. (2.77)

3.36 Detainees should be able to consult a pharmacist. (2.79)

3.37 The centre should receive regular pharmacy support, including regular visits by a pharmacist. (2.80)

3.38 Handcuffing risk assessments for healthcare appointments should be fully individualised and handcuffs should be used for attendance at medical appointments only under exceptional circumstances. (2.85)

3.39 Detainees should not be handcuffed during medical or dental examinations. (2.86)

Activities

3.40 Periodic surveys of the detainee population should be carried out to ensure that work places meet demand. (2.94)

Rewards scheme

3.41 Detainees moved to the separation unit under rule 40 or 42 should not automatically be downgraded to the standard level of the incentives and earned privileges scheme. (2.99)

3.42 The incentives and earned privileges policy should set out the considerations that will determine whether the internet is banned. (2.100)

Use of force

3.43 All staff should be trained in de-escalation techniques. (2.102)

Single separation

3.44 The notification that the detainee has been placed on rule 40 should include details of how to appeal the decision in a language the detainee can understand. (2.105)

3.45 Rule 40 rooms should be fully furnished, and furniture removed only if necessary for good order and safety. (2.106)

3.46 In accordance with rule 42 of the detention centre rules, detainees should not be held in special accommodation after they have ceased to be refractory or violent. (2.112)

Appendix 1: Inspection team

Hindpal Singh Bhui	Team leader
Lucy Young	Inspector
Ian Macfadyen	Inspector
Eileen Bye	Inspector
Mandy Whittingham	Healthcare inspector
Michael Skidmore	Researcher

Appendix 2: Population profile

Population breakdown by:

(i) Age	No. of men	No. of women	No. of children	%
Under 1 year	NA	NA	NA	NA
1 to 6 years	NA	NA	NA	NA
7 to 11 years	NA	NA	3	2
12 to 16 years	NA	NA	NA	NA
16 to 17 years	NA	NA	NA	NA
18 to 21 years	26	1	NA	16
22 to 29 years	56	2	NA	34
30 to 39 years	46	5	NA	30
40 to 49 years	26	2	NA	17
50 to 59 years	1	NA	NA	1
60 to 69 years	1	NA	NA	1
70 or over	NA	NA	NA	NA
Total	156	10	3	101

(ii) Nationality	No. of men	No. of women	No. of children	%
Afghanistan	6	NA	NA	4
Albania	1	NA	NA	1
Algeria	4	NA	NA	2
Angola	1	NA	NA	1
Bangladesh	2	NA	NA	1
Belarus	NA	NA	NA	NA
Brazil	1	NA	NA	1
Cameroon	1	NA	NA	1
China	22	1	NA	14
Colombia	NA	NA	NA	NA
Congo (Brazzaville)	NA	NA	NA	NA
Congo Dem. Republic (Zaire)	3	NA	NA	2
Ethiopia	1	NA	NA	1
Ecuador	NA	NA	NA	NA
Estonia	NA	NA	NA	NA
Gambia	1	NA	NA	1
Ghana	5	1	NA	4
Guinea	3	NA	NA	2
India	7	NA	NA	4
Iraq	12	NA	NA	7
Iran	13	NA	NA	8
Ivory Coast	1	NA	NA	1
Korea	NA	1	NA	1
Jamaica	2	NA	NA	1
Kenya	2	NA	NA	1
Kosovo	NA	NA	NA	NA
Latvia	NA	NA	NA	NA
Libya	2	2	NA	2
Liberia	1	NA	NA	1
Morocco	2	NA	NA	1

Moldova	NA	NA	NA	NA
Nigeria	9	1	NA	6
Niger	1	NA	NA	1
Portugal	1	NA	NA	1
Pakistan	8	NA	NA	5
Rwanda	2	NA	NA	1
Somali	8	2	NA	6
Sierra Leone	1	NA	NA	1
Sri Lanka	4	1	3	5
S. Africa	2	1	NA	2
Sudan	5	NA	NA	3
Turkey	3	NA	NA	2
Ukraine	2	NA	NA	1
Vietnam	5	NA	NA	3
Yugoslavia (FRY)	NA	NA	NA	NA
Syria	1	NA	NA	1
Zambia	NA	NA	NA	NA
Zimbabwe	2	NA	NA	1
Other (please state what)	NA	NA	NA	NA
No State	2	NA	NA	1
Total	149	10	3	102

(iii) Religion/belief	No. of men	No. of women	No. of children	%
Buddhist	7	NA	NA	4
Roman Catholic	11	NA	NA	7
Orthodox	1	NA	NA	1
Other Christian religion	28	7	3	22
Hindu	3	NA	NA	2
Muslim	75	1	NA	45
Sikh	7	NA	NA	4
Agnostic/atheist	6	NA	NA	4
Unknown	17	2	NA	11
Other	1	NA	NA	1
Total	156	10	3	101

(iv) Length of time in detention in this centre	No. of men	No. of women	No. of children	%
Less than 1 week	26	8	3	22
1 to 2 weeks	11	1	NA	7
2 to 4 weeks	25	1	NA	15
1 to 2 months	39	NA	NA	23
2 to 4 months	30	NA	NA	18
4 to 6 months	10	NA	NA	6
6 to 8 months	8	NA	NA	5
8 to 10 months	2	NA	NA	1
More than 10 months	5 (20 months)	NA	NA	3
Total	156	10	3	100

(v) Detainees' last location before detention in this centre	No. of men	No. of women	No. of children	%
Community	21	4	3	17
Another detention centre	74	5	NA	47
Prison	61	1	NA	36
Total	156	10	3	100