

Report on an inspection of the short-term holding facility

at

**Gatwick Airport**

**North Terminal**

by HM Chief Inspector of Prisons

**16 – 17 July 2013**

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# Fact page

**Task of the establishment**

To hold immigration detainees for up to 24 hours

**Location**

North terminal, Gatwick Airport

**Name of contractor**

Tascor

**Last inspection**

17 – 18 August 2009

**Escort provider**

Tascor

# Overview

Gatwick airport is the second busiest in the UK. It operates 24 hours a day and receives passengers from around the world. During 2012, over 34 million passengers passed through the airport.

The short-term holding facility located airside at the North Terminal is used to hold three categories of detainee for up to 24 hours: detainees held while immigration officers investigate whether they are allowed to enter the UK; detainees who have been refused entry and are being returned to their country of origin; and detainees transferred from other places of detention who are being removed from the UK.

The facility is run on behalf of the Home Office by the private contractor, Tascor. During our inspection, four detainee custody officers staffed the facility, which has two holding rooms. In the three months before our inspection, people were held on 677 occasions, including 18 children. Families are often transferred to the neighbouring family unit at Tinsley House Immigration Removal Centre. Staff were generally empathetic and courteous to detainees but more use of telephone interpretation was needed. The quality of accommodation was poor and the family room was not fit for purpose. Multi-agency arrangements to prevent child trafficking included routine sampling of children's DNA, which was unnecessary. There was no Independent Monitoring Board to oversee the facility.

## **Gatwick Airport North Terminal Short-Term Holding Facility**

Inspected: 16–17 July 2013

Last inspected: 17-18 August 2009

# About this inspection and report

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

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

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of detainees, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. The tests have been modified to fit the inspection of short-term holding facilities, both residential and non-residential. The tests for short-term holding facilities are:

**Safety** – that detainees are held in safety and with due regard to the insecurity of their position

**Respect** – that detainees are treated with respect for their human dignity and the circumstances of their detention

**Activities** – that the centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees

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

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

# Summary

## Safety

- S1 Forty-six per cent of all detainees held in the three months before our inspection had just arrived in the UK and been stopped by an immigration officer. Forty-seven per cent came from immigration removal centres (IRCs). Detainees reported positive treatment by escorts. Risk and health information was not fully recorded on documentation accompanying detainees. Escorts did not use interpretation services to communicate with detainees who did not speak English.
- S2 Detainees were left unaccompanied in interview rooms adjacent to the facility. Telephone interpretation was not used during reception and supervision of non-English speakers. Detainees were not routinely offered free telephone calls.
- S3 Detainees felt safe and there was no evidence of bullying but men and women could be held together. Self-harm incidents were rare and documentation confirmed that incidents were handled appropriately. All staff carried anti-ligature knives. There was no policy on the safeguarding of at-risk adults.
- S4 Eighteen children were held during the three months before our inspection: 14 accompanied and four unaccompanied. Some families were taken to the family unit at Tinsley House for overnight stays. Some facility staff had received safeguarding training from Barnardo's. The work of the Border Force minors team – immigration staff specially trained to work with children – was hampered by a lack of staff, resources and training. Not all members of the minors team had been checked by the Disclosure and Barring Service. Border Force and West Sussex children's services, who had a permanent presence at the airport, worked constructively together to safeguard children. Suspected child victims of trafficking could be referred to the national referral mechanism but DNA samples were inappropriately taken from them.
- S5 Facility staff did not use control and restraint techniques to enforce removal, and rarely used force. Detainees could maintain contact with their existing solicitors. Detainees claiming asylum could contact the Civil Legal Advice helpline.
- S6 In the three months prior to the inspection, 677 people were held for an average of five hours 34 minutes, with the longest being held for 23 hours 50 minutes.

## Respect

- S7 The accommodation was poor and the family room was not fit for purpose. Facility staff were generally courteous and empathetic to detainees but less so to non-English speakers because telephone interpretation was not used. Detainees could practise their religion and staff generally demonstrated cultural awareness, but they had not received diversity and equality training. Detainees could submit formal complaints. Snacks and fresh fruit were available and detainees were offered sandwiches and unappetising microwavable meals.

## Activities

- S8 There was a television for detainees and a small range of books and magazines, some of which were in foreign languages. Detainees could not smoke or go out into the fresh air.

## Preparation for removal and release

- S9 No information was available to detainees returning to their country of origin, apart from Jamaicans. Detainees could not use email or the internet. There were facilities for detainees to make telephone calls but these were not routinely explained to all detainees. Information was available to detainees transferring to IRCs.



# Section 1. Safety

## Escort vehicles and transfers

### Expected outcomes:

**Detainees under escort are treated safely, decently and efficiently.**

- I.1 Forty-six per cent of detainees held in the three months before our inspection had just arrived in the UK and been stopped by an immigration officer. Twenty-nine per cent arrived from neighbouring Brook House and Tinsley House immigration removal centres (IRCs). Eighteen per cent arrived from other IRCs. In 4% of cases the location was not recorded. The remainder arrived from prisons, hospital or other short-term holding facilities (STHFs). Four detainees were transferred under escort to the holding facilities at Gatwick during the inspection. They all said that escort staff had been courteous.
- I.2 Risk information in the person escort records of two of the four transfers was not completed correctly. In one, a detainee had been transferred twice in the space of a few days. The record for the first transfer indicated a ‘high risk’ and described the detainee’s ‘violent behaviour’. The most recent record suggested that there were no risks.
- I.3 We spoke to three of the escorted detainees. We used an interpreter as one spoke no English and another very little English. No interpretation was used during their transfer.
- I.4 Staff received advance notice of transfers to the facility. Detainees were transported overnight for an early morning flight, but for logistical reasons, other detainees were often transported with them even if they were on a later flight. These unnecessary overnight moves were tiring and disorientating. The reasons for detainees arriving more than five hours before their flight were recorded in a log, but they were administrative or logistical rather than reflecting the detainees’ interests; for example, in one case it was recorded ‘[detainee] will be dropped early as no Tascor crews to drop’.
- I.5 Vehicles had air conditioning, but little room for luggage. Windows were darkened. Vehicles were stocked with food and hygiene packs before each journey. The vehicle we inspected was clean. Families were transported in the same kind of vehicle.

### Recommendations

- I.6 **Person escort records should be completed in full with special attention to health and risk factors.**
- I.7 **Detainees should not be transported overnight unless they have an early flight, and should not have excessive waits before departure.**

## Arrival

### Expected outcomes:

**Detainees taken into detention are treated with respect, have the correct documentation, and are held in safe and decent conditions. Family accommodation is suitable.**

- 1.8** The facility was staffed by four detainee custody officers (DCOs), one of whom was female. We were told that there was a shortage of female staff and there was not always a female officer on duty. Staff said that they would not accept a detainee without a written authority to detain (IS91), although this and other official documentation was often incomplete.
- 1.9** Staff told us that detainees were consistently left unattended by Border Force staff in interview rooms adjoining the staff area of the facility. Facility staff were unable to exercise care and control of a person in this situation, because they had not been issued with an IS91 and delivered into their care. We observed a woman from New Zealand, clearly distraught, who had been left unattended in an interview room.
- 1.10** Newly arrived detainees were offered food and drink and given a very brief induction interview and a rub-down search in a reasonably private area. If there was no female DCO present, a female detainee was searched by metal detector wand only.
- 1.11** Reception, supervision and care arrangements were poor for detainees who did not speak English. Telephone interpreters were not used for any induction interviews while we were at the facility. Two detainees spoke no English. We spoke to one of them with an Albanian interpreter who told us he had been unable to request a telephone call and was unclear when he was going to be removed. Another detainee who spoke poor English had been unable to express concern about being removed on a long flight to China with no support for her back (medical staff at Yarl's Wood were aware of her back pain but this had not been communicated to escort staff or staff at the holding facility).
- 1.12** Staff told us that initial free telephone calls were only offered to detainees with no money. Only one of the four detainees we spoke to had been asked if he needed to make a telephone call, free or otherwise. The others told us they needed to make a call, including the distraught woman from New Zealand who wanted to speak to her parents.
- 1.13** DCOs were familiar with protocols for the issue of medication. They told us they were able to call a paramedic for medical emergencies, but they felt procedures were cumbersome for non-medical emergencies, as medical attention had to be authorised by the airport manager through Border Force.

## Recommendations

- 1.14 A female DCO should be on duty at all times.**
- 1.15 No detainee should be left unattended in an interview room within the facility unless an IS91 has been issued.**
- 1.16 DCOs should use telephone interpretation to communicate with detainees who do not speak English.**
- 1.17 DCOs should routinely check if newly arrived detainees need to make a telephone call. Facilities for making and receiving calls should be explained clearly. Detainees with no telephone or money should be given a free five-minute phone call.**

## Bullying and personal safety

### Expected outcomes:

**Detainees feel and are safe from bullying and victimisation.**

- I.18** Staff had a clear view of the two holding rooms. All detainees we spoke to felt safe and we saw no evidence of bullying or victimisation. Staff were aware of the need to monitor detainees in the holding rooms to ensure their personal safety. They told us that if a detainee became agitated they were removed from the holding room.
- I.19** Women and men shared the same holding room. We were told that if a woman felt uncomfortable sharing accommodation she would be allowed to stay in the family room, if it was free. However, we were not confident that a woman who spoke no English could communicate her fears, given the limited use of interpreters.
- I.20** Posters in the holding rooms advertised a confidential helpline for people who were experiencing bullying and harassment. Tascor had an anti-bullying and harassment policy but staff were unaware of it and had received no training.

## Self-harm and suicide prevention

### Expected outcomes:

**The facility provides a safe and secure environment which reduces the risk of self-harm and suicide.**

- I.21** Staff were unaware of the Tascor policy on suicide and self-harm and none whom we spoke to had received any training. However, when questioned they were reasonably clear how to identify and safeguard people at risk and the procedures to follow to enable care to be properly monitored. We were shown an incident log. Reports showed that self-harm was rare, but appropriately handled. In the 12 months prior to our inspection only one incident relating to possible self-harm had been recorded - a razor was found in a detainee's bible. She had not used it and claimed it was for cutting her nails.
- I.22** Inadequate use of interpreters raised serious concerns about whether the facility provided a safe and secure environment for detainees who did not speak English.
- I.23** All staff carried anti-ligature knives and the holding rooms were free of obvious ligature points.

### Recommendation

- I.24 Staff should receive training in suicide and self-harm prevention.**

## Safeguarding (protection of adults at risk)

### Expected outcomes:

**The centre promotes the welfare of all detainees, particularly adults at risk, and protects them from all kinds of harm and neglect.<sup>1</sup>**

- I.25** There was no policy for safeguarding adults at risk or procedures for identifying detainees who may need to be placed in the care of social services. Furthermore, there were no links with adult social services. Care plans were only used for children. There was very basic awareness of trafficking and Crimestoppers posters on trafficking were displayed in the

<sup>1</sup> We define an adult at risk as a person aged 18 years or over, 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. 'No secrets' definition (Department of Health 2000).

holding rooms. Adult victims of trafficking could be referred to the national referral mechanism by Border Force officers.

## Recommendation

- I.26 A policy for managing vulnerable detainees should be developed in liaison with the local director of adult social services and the local safeguarding adults board.**

## Safeguarding children

### Expected outcomes:

**The facility promotes the welfare of children and protects them from all kinds of harm and neglect.**

- I.27** In the three months before our inspection, 18 children were held at the facility: 14 were accompanied and four unaccompanied. Accompanied children were held for an average of four hours 59 minutes with the longest held for eight hours 55 minutes. Unaccompanied children were held for an average of three hours 48 minutes with the longest held for five hours and five minutes.
- I.28** Families with children could be held at the family unit at Tinsley House IRC just outside the airport where facilities were far more suitable (see HMIP 2012 Tinsley House report).
- I.29** Recently appointed DCOs received safeguarding children training as part of their initial training. Some DCOs who had been in post for longer had taken a two-day Barnardo's training package which they spoke positively about.
- I.30** DCOs said they reported safeguarding concerns to Border Force. Some staff were aware of the Border Force minors chief immigration officer (CIO) but could not identify the Tascor national children's champion. DCOs completed care plans for unaccompanied children which clearly identified the officer responsible for the child's care. The Disclosure and Barring Service checked the suitability of DCOs to work with children.
- I.31** The Border Force minors team comprised a CIO and immigration officers who had completed tier three of the Keeping Children Safe training package. Not all members of the team had been checked to enhanced level by the Disclosure and Barring Service. The CIO was child focused and committed but there were not enough immigration officers in the team to ensure that one worked on every shift. Minors team members had not received recent refresher training. Children were interviewed in the austere interview rooms with chairs chained to the floor.
- I.32** At least one social worker from West Sussex children's services worked at the airport Monday to Friday during office hours. Children's services worked constructively with Border Force. Age dispute cases were often released into the care of social services for a Merton compliant<sup>2</sup> age assessment to be conducted within seven days. However, on occasion CIOs assessed the age of young people without referral to children's services<sup>3</sup>. Children's services and Border Force confirmed there were delays in social workers attending the airport out of

<sup>2</sup> The High Court Merton judgement was handed down in 2003 and 'gives guidance as to the requirements of a lawful assessment by the local authority of the age of a young asylum seeker claiming to be under the age of 18 years'.

<sup>3</sup> Where the appearance and demeanour of the young person strongly suggests they are significantly over 18 Border Force can treat the young person as an adult.

hours. Arrangements were in place for appropriate adults to attend interviews with immigration officers. If social services did not attend, the charity Gatwick Travel-Care could attend.

- I.33** Potential victims of trafficking were referred to the national referral mechanism, with Border Force and social services as first responders. Staff told us that the number of referrals had risen with increased awareness of the mechanism. An up-to-date, comprehensive trafficking protocol produced by children’s services set out how potential trafficking victims at the airport would be protected.
- I.34** Operation Newbridge, a joint operation between Border Force, Sussex Police and children’s services, sought to protect child victims of trafficking, and a process map set out each agency’s responsibility. While the operation was to be lauded for joint working, it was unnecessary for all potential child victims of trafficking to have a DNA sample taken by the police. The procedure was intrusive and unnecessary as all children over five had their fingerprints taken. We were told that the DNA was used to trace children who were re-trafficked but it was not clear why fingerprints could not serve this purpose and the Border Force and children’s services could not give us an example of a missing child being recovered through DNA.

## Recommendations

- I.35** **A member of the Border Force minors team should be available on every shift. Team members should receive regular child safeguarding refresher training and should be checked to enhanced level by the Disclosure and Barring Service.**
- I.36** **Children should be interviewed in a child friendly environment.**
- I.37** **Potential victims of child trafficking should not be subject to unnecessarily intrusive multiple identification procedures. DNA should not be taken from children when fingerprints have already been provided.**

## Use of force

### Expected outcomes:

**Force is only used as a last resort and for legitimate reasons.**

- I.38** Force was rarely used and none had been recorded in the previous year. Facility staff said they no longer used control and restraint techniques to enforce removal but tried to encourage detainees to comply by talking to them, which was appropriate. If a detainee still refused to fly, the removal was cancelled and the detainee transferred to an IRC. Removal directions were reset and specialist overseas escorts accompanied the detainee to their country of origin. Staff received annual control and restraint training.

## Legal rights

### Expected outcomes:

**Detainees are fully aware of and understand their detention. Detainees are supported by the facility staff to exercise their legal rights freely.**

- I.39** Detainees could generally maintain telephone contact with their solicitors and were allowed to use the facility fax machine, but not email. Legal visits were not permitted as the facility was located airside.
- I.40** Detainees without a solicitor who wanted legal advice were directed to notices in the holding rooms promoting the Community Legal Advice helpline. The helpline, now re-launched as Civil Legal Advice, put detainees claiming asylum in touch with legal aid solicitors. Detainees could retain their legal documents.

## Casework

### **Expected outcomes:**

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

- I.41** In the three months before our inspection, people were detained on 677 occasions: 461 men, 198 women and 18 children. On average they were held for five hours 34 minutes. Eighteen detainees were held for over 20 hours, with the longest being held for 20 hours 50 minutes.
- I.42** Detainees were given written reasons for detention (IS91R) in English only. The reasons were explained to detainees who could not speak English with the aid of an interpreter. Detainees we spoke to understood the reasons for their initial detention but many were anxious about what would happen next, especially the New Zealander mentioned above.

## Recommendations

- I.43** **Detainees should be provided with written reasons for their detention in a language they can understand.**
- I.44** **Detainees should only be held in the holding room with written authority to detain (IS91).**

## Housekeeping point

- I.45** Border Force should regularly advise and update detainees on the next steps in their case and check detainees' understanding.

# Respect

## Accommodation

### Expected outcomes:

**Detainees are held in a safe, clean and decent environment.**

- I.46** The facility was in use 24 hours a day, seven days a week. Detainees were frequently held overnight or after long flights. The facility comprised a staff area and two holding rooms, one designated for family use (see safeguarding children section). Adjacent to the staff area were a number of interview rooms used by immigration staff.
- I.47** The accommodation was poor. Decoration throughout was shabby and, combined with the lack of fresh air and natural light, contributed to a dismal environment. Staff could not control the temperature. The facility was not suitable for lengthy detentions.
- I.48** The family room was not fit for purpose. It was particularly dismal, cramped and cluttered and poorly decorated. It had one small table with four bench seats attached which was uncomfortable and could only accommodate one family. There was one beanbag in the room, some toys, a nappy changer and a travel cot. There was one toilet leading from the room which was reasonably clean but it had no seat and there was no shower.
- I.49** The main holding room needed decorating. It contained functional hard seating, which was sufficient for the numbers held. Unlike the family room, it did have a payphone. Two toilets adjoined the room. The toilet designated for female use had a supply of sanitary items. The lino was peeling away from the floor leading to the male toilet and was a trip hazard. Both toilets needed cleaning. There was a reasonably clean water fountain. Two non-adjustable reclining couches were suitable for short rests but unsuitable for sleeping, or for pregnant women.
- I.50** Both holding rooms had a supply of blankets and pillows but overall the facilities were inadequate for overnight detention.

## Recommendations

- I.51** **The holding rooms should be redecorated and refurbished, and one should be suitable for families with children.**
- I.52** **Detainees should not be held for long periods or overnight without access to appropriate sleeping and washing facilities.**

## Housekeeping point

- I.53** There should be suitable facilities for pregnant women to lie down.

## Positive relationships

### Expected outcomes:

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

- I.54** Overall, facility staff were courteous to detainees, empathised with their situation and tried to reassure them. However, this was less successful for non-English speakers because telephone interpretation was not often used. Staff wore identification cards around their necks but the writing was too small to read easily.

## Housekeeping point

- I.55** DCOs should wear clear identification badges.

## Equality and diversity

### Expected outcomes:

**There is understanding of the diverse backgrounds of detainees and different cultural backgrounds. The distinct needs of each protected characteristic, including race equality, nationality, religion, disability, gender, transgender, sexual orientation, age and pregnancy, are recognised and addressed.**

- I.56** Recently appointed DCOs had received equality training as part of their initial training course but others had not. Tascor's diversity and disability policies were available to staff but there were no local equality impact assessments. Detainees could practise their religion and religious books and artefacts were available. The detainee subsequently told us he was Muslim but was not fasting. The times of sunset and sunrise were displayed in the facility office. Telephone interpretation had been used on 34 occasions in the last three months, more than at the south terminal facility but a relatively low number given the throughput of detainees.

## Recommendation

- I.57** Telephone interpretation should be used to communicate with detainees who speak little or no English.

## Complaints

### Expected outcomes:

**Effective complaints procedures are in place for detainees which are easy to access and use, in a language they can understand. Responses are timely and can be understood by detainees.**

- I.58** Detainees could complain through the Home Office detention service complaints system. Complaint forms in English and other languages were freely available in the holding room. Detainees could deposit completed complaint forms in a secure box which was emptied daily. No complaints about Tascor had been submitted in the previous 12 months. The Home Office professional standards unit had last received a complaint about the facility in November 2011 which was found to be unsubstantiated.



## Catering

### **Expected outcomes:**

**Detainees are offered varied meals to meet their individual requirements. Food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.**

- I.59** There was a selection of long-life microwave meals with halal and vegetarian options. Detainees were also offered drinks from a vending machine and sandwiches from a fridge that was restocked daily. Snacks and fruit were available in both holding rooms. All packaged food was in date. Staff told us they could use petty cash to buy food in the airport for anyone with special dietary needs.
- I.60** Detainees in the holding rooms were asked at regular intervals if they required food and drink and this was logged. Detainees could only complain about food through the Border Force complaints procedure, but could comment on food on Tascor suggestion forms available in 16 languages in both holding rooms.

# Activities

## **Expected outcomes:**

**The facility encourages activities to preserve and promote the mental and physical well-being of detainees.**

**1.61** Detainees had access to a small television, books, magazines and newspapers, some of which were in different languages. Some books were unsuitable for detainees, for example the Sunday Telegraph Good Garden Guide 2006. Children’s toys, books and DVDs were available in the family holding room. Detainees could not smoke or go outside for fresh air. Chess was available.

## **Recommendation**

**1.62** Detainees held for a few hours should have access to fresh air.

# Preparation for removal and release

## **Expected outcomes:**

**Detainees are able to maintain contact with the outside world and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property. Families with children and others with specific needs are not detained without items essential to their welfare.**

- I.63** In the three months before our inspection, holding room logs showed that 49% of detainees were removed from the UK, 19% detained elsewhere, 14% granted permission to enter the UK and 14% granted temporary admission. The remainder were taken to the police or hospital or their destination was not recorded in the logs. There was an information booklet to assist detainees who were being removed to Jamaica, but not to other countries. Detainees had no access to email and the internet. As the facility was airside, visitors were not allowed. There was a small stock of clothing, but it was not appropriate for removal to a cold climate.
- I.64** There were adequate facilities for incoming and outgoing calls, including free calls for those with no money, but these were not offered systematically to all detainees. Non-English speakers were particularly hampered from making free calls because of the infrequent use of telephone interpretation services (see recommendation I.57).
- I.65** Information cards were available containing basic details about other centres to which detainees might be transferred.

## **Recommendations**

- I.66** Detainees should have access to the internet.
- I.67** Information booklets should be available to assist detainees with reintegration to their country of origin.

## **Housekeeping point**

- I.68** A wide range of clothing suitable to a variety of climates should be available.

## Section 2. Recommendations and housekeeping points

### Recommendations

To the Home Office

#### Arrival

- 2.1** No detainee should be left unattended in an interview room within the facility unless an IS91 has been issued. (1.15)

#### Safeguarding children

- 2.2** A member of the Border Force minors team should be available on every shift. Team members should receive regular child safeguarding refresher training and should be checked to enhanced level by the Disclosure and Barring Service. (1.35)
- 2.3** Children should be interviewed in a child friendly environment. (1.36)
- 2.4** Potential victims of child trafficking should not be subject to unnecessarily intrusive multiple identification procedures. DNA should not be taken from children when fingerprints have already been provided. (1.37)

#### Casework

- 2.5** Detainees should be provided with written reasons for their detention in a language they can understand. (1.43)
- 2.6** Detainees should only be held in the holding room with written authority to detain (IS91). (1.44)

#### Accommodation

- 2.7** The holding rooms should be redecorated and refurbished, and one should be suitable for families with children. (1.51)

### Recommendation

To the Home Office and escort contractor

#### Escort vehicles and transfers

- 2.8** Detainees should not be transported overnight unless they have an early flight, and should not have excessive waits before departure. (1.7)

## Recommendations To the Home Office and facility contractor

### Accommodation

- 2.9** Detainees should not be held for long periods or overnight without access to appropriate sleeping and washing facilities. (1.52)

### Activities

- 2.10** Detainees held for a few hours should have access to fresh air. (1.62)

### Preparation for removal and release

- 2.11** Detainees should have access to the internet. (1.66)
- 2.12** Information booklets should be available to assist detainees with reintegration to their country of origin. (1.67)

## Recommendation To the escort contractor

### Escort vehicles and transfers

- 2.13** Person escort records should be completed in full with special attention to health and risk factors. (1.6)

## Recommendations To the facility contractor

### Arrival

- 2.14** A female DCO should be on duty at all times. (1.14)
- 2.15** DCOs should use telephone interpretation to communicate with detainees who do not speak English. (1.16)
- 2.16** DCOs should routinely check if newly arrived detainees need to make a telephone call. Facilities for making and receiving calls should be explained clearly. Detainees with no telephone or money should be given a free five-minute phone call. (1.17)

### Self-harm and suicide prevention

- 2.17** Staff should receive training in suicide and self-harm prevention. (1.24)

## **Safeguarding (protection of adults at risk)**

- 2.18** A policy for managing vulnerable detainees should be developed in liaison with the local director of adult social services and the local safeguarding adults board. (1.26)

## **Equality and diversity**

- 2.19** Telephone interpretation should be used to communicate with detainees who speak little or no English. (1.57)

## **Housekeeping points**

### **Casework**

- 2.20** Border Force should regularly advise and update detainees of the next steps in their case and check detainees' understanding. (1.45)

### **Accommodation**

- 2.21** There should be suitable facilities for pregnant women to lie down. (1.53)

### **Positive relationships**

- 2.22** DCOs should wear clear identification badges. (1.55)

### **Preparation for removal and release**

- 2.23** A wide range of clothing suitable to a variety of climates should be available. (1.68)

## Section 3. Appendix

### Appendix I: Inspection team

Colin Carroll  
Deri Hughes-Roberts

Inspector  
Inspector