Report on an unannounced full follow-up inspection of

Harmondsworth Immigration Removal Centre

14–18 January 2008

by HM Chief Inspector of Prisons

Printed and published by:
Her Majesty's Inspectorate of Prisons
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Introduction

Harmondsworth Immigration Removal Centre (IRC) has had a difficult and troubled history. Our last inspection described it as the worst IRC we had inspected, and pointed in particular to poor staff-detainee relationships, a culture of over-control, and continuing problems of detainee and casework management by the Border and Immigration Agency (BIA). The problems that we identified were accepted by the contractor and the BIA detention authorities, and a new Director took up post soon afterwards.

Four months later, there were serious disturbances, which destroyed much of the living accommodation and closed the centre for a time. The inquiry that followed found that, under the new Director, steps had been taken to address some of the cultural issues within the centre, but that there remained serious deficiencies in BIA's casework management, and in the physical layout of the centre.

This unannounced inspection took place only six months after Harmondsworth had reopened two wings, holding half of its previous population. The other wings were to be rebuilt, to higher security and safety standards. The effective closure and gradual re-filling of the centre had given an opportunity to rebuild staff confidence, and to inculcate a more appropriate culture.

All those we met – both staff and detainees – recognised the change that had taken place under the new management. This was confirmed by the evidence of the inspection, which showed improvement in all of our four key areas – safety, respect, purposeful activity and resettlement – though there was still some way to go to ensure that those changes were firmly embedded and could withstand the expansion of the centre to full capacity.

The most improved area was respect. In general, there was a different attitude and approach from staff, and this was confirmed in our detainee survey, where 70% of detainees, as opposed to 37% last time, said that most staff treated them with respect. This was not, however, yet the case for all staff – as we observed – and the new culture had not yet moved to a proactive, as opposed to relaxed, approach to supporting detainees. This was evident in the poor quality of history sheets, the limited role of residential staff in welfare issues, and the approach to ensuring that detainees participated in activities. There were also some continuing deficits in complaints handling, and some gaps in the approach to diversity. Mental healthcare, identified as a major need in our last report, was still unsatisfactory.

Safety had also improved, though not sufficiently to yet raise our overall assessment. Security in the centre was much less intrusive, and support for detainees in the early days had improved noticeably. There was, however, still considerable evidence of insecurity and frustration caused by immigration casework delays, and sudden and apparently random movements around the immigration detention estate – both contributory factors to the previous disturbances. Assessing risks to, and of, detainees was made much more difficult by the fact that relevant detailed information did not always arrive with them.

These were not factors the centre itself could control. But there were some aspects of safety that centre managers could improve. Systems for identifying and dealing with bullying were poor, and there were deficiencies in the management of those at risk of self-harm by residential staff. While neither bullying nor self-harm were current problems, they clearly had the potential to become so, given the nature of the population and the plans for expansion. Use of force and of special accommodation had decreased significantly, which was welcome. However, we still found examples of detainees spending too long in separated conditions, and

video evidence of the use of force to remove detainees contained some disturbing examples of poor practice, which had not been monitored or dealt with by managers.

Activities had also improved, though there was still a great deal of scope for development. Detainees had access to the internet, provided that they could physically get to the computer room. Some paid work was available, but not enough to meet the need, and systems for quality assurance were weak. It was particularly disappointing that the provision of English for speakers of other languages (ESOL) had effectively collapsed. Plans for the extension of the centre will need to include adequate provision for sufficient activity for the expanded population.

The work of the very active welfare team had greatly assisted detainees in preparing for removal or release, and this was also supported by an active chaplaincy team. The welfare team, however, needed specific training and working protocols to ensure confidentiality, and also needed to be able to rely on support from residential staff, who tended to refer all queries to the team.

Overall, this inspection recorded significant improvement in a centre that has long been of concern to us and the detention authorities. The build-up to reopening had provided space to work with staff to change the culture and approach of the centre. However, managers were aware, and this inspection confirmed, that there was still more to do before the centre expanded to full capacity. Negative staff attitudes had been effectively challenged, but positive staff interaction was not yet the norm. Processes to support detainees' safety needed to be robust and closely managed, and activities expanded and fully used. BIA also needs to make sure that its own systems are more effective and less remote and impersonal. But it is clear from this inspection that there is now much to build on at Harmondsworth, and that the centre is travelling in the right direction.

Anne Owers March 2008
HM Chief Inspector of Prisons

Fact page

Task of the establishment
Immigration Removal Centre

Location
Harmondsworth, West Drayton, Middlesex

Contractor
Kalyx (previously UKDS)

Certified normal accommodation
259

Operational capacity
259

Main escort provider
G4S

Last inspection
July 2006

Brief history
Harmondsworth Immigration Removal Centre, near Heathrow airport, opened in September 2001, under an eight-year contract to build and manage the centre awarded to UKDS (now Kalyx). Following a second major disturbance in November 2006, the centre was partially out of commission, during which time 60 detainees occupied makeshift dormitories in the healthcare and World Faith areas. The centre reopened one of the wings in June and the other in August 2007, taking the centre capacity up to 259 male immigration detainees. The original capacity was 501.

Description of residential units
Two house blocks, Cedar and Dove, accommodate 259 male detainees, mostly in two- or three-person rooms. There are also four cells in the care and separation unit (detention centre rule 42) and up to 16 beds in the welfare and support unit (rule 40), which are available for normal single accommodation when not in use for rule 40. There is also a 20-bed healthcare department with three single side rooms.

Section 1: Healthy establishment assessment

Introduction

HE.1 The purpose of this inspection was to follow up the recommendations made in our last inspection of 2006 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy establishment. The four criteria of a healthy establishment 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 Immigration and Nationality Directorate.

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

HE.3 Although this was a custodial establishment, we were mindful that detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention

Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees:

- in a relaxed regime
- with as much freedom of movement and association as possible consistent with maintaining a safe and secure environment
- to encourage and assist detainees to make the most productive use of their time
- respecting in particular their dignity and the right to individual expression.

HE.4 The statutory instrument also states that due recognition will be given at immigration removal centres to the need for awareness of:

- the particular anxieties to which detainees may be subject and
- the sensitivity that this will require, especially when handling issues of cultural diversity.

Safety

HE.5 There was a significant reduction in detainee complaints about staff intimidation, and more detainees said they felt safe than at the last inspection. Detainees had inadequate access to legal advice and were given insufficient information about the progress of their cases. Some were subject to excessive movements around the detention estate or inadequate information for assessing risk. Arrival procedures and outcomes had improved. Security was reasonably well managed and more proportionate, but freedom of movement was still too restricted. The management of those vulnerable to self-harm had improved, but there were still a number of procedural weaknesses. Identification and management of bullying were poor. While use of force had reduced significantly, forced removals were not always well managed, or routinely monitored. Separation was used more sparingly, but detainees were not always moved out promptly. There were weaknesses in child protection. Despite improvements, Harmondsworth was still not performing sufficiently well against this healthy establishment test.

HE.6 Detainees were subject to excessive movements around the detention estate, often for no clear reason and with little notice. Over a third had arrived from prisons, but fewer than half of these arrived with prison records. This hindered risk assessments. Many new arrivals showed evidence of mental disorder – in our survey, 45% of respondents said they had felt depressed or suicidal on their arrival, against the IRC comparator[1] of 27%.

HE.7 The reception area was clean and the process was relaxed. Survey results indicated significant improvements in the provision of information and services on arrival, and many more said they were well treated in reception. The provision to make free telephone calls on arrival was not adequately advertised or consistently implemented. First night procedures had improved, and room sharing risk assessments were efficient.

[1] The comparator figure is calculated by aggregating all survey responses together and so is not an average across establishments.

HE.8 Induction had improved significantly, and induction orderlies supported the process. Detainee 'Friends' also supported new arrivals. The on-site Border and Immigration Agency (BIA) team saw all new arrivals within two days. Some multilingual information was provided, but more language support was needed for the induction of non-English speakers.

HE.9 There had been a recent rise in age-dispute cases. There were good arrangements with local social services for managing such cases, but there were unacceptable delays when assessments were referred out of the local area. The centre accepted multi-agency public protection arrangements (MAPPA) cases, and a few detainees had been convicted of offences against children. However, the latter were not systematically identified and managed during visits.

HE.10 Vulnerability to self-harm was most often associated with immigration concerns. With some significant exceptions, mainly staff in the welfare team, there was insufficient positive staff engagement with detainees or knowledge of their circumstances and stresses. Self-harm monitoring assessment, care in detention and teamwork (ACDT) reviews were conducted sensitively, but the quality of entries in ACDT records was generally poor and suggested limited interaction. Care plans were weak and in some cases absent. The system for highlighting food and fluid refusals was efficient. The special accommodation in healthcare was inappropriate for vulnerable detainees, and there were no records of use. A death in custody action plan produced following a suicide in 2004 was being reviewed and updated.

HE.11 Few detainees reported problems with bullying. However, the anti-bullying policy was not effective in practice, and investigations and reviews were particularly poor. Victim care plans did not identify which individuals were responsible for actions, and there was no analysis of trends, including alleged staff bullying. Our in-depth safety interviews and survey (see Appendices III and IV) indicated a substantial reduction in detainees' previous concerns about staff intimidation.

HE.12 Rules were noticeably more sensible than at the last inspection, but there were still some excessive restrictions. Full searching was now risk assessed, and done sparingly. The security information and incident reporting systems were used appropriately to identify and take action on important issues. However, there was insufficient monitoring or analysis of trends and patterns. There was more opportunity for detainees to move between different parts of the centre, but restriction on movements still frustrated detainees, particularly when they wanted to attend the world faith centre.

HE.13 Use of force had reduced significantly, and use of force forms were completed to a reasonable standard. However, videos of forced removals showed some unnecessary escalation and poor staff practice. Managers did not check these recordings systematically.

HE.14 The rule 40 (removal from association) and rule 42 (temporary confinement) units were clean and fit for purpose. Separation under these rules had declined substantially. However, detainees were not always held for the shortest possible period, as required under detention centre rules. Closed visits were imposed automatically and inappropriately for anyone held under rule 42.

HE.15 Interviews suggested that immigration concerns and lack of legal advice were the major reasons for detainees feeling unsafe. Access to legal advice was severely

limited. Detainees reported difficulties in obtaining anything other than initial advice, and commonly lacked advice and representation for bail and appeal hearings. Detainees could see legal advisers at the twice-weekly surgeries, but few cases were accepted.

HE.16 There were two on-site BIA teams for fast-track and non-fast-track cases. They saw all new arrivals within two days and on application. Few detainees said that it was easy to see immigration staff, and they appeared to be frustrated about the quality and usefulness of the contact. Some detainees were held for many months with limited progress in their cases.

Respect

HE.17 There had been major improvements in the culture of the centre, and most detainees now reported respectful treatment from staff, though there was still insufficient positive engagement. Residential units were of a good standard. The management of diversity was underdeveloped. Health services were generally satisfactory, though provision for secondary care and mental health was poor. Detainees had little confidence in the complaints system, although most were dealt with adequately. The rewards scheme involved inappropriate restrictions. The standard of food was mixed. Overall, the centre was performing reasonably well against this healthy establishment test.

HE.18 Detainees' rooms were clean, well equipped and, except for those in triple rooms, reasonably spacious. All detainees had their own room keys. The toilet and shower facilities were clean. However, detainees complained about erratic room temperatures and airless conditions, and the equipment in association areas remained limited. Detainee consultation meetings were poorly attended, and there was little evidence that issues were followed up.

HE.19 The atmosphere in the centre was noticeably calmer and more relaxed than at the last inspection, and far more detainees now said they were treated respectfully by centre staff. Detainees were usually addressed politely, though some staff made little effort to get to know those in their care.

HE.20 Detainees reported few problems relating to diversity, but management systems had not improved. The scrutiny of complaints and monitoring by the cultural and religious affairs committee was inadequate. Though detainees had sometimes been asked inappropriately to interpret during sensitive health consultations, use of professional interpretation was substantially better than at the last inspection. There was a lack of systematic identification or management of detainees with disabilities.

HE.21 The religious affairs team was now much better integrated into the daily life of the centre. Facilities for worship were good, and detainees appreciated the spiritual and pastoral services provided by the team. However, there was insufficient provision for Muslims, who made up almost half of the detainees, and access to worship remained a problem.

HE.22 There was a two-level reward scheme, with regular formal reviews. Nearly all detainees were on the enhanced level. Demotion led to inappropriate restrictions, such as loss of employment and limitations on visits.

HE.23 Replies from the centre to detainee complaints were mostly prompt, polite and relevant. However, not all complaints about staff dealt with by Kalyx were rigorously investigated. None of the five complaints referred to BIA in the previous six months had been completed.

HE.24 Healthcare provision was adequate and access were generally good, with minimal waiting times for GP and dental appointments and regular daily access to nursing staff. Since the last inspection, six nurses had been trained in the treatment of minor illness and injury, enabling speedier treatment. The availability of secondary care for non-emergency cases was limited, and non-urgent cases were not referred for outside hospital appointments. Mental health provision was extremely limited, and there had been no mental health needs analysis.

HE.25 The standard of food was mixed. Detainees were highly critical about its quality and variety. The shop list was still short, and fewer than a quarter of detainees surveyed said that it offered a sufficient variety of goods.

Activities

HE.26 Activity provision for short stay detainees was good, but there was insufficient occupation for those held for longer periods. Paid work was limited and insufficiently varied. Core education provision, participation and access were reasonable, but English classes had effectively collapsed. Quality improvement arrangements were weak. The centre was not performing sufficiently well against this healthy establishment test.

HE.27 There was a generally good range of activities for detainees who were at the centre for a short period. Internet access was a positive and popular development, which was generally fully utilised. There was a well-equipped games room, and competitions with cash prizes.

HE.28 Detainees could develop their skills effectively in a wide range of art and craft activity at different levels. There was tutor support for learning, and the centre had started to offer accredited short courses in information and communications technology in addition to more substantial courses. However, provision of English for speakers of other languages (ESOL), a particularly important resource for detainees, had been poor since August 2007.

HE.29 There were insufficient activities for detainees who stayed at the centre for longer periods. Some paid work had been introduced, but this had yet to expand. Only 21 detainees were in work, which was all part-time and mostly mundane and unattractive. Most detainees did not know that work was available.

HE.30 The education suite was modern and spacious, with attractive and colourful displays. Learning resources in classes were plentiful and appropriate. As at the previous inspection, detainees' participation in activity varied considerably. There were sufficient education spaces for detainees, and easier access from the residential units.

HE.31 There was inadequate monitoring of education take-up, and collated data was not used to identify any groups over- or under-represented. Quality improvement

arrangements were poorly developed. There was a lack of appropriate self-assessment or development planning for activities.

HE.32 The library was adequately sized with sufficient seating and tables. The book stock was extensive and there was a good range of bilingual dictionaries, English and foreign language newspapers, DVDs and CDs. There was a satisfactory range of legal texts, and detainees could download information from the internet.

HE.33 Access to physical education had improved since the last inspection, and the expanded gymnasium was a reasonable facility.

Preparation for release

HE.34 The creation of a welfare team had been a major advance, though staff needed more training for this role. Mobile telephones and email and internet access had enhanced detainees' communications, and they could also send unlimited faxes. Consultation with visitors about their experiences had improved, though visitors still reported negatively on their experiences. The centre was performing reasonably well against this healthy establishment test.

HE.35 The relatively new seven-person welfare team provided an accessible and useful service. The team could provide quick answers to most basic enquiries and staff were enthusiastic in their attempts to resolve problems, many of which related to property. Outside contacts had been developed to help detainees prepare for release or removal. However, detainees were concerned that welfare staff inappropriately shared what they thought was confidential information with BIA, and there was scope for the team to provide more systematic pre-discharge assessment and support for detainees.

HE.36 The visits area remained clean and functional, but was austere. There had been significant improvements in consultation with visitors about their experience, and in the management of visitor and detainee interactions during visits. However, our survey indicated poor perceptions of treatment by visits staff, which needed further exploration.

HE.37 There was now an unlimited fax service on each unit. Detainees could receive incoming calls on their room telephones, and there were sufficient public payphones. Most detainees also had mobile telephones.

HE.38 Removals appeared to be well managed in most cases, but some staff had used deception to persuade detainees to leave the main units prior to removal.

Main recommendations

HE.39 Detailed information relevant to risk and needs should be provided to escorting and receiving establishment staff on fully completed IS91 detention authority forms, including information on those transferring from prisons.

HE.40 Staff should be trained in anti-bullying procedures, and be able to recognise and manage bullies and victims.

HE.41 Multidisciplinary assessment, care in detention and teamwork (ACDT) reviews should make reference to the care map, progress against each action should be logged, and new actions identified and carried out as appropriate.

HE.42 Security and centre procedures should comply with the purpose of detention centres, as set out in the Detention Centre Rules.

HE.43 There should be a mental health needs analysis to identify and determine the need for specialist psychiatric support for detainees.

HE.44 There should be sufficient and appropriate learning and skills provision and employment to meet the needs of both long- and short-term detainees.

HE.45 Detainees should have prompt access to suitably qualified legal representatives.

HE.46 There should be sufficient, suitably qualified immigration staff to ensure that all detainees receive prompt explanation of their status and responses to queries, and that all detained casework is diligently monitored and progressed.

HE.47 Residential staff should take a more proactive role in managing and supporting detainees, particularly those who are vulnerable, and should be a visible presence on the residential units.

Progress on main recommendations since the previous report

(The paragraph numbers at the end of each main recommendation refer to its location in the previous inspection report)

Main recommendations — To the Director General, IND [now Border and Immigration Agency, BIA]

MR1 Direction signs to Harmondsworth immigration removal centre (IRC) should be installed immediately. (HE.37)

Achieved. A signpost on the A4 identified both Harmondsworth and Colnbrook immigration centres, and each was identified separately nearer the centres. This had improved access for visitors and emergency services.

MR2 There should be sufficient, suitably experienced, on-site immigration staff to engage with all detainees and respond to their queries. (HE.45)

Partially achieved. There were now two separate immigration teams based at Harmondsworth. One dealt with the fast-track asylum process, and a smaller team linked with Border and Immigration Agency (BIA) caseholders located elsewhere. However, detainees were still concerned about their access to immigration staff, and detainees still had limited assistance with their casework. See section 4 on casework.

MR3 Detainees and staff in the education centre should have access to the internet. As a priority, direct internet access should be available to staff in the library to properly meet detainees' diverse information needs. (HE.46)

Achieved. The education department now had a network of 20 up-to-date computers with internet access, available for detainees to use when it was open. Education staff supervised the room effectively and helped detainees in using the computers. There was an effective booking system, and any empty spaces were offered on a drop-in basis. The facility was very popular and usually full, apart from the morning session. Detainees could send and receive emails freely, and had access to a wide range of websites, including those offering legal advice and information. Software blocked access to unsuitable websites, but many detainees complained that innocuous sites were also blocked and that applications to unblock them took time. Detainees no longer requested web-based material from the library, and this part of the recommendation was no longer relevant.

Main recommendations — To IND [BIA] and centre manager

MR4 Detailed information relevant to risk and needs should be provided to escorting and receiving establishment staff on fully completed IS91 detention authority forms, including information on those transferring from prisons. (HE.35)

Not achieved. There had been some improvement in transmission of risk information. The movement notification faxed to the receiving establishment by BIA's detainee escorting and population management unit (DEPMU) now included a summary of this information. However, the risk factors section on the IS91 detention authority was often blank. About a third of the

population had served a custodial sentence, but more than half of detainees transferred from prison at the end of a sentence arrived with no prison file. The movement notification sometimes only arrived when the transferee was already en route, which left staff with little time to consider or prepare for the arrival of potentially challenging individuals.
See main recommendation HE.39.

MR5 Centre managers should identify the causes of the high reported levels of victimisation of detainees by staff and take appropriate action. All complaints made by detainees should be fully investigated and serious allegations against staff monitored. (HE.38)

Partially achieved. Staff intimidation was a major concern at the last inspection. While some concerns were still indicated in our survey, our overall finding, supported by the in-depth safety interviews (see Appendix III), was that detainees now felt much less threatened by staff. However, there had been no analysis of the underlying causes of staff victimisation of detainees, which complaints indicated was still a problem. There was evidence of investigations of staff accused of bullying detainees, but the lack of formal monitoring meant it was not possible to ascertain if all complaints against staff resulted in an investigation. The responses to some of the complaints suggested that it did not.
See recommendation 8.61.

MR6 Detainees should have access to sufficient independent legal advice to meet their needs in respect of their immigration status and immigration bail rights. (HE.44)

Partially achieved. Although legal advice was available it was severely restricted, and both staff and detainees complained about this. See section 3 on legal rights.

Main recommendations — To the centre manager

MR7 The centre should monitor notifications issued under rule 35 of the Detention Centre Rules, including allegations of torture, following transmission to the Immigration and Nationality Directorate (IND) caseholder. IND should review the case and respond promptly. (HE.36)

Partially achieved. This rule requires a report to be made if a detainee's health is likely to be injuriously affected by detention, including any allegation of torture or suicidal intent. The BIA office in the centre sent notifications to the BIA caseholder, but these did not appear to be taken into account in decisions to detain, and the process was not clear to detainees or open to challenge by them. See paragraph 4.8 and recommendations 4.10 and 4.11.

MR8 Detainee custody officers (DCOs) should interact with detainees and be encouraged to develop knowledge of and positive relationships with them. (HE.39)

Partially achieved. The DCOs in the welfare team engaged well with detainees. However, most unit staff had more distant relationships and limited interaction with or knowledge of detainees. See main recommendation HE.47, also paragraph 2.21 and further recommendation 2.22.

MR9 There should be well understood multidisciplinary procedures in place to identify and manage the risk of self-harm and effective and speedy resolution of identified failings. (HE.40)

Partially achieved. The recently introduced assessment, care in detention and teamwork

(ACDT) self-harm monitoring procedures had been embedded. Staff responded promptly to instances or threats of self-harm and followed procedures. The ACDT coordinator was a valuable source of knowledge and support, monitored casework and attended and contributed to some reviews. However, there were some concerns about the quality of ACDT work (see paragraphs 5.16 and 5.17).

MR10 All detainees should receive an effective induction from adequately resourced induction staff. (HE.41)

Partially achieved. An effective formal induction was now delivered daily by induction staff. However, the programme did little to engage non-English speakers. See paragraph 1.13.

MR11 All security and centre procedures should be revised to ensure that they comply with the purpose of detention centres, as set out in the Detention Centre Rules. (HE.42)

Partially achieved. Security procedures were under revision. This included development of the local security strategy (LSS), and common audit baselines and expectations based on a BIA security audit. Not all of the detention centre rules were complied with – for example, rule 42 (see paragraph 8.37).
See main recommendation HE.42.

MR12 There should be a mental health needs analysis to identify and determine the clinical need for specialist psychiatric support for detainees. (HE.43)

Not achieved. There had been no specific mental health needs analysis. An audit of health services had recorded activity over a four-month period, including the number of appointments with the psychiatrist, but this had not considered unmet need.
See main recommendation HE.43.

MR13 Paid work, or incentives in addition to competitions, should be introduced. (HE.47)

Achieved. The centre had introduced some paid work, although few detainees knew this was available and progress to expand opportunities had been slow. See paragraph 7.17 and further recommendation 7.21.

MR14 There should be a welfare scheme to prepare detainees for their removal or release. (HE.48)

Partially achieved. A welfare team had been set up In May 2007 and offered considerable assistance to detainees, though little active preparation for release. See 'welfare' in Section 10.

Progress on recommendations since the last report

Section 1: Arrival in detention

Expected outcomes:
On arrival, detainees are treated with respect and care and are able to receive information about the centre in a language that they understand.

Escort vans and transfers

1.1 Escort staff should be given clear guidance on their powers and responsibilities when they escort detainees to consulates. (1.17)

Not achieved. There was no evidence that such guidance had been issued and understood. Detainees were regularly escorted from Harmondsworth to consulates for interviews to advance travel documentation. In one case, a Libyan detainee told us he was anxious about being taken to the Libyan diplomatic office because he feared that the Border & Immigration Agency (BIA) had not properly assessed the reaction of his national authorities.
We repeat the recommendation.

1.2 When detainees are held in police stations, police custody records should be attached to the IS91 IND detention authority, to provide a continuous record of detention history. (1.18)

Not achieved. Some IS91 immigration detention authorities we examined were for detainees initially detained in police stations, usually for a couple of days, before transfer to immigration detention. With one exception, no police custody records were attached, and reception staff confirmed that they rarely received any information from the police station. In the single exception, the file included a copy of a report by the police physician noting medication issued to a substance user. Some detainees who had been held in police stations told us that they had not been able to make telephone calls, take a shower or get a change of clothing. However, without the custody records it was not possible to verify this or the property they had with them when first detained – tracing missing property was a recurrent problem at the centre. Two detainees initially detained in a police station showed us their immigration documentation. Neither had reasons for detention, which should have been issued when they were detained. On another file, the IS91 was signed but not dated and the accompanying IS91R (reasons for detention to be given to the detainee) was dated but not signed to indicate that the reasons had been explained to the detainee. See also paragraph MR4.
We repeat the recommendation.

Additional information

1.3 Staff and detainees commented on the number of times detainees were moved about the detention estate, often at short notice, and how disruptive this was. Some detainees were so frustrated that they had refused to move again, particularly if they knew there was little chance that friends or relatives in the London area could get to Dungavel in Scotland or Haslar in Gosport to visit them or deliver property before their removal. This reaction was marked down as 'disruptive' and 'non-compliant'. Examples included a young man who had been detained in

five places in 13 days – two days in a Kent police station, transfer to the Port of Dover detention centre at 3am, transfer to Colnbrook IRC near Heathrow later that day, return to Dover five days later, then, after six days, transfer back to Harmondsworth, where a few weeks later he was put on assessment, care in detention and teamwork (ACDT) self-harm monitoring.

Further recommendation

1.4 Detainees should not be moved around the detention estate excessively, without explanation and with little notice.

Reception

1.5 Documentation relevant to detainees' legal proceedings should not be taken away from them. (1.19)

Achieved. Reception staff had been made aware that they were not to deprive detainees of legal documents. The safe, where any retained items were stored, contained only valuables and identity documents, such as passports.

1.6 There should be a published policy outlining any documents that detainees cannot retain in possession and explaining the reasons for the restriction. Staff should adhere to the policy. (1.20)

Partially achieved. Although we saw no evidence that detainees were deprived of documents inappropriately, unusually the advice sheet posted in reception and given to detainees listed permitted items rather than prohibited items. This was confusing for detainees, even if they read English, as it was not clear if they could have an item that did not happen to be on the non-exhaustive list of permitted items.

Further recommendation

1.7 There should be a published list only of banned items.

1.8 All detainees should be offered a free, private telephone call on reception and this should be documented. (1.21)

Partially achieved. The policy was to offer all new arrivals a free telephone call. They were given coins to use the payphone in reception: some said they were given £1 but the policy indicated 50p, which might not suffice to a mobile number. This offer was noted on the reception record. Some people chose not to take up the offer because the centre allowed them to keep their mobiles. However, when a detainee had telephoned and was unable to get an answer, this was not always picked up when he arrived on the residential unit, unless he raised this with staff. In this case, he was referred to the welfare office, as the residential staff office had no outside line. Welfare staff were not always in their office, which caused further delay. One detainee said that when he asked the unit staff if he could make a call he was told that, as he had been in the centre 24 hours, he had accrued 86p, the daily allowance, which he should collect from the shop and use to make a call. In our survey, only 34% of respondents said they had a free telephone call on arrival, against a comparator of 59%. Managers were revising the procedure to meet this expectation during the inspection.
We repeat the recommendation.

First night and induction

1.9 The multilingual induction booklet should be updated and republished as soon as possible. (1.22)

Partially achieved. A leaflet, available in eight languages, was given to new arrivals, with a summary of information likely to be of interest to them. A video on the reception procedure was played in the reception holding rooms. Touch screens in some areas, including the residential units, provided pictorial and brief written and oral information on various subjects, written and translated specifically for Harmondsworth. The centre chose to update information on the touch screens rather than reprint the multilingual packs every time details changed. We frequently saw detainees using these machines, and the oral information assisted those with poor reading. The induction coordinator was compiling a folder of further information to be translated. See also paragraph MR10.

Further recommendation

1.10 Detainees should have sufficient detailed material, professionally translated, to meet their induction needs.

Additional information

1.11 There were almost 600 arrivals and discharges a month. The reception area, including holding rooms, was clean and well ordered. Once processed, new arrivals were offered drinks and food. Any information relevant to room sharing risk assessment was documented and followed up by residential staff within three hours, and then within a further two hours of the detainee's arrival on the unit. Key information given to new arrivals included a copy of the compact and a letter of advice for visitors, available in various languages.

1.12 In our survey, 85% of respondents said they had arrived with problems, higher than the comparator of 74%, although only 17%, against 25%, said they received help or support from staff in dealing with these. Forty-five per cent of respondents said they had felt depressed or suicidal on arrival, against the comparator of 27%. However, 56% said they felt safe on their first night, the same as the comparator. In many cases, anxiety related to the proximity of removal directions. Just over half of people leaving the centre were removed, a third were transferred, and a minority were released.

1.13 An hour-long induction session ran every day, and sometimes twice a day. There were two full-time staff, a well-resourced induction room, and a commitment to providing information to new arrivals and helping them with immediate needs. Induction orderlies and detainee Friends collected new arrivals for induction, found people who spoke the same language to help, and showed them around. Induction was documented and monitored to ensure that all new arrivals received it. Detainees told us that they had received induction and found it useful. Information provided included pictorial displays. Detainees were encouraged to join the detainee consultative committee, and were given multilingual complaints forms. Referrals were taken up for the Independent Monitoring Board or welfare officers. However, some detainees with little English or poor literacy absorbed little. We spoke to a large group of Chinese detainees through an interpreter and found they had understood little of the induction process. Immigration staff conducted their own induction within a day or two of arrival.

Good practice

1.14 *New arrivals were given a letter for their visitors with detailed advice about visiting arrangements and what they could bring for the detainee. This was available in a range of languages*.

Section 2: Environment and relationships

Residential units

Expected outcomes:
Detainees are held in decent conditions in an environment that is safe, well maintained and respectful of cultural norms.

2.1 Detainees should have a risk and compatibility assessment before they are allocated to share a room. (2.10)

Achieved. All new arrivals were assessed for their suitability for sharing accommodation. Reception staff used a form to record relevant details, a manager completed this, and accommodation was allocated. The files that we sampled indicated that the assessments were basic, but sufficiently detailed to identify any problems and take appropriate action. Residential staff were flexible if detainees wanted to change rooms, and changes were frequent.

2.2 The decoration of the units should be more varied and less institutional. (2.11)

Achieved. There was now a varied colour scheme and corridors were painted in different colours. Detainee artwork was displayed in most communal areas. Noticeboards had been installed in all the rooms and gave detainees the opportunity to personalise them.

2.3 The temperature in living areas should be closely monitored, especially at nights, and ventilation should be improved where necessary. (2.12)

Not achieved. We continued to receive many complaints from detainees about the temperature and ventilation in their rooms. Although temperatures were closely monitored by a sophisticated computer, this did not appear to be used to respond to complaints. Detainees said the rooms could be very cold in winter and very hot in summer. Some said that some rooms, particularly the three-bedded ones, were airless and caused headaches. A number of detainees said they had not received advice about how to use the room thermostats, which had a time lag.

Further recommendations

2.4 Detainees' concerns about heating and ventilation should be taken seriously, and there should be determined efforts to resolve any problems.

2.5 All detainees should be given clear information about how to operate room thermostats.

2.6 There should be more association facilities, including on the living units. (2.13)

Not achieved. Although adequate association space had been allocated on the residential units, these areas remained sparsely furnished with little equipment, apart from a small collection of board games. There was a well-equipped association area in the education department.
We repeat the recommendation.

2.7 There should be a list that clarifies the items that detainees are allowed to have in their possession, which should appropriately reflect the legal and security status of detainees. (2.14)

Partially achieved. The centre had produced such a list and publicised it on the units, but the spirit of the recommendation had been misinterpreted: a list of permitted items rather than banned items could not possibly be exhaustive. See recommendation 1.7.

2.8 All showers, toilets and laundry equipment should be kept in working condition. (2.15)

Achieved. The maintenance manager kept close oversight of facilities and equipment, and repairs were carried out promptly.

Additional information

2.9 Two residential units were occupied, Cedar and Dove. They had been recently refurbished, and were brightly decorated and clean. There was little graffiti, and the outside areas were also clean and tidy. The remaining units were being reconstructed following the major disturbance in 2006.

2.10 All the rooms were of a similar size and suitable for single or double occupancy. A few were occupied by one detainee, usually those with mobility problems. Most detainees shared double rooms, and 16 rooms were occupied by three detainees. Though we received few complaints, these rooms could be cramped. All rooms were well equipped with good quality furniture, curtains and rugs. Detainees had their own room keys, and could store their property in lockable cupboards.

2.11 Detainee consultation meetings were held regularly, although attendance was poor. There was little evidence that issues raised were followed through, and many detainees felt that meetings were ineffective. General information was displayed on noticeboards, but was limited in scope and tended to be in English only.

2.12 Detainees could wear their own clothes, and most did. There were well equipped and easily accessible laundries on each residential landing. It was unclear why in our survey only 31% of respondents said they were offered enough clean suitable clothing for the week against a comparator of 57%, as detainees could obtain clothes from stores in reception or the world faith department.

2.13 Detainees had access to showers and baths, and in our survey all respondents said they could shower every day. The shower and toilet areas were well maintained and clean. Detainees' rooms were cleaned once a day, and detainees could also request a dustpan and brush.

Further recommendations

2.14 Double rooms should not be used for three detainees.

2.15 Detainee consultation meetings should be better promoted. Action points should be acted upon and reviewed at subsequent meetings.

Housekeeping points

2.16 A wider range of general information in different languages should be displayed.

2.17 The centre should investigate the reasons for detainees' negative views on access to clean clothes.

Staff-detainee relationships

Expected outcomes:
Detainees are treated respectfully by all staff, with proper regard for the uncertainty of their situation and their cultural and ethnic backgrounds. Positive relationships act as the basis for dynamic security and detainees are encouraged to take responsibility for their own actions and decisions.

2.18 Staff should not address detainees by surnames alone. (2.25)

Partially achieved. Managers had instructed staff to address detainees politely, and most referred to detainees as 'Mr'. However, some staff continued to use surnames alone.
We repeat the recommendation.

2.19 Staff should not enter detainees' rooms without knocking. (2.26)

Partially achieved. Despite management instructions to staff, some detainees still complained that staff entered rooms unannounced. Detainees had also raised this in consultation meetings.
We repeat the recommendation.

Additional information

2.20 Although we still had some concerns about the level of staff-detainee interaction, most detainees were positive about their treatment by staff. In our survey, 69% of respondents said that most staff treated them with respect. This was similar to the comparator, and significantly higher than the 37% response at the last inspection.

2.21 In our survey, 55% of respondents said there was a member of staff they could turn to if they had a problem, significantly above 31% at the last inspection. The welfare team appeared to have been instrumental in this improvement, and seemed to fulfil a role similar to that of personal or care officers (see paragraph 10.2). While there were notable exceptions, most unit staff had more distant relations with detainees, and many referred simple matters that they could have dealt with themselves to the welfare team. This created the impression that they were not responsible for general detainee welfare. Detainee unit history sheets usually contained regular but brief and superficial entries, suggesting that most staff had limited interaction with or knowledge of detainees. See main recommendation HE.47

Further recommendation

2.22 A care officer scheme that involves all unit staff should be developed.

Section 3: Legal rights

Expected outcomes:
Detainees are able to obtain expert legal advice and representation from within the centre. They can receive visits and communications from their representatives without difficulty to progress their cases efficiently.

Additional information

3.1 Staff and detainees complained about the lack of legal advice. Legal advice was available, but severely restricted. In our survey, 34% of respondents, against the comparator of 29%, said they had problems accessing legal advice when they arrived.

3.2 Fast-track detainees (asylum seekers) were the majority of the population, with notional free initial legal advice (see also paragraph 4.1). However, because of legal aid restrictions, many only saw their adviser at the initial stage of the process. If they wanted representation at their appeals, detainees had to pay. Some could pay for advice or for representation, but not usually for the representative to visit the centre to take proper instructions for the appeal. In recent months, just over half of fast-track appellants had been represented and 2% won their appeals.

3.3 The Legal Services Commission funded legal advice surgeries two days a week. Detainees could book 30-minute slots, which were not always fully booked. Providers were not able to take on many cases for further advice or representation. This was a concern as, irrespective of the merits of their immigration case, detainees suffering prolonged detention needed help with bail applications.

3.4 Much staff time was taken up when detainees went to them to seek help in understanding official documents and how they should react. The issuing bodies, Border & Immigration Agency (BIA) and the courts, did not take sufficient account of unrepresented detainees' limited ability to understand legal terminology, even if they spoke reasonable English. Although it was evident from the files that detainees had no legal representative, BIA caseholders continued to act as if they did.

> *The centre doctor had reported that a detainee had: 'finger deformities consistent with his account of having had his hands stamped on and fingers fractured. Multiple 1' long sharp laceration scars over back consistent with his account of interrogation under torture. I cannot think of any other way that he could have been scarred in this way. Scars could <u>not</u> [emphasis in original] have been self-inflicted. Scars are precisely distributed for maximum pain effect.' The BIA caseholder acknowledged receipt and the same day set removal directions, noting that his home consulate had agreed. Just before the detainee was removed, the caseholder recorded that the torture allegation had been referred to in his failed appeal, and this report from the centre doctor would not be considered as further representation unless his solicitors 'officially make further reps', noting in the next sentence that he did not have a solicitor. There was no indication that the detainee was notified appropriately.*

3.5 Staff faxed legal documents without charge, including numerous requests for advice to solicitors listed in the Immigration Law Practitioners Association directory, generally to no avail. Some detainees with legal representatives lost them when they were moved to a different area.

Further recommendation

3.6 The centre should consult the Legal Services Commission to improve detainee access to legal advice and representation.

Section 4: Casework

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

Additional information

4.1 Two separate immigration teams were based at Harmondsworth. One team of 59 staff, including 35 caseworkers, was dedicated to the fast-track asylum process. Individual case owners interviewed asylum applicants soon after arrival, decided their cases and dealt with appeals, which were heard at the on-site tribunal hearing centre within a few weeks, according to a fixed timetable. Two-thirds of Harmondsworth beds (170) were assigned to fast track.

4.2 The refusal rate in fast-track cases was 99%. At the end of the determination process, most people stayed detained, sometimes for considerable periods. Although the files for these detainees had previously transferred to a different Border & Immigration Agency (BIA) office overseeing long-term detention, following a recent change of policy these long-term detainees remained the responsibility of the fast-track team. The team had begun to issue monthly detention reviews and respond to detainee applications.

4.3 For the remainder of the population, the smaller BIA team in the centre linked with BIA caseholders located elsewhere. This team consisted of 2.5 executive officers (one on secondment), an administrative officer, and two immigration officers temporarily on detached duty from a west London local enforcement office, supervised by an experienced BIA manager, who was also the contract monitor. The team saw all non-fast-track new arrivals within a day or two of arrival, checked their status on BIA's casework information database, and dealt with any queries from detainees. Inquiries were usually dealt with within a day. Members of this team had put some effort into developing a relationship with custodial staff and detainees and were known around the centre, where their photographs were displayed.

4.4 In our survey, only 16% of respondents said it was easy to see immigration staff when they wanted to, against a comparator of 30%. In our safety interviews (see Appendix III), immigration uncertainty was the most dominant concern and detainees reported frustration and psychological distress at the workings of the immigration detention system. This rated twice as high as any other safety concern, with 16 out of 20 detainees interviewed rating it at the highest level of concern; 'very much a problem'.

A Congolese man detained for 13 months, after serving a six-month custodial sentence, had made repeated requests to transfer back to Dungavel in Scotland, where he had a solicitor, a surety and an address to support a bail application. Fresh information about his asylum claim was apparently lost by BIA. In England, his bail application failed, his requests for transfer were refused, and he was prosecuted for failing to comply with his removal – even though removals to the Congo had been suspended, and further evidence could not be considered until fresh guidance was issued. When his further information was considered, prosecution was not pursued, but he remained detained, though without any timescale for his removal. He had a history of vulnerability and had been identified as at risk of suicide, due to hopelessness. None of his monthly detention reviews referred to the significant changes in his external and personal circumstances.

4.5 The non-fast-track team regularly provided helpful information and advice, but because of their restricted functions, these staff had limited knowledge of or ability to progress casework. The quality of information provided by external caseholders was often poor. Fewer than half of survey respondents said they received regular monthly reviews. The reviews were in English only, and some that we saw did not reflect all relevant circumstances.

4.6 The population pro forma (see Appendix II) showed that 10% of detainees had been in the centre for over four months. However, these statistics do not indicate overall duration of detention, and we found examples of people cumulatively detained for more than six months, and some for more than a year.

4.7 We also came across more than one case of young people claiming to be minors, but whose age was queried (see also paragraph 5.64). BIA policy is that they should be given the benefit of the doubt unless evidence strongly indicates otherwise. In a few recent cases, Harmondsworth staff were sufficiently doubtful to isolate young detainees pending social services formal assessment. During the inspection, one young man was released as a minor. This was not an isolated incident, and some BIA offices were clearly not observing their own policy.

4.8 Detention Centre Rule 35 notifications now asked for confirmation from the BIA caseholder that the report was taken into account in the decision to maintain detention. In the previous 11 weeks, 38 notifications had been recorded. Of 20 we looked at, 15 had only received acknowledgement, usually promptly, three had no response recorded, and only two received a comment that suggested the notification had been considered. This process focused on allegations of torture, which meant it was not possible to monitor observance of the wider intent of the rule. The process was not transparent to detainees, who therefore could not query the caseholder's reaction, or lack of reaction.

Further recommendations

4.9 The Border & Immigration Agency (BIA) should monitor cases of unaccompanied young people who are detained, but subsequently assessed to be minors and released to the care of local authorities, and pass this information back to the detaining BIA office.

4.10 Procedures to comply with Detention Centre Rule 35 should make clear that a medical report is mandatory whenever a detainee's health 'is likely to be injuriously affected by continued detention or any conditions of detention'.

4.11 A medical report should trigger a prompt review of detention, and the detainee should be informed of the basis and outcome of the review.

4.12 The effect of any transfer on detainees' contact with legal representatives and on bail applications should be taken into account before any move.

4.13 Reasons for and reviews of detention should reflect all relevant circumstances for and against continuing detention, and should be issued and explained in a language the detainee understands.

Section 5: Duty of care

Expected outcomes:
The centre exercises a duty of care to protect detainees from risk of harm. It provides safe accommodation and a safe physical environment.

Bullying

5.1 The anti-bullying policy should be based on evidence of detainees' experiences. (5.22)

Not achieved. The anti-bullying strategy was not based on evidence of detainees' experiences. A survey based on 50 detainee interviews (selected at random) was being conducted during the week of the inspection.
We repeat the recommendation.

5.2 Anti-bullying and victim support logs should be completed in all cases, and victims should be actively supported to engage in all aspects of the regime without fear of victimisation. (5.23)

Partially achieved. Figures provided by the centre showed eight bullying plans had been opened between July and September 2007 and seven care maps for victims. However, these were of poor quality, and there was a significant lack of active support and constructive interventions for either victims or bullies.
We repeat the recommendation.

5.3 One member of staff should take lead responsibility for anti-bullying work. (5.24)

Achieved. The residential manager had responsibility for anti-bullying work.

5.4 Anti-bullying meetings should be multidisciplinary, include detainee representation and consider issues in depth. (5.25)

Not achieved. We saw minutes for the anti-bullying meetings in July and September 2007. The quality of these meetings was wholly inadequate. They had been attended by staff from across disciplines, including the assessment, care in detention and teamwork (ACDT) coordinator, cultural and religious affairs liaison officer (CRALO) and security manager. The first set of minutes recorded 'nothing to report' under each heading. The second set reported on bully logs that had been opened, but was merely descriptive. There was no reference to victims, and no analysis of underlying trends. Detainees were not invited. In theory, consultation should have taken place at the general detainee consultation meetings, but the minutes of these meetings made no mention of bullying, apart from headings in two sets of minutes with 'no issues raised' recorded. On another occasion, detainees were informed of the bully line number on the new key bands, and that there would be an anti-bullying survey.
We repeat the recommendation.

5.5 The anti-bullying telephone line should encourage callers to leave messages and explain the support available to victims. (5.26)

Partially achieved. The anti-bullying line was checked daily and messages responded to within 24 hours. The message was in several languages, but simply confirmed it was the bully line and asked callers to leave their name and number for a senior member of staff to call

them. The message did not explain the support available to victims.
We repeat the recommendation.

Additional information

5.6 In our survey and detainee groups, relatively few detainees reported problems with bullying in the centre. However, our safety interviews (Appendix III) suggested some problems arising from the aggressive body language of some detainees.

5.7 There was a basic anti-bullying policy. Detainees were not made sufficiently aware of behaviour that was unacceptable and potential consequences. It was not clear how, if at all, allegations of bullying behaviour were responded to. Some staff were of the view that not all instances of bullying were managed through the bullying procedures. It was also not clear if allegations of bullying were managed promptly and treated consistently and fairly. Investigations of incidents were very limited and there were no full records, such as transcripts of interviews or dates and times of incidents. There was no evidence that victims or bullies were kept informed and supported or that identified bullies were managed through the rewards scheme. Few effective interventions were recorded, and reviews were particularly poor. For example, in one case a detainee was removed from the bullying procedures, even though one of the alleged incidents of bullying had been witnessed and recorded by a DCO. Another case was closed with no review.

5.8 Victim care maps did not specify the individuals responsible for actions. Often these merely stated that all staff should support, interact and encourage detainees. There was no analysis of trends, including alleged staff bullying, and no quality assurance system.

Further recommendations

5.9 The anti-bullying policy should be better publicised, and detainees should be clearly informed of unacceptable behaviour and the consequences of bullying.

5.10 Intelligence from various sources, including security and safer detention procedures, should be used to identify and manage bullying, and trends should be analysed.

Self-harm and suicide

5.11 One member of staff should take lead responsibility for suicide and self-harm prevention work (5.27)

Achieved. There was an experienced and capable full-time ACDT coordinator. She was also a national trainer and audited ACDT procedures for other Kaylx sites. She was responsible for ACDT training at the centre. Almost all staff were trained and regular refresher training was scheduled. There was also mental health awareness training for staff.

5.12 Suicide prevention committee meetings should include representation from detainees and the Samaritans. (5.28)

Not achieved. There was no detainee or Samaritan representation at the ACDT meeting we observed, and minutes of previous meetings also showed their absence. We were told that funding problems meant that the Samaritans had withdrawn from direct involvement in the

centre.
We repeat the recommendation.

5.13 Action points from suicide prevention meetings and the suicide prevention liaison officer's reports should be systematically followed up and progress recorded at subsequent meetings. (5.29)

Achieved. Action points from previous meeting were systematically followed up and progress recorded.

5.14 The results of important investigations, such as those by the Prisons and Probation Ombudsman, should be shared with centre staff, and action plans should be drawn up collaboratively. (5.30)

Achieved. There had been no death in custody investigation since the last inspection. A previous death in custody plan was regularly reviewed and updated, and was discussed at some suicide prevention meetings.

5.15 Detainees should be able to contact the Samaritans free of charge. (5.31)

Achieved. Mobile telephones on each unit gave free access to the Samaritans.

5.16 Staff should interact positively with detainees at risk of self-harm rather than simply observing them, and monitoring checks should be regular but unpredictable. (5.32)

Partially achieved. ACDT records of contact showed regular observations, but the quality of entries was generally poor, suggesting little interaction with detainees and a lack of knowledge of their circumstances and stresses. Some monitoring checks were predictable. The unit above healthcare often held detainees on ACDT, normally those in need of constant watch, as this made observations easier. Detainees reported reasonable relationships with staff there. DCOs often sat in the office on one side of the corridor and detainees in the large room opposite. In the case of constant watches, of which there was one during our inspection, a DCO sat in a chair at the end of the detainee's bed. We observed a lack of meaningful interaction by some staff.
We repeat the recommendation.

5.17 Reviews for those at risk of self-harm should be multidisciplinary and support plans should specify the action to be taken and by whom. (5.33)

Not achieved. The review we observed was not multidisciplinary, with only the suicide prevention coordinator and duty manager present in addition to the detainee. The minutes of other reviews showed this was often the case, though sometimes other departments, such as world faith and education, did attend. Actions were not SMART (specific, measurable, achievable, realistic and time bound), and individuals responsible for action were not specified in the care maps. Although there was a separate log of referrals, this key information was not on the care map or available at the review meeting. Reviews tended to be held ad hoc, which affected attendance from other disciplines, and detainees were not aware of the date of the next review. Staff who led the review we observed were thorough, sensitive and knowledgeable about the detainee at risk, but minutes of other reviews indicated little evidence of review of progress against the original care map. ACDT care plans were generally weak, and absent in two cases reviewed. Information on assessment forms was not used to formulate the care map, and so personal factors or significant events that may have triggered

self-harm were sometimes missed. There was a lack of identified purposeful activity in care maps, and no routine follow-up after a care and support plan had been closed.

Further recommendations

5.18 Where possible, self-harm at-risk reviews should be scheduled to allow other disciplines to attend, and the detainee should be advised in advance of the timing of his review.

5.19 Care maps should always be completed. They should be based on information from the initial assessment interview, the views of the detainee and, where appropriate, the views of other disciplines and the detainee's friends or family. Action should be SMART (specific, measurable, achievable, realistic and time bound), and ascribed to individuals.

5.20 Post-assessment, care in detention and teamwork (ACDT) closure reviews should be held in all cases to identify, assess and respond to any re-emerging risks.

5.21 Professional interpreters should be used during F2052SH (self-harm monitoring) reviews, unless the detainee concerned requests another detainee to be used. (5.34)

Partially achieved. There was little use of professional interpreters in ACDT assessments and reviews, and staff or detainees were often used to interpret. The ACDT coordinator explained that consent was sought, and also that the ACDT process had been translated into a number of languages for the interpreter to read to the detainee. She emphasised the desire to remove, where possible, the impersonal element of translation over the telephone. However, it was not possible to check the information given by detainee interpreters, and the use of staff to interpret could raise issues if staff relationships were a difficulty for the detainee.

Further recommendation

5.22 Professional interpretation services should be used during self-harm reviews. Detainees and/or staff should be used in a supporting role when the individual under review wishes.

5.23 All detainee custody officers (DCOs) should carry ligature knives and should be aware of the contents of suicide prevention kits. (5.35)

Achieved. All DCOs now carried anti-ligature knives, and staff interviewed at random during the inspection were aware of the contents and location of anti-ligature kits.

5.24 There should be a central food and fluid refusal record. Food and fluid refusal procedures should be clarified to all staff and implemented consistently across the centre. (5.36)

Achieved. ACDT procedures were used effectively to record food and fluid refusal, and the ACDT coordinator held a central record. However, the quality of care maps in relation to the management of food and fluid refusal was variable.

5.25 A buddy scheme should be set up. (5.37)

Partially achieved. The centre had recently introduced a Friends' scheme, which provided an initial point of contact for detainees. For example, Friends gave a tour of facilities, such as the

dining hall and gym, after the induction. However, this service (which was paid) was underused.

Further recommendation

5.26 The Friends' scheme should be extended, particularly to support vulnerable detainees.

Additional information

5.27 There had been 148 ACDT self-harm monitoring documents opened in 2007 and, before the introduction of ACDT, 18 F2052SH forms. Vulnerability to self-harm was most often associated with immigration concerns, which were exacerbated by delays. For example, one detainee who wished to be removed was placed on ACDT after his flight home had been cancelled for the seventh time.

5.28 There was a suicide and self-harm policy, but no formal link with bullying. If a link became apparent, the ACDT coordinator worked with the anti-bullying coordinator to manage this. Staff could recall only one such case, but the lack of strong anti-bullying procedures could have affected identification of such links.

5.29 We observed the well-attended monthly ACDT meeting. This lasted less than 15 minutes, and was mainly feedback from the ACDT coordinator on open ACDTs, training etc. There was no discussion of cases, strategy or practice. Minutes of meetings for the last 12 months showed a similar pattern.

5.30 The new ACDT system was well organised, with photographs of detainees with open ACDTs, seven-day reviews and food refusals clearly displayed on a board in the coordinator's office as well as on the units. The daily assessors were also clearly identified.

5.31 The unit above healthcare used to manage those at risk of self-harm or who had self-harmed had two six-bed rooms, a safer custody suite, and two single rooms. During the inspection, only the two larger rooms were in use; one for an age-dispute case and one for self-harm. The safer custody suite was a bare room with a bed on a plinth in the middle, and a large observation panel in one wall. We received mixed reports about the use of this room. It appeared to have been used infrequently and in cases where a detainee was refractory, as well as at risk of self-harm. There was no record of use, so this could not be verified. This room was not suitable to manage a detainee at risk of self-harm.

5.32 Use of this unit to separate detainees risked increasing isolation. However, there were efforts to reintegrate detainees into activities such as world faith, education and the gym. The lack of structured involvement from these areas in reviews was a significant weakness in the management of self-harm and support for vulnerable detainees. Detainees told us they felt more supported by staff in the self-harm management unit than on the residential units. We observed that residential staff tended to be in offices rather than interacting with detainees. On the evening following a serious attempted hanging in the showers on level three (the detainee was saved by fellow detainees), eight DCOs were in an office on level one and none on level three. See main recommendation HE.47.

5.33 Since October 2007, the ACDT coordinator had completed a review report in all self-harm cases. Fourteen such reviews had been completed. These were analysed by type of self-harm and usually location and, in a few cases (six out of 14), a trigger was identified. However, this

information was not widely used, and there was no evidence that ACDT meetings discussed the findings.

Further recommendations

5.34 Assessment, care in detention and teamwork (ACDT) self-harm monitoring meetings should be more strategic and include discussions about strategy and improving practice. They should analyse information from other sources, such as security and bullying, as well from self-harm incident reports.

5.35 The safer custody room should not be used to hold detainees at risk of or those who have self-harmed.

5.36 Prisons and centres transferring detainees on an open self-harm monitoring procedure or previously subject to these procedures should provide all the relevant paperwork and indicate such cases before their arrival at the centre.

Health and safety

5.37 Fire evacuation signs should be displayed in a greater range of languages. (5.38)

Achieved. Internationally recognised signage was now used.

Diversity

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

5.38 The arrangements for detainees to make complaints about race and diversity related issues should be simplified. (5.50)

Partially achieved. The arrangements for managing race complaints had been streamlined. The standard complaints form was used and included a box to be marked if the complaint had a racial element.

5.39 There should be a log of all complaints relating to race and diversity. (5.51)

Not achieved. The diversity policy stated that racist incident complaints would be logged by the cultural and religious affairs liaison officer (CRALO) and relayed for further analysis to the cultural and religious affairs committee (CRAC). In the previous six months, only one complaint had been logged though, on reviewing all complaints in this period, we identified 18 that had been marked as having a racist element, all alleging racism by staff. There had been no formal complaints from detainees about racist behaviour by other detainees, even though many staff referred to conflict between different groups. CRAC meetings did not refer to any of this information. Complaints relating to other aspects of diversity were also not formally logged and reviewed. There were no management leads for wider diversity areas, including sexual orientation and disability. We identified two complaints that claimed homophobia, but neither

had been scrutinised beyond the formal investigation. (See further recommendation 5.47.) We repeat the recommendation.

Further recommendations

5.40 The cultural and religious affairs committee (CRAC) should examine information relating to racial, religious and cultural conflict between detainees.

5.41 Investigations relating to race and diversity should be thorough and recorded in detail. (5.52)

Not achieved. Records of investigations were incomplete, with only a summary of the findings and outcome. Investigations carried out by different managers varied in quality and depth. There was no specific mechanism to identify complaints relating to wider issues of diversity or for their investigation by identified managers. The centre planned to recruit a diversity manager who would quality control such complaints.

Further recommendations

5.42 CRAC should scrutinise all racist incident complaint investigations to ensure quality control and consistency.

5.43 Complaints relating to issues of diversity other than race and religion should be scrutinised in a centre committee and be subject to quality control by a specified individual.

5.44 Detainees and representatives from relevant outside bodies should be invited to attend the cultural and religious affairs committee (CRAC). (5.53)

Partially achieved. The CRAC met monthly and was generally well attended by managers. Since October 2007, the meetings had been attended by two detainees. No outside organisations had attended the CRAC in the previous six months.

Further recommendation

5.45 Representatives from outside bodies and organisations should be sought to attend all CRAC meetings.

5.46 Statistical information should be collected to enable monitoring and analysis of relevant aspects of diversity. (5.54)

Partially achieved. The CRALO prepared monthly reports, which included a wide range of statistical information from most departments. However, this information was subject to only limited evaluation and scrutiny by the departments or the CRAC. The CRAC discussion was usually limited to an evaluation of the race composition of the detainee population. Longer term trends were not considered.

Further recommendation

5.47 The CRAC should scrutinise monthly statistical information thoroughly and evaluate patterns and trends over time.

5.48 There should be greater use of professional interpreting services, particularly for issues of confidentiality. (5.55)

Achieved. In the previous six months, the centre had used professional interpreting services 176 times compared with only 11 times in the equivalent period before our last inspection. Of the 176 uses, 99 (56%) had been for individuals accessing healthcare, where confidentiality was particularly significant. Nevertheless, informal interpretation by other detainees and staff was also used widely. At the time of our inspection, 111 staff spoke 42 languages other than English, and there was a database of this resource.

Additional information

5.49 The centre had a comprehensive diversity and race policy, but this referred primarily to race and ethnicity. Although the policy stated that all staff should receive annual refresher training in diversity, only 68 staff had attended this in 2007. The training pack was almost exclusively orientated to race, with scant reference to the wider issues of diversity.

5.50 Two rooms on Dove unit had been purpose built to accommodate detainees with a disability, but there were no formal mechanisms to assess need. In our survey, 15% of respondents said they had a disability, but no one at the centre could produce a log of those so identified. The reception healthcare assessment did not include disability, and there was no formal assessment elsewhere. Facilities in healthcare for detainees with a disability were also limited (see paragraph 6.35). The management of disability was undertaken on an ad-hoc basis.

5.51 Each month the CRALO selected detainees to complete questionnaires about their experiences in the centre. Information from these was forwarded to departmental heads to analyse and then respond to the CRALO for his monthly report. The analysis by departmental heads varied considerably, and it was difficult to see if it had led to any change.

Further recommendations

5.52 A more comprehensive diversity policy should be developed, incorporating all aspects of diversity, including disability and sexual orientation.

5.53 All staff should receive annual refresher training in diversity, which should include disability and sexual orientation.

5.54 There should be an identified lead officer for wider diversity issues such as disability.

Faith

Expected outcomes:
All detainees are able to practise their religion fully and in safety. The chaplaincy plays a full part in centre life and contributes to detainees' overall care, support and release plans.

5.55 Detainees should be able to attend religious activities as well as classes. (5.64)

Achieved. The arrangements for detainee movement had become more flexible. Detainees could now attend the world faith area up to three times a day, and as they no longer had to remain there for 90-minute sessions, they could attend both religious activities and classes. There were still some delays in movement, however, as staff were not always available to escort detainees. Some detainees – particularly devout Muslims wanting to attend worship – were still frustrated that they could not move about the centre more freely. This dissatisfaction was reflected in the poor survey results (see paragraph 5.61)

Further recommendation

5.56 Detainees should be able to visit and return from the world faith centre whenever they wish during the core day.

5.57 There should be no blanket restrictions on attendance at communal worship. (5.65)

Achieved. No group of detainees was any longer automatically barred from attending communal worship.

5.58 The role of pastoral work within the centre, and its independence from the Immigration and Nationality Directorate (IND), should be recognised and supported. (5.66)

Achieved. The chaplaincy team was now better integrated into the daily life of the establishment, and the world faith manager told us that the new director understood and valued its pastoral function.

5.59 Members of the chaplaincy team should be involved routinely in suicide and self-harm reviews. (5.67)

Partially achieved. A list of all suicide and self-harm reviews was now copied to the chaplaincy. Members of the team did not regularly attend reviews, but maintained regular contact with the suicide prevention liaison officer about active cases with which they were involved.

Additional information

5.60 The chaplaincy continued to cater well for the religious, spiritual and pastoral needs of detainees. The size of the team had been scaled down with the decrease in the detainee population. It consisted of a full-time world faith manager, who was a Christian chaplain, and his assistant, a Sikh chaplain. The rest of the team was made up of a pool of part-time chaplains from various faiths. A Muslim chaplain had been appointed since the previous inspection, which was an important development because almost half the detainee population

was Muslim. However, he was only employed for two half-days a week, and many Muslim detainees told us they were frustrated by his limited presence.

5.61 The facilities for worship remained very good, and most detainees were positive about their contact with chaplains. Members of the chaplaincy team carried out a wide range of pastoral work and sought modest funds from Jesuit Refugee Service resources to help detainees return home. Despite this work and positive feedback on the team during the inspection, our survey results were poor, which seemed to reflect the problem of access (see paragraph 5.55). Only 58% of respondents felt their religious views were respected, which was significantly below the comparator of 74%, and only 50%, against 62%, said they were able to speak to a religious leader of their faith.

Further recommendation

5.62 There should be sufficient input by a Muslim chaplain to meet the needs of Muslim detainees.

Childcare and child protection

Expected outcomes:
Children are detained only in exceptional circumstances and then only for a few days. The rights and needs of children for care and protection are respected and met in full.

Additional information

5.63 There were good arrangements with the local social services department for the management of age-dispute cases. The Border & Immigration Agency (BIA) faxed a pro forma as soon as a case was identified, and the Refugee Council, caseholder and IMB were advised. Assessments were undertaken promptly by social services. Detainees deemed to be under 18 were generally released into the care of the local authority on the same day (although in one case in the last 12 months there had been a delay because no suitable accommodation was immediately available). However, cases tended not to be processed as quickly if they were referred to another social services department. In the case of one detainee released to the local authority during the inspection it took 54 days to obtain a decision.

5.64 There had been a recent rise in age-dispute cases. The centre treated all age-dispute cases as being under 18, until confirmation was received to the contrary. The young person was located on level three above healthcare (a designated place of safety), where he was accommodated alone or with other age-dispute detainees. A DCO was allocated responsibility for them. These detainees were not permitted to mix with adults, and were taken to the library, education and gym at times when adults were not there. However, if there was only one age-dispute case the young person could become very isolated. This was the case with a young person held during our inspection who spent most of his time in bed.

5.65 DCOs supporting age-dispute detainees lacked guidance in their role and had little meaningful interaction with these young people. One DCO was not aware that one such detainee in her care had a history of self-harm, even though there was clear information on this in his file on her desk. Recording on history sheets was also poor. Entries were not daily and were mostly descriptive – such as, 'watching TV' – rather than demonstrating meaningful interaction by staff.

5.66 The centre accepted all levels of multi-agency public protection arrangements (MAPPA) cases, including detainees convicted of offences against children. One detainee was subject to a sex offending prevention order (SOPO) prohibiting him from an environment likely to have children under 16. He was managed on closed visits, but this was the result of the sending prison highlighting the order. There were no checks, for example, on the use of the internet café by the detainee subject to a relevant SOPO.

5.67 There was no internal system to identify and manage during visits three detainees who had committed sexual offences against children. Visits staff were not aware of any procedures to identify and manage those who posed a risk to children in family visits, and recognition that this could be a concern appeared to relate only to sexual offences. This was a concern, as men who had child visitors could go into the play area with them (and therefore with other children). Although managers said that such detainees could be identified via the detainee database and placed nearer the desk, we saw no evidence of this. Visits were not pre-booked, which made the identification of newly arrived detainees who posed such a risk even more of a priority.

Further recommendations

5.68 Detainee custody officers supervising people whose age is disputed should receive specific training for this role.

5.69 Visits staff should follow basic child protection and public protection procedures.

5.70 Detainees who pose a risk to children or others should be identified on reception.

Section 6: Health services

Expected outcomes:
Healthcare is provided at least to the standard of the National Health Service, includes the promotion of well being as well as the prevention and treatment of illness and recognises the specific needs of detainees as displaced persons who may have experienced trauma.

6.1 The contract for primary care services should be revised to ensure there is an appropriate balance between GP and nurse-led sessions so that resources are used appropriately to meet all health needs. (6.51)

Achieved. The contract for GP services had been reviewed, and these had been reduced from 11 hours a day to five hours on weekdays and one two-and-a-half hour session on weekends and bank holidays. Some nurses had been trained to treat minor injuries and illness (see paragraph 6.4).

6.2 Centres should be given sufficient notice of detainee movement to enable healthcare staff to make the necessary preparation, including the transfer of medical notes and appropriate discharge arrangements on release. (6.52)

Partially achieved. We were told that it was usual for healthcare staff to be notified before detainee movement. However, there had been at least one occasion when prescription medication had to be delivered to the airport terminal because it had not been possible to obtain this before a detainee was moved. Although healthcare staff had good arrangements with the local pharmacy to get medication at short notice when necessary, they needed to have sufficient notice of movement to make appropriate discharge arrangements.
We repeat the recommendation.

6.3 Specialist nursing staff such as registered mental health nurses should be recruited to develop a primary mental health service, so that detainees with identified mental health needs are cared for appropriately. Such nurses should have protected time to practise their specialism. (6.53)

Not achieved. There had been no mental health needs assessment to identify the level of need for primary mental health services. There was one registered mental health nurse (RMN) on the staff team, who worked permanent night duty covering generic nursing duties. There were also three bank nurses with RMN qualifications who also undertook generic duties. The only primary mental health provision was provided by GPs.
We repeat the recommendation.

6.4 Nurses should be trained in the treatment of minor illnesses. (6.54)

Achieved. Six members of nursing staff had been training in the treatment of minor injuries and illness, enabling nurses to deliver more treatments.

6.5 A counselling service should be available to all detainees. (6.55)

Not achieved. There were no counselling services available to detainees.
We repeat the recommendation.

6.6 Healthcare staff should receive specific training in the identification and management of detainees who have been tortured. Such training should be part of the induction

programme and updated regularly. (6.56)

Not achieved. Although there had been attempts to access such training, none had been received.
We repeat the recommendation.

6.7 Patients transferred to hospital following an emergency call should only be handcuffed following an individual risk assessment that this is necessary, taking into account the views of medical staff. (6.57)

Achieved. Detainees were not routinely handcuffed for external medical appointments. In all the cases we looked at, individual risk assessments had been carried out. In the few cases where handcuffs had been used there had been clear security indications for this, confirmed by healthcare risk assessment.

6.8 Mental health awareness training should be introduced for all custody staff. (6.58)

Achieved. All staff had attended basic mental health awareness training as part of their assessment, care in detention and teamwork (ACDT) training. The refresher training for this also included a mental health component.

6.9 Healthcare staff should attend all F2052SH (self-harm monitoring) reviews. (6.59)

Achieved. ACDT had been introduced since our last inspection, and healthcare staff attended reviews when requested to contribute. Although healthcare staff now received better notice of reviews, short notice sometimes made it difficult to attend, for example, if a review was scheduled at the same time as medication treatment (see further recommendation 5.18).

6.10 The reorganised inpatient area should be refurbished to meet the needs of patients, including baths accessible to disabled patients. (6.60)

Not achieved. The inpatient area had not been refurbished, and the bathroom remained unsuitable for disabled patients.
We repeat the recommendation.

6.11 The healthcare manager should hold detainee consultative groups to discuss health issues. (6.61)

Not achieved. The healthcare manager did not hold detainee consultative groups to discuss health issues, and did not regularly attend the detainee consultative meetings. Detainees had generally poor perceptions of healthcare, and some approached us to express their dissatisfaction. In our survey, only 24% of respondents said the overall quality of healthcare was good or very good, against a comparator of 37%.
We repeat the recommendation.

6.12 Professional interpreters should be used whenever there is a clinical need. (6.62)

Partially achieved. Healthcare staff used the telephone interpretation service, and were clear about when and how to use the service. Over half the centre's use was by healthcare professionals. The healthcare team also had a wide range of languages. However, some detainees told us that they were not offered interpretation, which they felt would have been helpful. We also met two detainees who had been asked by other detainees to interpret for

them at healthcare appointments, although they had felt very uncomfortable in this role. We repeat the recommendation.

Further recommendation

6.13 Detainees should only be used as interpreters in healthcare interviews in exceptional circumstances.

6.14 Triage algorithms should be developed to ensure consistency of advice and treatment to all detainees. (6.63)

Achieved. Triage algorithms had been developed and were in place.

6.15 There should be a system for implementing clinical supervision for nurses and this should include training. (6.64)

Not achieved. Although we were told there were some group clinical supervision sessions, there were no records of clinical supervision. Some staff had been trained as supervisors and all staff had been offered clinical supervision, but there had been no uptake. We repeat the recommendation.

Additional information

6.16 Health services were provided by a team of Kalyx-employed nurses and visiting GPs. A dentist and psychiatrist visited weekly and an optician twice a month. We found no links to the local NHS. During our inspection, a detainee was admitted who required aids to daily living, such as a raised toilet seat. The centre was unsuccessful in its approach to the local loans service for the required equipment, and had to purchase these. This created a delay in services for the detainee, and meant that the healthcare team lacked the input of specialist advice in the selection and use of the items.

6.17 We were told that an application to register with the Healthcare Commission had been made, and confirmation of this was awaited.

6.18 Healthcare services were led by a nurse-trained healthcare manager. There were 8.6 registered general nurses (RGNs) in post, one of whom was also a registered mental health nurse (RMN), six healthcare assistants and one administrator. Two agency staff were used regularly, and a bank of nurses covered ad hoc shifts. Recruitment was in progress to fill two vacancies being covered by agency staff.

6.19 There were contracts for general practice, pharmacy and dental services. Waiting lists were short and most services could be accessed on the practitioner's next visit, and detainees could self-refer. There were no contracts for a visiting psychiatrist or optician, and counselling was not available. Detainees attended a local hospital for sexual health clinics and physiotherapy.

6.20 The centre had a portable x-ray machine, and a radiographer attended when required. Records of use were maintained, and there was a maintenance contract for this equipment, which had been used 63 times in 2007.

6.21 There were two consultation rooms and a treatment room in the primary care department. These rooms were clean, tidy, well equipped and welcoming. The option of seeking a second

medical opinion was clearly displayed, although in English only. The waiting room was light and airy, with adequate seating and health promotion and information leaflets, although these were in English only, except for material about TB.

6.22 There was no nurse overseeing the care of older detainees, although a nurse with a background in this area was to be allocated to this role. At the time of our inspection the centre had five detainees over 50.

6.23 An information sheet outlining health services at Harmondsworth and how to access them was available in a range of languages, and a copy was given to all new arrivals as part of the healthcare reception.

6.24 Detainees awaiting specialist appointments while at the centre were not always put on a medical hold. We were told that non-urgent referrals were not made as the detainee was likely to have moved on before their appointment, and such appointments could be dealt with at a later date. Persons in detention are entitled to the full range of NHS services, so all referrals should be made, although those that are not acute should not be placed on a medical hold.

6.25 There were bi-monthly clinical governance meetings, which discussed an appropriate range of topics. Medicines and therapeutic meetings were not held separately and were incorporated into the main clinical governance meetings, whose agenda and minutes showed that medicines management did not play a significant role.

6.26 There was an electronic clinical management system. Hard copies of records that accompanied new arrivals and copies of letters and reports were stored separately, although the hard copy of the detainee's record was used for all clinics. Both systems were well maintained, with good entries, but staff expressed frustration that it was difficult to maintain information on patients with lifelong conditions, for whom a manual register had to be used, and to gather audit information from the system. An upgrade of this system was expected in the near future. An entry was made in the clinical record if the interpretation service had been used. Care plans were either absent or poor in the records of recent inpatients that we reviewed.

6.27 There were no information-sharing protocols with appropriate agencies or with non-clinical detention centre staff, including the DCOs who worked in the primary care or inpatient areas.

6.28 Healthcare reception screening was thorough and supportive. Healthcare staff took a holistic approach that allowed the detainee to express concerns and questions. If a detainee arrived at a meal time the nurse checked that the interview did not cause them to miss their meal. Detainees were asked their first language and offered the telephone interpreting service if required. Questionnaires were available in several languages. All detainees were offered an appointment with a GP for the day following their reception.

6.29 Clinical equipment was regularly checked and maintained, and records were kept. Healthcare staff were aware of its location and use. Clinical staff had completed basic life support training, although not in the previous 12 months. All healthcare staff had also completed first aid training.

6.30 Detainees accessed health services by verbal application rather than forms. Detainees could go to the primary care department at four times during the day and speak to the nurses on duty. The nurse could provide treatment for a minor illness or injury or make an appointment for the next GP clinic. It was not clear if detainees recognised this approach by nursing staff as having received treatment, although it was clearly explained on the information sheet for new

arrivals. Detainees with lifelong conditions were supported on an individual basis, and their care was GP led. There were no community-based services for detainees with long-term physical or mental health conditions. There was a palliative and end-of-life policy.

6.31 Detainees who moved to another centre were accompanied by their clinical records, including a printout of their electronic record. Detainees who returned to the community or who left the country were not given a discharge letter for their doctor or routinely seen by healthcare staff before they left. However, detainees with HIV received up to six months' supply of medication and were given contact details of local HIV clinics in the area of the world where they were returning. The local sexual health clinic also attempted to prescribe them medication they could continue in their area of return. Departing detainees being treated for TB were given the remainder of their course of treatment. Other detainees taking prescribed medication were given at least a week's supply.

6.32 The pharmacist attended the centre regularly, although she did not have direct contact with detainees. The dentist attended weekly. There was no waiting list for the service, and the list was cleared each week. Dental services provided treatment for pain. The dental contract included ad hoc emergency advice, and the dentist made an additional visit if a detainee was in acute pain. The GPs also prescribed analgesics and antibiotics if necessary.

6.33 There was a designated room where medication was stored, with a hatch to the healthcare corridor where detainees collected their medication. The room was clean and tidy, and a computer terminal was appropriately located to record medications. There was a list of detainees who took medication that could not be missed, and staff followed up those who did not attend. Detainees could only approach the hatch one at a time, unless they asked for a detainee to accompany them to interpret. However, the unit DCO was often close to the hatch and able to hear conversations between healthcare staff and detainees, which compromised detainee confidentiality. The medicines cupboards were tidy and well maintained, and we did not find any out-of-date medicines. Most medication was patient named, with a small supply of stock items. Patient information leaflets were available, but in English only. The temperature of the medicine fridge was checked and recorded daily, and staff were clear of the procedure if the recording was outside the acceptable range.

6.34 The 20 inpatient beds were not included on the certified normal accommodation of the centre. This area was also used to locate detainees who required close observation because of risk of self-harm and suicide, and also age-dispute cases who were not able to mix with the general population. These detainees were not under the care of the healthcare staff. There was only a healthcare presence in the area when it held inpatients, otherwise it was staffed by DCOs.

6.35 Facilities in the inpatient unit for detainees with mobility problems or who were wheelchair users were poor. There were two adapted toilets, which were small but had grab rails. The bathrooms were unsuitable, with poorly positioned baths, poor access showers and no rails.

6.36 The only primary mental healthcare services were provided by the GPs. There was no specific mental health caseload, and there had been no mental health needs assessment. A psychiatrist visited one day a week, but there was no contract for this service. Only one permanent member of the primary care team was an RMN, and he was on permanent night duty, covering generic healthcare duties. There was no interaction with the local community mental health team (CMHT), and we were told that it was difficult to transfer detainees to mental health beds in the community. We reviewed the records of a detainee who had been transferred to a prison inpatient bed following failed attempts to transfer him to a medium-secure bed in the community.

6.37 Detainees identified as requiring detoxification received support from a GP with special interest in substance use. The healthcare manager also had experience of working with substance users.

Further recommendations

6.38 The reasons for detainees' poor perception of health services should be identified and addressed.

6.39 There should be information-sharing protocols with appropriate agencies.

6.40 There should be formal arrangements with local health and social care agencies for the loan of occupational therapy equipment and specialist nursing advice to ensure that detainees can access mobility and health aids.

6.41 There should be contracts for the visiting psychiatrist and optician.

6.42 Detainees should receive a full range of NHS services, including referral to secondary care when clinically indicated.

6.43 There should be a medicines and therapeutic committee.

6.44 All inpatients should have a clinical care plan that is regularly reviewed and updated.

6.45 Detainees should have direct access to a pharmacist.

6.46 Facilities for disabled detainees in the inpatient unit should be improved in consultation with an occupational therapist.

6.47 A privacy hood should be installed over the medicine hatch.

6.48 There should be timely transfer of detainees to NHS mental health beds when required.

Section 7: Activities

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

Education and skills training

7.1 There should be increased provision of education for detainees during evenings and weekends, and for those in healthcare and in rule 40 (removal from association) and 42 accommodation. (7.21)

Partially achieved. The centre had extended education provision from four to five evenings a week, and increased the number of activity places to match those during the day. Access at weekends remained poor, and was confined to morning sessions. Despite the addition of internet access, the range of activity also remained narrow. Provision for those in rule 40 and 42 accommodation had been extended to include occasional individual tuition in English for speakers of other languages (ESOL) and art. Officers escorted some detainees from healthcare to attend ESOL and other education activity.

Further recommendation

7.2 Education for detainees and internet access should be extended to weekend afternoons and evenings.

7.3 The development of detainees' oral skills in English for speakers of other languages (ESOL) classes should be prioritised. (7.22)

Not achieved. Although there had been some progress in early 2007 in developing the speaking skills of detainees attending ESOL classes, the ESOL coordinator and one of the two ESOL tutors had left the centre at the end of August. Since then, the take-up of ESOL classes had declined sharply and curriculum development had stalled. It was rare for more than one or two detainees to attend an ESOL class. Evening ESOL classes focused narrowly on game-based activity and were poorly attended. A new coordinator and tutor were due to take up post.
We repeat the recommendation.

7.4 There should be a suitable range of information and communication technology (ICT) short courses, and ICT assignments should be appropriate for learners' experience, interests and level of English. (7.23)

Not achieved. Accredited short courses in ICT were now offered, but had failed to recruit learners and no detainee had achieved an award. Very few detainees studied long enough to complete the more substantial ICT accreditation offered. ICT assignments continued to rely on material in generic workbooks, which bore little relation to detainees' interests or experience. The centre had started to develop some materials for learners with low levels of English, but these were poorly written and covered only a small range of activity.
We repeat the recommendation.

7.5 There should be suitable arrangements to improve the quality of education, including regular self-assessment of the provision and structured observation of tutor

performance. (7.24)

Not achieved. Self-assessment arrangements had not been implemented. The education manager prepared monthly reports on the provision, but these did not identify the strengths or areas for improvement. An initiative to observe tutor performance had ended after the staff who carried this out had left the centre. By the time of our inspection there had been only three observations, and no further observations were timetabled. The centre did not regularly review the effectiveness of courses and activities.
We repeat the recommendation.

7.6 Participation in education should be monitored by ethnicity and nationality to ensure that particular groups are not excluded. (7.25)

Not achieved. The education manager had started producing monthly snapshot data on the nationality of attendees on one day a week, which was part of the CRALO's monthly report. However, the records of learner attendance could not be readily used to identify patterns and trends accurately. The data did not identify the activity attended, and totalled all attendance at each session in the day – which meant that a detainee who attended three sessions was counted three times. The centre did not use the collated data to assess the profile of learners against the detainee population, or to identify whether any groups were excluded.

Further recommendation

7.7 There should be sufficiently thorough monitoring to identify accurately the ethnicity and nationality of detainees participating in education to ensure that particular groups are not excluded.

7.8 There should be better arrangements to inform detainees about activities, including written information in English and other languages. (7.26)

Achieved. New induction arrangements included information on activities offered. An induction booklet, available in 16 languages, included brief information, and a more detailed booklet on activities was also available, but in English only. There was some information about activities, in eight languages, on the touch screens in the residential units, and the Friends who helped new arrivals also gave information.

7.9 Detainees should have more flexible and open access to education and the library. (7.27)

Achieved. Access to education and the library was more flexible. Additional movement to and from the education area in the morning and afternoon allowed detainees greater choice of the time they attended and for how long. It also reduced much of the potential for clashes between going to education or the library and visits or participation in PE. However, the revised arrangements still required detainees to spend a minimum of an hour and a half in the education department. This was restrictive for those who just wanted to borrow or return an item from the library or use the internet briefly.

Further recommendation

7.10 Detainees should be able to visit and leave the education department freely during opening hours.

Additional information

7.11 The range of activities in the education department for short-stay detainees was generally good, but poorer for long-stay detainees (see paragraph 7.15). There was access to the internet, education classes, games and a library in a modern and spacious suite of rooms, with attractive wall displays.

7.12 As at the previous inspection, detainees' participation in activity varied considerably. It was generally good in the afternoons and evenings, but lower in the mornings. On weekdays, there was increased capacity at evening sessions, which, along with daytime sessions, had 120 places, sufficient for about half the population. Places at weekend sessions were fewer, at 60, and were restricted to mornings. At all sessions, the number of places exceeded the number of detainees wanting to attend. The number participating was similar to the last inspection, when there had been twice as many detainees. However, when the centre returned to operating at full capacity, the number of places would not be sufficient. In our survey, 48% of respondents said they attended education, significantly above the comparator of 34%. Detainees did not receive payment for attendance at education or PE.

7.13 Most participants were engaged and interested in their activity, and relationships between staff and detainees were informal and positive. Resources for activities were sufficient, and learning resources in classes were plentiful and mainly appropriate. There was a well-equipped games room and competitions with cash prizes, in the form of credit at the shop, which were popular with detainees. External organisations provided suitable sessions and short projects, which attracted detainees. These included short courses in music production, a drama course for ESOL learners, and yoga sessions.

7.14 Education classes were satisfactory overall. Art classes were good and allowed detainees to develop their skills and interests in a wide range of activity at three levels. Music tuition and mural painting in the world faith corridor were highly appreciated by the detainees involved, although there were only three sessions a week for these activities. ICT teaching was satisfactory, but attendance at ICT sessions had declined since the introduction of internet access. However, some detainees used the facilities to draft letters and submissions in support of their legal cases. Tutor support was readily available.

7.15 There was insufficient activity for detainees who stayed at the centre for long periods. Unless they were interested in art or a computer course, there was little education or work that met their intellectual needs or made productive use of their time. In particular, the opportunities for paid work were narrow (see paragraph 7.17).

7.16 Arrangements to prepare and develop staff were poor. Induction for new staff was brief and did not sufficiently cover important areas, such as security and managing detainees. Although a more extensive induction for groups of staff was available, this took place only occasionally. At the time of our inspection, five of the 17 education staff had not yet had a full induction. Established staff rarely received support for professional development.

7.17 The centre had introduced some paid work in July 2007, and offered 30 part-time jobs with pay rates averaging 50p an hour or £1.50 per three hour session. Progress to expand this had been slow. At the time of our inspection, 21 detainees were in paid work as orderlies in the gym, at induction and in the residential units. Nine were Friends in the residential units showing new arrivals the facilities and explaining procedures. Jobs picking up litter and removing graffiti were unfilled. The scheme was explained to detainees at induction, but not

otherwise promoted. Application rates were low and few applications were refused. In our survey, only 36% of respondents were aware that paid work was available.

7.18 The centre had recently improved several elements of the work scheme, including clearer job descriptions and a more thorough application system. It was reviewing the jobs it offered, and planned to extend the scheme to provide 40 posts.

Further recommendations

7.19 Plans to extend the capacity of the centre should include a significant increase in the space allocated to education and activities.

7.20 Induction for education staff should be thorough and timely.

7.21 There should be significantly more opportunities for paid work for detainees, and these should be promoted effectively.

Library

7.22 At least one member of the library staff should be a qualified librarian or library assistant. (7.28)

Not achieved. The centre had been unable to recruit a member of staff with the appropriate qualifications. Plans for an existing staff member to attend a course to qualify as a library assistant were unlikely to take effect for several months.
We repeat the recommendation.

Additional information

7.23 The library was in the education suite and open at the same time as the other education facilities. It was adequately sized and furnished. The book stock was extensive, offering fiction and non-fiction in more than 20 languages. The stock on display was rotated to offer new titles and reflect detainees' language needs. A good range of bilingual dictionaries was available for loan or reference. The selection of English and foreign language newspapers was good. Detainees could borrow from a good range of DVDs in 13 languages, although stock loss was high. Ten audio players were provided for detainees to play their own or the library's CDs. The library held a satisfactory range of legal texts, and detainees could download information from the internet. Detainees' access to the library had improved and was more flexible than at the last inspection, but users were still not able to move sufficiently freely between the library and residential units.

Physical education

7.24 More spacious gymnasium facilities should be provided with appropriate changing and showering facilities for physical education activities. (7.29)

Achieved. The gymnasium had been increased in size, and now included a popular free weights area as well as cardiovascular exercise equipment. The area was sufficient for up to 15 detainees to use the facilities in safety and comfort. Revised attendance rota and

movement arrangements for PE allowed detainees the opportunity to change and shower in the residential accommodation.

Additional information

7.25 Access to PE had improved since the last inspection and was good, and there were day and evening sessions every day. Detainees had to join sessions at the advertised times, but those attending the gym who had completed their regime were escorted back to the residential units on request, rather than having to wait until the main movement. PE was effectively promoted at induction, and through visits to residential units by PE staff. The number participating was similar to that a year before, when the centre had held twice as many detainees.

7.26 The staff team was enthusiastic, with good expertise and knowledge of games. All had basic qualifications for the role. The staff had initiated a number of well-received projects with external organisations and individuals, such as a coaching session from Fulham football club, and a table tennis event featuring an Iranian champion who had once been an immigration detainee. They had also run successful competitive events between detainees and IRC officers.

7.27 The sports hall was sufficiently spacious for team games, such as five-a-side football, but the well-used outdoor area was cramped. Detainees had appropriate supplies of clean kit and suitable footwear.

7.28 Arrangements to assess detainees' fitness for participation were unsatisfactory. PE staff carried out a basic health check as part of PE induction, but did not usually receive a professional healthcare assessment of detainees' fitness.

7.29 PE staff recorded the nationality of participants and supplied this to the CRALO. However, this data was not used to assess the profile of participants against the population as a whole, or to identify any groups who were excluded.

Further recommendations

7.30 A healthcare assessment of detainees' fitness for PE should be available to the PE department before detainees start PE activity, and should be timely.

7.31 Data on the take-up of PE by ethnicity and nationality should be analysed to ensure that particular groups are not excluded.

Section 8: Rules and management of the centre

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

Rules of the centre

8.1 Detainees placed on rule 42 of the Detention Centre Rules (temporary confinement) should only be strip searched following a risk assessment (8.34)

Achieved. Strip searching now only took place following a risk assessment by staff and management, including in the separation unit for detainees on rule 42.

Security

8.2 All detainees should be risk assessed on arrival. Monitoring of telephone calls and mail should be considered for those with previous convictions for sexual or harassment offences, and restrictions on child visitors should also be considered where previous convictions suggest this is necessary. (8.38)

Partially achieved. New arrivals were risk assessed through interviews and examination of accompanying paperwork, and reception staff highlighted any concerns to the duty manager and security. Detainees considered to be a risk were placed in the welfare and support unit (WASU) for further assessment. There were concerns over the lack of information from prisons, and fewer than half of ex-prisoners arrived with their core record or security file (see main recommendation HE.39). Notices of prominent detainees who had been highlighted by security were displayed in the staff canteen and the security office. However, it was not clear why they were prominent, how up to date the information was, and if any necessary restrictions were in place. Information on detainees with previous convictions for sexual offences was not thorough, and was not shared between departments or with visits staff. Visits staff were unaware of any procedures for restrictions on child visitors for those convicted of sexual offences (see paragraph 5.67 and further recommendation 5.70).

Additional information

8.3 The security office was staffed by two security analysts and two detainee custody officers. There was only one manager in security, and in their absence there was little management oversight.

8.4 Security staff gathered information through security information reports (SIRs), incident reports and initial risk assessments of detainees. This information was recorded systematically. The number of SIRs had reduced steadily from July 2007, when 118 had been recorded, to 38 in December 2007. However, incident reports had risen over the same period and both systems were used appropriately. All SIRs were completed in a timely manner, but a significant number had no manager's comments or actions.

8.5 The security committee met monthly, but had not met for two months until the week of the inspection. The meetings were not always well attended. Previous action points were unclear

and not addressed. The meeting we observed was brief. Although well attended, it did not analyse any security information or identify emerging patterns or trends. This diminished the assessment of security intelligence and subsequent security objective-setting.

8.6 The centre perimeter was monitored via closed circuit television (CCTV) and protected by an alarmed electronic protection beam. Some internal doors were operated by personal identification to a camera monitored in the control room, and staff there could also operate electronic doors if required. Ash and Beech units had been closed since the disturbance, and plans for their future had yet to be finalised.

8.7 Detainee movement around the centre had improved considerably since the last inspection, but could still be too restricted (see paragraphs 5.55 and 7.9). Some rules were also still too restrictive; for example, detainees reported having to choose between having a shave and going to education in the morning, as razors were issued only till 9am and had to be returned then for the detainee to retrieve his identity card.

8.8 Area searches were completed monthly and all areas were fabric checked daily. There had been 18 strip searches in the previous six months, which were based on adequate risk assessment. We found one incident where the duty manager had authorised a full strip search when control and restraint had been applied, but this had not been recorded by security.

8.9 Closed visits were reviewed monthly. A monthly security bulletin had good observational information, but little analysis, and few residential staff had seen it. A monthly security risk report, which measured protests and threats of riot, was also not widely shared with staff, and did not explain clearly why someone was a prominent nominal (an individual targeted for legitimate security reasons). However, the daily briefings to staff were of value and shared some security information. We observed the handover to night staff, which was thorough and insightful, with a group exchange and sharing of information.

Further recommendations

8.10 Security information report (SIRs) should be managed properly and all management sections should be completed.

8.11 Security meetings should be held monthly and thoroughly analyse the gathered intelligence and set security objectives.

8.12 Action points from security meetings should be clear and followed up at subsequent meetings.

8.13 There should be accurate records of full strip searches.

8.14 The monthly security bulletin should be issued to all staff.

8.15 The identification of prominent and developing nominals should be clear and based on up-to-date security information.

Housekeeping point

8.16 The issue of razors to detainees should not limit their access to activities.

Rewards scheme

8.17 The sanctions-based incentives and earned privileges (IEP) scheme should be replaced with a scheme that positively rewards detainees for engaging in the regime, and that treats access to education, faith provision and unrestricted visits as entitlements not privileges. (8.35)

Not achieved. The revised rewards scheme was still an incentives and earned privileges (IEP) procedure that closely mirrored a prison scheme, rather than one that rewarded detainees for active participation in the regime. Published in February 2007, it was already out of date and referred to the situation prior to the temporary closure of the centre in 2006 – for example, making reference to Ash unit, which had closed after the disturbance. More importantly, access to activities such as education was denied if a detainee was downgraded to standard (see paragraph 8.22), which was indicative of a punishment rather than a rewards scheme.
We repeat the recommendation.

8.18 Detainees, particularly those who do not speak English, should be made aware of the details of a revised rewards scheme. (8.36)

Partially achieved. The rewards scheme was explained on induction, but little information was given to detainees to take away and read. The scheme was not explained on noticeboards in any language other than English. Detainees did not have a good understanding of the scheme, which could have been explained on the touch screens in the residential units and reception.
We repeat the recommendation.

Further recommendation

8.19 A revised rewards scheme should have up-to-date information and be explained on the information touch screens.

8.20 Detainees should not be demoted to standard level for refusing to leave the centre to board flights. (8.37)

Achieved. Detainees were no longer demoted to standard level for this reason. The scheme was now based on patterns of behaviour, and three warnings were generally issued prior to demotion.

8.21 The revised rewards scheme should be monitored by nationality, ethnicity and location. (8.39)

Partially achieved. The CRALO had produced a graph that showed how many detainees had been on standard regime and their nationality. But this was purely an observational tool, with no analysis of the information or any emerging patterns or trends.
We repeat the recommendation.

Additional information

8.22 Detainees demoted to standard level could be restricted to the welfare and support unit (WASU). They lost their jobs and, if sent to WASU, could have their mobile telephones

removed. Their weekly allowance was reduced from £6 to £4. Their access to education was curtailed to outreach, in which a teacher came to the unit to give them work. Their access to worship was also restricted, and staff were not entirely clear about this. However, they had a separate slot to attend the gym. Detainees on standard also had a reduced weekly post allowance, and visiting times were restricted to one hour per day or one three-hour session per week. Staff in the WASU monitored their behaviour and noted it in detainee history files. Their entries had meaningful and purposeful comments.

8.23 Standard regime was not imposed lightly or without effective management oversight. In the previous five months, it had been used on 69 occasions and the longest a detainee had spent on standard was 16 days. Reviews were weekly, but some detainees were reviewed early and returned to enhanced. The review process was robust and taken seriously by management. During our inspection, only two detainees were on standard.

8.24 General wing history files showed little evidence of detainees' behaviour relating to the incentives scheme, and few had in-depth, knowledgeable or insightful comments on detainees.

Further recommendations

8.25 Detainees should not routinely have their mobile telephones removed if sent to the welfare and support unit (WASU). This should be done on a risk assessed basis only.

8.26 Wing history files should reflect detainees' behaviour and directly link to the rewards scheme.

Use of force and single separation

8.27 The use of Detention Centre Rule 40 (removal from association) should be closely monitored to ensure that it is only used where necessary for security and safety and that detainees remain on these restrictions for the shortest possible time. (8.40)

Partially achieved. The use of rule 40 was monitored by senior managers daily, and decisions to place detainees on rule 40 were appropriate. Levels of use had decreased recently, though in the last five months it had been used 120 times, with an average stay of two days. In September and October 2007, rule 40 had been used for two separate detainees for 27 and 17 consecutive days, and it was unclear from the available documentation why such lengthy periods were justified. We also found that detainees placed on rule 40 were often not released until just before the 24-hour point, when the centre had to seek further Border & Immigration Agency (BIA) authorisation, suggesting that the detainees could have been moved earlier. In September 2007, this applied to five out of eight detainees on rule 40, and in December 2007 to six out of 12. (See further recommendation 8.45.)

8.28 Detainees placed on rule 40 should be given written reasons and a copy of the regime in a language that they can understand. (8.41)

Partially achieved. Written reasons were given to detainees to explain why they were placed on rule 40, but in English only. In some cases, staff, and occasionally other detainees, interpreted them for some detainees who did not understand English, but this was not routine and a professional interpretation service was not used. The regime was published in several languages.
We repeat the recommendation.

Further recommendation

8.29 When reasons for rule 40 or rule 42 are explained in a detainee's language, this should be recorded. Other detainees should not be asked to explain such paperwork.

8.30 Written requests by centre managers for continued confinement under rule 40 should fully explain the reasons why such restrictions are necessary. (8.42)

Partially achieved. Initial information was not comprehensive, and occasionally superficial. Further requests followed the same pattern – while some managers explained the situation thoroughly, others did not. Some immigration staff replies to detainees about further restrictions were also not thorough.

Further recommendation

8.31 Written requests by centre managers for continued confinement under rule 40 should fully explain the reasons why such restrictions are necessary, and immigration staff should be similarly thorough in explaining to detainees why further restrictions apply.

8.32 Detainees placed on rule 40 should have an avenue of appeal and this should be explained to them in a language they can understand. (8.43)

Partially achieved. Detainees understood why they were on the unit, and had access to staff and managers to discuss their situation. Some were vocal in requesting an appeal, but none followed up their options and we saw no evidence that appeals had been heard. The appeal process was not clear for those who could not understand English, and was not explained in any language other than English.

Further recommendation

8.33 Detainees placed on rule 40 should have the appeal process explained to them in a language they can understand.

8.34 The establishment should have a published policy explaining the circumstances in which physical education (PE) and education bans can be imposed on detainees. Reasons for any bans should be recorded and detainees should have clear avenues of appeal. (8.44)

Achieved. This was now incorporated into the revised rewards scheme. Restrictions were not imposed on detainees arbitrarily, and poor behaviour was now directed through the rewards scheme, which was subject to management scrutiny (see also paragraph 8.23).

8.35 Managers should investigate the high levels of use of force involving detainees on Detention Centre Rules 40 and 42 (removal from association and temporary confinement). (8.45)

Achieved. Managers had put considerable effort into reducing use of force across the centre,

and it had also gone down on the units that operated rules 40 and 42. We found no recent use of force forms that originated in the separation unit.

8.36 Detainees placed on rule 42 should be provided with written reasons and a copy of the regime in a language that they can understand. (8.46)

Partially achieved. Written reasons were given to detainees to explain why they were placed on rule 42, but in English only. In some cases, staff, and occasionally other detainees, interpreted them for some detainees who did not understand English, but this was not routine and a professional interpretation service was not used. The regime was published in several languages. (See further recommendation 8.29)

8.37 The level of use of rule 42 should be closely monitored and, where used, detainees should be removed from it at the earliest opportunity. (8.47)

Partially achieved. In the previous five months, rule 42 had been used on 39 occasions with an average stay of 30 hours, which was significantly less than at the last inspection. It had been used 17 times in the last three months. In recent months two detainees had spent nine and six consecutive days on the unit. Although both had displayed difficult behaviour (one was a dirty protest), the available documentation did not make clear why the length of detention was justified. Rule 42 was used only once, for a short period, during our inspection. The use of rule 42 was monitored daily by senior managers, and decisions to place detainees on this rule appeared appropriate. This was a considerable improvement on the situation at the last inspection. Most were moved out of rule 42 accommodation at an early stage. However, we found occasional cases where detainees were not released until just before the 24-hour point, when the centre had to seek further BIA authorisation, suggesting that the detainees could have been moved earlier. There was no analysis of trends or patterns. (See further recommendation 8.45.)

8.38 Rule 42 should not be used to hold detainees during periods of personal crisis. (8.48)

Achieved. Detainees were no longer held on rule 42 during periods of personal crisis. Healthcare and the residential units were now used.

Additional information

8.39 The welfare and support unit (WASU) provided the rule 40 regime and the care and separation unit (CASU) covered rule 42 provision. Both units were clean, free of graffiti, and suitable for their purpose.

8.40 The bedrooms on WASU had separate showers and toilets. There was a general association room with a television. Detainees were allowed to move around the unit for most of the day and had regular access to fresh air. A member of the chaplaincy team visited daily, along with the duty manager. Staff checked on detainees regularly, and completed detainee history files to a high standard – entries were generally insightful and recorded the regime provided.

8.41 CASU was a four-cell unit that was used sparingly. The cells were stark, but clean. The regime was reasonable, with access to the duty manager and the chaplaincy as well as fresh air. However, there was a closed visits rule for all detainees on CASU, which was inappropriate.

8.42 Use of force had reduced, proportionate to the population, by about 20% since the last inspection. There had been 43 incidents in the previous six months. Over 90% of staff had received control and restraint refresher training in the last 12 months. Responses to our survey

indicated that use of force was significantly lower than the comparator, and only 8%, against 17%, said staff had restrained them in the last six months. The completed use of force forms we looked at were reasonably well completed. Reports were informative, and there were good examples of de-escalation. However, in one incident where two detainees had been fighting, the officer stated: 'I approached and took control of Mr [the detainee] by grabbing him around the upper body and driving him to the floor.' This action was inappropriate. Healthcare staff always checked the detainee for injuries within a reasonable timescale, usually immediately after the incident. In some documentation it was not clear how the incident was concluded.

8.43 Some planned use of force removals were filmed and saved on DVD. We watched some of these and found mixed responses. One incident clearly showed significant attempts to calm down a very aggressive and upset detainee, where the attempts at de-escalation were good and professional. However, other incidents were not managed appropriately. The language used was unnecessary and unprofessional, for example, 'get him in the fucking cell'. In an incident where a manager shouted at a detainee, 'you need to listen big and I mean listen big', the situation was further exacerbated unnecessarily by an order for him to pick up his property and carry it to the CASU, when a member of staff could have brought it. This incident was poorly managed throughout, with unclear instructions to the detainee. He was asked to bring his knees to his chest during a forced full strip search while he was on the floor, so he could be helped to stand up, but this was not explained to him, and he was clearly scared when he shouted, 'what are you going to do to me?'

8.44 Managers had not viewed these DVDs until the week of our inspection. These filmed incidents should have been checked for appropriateness and to identify training needs. Although the management of use of force had improved, there was a lack of examination of incidents, management checks of records or monitoring of patterns.

Further recommendations

8.45 Detainees on rule 40 and rule 42 should be returned to normal accommodation at the earliest opportunity.

8.46 Senior managers should view all filmed interventions to ensure appropriate management of use of force incidents.

8.47 Use of force should be monitored and senior managers should identify and minute any trends or patterns.

Complaints

8.48 Information about making applications and complaints should be fully explained to new arrivals, well publicised around the residential units and available in a range of appropriate languages. (8.49)

Partially achieved. Complaint forms were available in translation around the units, and the complaints procedure was explained on induction. However, some detainees did not understand it; in particular, Chinese detainees in our focus group were not aware of the procedures, and their literacy levels seemed too poor for them to use the translated materials even after these were explained by an interpreter. They had not had the benefit of interpretation services at induction.

Further recommendation

8.49 Interpretation services should be used where required to explain the complaints system to new arrivals. Regular discussion groups, using an interpreter, should take place with detainees who do not speak English fluently.

8.50 All stages of applications should be recorded, including the outcome, and there should be effective arrangements for tracking and monitoring their progress. (8.50)

Achieved. We received no complaints about the applications process, which appeared to work effectively.

8.51 Complaint forms and confidential access envelopes should be freely available to detainees on all residential units. There should be secure boxes for detainees to submit these, which should only be opened by approved key holders. (8.51)

Partially achieved. Complaint forms in a range of languages were readily available on residential units, and the boxes were alongside the forms and were locked. BIA staff emptied these each day. Only one rack of forms that we checked had confidential access envelopes.

Housekeeping point

8.52 Confidential access envelopes for complaint forms should be available on all units.

8.53 All non-returns of complaint forms should be fully investigated. (8.52)

Not achieved. We found examples where complaints had not been followed up. In one case, a detainee failed to respond to a request for further information in a complaint about staff, and there was no action to follow this up. In other cases the detainee had moved on, although BIA did follow through complaints after detainees had left.
We repeat the recommendation.

Further recommendation

8.54 When further information about a complaint is required, the detainee should be invited to an interview for a more detailed discussion.

8.55 The work of the Independent Monitoring Board (IMB) should be fully explained to detainees on induction, publicised around the centre and available in a range of appropriate languages. (8.53)

Achieved. The role of the IMB was explained during induction. Photographs of IMB members were displayed in reception, the induction room and around the centre. Many detainees appeared to know who the IMB members were, even if they were not always clear about their remit. Information had been translated into various languages, including in the BIA complaints information pack. The IMB was also producing translated material about its role.

Additional information

8.56 The process for dealing with complaints was complicated. BIA staff emptied the complaints box and took the more serious ones (usually against staff) and returned the rest to the centre to deal with. BIA staff logged the complaints they kept (five in the previous six months) and the centre logged those they received, but there was no central log of complaints when the box was emptied. One detainee told us he had submitted a complaint about staff and had not received a reply, but without a central log, no record of this could be found. The centre complained of delays in receiving complaints back from BIA. In one case, the complaint had been made on 27 December 2007, the detainee left on 30 December and the centre received the complaint on 17 January, so full investigation was not possible.

8.57 Seventy-seven complaints had been recorded in the last six months of 2007, but the monitoring of these was not sufficiently robust. For example, they were not monitored by ethnicity and nationality, or for bullying by staff. We found two cases where the clerk had deemed a complaint not to be a complaint, and so had not logged it. The monthly monitoring sheet was not completed to show how many were deemed not to be a complaint or how many were upheld, although the form had space for this information. The complaints clerk decided who the complaint was allocated to. If it was a serious staff issue, she asked the human resources department for terms of reference. There was no quality assurance monitoring.

8.58 Of the five recent complaints that had gone to BIA, four were about staff – three alleged physical assault from DCOs, and one alleged sexually inappropriate behaviour by a DCO. The centre had dealt with seven complaints about staff in 2007 and two in 2008 to date. The quality of the investigations by the centre was variable. There were no transcripts of interviews, and relevant individuals were not always interviewed. Four of the complaints against staff had summaries of interviews, but the other three had no evidence on file, which made it impossible to judge the validity of responses. In only one allegation about staff was there a clear statement that the staff member's actions had been unhelpful. Our further investigation revealed that appropriate action had been taken in this case, but had not been recorded. There had been no analysis of the underlying causes of staff victimisation of detainees.

8.59 Four of the complaints received between July and December 2007 were not in English. Generally staff were asked to translate, but this was not appropriate as the complaint could have been against staff.

8.60 Complaints were usually answered promptly, addressed the detainee by name, were polite and clearly identified the person responding. Responses generally addressed the issues raised. In one case about lost property, the response said this was a matter for the escort contractors, but there was no evidence this had been passed on to them. In another case, there was no copy of the response to the detainee on file.

Further recommendations

8.61 Centre managers should monitor and analyse complaints about victimisation of detainees by staff and take appropriate action.

8.62 All complaints should be logged centrally when the complaints box is emptied. The Border & Immigration Agency (BIA) should deal with complaints swiftly, and the log should always indicate the time taken to complete investigations.

8.63	Complaints should be subject to quality assurance by a senior member of staff.
8.64	Complaints should be monitored thoroughly, for example, by ethnicity and nationality and for bullying, and this data should be used to inform practice.
8.65	Transcripts of interviews should be made and kept on file, and actions taken recorded.
8.66	Staff should not be used to translate detainee complaints.
8.67	Complaints that concern outside bodies, such as escort contractors, should be passed on to the relevant agency and the detainee should be informed accordingly.
8.68	Copies of responses to detainees about complaints should be kept on file.

Section 9: Services

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

Catering

9.1 There should be food comments books in all the serveries, located where detainees can see them. (9.10)

Achieved. Food comments books had been placed in the two serveries, and posters reminded detainees that they could use them to make their views known. Although there were regular entries by detainees, almost half were offensive or not serious. However, there was little evidence that genuine comments were taken seriously by staff and acted upon.

Further recommendation

9.2 Detainees' comments about food should be taken seriously.

9.3 There should be a full catering survey of detainees and the results acted upon. (9.11)

Not achieved. This recommendation was rejected on the basis that the population was too transient, which was a dismissive approach. Regardless of detainees' length of stay, a survey was important to understand their strong negative views about the food.
We repeat the recommendation.

9.4 The detainee committee meetings should be used for formal consultation with detainees about the reasons for their negative views of the food and ways to resolve this. (9.12)

Not achieved. Attendance at the regular detainee committee meetings was often poor, and there was limited representation by catering staff. There was little evidence that the committee meetings gave detainees an opportunity to express their views about catering or that appropriate action was taken.

Further recommendation

9.5 The head of catering should attend all detainee committee meetings and fully respond to all food issues raised.

Additional information

9.6 Detainees were extremely negative about the standard of food. In our survey, only 20% of respondents thought that the food was good or very good, which was significantly below the comparator of 35%, and also below the 23% response at the previous inspection. Consultation arrangements were inadequate (see above). For example, managers had decided to remove pork from the menu to satisfy Muslim detainees that the food prepared for them was not

contaminated. However, the smaller group of Chinese detainees, who regarded pork as essential to their diet, felt this was unfair to them. The decision had created unnecessary tension, which could have been avoided with better consultation and more measured responses. Another example of the poor response to detainees' food needs was the requirement for medical approval before a detainee could receive a vegan diet. This was unnecessarily bureaucratic.

9.7 The quality of food that we sampled was not as poor as the reports from detainees suggested. The food was fresh, and the chef had £3 per head per day to provide three hot meals, six hot drinks and three snacks. It seemed that detainees' perception reflected their view that their cultural preferences were not taken seriously. There was scope for detainees to have opportunities to prepare their national dishes themselves, as happens in similar establishments.

Further recommendations

9.8 Detainees who request a vegan diet should be offered this without medical approval, unless there are specific health concerns.

9.9 Detainees should be given the opportunity to prepare their national dishes for themselves and others.

Centre shop

9.10 The range of items stocked in the centre shop should be increased, in consultation with the detainee population. Items should not be banned unless there is a clear and identifiable risk. (9.13)

Not achieved. The range of items remained limited. In our survey, only 24% of respondents said the shop sold a wide enough range of goods to meet their needs, against the comparator of 37%. Detainees were now consulted at regular meetings, but there was little evidence that suggestions were followed up (see below). Tinned goods were still prohibited because of concern about the potential harm from metal containers – although these products are allowed in many prisons. There were few items to cater for the ethnically and culturally diverse population.
We repeat the recommendation.

9.11 All detainees should have the opportunity to comment or make suggestions about products they would like the shop to stock. (9.14)

Partially achieved. Detainee consultative committee meetings were poorly attended and, until recently, there was little follow-up of matters raised (see recommendation 2.15). There were feedback forms in the centre's two shops, but none had been completed. Many detainees said they did not know about the consultation arrangements, and those who did expressed little confidence in them.

9.12 There should be a committee, involving detainees, to oversee the spending of money from the general purpose fund. (9.15)

Not achieved. General purpose fund expenditure was agreed between centre managers and Border & Immigration Agency (BIA) staff. At the end of December 2007, the fund had about

£14,000, much of which was to be spent on improving facilities in association areas.
We repeat the recommendation.

Additional information

9.13 Detainees had unlimited access to their own cash and received 86p a day. They had access to the shop every day, in the morning or the afternoon, and could also exchange foreign currency at a reasonable rate.

Section 10: Preparation for release

Expected outcomes:
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.

Welfare

10.1 Links with community-based organisations that can support detainees should be strengthened and extended. (10.23)

Achieved. The new welfare department had made considerable efforts to develop external links. The Refugee Council now ran weekly workshops and surgeries and saw up to nine detainees on each visit. Bail for Immigration Detainees (BID) also ran some surgeries to support detainees applying for bail. The last surgeries had been run in November 2007, with 18 detainees attending each of two sessions. There had been recent contact with the International Organisation for Migration, and there had been a meeting with staff to plan detainee surgeries. Other organisations had been contacted for specific issues or needs, including the Salvation Army and International Red Cross.

Additional information

10.2 A well-resourced welfare team had been set up In May 2007. It consisted of six officers and one team leader, with three or four staff on duty between 7.30am and 8.30 pm. The team responded to one-off queries as well as handling ongoing casework and was a laudable development. On average, there were about 550 one-off contacts and 35 cases each month. In the previous four months, the main issues dealt with had related to property (66), immigration cases (31), and obtaining funding and financial support (32). The group worked with considerable effort and enthusiasm, but the staff had had no structured training and sometimes struggled to answer basic questions and provide assistance. Set up as a pilot project, the team's work to date had been a success. However, unit staff in the centre tended to refer issues to the welfare department that they should have dealt with themselves.

10.3 Some detainees expressed frustration with and lack of confidence in the welfare team. There was a belief that information shared with the team was subsequently passed to the Border & Immigration Agency (BIA). We saw no evidence to suggest that information was passed to BIA inappropriately. However, the team had no confidentiality policy to ensure consistency and enhance confidence

10.4 The welfare department was also responsible for the selection and management of detainee Friends (see paragraph 1.13). At the time of the inspection, five detainees on Dove and four on Cedar were Friends, offering initial contact for new arrivals and showing them around. Their role was valuable, but could have been further developed (see further recommendation 5.26).

Further recommendations

10.5 Staff who work as welfare officers should have structured training covering key aspects of the work.

10.6 The welfare team should have a clear and well-publicised confidentiality policy that is outlined to detainees who contact them.

Visits

10.7 Identity requirements for visitors should be clear and not unduly restrictive: photographic identification should not be necessary. (10.24)

Partially achieved. Photographic identification was no longer required, but it was still necessary for visitors to provide two forms of identification, including one with an address. Staff were not clear if this identification was required on the first visit only or on all visits.

Housekeeping point

10.8 Identity requirements for visitors should be clear, and staff should be briefed on them.

10.9 Staff should exercise appropriate discretion in granting entry to visitors who have difficulty producing the required proof of identity. (10.25)

Achieved. Although no formal record was available, staff who worked regularly in the visits area told us that only one visitor in the previous six months had been refused entrance because they were unable to produce adequate identification. Detainees did not raise with us the issue of visitors refused entry

Further recommendation

10.10 There should be a formal record of all visitors refused entrance because they cannot produce suitable identification.

10.11 The decoration and atmosphere in the visits area should be more welcoming. (10.26)

Not achieved. Although clean and spacious, the visits area remained austere and impersonal. We repeat the recommendation.

10.12 There should be a complaints system and comments book in the visits area. (10.27)

Achieved. There was now a comment card system inviting views from visitors about their treatment and the service they received. A summary of recent comments was displayed in the visitor centre, with a helpful commentary about how complaints were addressed, as well as apologies for delays in opening times.

10.13 Visitors should be consulted on their views on the visiting arrangements and the centre should take action accordingly. (10.28)

Achieved. See above.

10.14 There should be no restrictions on contact between families and detainees during visits, except to maintain decency. (10.29)

Achieved. Clear instructions about standards of decency in the visits area had recently been published and were displayed. Detainees were reminded about these before they were admitted to the visits area. Staff and detainees seemed content with the current arrangements for dealing with physical contact, and we observed only appropriate interaction between detainees and their visitors.

Additional information

10.15 Detainee access to visits remained good. Visits were available every day between 2pm and 9pm. Staff exercised their discretion to allow visits to last as long as the detainee and visitors wanted, and most visits, apart from at the busy weekend period, lasted over two hours.

10.16 In our survey, significantly more respondents than the comparator, 62% against 40%, said they had had a visit. However, only 30%, against 44%, reported that they had been treated well or very well by visits staff.

Further recommendation

10.17 The centre should further investigate the reasons behind many detainees' negative perceptions of visits staff.

Telephones and mail

10.18 Telephones should not be removed from detainees' rooms as a punishment. (10.30)

Achieved. Telephones were no longer removed from rooms as a sanction for poor conduct.

Additional information

10.19 In our survey, 67% of respondents said that it was easy to receive incoming calls, higher than the comparator of 51%. Only 45% said it was easy to make outgoing calls, below the comparator of 54%, and this appeared to have been because of the expense of international calls. Detainees had telephones in their rooms to receive incoming calls. There were sufficient pay telephones in each residential area, and around 90% of detainees carried their own mobile telephones. The mobile telephone cards sold in the shop were reasonably priced.

10.20 Detainees continued to receive one free domestic letter a week, and unlimited free mail for legal correspondence. We came across a case where a member of staff had assiduously helped to track down mail that had gone missing outside the establishment.

10.21 The arrangements for use of fax machines had improved, and there were now separate facilities on each residential unit, as well as a central resource for international material. The machines were staffed during the day and detainees had open access to this service with no restrictions on the amount of material that could be sent.

Removal and release

10.22 Detainees should be given written notice in advance of transfer, removal or discharge, except in exceptional circumstances. (10.31)

Partially achieved. Detainees were usually given at least 48 hours' written notice of removal. During our inspection, we observed Operation Ravel, involving the removal of eight detainees to Afghanistan. Some of these detainees told us that they had been given no notice. We checked this and found that they had been told a few days earlier that they were to be removed, but not when. However, four of the eight removed were on the reserve list, and even the staff at Harmondsworth did not know they were to be included until the bus arrived at the centre. Such short notice removal had an unsettling effect on the detainees themselves and others in the centre.

Further recommendation

10.23 The centre should be informed well in advance of detainees who are to be removed, and this should be conveyed immediately to detainees affected, unless there is clear justification for not doing so.

10.24 Detainees due for transfer, discharge or removal and considered at risk of self-harm or violent behaviour should be subject to a multidisciplinary care plan and risk assessment. (10.32)

Partially achieved. An at-risk list included detainees who said they would harm themselves in response to an identified trigger, usually receipt of removal directions. As soon as removal directions were received, an assessment, care in detention and teamwork (ACDT) care map was devised. During the inspection, two detainees on the at-risk list received removal directions. One attempted to self-harm and, following a search, a razor he had secreted on his body was removed. There was a serious suicide attempt by another detainee who had received removal directions, but who was not on the at-risk list. There was no such system for those considered to pose a risk of violent behaviour.

Further recommendations

10.25 Staff should be alerted to the identity of all detainees who have received removal directions so that they can monitor them more closely.

10.26 Detainees due for transfer, discharge or removal, particularly those who are considered to pose a risk of self-harm or violent behaviour, should be subject to multidisciplinary case management procedures.

Additional information

10.27 We were told that staff sometimes used what was termed ‘trickery’ when there were concerns about the level of cooperation from a detainee being removed. One example given was telling the detainee that he was moving rooms, when in reality he was being removed from the centre. This was an unnecessary deception, and staff had the skills to separate detainees from others and achieve removals without resorting to such a tactic. As some detainees returned after failed removals, it also had the potential to reduce confidence among other detainees and destabilise the centre.

10.28 Detainees identified for a planned removal were approached by the welfare team to complete a discharge questionnaire. This covered views on the helpfulness of staff and usefulness of

facilities. Between 50% and 60% of detainees usually refused to complete these, and information from them was therefore limited, though useful to some extent. Although areas of concern were reported to the head of care and welfare each month, no analysis had been undertaken and there was no evidence of any further action.

10.29 There was no systematic pre-discharge assessment or preparation for detainees, who were particularly vulnerable on receipt of removal directions.

Further recommendations

10.30 Detainees should not be moved around or from the centre by deception.

10.31 Discharge questionnaires should be analysed and the results distributed to centre managers. Any actions taken as a result should be recorded.

10.32 All detainees should have pre-discharge assessment and preparation to minimise risks and maximise assistance.

Section 11: Summary of recommendations, housekeeping and good practice

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 recommendation — To BIA

11.1 There should be sufficient, suitably qualified immigration staff to ensure that all detainees receive prompt explanation of their status and responses to queries, and that all detained casework is diligently monitored and progressed. (HE46)

Main recommendation — To BIA and centre manager

11.2 Detailed information relevant to risk and needs should be provided to escorting and receiving establishment staff on fully completed IS91 detention authority forms, including information on those transferring from prisons. (HE.39)

Main recommendations — To the centre manager

11.3 Staff should be trained in anti-bullying procedures, and be able to recognise and manage bullies and victims. (HE40)

11.4 Multidisciplinary assessment, care in detention and teamwork (ACDT) reviews should make reference to the care map, progress against each action should be logged, and new actions identified and carried out as appropriate. (HE41)

11.5 Security and centre procedures should comply with the purpose of detention centres, as set out in the Detention Centre Rules. (HE42)

11.6 There should be a mental health needs analysis to identify and determine the need for specialist psychiatric support for detainees. (HE43)

11.7 There should be sufficient and appropriate learning and skills provision and employment to meet the needs of both long- and short-term detainees. (HE44)

11.8 Detainees should have prompt access to suitably qualified legal representatives. (HE45)

11.9 Residential staff should take a more proactive role in managing and supporting detainees, particularly those who are vulnerable, and should be a visible presence on the residential units. (HE47)

Recommendations — To BIA

Arrival in detention

11.10 Escort staff should be given clear guidance on their powers and responsibilities when they escort detainees to consulates. (1.1)

11.11 When detainees are held in police stations, police custody records should be attached to the IS91 detention authority, to provide a continuous record of detention history. (1.2)

11.12 Detainees should not be moved around the detention estate excessively, without explanation and with little notice. (1.4)

Casework

11.13 The Border & Immigration Agency (BIA) should monitor cases of unaccompanied young people who are detained, but subsequently assessed to be minors and released to the care of local authorities, and pass this information back to the detaining BIA office. (4.9)

11.14 A medical report should trigger a prompt review of detention, and the detainee should be informed of the basis and outcome of the review. (4.11)

11.15 The effect of any transfer on detainees' contact with legal representatives and on bail applications should be taken into account before any move. (4.12)

11.16 Reasons for and reviews of detention should reflect all relevant circumstances for and against continuing detention, and should be issued and explained in a language the detainee understands. (4.13)

Health services

11.17 Centres should be given sufficient notice of detainee movement to enable healthcare staff to make the necessary preparation, including the transfer of medical notes and appropriate discharge arrangements on release. (6.2)

Recommendation

To BIA and Prison Service

11.18 Prisons and centres transferring detainees on an open self-harm monitoring procedure or previously subject to these procedures should provide all the relevant paperwork and indicate such cases before their arrival at the centre. (5.36)

Recommendations

To BIA and the centre manager

Rules and management of the centre

11.19 All complaints should be logged centrally when the complaints box is emptied. The Border & Immigration Agency (BIA) should deal with complaints swiftly, and the log should always indicate the time taken to complete investigations. (8.62)

11.20 Complaints that concern outside bodies, such as escort contractors, should be passed on to the relevant agency and the detainee should be informed accordingly. (8.67)

11.21 Copies of responses to detainees about complaints should be kept on file. (8.68)

Preparation for release

11.22 The centre should be informed well in advance of detainees who are to be removed, and this should be conveyed immediately to detainees affected, unless there is clear justification for not doing so. (10.23)

Recommendations

To the centre manager

Arrival in detention

11.23 There should be a published list only of banned items. (1.7)

11.24 All detainees should be offered a free, private telephone call on reception and this should be documented. (1.8)

11.25 Detainees should have sufficient detailed material, professionally translated, to meet their induction needs. (1.10)

Residential units

11.26 Detainees' concerns about heating and ventilation should be taken seriously, and there should be determined efforts to resolve any problems. (2.4)

11.27 All detainees should be given clear information about how to operate room thermostats. (2.5)

11.28 There should be more association facilities, including on the living units. (2.6)

11.29 Double rooms should not be used for three detainees. (2.14)

11.30 Detainee consultation meetings should be better promoted. Action points should be acted upon and reviewed at subsequent meetings. (2.15)

Staff-detainee relationships

11.31 Staff should not address detainees by surnames alone. (2.18)

11.32 Staff should not enter detainees' rooms without knocking. (2.19)

11.33 A care officer scheme that involves all unit staff should be developed. (2.22)

Legal rights

11.34 The centre should consult the Legal Services Commission to improve detainee access to legal advice and representation. (3.6)

Casework

11.35 Procedures to comply with Detention Centre Rule 35 should make clear that a medical report is mandatory whenever a detainee's health 'is likely to be injuriously affected by continued detention or any conditions of detention'. (4.10)

Duty of care

11.36 The anti-bullying policy should be based on evidence of detainees' experiences. (5.1)

11.37 Anti-bullying and victim support logs should be completed in all cases, and victims should be actively supported to engage in all aspects of the regime without fear of victimisation. (5.2)

11.38 Anti-bullying meetings should be multidisciplinary, include detainee representation and consider issues in depth. (5.4)

11.39 The anti-bullying telephone line should encourage callers to leave messages and explain the support available to victims. (5.5)

11.40 The anti-bullying policy should be better publicised, and detainees should be clearly informed of unacceptable behaviour and the consequences of bullying. (5.9)

11.41 Intelligence from various sources, including security and safer detention procedures, should be used to identify and manage bullying and trends should be analysed. (5.10)

11.42 Suicide prevention committee meetings should include representation from detainees and the Samaritans. (5.12)

11.43 Staff should interact positively with detainees at risk of self-harm rather than simply observing them, and monitoring checks should be regular but unpredictable. (5.16)

11.44 Where possible, self-harm at-risk reviews should be scheduled to allow other disciplines to attend, and the detainee should be advised in advance of the timing of his review. (5.18)

11.45 Care maps should always be completed. They should be based on information from the initial assessment interview, the views of the detainee and, where relevant, from other disciplines and, if appropriate and with the detainee's consent, his friends or family. Action should be SMART (specific, measurable, achievable, realistic and time bound), with an individual identified as responsible for each one. (5.19)

11.46 Post-assessment, care in detention and teamwork (ACDT) closure reviews should be held in all cases to identify, assess and respond to any re-emerging risks. (5.20)

11.47 Professional interpretation services should be used during self-harm reviews. Detainees and/or staff should be used in a supporting role when the individual under review wishes. (5.22)

11.48 The Friends' scheme should be extended, particularly to support vulnerable detainees. (5.26)

11.49 Assessment, care in detention and teamwork (ACDT) self-harm monitoring meetings should be more strategic and include discussions about strategy and improving practice, and analyse

information from other sources, such as security and bullying, as well from self-harm incident reports. (5.34)

11.50 The safer custody room should not be used to hold detainees at risk of or who have self-harmed. (5.35)

11.51 There should be a log of all complaints relating to race and diversity. (5.39)

11.52 The cultural and religious affairs committee (CRAC) should examine information relating to racial, religious and cultural conflict between detainees. (5.40)

11.53 CRAC should scrutinise all racist incident complaint investigations to ensure quality control and consistency. (5.42)

11.54 Complaints relating to issues of diversity other than race and religion should be scrutinised in a centre committee and be subject to quality control by a specified individual. (5.43)

11.55 Representatives from outside bodies and organisations should be sought to attend all CRAC meetings. (5.45)

11.56 The CRAC should scrutinise monthly statistical information more thoroughly and evaluate patterns and trends over time. (5.47)

11.57 A more comprehensive diversity policy should be developed, incorporating all aspects of diversity, including disability and sexual orientation. (5.52)

11.58 All staff should receive annual refresher training in diversity, which should include disability and sexual orientation. (5.53)

11.59 There should be an identified lead officer for wider diversity issues such as disability. (5.54)

11.60 Detainees should be able to visit and return from the world faith centre whenever they wish during the core day. (5.56)

11.61 There should be sufficient input by a Muslim chaplain to meet the needs of Muslim detainees. (5.62)

11.62 Detainee custody officers supervising people whose age is disputed should receive specific training for this role. (5.68)

11.63 Visits staff should follow basic child protection and public protection procedures. (5.69)

11.64 Detainees who pose a risk to children or others should be identified on reception. (5.70)

Health services

11.65 Specialist nursing staff such as registered mental health nurses should be recruited to develop a primary mental health service, so that detainees with identified mental health needs are cared for appropriately. Such nurses should have protected time to practise their specialism. (6.3)

11.66 A counselling service should be available to all detainees. (6.5)

11.67 Healthcare staff should receive specific training in the identification and management of detainees who have been tortured. Such training should be part of the induction programme and updated regularly. (6.6)

11.68 The reorganised inpatient area should be refurbished to meet the needs of patients, including baths accessible to disabled patients. (6.10)

11.69 The healthcare manager should hold detainee consultative groups to discuss health issues. (6.11)

11.70 Professional interpreters should be used whenever there is a clinical need. (6.12)

11.71 Detainees should only be used as interpreters in healthcare interviews in exceptional circumstances. (6.13)

11.72 There should be a system for implementing clinical supervision for nurses and this should include training. (6.15)

11.73 The reasons for detainees' poor perception of health services should be identified and addressed. (6.38)

11.74 There should be information-sharing protocols with appropriate agencies. (6.39)

11.75 There should be formal arrangements with local health and social care agencies for the loan of occupational therapy equipment and specialist nursing advice to ensure that detainees can access mobility and health aids. (6.40)

11.76 There should be contracts for the visiting psychiatrist and optician. (6.41)

11.77 Detainees should receive a full range of NHS services, including referral to secondary care when clinically indicated. (6.42)

11.78 There should be a medicines and therapeutic committee. (6.43)

11.79 All inpatients should have a clinical care plan that is regularly reviewed and updated. (6.44)

11.80 Detainees should have direct access to a pharmacist. (6.45)

11.81 Facilities for disabled detainees in the inpatient unit should be improved in consultation with an occupational therapist. (6.46)

11.82 A privacy hood should be installed over the medicine hatch. (6.47)

11.83 There should be timely transfer of detainees to NHS mental health beds when required. (6.48)

Activities

11.84 Education for detainees and internet access should be extended to weekend afternoons and evenings. (7.2)

11.85 The development of detainees' oral skills in English for speakers of other languages (ESOL) classes should be prioritised. (7.3)

11.86 There should be a suitable range of information and communication technology (ICT) short courses, and ICT assignments should be appropriate for learners' experience, interests and level of English. (7.4)

11.87 There should be suitable arrangements to improve the quality of education, including regular self-assessment of the provision and structured observation of tutor performance. (7.5)

11.88 There should be sufficiently thorough monitoring to identify accurately the ethnicity and nationality of detainees participating in education to ensure that particular groups are not excluded. *(7.7)*

11.89 Detainees should be able to visit and leave the education department freely during opening hours. (7.10)

11.90 Plans to extend the capacity of the centre should include a significant increase in the space allocated to education and activities. (7.19)

11.91 Induction for education staff should be thorough and timely. (7.20)

11.92 There should be significantly more opportunities for paid work for detainees, and these should be promoted effectively. (7.21)

11.93 At least one member of the library staff should be a qualified librarian or library assistant. (7.22)

11.94 A healthcare assessment of detainees' fitness for PE should be available to the PE department before detainees start PE activity, and should be timely. (7.30)

11.95 Data on the take-up of PE by ethnicity and nationality should be analysed to ensure that particular groups are not excluded. (7.31)

Rules and management of the centre

11.96 Security information report (SIRs) should be managed properly and all management sections should be completed. (8.10)

11.97 Security meetings should be held monthly and thoroughly analyse the gathered intelligence and set security objectives. (8.11)

11.98 Action points from security meetings should be clear and followed up at subsequent meetings. (8.12)

11.99 There should be accurate records of full strip searches. (8.13)

11.100 The monthly security bulletin should be issued to all staff. (8.14)

11.101 The identification of prominent and developing nominals should be clear and based on up-to-date security information. (8.15)

11.102 The sanctions-based incentives and earned privileges (IEP) scheme should be replaced with a scheme that positively rewards detainees for engaging in the regime, and that treats access to education, faith provision and unrestricted visits as entitlements not privileges. (8.17)

11.103 Detainees, particularly those who do not speak English, should be made aware of the details of a revised rewards scheme. (8.18)

11.104 A revised rewards scheme should have up-to-date information and be explained on the information touch screens. (8.19)

11.105 The revised rewards scheme should be monitored by nationality, ethnicity and location. (8.21)

11.106 Detainees should not routinely have their mobile telephones removed if sent to the welfare and support unit (WASU). This should be done on a risk assessed basis only. (8.25)

11.107 Wing history files should reflect detainees' behaviour and directly link to the rewards scheme. (8.26)

11.108 Detainees placed on rule 40 should be given written reasons and a copy of the regime in a language that they can understand. (8.28)

11.109 When reasons for rule 40 or rule 42 are explained in a detainee's language, this should be recorded. Other detainees should not be asked to explain such paperwork. (8.29)

11.110 Written requests by centre managers for continued confinement under rule 40 should fully explain the reasons why such restrictions are necessary, and immigration staff should be similarly thorough in explaining to detainees why further restrictions apply. (8.31)

11.111 Detainees placed on rule 40 should have the appeal process explained to them in a language they can understand. (8.33)

11.112 Detainees on rule 40 and rule 42 should be returned to normal accommodation at the earliest opportunity. (8.45)

11.113 Senior managers should view all filmed interventions to ensure appropriate management of use of force incidents. (8.46)

11.114 Use of force should be monitored and senior managers should identify and minute any trends or patterns. (8.47)

11.115 Interpretation services should be used where required to explain the complaints system to new arrivals. Regular discussion groups, using an interpreter, should take place with detainees who do not speak English fluently. (8.49)

11.116 All non-returns of complaint forms should be fully investigated. (8.53)

11.117 When further information about a complaint is required, the detainee should be invited to an interview for a more detailed discussion. (8.54)

11.118 Centre managers should monitor and analyse complaints about victimisation of detainees by staff and take appropriate action. (8.61)

11.119 Complaints should be subject to quality assurance by a senior member of staff. (8.63)

11.120 Complaints should be monitored thoroughly, for example, by ethnicity and nationality and for bullying, and this data should be used to inform practice. (8.64)

11.121 Transcripts of interviews should be made and kept on file, and actions taken recorded. (8.65)

11.122 Staff should not be used to translate detainee complaints. (8.66)

Services

11.123 Detainees' comments about food should be taken seriously. (9.2)

11.124 There should be a full catering survey of detainees and the results acted upon. (9.3)

11.125 The head of catering should attend all detainee committee meetings and fully respond to all food issues raised. (9.5)

11.126 Detainees who request a vegan diet should be offered this without medical approval, unless there are specific health concerns. (9.8)

11.127 Detainees should be given the opportunity to prepare their national dishes for themselves and others. (9.9)

11.128 The range of items stocked in the centre shop should be increased, in consultation with the detainee population. Items should not be banned unless there is a clear and identifiable risk. (9.10)

11.129 There should be a committee, involving detainees, to oversee the spending of money from the general purpose fund. (9.12)

Preparation for release

11.130 Staff who work as welfare officers should have structured training covering key aspects of the work. (10.5)

11.131 The welfare team should have a clear and well-publicised confidentiality policy that is outlined to detainees who contact them. (10.6)

11.132 There should be a formal record of all visitors refused entrance because they cannot produce suitable identification. (10.10)

11.133 The decoration and atmosphere in the visits area should be more welcoming. (10.11)

11.134 The centre should further investigate the reasons behind many detainees' negative perceptions of visits staff. (10.17)

11.135 Staff should be alerted to the identity of all detainees who have received removal directions so that they can monitor them more closely. (10.25)

11.136 Detainees due for transfer, discharge or removal, particularly those who are considered to pose a risk of self-harm or violent behaviour, should be subject to multidisciplinary case management procedures. (10.26)

11.137 Detainees should not be moved around or from the centre by deception. (10.30)

11.138 Discharge questionnaires should be analysed and the results distributed to centre managers. Any actions taken as a result should be recorded. (10.31)

11.139 All detainees should have pre-discharge assessment and preparation to minimise risks and maximise assistance. (10.32)

Housekeeping points

11.140 A wider range of general information in different languages should be displayed. (2.16)

11.141 The centre should investigate the reasons for detainees' negative views on access to clean clothes. (2.17)

11.142 The issue of razors to detainees should not limit their access to activities. (8.16)

11.143 Confidential access envelopes for complaint forms should be available on all units. (8.52)

11.144 Identity requirements for visitors should be clear, and staff should be briefed on them. (10.8)

Example of good practice

11.145 New arrivals were given a letter for their visitors with detailed advice about visiting arrangements and what they could bring for the detainee. This was available in a range of languages. (1.14)

Appendix I: Inspection team

Hindpal Singh Bhui	Team leader
Eileen Bye	Inspector
Hazel Elliot	Inspector
Keith McInnis	Inspector
Ian Macfadyen	Inspector
Gerard O'Donoghue	Inspector
Mandy Whittingham	Healthcare inspector
Alastair Pearson	Ofsted inspector
Helen Meckiffe	Researcher
Sherrelle Parke	Research trainee

Appendix II: Detainee population profile

(i) Age	Number	%
18 years to 21 years	37	*14.86*
22 years to 29 years	82	*32.93*
30 years to 39 years	84	*33.73*
40 years to 49 years	41	*16.47*
50 years to 59 years	5	*2.01*
Total	249	*100*

(ii) Nationality	Number	%
Afghanistan	26	*10.4*
Algeria	12	*4.8*
Angola	5	*2.0*
Bangladesh	13	*5.2*
Cameroon	1	*0.4*
China	11	*4.4*
Colombia	1	*0.4*
Dem Republic Congo	4	*1.6*
Croatia	1	*0.4*
Cuba	1	*0.4*
Egypt	1	*0.4*
Eritrea	3	*1.2*
Ethiopia	2	*0.8*
Gambia	3	*1.2*
Ghana	6	*2.4*
Guinea	1	*0.4*
India	3	*1.2*
Iran	11	*4.4*
Iraq	6	*2.4*
Ivory Coast	1	*0.4*
Jamaica	27	*10.8*
Jordan	1	*0.4*

Kenya	4	*1.6*
Kosovo	3	*1.2*
Liberia	1	*0.4*
Libya	2	*0.8*
Malawi	1	*0.4*
Malaysia	2	*0.8*
Mexico	1	*0.4*
Morocco	2	*0.8*
Nigeria	11	*4.4*
Pakistan	31	*12.4*
Palestine	1	*0.4*
Philippines	1	*0.4*
Russia	1	*0.4*
Rwanda	1	*0.4*
Sierra Leone	2	*0.8*
Somalia	11	*4.4*
South Africa	1	*0.4*
Sri Lanka	8	*3.2*
Sudan	2	*0.8*
Trinidad & Tobago	1	*0.4*
Tunisia	2	*0.8*
Turkey	5	*2.0*
Uganda	10	*4.0*
Vietnam	2	*0.8*
Zimbabwe	2	*0.8*
Other	1	*0.4*
Total	249	*99.6*

(iv) Religion/belief	Number	%
Buddhist	7	*2.8*
Bahai	1	*0.4*
Roman Catholic	43	*17.3*
Orthodox	2	*0.8*
Other Christian religion	22	*8.8*

Hindu	5	*2.0*
Muslim	114	*45.8*
Sikh	2	*0.8*
Agnostic/atheist	1	*0.4*
Unknown	49	*19.7*
Church of England	1	*0.4*
Rastafarian	2	*0.8*
Total	249	*100*

(v) Length of time in detention in this centre	Number	%
Less than 1 week	32	*12.85*
1 to 2 weeks	11	*4.4*
2 to 4 weeks	82	*32.9*
1 to 2 months	54	*21.7*
2 to 4 months	45	*18.1*
4 to 6 months	23	*9.2*
6 to 8 months	2	*0.8*
Total	249	*100*

(vi) Detainees last location before detention in this centre	Number	%
Community	60	*24.1*
Another IRC	27	*10.8*
Short-term holding facility	18	*7.2*
Police station	59	*23.7*
Prison	85	*34.1*
Total	249	*100*

Appendix III: Summary of safety interviews

Twenty detainees, 10 each from Cedar and Dove units, were interviewed on 15 January 2008 regarding issues of safety at Harmondsworth. This is a small sample (8%) of the total population. Random individuals were approached on the units and in the education areas of the centre. Participation in the interview process was voluntary.

An interview schedule was used in order to maintain consistency, so all interviewees were asked the same questions.

Demographic information

- The average length of time in detention was approximately five months and ranged from three days to 1.5 years.
- Length of time at Harmondsworth ranged from 30 minutes to 7.5 months. The average length of time spent at Harmondsworth was approximately two months.
- For 12 interviewees, this was their first time in detention.
- Ages ranged from 20 to 44, the average being 33.
- Four interviewees were Nigerian, three Iranian, three Jamaican, two Kenyan, two Indian, two Ugandan, one Turkish, one Libyan, one Ugandan and one from Guinea.
- All interviewees spoke English but only nine spoke English as a first language.
- Seven interviewees identified their religion as Christian, five Muslim, two Catholic, two had no religion and the remaining detainees identified as Church of England, Anglican Church, Bahai and Sikh.
- Three interviewees stated they had a disability.

Safety

All interviewees were asked to identify areas of concern with regards to safety within Harmondsworth, as well as rating how unsafe each issue they identified made them feel on a scale of 1 to 4 (1 = a little bit of a problem to 4 = very much a problem). A 'seriousness score' was then calculated, multiplying the number of individuals who thought the issue was a problem by the average rating score.

The top four issues were reported as safety concerns by at least half of the interviewees.

	2008		
	Yes, this is a problem	Average rate	Seriousness score
Uncertainty/insecurity because of immigration case	16	4	64
Lack of confidence in staff	11	3	33
Lack of trust in centre staff	10	3	30
Access to legal advice	10	3	30
Aggressive body language of detainees	8	3	24
Healthcare facilities	7	3	21
Isolation (within the centre)	5	4	20

The way staff behave with detainees	5	3	15
Surveillance cameras on residential units	4	3.5	14
Number of staff on duty at night	3	4	12
Procedures for discipline	3	4	12
Availability of drugs	5	2	10
Lack of communication with family/ friends	4	2.5	10
Overcrowding	5	2	10
Number of staff on duty during the day	5	2	10
Discrimination by staff on the basis of culture or ethnicity	3	3	9
Information in translation	3	2.5	7.5
Surveillance cameras elsewhere in the centre	2	3.5	7
Layout of centre	2	3	6
Response of staff to fights/ bullying in the centre	2	3	6
Aggressive body language of staff	3	2	6
Discrimination by detainees on the basis of culture or ethnicity	3	1.5	4.5
Discrimination by detainees on the basis of sexual orientation	1	4	4
The way meals are served	2	1.5	3
Information about centre regime	1	3	3
Gang culture	2	1.5	3
Response of staff to self harm incidents in the centre	2	1.5	3
Existence of an illegal market	1	1	1
Staff members giving favours in return for something	1	1	1
Discrimination by detainees on the basis of religion	1	1	1
Discrimination by staff on the basis of religion	0	0	0
Discrimination by staff on the basis of sexual orientation	0	0	0
Discrimination by staff on the basis of disability	0	0	0
Discrimination by detainees on the basis of disability	0	0	0
Discrimination by staff on the basis of age	0	0	0
Discrimination by detainees on the basis of age	0	0	0

Examples of comments for the top four issues

Uncertainty/insecurity because of immigration case
'Immigration have no regard for the process. They don't do what they say they will.'

'Sometimes disregard cases. Lost father in similar troubles in Kenya so the current situation is bringing things back. Also girlfriend is from another warring tribe which puts them at risk.'

'Been in UK 10 years. Don't want to go back as family are here.'

'Don't have documents. Have family here and in Jamaica but have no way of contacting them.'

Lack of confidence in centre staff
'Spoke to welfare in confidence and then found out it had been passed to immigration.'

'Healthcare staff said was being disruptive to avoid flight but they're lying.'

Lack of trust in centre staff
'Some staff are ok, both others aren't. Welfare staff are more like MI6 for immigration.'

'Only have problem with staff in visits and healthcare.'

'Trusted welfare staff but they were insensitive by saying that he was just like everyone else going back to Kenya.'

Access to legal advice
'Not sufficient info here – only two legal books in the library and only one is important – there's always a big queue for it. Don't feel the legal surgery advice is independent. Can't get the info you need from the internet – BID and legal advice sites are blocked. Info is power, anything could happen if you don't have the right information.'

'Can't get legal aid because no one is willing to take it on.'

Overall safety rating

In 2008 interviewees rated their feelings of safety at Harmondsworth as 3 ('good') on a scale of 1 ('very bad') to 4 ('very good'). This is an improvement on the safety rating of 2 ('satisfactory') that was found in 2006.

Comparison to 2006

In 2008, 20 detainees were interviewed, and in 2006, 16 detainees were interviewed. The table below compares the percentage of those interviewed who said issues were a problem. Areas highlighted in green signify a decrease and areas highlighted in blue signify an increase in the proportion of detainees reporting the problem compared to 2006.

	% of interviewees reporting a problem	
	2008	2006
Uncertainty/insecurity because of immigration case	80%	100%

Lack of confidence in staff	55%	63%
Lack of trust in centre staff	50%	81%
Access to legal advice	50%	75%
Aggressive body language of detainees	40%	0%
Healthcare facilities	35%	88%
Isolation (within the centre)	25%	69%
The way staff behave with detainees	25%	94%
Surveillance cameras on residential units	20%	44%
Number of staff on duty at night	15%	44%
Procedures for discipline	15%	50%
Availability of drugs	25%	19%
Lack of communication with family/ friends	20%	56%
Overcrowding	25%	38%
Number of staff on duty during the day	25%	63%
Discrimination by staff on the basis of culture or ethnicity	15%	56%
Information in translation	15%	100%
Surveillance cameras elsewhere in the centre	10%	50%
Layout of centre	10%	38%
Response of staff to fights/ bullying in the centre	10%	31%
Aggressive body language of staff	15%	63%
Discrimination by detainees on the basis of culture or ethnicity	15%	6%

Discrimination by detainees on the basis of sexual orientation	5%	6%
The way meals are served	10%	50%
Information about centre regime	5%	N/A
Gang culture	10%	13%
Response of staff to self-harm incidents in the centre	10%	44%
Existence of an illegal market	5%	6%
Staff members giving favours in return for something	5%	0%
Discrimination by detainees on the basis of religion	5%	19%
Discrimination by staff on the basis of religion	0%	38%
Discrimination by staff on the basis of sexual orientation	0%	6%
Discrimination by staff on the basis of disability	0%	19%
Discrimination by detainees on the basis of disability	0%	6%
Discrimination by staff on the basis of age	0%	0%
Discrimination by detainees on the basis of age	0%	0%

Appendix IV: Summary of detainee survey responses

Detainee survey methodology

A voluntary, confidential and anonymous survey of the detainee population was carried out for this inspection. The results of this survey formed part of the evidence base for the inspection.

Choosing the sample size

At the time of the survey on 8-9 January 2008, the detainee population at Harmondsworth was 252. The questionnaire was given to 214 detainees. Overall, this represented 85% of the detainee population.

Selecting the sample

Questionnaires were offered to all adult detainees available at the time of the visit. Completion of the questionnaire was voluntary. Interviews were offered to any respondents with literacy difficulties. Questionnaires were offered in 24 languages.

Methodology

Every attempt was made to distribute the questionnaires to each respondent on an individual basis. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- have their questionnaire ready to hand back to a member of the research team at a specified time;
- to seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire.

Response rates

In total, 86 respondents completed and returned their questionnaires. This represented 34% of the prison population. The response rate was 40%. In total 126 questionnaires were not returned or returned blank. Sixty-two questionnaires (72%) were returned in English, nine (10%) in Urdu, three in Bengali (3%), three in Chinese (3%), three in Farsi (3%), two in Arabic (2%), two in Kurdish Sorani and one each in Tamil and Somali.

Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted, in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey, are the comparator figures for all detainees surveyed in detention centres. This comparator is based on all responses from detainee surveys carried out in eight detention centres since April 2007.

In the above document, statistically significant differences are highlighted. Statistical significance merely indicates whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by grey shading, results that are significantly worse are indicated by a black background and where there is no significant difference, there is no shading.

It should be noted that, in order for statistical comparisons to be made between the most recent survey data and that of the previous survey, both sets of data have been coded in the same way, though some of the questions and response options may have changed. This may result in percentages from previous surveys looking higher or lower. However, both percentages are true of the populations they were taken from, and the statistical significance is correct.

Detainee Survey Responses Harmondsworth IRC 2008

Detainee Survey Responses (Missing data has been excluded for each question) Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

	Any numbers highlighted in green are significantly better than the IRC comparator/ last survey
	Any numbers highlighted in blue are significantly worse than the IRC comparator/ last survey
	Numbers which are not highlighted show there is no significant difference between the 2008 survey and the IRC comparator

		Harmondsworth IRC 2008	IRC Comparator		Harmondsworth IRC 2008	Harmondsworth IRC 2006
SECTION 1: General Information (not tested for significance)						
Number of completed questionnaires returned		**86**	**869**		**86**	**113**
1	Are you male?	**100%**	**83%**		**100%**	**100%**
2	Are you aged under 21 years?	**17%**	**13%**		**17%**	**13%**
5	Is English your first language?	**34%**	**24%**		**34%**	**41%**
6	Do you understand spoken English?	**87%**	**76%**		**87%**	**87%**
7	Do you understand written English?	**80%**	**67%**		**80%**	**79%**
8	Are you Muslim?	**49%**	**44%**		**49%**	
9	Do you consider yourself to have a disability?	**15%**	**30%**		**15%**	
10	Do you have any children under the age of 18?	**43%**	**45%**		**43%**	**46%**
SECTION 2: Immigration Detention (not tested for significance)						
11	When being detained, were you told the reasons why in a language you could understand?	**74%**	**65%**		**74%**	
12	Following detention, were you given written reasons why you were being detained in a language you could understand?	**67%**	**58%**		**67%**	
13	Were you first detained in a police station?	**58%**	**54%**		**58%**	
14	Including this Centre, have you been held in six or more places as an immigration detainee since being detained?	**11%**	**13%**		**11%**	
15	Have you been here for more than one month?	**79%**	**51%**		**79%**	**75%**
SECTION 3: Transfers and Escorts						
16	Did you know where you were going when you left the last place where you were detained?	**34%**	**42%**		**34%**	**37%**
17	Before you arrived here did you receive any written information about what would happen to you in a language you could understand?	**34%**	**23%**		**34%**	
18	Did you spend more than four hours in the escort van to get to this centre?	**34%**	**28%**		**34%**	**24%**
19	Were you treated well/very well by the escort staff?	**51%**	**62%**		**51%**	**51%**

Key to tables							
	Any numbers highlighted in green are significantly better than the IRC comparator/ last survey	Harmondsworth IRC 2008	IRC Comparator		Harmondsworth IRC 2008	Harmondsworth IRC 2006
	Any numbers highlighted in blue are significantly worse than the IRC comparator/ last survey					
	Numbers which are not highlighted show there is no significant difference between the 2008 survey and the IRC comparator					
SECTION 4: Reception and First Night						
21	Were you seen by a member of healthcare staff in reception?	**96%**	**80%**		**96%**	**73%**
22	When you were searched in reception was this carried out in a sensitive way?	**62%**	**64%**		**62%**	**47%**
23	Were you treated well/very well by staff in reception?	**53%**	**62%**		**53%**	**30%**
24a	Did you receive information about what was going to happen to you on your day of arrival?	**34%**	**30%**		**34%**	**10%**
24b	Did you receive information about what support was available to people feeling depressed or suicidal on your day of arrival?	**35%**	**29%**		**35%**	**21%**
24c	Did you receive information about how to make applications on your day of arrival?	**24%**	**30%**		**24%**	**26%**
24d	Did you receive information about healthcare services at the Centre on your day of arrival?	**49%**	**23%**		**49%**	
24e	Did you receive information about the religious team on your day of arrival?	**43%**	**16%**		**43%**	
24f	Did you receive information on how to make a bail application on your day of arrival?	**21%**	**14%**		**21%**	
24g	Did you receive information about how people can visit you on your day of arrival?	**47%**	**34%**		**47%**	**31%**
25	Was any of this information provided in a translated form?	**9%**	**15%**		**9%**	
26a	Did you receive something to eat on your day of arrival?	**72%**	**63%**		**72%**	**46%**
26b	Did you get the opportunity to make a free telephone call on your day of arrival?	**34%**	**59%**		**34%**	**18%**
26c	Did you get the opportunity to have a shower on your day of arrival?	**50%**	**50%**		**50%**	
26d	Did you get the opportunity to change into clean clothing on your day of arrival?	**45%**	**36%**		**45%**	
27	Did you feel safe on your first night here?	**56%**	**56%**		**56%**	**39%**
28a	Did you have any problems when you first arrived?	**85%**	**74%**		**85%**	**81%**
28b	Did you have any problems with loss of transferred property when you first arrived?	**26%**	**22%**		**26%**	**19%**
28c	Did you have any housing problems when you first arrived?	**18%**	**12%**		**18%**	**13%**
28d	Did you have any problems contacting employers when you first arrived?	**7%**	**7%**		**7%**	**15%**
28e	Did you have any problems contacting family when you first arrived?	**22%**	**20%**		**22%**	**30%**
28f	Did you have any problems ensuring dependents were being looked after when you first arrived?	**15%**	**9%**		**15%**	**10%**
28g	Did you have any problems accessing your phone numbers when you first arrived?	**17%**	**24%**		**17%**	
28h	Did you have any problems accessing legal advice when you first arrived?	**34%**	**29%**		**34%**	

Key to tables						
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	Any numbers highlighted in blue are significantly worse than the IRC comparator/ last survey					
	Numbers which are not highlighted show there is no significant difference between the 2008 survey and the IRC comparator					
SECTION 4: Reception and First Night continued						
28i	Did you have any problems getting access to your immigration case papers when you first arrived?	**26%**	**29%**		**26%**	
28j	Did you have any money/debt worries when you first arrived?	**10%**	**18%**		**10%**	**27%**
28k	Did you have any problems with feeling depressed or suicidal when you first arrived?	**45%**	**27%**		**45%**	**41%**
28l	Did you have any drug problems when you first arrived?	**3%**	**6%**		**3%**	**9%**
28m	Did you have any alcohol problems when you first arrived?	**6%**	**6%**		**6%**	**6%**
28n	Did you have any health problems when you first arrived?	**29%**	**26%**		**29%**	**43%**
28o	Did you have any problems with needing protection from other detainees when you first arrived?	**12%**	**6%**		**12%**	**7%**
29	Did you receive any help/support from any member of staff in dealing with these problems within the first 24 hours?	**17%**	**25%**		**17%**	**13%**
SECTION 5: Legal Rights and Immigration						
31	Do you have a solicitor or legal representative?	**69%**	**62%**		**69%**	**64%**
32	Do you get legal aid (free advice under the legal aid scheme)?	**51%**	**51%**		**51%**	
33	Is it easy/very easy to communicate with your solicitor or legal representative?	**30%**	**28%**		**30%**	
34	Are you able to send a fax to your legal representative free of charge?	**66%**	**60%**		**66%**	**89%**
35	Are you able to send letters to your legal representative free of charge?	**41%**	**41%**		**41%**	**64%**
36	Have you had a visit from your solicitor/legal representative?	**38%**	**35%**		**38%**	**45%**
37	Can you get access to books about your legal rights?	**45%**	**18%**		**45%**	
38	Is it easy/very easy for you to obtain bail information?	**27%**	**29%**		**27%**	
39	Can you get access to official information reports on your country?	**30%**	**24%**		**30%**	**27%**
40	Is it easy/very easy to see immigration staff when you want?	**16%**	**30%**		**16%**	**8%**
41	Have you had a review of your detention every month?	**41%**	**29%**		**41%**	
42	Was the review written in a language you could understand?	**34%**	**31%**		**34%**	

Key to tables							
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SECTION 6: Respectful Detention						
44	Are you normally offered enough clean, suitable clothes for the week?	**31%**	**57%**		**31%**	**30%**
45	Are you normally able to have a shower every day?	**100%**	**91%**		**100%**	
46	Is it normally quiet enough for you to be able to sleep in your room at night?	**72%**	**57%**		**72%**	**48%**
47	Can you normally get access to your property held by staff at the Centre, if you need to?	**50%**	**51%**		**50%**	**47%**
48	Is the food good/very good?	**20%**	**35%**		**20%**	**23%**
49	Does the shop sell a wide enough range of goods to meet your needs?	**24%**	**37%**		**24%**	**20%**
50	Do you feel that your religious beliefs are respected?	**58%**	**74%**		**58%**	**64%**
51	Are you able to speak to a religious leader of your own faith if you want to?	**50%**	**62%**		**50%**	**59%**
52	Is it easy/very easy to contact the Independent Monitoring Board?	**22%**	**21%**		**22%**	**4%**
53	Is it easy/very easy to get a complaint form?	**53%**	**49%**		**53%**	**15%**
54	Have you made a complaint since you have been at this Centre?	**39%**	**43%**		**39%**	
55a	Do you feel complaints are sorted out fairly?	**8%**	**15%**		**8%**	**8%**
55b	Do you feel complaints are sorted out promptly?	**7%**	**21%**		**7%**	**11%**
SECTION 7: Staff						
57	Do you have a member of staff you can turn to for help if you have a problem?	**55%**	**61%**		**55%**	**31%**
58	Do most staff treat you with respect?	**69%**	**73%**		**69%**	**37%**
59	Do staff speak to you most of the time/all of the time?	**20%**	**21%**		**20%**	
60	Have any members of staff physically restrained you in the last six months?	**8%**	**17%**		**8%**	**15%**
61	Have you spent a night in the segregation unit in the last six months?	**21%**	**23%**		**21%**	**27%**
SECTION 8: Safety						
63	Have you ever felt unsafe in this Centre?	**47%**	**46%**		**47%**	**61%**
64	Do you feel unsafe in this Centre at the moment?	**39%**	**50%**		**39%**	
65	Has another detainee or group of detainees victimised (insulted or assaulted) you here?	**34%**	**26%**		**34%**	**32%**
66a	Have you had insulting remarks made about you, your family or friends since you have been here? (By detainees)	**13%**	**8%**		**13%**	**7%**
66b	Have you been hit, kicked or assaulted since you have been here? (By detainees)	**9%**	**5%**		**9%**	**12%**

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	Any numbers highlighted in blue are significantly worse than the IRC comparator/ last survey					
	Numbers which are not highlighted show there is no significant difference between the 2008 survey and the IRC comparator					
SECTION 8: Safety continued						
66c	Have you experienced unwanted sexual attention here from another detainee?	**2%**	**3%**		**2%**	**5%**
66d	Have you been victimised because of your cultural or ethnic origin since you have been here? (By detainees)	**5%**	**6%**		**5%**	**10%**
66e	Have you been victimised because of your nationality since you have been here? (By detainees)	**8%**	**5%**		**8%**	**10%**
66f	Have you ever had your property taken since you have been here? (By detainees)	**10%**	**7%**		**10%**	**4%**
66g	Have you ever been victimised because you were new here? (By detainees)	**3%**	**5%**		**3%**	**7%**
66h	Have you been victimised because of drugs since you have been here? (By detainees)	**0%**	**3%**		**0%**	**5%**
66i	Have you been victimised here because of your sexuality? (By detainees)	**3%**	**4%**		**3%**	
66j	Have you ever been victimised here because you have a disability? (By detainees)	**2%**	**7%**		**2%**	
66k	Have you ever been victimised here because of your religion/religious beliefs? (By detainees)	**5%**	**5%**		**5%**	
67	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	**34%**	**24%**		**34%**	**44%**
68a	Have you had insulting remarks made about you, your family or friends since you have been here? (By staff)	**12%**	**7%**		**12%**	**7%**
68b	Have you been hit, kicked or assaulted since you have been here? (By staff)	**10%**	**5%**		**10%**	**7%**
68c	Have you experienced unwanted sexual attention here from staff?	**5%**	**4%**		**5%**	**5%**
68d	Have you been victimised because of your cultural or ethnic origin since you have been here? (By staff)	**9%**	**7%**		**9%**	**14%**
68e	Have you been victimised because of your nationality since you have been here? (By staff)	**9%**	**7%**		**9%**	**23%**
68f	Have you ever been victimised because you were new here? (By staff)	**6%**	**4%**		**6%**	**7%**
68g	Have you been victimised because of drugs since you have been here? (By staff)	**3%**	**3%**		**3%**	**2%**
68h	Have you been victimised here because of your sexuality? (By staff)	**2%**	**1%**		**2%**	
68i	Have you ever been victimised here because you have a disability? (By staff)	**2%**	**3%**		**2%**	
68j	Have you ever been victimised here because of your religion/religious beliefs? (By staff)	**5%**	**11%**		**5%**	
69	If you have been victimised by detainees or staff, did you report it?	**18%**	**15%**		**18%**	**24%**
70	Have you ever felt threatened or intimidated by another detainee/group of detainees in here?	**20%**	**31%**		**20%**	
71	Have you ever felt threatened or intimidated by a member of staff in here?	**31%**	**42%**		**31%**	

Key to tables						
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	Any numbers highlighted in blue are significantly worse than the IRC comparator/ last survey					
	Numbers which are not highlighted show there is no significant difference between the 2008 survey and the IRC comparator					
SECTION 9: Healthcare						
73	Is health information available in your own language?	**38%**	**25%**		**38%**	**13%**
74	Do you know whether counselling is available at this Centre?	**23%**	**27%**		**23%**	
75	Are you able to see a doctor of your own gender?	**49%**	**45%**		**49%**	
76	Is a qualified interpreter available if you need one during healthcare assessments?	**11%**	**15%**		**11%**	**6%**
77	Are you currently taking medication?	**39%**	**49%**		**39%**	
78	Are you allowed to keep possession of your medication in your own room?	**23%**	**11%**		**23%**	
79	Do you think the overall quality of health care in this Centre good/very good?	**24%**	**37%**		**24%**	**21%**
SECTION 10: Activities						
81	Do you have unrestricted access to the Centre facilities for at least 12 hours each day?	**37%**	**27%**		**37%**	
82	Are you doing any education here?	**48%**	**34%**		**48%**	**48%**
83	Is the education helpful?	**40%**	**27%**		**40%**	**35%**
84	Can you work here if you want to?	**36%**	**21%**		**36%**	
85	Is there enough to do here to fill your time?	**37%**	**43%**		**37%**	**25%**
86	Is it easy/very easy to go to the library?	**41%**	**41%**		**41%**	
87	Is it easy/very easy to go to the gym?	**46%**	**54%**		**46%**	
SECTION 11: Keeping in Touch with Family and Friends						
89	Is it easy/very easy to receive incoming calls?	**67%**	**51%**		**67%**	**62%**
90	Is it easy/very easy to make outgoing calls?	**45%**	**54%**		**45%**	**55%**
91	Have you had any problems with sending or receiving mail?	**32%**	**34%**		**32%**	
92	Have you had a visit since you have been in here from your family or friends?	**62%**	**40%**		**62%**	**51%**
93	Have you had a visit since you have been here from volunteer visitors?	**17%**	**23%**		**17%**	**13%**
94	Do you feel you are treated well/very well by visits staff?	**30%**	**44%**		**30%**	