Report on an unannounced short follow-up inspection of

Haslar Immigration Removal Centre

31 May – 3 June 2011

by HM Chief Inspector of Prisons

Printed and published by:
Her Majesty's Inspectorate of Prisons
1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

Contents

Introduction

Haslar immigration removal centre (IRC), in Portsmouth, is one of four run by the Prison Service. On our previous visit in 2009, we commended the efforts of staff in caring appropriately for detainees but decried the lack of investment in the centre which had left it with some of the worst accommodation in the immigration estate. Open, noisy dormitory units had contributed to tensions among detainees and provided an unacceptable environment. This unannounced follow-up visit found a much more decent and secure living environment as a result of substantial investment in a refurbishment programme by the National Offender Management Service (NOMS).

Detainees generally reported feeling safe in the centre. Incidents of bullying, violence and self-harm were low, and staff responses to issues were appropriately low key. However, our safety assessment also includes immigration casework – so central to a detainee's predicament – and none of our previous recommendations in this area had been achieved by UKBA. As a result, we concluded that insufficient progress had been made on safety overall. It was of particular concern that procedures to safeguard the most vulnerable detainees, those who might be children and those who might not be fit to be detained, potentially as a result of torture, were not robust.

By contrast, the environment had been transformed and this had contributed to an improved atmosphere and reinforcement of already positive staff-detainee relationships. Other important areas, such as diversity and health care, had also improved. In relation to activities, the education department continued to provide an excellent resource for detainees and had made further improvements. However, there had been no change in the amount of work available and some detainees still had too little to fill their time.

In order to help detainees prepare for release or removal, a dedicated welfare officer provided much-valued assistance. Major work had also been undertaken to build a new visitors centre, which was nearing completion. Internet and email access, crucial to helping detainees maintain affordable contact with their families and keep up to date with legal developments relevant to their cases, was – at last – on the verge of implementation. We will expect to see these facilities fully established at the next inspection.

This report describes some impressive progress against our recommendations since the last inspection. Two-thirds of our recommendations had been fully or partially achieved, including most of the main recommendations. In particular, there was now a much improved and more decent physical environment. However, we were concerned that there had been minimal progress on our recommendations regarding immigration casework and we expect UKBA to address these continued failings, which impact significantly on what was otherwise an impressive centre.

Nick Hardwick
HM Chief Inspector of Prisons

July 2011

Fact page

Task of the establishment
The detention, care and welfare of people subject to immigration control.

Location
Gosport, near Portsmouth, Hampshire

Contractor
HM Prison Service (under a three-year Service Level Agreement with the UK Border Agency)

Number held
135

Certified normal accommodation (CNA)
160

Operational capacity
160

Escort provider
Reliance (started 1 May 2011)

Last inspection
April 2009

Brief history
Haslar is the UK's oldest operating immigration detention centre. It was originally an army facility, then a young offender detention centre, and has held immigration detainees since 1989. In February 2002, Haslar was officially redesignated as an immigration removal centre and began operating under detention centre rules.

Description of residential units
The centre has a total of 160 beds, organised into one-, two-, three- and four-person rooms, grouped into six dormitories. Each dormitory has an association area, bathroom and shower facilities, a water boiler and telephone lines. The residential units have recently been extensively refurbished.

Section 1: Summary

Introduction

1.1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2009 and assess the progress achieved. All full inspection reports include a summary of outcomes for detainees against the model of a healthy establishment. The four criteria of a healthy establishment are:

Safety	that detainees are held in safety and with due regard to the insecurity of their position
Respect	that detainees are treated with respect for their human dignity and the circumstances of their detention
Purposeful activity	that detainees are able to be purposefully occupied while they are in detention
Preparation for release	that detainees are able to keep in contact with the outside world and are prepared for their release, transfer or removal.

1.2 Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress. Inspectors draw up a brief healthy establishment summary setting out the progress of the establishment in the areas inspected and giving an overall assessment against the following definitions:

Making insufficient progress
Overall progress against our recommendations has been slow or negligible and/or there is little evidence of improvements in outcomes for detainees.

Making sufficient progress
Overall there is evidence that efforts have been made to respond to our recommendations in a way that is having a discernible positive impact on outcomes for detainees.

Safety

1.3 At our last full inspection in 2009 we found that outcomes for detainees against this healthy establishment test were reasonably good. We made 33 recommendations in this area (including two main recommendations), of which 12 had been achieved, three partially achieved and 18 had not been achieved. In many areas there had been measurable improvement, but none of the immigration casework recommendations had been achieved, including a main recommendation.

1.4 Some detainees still arrived at the centre without being clearly informed that they were going there. Escort records were completed adequately and showed the offer of comfort breaks; however, detainees complained to us of long journeys without such breaks. Reception staff reported that some escort vehicles had not been stocked with adequate food supplies since

the recent change of escorting contract. Telephone interpreting was used regularly during reception interviews to communicate with detainees who were not fluent in English.

1.5 There were fewer tensions and incidents than at the time of the previous inspection. There was little use of force, although handcuffs were still used routinely during escorts. Separation was also infrequent and its governance had improved.

1.6 Detainees reported feeling safe in the centre and there was no evidence of bullying. The violence reduction policy had been revised and there was a comprehensive programme of staff training in dealing with bullying behaviour. Detainees who had been in separation for antisocial behaviour had subsequently been returned to normal location, rather than transferred out. There was analysis and discussion of relevant data at safer community meetings but it did not show trends over time.

1.7 There was little self-harm, and assessment, care in detention and teamwork (ACDT) forms were of reasonable quality, although some lacked post-closure reviews and management checks. There was now a comfortable care suite, which provided a reasonable environment for distressed detainees. Informal peer support was available but this was not sufficiently systematic to ensure consistent support for vulnerable people.

1.8 Detainees had weekly access to a surgery for legal advice and the welfare officer provided assistance to people who needed to contact solicitors. Bail advice sessions were popular but did not take place regularly enough to meet the need. Some, but not all, immigration files were quality checked monthly but there was no written evidence of actions to be taken. There were some examples from our case file analysis of detainees being held for long periods in detention with no imminent prospect of removal, despite complying with UKBA. The timeliness of monthly detention reviews was recorded but they were not followed up systematically. In an age dispute case we reviewed, UKBA caseworkers did not respond promptly to new documentary evidence showing that a detainee was under 18, which led to a child being unnecessarily detained. He was subsequently confirmed as a minor and moved to social services care. Initial Rule 35 letters (notifying UKBA if a detainee's health is likely to be injuriously affected by detention, including if they may have been the victim of torture) submitted by health services staff were of variable quality, and most of the responses by case owners were poor.

1.9 On the basis of this short follow-up inspection, we considered that there was insufficient progress being made against our recommendations.

Respect

1.10 At our last full inspection in 2009 we found that outcomes for detainees against this healthy establishment test were not sufficiently good. We made 58 recommendations in this area, of which 40 had been achieved, seven partially achieved, eight had not been achieved and three were no longer relevant.

1.11 A refurbishment programme had greatly improved the quality of the accommodation. Noise levels were considerably reduced and the atmosphere was calmer. The centre was clean and well maintained, and detainees had televisions in their rooms. The public address system was not always heard by detainees. There was an improved system to account for detainees' personal laundry.

1.12 Staff–detainee relationships were good, and most detainees reported respectful treatment by staff. The welfare officer and personal officers saw detainees quickly after arrival to assess need and address immediate concerns. Specific training on asylum and refugee experiences was not yet in place.

1.13 Detainees seemed to live in harmony with each other and an integrated diversity strategy had been developed. Overall management of diversity had improved, with nearly all relevant recommendations achieved. Consultation meetings were held each month with different language groups. Detainees with disabilities were identified at an early stage and had their needs assessed. Chaplaincy cover had improved and sufficient time was now allocated to the Muslim chaplain.

1.14 There were few complaints but some took too long to reach the centre manager after the initial sift by the UK Border Agency (UKBA). The centre dealt with complaints quickly and replies were respectful. Complaints forwarded to other establishments were appropriately followed up by the welfare officer to help detainees achieve a resolution. This was despite UKBA guidance that discouraged such follow-up. There was no longer an active rewards scheme and there seemed little need for one.

1.15 Detainees complained about the quantity and quality of the food. Considerable attempts had been made to ameliorate this dissatisfaction through consultation and changed procedures.

1.16 The health care centre was well staffed and provided a good overall service. Nearly all previous recommendations had been met. We received some detainee complaints about access to health care and the level of treatment provided. There were regular GP clinics and health services staff had made attempts to reduce the failure to attend rate through liaison with detainees. Dental care was for emergencies only; there were no routine dental check-ups or treatment for the large number of people who were detained for more than a few months.

1.17 On the basis of this short follow-up inspection, we considered that there was sufficient progress being made against our recommendations.

Activities

1.18 At our last full inspection in 2009 we found that outcomes for detainees against this healthy establishment test were reasonably good. We made eight recommendations in this area, of which three had been achieved, one partially achieved and four had not been achieved.

1.19 The education department remained a well-managed area, and education staff had been creative in trying to increase activities within the budget. The library was small but well organised and welcoming. English for speakers of other languages (ESOL) tuition had further improved.

1.20 The amount of paid work remained the same, at 29 places. There were a few vacancies and, overall, work was not sufficiently well promoted on noticeboards and along corridors. A useful business course continued to be run and had been developed in line with need.

1.21 On the basis of this short follow-up inspection, we considered that there was sufficient progress being made against our recommendations.

Preparation for release

1.22 At our last full inspection in 2009 we found that outcomes for detainees against this healthy establishment test were reasonably good. We made 14 recommendations in this area, of which four had been achieved, three partially achieved and seven had not been achieved.

1.23 The welfare officer performed a valuable role for detainees, helping them to resolve practical matters and progress legal cases. The distance that visitors had to travel was a common concern, and there was no assisted visits scheme to help them maintain family ties. A major project to build a new visitors centre was nearly complete. Longer visits were available during weekdays but had not been trialled at weekends, when some detainees said they would have been more valuable.

1.24 Detainees did not have access to the internet or email at the time of the inspection but a reasonably sized internet suite was nearing completion. Telephone access was generally good. Removed detainees did not systematically receive funds to reach their destinations but the Haslar Detainee Visitors group provided them with some valuable assistance.

1.25 On the basis of this short follow-up inspection, we considered that there was sufficient progress being made against our recommendations

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

To the UK Border Agency (UKBA) and NOMS

2.1 The dormitories should be rebuilt to give detainees privacy and to minimise noise and light intrusion. (HE40)

Achieved. The residential units had been substantially refurbished since the previous inspection, and there were no longer any rooms without doors or walls going up to the ceiling. This improved the quality and decency of the accommodation and helped to create a calmer atmosphere with much reduced noise levels. Most detainees shared rooms containing two to four beds. There were two single rooms on the induction wing. While some rooms were cramped, they were generally fit for purpose. The accommodation was bright, clean and well maintained. Detainees did not have privacy keys to their rooms but each had a lockable cupboard. All rooms had televisions.

2.2 Where there is no prospect of a detainee being removed because his country of origin declines to issue travel documents, the caseworker should address any such continued detention as a matter of law and fact. (HE41)

Not achieved. The longest-held detainee had been held for more than two years because of delays in obtaining travel documents. The detainee wanted to return to his country of origin as soon as possible. His file indicated that he had complied with all his re-documentation interviews and requests for information. His applications for emergency travel documents had been repeatedly refused by the Indian High Commission because they were unable to verify that the detainee had lived at the address he had given. At a bail hearing in May 2009, the home office presenting officer had advised the immigration judge that, '…we believe that a document will be available within a reasonable period'. Two years later, the detainee remained in detention. The caseworker, while addressing the facts of the detainee's case, did not refer to *Hardial Singh* principles in the monthly review – that is, the caseworker did not address the fact that that UKBA was not able to effect the detainee's deportation within a reasonable period of time.
We repeat the recommendation.

2.3 There should be a care suite with appropriate facilities for detainees at risk of self-harm. (HE42)

Achieved. There were two rooms for detainees in crisis: a safer cell and a care suite. Both were located in the special accommodation unit. The care suite was used for detainees in crisis who did not present a risk of self-harm. Those in crisis could be accompanied by a friend. The room contained three beds, carpets, three soft seats, a table, television and paintings. The in-cell toilet was screened by a shower curtain. Records indicated that the suite had been used twice in 2011, although the true figure was higher. Staff did not always record stays in the suite if the detainee was accompanied by a friend or when it was used by health services staff to isolate a detainee with a suspected contagious disease (for example, tuberculosis). The safer cell was used for detainees who presented an immediate risk of self-harm. While attempts had

been made to soften the cell's appearance by painting murals on the walls, the atmosphere was stark. Detainees were held in this room under Rule 40 of the detention centre rules (removal from association in the interests of security or safety). The safer cell also doubled as a segregation cell. The centre did not record stays in the safer cell of less than 30 minutes. During the inspection, a young man was picked up by a UKBA arrest team. On his way to the centre, he threatened self-harm and was immediately placed in the safer cell. An assessment, care in detention and teamwork (ACDT) form was opened and specified that he should be observed at least once an hour. He was subsequently locked in the safer cell, which was not staffed. This meant that there were at least two locked doors between the detainee and a member of staff, which was potentially unsafe.

Further recommendation

2.4 The special accommodation unit should be staffed when detainees are placed in the safer cell because of a risk of self-harm or suicide.

2.5 The centre should significantly increase the amount of paid work for detainees, including the implementation of planned workshops. (HE43)

Not achieved. The amount of paid work had not increased. There were still 29 work places, of which 26 were currently filled. Three detainees were on a waiting list for employment. Plans to employ detainees in a bicycle repair workshop or in horticultural or recycling activities had not been implemented. Those employed worked an average of 14 hours per week, a slight increase on the average working hours at the time of the previous inspection. Detainees were offered training in basic food hygiene and manual handling at an early stage in the process to facilitate a speedy move into work when a vacancy arose. Jobs were advertised but this information was not well promoted through the noticeboards or in public areas, and was not well known to detainees. All the information was in written form, with no visual supplements. The participation of the small number of longer-term detainees was monitored and they were all involved in either work or educational and PE activities. Managers considered that there was less demand for employment in the centre, particularly as the current length of stay of a large proportion of detainees at the centre was much shorter than at the time of the previous inspection.
We repeat the recommendation.

2.6 Detainees should have access to email and the internet. (HE44)

Not achieved. A reasonably sized internet suite was nearing completion at the time of the inspection, and was due to be operational by August 2011. All equipment, including computers, desks and chairs, had already been purchased and was in storage at the centre. Once operational, detainees would have supervised access to the internet and email.

To the centre manager

2.7 There should be a diversity strategy for detainees that addresses needs relating to the wider aspects of diversity, including sexuality, age and disabilities, as well as race, culture and religion. (HE45)

Achieved. There was a diversity and equality policy covering all areas in outline, and fuller supplementary policies on older people and those with disabilities. An annual diversity and equality report gave a further comprehensive update on progress in all areas.

2.8 Initial personal officer interviews should take place within the detainee's first week of arrival. (HE46)

Achieved. Computerised case notes indicated that nearly all detainees were interviewed by their dormitory (personal) officer, welfare officer and induction officer within a few days of arrival. Although in some cases it was not obvious that the personal officer was making relevant entries, it was clear in nearly all cases we saw that immediate concerns were being picked up and addressed by staff.

Other recommendations

To the chief executive, UKBA

2.9 All detainees should be informed of their destination before they are transferred. (1.24)

Not achieved. Reception staff at the centre informed detainees of their destination and provided an information leaflet on the receiving immigration removal centre (IRC). However, some detainees told us that they had not been made aware of their destination when leaving their previous establishment, including one ex-foreign national prisoner who reported that staff said they were not allowed to tell him where he was going.
We repeat the recommendation.

2.10 All casework files should be quality checked monthly. (3.22)

Not achieved. Some, but not all, contact management files were quality checked each month. While a note was made in red ink on the file to indicate that it had been reviewed, there was no written evidence of actions to be taken. Following the review, the file was passed to a contact management officer, who was asked verbally to perform the required action. There was no follow-up to confirm that the action had been completed, and no monitoring of lessons learned from the quality checks.
We repeat the recommendation.

2.11 In consultation with the centre, UKBA should ensure that all detainees receive a copy of the bail summary in due time before the hearing, and the on-site immigration team should monitor the receipt of bail summaries. (3.23)

Not achieved. Only those bail applicants who did not have legal representation were systematically served with a bail summary. Where a detainee was legally represented, the bail summary was served by the presenting officer on the legal representative and not on the detainee. The detainee then relied on the legal representative sending them a copy of the bail summary, leading to unnecessary delays. The on-site contact management team did not systematically monitor and record the receipt or otherwise of bail summaries in a way that allowed for monitoring of trends.
We repeat the recommendation.

2.12 Monthly reviews of detention (form 151F) should be timely and show a balanced consideration of all factors relevant to continuing detention. The review letter should routinely include a subheading that refers to progress since the last report to ensure

that this issue is addressed and that reasons are given when there is a lack of progress. (3.24)

Not achieved. Not all monthly reviews were served on time. The onsite contact management team recorded the service of monthly reviews on a spreadsheet, which highlighted overdue reports. Outstanding reviews were to be chased by telephone (or fax at weekends) with the case owner responsible for issuing the review. However, the system was not working properly. On the first day of our inspection, the spreadsheet indicated 25 were overdue; this was checked by UKBA staff and we were informed that, in fact, 13 reviews had actually been overdue. Not all reviews showed a balanced consideration of all relevant factors. In a Zimbabwean case, the review failed to note that the detainee had family ties. His partner, three children, mother and siblings were all present and settled in the UK. It was not evident from the monthly review that these factors had been considered by the case owner before continuing detention. While some reviews noted progress since the last report, many did not, and there was no subheading to prompt referral to this. When there was no progress, reasons were not given.
We repeat the recommendation.

2.13 In an age-dispute case, the UKBA caseworker should respond within 24 hours of receipt to documentary evidence that shows that the detainee is under 18. (3.25)

Not achieved. In an age dispute case we reviewed, UKBA did not respond promptly to new documentary evidence showing that a detainee, who was eventually confirmed to be a child, was under 18. The child had entered the UK clandestinely and claimed asylum at the asylum screening unit in Croydon on 24 March 2011. Initially, UKBA did not dispute the child's age. As an unaccompanied asylum-seeking child, he was supported by the local authority, Greenwich social services. After receiving the child into their care, the local authority conducted an age assessment and concluded that he was over 18. On 7 April, the child was detained at Brook House IRC. On arrival there, he presented an original identity document from Iran. A copy of this was faxed to the UKBA case owner in Croydon, who considered the new evidence on 12 April. The case owner recorded on the file, 'Photocopied documents cannot be accepted as proof of identity by UKBA. All documents must be originals.' While a photocopied document carries less weight than an original document, UKBA's published age assessment policy is to consider the identity document alongside the local authority assessment. After four days at Brook House, the child was transferred to Haslar. The original identity document was taken from the child on arrival at Haslar and sent to the case owner, who arranged for the document to be analysed at UKBA's national document fraud unit. On 18 April, the document expert confirmed that it was 'not counterfeit' and that there was no evidence of 'falsification or alteration'. Later on the same day, the case owner sought advice from a more senior colleague; the advice given was recorded in the file, '… further investigations to be carried out to find out if the issuing of fraudulently obtained documents are common practice in Iran. I was also advised the age assessment will take precedence over the birth certificate if we cannot prove that the birth certificate was fraudulently obtained'. This meant that, regardless of the outcome of the investigations, the child would remain in detention. The UKBA case owner failed to notify Greenwich social services of the additional evidence. Prison Service records noted that the child spent a lot of time during his first two days at Haslar crying in the welfare office. At one point he was located to the care suite in order to compose himself. No further consideration appeared to have been given to the case until the child's legal representatives threatened judicial review. On 10 May, a second age assessment was arranged. On interviewing the child, Hampshire social services assessed him as being of the age he had claimed. The local authority was unable to accommodate the child on the day of the age assessment, so the detainee was relocated to the centre's special accommodation unit for one

night and released the next day, after spending more than a month in detention.
We repeat the recommendation.

2.14 Unless the documentary evidence of age submitted in an age-dispute case is clearly unreliable, detainees under 18 should not be detained while the age-dispute issue is resolved. (3.26)

Not achieved. See recommendation 2.13.
We repeat the recommendation.

2.15 The UKBA caseworker should respond to rule 35 letters within the required two working days, detailing in every instance the consideration given to continued detention in the light of the rule 35 letter and the detainee's circumstances. (3.27)

Not achieved. We reviewed 10 Rule 35 reports (notifying UKBA if a detainee's health is likely to be injuriously affected by detention, including if they may have been the victim of torture) and their replies. Some reports took too long to reach the contact management team, since health services staff put them in the (weekday only) internal mail instead of faxing them. Other than this initial delay, reports and their replies were usually quickly conveyed between the contact management team and case owners. The contact management team chased outstanding replies. The initial Rule 35 reports submitted by the health care department were of variable quality. For example, a detainee claimed to have been tortured with cigarette burns. While the location of the scarring was noted on a diagram, the health services team offered no opinion as to whether the scarring was consistent with cigarette burns. The case owner maintained detention, stating that the report merely repeated the detainee's account of torture. UKBA had not released any of the 10 detainees whose Rule 35 reports and replies we reviewed. Most of the responses by case owners were brief and dismissive. In two cases, the case owner noted that because the detainees' asylum claims had been dismissed at the First-tier Tribunal, they could not be torture survivors. In one case, the case owner did not appear to understand the Rule 35 process and merely replied with a letter akin to an asylum 'reasons for refusal' letter.
We repeat the recommendation.

2.16 When the transfer of a separated detainee is approved, this should be carried out on the same day unless exceptional circumstances cause delay. (7.36)

Not achieved. In 2011 there had been a number of cases where a detainee had passed two nights in the separation unit after the need for transfer out had been established and the Part C form submitted.
We repeat the recommendation.

2.17 UKBA should introduce an assisted visits scheme to help family and friends of detainees who have difficulty with travel costs. (9.24)

Not achieved. An assisted visits scheme had not been introduced. In our focus groups, the long and costly journey facing visitors was a common concern among detainees, and many said that it limited the number of visits they were able to receive. The centre had undertaken a study of visits, showing that between 1 August 2009 and 31 January 2010 the average number of daily visitors ranged from approximately three to 13, which seemed low.
We repeat the recommendation.

To the centre manager

Arrival in detention

2.18 Detainees who are transferred from Haslar should not be searched twice in reception before leaving. (1.25)

Not achieved. Detainees leaving the centre were still searched twice – once by centre staff and then again by escort staff. The rationale given was that this was a requirement of both UKBA and Reliance (the escort provider). This paid little heed to common sense, given that the searches were sometimes undertaken one immediately after the other.
We repeat the recommendation.

2.19 Telephone interpreting should be used for the first night interview and risk assessments and for induction whenever a detainee is unable to speak and understand English. (1.26)

Achieved. Reception staff were familiar with the telephone interpreting service, and on one day during the inspection used it four times when interviewing new detainees. The centre kept records of use, although it was not possible to determine from these the exact number of calls made by reception (see also recommendation 2.33).

2.20 All information displayed in the reception waiting area should be in a range of languages. (1.27)

Not achieved. The detainee induction booklet, available in 20 languages, was normally displayed in one of the holding rooms, but during the inspection the holders were virtually empty. In a second holding room there was information on six other IRCs, including one that had been closed for some time, all in English only. Most information on noticeboards was also in English only.
We repeat the recommendation.

2.21 Information about how to access legal and bail advice should be a routine part of induction, and also included in the translated induction booklet. (1.28)

Partially achieved. The welfare officer routinely saw all new detainees shortly after arrival, as part of the induction process. The officer provided information on accessing legal surgeries and booked appointments for detainees if necessary, checked if detainees had a solicitor and provided a list of law firms if required, and provided assistance in filling out bail forms. However, this information was not available in written form in the translated induction booklet.
We repeat the recommendation.

2.22 Escort staff should record details of toilet stops and the issue of refreshments on the escort record. (1.29)

Achieved. We looked at the detainee welfare records of 14 detainees as they arrived at the centre. All had been fully completed by escort staff and showed the offer of comfort breaks. However, detainees in our focus groups and some of the newly arriving detainees we spoke to said that they had experienced long journeys to the centre with no comfort breaks. Reception staff said that they had received at least one call from escort staff en route to the centre,

asking if food could be provided on arrival because there were no refreshments on board the vehicle.

Environment and relationships

2.23 The public address system should be replaced by a less intrusive form of communication. (2.15)

Not achieved. The public address system was still used to contact detainees. The centre had looked into replacement options – for example, employing a 'runner' or issuing all detainees with pagers – but had decided to maintain the system. It was now not only intrusive in the communal areas, but sometimes ineffective in contacting detainees in their refurbished and better sound proofed rooms. It was not always heard by detainees from their rooms, particularly since the residential units had been rebuilt.
We repeat the recommendation.

2.24 All rooms should have window curtains. (2.16)

Achieved. All rooms had curtains.

2.25 All communal association areas should be kept in good decorative order. (2.17)

Achieved. All communal association areas, together with other parts of the centre, were in good decorative order, clean and well lit.

2.26 Unit notice boards should display material translated into a range of relevant languages. (2.18)

Partially achieved. Not all material displayed on noticeboards was translated into relevant languages. Information about complaints and the availability of telephone interpreting services was translated, but little else.
We repeat the recommendation.

2.27 Staff should ensure that observation panels in room doors are not obstructed. (2.19)

Not achieved. Some detainees continued to cover their observation panels in their rooms.
We repeat the recommendation.

2.28 Damaged chairs in communal association rooms should be replaced. (2.20)

Achieved. Chairs in communal areas were all in good condition.

2.29 Worn mattresses should be replaced and the mattress exchange programme should be publicised to detainees. (2.21)

Achieved. All mattresses had been replaced recently, and detainees were able to exchange them on request. The centre stored a number of spare mattresses and could request further mattresses from a central national location. The exchange programme was not publicised on induction or through notices on the wings. Detainees we spoke to said that they were not aware of any formal exchange programme but would approach an officer on their wing if they needed one.

2.30 There should be effective accounting of detainees' personal laundry. (2.22)

Achieved. The system for accounting for detainees' personal laundry had improved. Detainees could have up to 10 items of personal clothing laundered once a week. Each item of laundry was recorded on a sheet with the detainee's name. A tagging gun was used to attach a number relating to the detainee to each piece of clothing. After washing and drying, the laundry was sorted according to the number tags. The tags were then removed and the detainee signed the sheet to confirm that they had received the laundry. Staff acknowledged that on occasion the tags accidently came off but they were able to identify the owner by cross-referencing with the laundry sheet. Detainees we spoke to confirmed that the system was effective.

Staff–detainee relationships

2.31 Staff should receive training to enhance their understanding of the experiences and histories of people seeking asylum, refugees and those detained under immigration powers. (2.28)

Not achieved. Although staff had received cultural awareness training, there was no specific programme to address the understanding of asylum and refugee issues.
We repeat the recommendation.

2.32 Staff should not use surnames alone when they address detainees. (2.29)

Achieved. In our detainee group interviews, politeness and respect from staff were considered to be some of the most positive aspects of life at the centre. Staff addressed detainees appropriately in writing and in the verbal exchanges we witnessed.

2.33 Personal officer interviews with detainees who speak little English should take place through a professional interpreting service. (2.30)

Partially achieved. The telephone interpreting service was used regularly across the establishment, and staff were aware of its availability. The number of calls typically averaged around 50 a month. Some detainees brought friends with them to interpret during interviews, and in such cases personal officers did not use telephone interpretation unless the discussion was sensitive. However, some case note entries by personal officers also showed that some interviews had been conducted with detainees who spoke little English, without any form of interpretation.
We repeat the recommendation.

2.34 Staff should be encouraged to wear a less formal uniform to help distinguish prison and IRC roles. (2.31)

Not achieved. We were told that restrictions imposed by cost meant that more relaxed uniforms were not yet available, although there were plans to issue them.
We repeat the recommendation.

2.35 Staff should not carry defensive weapons. (2.32)

Not achieved. This recommendation had been rejected on the grounds that batons were part of the standard prison officer equipment.
We repeat the recommendation.

Casework

2.36 In consultation with the Legal Services Commission, the centre should improve detainee access to specialist legal advice and representation, including bail applications. (3.8)

Achieved. Since the previous inspection, the Legal Services Commission had re-tendered their contract for providing immigration advice at the centre. Three firms of solicitors provided services at the detention duty advice surgery, which was held every Friday. Up to 10 detainees could be seen a day, each for half an hour. Detainees were seen by the welfare officer on induction and asked if they had a legal representative; if they did not, they were given an appointment to see one in the detention duty advice surgery. Other detainees not on induction could also request to see a solicitor through the surgery. The welfare officer confirmed that the surgery was rarely oversubscribed. He distributed a list of local solicitors for detainees seeking non-publically funded legal representation.

2.37 The centre should formalise the arrangement for Bail for Immigration Detainees to provide a weekly full-day advice session with access to translation and interpreting facilities. (3.9)

Not achieved. Bail for Immigration Detainees (BID) attended the centre on an ad hoc basis, usually once a month. No attendance records were kept by the centre but staff told us that the sessions were popular and did not take place sufficiently regularly. BID provided two-hour workshops in the education department followed by individualised one-on-one advice. As BID was a small charity without a legal aid contract, it could not afford to provide its own translating or interpreting services; the centre did not provide assistance with this.
We repeat the recommendation.

Bullying

2.38 Staff should receive training in the new system for managing bullying behaviour. (4.15)

Partially achieved. As of March 2011, 45% of staff had undergone anti-bullying training. A new comprehensive anti-bullying training package had been developed in April 2011, following revision of the violence reduction policy in January 2011. At the time of the inspection, nine members of staff had received training under the new package. The package was well designed, comprehensive and covered bullying definitions, types, reasons and effects of bullying, prevention and intervention.

2.39 Detainees displaying anti-social behaviour should only be transferred out of the centre as a last resort, and there should be more attempts to manage them within the population. (4.16)

Achieved. Some detainees who had been in separation for antisocial behaviour had subsequently been returned to normal location, rather than being transferred out. Detainees said that they felt very safe in the centre and we saw no evidence of bullying. In the previous six months, no anti-bullying booklets had been opened and no detainees had been transferred out of the centre for displaying bullying behaviour.

2.40 Safer community data and trends should be systematically analysed and discussed at safer community meetings. (4.17)

Partially achieved. Safer community data were regularly analysed and discussed at the safer community meetings. The safer community coordinator produced a report containing the data and delivered it at the meeting; however, trends over time were not analysed.

2.41 The violence reduction detainee survey for 2009 should be completed promptly and used to inform the violence reduction strategy. (4.18)

Not achieved. A violence reduction survey had been conducted in 2009 but the violence reduction policy had not been updated until January 2011. The results of the survey were therefore too old to inform the January 2011 policy properly. A violence reduction survey had been conducted in April 2011, three months after the policy had been published.

Suicide and self-harm

2.42 The safer communities coordinator should quality check assessment, care in detention and teamwork (ACDT) forms frequently to ensure that actions requested by managers have been carried out, and that inadequate care maps are revised appropriately. (4.19)

Not achieved. The safer community coordinator did not frequently check ACDT forms. These were of reasonable quality but some lacked post-closure reviews and active checks by managers.
We repeat the recommendation.

2.43 The safer communities meeting should take place every month. (4.20)

Not achieved. The safer community meetings continued to be held bimonthly. However, this was now proportionate to the risks and needs of the population.

2.44 Force should not be used on detainees to reduce the risk of self-harm, unless there is clear imminent danger of serious physical harm. (4.21)

Achieved. We found no evidence that force was being used on detainees to reduce the risk of self-harm.

2.45 The formal peer support scheme should be implemented. (4.22)

Not achieved. There was no operational peer support scheme to help detainees in crisis. Inductees were asked if they were willing to act as peer supporters and might have been called on an ad hoc basis. We were told that the names of detainees who were so willing were kept on a list, but we did not receive a copy.
We repeat the recommendation.

Diversity

2.46 The race equality officer should be trained for the role, including completing investigations. (4.44)

Achieved. The diversity manager and diversity and equality officer had received the full training for race equality officers.

2.47 Detainees who submit a race complaint should receive a response, even if they have moved on to another establishment. If they are being removed before the investigation is completed, they should be given an update on the investigation so far. (4.45)

Achieved. Although there had been no recent cases, there was a system for responses to be forwarded to other establishments if a detainee was transferred while his or her complaint was being investigated. This was for updates to be given to those being removed in such circumstances and also to inform removed detainees in their destination country of the outcome.

2.48 Consultation meetings should be held frequently with all non-English language groups of detainees, and there should be action plans to address their areas of concern. (4.46)

Achieved. Each month, in addition to the normal weekly detainee consultative meetings, a meeting was held with a non-English-speaking group using telephone interpretation. This had proved effective in dealing with their concerns, and supported a generally tolerant and harmonious atmosphere among detainees.

2.49 There should be assessments of locally implemented policies to determine their impact on minority groups and different nationalities. (4.47)

Achieved. A programme of equality impact assessments had been followed (four in 2010 and three due in 2011). These were comprehensive and set a good standard.

2.50 Detainees should be represented at equal opportunities meetings. (4.48)

Achieved. All equality issues were handled at the quarterly diversity and equality action team meetings, at which detainees were well represented.

2.51 Emergency evacuation plans should automatically be completed on all detainees with disabilities who need one. (4.49)

Achieved. The disability liaison officer had completed evacuation plans for all those who would need assistance in case of emergency. Copies were held in dormitory offices and in other strategic locations.

2.52 There should be a clear procedure for identifying detainees with disabilities, assessing their needs and creating a support plan shortly after their arrival. (4.50)

Achieved. The disability liaison officer had seen all those identified in reception or induction (by health services, reception, induction and education staff) within two or three days of arrival, had kept full records and had made the appropriate referrals.

2.53 Diversity monitoring should include nationality, age and disability as well as other aspects of diversity, should allow trends to be analysed over time, and should be routinely discussed at diversity meetings. (4.51)

Partially achieved. There was ad hoc monitoring of some diversity issues, which had been discussed at diversity meetings, but the implementation of a full system for the collation and analysis of monitoring statistics had been delayed by technical factors.
We repeat the recommendation.

Faith

2.54 All detainees should have access to a chaplain of their faith each week. (4.57)

Partially achieved. There was improved cover by Sikh and Buddhist chaplains. There was no regular visit from a Roman Catholic chaplain but the local parish priest came in when requested.

2.55 The Muslim chaplain's input should be increased to match the needs of the Muslim population. (4.58)

Achieved. The Muslim chaplain's attendance at the establishment had increased to 16 hours a week, which was sufficient for the needs of the population.

2.56 Detainees should be able to attend study groups in their faith. (4.59)

Achieved. There were regular religious study sessions for Christians, Muslim, Sikhs and Buddhists.

2.57 Chaplains should be involved with preparing detainees for release, removal or transfer when required. (4.60)

Achieved. Although the developing work of the welfare officer had reduced the need for chaplaincy provision in this area, the chaplains had responded practically to a number of cases of need, providing clothing and also liaising with outside agencies to support resettlement after release.

Health services

2.58 Service level agreements should be in place for all health services. (5.41)

Achieved. The new commissioning contract for health services had been established with NHS Hampshire Primary Care Trust at the time of the previous inspection, with Solent NHS Trust as the provider. Service Level Agreements were in place for all elements of health care provision.

2.59 There should be feedback from incident reports. (5.42)

Achieved. Incident reports were a standing agenda item for all monthly health care meetings and the partnership board meetings that were held quarterly. Feedback contributed to the health care delivery plan and action plans from the partnership board.

2.60 There should be sufficient administrative cover to avoid the use of clinical time for administrative tasks. (5.43)

Achieved. The health care administrator was now employed full time and this provided sufficient cover to avoid the use of clinical staff for administration.

2.61 All staff should have at least annual resuscitation and defibrillation training, and records of this should be maintained. (5.44)

Achieved. All health services staff were in date for mandatory training in basic life support, including the use of automated external defibrillators. All training was recorded appropriately.

2.62 All health care staff should receive training in the recognition of signs of trauma and torture, and how to support these detainees. (5.45)

Not achieved. Health services staff had been unable to locate a provider of suitable training in the recognition of signs of trauma and torture, and how to support these detainees. Some in-house sharing of knowledge and experience was carried out by health services staff.
We repeat the recommendation.

2.63 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 detainees can access mobility and health aids. (5.46)

Achieved. The new contract for health services was well established with the primary care trust (PCT) and this had facilitated access to occupational therapy equipment and specialist advice when required.

2.64 Arrangements for the provision of psychiatrist sessions should be clarified. (5.47)

Achieved. Arrangements had been made with the community mental health team for the provision of psychiatrist sessions as required.

2.65 If a detainee is registered with a GP or any relevant care agencies, they should be contacted at the beginning of detention, with the detainee's consent, to provide relevant information to ensure continuity of care. (5.48)

Achieved. All detainees were requested to sign a consent form approving access to previous health care records. Contact was made with GPs and other care agencies as required at the beginning of detention.

2.66 All nurses should receive clinical supervision, and records of this should be maintained. (5.49)

Achieved. Clinical supervision was available for all nursing staff on a one-to-one basis. The health care manager maintained records appropriately.

2.67 There should be an auditable dual-labelling system for medication stock. (5.50)

Achieved. Lloyds Pharmacy provided all medications on a supply contract. All medicines were prescribed using SystmOne and there were no paper prescriptions. Medicines were dual labelled and a separate record maintained in addition to the electronic record.

2.68 Resuscitation kits should be checked weekly, and this should be clearly recorded. (5.51)

Achieved. Resuscitation equipment was available in the health care centre and was well maintained. Checks were carried out and recorded weekly. An automated external defibrillator was located centrally and a record of daily checks was maintained.

2.69 The in-possession medication policy should include how the risk assessment is done, and who is responsible for undertaking it. (5.52)

Achieved. The in-possession medication policy had been reviewed and revised. This included an algorithm for assessment completion. All nursing staff were involved in carrying out the risk assessments.

2.70 Where practicable, the use of patient-named medication should be encouraged. (5.53)

Achieved. Almost all medication was provided by the pharmacy on a patient-named basis.

2.71 Out-of-date patient group directions should be revised. (5.54)

Achieved. All patient group directions (PGDs) had been revised and were available via the PCT intranet, with paper copies held in the pharmacy. At the time of the inspection, the PCT had restricted the use of the PGDs until further training of health services staff had been completed. This policy was inhibiting the efficient delivery of health services.

2.72 The medicines and therapeutics committee should meet at least four times a year, and all stakeholders should attend. (5.55)

Achieved. The medicines and therapeutics committee had been developed since the previous inspection and met quarterly. All stakeholders attended, including health services leads and representatives from neighbouring services.

2.73 Hospital appointments should not be cancelled due to lack of escorts. (5.56)

Partially achieved. Attendance at hospital appointments had improved since the previous inspection. Most cancelled appointments were due to detainees being removed or transferred but a limited number continued to occur when transport was not available.

2.74 All health care staff should have personalised training plans reflecting organisational needs and personal development. (5.58)

Achieved. All health services staff maintained records of their continued professional development, which also reflected the health care needs of the centre population. All health services staff completed PCT induction programmes and follow-on training, some of which was mandatory. Additionally health services staff were included in the establishment training programme.

2.75 A lifelong conditions register should be maintained. (5.62)

Achieved. Lifelong conditions were recorded on the SystmOne electronic record and in a separate register.

Additional information

2.76 Some detainees complained about poor access to health care and told us that treatment was too basic. These complaints were not borne out by the records we saw or our observations. Detainees' access to a GP was good, with daily clinics available on weekdays and Saturdays. There were very short waiting times but the failure to attend rate was high; the department had taken measures to improve this through liaison with detainees.

2.77 The quality of dental services was good but there were unacceptable restrictions placed on the level of access, resulting in the provision of care only for patients whose needs were

considered urgent; there were no routine dental check-ups or treatment for the large number of people who were detained for more than a few months.

Further recommendation

2.78 Detainees should have access to routine dental care.

Work and learning and skills

2.79 The intensive business course should be evaluated. (6.31)

Achieved. The business course was offered every few months when where was sufficient demand, and it had been formally evaluated through the self-assessment process since the previous inspection. In response to the high turnover of detainees at Haslar, which was felt to deter detainees from applying for the course, the programme had been adapted. The course still took place over two weeks but the subject areas had been better planned to be able to offer a one-week programme with an internal certificate from Highbury College, the education contractor, for those who did not stay at the centre long enough to complete the two-week programme.

2.80 Detainees learning ESOL should receive teaching and suitable structured practice to develop their listening and speaking skills and ESOL teachers should have appropriate specialist language teaching qualifications. (6.32)

Achieved. Of the four teachers of English for speakers of other languages (ESOL) at Haslar, three had appropriate basic qualifications in the teaching of ESOL, and the other had achieved an ESOL teaching qualification at level 5. Further training in the teaching of ESOL had taken place in 2011, tailored to the needs of the centre and its detainees, and had included training to develop teaching resources and methodology and to improve the structured practice of speaking and listening skills in ESOL classes. The latter had been successfully integrated into current classroom practice.

2.81 Education classes and supervised access to education facilities should be provided at weekends and extended at other times. (6.33)

Not achieved. Education classes and supervised access to education facilities had not been extended and no education was provided at weekends. Classes continued to be offered for just over 25 hours a week, and detainees had around five hours' additional access to education facilities before and after classes. The education manager and her staff had worked creatively to extend the range of activities within funding constraints.
We repeat the recommendation

2.82 Detainees' freedom of movement within the centre should be increased in the evenings and extended overall. (6.34)

Not achieved. Freedom of movement remained the same, at around 12 hours a day. Although educational activities were available on three evenings a week and access to the gym had been extended to six evenings a week, detainees were confined to their dormitory areas after 8.15pm.
We repeat the recommendation.

Library

2.83 Library opening should extend to evenings and weekends. (6.35)

Not achieved. The opening hours of the library were the same as at the time of the previous inspection, at just over 20 hours a week (five weekday mornings and four afternoons). However, the library continued to offer a well-organised and welcoming service.
We repeat the recommendation.

2.84 Staff should have direct access to the internet in the library. (6.36)

Achieved. Staff had direct access to the internet in the library through the filtered prison system intranet. In addition, teaching staff had access to a non-filtered intranet system in the education department which had been provided by Highbury College.

2.85 The library should provide ready access to a range of relevant up-to-date legal resources. (6.37)

Partially achieved. Most of the relevant legal resources were available in the library and were up to date. Hard copies of information on immigration law and human rights were retained in the library as reference material. Library staff also provided detainees with other essential material which was accessible via the internet. Information on statutory rights was available in a locked filing cabinet and the library had access to the Joint Council for the Welfare of Immigrants (JCWI) subscription service. However, detainees did not have ready access to country of origin reports.

Rules of the centre

2.86 Managers should publish a set of centre rules, and include it in the next update of the induction booklet (including translations). (7.24)

Not achieved. Although the induction booklet contained some indications of behavioural expectations (especially on smoking), there was no single set of rules, translated into other languages, which could give detainees an immediate grasp of what was expected of them.
We repeat the recommendation.

2.87 Staff should report and record all breaches of the no smoking rule, and managers should authorise a fair and consistent response in each case on the basis of a published policy. (7.25)

Achieved. We saw no evidence of any breaches of the no smoking rule. Staff we spoke to took the same line in challenging those who showed evidence of smoking in the wrong places and in submitting security reports.

Security

2.88 The security committee should draw up and implement a strategy for improving safety in the dormitory areas. (7.26)

Achieved. The security committee had addressed this need before the improvements to the dormitory areas had been carried out. Since the implementation of these improvements, the

level of risk and tension had reduced so much in the dormitory areas that a special strategy was no longer required for them.

2.89 There should be regular and systematic mediation and consultation meetings with and between small groups of detainees of different cultural backgrounds, focusing on actual and potential points of tension. (7.27)

Achieved. Meetings, using interpretation, had taken place with members of groups whose conflicting preferences had caused difficulties, and these had been effective in increasing understanding and reducing tension. Changes in the make-up of the detainee population, as well as the dormitory improvements, had reduced the need for such regular formal means of mediation.

Rewards scheme

2.90 All detainees should be able to place catalogue orders on an equal basis. (7.28)

Achieved. With the removal of the rewards scheme, all detainees had equal access to catalogue orders.

2.91 In accordance with the centre's own policy, detainees should only be downgraded under the rewards scheme for a pattern of behaviour, not a single action. (7.29)

No longer relevant. The rewards scheme no longer existed.

2.92 The application of the rewards scheme should be monitored by ethnicity and nationality, and this data should be published to staff and detainees and any apparent imbalances addressed. (7.30)

No longer relevant. The rewards scheme no longer existed.

2.93 Forms to appeal against a warning should be available in a range of common languages. (7.31)

No longer relevant. The rewards scheme no longer existed.

Use of force and single separation

2.94 Detainees under escort should be handcuffed only where there is a specific evidenced risk justifying it. (7.32)

Not achieved. All those escorted to hospital appointments were handcuffed, in line with National Offender Management Service (NOMS) directives, on the grounds that the hospital areas used were insecure. It remained inappropriate that those with no evidenced escape risk should be thus indiscriminately handcuffed. Otherwise, use of force was very infrequent. We repeat the recommendation.

2.95 The criteria for Rules 40 and 42 should be applied correctly when authorising separation of detainees (7.33).

Achieved. Use of Rule 42 (temporary confinement) was rare, and separation under Rule 40,

which occurred less than once a week, was properly authorised and documented in all cases, with improved record keeping.

2.96 Staff should not strip search detainees on entry to the special accommodation unit unless there are specific grounds for suspicion that potentially harmful items may be concealed. (7.34)

Achieved. Strip-searching on entry to the unit had not occurred for a year, and was undertaken only on the authority of the centre manager in response to specific evidence.

2.97 Vulnerable detainees should only be removed from normal location when there is clear evidence of imminent physical self-harm that cannot otherwise be managed. (7.35)

Achieved. The establishing of the care suite had created an intermediate stage of support and supervision, short of full separation conditions, leaving use of the separation 'safer cell' for those rare occasions (twice in 2011 to date, for a few hours each time) when the risk of serious self-harm appeared acute.

Complaints

2.98 Complaints forwarded externally should be actively followed up to ensure that a full response is received within the required timescale. (7.37)

Partially achieved. The local UKBA team was responsible for emptying the complaints boxes daily. Complaints were then forwarded to UKBA at Croydon, where they were filtered out and those relating to the centre were sent back to the head of residence. This resulted in some unnecessary delays, in one case of eight days, before the centre could begin to action the complaint. However, once received by the centre, complaints were followed up in a timely manner. When the complaint involved another establishment, such as a prison, UKBA in Croydon had advised the centre to respond only by providing the address of the establishment to the detainee and recommending him or her to contact them directly. This was unhelpful guidance, and it was appropriate that the conscientious welfare officer provided assistance in these cases to help detainees get a resolution to the complaint.

2.99 Replies to complaints should be polite, respectful and addressed directly to the complainant. (7.38)

Achieved. All responses to complaints about the centre were written by the head of residential. Of those we looked at, all were typed, addressed to the detainee and set out the actions taken in a polite and respectful manner.

2.100 There should be formal quality assurance of replies to complaints. (7.39)

Not achieved. There was no formal quality assurance of responses to complaints. We repeat the recommendation.

2.101 The monthly monitoring report on complaints should record where complaints originate, so that emerging patterns can be identified and addressed. (7.40)

Not achieved. The centre did not produce a monthly monitoring report on complaints. Although the number of complaints was low, at only 12 since January 2011, this did not allow for any analysis or identification of emerging patterns.

Further recommendation

2.102 A monthly monitoring report on complaints should be introduced, including a record of where complaints originate, so that emerging patterns can be identified and addressed.

2.103 Information about the complaints process should be published on centre notice boards in a range of common languages. (7.41)

Achieved. Information about the complaints process was posted in a range of common languages on noticeboards in the dormitory association rooms and, to a lesser extent, in the main centre corridor.

Catering

2.104 There should be an effective system to identify detainees not taking meals. (8.14)

Achieved. Although detainees were not individually checked in to the dining hall, on the basis that this had been found to be intrusive, dormitory officers checked that each member of their dormitory had left for lunch, and special checks were made on those identified as being at risk. In practice, any missing of meals was quickly picked up by staff.

2.105 Detainees working in the kitchen should be able to gain recognised vocational qualifications. (8.15)

Partially achieved. No detainees had completed any recognised vocational qualifications in the kitchen. However, the establishment had set up such training and three detainees had begun a course before each dropping out for various reasons. The high turnover of detainees, and a reduced demand for kitchen worker places, had made this recommendation difficult to achieve.

Additional information

2.106 A number of detainees criticised the quality, and especially the quantity, of food. They also felt that the 5.15pm evening meal time was too early. Managers had tried many options to address the substance of these complaints, changing a number of procedures. The amount, quality and variety of food were acceptable at the time of the inspection.

Centre shop

2.107 New arrivals should be offered the choice of a smoker's or non-smoker's pack. (8.16)

Achieved. Both types of pack were available, for the same price, in reception.

Welfare

2.108 There should be an additional welfare officer and cover should be provided at weekends. (9.22)

Not achieved. There was one welfare officer who worked from Monday to Friday, providing a service of which detainees spoke highly. There was no dedicated welfare provision at

weekends. In our focus groups, detainees expressed concern at this and said that, although dormitory officers were helpful, they were not able to provide specialist welfare support.
We repeat the recommendation.

Visits

2.109 Visits should be longer to encourage more visitors to make the long journey. (9.23)

Partially achieved. An additional all-day visit session had been introduced on a Wednesday, while the Saturday morning and Monday evening sessions had been removed. This decision followed a small piece of work undertaken by the centre in 2009/10, looking at visits demand. However, some detainees said that two-hour visits at weekends were not sufficient for their friends and family who had to travel long distances to the establishment, and that midweek all-day sessions were not helpful for visitors who worked. The extra all-day session had not been trialled at the weekend, and no follow-up study had taken place to establish whether the changes had encouraged more visitors to make their long journey.

2.110 There should be a visitors centre with appropriate facilities. (9.25)

Partially achieved. The construction of a small visitors centre, located just outside the gatehouse, was nearing completion at the time of the inspection, the plans including toilet facilities and a kitchenette area. The centre was due to be operational by the end of the summer 2011.

2.111 Substantial food should be available in the visits hall. (9.26)

Not achieved. There was no provision in the visits hall, except for tea, coffee and biscuits, or sandwiches on all-day visits sessions. This was insufficient, particularly for families who had travelled long distances to visit the centre.
We repeat the recommendation.

2.112 Information displayed in the visits hall should be in a range of languages. (9.27)

Not achieved. There was little information displayed in the visits hall, and most of this was in English only. The exception to this was a folder in the waiting area outside the visits hall, which contained information on making a racist incident complaint in 14 languages.
We repeat the recommendation.

2.113 Feedback should be sought from all visitors and findings should be turned into an action plan that is reviewed regularly. (9.28)

Achieved. A visitors survey had been undertaken in March 2010, with a resultant action plan, which had been posted in the visits hall. In addition, a visitors comments book was situated in the visits hall, and was well used. The duty manager, an Independent Monitoring Board representative and a member of the diversity team all regularly checked and signed the book.

Telephones

2.114 Telephones should be located in quieter areas. (9.29)

Partially achieved. The telephones for incoming calls had all been moved out of the association areas and onto the dormitory corridors, which were much quieter. The telephones

for outgoing calls, which required the purchase of a telephone card from the shop, had not been moved. On the whole, detainees used either their own mobile telephone or one provided by the Haslar Detainee Visitors Group.

2.115 There should be assistance for detainees who do not have the funds to telephone their family. (9.30)

Achieved. While there was no ongoing financial assistance for detainees to telephone their family, staff allowed them to use their landline telephones to make calls, including international calls. We saw both the welfare office and dormitory staff facilitating this.

Mail

2.116 Detainees should be informed of their entitlement to send mail at no cost. (9.31)

Achieved. Detainees in our focus groups were aware of this entitlement, and it was routinely covered as part of the induction.

Removal and release

2.117 Detainees who are removed should be given the funds to reach their final destination. (9.32)

Not achieved. No formal UKBA system of financial assistance had been introduced for those returning to their country of origin, apart from the Voluntary Return Scheme. The Haslar Detainee Visitors Group was able to help out with small sums of money on occasion, and the welfare officer had links with community organisations such as the Red Cross, but beyond this little was available to detainees with no funds of their own.
We repeat the recommendation.

2.118 Detainees who are transferred should be given reasons in writing. (9.33)

Not achieved. Staff made detainees aware of an imminent transfer as quickly as possible after receiving notification from the Detainee Escorting and Population Management Unit, and the reasons were stated on the movement order. However, detainees did not receive written confirmation of the reasons for transfer.
We repeat the recommendation.

2.119 There should be a protocol detailing the centre's responsibilities when a detainee makes an allegation of assault during a removal attempt. (9.34)

Achieved. A manager's order to staff had been issued by the centre in April 2011, setting out the procedure that staff should follow in the event of assault allegations made during a removal. It incorporated input from health services staff and assistance for detainees in making a complaint to UKBA.

Section 3: Summary of recommendations

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

Main recommendation

To the chief executive, UKBA and NOMS

3.1 Where there is no prospect of a detainee being removed because his country of origin declines to issue travel documents, the caseworker should address any such continued detention as a matter of law and fact. (2.2)

Main recommendation

To the centre manager

3.2 The centre should significantly increase the amount of paid work for detainees, including the implementation of planned workshops. (2.5)

Recommendations

To the chief executive, UKBA

3.3 All detainees should be informed of their destination before they are transferred. (2.9)

3.4 All casework files should be quality checked monthly. (2.10)

3.5 In consultation with the centre, UKBA should ensure that all detainees receive a copy of the bail summary in due time before the hearing, and the on-site immigration team should monitor the receipt of bail summaries. (2.11)

3.6 Monthly reviews of detention (form 151F) should be timely and show a balanced consideration of all factors relevant to continuing detention. The review letter should routinely include a subheading that refers to progress since the last report to ensure that this issue is addressed and that reasons are given when there is a lack of progress. (2.12)

3.7 In an age-dispute case, the UKBA caseworker should respond within 24 hours of receipt to documentary evidence that shows that the detainee is under 18. (2.13)

3.8 Unless the documentary evidence of age submitted in an age-dispute case is clearly unreliable, detainees under 18 should not be detained while the age-dispute issue is resolved. (2.14)

3.9 The UKBA caseworker should respond to rule 35 letters within the required two working days, detailing in every instance the consideration given to continued detention in the light of the rule 35 letter and the detainee's circumstances. (2.15)

3.10 When the transfer of a separated detainee is approved, this should be carried out on the same day unless exceptional circumstances cause delay. (2.16)

3.11 UKBA should introduce an assisted visits scheme to help family and friends of detainees who have difficulty with travel costs. (2.17)

Arrival in detention

3.12 Detainees who are transferred from Haslar should not be searched twice in reception before leaving. (2.18)

3.13 All information displayed in the reception waiting area should be in a range of languages. (2.20)

3.14 Information about how to access legal and bail advice should be a routine part of induction, and also included in the translated induction booklet. (2.21)

Environment and relationships

3.15 The public address system should be replaced by a less intrusive form of communication. (2.23)

3.16 Unit notice boards should display material translated into a range of relevant languages. (2.26)

3.17 Staff should ensure that observation panels in room doors are not obstructed. (2.27)

Staff–detainee relationships

3.18 Staff should receive training to enhance their understanding of the experiences and histories of people seeking asylum, refugees and those detained under immigration powers. (2.31)

3.19 Personal officer interviews with detainees who speak little English should take place through a professional interpreting service. (2.33)

3.20 Staff should be encouraged to wear a less formal uniform to help distinguish prison and IRC roles. (2.34)

3.21 Staff should not carry defensive weapons. (2.35)

Casework

3.22 The centre should formalise the arrangement for Bail for Immigration Detainees to provide a weekly full-day advice session with access to translation and interpreting facilities. (2.37)

Suicide and self-harm

3.23 The special accommodation unit should be staffed when detainees are placed in the safer cell because of a risk of self-harm or suicide. (2.4)

3.24 The safer communities coordinator should quality check assessment, care in detention and teamwork (ACDT) forms frequently to ensure that actions requested by managers have been carried out, and that inadequate care maps are revised appropriately. (2.42)

3.25 The formal peer support scheme should be implemented. (2.45)

Diversity

3.26 Diversity monitoring should include nationality, age and disability as well as other aspects of diversity, should allow trends to be analysed over time, and should be routinely discussed at diversity meetings. (2.53)

Health services

3.27 All health care staff should receive training in the recognition of signs of trauma and torture, and how to support these detainees. (2.62)

3.28 Detainees should have access to routine dental care. (2.78)

Work and learning and skills

3.29 Education classes and supervised access to education facilities should be provided at weekends and extended at other times. (2.81)

3.30 Detainees' freedom of movement within the centre should be increased in the evenings and extended overall. (2.82)

Library

3.31 Library opening should extend to evenings and weekends. (2.83)

Rules of the centre

3.32 Managers should publish a set of centre rules, and include it in the next update of the induction booklet (including translations). (2.86)

Use of force and single separation

3.33 Detainees under escort should be handcuffed only where there is a specific evidenced risk justifying it. (2.94)

Complaints

3.34 There should be formal quality assurance of replies to complaints. (2.100)

3.35 A monthly monitoring report on complaints should be introduced, including a record of where complaints originate, so that emerging patterns can be identified and addressed. (2.102)

Welfare

3.36 There should be an additional welfare officer and cover should be provided at weekends. (2.108)

Visits

3.37 Substantial food should be available in the visits hall. (2.111)

3.38 Information displayed in the visits hall should be in a range of languages. (2.112)

Removal and release

3.39 Detainees who are removed should be given the funds to reach their final destination. (2.117)

3.40 Detainees who are transferred should be given reasons in writing. (2.118)

Appendix I: Inspection team

Hindpal Singh Bhui	Team leader
Bev Alden	Inspector
Colin Carroll	Inspector
Martin Kettle	Inspector
Mick Bowen	Health services inspector
Linda Truscott	Ofsted inspector

Appendix II: Detainee population profile

Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

(i) Age	No. of men	No. of women	No. of children	%
Under 1 year	0	NA	NA	0
1 to 6 years	0	NA	NA	0
7 to 11 years	0	NA	NA	0
12 to 16 years	0	NA	NA	0
16 to 17 years	0	NA	NA	0
18 years to 21 years	13	NA	NA	9.6
22 years to 29 years	49	NA	NA	36.3
30 years to 39 years	49	NA	NA	36.3
40 years to 49 years	17	NA	NA	12.6
50 years to 59 years	5	NA	NA	3.7
60 years to 69 years	2	NA	NA	1.5
70 or over	0	NA	NA	0
Total	135			100

(ii) Nationality Please add further categories if necessary	No. of men	No. of women	No. of children	%
Afghan	6	NA	NA	4.4
Albanian	1	NA	NA	0.7
Algerian	2	NA	NA	1.5
Angolan	0	NA	NA	0
Bangladeshi	18	NA	NA	13.3
Belarusian	0	NA	NA	0
Cameroonian	0	NA	NA	0
Chinese	7	NA	NA	5.2
Congolese	1	NA	NA	0.7
Ecuadorian	0	NA	NA	0
Estonian	0	NA	NA	0
Georgian	0	NA	NA	0
Ghanaian	3	NA	NA	2.2
Indian	23	NA	NA	17
Iranian	4	NA	NA	3
Iraqi	4	NA	NA	3
Ivorian	0	NA	NA	0
Jamaican	1	NA	NA	0.7
Kenyan	1	NA	NA	0.7
Latvian	0	NA	NA	0
Lithuanian	0	NA	NA	0
Malaysian	2	NA	NA	1.5
Moldovan	1	NA	NA	0.7
Nigerian	7	NA	NA	5.2
Pakistani	14	NA	NA	10.4
Russian	0	NA	NA	0
Sierra Leonean	1	NA	NA	0.7
Turk	4	NA	NA	3

Ukrainian	4	NA	NA	3
Vietnamese	1	NA	NA	0.7
Zambian	0	NA	NA	0
Zimbabwean	1	NA	NA	0.7
Not stated	5	NA	NA	3.7
Other (please state)				
Czech	1	NA	NA	0.7
Eritrean	2	NA	NA	1.5
Ethiopian	1	NA	NA	0.7
Gambian	2	NA	NA	1.5
Guinean	1	NA	NA	0.7
Malawian	1	NA	NA	0.7
Moroccan	1	NA	NA	0.7
Polish	1	NA	NA	0.7
Rwandan	1	NA	NA	0.7
Saudi Arabian	1	NA	NA	0.7
Senegalese	1	NA	NA	0.7
Slovak	1	NA	NA	0.7
Spaniard	1	NA	NA	0.7
Sri Lankan	6	NA	NA	4.4
Sudanese	1	NA	NA	0.7
Tanzanian	1	NA	NA	0.7
Yemenite	1	NA	NA	0.7
Total	135			100

(iv) Religion/belief Please add further categories if necessary	No. of men	No. of women	No. of children	%
Buddhist	4	NA	NA	3
Roman Catholic	5	NA	NA	3.7
Orthodox	1	NA	NA	0.7
Other Christian Religion	18	NA	NA	13.3
Hindu	10	NA	NA	7.4
Muslim	65	NA	NA	48.1
Sikh	16	NA	NA	11.9
Agnostic /atheist	7	NA	NA	5.2
Not stated	6	NA	NA	4.4
Other		NA	NA	
Orthodox (Greek/Russian)	1	NA	NA	0.7
Other	1	NA	NA	0.7
Rastafarian	1	NA	NA	0.7
Total	135			100

(v) Length of time in detention in this centre	No. of men	No. of women	No. of children	%
Less than 1 week	17	NA	NA	12.6
1 to 2 weeks	27	NA	NA	20
2 to 4 weeks	35	NA	NA	25.9
1 to 2 months	26	NA	NA	19.3
2 to 4 months	18	NA	NA	13.3

4 to 6 months	4	NA	NA	3
6 to 8 months	2	NA	NA	1.5
8 to 10 months	2	NA	NA	1.5
More than 10 months (please note the longest length of time)	3 (2 years, 2 months)	NA	NA	2.2
Unknown	1	NA	NA	0.7
Total	135			100

(vi) Detainees' last location before detention in this centre	No. of men	No. of women	No. of children	%
Community	10	NA	NA	7.4
Another IRC	115	NA	NA	85.1
A short-term holding facility (e.g. at a port or reporting centre)	3	NA	NA	2.2
Police station	0	NA	NA	0
Prison	7	NA	NA	5.1
Total	135			100