Report on an unannounced short follow-up inspection of

Dover Immigration Removal Centre

3 – 5 April 2012

by HM Chief Inspector of Prisons

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Introduction

Dover has operated as an immigration removal centre (IRC) since 2002, receiving a number of fairly positive inspection reports over that period. At our previous inspection in 2010, we reported that the centre provided a reasonably safe environment. During this short follow-up inspection, we found that considerable efforts had been made to carry out improvements and we identified progress in some key areas.

Improvements had been made to the treatment of detainees on reception and induction, but the high number of movements of detainees at night continued to be disruptive. The level of self-harming behaviour remained low and there was little evidence of bullying. We had concerns about the high level of strip-searching and poor governance.

The quality of information provided by immigration staff to detainees who were worried about their cases had not improved and remained inadequate. We were told that age dispute cases no longer arose at the centre, and that age assessments were no longer carried out as a result. This was not a credible position given that age disputes can arise at any time and should be assessed by children's professionals.

Some refurbishment of the residential areas had been carried out since the previous inspection but most of the living accommodation was still cramped and did not provide sufficient privacy. Apart from the quite intrusive physical security, we did not see evidence of the prison-like culture, which we had noted previously.

Relationships between staff and detainees were good and the support provided to minority groups had improved. A wider range of health services was now available and safer practices had been introduced to dispense medication. Better support was also available to detainees with drug problems and this now extended to detainees with alcohol problems.

There had been a modest increase in the number and range of education classes since the previous inspection and detainees had more access to the library. Restrictions which had previously delayed detainees starting work had been lifted, but a significant proportion of detainees were still not permitted to work because they failed to cooperate with the UK Border Agency (UKBA). Internet access and the facility to send emails had been introduced since the previous inspection and this made it much easier for detainees to maintain contact with their family and friends. However, detainees were locked up for too long and experienced too many restrictions on their freedom of movement.

Attempts were being made to improve welfare support but this remained inadequate. Visiting arrangements were poor and detainees did not receive sufficient practical help prior to discharge.

Dover IRC remained a reasonably safe place for detainees and we saw incremental improvements in the physical environment, the facilities and the culture in the centre. The two key areas that still needed to be addressed were the poor quality of information provided by UKBA to detainees and the lack of adequate support to help detainees prepare for release or removal.

Nick Hardwick
HM Chief Inspector of Prisons

June 2012

Fact page

Task of the establishment
The provision of secure, humane accommodation of detainees in a relaxed regime with as much freedom of movement and association as possible, consistent with providing a safe and secure environment, while encouraging and assisting detainees to make the most productive use of their time, and respecting their dignity and right to individual expression.

Location
Dover, Kent

Name of contractor
HM Prison Service

Number held
285

Certified normal accommodation
316

Operational capacity
316

Last inspection
May 2010

Brief history
Dover was converted into a prison in 1952. In 1957 it became a Borstal. It continued to hold young offenders until April 2002, when it was redesignated as an immigration removal centre operating under Detention Centre Rules 2001. It is run by the Prison Service and holds adult males in secure conditions. A UKBA manager and team are based on site to liaise with case owners, the Port Authorities and detainees.

Short description of residential units
The centre consists of five residential units: Deal, Sandwich, Romney, Rye and Hastings, and one small separation unit named Hythe. Much of the accommodation comprises six-bed dormitories, although there are also single and double rooms. All living accommodation provides integral sanitation and access to a power supply.

Escort provider
Reliance

Health service commissioner and providers
Eastern and Coastal Kent NHS
HM Prison Service

Learning and skills providers
The Manchester College

Section 1: Summary

Introduction

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

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

1.3 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2010 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

Activities – 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.

1.4 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

1.5 At the last inspection in 2010, we judged that outcomes for detainees against this healthy establishment test were reasonably good. We made 45 recommendations in this area, of

which 20 had been achieved, 10 partially achieved and 15 had not been achieved. We have made four further recommendations.

1.6 There were still significant numbers of moves at night and these were disruptive for detainees. Risk assessments were now completed systematically on most transfers, but not always when detainees were received from police custody. Some improvements had been made to the reception area, but the poor design continued to make it difficult for staff to supervise.

1.7 Health care staff were now notified of discharges and saw the majority of these detainees prior to release, so that they could ensure that medication was dealt with appropriately.

1.8 Improvements had been made to the induction process, which was now more structured and included input from a wider range of staff. Peer supporters also played a useful role in induction, particularly with those for whom English was not the first language.

1.9 There was little use of telephone interpretation services and it was not monitored. In some cases, detainees referred to as Helping Hands were used to interpret for their peers during personal or sensitive discussions, which was inappropriate.

1.10 Levels of bullying did not appear to be high and, where bullying occurred, it was managed well. Staff had a clearer idea of bullying hotspots and these areas were prioritised for supervision.

1.11 The number of detainees transferred in to the centre on open ACDTs (assessment, care in detention and teamwork) had declined and the number of open ACDT cases held in the centre remained low.

1.12 Since the previous inspection, staff had established good working relationships with the county social services department, in relation to age dispute cases. We were told that social services had begun to respond promptly whenever an age dispute case arose at the centre, and carried out a Merton compliant[1] age assessment. However, following a change in work practice by the UK Border Agency (UKBA) the previous year, all age dispute cases were now determined by the chief immigration officer at the point of detention and it was not clear if Merton compliant age assessments were still being carried out. This was a retrograde step, as age dispute cases should always be determined by a social worker.

1.13 The preponderance of razor wire in the centre was disproportionate to the security required for the population. We welcomed the fact that batons had not been used since the previous inspection but staff still carried them routinely.

1.14 We had concerns about the governance of strip-searching. The reasons for strip-searching were not adequately recorded. The number of detainees who had been strip-searched following an incident of self-harm appeared high, although it was not possible to determine if strip-searching was proportionate because of the poor quality of the records. The proportion of strip-searches authorised retrospectively was also high.

1.15 Services were available to detainees through the Detention Duty Advice scheme and Bail for Immigration Detainees workshops, but they were not well advertised.

[1] The Merton judgement was handed down by Burnton J in the High Court on 14 July 2003, and gives guidance as to the requirements of a lawful assessment by a local authority of the age of a young asylum seeker claiming to be under the age of 18 years.

1.16 The quality of advice provided by immigration staff remained inadequate. Interviews were very brief and we observed 10 detainees being interviewed within 60 minutes. Interpreters were not always used when they were needed.

1.17 Accumulated periods of detention were recorded but not always provided to detainees on time.

1.18 Rule 35 reports were poor. They were often handwritten and difficult to read and did not contain photographs or body maps. The replies given to Rule 35 reports were generally prompt but dismissive.

1.19 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Respect

1.20 At the last inspection in 2010, we judged that outcomes for detainees against this healthy establishment test were reasonably good. We made 42 recommendations in this area, of which 19 had been achieved, 13 partially achieved and 10 had not been achieved. We have made two further recommendations.

1.21 Detainees whom we spoke to were generally content with the living conditions. Communal areas and corridors were now clean and reasonably well decorated. The sleeping accommodation remained the same as we had found previously; most of it was cramped and some afforded little privacy. Detainees did not have room keys.

1.22 Some showers had been refurbished but had become shabby again because of poor ventilation. A number of the showers were faulty and had inadequate screening. The communal toilets were clean but they also lacked adequate privacy screening. There was access to hot drinking water after lock up, but detainees who wanted to use a flask had to buy one.

1.23 Detainees were issued with a useful leaflet about diversity on induction. Work to support detainees with a disability had improved, with better identification on admission and sustained follow-up help offered. Discreet support was offered to gay detainees.

1.24 Detainees reported positively about their relationships with staff and this was consistent with what we observed.

1.25 Complaints were now being monitored to discern patterns and trends, and quality checks had been introduced. The standard of replies to complaints was adequate but detainees were sometimes unreasonably expected to pursue matters themselves.

1.26 A number of health care staff had completed useful training in how to recognise and treat signs of torture. Secondary dispensing had ceased and safer methods of dispensing medication had been introduced. Primary care counselling was now available and was being delivered by the registered mental health nurses. A suitable range of health care support was provided for most detainees who were less able to cope with day-to-day life on the residential units.

1.27 There were no hand washing facilities in the health care room on reception and some health care staff had not received up-to-date basic life support training.

1.28 A dental suite had been opened and a good service was being provided with very short waiting times.

1.29 The provision of support to detainees who had drug-related problems had improved since the previous inspection. Maintenance therapy and clinical management were both in place but detoxification was still not available. Support was also available for detainees who had alcohol problems.

1.30 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Activities

1.31 At the last inspection in 2010, we judged 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, seven partially achieved and three had not been achieved. We have made three further recommendations.

1.32 The number and range of classes had increased since the previous inspection and the take up of education had increased by about 5%. More efficient attendance records were kept and a useful survey was being carried out to try to establish why detainees dropped out of class. Accreditation of ESOL (English for speakers of other languages) had improved. There were still no weekend education classes and coordination between education and work needed improvement. Detainees were now able to use desktop computers for personal work and study.

1.33 The previous restriction on detainees having to wait four weeks to take up a job had been lifted and they could now start work promptly.

1.34 Detainees who did not cooperate with UKBA were still not permitted to carry out paid work. Records indicated that this affected as many as 9% of detainees who applied.

1.35 There had been a slight extension of library opening hours, but it was still not open at the weekend and in the evenings. The new staff cover arrangements ensured that the library was no longer closed for extended periods.

1.36 Freedom of movement remained unchanged since the last inspection. Detainees still did not receive 12 hours' freedom of movement and were locked up too early and for too long. The situation was worse for detainees on Rye unit than elsewhere.

1.37 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Preparation for release

1.38 At the last inspection in 2010, we judged that outcomes for detainees against this healthy establishment test were not sufficiently good. We made 20 recommendations in this area, of which one had been achieved, two partially achieved and 17 had not been achieved. We have made three further recommendations.

1.39 With the introduction of internet access and the facility to send emails, it was now easier for detainees to maintain contact with their family and friends.

1.40 Links with Dover Detainee Visitors Group were good but there was still no effective welfare support available for detainees from within the centre. Plans to develop a care map model to assist detainees were well conceived, but the success of this initiative depended on considerable further work being undertaken to broaden links with other organisations.

1.41 Little progress had been made to improve the visiting facilities. The searching of visitors was still not carried out in private and visits did not always start on time. The play area for children was poorly equipped and the closed visit booths were cramped.

1.42 When detainees were transferred to or from other centres, they seldom received much notice and were sometimes given no explanation.

1.43 Basic refreshment packs were provided for detainees being released, but financial support was limited to a rail warrant, which did not always allow detainees to complete their journey.

1.44 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient progress 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)

2.1 Detainees should not be moved during the night unless this is required for urgent operational reasons. (HE.45)

Not achieved. This recommendation was rejected as impractical. A substantial number of routine overnight moves continued to take place, causing an unnecessary level of disruption to detainees. From October 2011 to February 2012, an average of 230 detainees a month arrived or departed between 8pm and 6am. The majority were arrivals, an average of 169 each month. Detainees who arrived after the evening lock up were likely to spend longer in reception as there were fewer staff on duty to act as escorts between reception and the first night unit. As a consequence, newly arrived detainees were moved to the main prison in groups rather than individually and those who had finished their reception procedures had to wait for the others to be ready.
We repeat the recommendation.

2.2 All information supplied to detainees should be in a language they easily understand. (HE.46)

Achieved. A 'quick' written guide was given to detainees on arrival so they knew what to expect prior to their induction. It provided basic information about the centre and was available in 23 languages. It also included a check on whether detainees were hungry or needed to make a telephone call.

2.3 The induction process should be reviewed and redeveloped to include a one to-one interview for all new arrivals and a comprehensive induction programme, including visits from staff from different departments in the centre. (HE.47)

Partially achieved. The induction process had been reviewed but did not include a one-to-one interview with induction staff for all new arrivals. Induction took place on the day or day after detainees arrived and, in our discussion groups, detainees were positive about its value and the information provided. Members of staff from key areas of the centre, including education and chaplaincy and the UK Border Agency (UKBA), saw new arrivals individually within 24 hours of their arrival.

2.4 UKBA should urgently improve the quality of information provided on site to detainees, the timeliness and quality of reviews, and the response to rule 35 letters. (HE.48)

Partially achieved. The quality of written information provided to detainees by UKBA had improved. They were given a leaflet about the on-site UKBA team, the complaints procedure, detention duty advice scheme, how to apply for bail and assisted voluntary return. This information was not adequately reinforced in induction interviews and the timeliness and quality of progress reports was poor, with almost 50 overdue on the first day of our inspection. The first review of detention was often detailed but focussed on factors that reinforced detention. Subsequent reviews added little to the first review. The timeliness of rule 35 replies had improved since our last inspection and a UKBA wide system was in place to ensure that late

reports were monitored and chased. The responses that we reviewed were dismissive and none had led to the release of a detainee (see section on immigration casework).
We repeat the recommendation.

2.5 Telephone interpreting services and/or professional interpreters should be used for confidential matters, or when sensitive information is being discussed, to ensure that detainees who do not speak English understand important/essential information. (HE.49)

Not achieved. Telephone interpretation services had been used 331 times during 2011-2012. The most frequently used languages were Arabic and Mandarin. The centre did not monitor use by different departments and could not ensure that areas of the centre which should be making good use of the service were doing so. Many staff we spoke to said they used the Helping Hands peer supporters to interpret for their peers. While this was an excellent resource for many informal purposes, in some circumstances it was being used inappropriately, for example during assessment, care in detention and teamwork (ACDT) reviews.
We repeat the recommendation.

2.6 The take up of education should be facilitated by better coordination with work and by providing more classes at evenings and weekends. (HE.50)

Partially achieved. There had been an increase in the number of classes available in the evening but there were still no classes at the weekend. Other changes had been made to the programme, including the introduction of popular well-attended two-week short courses. Improved coordination had led to a greater proportion of detainees receiving induction to education: take up of education had risen modestly by about 5% since the last inspection. The centre had made little progress in improving the coordination of education with work, although a strategy was being developed to facilitate this.

2.7 The recently appointed education manager had initiated a long-term survey to determine why detainees dropped out from, or did not take part in, education. This piece of work was still in the process of being completed.

Further recommendation

2.8 The coordination of education with work should be improved and classes should be offered at the weekend.

2.9 A dedicated team of trained staff should be set up to provide for detainees' welfare needs. (HE.51)

Not achieved. There was still no dedicated welfare team but members of staff had begun to be allocated responsibility as designated welfare officers (see good practice 2.37).

2.10 The centre should provide internet access and detainees should be able to send emails. (HE.52)

Achieved. The centre provided a room with 14 computers connected to the internet. Detainees who used it were assigned a personal Dover IRC email address, enabling them to send and receive emails. Detainees wishing to use the internet specified the websites they wished to have access to, which were then enabled by centre staff. Email and internet access was more

tightly controlled than in most IRCs. Sessions were scheduled every morning and afternoon and on weekday evenings. Take up of this extremely useful resource was high and increasing.

Recommendations

Arrival in detention

Escort vans and transfers

2.11 Detainees should be given refreshments during their journeys to the establishment. (1.6)

Achieved. Detainees in our groups told us that they were offered water and sandwiches during their journeys. We examined a small sample of person escort records (PERs), most of which recorded that the detainee had been offered food and drink. The few who had not been offered refreshments had had relatively short journeys.

2.12 Risk analysis forms should always be completed for detainee transfers. (1.7)

Partially achieved. PERs were completed for most detainees who arrived at or left the centre. We were told that completed PERs did not arrive with all detainees who came from police custody. Information contained in IS91Ms (movement notification forms) tended to be of a general nature, for example criminal antecedents, rather than describing known risks.
We repeat the recommendation.

2.13 Escort staff should provide reception staff with all necessary information about the detainees in their care so that they can make a comprehensive assessment of detainees' health and welfare. (1.8)

Achieved. Escort staff handed over all the information they had about detainees in their care to reception staff and described verbally how the detainee had been during the journey and any concerns they had identified en route.

2.14 Transfer journeys between centres should, whenever possible, be direct, without unnecessary stops. (1.9)

Achieved. In the PERs that we sampled, journeys had been direct. In our discussion groups, some detainees spoke about long journeys, but they did not describe circuitous trips with unnecessary stops. We found evidence of detainees experiencing lengthy waits at reporting centres prior to embarking on transport to the removal centre. On one evening during the inspection three detainees arrived from reporting centres in Croydon at 11.30pm.

Further recommendation

2.15 Detainees should not have extended waits at reporting centres for transport to a removal centre.

2.16 Detainees should not be subject to multiple moves between immigration removal centres (IRCs). (1.10)

Partially achieved. Some detainees were subject to moves around the immigration removal estate and were given no explanation. We observed one detainee with health problems who arrived at the centre at 8pm from another removal centre. He said he did not know why he had been moved and there was nothing contained in the relevant documentation for staff to explain the move to him. He was distressed at being moved further from his family and was allocated to a single room with one-to-one induction the following morning. Staff told us that this was not an unusual occurrence. Some detainees were also subject to short-term moves to other centres to facilitate interviews with embassies or high commissions.

Further recommendation

2.17 Detainees and staff at receiving centres should be given clear information about why a move is being carried out.

Reception

2.18 The reception area should be redesigned to include private interview rooms and to provide better movement flow of detainees being received and discharged simultaneously. (1.16)

Not achieved. Although an interview room was now available for health care staff to use, the reception area remained essentially as it had been at the previous inspection. Proposals had been made to use the space more efficiently, but these had not been implemented. Despite the inadequacies of the physical environment, detainees in our discussion groups talked positively about their reception experience and we observed staff treating newly arrived detainees in a professional and friendly manner.
We repeat the recommendation.

2.19 There should be better supervision of the detainee holding room. (1.17)

Not achieved. Supervision of the holding room had not changed since the previous inspection and remained inadequate. A new CCTV system had been purchased but was not installed as no decision had been made about the changes required to the reception area. A new CCTV system had been purchased but it was unclear if or when it would be installed.
We repeat the recommendation.

2.20 New arrivals should be offered hot and cold food. (1.18)

Partially achieved. Meals were kept on the induction unit for detainees who arrived close to meal times, but only instant noodle snacks were available for detainees who arrived at other times. Hot and cold drinks were freely available in the holding area.
We repeat the recommendation.

2.21 Initial interviews and the room sharing risk assessment should be carried out in private. (1.19)

Partially achieved. Interviews were carried out in rooms off the main reception area but they had no doors and this compromised privacy. Health care interviews took place in a private room in reception.

2.22 The detainee shower should be relocated to a more suitable area and adequately screened. (1.20)

Not achieved. Additional screening had been added to the shower, but its location in the middle of the busy holding area remained inappropriate. Staff told us that few detainees used the shower, preferring to wait until they got to the induction unit.

2.23 Discharging health services staff should be made aware of all impending departures and conduct individual risk assessments to determine whether medication should be allowed in possession, and escorting staff should be instructed accordingly. (1.21)

Achieved. Processes were in place to alert health care of any detainee due for discharge so that an appropriate risk assessment for medication could be carried out. Detainees were occasionally released via video link and did not always see a health care professional prior to leaving the centre.

First night and induction

2.24 The detainee peer supporters should meet all new arrivals to offer support. (1.28)

Partially achieved. Detainee peer supporters were used regularly to help new detainees settle in. Their role and availability was advertised to all new detainees during the induction programme but in our discussion groups several detainees told us they had not met a peer supporter and were not aware of their role in offering support and assistance.
We repeat the recommendation.

Environment and relationships

Residential units

2.25 Sleeping accommodation should provide much more privacy and better facilities. (2.14)

Not achieved. The sleeping accommodation on residential units remained the same as at the previous inspection and was still inadequate.
We repeat the recommendation.

2.26 Detainees should have access to hot water until midnight. (2.15)

Achieved. Although detainees were still locked up by 8.30pm with no access to the hot water boiler, they were able to fill a flask with hot water and keep it in their room overnight. Flasks were not routinely issued by staff and detainees were required to buy one from the shop.

Further recommendation

2.27 Detainees should be issued with a hot water flask.

2.28 Important notices should be displayed in a variety of languages. (2.16)

Not achieved. A small number of internationally recognised pictorial symbols were used in the centre, and some notices about the facilitated returns scheme were displayed in other

languages, but the vast majority of key information on display about the regime was only in English.
We repeat the recommendation.

2.29 Detainees should be given keys to their rooms. (2.17)

Not achieved. Detainees still did not have keys to their rooms. A costing exercise had been carried out and the level of finance required was considered too high.

2.30 The toilets in the dormitories on Sandwich should be deep cleaned. (2.18)

Achieved. The toilets had been deep cleaned as part of a rolling programme.

2.31 Detainees on Rye unit should be locked behind their doors for the minimum amount of time, and no longer than detainees on other units. (2.19)

Not achieved. Detainees on Rye unit were locked behind their doors for 15 minutes before lunch and for 30 minutes before tea for a roll count and to allow staff to have their break. On the other units, detainees were locked on to the unit, but not behind their doors.
We repeat the recommendation.

2.32 The communal toilets on the ground floor of Romney unit should be adequately screened. (2.20)

Not achieved. The communal toilets on Romney unit remained inadequately screened, affording little privacy to detainees.
We repeat the recommendation.

2.33 Repairs and redecoration should be undertaken on all relevant residential units. (2.21)

Partially achieved. A programme of redecoration had been undertaken and the units were predominantly clean and freshly painted, with little graffiti. However, some of the shower units were so poorly ventilated that they were already subject to damp and peeling paint despite relatively recent refurbishment. Some repairs were also required, particularly to the windows in the communal areas of Deal, many of which had broken latches and could not be closed in cold weather or fully opened in warm weather. We also noted that there were cracked windows in rooms on Deal. Despite these shortcomings, detainees we spoke to were generally content with the living conditions.
We repeat the recommendation.

2.34 The showers on Sandwich and Deal units should be refurbished and offer adequate levels of privacy. (2.22)

Partially achieved. The ground floor showers on both Sandwich and Deal had been refurbished to a good standard. The showers upstairs on Sandwich had not been refurbished and were out of order. Some of the showers upstairs on Deal had no dividing curtains, while others had curtains which did not close properly and offered inadequate privacy.
We repeat the recommendation.

Staff-detainee relationships

2.35 Staff should routinely knock on doors before entering a detainee's room. (2.30)

Achieved. We did not observe any staff entering rooms without knocking first, and detainees confirmed that it was normal practice for staff to knock. In general, detainees told us that their relationships with staff were positive. They said they were treated with respect and found most staff helpful. This was consistent with what we observed.

2.36 Detainees should have a named care officer, who should have a conversation with them at least monthly, keeping a record of each welfare request, the action taken and by whom. The record should clearly indicate when the request has been completed satisfactorily. (2.31)

Partially achieved. A system had been introduced at the beginning of 2012 for each detainee to be allocated a named officer. These officers were required to have a conversation with detainees at least fortnightly and to record in detail issues arising from the discussion and actions taken. These arrangements were not fully embedded and written records indicated that not all staff were conducting these conversations frequently enough. The quality of records ranged from very good to very poor, with some simply stating 'no problems'.

Good practice

2.37 *The names of allocated welfare officers were displayed in detainees' rooms on Romney unit. This was a simple but useful way of helping detainees to identify whom they could approach for help.*

Casework

Legal rights

2.38 Notices should be displayed around the centre, in a variety of languages, promoting the Detention Duty Advice Scheme and the monthly Bail for Immigration Detainees workshop. (3.8)

Not achieved. Notices about the Bail for Immigration Detainees workshop had been produced in four languages - Chinese, French, Hindi and Arabic - but only the English versions were displayed around the centre. The function of the detention duty advice scheme was explained to detainees on induction but its role was not promoted or reinforced throughout the centre with notices.
We repeat the recommendation.

2.39 Electrical sockets and telephones with two handsets should be fitted in the consultation rooms in the visits hall. (3.9)

Achieved. Electrical sockets and hands-free 'spider' telephones were available in two consultation rooms in the visits hall.

Immigration casework

2.40 UKBA should systematically record and monitor periods of accumulated detention. (3.23)

Achieved. The onsite UKBA contact management team recorded periods of accumulated detention. They kept electronic records of the time detainees spent in the centre and across the detention estate.

2.41 Newly arrived detainees should be advised of their right to apply for bail, legal aid, legal representation and their appeal rights and should be assisted in doing so. (3.24)

Partially achieved. All detainees were inducted by the UKBA contact management team within 48 hours of arrival. Inductions were brief and the nine that we observed were completed within an hour. Confidentiality was compromised by an open door. In one instance, telephone interpreting was not used when it was clearly needed. Detainees were advised that they could apply for bail and legal representation through the detention duty advice scheme and they were given a leaflet reinforcing the information given at the induction interview. The interview room was dirty and the chairs were chained to the floor, giving an unwelcoming impression.
We repeat the recommendation.

2.42 Monthly reviews of detention should be timely and demonstrate a balanced consideration of all factors relevant to the case. (3.25)

Not achieved. Monthly progress reports were not timely and the UKBA contact management records showed that 49 progress reports were overdue. Most monthly reviews emphasised factors supporting detention with little attention given to factors which might favour release, for example ties to the UK.
We repeat the recommendation.

2.43 The reasons for the discrepancies between UKBA and health care records of Rule 35 applications should be investigated and the findings acted on. (3.26)

Achieved. The UKBA manager and head of health care had investigated discrepancies and taken action to reduce them. Health care and UKBA records were congruous for 2012.

2.44 Rule 35 applications should be responded to on time and in detail. (3.27)

Not achieved. Rule 35 reports were poor. They were often handwritten and difficult to read. Cases involving torture described scarring but lacked photographs or body maps. There were no judgements on whether scarring was consistent with the alleged method of abuse. For example, in a case where the detainee claimed to have been shot, there was no judgement on whether the scars were consistent with gunshot wounds.

2.45 Replies were timely but dismissive. In one case, despite a report by a health care professional which described scarring, the reply stated: 'there is no medical evidence to support your contentions.....You say that you were … beaten, kicked and sodomised, which has left you with back pain and a bleeding anus..... Were it even vaguely credible that you were ill treated in the manner described, it is considered that you would have raised this at the earliest opportunity'.
We repeat the recommendation.

Duty of care

Bullying

2.46 Areas where detainees feel least safe should be properly and consistently supervised. (4.17)

Achieved. At our last inspection, the shop, dining hall and health centre were identified as areas where detainees felt less safe. These areas were now satisfactorily supervised. Detainees in our groups told us they felt safe in the centre and that bullying was not a serious problem.

2.47 Detainees should be informed of the centre's anti-bullying policy, the expected levels of behaviour and possible anti-bullying measures. (4.18)

Achieved. Detainees were advised of expected levels of behaviour during induction. A leaflet in 21 languages explaining how detainees should conduct themselves was distributed during induction but not all detainees received a copy. Despite this, detainees we spoke to knew how to seek help and report bullying.

2.48 Anti-bullying logs should include objectives set to challenge detainees' behaviour. (4.19)

Achieved. Anti-bullying logs included a support plan setting out objectives which addressed identified problem areas.

2.49 Victims of bullying should have an individual plan to offer them appropriate support. (4.20)

Achieved. Individual plans were used to support victims of bullying. A multidisciplinary meeting to agree the plan was followed up by regular case reviews and ongoing observation logs.

Suicide and self-harm

2.50 The number of detainees being transferred in on open assessment, care in detention and teamwork (ACDT) should be reduced. (4.21)

Achieved. The number of detainees arriving at the centre on open ACDTs had reduced from 32 in 2009 to 14 in 2010 and 12 in 2011. Some of these detainees had requested a move to an IRC from prison. The number of open ACDT cases within the centre at any one time remained low.

2.51 Where appropriate, family and friends should be engaged in case reviews. (4.22)

Achieved. Detainees were asked if they would like family and friends to be involved in their case reviews. Detainees could sign a consent form to enable staff to contact their family and friends to discuss their case, but to date no detainees had taken up this offer.

2.52 All staff should receive regular ACDT refresher training. (4.23)

Not achieved. Only 63% of staff had received annual ACDT refresher training.
We repeat the recommendation.

2.53 Helping Hands peer support workers should only be asked to support at-risk detainees if they are willing and have appropriate Samaritan support and training to do so. (4.24)

Achieved. The Helping Hands peer support workers we spoke to had been properly briefed about their role. They said that they were not asked or expected to support detainees in crisis.

Childcare and child protection

2.54 UKBA should actively pursue the earliest possible social services assessment of detainees whose age is in dispute. (4.32)

Not achieved. We were informed that decisions about age dispute cases were no longer made at the centre and were now being made by a chief immigration officer (CIO) at the point of detention. No age dispute cases had arisen at the centre since October 2011. Prior to this, centre staff had referred all age dispute cases to the local social services department who had completed assessments speedily.

Further recommendation

2.55 Assessments of age dispute cases should always be carried out by a qualified social worker.

2.56 A policy for detainees whose age is in dispute should be agreed with all involved parties. The policy should include risk assessment and review paperwork, and describe a case management process with clear timings for reviews. (4.33)

Not achieved. There was no up-to-date or jointly agreed local policy on age dispute cases. A safeguarding children policy had been produced in March 2011, but its status was unclear as it had not been signed. Staff were following a 'guidance note' issued by the local UKBA manager in October 2011, which advised them to accept judgements on age dispute cases made by the CIO at the local immigration team. Although we were informed that age dispute cases were no longer held at the centre, it was still important that a policy was agreed so that any individual presenting as a minor at the centre was dealt with properly.

Further recommendation

2.57 A local policy on the handling of age dispute cases, which follows the guidelines set out in the Merton judgement, should be agreed by UKBA, the centre manager and Kent Social Services.

2.58 Detainees whose age is in dispute should not be held in the separation unit. (4.34)

Not achieved. The last recorded case of a detainee held at the centre involving an age dispute was in July 2011. We were informed, however, that if individuals disputing their age arrived at the centre, they would still be held in the separation unit.
We repeat the recommendation.

2.59 A policy should be developed to address the safety of children who visit Dover IRC. (4.35)

Achieved. The safeguarding children policy published in March 2011 addressed the safety of child visitors to the centre. A list of detainees who could present a risk to visiting children was kept up to date and staff supervising the visits area were aware of these details.

Diversity

2.60 Detainees should be informed of how they can access support regarding any diversity issue. (4.47)

Partially achieved. A leaflet had been produced in a range of different languages containing information about diversity, and detainees were shown this during induction. The leaflet explained how detainees could seek help from staff in the diversity team or from peer supporters, in relation to problems associated with race, disability, age and sexual orientation. A number of posters were displayed throughout the centre, promoting various aspects of diversity.

2.61 All staff should receive diversity training in the next 12 months. (4.48)

Partially achieved. Eighty-five per cent of staff had participated in a Challenge it, Change it workshop and there were plans for the remainder to receive training.

2.62 The diversity and race equality team (DREAT) should ensure that staff are clear about their responsibilities in challenging homophobic behaviour and feel confident in doing so. (4.49)

Partially achieved. The Challenge it, Change it training covered the subject of harassment on the basis of sexual orientation. We were given anecdotal accounts of situations where staff had challenged detainees who were displaying homophobic behaviour towards other detainees.

2.63 Detainees were asked discreetly about their sexuality on admission and this information was handled confidentially and sensitively. A follow-up interview was carried out a month later to check that detainees were not experiencing any difficulties as a result of their sexuality.

2.64 The DREAT should keep a record of detainees who cannot speak or read English and this should be accessible to residential staff. (4.50)

Not achieved. No systematic record was kept of detainees who could not speak English, although residential staff appeared knowledgeable about detainees who had difficulty communicating in English. Residential staff had a list of peer supporters who spoke numerous languages and officers commonly used this to direct help to detainees who needed assistance.

2.65 Detainees with disabilities should be identified at the earliest stage and disability should be included in regime monitoring. (4.51)

Partially achieved. Detainees with disabilities were identified successfully on admission and staff working in the DREAT maintained an up-to-date record of these detainees which was helpfully circulated to staff each day. This information was not included in regime monitoring.

2.66 Detainees with disabilities should have their needs assessed and care plans and personal emergency evacuation plans should be drawn up where appropriate. Staff should be aware of these. (4.52)

Achieved. Detainees were assessed on admission to determine if they had a disability. Since the beginning of the year, eight detainees had been identified as having some form of disability. Staff wrote individual care plans and personal emergency evacuation plans for them where necessary. The quality of the plans that we examined was sound and an up-to-date list of detainees who needed assistance due to a disability was circulated through a daily briefing.

2.67 Detainees with mobility problems should be able to access their rooms easily. (4.53)

Achieved. The site was uneven and unsuitable for wheelchair users. Some detainees had reduced mobility or had to use a crutch and in these cases they were allocated ground floor accommodation.

Health services

2.68 The health centre should be expanded, so that it is able to house the full range of required primary and secondary health services and associated equipment. (5.10)

Achieved. Work had been completed to create space in rooms to be used for other purposes in the health centre, and a new dental suite had been provided adjacent to the health centre. However, the largest clinical room remained congested due to the fixed cabinetry furniture and computer desk.

2.69 Health services staff should be trained to recognise and treat signs of trauma and torture. (5.11)

Partially achieved. Reception screening was used to identify detainees who had potentially been subjected to torture. Two members of health care staff had been appropriately trained to assess and treat them. There were plans to train more staff when e-learning materials from UKBA were available.

2.70 Restraints should not be used during visits to outside medical or dental facilities unless in exceptional circumstances after a risk assessment. (5.12)

Not achieved. This recommendation had been rejected. Restraints continued to be used during clinical consultations at outside appointments for most detainees.
We repeat the recommendation.

2.71 The contents of the resuscitation equipment bags should be reviewed and staff trained in the use of the kit in accordance with national regulatory standards. (5.20)

Partially achieved. The contents of the resuscitation bag had been reviewed and were being updated at the time of the inspection. Not all staff had up-to-date basic life support training.

2.72 The pharmacist should be supported to develop pharmacy-led clinics and medicine use reviews for the detainee population. (5.34)

Achieved. Detainees wishing to see a pharmacist were allocated appointments on SystmOne. The pharmacist monitored patterns in prescriptions received and used SystmOne to assist with individual medication reviews.

2.73 Secondary dispensing of medications by nurses should stop. (5.35)

Achieved. We were informed that secondary dispensing had ceased and we saw no evidence of it.

2.74 Security arrangements and the presence of officers at the pharmacy hatch during medication collection times should be reviewed, in order to minimise potential bullying and diversion of supplies. (5.36)

Achieved. SystmOne was now used to make appointments for patients to receive their medications and this had substantially reduced congestion in the queue. Patients could attend for their medications throughout the morning and during an extended period in the afternoon/evening. We observed patients collecting medication from the hatch while others sat and waited their turn. Divertible medications were not given in possession.

2.75 Prescription charts should record the diagnosis. (5.37)

Achieved. Electronic prescriptions were in use on SystmOne. The patient's prescription was linked to his clinical record which contained the diagnosis.

2.76 Patient group directions for antimicrobials should be reviewed, and a local microbiologist should be involved in drawing up the new ones. (5.38)

Achieved. Patient group directions had been reviewed and adjustments made to antimicrobials in line with Health Protection Agency requirements.

2.77 Detainees should receive oral health promotion, dental checks and treatment at least to a standard and range equal to that in the NHS. (5.43)

Achieved. A full range of dental treatments was available to patients, except cosmetic dentistry. Seventeen per cent of detainees stayed less than a week at the centre and 52% less than four weeks. The nature of individual treatment was inevitably affected by the length of stay and it was only possible to offer emergency dentistry to patients staying for shorter periods.

2.78 Primary care counselling services should be commissioned by the primary care trust. (5.50)

Achieved. Primary care was commissioned by the primary care trust. Registered mental health nurses on the primary care team offered counselling, brief interventions and solution-based approaches for common mental health problems.

2.79 Staff members offering care and support to detainees with post-traumatic stress disorder should be appropriately trained and have access to clinical supervision. (5.51)

Achieved. Staff members working with patients with post-traumatic stress disorder were appropriately qualified and in receipt of regular clinical supervision from an external practitioner.

2.80 The health centre should provide day care for those less able to cope with life on the residential units. (5.52)

Partially achieved. This recommendation had been rejected. Health care offered one-to-one clinical support and planned activities were available to detainees, for example relaxation classes, sleep improvement therapy, loss counselling, education and gymnasium sessions.

However, health care did not offer a daily programme of support for detainees with emotional distress or those who found it difficult to cope in open social settings.

Substance use

2.81 Following initial clinical assessment and subject to confirmation, existing prescribing regimes for substance-dependent detainees should be continued or an equivalent provided. (5.58)

Achieved. Following assessment and confirmation, detainees arriving at the centre were offered continuation of existing prescribing regimes.

2.82 Specialist staff should complete a comprehensive assessment of substance-related needs on the day after arrival to determine a suitable stabilisation or detoxification prescribing programme for the detainee. (5.59)

Partially achieved. Health care staff with specialist competencies undertook detailed clinical assessment on the day after arrival. Clinical management of stable substance misuse was available. Detoxification was planned but not available at the time of our inspection.

2.83 Detainees should receive effective support during and after clinical intervention, including for dual diagnosis. Clinical treatment should be integrated with psycho-social interventions. (5.60)

Partially achieved. A fully integrated drug treatment service had not yet started. Support for detainees with dual diagnosis was available from the mental health in-reach team.

2.84 There should be a range of effective alcohol avoidance strategies. (5.61)

Achieved. We were informed that it was rare for detainees to request support for alcohol related problems. Nurses trained to Royal College of General Practitioners level 1 offered individual harm minimisation approaches to alcohol dependent patients. There was access to Alcoholics Anonymous.

Activities

Work and learning and skills

2.85 The requirement for detainees to be at the centre for four weeks before applying for work should be removed. (6.23)

Achieved. The restriction no longer existed. Detainees were able to apply for work on arrival at the centre.

2.86 Consideration of detainees' cooperation with UKBA should not be part of the process for allocating paid work roles. (6.24)

Not achieved. Consideration of detainees' cooperation with UKBA remained part of the process for allocating work roles. In the two months preceding the inspection, 347 detainees had applied for work, of whom 30 had been refused solely or partly because of their reported lack of cooperation with UKBA.
We repeat the recommendation.

2.87 The centre should improve the education building internally and externally to make it more welcoming and accessible to detainees. (6.25)

Partially achieved. Improvements to signage inside the education building made it easier for detainees to find their class rooms. Flowering plants were now growing under the front wall of the building but these were behind forbidding security fencing to which razor wire had been added since the previous inspection.

Further recommendation

2.88 The external fencing at the front of the education building should be altered to present a more welcoming aspect to detainees.

2.89 Music classes should be relocated to a room with sufficient space for classes and music equipment. (6.26)

Achieved. Music classes had been relocated to a spacious, well equipped classroom which allowed detainees to take part in a range of different activities simultaneously. The classes were very popular.

2.90 The structure of information technology courses should enable detainees to work towards short internally or externally accredited units of study. (6.27)

Partially achieved. The centre had restructured courses for beginners into short units of study leading to internal accreditation, but demand was very poor because most detainees already had some computer skills. In response, the centre was experimenting with recording the detainee's requirements on an individual learning plan, to produce short internally accredited units of study. It was too soon to assess the impact of this initiative.

2.91 Detainees should have the use of computers for personal work and study. (6.28)

Achieved. The centre had provided three computers for detainees to use for personal work and study, located in the same room as those used for internet access.

2.92 Accreditation offered to detainees following the English for speakers of other languages (ESOL) course should include assessment of speaking skills. (6.29)

Achieved. The education department recognised detainees' achievements in speaking English through the award of internally accredited certificates in ESOL. Tutors measured improvement in speaking skills against targets set in detainees' individual learning plans. Since November 2011, 41 detainees had achieved certificates.

2.93 Effective analysis of detainees' participation in education should be used accurately to identify patterns of participation by individuals and groups. (6.30)

Partially achieved. An initial study of participation in education had been carried out using existing centre data on diversity in conjunction with data collected by the education department, but this lacked sufficient detail. Initiatives to make use of recent improvements in the quality of attendance data as a basis for more effective analysis of patterns of participation were at an early stage.

2.94 The centre should increase detainees' freedom of movement around the centre to at least 12 hours a day, reduce the length of time that detainees are locked in their rooms each day and establish a later evening lock-up time. (6.31)

Not achieved. Freedom of movement had not increased since the last inspection and remained poor. Detainees' free movement around the centre was still less than 12 hours a day. Detainees continued to be locked up in their rooms too early and for too long.
We repeat the recommendation.

Library

2.95 Library facilities should provide sufficient seating and study space, with improved facilities including audio playback. (6.32)

Partially achieved. The library now loaned audio playback equipment for detainees' use. There had been a small increase in the number of tables and chairs but otherwise study facilities and space were unchanged.

2.96 Library opening hours should be extended to evenings and weekends, with adequate arrangements to cover any absence of library staff. (6.33)

Partially achieved. New cover arrangements were in place to ensure the library was no longer closed due to staff absence. Library hours remained unchanged apart from a very slight extension to weekday opening and this meant that detainees who were working could not use it.

Further recommendation

2.97 Library opening hours should be extended to evenings and weekends to meet the needs of detainees in work.

2.98 Library management systems should enable accurate monitoring of stock and patterns of borrowing. (6.34)

Not achieved. Library management systems remained unchanged and did not enable librarians to ensure that books stocked met the needs of the detainee population.
We repeat the recommendation.

Physical education

2.99 Collation and analysis records of attendance should be sufficiently thorough and detailed to establish clearly how inclusive PE is of individuals or groups. (6.35)

Partially achieved. PE staff' continued to record detainees' attendance meticulously. In September 2011 and March 2012, the centre had collated and analysed recent attendance records. The analyses provided clear data on the take up of different activities by individuals and groups, but needed further development to establish fully the inclusivity of PE.

Rules and management of the centre

Security

2.100 The level of physical security should be proportionate for an IRC. (7.28)

Not achieved. While some razor wire had been taken down since our last inspection, an unnecessary amount remained on fencing, walls and buildings, and some had been added (see paragraph 2.87).
We repeat the recommendation.

2.101 Strip-search records should be completed to an acceptable standard, to include a qualitative record of why this had been authorised, and regularly reviewed by the use of force committee. (7.29)

Not achieved. Thirteen detainees had been strip-searched in 2011 and the justification for this had not been adequately recorded, for example one record stated: 'Seen in grounds in a suspect manner'. The number of detainees strip-searched due to the threat of self-harm appeared high, although it was impossible to judge whether this was always proportionate, for example one record said: 'Possible self-harm'. Another case demonstrated a disproportionate response: a detainee who had self-harmed was strip-searched before being placed on constant watch. The searching policy did not give adequate guidance to staff on when strip-searching should be used. It did state that detainees could only be strip-searched with the authority of the duty manager, but too many were authorised retrospectively. Five in our sample of 20 cases involved retrospective authorisation.
We repeat the recommendation.

Further recommendation

2.102 Strip-searching should only be conducted in the most exceptional circumstances.

Use of force and single separation

2.103 Personal protection equipment should only be worn where and for as long as necessary to assist in de-escalation. (7.30)

Achieved. Personal protection equipment had been used once during 2011. Records indicated that de-escalation had been applied and the equipment only used for as long as necessary. The incident had been filmed, but when we asked for a copy, it could not be located.

2.104 Any use of extendable batons should be investigated at the earliest opportunity. (7.31)

Achieved. Extendable batons had not been used since our last inspection.

2.105 Staff should not routinely carry extendable batons. (7.32)

Not achieved. Staff continued to carry extendable batons routinely.
We repeat the recommendation.

2.106 The use of force committee should review individual use of force incidents and comment on them in the minutes. (7.33)

Achieved. The committee met once every two months. Use of force was a standing item on the agenda and individual incidents were discussed. A referral had been made to the regional deputy director of custody to investigate whether force had been used appropriately in one case. The matter had been thoroughly investigated and the recommendations accepted.

2.107 The special cell should only be used when needed, and not for detainees who are compliant. (7.34)

Achieved. Detainees had been placed in the special cell under rule 42 (temporary confinement) of the detention centre rules on seven occasions in 2011, a reduction from our last inspection. Documentation was in good order and explained clearly the necessity to use temporary confinement and that it was not used for longer than necessary. Compliant detainees were not placed in the special cell.

Complaints

2.108 Complaints should be monitored and reported in such a way that local management, including UKBA managers, can track response performance and analyse any emerging trends and areas of repeat complaints. (7.35)

Achieved. Monthly monitoring reports were produced for consideration by the senior management team. These had not revealed any significant patterns or trends. An average of 12 complaints had been submitted each month between September 2011 and February 2012. Property was the main cause for complaint and the centre had adapted their monitoring in the month prior to the inspection to differentiate between property complaints relating to Dover and other places of detention.

2.109 A senior manager should make a 10% quality check of complaints to ensure that responses are appropriate and respectful. (7.36)

Achieved. The deputy centre manager undertook regular quality checks of complaints and we saw evidence of appropriate feedback to staff who had dealt with complaints. Most responses that we looked at were polite and helpful in addressing the issue raised but a few were brusque or did not fully answer the complaint. These areas were being addressed through the quality checks.

2.110 UKBA should review the complaints system, to ensure that complaints are responded to within three days, or 10 days in exceptional circumstances. (7.37)

Not achieved. This recommendation had been rejected and the policy remained unchanged. The shortest time for response was within 10 days of the complaint being allocated to a member of staff to investigate. Responses could take longer than that if the complaint was submitted in a language other than English and needed translation. In our discussion groups, the perception of detainees was that complaints took a long time to be answered, even though they were being responded to within the timescales set down by UKBA.
We repeat the recommendation.

2.111 When complaints are sent to other IRCs or to prisons, an audit trail should be maintained at the centre, to ensure that the detainee receives a response. (7.38)

Not achieved. This recommendation had been rejected. There was no audit trail of complaints sent to another IRC or a prison, although in practice very few were sent. Several responses that we saw provided the address of the prison or IRC so that detainees could send their complaint directly to them, and suggested that they seek help from a member of unit staff. The majority of complaints that required referral concerned missing property.

Further recommendation

2.112 Detainees' complaints should be sent to the authority which can resolve, and provide a substantive response to, the complaint

2.113 All detainees' property should accompany them when they are moved to the centre. (7.39)

Not achieved. Some detainees still arrived at the centre without their property.
We repeat the recommendation.

2.114 Information on how to make a complaint should be readily available, in a variety of languages appropriate to the population, on residential units. (7.40)

Partially achieved. Information on how to make a complaint was available from unit offices in over 20 languages, but not displayed on notice boards in languages other than English.

Services

Centre shop

2.115 Out-of-stock goods should be quickly replenished in the centre shop. (8.10)

Achieved. Stock was replaced regularly and popular perishable goods such as fruit were ordered twice weekly. Detainees had daily access to the shop and were consulted about items they would like the shop to stock. Clothes and other larger items could be ordered from catalogues with no administration fees.

Preparation for release

Welfare

2.116 In coordination with voluntary sector organisations, an assessment should be made of the welfare needs of all detainees in custody, before release, transfer or removal and they should be provided with appropriate support to meet these. (9.30)

Not achieved. There was no detailed assessment prior to release, transfer or removal. However, the centre was planning a new system of detailed assessment on arrival, to include resettlement issues such as accommodation, property and finances, so that staff could address needs during detention and avoid last-minute problems prior to discharge. A care mapping approach, similar to that used in ACDT, was a central theme of this new system. The centre had good links with Dover Detainee Visitors' Group which provided a range of valuable support to detainees, but significant work was needed to enhance links with other organisations so that the new system proved effective when implemented.

We repeat the recommendation.

2.117 An assessment of detainees' welfare needs should be made on their arrival and they should be referred to the appropriate service. (9.31)

Not achieved. Only a very basic assessment was undertaken by reception staff but this was due to be changed (see paragraph 2.116).
We repeat the recommendation.

Visits

2.118 The provision of weekend visits should be reviewed, with a view to extending them. (9.32)

Partially achieved. A review of weekend visits had been undertaken, but they had not been extended. Detainees and visitors whom we spoke to did not report any difficulty in obtaining or attending a weekend visit.

2.119 Arrangements should be made to allow visitors who wish to attend both visits sessions to remain in the centre between the two. (9.33)

Not achieved. Visitors were still required to leave the centre between visits sessions and wait in the visitors' centre outside. The centre had reviewed this since the last inspection but had concluded that there were insufficient staff resources to allow it.
We repeat the recommendation.

2.120 There should be adequate food and drink available for purchase during visits. (9.34)

Not achieved. Facilities in the visitors' centre and the visits hall remained the same as at the last inspection: hot and cold drinks and a snack vending machine. Visitors were not permitted to take their own food into the visits hall and the provision remained inadequate, particularly for visitors who had travelled long distances to the centre.
We repeat the recommendation.

2.121 Searching of visitors should take place in a private area. (9.35)

Not achieved. Searching in the visitors' centre had been trialled but discontinued due to concerns about cross contamination. Visitors were still searched at the gatehouse in view of others and we saw one female visitor undergoing a rub-down search in front of two workmen and two other visitors, which was inappropriate.
We repeat the recommendation.

2.122 Security procedures for visitors should be reviewed so that entry to the centre is not delayed. (9.36)

Not achieved. The security procedures for visitors remained the same. Male visitors were required to have their photograph taken at the gate on each visit. This was printed on a slow portable printer before entry was permitted, and staff confirmed that this continued to cause significant delays at weekends when the number of visitors was high. A biometric system was planned but had not yet been implemented.
We repeat the recommendation.

2.123 Visitors should be allowed to take papers and writing materials into visits, subject to an individual security assessment, and this policy should be applied consistently and publicised in visitor information. (9.37)

Not achieved. Visits staff confirmed that they did not allow visitors to take paper and writing materials into visits. A written direction from managers stated that such materials should be available in the visits hall but they were not there when we inspected it.
We repeat the recommendation.

2.124 Detainees should not be required to wear identifying clothing, except on the basis of an identified individual risk. (9.38)

Not achieved. All detainees were still routinely required to wear a fluorescent yellow sash during visits.
We repeat the recommendation.

2.125 The visits room should be furnished with movable tables and soft chairs. (9.39)

Not achieved. The furniture in the visits hall remained the same. Managers were concerned that movable tables and chairs would increase the likelihood of items being passed during visits.
We repeat the recommendation.

2.126 Closed visits booths should be of an adequate size and provide an appropriate environment for social visits. (9.40)

Not achieved. The closed visits booths remained the same as at the last inspection and were too small for purpose. It was evident from documentation that a proposal for new booths had been submitted.
We repeat the recommendation.

2.127 The play area in the visits room should be supervised, to allow adult visitors and detainees the option of having some private time together. (9.41)

Not achieved. The play area was poorly equipped and remained unsupervised. Detainees were unable to play with their children as they were required to remain seated throughout the visit, although we welcomed the pragmatic approach we saw some visits staff taking to this rule.

Further recommendation

2.128 The play area should be appropriately equipped and detainees should be permitted to play with their children in this designated area.

2.129 Visitors should be allowed to meet two detainees at the same time, subject to security assessment. (9.42)

Not achieved. Managers said that it was possible for visitors to meet two detainees at the same time subject to risk assessment, but visits staff were clear that they never allowed this to happen. A visitor wishing to see more than one detainee was required to see them consecutively.
We repeat the recommendation.

Removal and release

2.130 Up-to-date country of origin information should be provided to detainees issued with notice of removal. (9.43)

Not achieved. Country of origin information was not provided to detainees. Basic information about welfare and housing agencies would have been useful to all detainees, but particularly those returning with no accommodation or financial security in place.

Further recommendation

2.131 Information signposting detainees to available support agencies in their country of origin should be routinely provided with notice of removal.

2.132 Detainees should be given at least 24 hours' notice of transfer to another centre. (9.44)

Not achieved. Several staff told us that some detainees were still only given two to three hours' notice of a transfer to another centre as a result of late notification of the move from the Detainee Escorting and Population Management Unit. One detainee told us he had been given an hour to clear his room at his previous centre prior to transfer.
We repeat the recommendation.

2.133 The reasons for transfer to another place of detention should be explained to detainees, and they should be provided with information about the centre to which they are being transferred in good time, so that they can inform friends and family. (9.45)

Not achieved. Detainees we spoke to told us they had not been given information on the centre preceding transfer and staff confirmed that they often encountered detainees in reception who were bewildered about where they were going and why (see paragraph 2.16).
We repeat the recommendation.

2.134 Detainees discharged from detention should be given financial resources or adequate food and drink for their onward journey. (9.46)

Partially achieved. Detainees discharged from detention were provided with a basic refreshment pack for their journey and a travel warrant, although officers informed us that the warrant was not always sufficient to allow detainees to reach their final destination.

Further recommendation

2.135 Detainees discharged from detention should be given sufficient resources to reach their final destination.

2.136 When an allegation of assault has been made by a detainee, his removal should be delayed until a decision regarding prosecution has been made. (9.47)

Not achieved. The UKBA policy in these circumstances remained one of proceeding with the removal irrespective of the potential for prosecution.
We repeat the recommendation.

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.

Recommendations — To UKBA

Escort vans and transfers

3.1 Risk analysis forms should always be completed for detainee transfers. (2.12)

3.2 Detainees and staff at receiving centres should be given clear information about why a move is being carried out. (2.17)

Immigration casework

3.3 UKBA should urgently improve the quality of information provided on site to detainees, the timeliness and quality of reviews, and the response to rule 35 letters. (2.4)

3.4 Newly arrived detainees should be advised of their right to apply for bail, legal aid, legal representation and their appeal rights and should be assisted in doing so. (2.41)

3.5 Monthly reviews of detention should be timely and demonstrate a balanced consideration of all factors relevant to the case. (2.42)

3.6 Rule 35 applications should be responded to on time and in detail. (2.44)

Childcare and child protection

3.7 Assessments of age dispute cases should always be carried out by a qualified social worker. (2.55)

Recommendations — To UKBA and the centre manager

Childcare and child protection

3.8 A local policy on the handling of age dispute cases, which follows the guidelines set out in the Merton judgement, should be agreed by UKBA, the centre manager and Kent Social Services. (2.57)

Work and learning and skills

3.9 Consideration of detainees' cooperation with UKBA should not be part of the process for allocating paid work roles. (2.86)

Complaints

3.10 UKBA should review the complaints system, to ensure that complaints are responded to within three days, or 10 days in exceptional circumstances. (2.110)

3.11 Detainees' complaints should be sent to the authority which can resolve, and provide a substantive response to, the complaint. (2.112)

3.12 All detainees' property should accompany them when they are moved to the centre. (2.113)

Removal and release

3.13 Detainees should be given at least 24 hours' notice of transfer to another centre. (2.132)

3.14 The reasons for transfer to another place of detention should be explained to detainees, and they should be provided with information about the centre to which they are being transferred in good time, so that they can inform friends and family. (2.133)

3.15 When an allegation of assault has been made by a detainee, his removal should be delayed until a decision regarding prosecution has been made. (2.136)

Recommendations — To the escort contractor

Escort vans and transfers

3.16 Detainees should not be moved during the night unless this is required for urgent operational reasons. (2.1)

3.17 Detainees should not have extended waits at reporting centres for transport to a removal centre. (2.15)

Recommendations — To the centre manager

Reception

3.18 The reception area should be redesigned to include private interview rooms and to provide better movement flow of detainees being received and discharged simultaneously. (2.18)

3.19 There should be better supervision of the detainee holding room. (2.19)

3.20 New arrivals should be offered hot and cold food. (2.20)

First night and induction

3.21 The detainee peer supporters should meet all new arrivals to offer support. (2.24)

Residential units

3.22 Sleeping accommodation should provide much more privacy and better facilities. (2.25)

3.23 Detainees should be issued with a hot water flask. (2.27)

3.24 Important notices should be displayed in a variety of languages. (2.28)

3.25 Detainees on Rye unit should be locked behind their doors for the minimum amount of time, and no longer than detainees on other units. (2.31)

3.26 The communal toilets on the ground floor of Romney unit should be adequately screened. (2.32)

3.27 Repairs and redecoration should be undertaken on all relevant residential units. (2.33)

3.28 The showers on Sandwich and Deal units should be refurbished and offer adequate levels of privacy. (2.34)

Legal rights

3.29 Notices should be displayed around the centre, in a variety of languages, promoting the Detention Duty Advice Scheme and the monthly Bail for Immigration Detainees workshop. (2.38)

Immigration casework

3.30 Telephone interpreting services and/or professional interpreters should be used for confidential matters, or when sensitive information is being discussed, to ensure that detainees who do not speak English understand important/essential information. (2.5)

Suicide and self-harm

3.31 All staff should receive regular ACDT refresher training. (2.52)

Health services

3.32 Restraints should not be used during visits to outside medical or dental facilities unless in exceptional circumstances after a risk assessment. (2.70)

Work and learning and skills

3.33 The coordination of education with work should be improved and classes should be offered at the weekend. (2.8)

3.34 The external fencing at the front of the education building should be altered to present a more welcoming aspect to detainees. (2.88)

3.35 The centre should increase detainees' freedom of movement around the centre to at least 12 hours a day, reduce the length of time that detainees are locked in their rooms each day and establish a later evening lock-up time. (2.94)

Library

3.36 Library opening hours should be extended to evenings and weekends to meet the needs of detainees in work. (2.97)

3.37 Library management systems should enable accurate monitoring of stock and patterns of borrowing. (2.98)

Security

3.38 The level of physical security should be proportionate for an IRC. (2.100)

3.39 Strip-search records should be completed to an acceptable standard, to include a qualitative record of why this had been authorised, and regularly reviewed by the use of force committee. (2.101)

3.40 Strip-searching should only be conducted in the most exceptional circumstances. (2.102)

Use of force and single separation

3.41 Staff should not routinely carry extendable batons. (2.105)

Welfare

3.42 In coordination with voluntary sector organisations, an assessment should be made of the welfare needs of all detainees in custody, before release, transfer or removal and they should be provided with appropriate support to meet these. (2.116)

3.43 An assessment of detainees' welfare needs should be made on their arrival and they should be referred to the appropriate service. (2.117)

Visits

3.44 Arrangements should be made to allow visitors who wish to attend both visits sessions to remain in the centre between the two. (2.119)

3.45 There should be adequate food and drink available for purchase during visits. (2.120)

3.46 Searching of visitors should take place in a private area. (2.121)

3.47 Security procedures for visitors should be reviewed so that entry to the centre is not delayed. (2.122)

3.48 Visitors should be allowed to take papers and writing materials into visits, subject to an individual security assessment, and this policy should be applied consistently and publicised in visitor information. (2.123)

3.49 Detainees should not be required to wear identifying clothing, except on the basis of an identified individual risk. (2.124)

3.50 The visits room should be furnished with movable tables and soft chairs. (2.125)

3.51 Closed visits booths should be of an adequate size and provide an appropriate environment for social visits. (2.126)

3.52 The play area should be appropriately equipped and detainees should be permitted to play with their children in this designated area. (2.128)

3.53 Visitors should be allowed to meet two detainees at the same time, subject to security assessment. (2.129)

Removal and release

3.54 Information signposting detainees to available support agencies in their country of origin should be routinely provided with notice of removal. (2.131)

3.55 Detainees discharged from detention should be given sufficient resources to reach their final destination. (2.135)

Good practice

Staff-detainee relationships

3.56 The names of allocated welfare officers were displayed in detainees' rooms on Romney unit. This was a simple but useful way of helping detainees to identify who they could approach for help. (2.37)

Appendix I: Inspection team

Ian Macfadyen	Team leader
Bev Alden	Inspector
Colin Carroll	Inspector
Angela Johnson	Inspector
Paul Tarbuck	Health services inspector
Alastair Pearson	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				
1 to 6 years				
7 to 11 years				
12 to 16 years				
16 to 17 years				
18 years to 21 years	29			10.4
22 years to 29 years	94			33.6
30 years to 39 years	97			34.6
40 years to 49 years	47			16.8
50 years to 59 years	10			3.6
60 years to 69 years	3			1.1
70 or over	0			0
Total	280			100

(ii) Nationality Please add further categories if necessary	No. of men	No. of women	No. of children	%
Afghanistan	14			5
Albania	3			1.1
Algeria	17			6.1
Bangladesh	28			10
Bolivia	2			0.7
Brazil	2			0.7
Cameroon	3			1.1
China	11			3.9
Colombia	1			0.4
Congo	2			0.7
Egypt	1			0.4
Eritrea	1			0.4
France	1			0.4
Gambia	2			0.7
Ghana	9			3.2
Grenada	1			0.4
Guyana	1			0.4
India	42			15
Iran	8			2.9
Iraq	2			0.7
Israel	1			0.4
Italy	1			0.4
Jamaica	12			4.3
Japan	2			0.7

Kenya	1			0.4
Latvia	1			0.4
Libya	1			0.4
Lithuania	2			0.7
Malaysia	2			0.7
Mauritius	3			1.1
Malawi	1			0.4
Nepal	1			0.4
Nigeria	21			7.5
Pakistan	33			11.8
Portugal	1			0.4
Palestine	3			1.1
Rwanda	2			0.7
Senegal	1			0.4
Seychelles	1			0.4
Somalia	6			2.1
Sri Lanka	9			3.2
Saint Lucia	1			0.4
Sudan	11			3.9
Tanzania	2			0.7
Trinidad and Tobago	1			0.4
Tunisia	2			0.7
Turkey	3			1.1
Uganda	1			0.4
Ukraine	1			0.4
Vietnam	1			0.4
Not stated	1			0.4
Total	280			100

(iv) Religion/belief Please add further categories if necessary	No. of men	No. of women	No. of children	%
Atheist	4			1.4
Buddhist	10			3.6
Christadelphian	1			0.4
Christian	45			16.1
Church of England	7			2.5
Hindu	21			7.5
Jewish	1			0.4
Muslim	142			50.7
No Religion	11			3.9
Pentecostal	4			1.4
Rastafarian	1			0.4
Roman Catholic	7			2.5
Sikh	24			8.6
Taoist	1			0.4
Unknown	1			0.4
Total	280			100

(v) Length of time in detention in this centre	No. of men	No. of women	No. of children	%
Less than 1 week	48			17.1
1 to 2 weeks	30			10.7
2 to 4 weeks	69			24.6
1 to 2 months	48			17.1
2 to 4 months	41			14.6
4 to 6 months	25			8.9
6 to 8 months	4			1.4
8 to 10 months	6			2.1
10 + months	12			4.3
Longest stay (in days)	612			
Total	283			100