

Report on an unannounced inspection of

**Cedars pre-departure  
accommodation and overseas  
family escort**

by HM Chief Inspector of Prisons

**6 – 27 January 2014**

### **Glossary of terms**

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# Introduction

Cedars provides pre-departure accommodation for families subject to immigration control who are being removed from the UK. This is our second inspection of the facility. Forty-two families had been held there during 2013 for an average of just over three days. The relatively sparing use of the facility was reflected by the fact that only two families were detained during nearly four weeks that we spent at the centre. Cedars is a high quality, well managed institution – and it needs to be. Whatever one's views on immigration, the distress described in this report of the families passing through the centre and its potential impact on the children involved is disturbing. Among the 42 families held in 2013, force (mostly low level) had been used on 10 occasions, suicide and self-harm procedures had been initiated 25 times and there had been two recorded incidents of actual self-harm. Detainees had been placed on constant watch on 12 occasions.

A number of families were still detained on more than one occasion, which was a particularly disruptive upheaval for children, both emotionally and practically. We accompanied families under escort to and from the centre from the point of initial arrest. We were also able to inspect the progress of a family from the point of arrest by immigration officers to the point they arrived back in their home country following an escorted removal flight.

While escorts were managed reasonably well, we observed unnecessary light-touch restraint by escort staff, which escalated at least one situation. At our last inspection, families criticised the behaviour of immigration arrest teams and we directly observed them during this inspection. We had cause for concern and found that the needs of children were not central enough to the arrest process. In one case, extreme force was used for several minutes to batter down a family's door early in the morning. This would have been terrifying for the children had they been in the property. The reasons given for this tactic, which was not preceded by any attempt to knock on the door, lacked credibility.

The important role that Barnardo's staff played in the centre had been maintained and helped to ensure that the needs of children were uppermost in the minds of all staff. As at our last inspection, we found high quality residential units and attractive grounds which provided an appropriate environment for families and children of all ages. The careful planning for each family had been sustained and in some respects improved. Family welfare forms that allowed such planning were now more thorough. The level of individual care and attention for families on their reception into the centre remained exceptional. Despite undergoing an extremely stressful experience, the families detained at Cedars spoke highly of the care given to them by all staff. Health care provision was generally good.

Our previous serious concerns about the initiation of force against pregnant women and children had been allayed as staff had been instructed not to use force against them unless it was to prevent harm. Force had been used against five of the 42 families who had passed through Cedars in 2013; most was low level and it was subject to rigorous governance. Separation was little used but we were still not convinced that it needed to be used for as long as it was.

The distress experienced by parents and children who are subject to enforced removals is palpable for anyone who spends time in their company in Cedars, and this is no less true for the staff who work there. More should be done to address the jarring experiences some families have before arrival at Cedars, and to reduce the stress of removal. However, Cedars itself remains an example of best practice in caring for families who are to be removed. It has maintained effective joint working to mitigate the needs of some of the most vulnerable people subject to immigration control, and remains an exceptional facility.

**Nick Hardwick**  
HM Chief Inspector of Prisons

May 2014



# Fact page

## Task of the establishment

The detention, care and welfare of families subject to immigration control prior to removal from the UK. Families may be detained in the centre for up to 72 hours but this period may be extended with Ministerial authority to one week.

## Location

Pease Pottage, Crawley

## Name of contractor

G4S

## Number held

Two families during the inspection period

## Certified normal accommodation

Nine family apartments

## Operational capacity

44

## Last inspection

30 April – 25 May 2012

## Brief history

In December 2010, the Government published details of its new approach to removing families from the UK. The final stage of the new process may include detention in 'pre-departure accommodation', which is intended to be a last resort if options such as assisted voluntary return have failed. Cedars was opened in August 2011 as a secure facility to hold such families. The children's charity Barnardo's provides social work, welfare and family support services, working alongside G4S custodial staff at the facility.

## Short description of residential units

Nine apartments varying in size from one to three bedrooms. There are two specialist apartments: Orchid is for care of vulnerable individuals, usually those at risk of self-harm; Lavender is for the management of individuals presenting challenging behaviour.

## Centre manager

Sarah Newland	G4S
Sally Kendal	Home Office manager
Jennifer Carnegie	Barnardo's manager

## Escort provider

Tascor

## Health service commissioner and providers

G4S Medical Services

## Learning and skills providers

n/a

## Independent Monitoring Board chair

Merle Campbell



# About this inspection and report

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

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

All Inspectorate of Prisons reports include a summary of an establishment's performance against the model of a healthy establishment. The four tests of a healthy establishment are:

<b>Safety</b>	that detainees are held in safety and with due regard to the insecurity of their position
<b>Respect</b>	that detainees are treated with respect for their human dignity and the circumstances of their detention
<b>Activities</b>	that the centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees
<b>Preparation for removal and release</b>	that detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their country of origin and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.

Under each test, we make an assessment of outcomes for detainees and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the Home Office.

- **outcomes for detainees are good against this healthy establishment test.**  
There is no evidence that outcomes for detainees are being adversely affected in any significant areas.
- **outcomes for detainees are reasonably good against this healthy establishment test.**  
There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.
- **outcomes for detainees are not sufficiently good against this healthy establishment test.**  
There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.

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

Although this was a custodial establishment, we were mindful that detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees:

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

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

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

Our assessments might result in one of the following:

- **recommendations:** will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections
- **housekeeping points:** achievable within a matter of days, or at most weeks, through the issue of instructions or changing routines
- **examples of good practice:** impressive practice that not only meets or exceeds our expectations, but could be followed by other similar establishments to achieve positive outcomes for detainees.

Five key sources of evidence are used by inspectors: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Since April 2013, the majority of our inspections have been full follow-ups of previous inspections, with most unannounced. Previously, inspections were either full (a new inspection of the establishment), full follow-ups (a new inspection of the establishment with an assessment of whether recommendations at the previous inspection had been achieved and investigation of any areas of serious concern previously identified) or short follow-ups (where there were comparatively fewer concerns and establishments were assessed as making either sufficient or insufficient progress against the previous recommendations).

## This report

This explanation of our approach is followed by a summary of our inspection findings against the four healthy establishment tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees*. The reference numbers at the end of some recommendations indicate that they are repeated, and provide the paragraph location of the previous recommendation in the last report. Section 5 collates all recommendations, housekeeping points and examples of good practice arising from the inspection. Appendix II lists the recommendations from the previous inspection, and our assessment of whether they have been achieved.

Details of the inspection team and the detainee population profile can be found in Appendices I and III respectively.

Findings from the survey of detainees and a detailed description of the survey methodology can be found in Appendix IV of this report. Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant.<sup>1</sup>

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<sup>1</sup> The significance level is set at 0.05, which means that there is only a 5% chance that the difference in results is due to chance.



# Summary

## Safety

S1 *Some practices by arrest teams were disproportionate to the risks posed and not sufficiently focused on the needs of the children. Families spoke positively of escort staff, but lateness of escort crews was a persistent problem. Preparation for the arrival of families was very good. The arrivals process was well managed but some crowding still occurred. There was no evidence of bullying behaviour. Families at risk of self-harm were well supported. The strong child-centred culture continued in the centre and safeguarding and child protection procedures were appropriate. Use of force was normally low level and justifiable. Separation was rarely used excessively but in one case seemed unnecessarily long. Detainees had reasonable access to legal assistance. Good efforts were made by the Home Office to avoid detention, but too many families were still detained more than once. On-site immigration staff were accessible. **Outcomes for detainees were reasonably good against this healthy establishment test.***

S2 *At the last inspection in 2012, we found that outcomes for detainees in Cedars were reasonably good against this healthy establishment test. We made 14 recommendations in the area of safety, including one main recommendation. At this follow-up inspection we found that seven of the recommendations had been achieved, including the main recommendation, one had been partially achieved, and six had not been achieved.*

S3 We accompanied three Home Office arrest teams, one of which successfully made an arrest, and four Tascor escort teams, including one on an overseas removal (see preparation for removal and release section). All arrest teams were very well prepared and respectful towards families. Their practices in relation to dress and entry varied. One team did not wear body armour or helmets to avoid frightening children, but the others did. One team did not knock, apparently to avoid alerting the family, but then took about three minutes to break through the door. Had the family been there, this would have been a terrifying event for the children. The method of entry was not proportionate to identified risks and was not on the family welfare form, nor was the Independent Family Returns Panel informed in advance. Family escorts were generally well managed by Tascor, but late arrival of escort staff was a commonly reported problem.

S4 Preparation for the arrival of families was very good, and staff continued to receive a large amount of detailed information about families in advance of their arrival, now including good health information. Although improved, the time taken to book families in could have been further shortened, especially for people arriving at night. One family arrived at 11pm after a 12-hour journey; it took another one and a quarter hours for them to get to their room, and more of the reception process could have been completed in the morning.

S5 The arrivals area was attractive and welcoming and activities were tailored to the family that was arriving. Children were very well engaged by staff. However, there was still a tendency to have too many people in the area. Searching was appropriately low level for adults and children. Some rules, such as not allowing a parent to keep sealed crisp packets or drinks provided by escorts, were excessive. One parent was unable to use her mobile telephone overnight after arrival.

- S6 There had been no reported bullying of detainees in the centre. High staffing levels, a low number of detained families and close supervision meant that opportunities for bullying to take place between families were limited. There were systems in place to tackle bullying if it arose and staff we spoke to were familiar with them.
- S7 Detainees at risk of suicide or self-harm continued to be well cared for at the centre. Since the beginning of 2013, 25 assessment, care in residence and teamwork (ACRT) documents had been opened on one or more members of the 42 families held as a result of concerns about potential self-harm. There had been two incidents of actual self-harm in the centre over the same period and two further self-harm incidents occurred at the point of arrest. None resulted in serious or lasting injury and detainees were taken to hospital as needed.
- S8 ACRT observation records and reviews were good and suggested that staff made great efforts to meet the needs of detainees who were in distress. There had been 12 constant watches in 2013 but it was not always clear that the length of the constant watch was proportionate to actual self-harm risk. There had been two reported food refusals in the last year, which were managed appropriately.
- S9 Arrangements were in place where necessary to refer adults at risk to the local authority. Given the very short period of time detainees stayed at the centre and the high level of support they received, there was little requirement for this process to be followed.
- S10 A strong child-centred culture continued to exist in the centre. There were always staff present or available with a good range of relevant training qualifications and experience in social work and social care. There were close links between the local authority social services department and Barnardo's and working relationships between all agencies in the centre were positive. No formal child protection referrals had been made in the past year but appropriately, contact had been made with local authorities in relation to safeguarding matters. In two cases, Barnardo's had escalated concerns about the way families had been treated immediately before arrival at Cedars. Both cases were being investigated at the time of the inspection.
- S11 Resource packs on safeguarding had been produced for all managers and training in safeguarding had recently been delivered to staff. Family welfare forms had improved and all those that we saw were very detailed. There were jointly agreed procedures and regular multi-agency meetings, which enabled relevant safeguarding information to be exchanged. Families' cases were discussed at regular meetings.
- S12 Force had been used 10 times on five families in 2013, about 12% of the total. Most was low level, although handcuffs were used twice for short periods. Force was proportionate, necessary and used as a last resort in all cases except one, when a compliant and passive detainee's arms were unnecessarily held for over two hours by two officers while he was in the cool-down room and then in the Lavender suite. Use of force documentation was thorough and oversight by managers was good. Recently introduced body cameras were a positive innovation. They captured a lot of detail and sound and image quality was good. Unlike at our last inspection, we were pleased to see that force was not being used against children or pregnant women to effect removal. Lessons were learned through good debriefs following use of force and those involved were given feedback.

- S13 Separation was used sparingly. Only one detainee had been separated in 2013 in the cool-down room and Lavender suite. He was allowed to speak to his wife on the telephone while held in Lavender, but was not reunited with her until the family's removal more than 12 hours later. There should have been some attempt to reunite the family earlier. Separation was still governed by Rule 40 of the Detention Centre Rules, which do not apply at Cedars, but we were pleased to see a distinct and detailed separation log. The cool-down room remained an unnecessarily stark environment. Accommodation in Lavender was more relaxed and appropriate.
- S14 Detainees could maintain contact with existing solicitors by telephone and fax. Newly arrived detainees were asked if they required a solicitor. Detainees who did were referred to the Legal Aid Agency funded duty advice scheme. Home Office records from May 2012 to September 2013 showed that 23 of the 71 families held requested help from duty advice services and received an appointment the next day. Records were no longer kept of these requests. In 2013, 25 families had been released from Cedars, just over half as a result of legal action.
- S15 In 2013, 42 individual families were held at the centre for an average of just over three days. Most families continued to arrive from the north of England and Scotland. It was too early to tell if the restructuring of the family returns unit would bring about standardisation across the country. The advent of specialist family engagement officers was a progressive move. Families had good access to Home Office staff and the induction interview we observed was good. Rule 35 of the Detention Centre Rules did not apply at the centre but in 2013 five families were declared unfit to fly and released.

## Respect

S16 *Accommodation remained high quality and was designed to meet the needs of children and families. Relationships between staff and families were very good. Interpretation was used appropriately. Facilities for worship were good and families had good contact with chaplains. There had been no complaints since the last inspection. Food was healthy and appropriate for different ages. Health care provision was good and a registered children's nurse was in post. Families with mental health concerns could access appropriate support. **Outcomes for detainees against this healthy establishment test were good.***

S17 *At the last inspection in 2012, we found that outcomes for detainees in Cedars were good against this healthy establishment test. We made six recommendations in the area of respect. At this follow-up inspection we found that two of the recommendations had been achieved, two had been partially achieved, and two had not been achieved.*

- S18 The centre was well designed to meet the needs of children and families, providing a good overall environment. The accommodation remained in good order and was comfortable, spacious and appropriate for families and children of all ages. The external environment was attractive.
- S19 Relationships between families and staff from all the agencies working at Cedars remained good. Detainees received very high levels of care and attention. Some staff we spoke to were aware of the risk of overwhelming detainees with attention. Written records provided positive evidence of continuing good quality interaction between staff and detainees. Staff were consistently respectful when talking about or sharing information about detainees. Families spoke positively of the level of care they received in Cedars.

- S20 The equality and diversity manager met all arrivals to determine their needs, including dietary or religious requests. The apartment for detainees with mobility problems was suitably adapted. The equality and diversity policy was clear and kept under review and covered all protected characteristics. Monitoring of the detainee population took place quarterly and was used well to identify areas for staff training. There had been no diversity-related complaints since the previous inspection. Telephone interpretation was used well to enable detainees to participate fully in discussions.
- S21 There was good support for families to maintain their religious observance. Multi-faith facilities were very good. Spiritual and pastoral support was provided and chaplains were involved during difficult periods.
- S22 Complaint forms were available in a range of languages, and information on how to complain was readily available. No complaints had been made since the previous inspection. Detainees had very good access to staff to get issues dealt with quickly without resorting to the formal complaints process.
- S23 The food available to detainees continued to be of a high standard. Centre staff consulted carefully with detainees about their individual requirements and preferences when preparing menus. Detainees usually dined together, but they were also able to cook for themselves in the well-equipped kitchens in their apartments. Healthy snacks and drinks were available in the play areas throughout the day.
- S24 Health care provision was good overall. Governance was reasonable and there was now an up-to-date health needs assessment. This included mental health, but it had little specific information on Cedars. A new assessment was under way. Not all health care staff had had recent child safeguarding training. Level three training was appropriately planned for all health care staff in 2014. A registered children's nurse was now in post. In-possession medication was rarely allowed for any families, which was too restrictive. Family welfare forms indicated that appropriate health care information was being received in advance of arrival. Observed health screenings and assessments were thorough but varied in the level of sensitivity shown towards families. Families had 24-hour access to a nurse, and good access to GPs, including female GPs. There had been little call for mental health support in the last year but suitably qualified nurses were available.

## Activities

S25 *Families had good freedom of movement around the centre. The range of activities continued to meet the needs of detainees of all ages. Accommodation and resources were of excellent quality and allowed delivery of extensive activities. The promotion of cultural diversity through activities was particularly good. The library was welcoming and easy to use. **Outcomes for detainees were good against this healthy establishment test.***

S26 *At the last inspection in 2012, we found that outcomes for detainees in Cedars were good against this healthy establishment test. We made one recommendation in the area of activities. At this follow-up inspection we found that this recommendation had been achieved.*

S27 Families were not unnecessarily restricted in their movements around the centre. Leisure and activity accommodation in the centre was comfortable and very well equipped. Outside activity areas were attractive and welcoming. The library and the garden were open and accessible into the late evening and detainees could request access to library resources at any time.

- S28 The amount of information that Barnardo's received on the educational needs of the young people arriving in the centre had improved since the last inspection. Activities and facilities provided good physical and mental stimulation for children and adults. Children were occupied in age-appropriate activities for an appropriate length of time throughout the day. Planned activities comprised a well-balanced mixture of play, writing and reading as well as sports, physical exercise and more relaxing activities, such as watching television.
- S29 The promotion of cultural diversity through activities was excellent. Many activities focused on promoting positive images of the country families were being removed to, helping children to begin thinking about their destination. Barnardo's placed emphasis on creating awareness of different languages, national flags and religious festivals. Many displays around the centre served as a platform to showcase children's work.
- S30 Barnardo's had also designed and promoted a curriculum of activities for adults involving manual crafts, English language lessons and visits to the library and the gym, although there was little take-up. Detainees had access to television, books, newspapers and DVDs in a range of languages. A large selection of age-appropriate DVDs was also available for children.

## Preparation for removal and release

S31 *Pre-removal support was good. Released families were given appropriate support by Barnardo's. Visiting times were good and there was reasonable access to email, but too many internet sites were blocked. The observed overseas escort was generally well managed, but there was room for improvement. Escorts struggled to grasp the detail in removal plans. **Outcomes for detainees were good against this healthy establishment test.***

S32 *At the last inspection in 2012, we found that outcomes for detainees in Cedars were good against this healthy establishment test. We made six recommendations in the area of preparation for removal and release. At this follow-up inspection we found that two of the recommendations had been achieved, one had been partially achieved, and three had not been achieved.*

- S33 Support for families prior to removal was good. Useful and detailed information packs were provided on destination countries. Families who were released were provided with the means to return home, and in some cases Barnardo's staff travelled home with them to ensure they reached their destination safely, and provided additional reintegration support.
- S34 Social visiting times remained good and property could be brought in for detainees. As before, the visits area was bright and welcoming, but afforded little privacy and could not comfortably accommodate more than one family.
- S35 Families had free access to a fax machine, and to the internet and email. However, some sites were blocked, such as Migrant Help, some BBC News sites and hotmail. It took 48 hours to regain access to sites blocked by the filtering software which was too long given the short stays of most families. There was no access to Skype or to the social networking sites often used by children to maintain contact with friends.
- S36 There was a good range of clothing and suitcases for detainees needing them on removal. Financial assistance was also provided to help families reach their final destinations.

- S37 Escort staff were friendly and welcoming to families and attempted to put them at their ease. They found it hard to pick up quickly some important points in the detailed removal plans and had not received any specific training in child care issues or safeguarding.
- S38 During a failed removal, staff generally dealt with some difficult situations well; but an entirely compliant parent started struggling on the steps of the aircraft only when staff unnecessarily tried to grasp him by the arms.
- S39 The observed overseas escort was generally well managed. There was a detailed handover between G4S, Barnardo's staff and escorts at Cedars. Escort staff were polite and developed a good rapport with the people in their care. However, they insisted on holding the arms of another fully compliant detainee on departure from the centre, although there was no identified risk. This was at odds with the positive atmosphere created up to that point. Escort staff went to some lengths not to draw attention to the family on the aircraft. They dressed casually rather than wearing uniform, though a health professional with the team wore less discreet clothing. Good provision had been made for the family to reach the final destination safely, including a pre-booked hotel at the destination airport.

### Main concern and recommendation

- S40 **Concern:** An arrest team did not knock and took about three minutes to break through a family's door, which would have been a terrifying event for children if they had been there. The approach was not proportionate to identified risks and had not been approved by the Independent Family Returns Panel.

**Recommendation:** Home Office enforcement teams should conduct arrests as sensitively, calmly and quietly as possible. All elements of the arrest should be approved by the Independent Family Returns panel and should protect the welfare of children. Any deviation from the approved plan should be reported promptly to the panel.

# Section 1. Safety

## Escort vehicles and transfers

### Expected outcomes:

**Detainees travelling to and from the centre are treated safely, decently and efficiently.**

- 1.1** *We observed the escort of two families to Cedars, one from the point of arrest. We also observed the attempted arrest of two other families. Some elements of arrest plans were disproportionate to the risk posed and had not been approved by the Independent Family Returns Panel. Home Office enforcement teams varied in their dress and behaviour and some were intimidating. One detainee had her phone withheld and was unable to contact a legal adviser or family after arrest. The handover to escorts we observed took place out of sight of the public. Escort vehicles were generally fit for purpose but one did not have a functioning toilet for the whole journey. Escort staff were respectful and appropriate in their dealings with detainees, and escort journeys were generally well managed. Concern over the timeliness of escort arrival was a common feature in removal plans.*
- 1.2** Tascor was contracted to provide in-country and overseas escorts of detainees. We observed the escort of two families to the centre, one from the point of arrest. We also observed the attempted arrest of a third family. A further arrest was planned, but cancelled at short notice because of a lack of confidence in escorts arriving by the scheduled time to collect detainees. Concern over the timeliness of escort arrival was a common feature in removal plans.
- 1.3** The J family comprised a mother, father and two children aged seven and 12. This was the third attempt to secure their removal. There was a detailed arrest plan and the Home Office enforcement team was briefed before attending the property. All officers were wearing stab vests and carrying batons, which was disproportionate given that previous experience of the family indicated that they would be compliant. Two ‘method of entry’ officers, who could clearly be seen from the window of the bedroom thought to be occupied by a seven year old child, also wore helmets and body armour on the arms and legs. This could have been very frightening for the child and was disproportionate. In the event, the team gained entry with a key supplied by the landlord. The parents said that the arrest team were respectful to them. The interactions that we observed, particularly between the officers and children, confirmed this. The family were given one and a half hours to prepare for the escort, which the parents said was enough.
- 1.4** The handover to Tascor escorts took place in private at a police station. The escort lead had been briefed on the removal plan and had a copy of the family welfare form. The document gave detailed information on previous removal attempts and was too unwieldy to promote good welfare planning for the children. Tascor child care plans were in place. The escort coach was clean and comfortable, but the toilet became out of order during the last one and a half hours of the journey. Overall the escort was handled reasonably well and staff engaged very well with the family.
- 1.5** The G family comprised a mother and her three year old daughter. They were detained at a reporting centre during a routine appointment, where they were held in the family holding room for six hours by Home Office enforcement officers. The holding room was in fair condition and officers provided good care, but this was too long for such a young child. The arrest had taken place earlier than anticipated and the Tascor escort coach arrived late. The mother told us that her phone had been withheld and she had not been able to contact

anyone, including her solicitor. There was a payphone, but she had not been able to take numbers from her mobile. When we mentioned this to the enforcement officers, the phone was returned to the mother and staff helped to relay requests about legal matters to relevant staff in the main office.

- I.6** Tascor escorts introduced themselves to the family on arrival and carefully explained what was going to happen, although we saw no evidence of a care plan in line with Tascor policy. The detainees were seated on the coach with male officers in front of and behind them and the team leader stood in the aisle talking to the mother for some time. As a result the detainees, who were very calm and quiet throughout, were somewhat crowded. A choice of DVDs was provided, suitable for the child's age. Sandwiches and hot drinks were available, and milk for the child. Detainees were not allowed to shut the toilet door fully on board the coach. This was an unnecessary restriction and the mother told us she was particularly upset by it. All staff were respectful and appropriate in their dealings with the detainees, and responded well to the child's needs.
- I.7** The A family comprised a mother, father and two children aged 10 and four. This was the third enforcement operation against the family, although it was evident from the records and talking to staff that great efforts had been made to avoid an enforced removal. The arrest was planned in great detail. The lead immigration officer briefed the Home Office enforcement team. The intention was to make a forced entry without warning because the father '*could do something silly*'. The decision was based on three perceived risks: during a previous arrest attempt, the father had hidden behind a door and kicked out after being placed in handcuffs; the property was upstairs and someone could jump out of the window (although the family had not attempted this in the past); and the risk of self-harm to avoid arrest and removal (again the family had no history of this). The method of entry was not included on the family welfare form and had not been approved by the Independent Family Returns Panel. There was no written risk assessment or authorisation for the forced entry but a Home Office inspector had verbally authorised it on the previous day. In the event, the family's front door was so sturdy it was struck between 30 and 40 times over approximately three minutes before it gave way, giving the family ample time to jump out of a window or to self-harm. On entry, it was evident the family were not at home, but if they had been the process would have been terrifying for the children. All members of the team wore immigration enforcement uniforms, stab vests and ankle length boots. The two officers who broke the door down wore helmets and one officer wore body armour on his lower arms. Given the disproportionate nature of the forced entry and intimidating clothing, it was difficult to see how the children's welfare was being promoted in line with statutory requirements (see main recommendation).
- I.8** The S family comprised a mother and her 12 year old son who lived with the child's grandmother. The Home Office enforcement team met at 5.45am and was given a detailed briefing on the family and the arrest plan by the senior officer, who had clearly prepared the matter very thoroughly and had a detailed knowledge of the mother's case. The team included two 'method of entry' officers, but in contrast to the arrest of the J family and attempted arrest of the A family, they wore no body armour or helmets which the senior officer said was to avoid frightening the child. This was an appropriate and proportionate approach. However, in accordance with Home Office practice and with no identified risk, all officers wore stab vests, and carried handcuffs and batons, which would have been intimidating, particularly to children. The grandmother answered the door wearing a nightdress. She was not given the opportunity to dress before the team entered, but she and her grandson were treated decently and with respect. The mother was not at the premises and the arrest was aborted. Concern was expressed in the family welfare form that the mother had not told her son that they were going to be removed. The son was not given an explanation for the visit of the arrest team. We were told this was because they did not wish to cause undue distress to the son as removal was no longer about to take place.

## Recommendations

- 1.9 Detainees should have constant access to a telephone and their numbers while detained so that they can contact legal advisers, family and friends.**
- 1.10 The collection of all detainees by escorts should be timely and should adhere to the removal plan.**

## Housekeeping point

- 1.11 Detainees should be allowed to close the toilet door fully during escort, subject to individual risk assessment.**

## Arrival

### Expected outcomes:

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

**1.12** *Preparation for the arrival of families was very good. Detailed information on families was received well in advance of arrival, planning meetings with key staff were effective and support plans for the duration of a family's stay were in place. The arrivals area was attractive and welcoming, and age-appropriate toys and books were set out in advance. Searching was discreet and appropriate, but some security regulations were excessive. The booking-in process and health screening were too lengthy, particularly for those arriving late at night. One detainee was unable to use her mobile after arrival and overnight. A useful welcome pack was provided in apartments.*

- 1.13** Preparation for the arrival of families was very good. Family welfare forms were received at the centre well in advance of arrival and shared with senior staff. A summary sheet of relevant information was well communicated to appropriate staff, including health care, via a series of effective planning meetings. An arrival plan, a departure plan and a support plan for the duration of the family's stay were also produced. Those we saw were individualised and addressed the particular needs of each family effectively.
- 1.14** We observed the arrival of the G family (see section on escort vehicles and transfers). The centre was given enough notice of the estimated time of arrival, although this changed frequently and eventually the family arrived at 11pm. Mother and child had an IS91 form (authority to detain). The arrivals area was attractive and welcoming, and age-appropriate toys and books had been set out. A dedicated Barnardo's key worker and a G4S family care officer (FCO) had been allocated to the family and they engaged with the child while the mother was with reception staff. A search of the mother was undertaken out of sight of the child, who was only required to walk through the security portal. However, some security regulations were excessive; the family was not permitted to keep an unopened packet of crisps and drinks which had been provided by escorts. Staff were very welcoming and friendly, though occasionally a little over-zealous in their attempts to care for the family; for example, four different staff offered the family refreshments (repeatedly declined) within the space of 10 minutes. The area was slightly crowded, with six staff present.

- I.15** Reception staff told the mother that she could make a free five-minute telephone call if needed. She was not able to keep her mobile phone and the centre provided one for her, but the network she was on did not function in the centre. Staff were aware of this, but did not keep a stock of SIM cards on site for this eventuality. The detainee was told she would need to wait until the morning for a SIM to be bought for her. No further mention was made of the free five-minute call, which in these circumstances would have been appropriate, nor was it explained that if she needed to call family or friends a land line could be made available at any time (see recommendation I.9).
- I.16** The booking-in process and health screening, which was routine for all new arrivals, was still too lengthy in one case, despite staff attempts to reduce it. It took the G family one and a quarter hours from arrival at the centre to be moved to their accommodation; they arrived late at night after a 12-hour journey, and much of the reception process could have been undertaken in the morning. The family were taken to their accommodation by their designated Barnardo's key worker and FCO, where a good range of toiletries, basic food items and age-appropriate toys had been provided. A welcome pack containing key information about the centre and other helpful leaflets was also provided.

## Recommendation

- I.17** **The reception process should be undertaken quickly, particularly for those families who have undertaken long journeys and/or arrived late at night, and staff should avoid overwhelming families with attention on arrival.**

## Housekeeping point

- I.18** Security regulations should be commensurate to the risk posed by individual families. (see recommendation I.9)

## Bullying and personal safety

### Expected outcomes:

**Everyone feels and is safe from bullying and victimisation. Detainees at risk or subject to victimisation are protected through active and fair systems known to staff and detainees.**

- I.19** *We were told that bullying of detainees had not occurred in the centre and we did not find any evidence that it had. High levels of supervision and low occupancy contributed to providing a safe environment.*

- I.20** High staffing levels and close supervision, combined with a low throughput and small numbers of detainees held in the centre at any one time, meant that the opportunities for bullying were limited. There was no record of bullying and we found no evidence that it had occurred.

- I.21** There was an up-to-date anti-bullying policy which had been produced by G4S to be used in conjunction with Barnardo's safeguarding guidance. The policy outlined standard procedures to address bullying which consisted of a graded approach to challenge perpetrators and support victims. The Barnardo's guidance complemented this and contained a clear and straightforward statement covering workplace bullying. Although no bullying had been reported, staff we spoke to were not complacent, seemed alert to the potential for it to occur and knew what to do if it did. When out of their apartment, families were usually in quite close proximity to staff, who communicated with detainees frequently. This helped to create an environment where detainees were supported and protected.

## Self-harm and suicide prevention

### Expected outcomes:

**The centre provides a safe and secure environment that reduces the risk of self-harm and suicide. Detainees are identified at an early stage and given the necessary support. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.**

- I.22** *Detainees at risk of suicide or self-harm continued to be well cared for at the centre. There had been few acts of self-harm. Detainees at risk were usually assessed as vulnerable as a result of the enforcement action being taken against them. Arrangements were being made to improve support for vulnerable detainees who were being released.*

- I.23** Detainees at risk of suicide or self-harm were managed through the ACRT (assessment, care in residence and teamwork) care planning system. Since the beginning of 2013, 25 cases involving one or more members of the 42 families held had been dealt with in this way, most of which arose from detainees saying that they intended to, or might, harm themselves if they were removed. Over the same period there had been two recorded incidents of actual self-harm in the centre: a woman who said she had swallowed washing up liquid was briefly admitted to hospital, and a man who had placed a ligature round his neck was treated by a nurse at the centre. Two further occurrences of self-harm were recorded over the same period, which were linked to incidents during arrest. In one case, a detainee swallowed bleach when the arrest team arrived and was taken to hospital. In the other, a detainee took an overdose of medication and was taken to hospital by the arrest team. Both detainees were admitted to the centre shortly afterwards.
- I.24** Detainees had been placed on a constant watch on 12 occasions during 2013 and Orchid, the accommodation designed for detainees who were considered at high risk of suicide or self-harm, had been used twice for this purpose. It was not always clear that constant watches continued as a result of current risk and they were often maintained until the detainee left the centre.
- I.25** Three children from two families, both of which were subsequently released from the centre, had been placed on ACRT procedures during 2013. ACRT documentation had been modified for use with young people, including the use of picture cards to help young children express how they felt.

- I.26** ACRT review meetings were multidisciplinary and usually timely. Records were of a good standard. They were detailed and made frequent reference to the detainee's body language and mood, indicating that staff were aware of what to look for. Quality assurance was generally thorough but some records were not fully completed or signed. An internal check carried out in November 2013 had identified unnecessary delay to an initial review because a trained ACRT assessor was not available.
- I.27** Staff were alert to food refusal and this was handled sensitively. A telephone interpretation service was used in over a third of the ACRT cases we examined. All G4S staff carried ligature shears but Barnardo's staff did not. They told us that they rarely entered apartments without a G4S officer. In this event there was a risk of losing valuable time in an emergency.
- I.28** Steps were being taken to improve support for detainees who had been subject to ACRT procedures and were being released into the community. This had only been carried out in a few cases to date but was a significant improvement. Staff undertook a post-release review to ensure that relevant authorities in the home area, particularly social services, were notified of needs or problems that detainees might face.

## Recommendation

- I.29 All staff who may have sole, direct contact with detainees should carry ligature knives.**

## Housekeeping point

- I.30** An ACRT assessor should always be available when reviews need to be carried out.

## Safeguarding (protection of adults at risk)

### Expected outcomes:

**The centre promotes the welfare of all detainees, particularly adults at risk, and protects them from all kinds of harm and neglect.<sup>2</sup>**

- I.31** *The arrangements for at-risk adults remained the same as we found at the previous inspection. They were offered a high level of care and suitable arrangements were in place to refer at-risk adults to the local authority.*

- I.32** We were told that there had been no referrals to the local authority of at-risk adults since the previous inspection. Clear guidelines and procedures were in place and it was evident from talking to social workers who were the designated lead workers in this area that they were familiar with the process.

<sup>2</sup> We define an adult at risk as a person aged 18 years or over, 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. 'No secrets' definition (Department of Health 2000).

- I.33** Detainees lived in a safe and secure environment in the centre, protected from the risk of harm or neglect. When detainees were assessed as having problems, they were given a high level of care by Barnardo's key workers and social workers. The short time that detainees spent at the centre and the good level of support meant that there was little need to implement adult safeguarding procedures.

## Safeguarding children

### Expected outcomes:

**The centre promotes the welfare of children and protects them from all kind of harm and neglect.**

**I.34** *The child-centred culture in the centre continued to exist. This was evident in the work practices and ethos and in the surroundings. The safeguarding arrangements to protect children and young people in the centre were robust, but the protection available to them immediately before and after release and/or return was less clear.*

- I.35** The centre had previously been used as a residential school and considerable work had been carried out to make it suitable for its current purpose and to make it a safe place for children (see also accommodation and activities sections).
- I.36** Five qualified social workers were based at the centre, one of whom was always on call. In addition, six of the family project workers were qualified in early years work and four in youth work. These staff were suitably child centred in their approach and were responsive to the age ranges of children and young people admitted to the centre.
- I.37** Partner agencies' arrangements for training staff in safeguarding varied. All Barnardo's staff had completed at least two modules of their own training in safeguarding. Home Office staff undertook their own training, as well as completing the first module of Barnardo's training and participating in training delivered by West Sussex social services. G4S staff completed one day of their own safeguarding training, three days of training on child safeguarding and the first module of Barnardo's training. Tascor had 173 officers who had all completed internal safeguarding training, approved by Barnardo's, as part of their initial training course (see preparation for removal and release section). In addition, Barnardo's had recently delivered in-house safeguarding training, in the form of four local workshops, to a mixed staff group from the three agencies based at the centre. This approach ensured that staff all understood their safeguarding role and responsibilities in the centre. Tascor escort staff did not participate in this training.
- I.38** All Barnardo's, G4S and Home Office staff based at the centre had counter-terrorist clearance and enhanced Disclosure and Barring Service clearance.
- I.39** Barnardo's staff attended a weekly safeguarding meeting, chaired by the regional director and with a deputy director usually in attendance. The meeting reviewed all welfare and safeguarding issues and set agenda items included pregnant women, food refusal and child advocacy. The meeting also identified cases which needed to be escalated if they could not be dealt with locally. This was done by using Home Office procedures or by direct referral to the Barnardo's chief executive. We were told of two cases which had been escalated because of concerns about the treatment of families. One was being investigated by the Home Office professional standards unit and the other was the subject of a lessons-learned review by the Home Office, to which officials from the local authority and police had been

invited. In both cases, the concerns related to the treatment of families before their arrival at the centre.

- I.40** Regular multi-agency safeguarding meetings took place in the centre. A monthly safeguarding meeting involved Barnardo's, G4S and Home Office centre staff, and a more strategic bimonthly safeguarding meeting, which was chaired by the chair of the local safeguarding children board, involved the local authority and the police. There were close links between the local authority social services and the centre. We spoke to representatives of most agencies involved in safeguarding, and working relationships were described consistently as open and transparent, with effective exchange of relevant safeguarding information. Consequently, the child care arrangements at Cedars were subject to a high level of external scrutiny. No child protection referrals had been made in the past year but Barnardo's staff had regularly and appropriately consulted the local authority for advice on safeguarding matters. They had made six such referrals in the previous three months, mainly to encourage support for families who had been released.
- I.41** Barnardo's had recently carried out a safeguarding audit. We were unable to see this but were told that the findings were positive and recommendations related to improving existing practice. One recommendation was that 'learning lessons' exercises should be carried out in all cases. It was clear from discussion with staff that there was no systematic, cross-agency method of carrying out 'learning lessons' exercises.
- I.42** Cedars safeguarding guidance and procedures had been jointly agreed by all the partner agencies, and were effective for families detained there. However, it was not clear how children were to be safeguarded immediately before arrival and when the protection ceased after they were removed. This was significant because the serious safeguarding issues which had been escalated by Barnardo's related to incidents that took place before admission to the centre. It was also important because children and their families were being removed from the country to destinations where there was sometimes limited knowledge of the circumstances they were likely to face. We asked if consideration was given to female genital mutilation as a potential safeguarding issue and were told that this was considered in detail by the Independent Family Returns Panel and Barnardo's if it was raised as a concern by families or others. It was assumed that immigration judges or legal representatives would have considered this well before the arrival of families at Cedars. However, there was no guarantee that this would have happened or that it would be considered a problem by some parents. There was a need for more awareness of national and local prevalence, and more systematic consideration before removal.

## Recommendations

- I.43** **The local workshop approach to safeguarding training should be extended to include Tascor escort staff.**
- I.44** **A standard approach towards 'learning lessons' should be adopted by all agencies at the centre.**
- I.45** **The scope of the guidance and procedures to safeguard children should be extended to cover safe arrival at the centre and at the onward destination.**
- I.46** **The risk of female genital mutilation (FGM) should be systematically considered as a safeguarding concern, and there should be an understanding that FGM may be highly prevalent in specific communities in countries which overall exhibit a low prevalence.**

## The use of force and single separation

### Expected outcomes:

**Force is only used as a last resort and for legitimate reasons. Detainees are placed in the separation unit on proper authority, for security and safety reasons only, and are held on the unit for the shortest possible period.**

**I.47** *In 2013 force had been used on 10 occasions with five families, ranging from low level shepherding to full restraint. All but one incident had been proportionate, necessary and used as a last resort. Staff made efforts to avoid children witnessing the use of force but in one instance children saw their distressed mother being shepherded. Documentation was thorough. Force was not used against children or pregnant women. There were no published rules governing separation. The cool-down room was used rarely but it remained stark and unfurnished.*

**I.48** During 2013, force had been used on 10 occasions, involving five of the 42 families held at the establishment. Handcuffs had been used on two occasions for short periods. The force used ranged from low-level shepherding to full restraint techniques. All cases that we reviewed were proportionate, necessary and used as a last resort, apart from one. A detainee had become distressed and tried to self-harm by placing a cord around his neck and hitting himself. Staff restrained the detainee to prevent further harm and moved him to the cool-down room where he remained passive. Two officers sat beside the detainee and, according to logs, held his arms for 2 hours 20 minutes, first in the cool-down room and then in the Lavender suite, despite compliant behaviour. He was allowed to speak to his wife on the telephone while held in Lavender, but was not reunited with her until the family's removal more than 12 hours later. Given his compliance, there should have been some attempt to reunite them earlier and it was not clear why this was not done. Staff constantly talked to the detainee and reassured him through a telephone interpreter. The chaplain offered support.

**I.49** Force on departure from the facility had been used three times since our last inspection. In two cases, it was clear that staff went to great lengths to persuade parents to cooperate with their removal. In the third case, a mother spontaneously resisted her removal by trying to take her clothes off. Force used by centre staff was proportionate in all cases. However, some detainees were subject to unnecessary light touch restraint by escorts on removal (see preparation for release section).

**I.50** Staff made efforts to ensure children did not witness the use of force. If force was planned, children were moved beforehand. The blinds in the children's play area were drawn if a detainee was being moved to separation. The use of force log recorded whether children had witnessed force being used and in one instance children saw their distressed mother being shepherded into the departure area before removal. Barnardo's workers quickly moved the children to another area.

**I.51** We reviewed documentation for all use of force since our last inspection. It was completed to a good standard and oversight was good. Lessons were learned and disseminated to staff. Scenario based training took place throughout the year.

**I.52** Video recordings of the use of force had improved since our last inspection. Duty managers now wore body cameras. The sound and image quality was good. Staff told us that the cameras helped to de-escalate situations because detainees could see themselves on the camera's small screen. Video footage was only kept for four months, unless a complaint had been made.

- I.53** Force was no longer used against children or pregnant women to effect removal. The policy on force with these vulnerable groups was under review. G4S staff were trained to use physical control in care with children. This restraint training package was due to expire at the end of 2014 and planning on replacement training had not yet begun.
- I.54** The centre did not operate under the Detention Centre rules and the governance of separation remained unclear. However, we were pleased to see a distinct separation log which recorded events in detail.
- I.55** Staff completed Detention Centre rule 40 documents when separating a detainee. Detainees were separated in the cool-down room or the Lavender suite. The cool-down room was used for refractory or violent detainees and remained stark and unfurnished. Only one detainee had been held in separation in 2013 and three in 2012 since our last inspection.
- I.56** The Lavender suite contained three bedrooms and a lounge but no kitchen. The suite was less equipped than other apartments to minimise opportunities for self-harm. The conditions were good: there were soft furnishings, carpets and a television. It was often used for detainees on ACRT procedures. The reasons for separation were not always adequately explained in documentation. In one case the reasons given were generic and lacked detail about the individual: *'unpredictable disruptive behaviour and risk to herself and other people'*.

## Recommendations

- I.57** **Force and separation should only be used for the minimum time, and detainees should not be subject to light touch restraint by escort staff without an individualised risk assessment.**
- I.58** **Separation should be governed by clear rules.**
- I.59** **The cool-down room should be furnished and decorated.**

## Housekeeping point

- I.60** Documentation should explain the reasons for separation in detail and the individual risk factors that made separation necessary.

## Legal rights

### Expected outcomes:

**Detainees are fully aware of and understand their detention, following their arrival at the centre and on release. Detainees are supported by the centre staff to exercise their legal rights freely.**

- I.61** *Many families continued to oppose their removal. Detainees could maintain contact with solicitors and unrepresented detainees could see a solicitor through the Legal Aid Agency funded advice rota. Records were incomplete but indicated that about a third of families requested assistance through the rota.*

- I.62** Many families who had exhausted their statutory appeal rights continued to fight their cases by submitting fresh claims and judicial review applications. In 2013 more than half the 25 families released from the centre were as a result of legal action.
- I.63** Detainees could maintain contact with their solicitors by telephone and fax. Some internet sites that could help detainees with their cases were blocked, including some pages of BBC News, some newspapers, Detention Action and Migrant Help, and an immigration case law database (see preparation for release section).
- I.64** Home Office staff asked detainees during their induction interviews if they had a solicitor and those who did not were referred to the Legal Aid Agency funded duty advice scheme. Two firms of solicitors were contracted to provide advice. Appointments were made for the next day and solicitors had visited the centre on 12 occasions during 2013. Solicitors could bring laptops and mobile phones without cameras into the centre and consulted detainees in private interview rooms.
- I.65** The Home Office had stopped recording requests by detainees for legal advice in September 2013. From our last inspection until September 2013, 71 families had been held, 23 of whom had requested help from the duty advice rota.

### Housekeeping point

- I.66** The Home Office should record data concerning the duty advice rota, including whether the detainee required advice and the time of appointments.

### Casework

#### Expected outcomes:

**Decisions to detain are based on individual reasons that are clearly communicated and effectively reviewed. Detention is for the minimum period necessary and detainees are kept informed throughout the progress of their cases.**

**I.67** *In 2013, 42 families had been held for an average of just over three days and two hours. There had been 25 releases during 2013. Most families arrived from the north of England and Scotland. Detainees had good access to the on-site immigration team. Induction interviews were reasonably good. The legal basis for the centre's operation remained unclear.*

- I.68** Family engagement managers worked with families before detention to promote assisted voluntary return and self-check-in returns. The new Home Office family engagement managers were a positive innovation intended to improve work with families. The average length of detention in 2013 was three days, two hours, 18 minutes. The longest period of detention was five days, seven hours, one minute. The shortest was two days, 10 hours, 28 minutes.
- I.69** In 2013, 42 families had been held at the establishment, some more than once. Eight families returned to Cedars for a second time in 2013, two of whom had originally been held in 2012. Five of these families were removed and three released. Two of the released families were subsequently removed from the UK without the use of Cedars. In 2013, 23 families were removed from the UK via Cedars, 18 after their first stay and five after their second stay.

- I.70** There were 25 releases from Cedars during 2013: judicial review (nine), disruption by the detainee (six), injunction (three), unfit to fly (five), judicial review renewal application (one) and further submissions (one).
- I.71** As at our last inspection, most families arrived from the north of England and Scotland. The Home Office Family Returns Unit had been restructured in early 2013 and family engagement managers were recruited to work with families going through the process. The Home Office believed that these changes would increase the numbers entering the process from London and the south of England.
- I.72** The Home Office on-site contact management team comprised a manager, one full-time equivalent deputy and three contact officers. The team liaised between family engagement managers and detainees. The Home Office saw every detainee at least twice (induction and exit interviews) but detainees had good access to the team at other times. The Home Office induction interview that we observed was reasonably good.
- I.73** The legal basis for the centre's operation remained unclear. It was governed not by the Detention Centre rules but by interim operating instructions. We were told at our last inspection that short-term holding facility rules would apply but these had not been published. There was no formal protection procedure akin to Detention Centre Rule 35 which protects torture survivors and other vulnerable detainees; in practice, five families were declared unfit to fly and released from the centre.

## Recommendations

- I.74** **The Home Office should ensure that local immigration teams are consistent in their approach to detention.** (repeated recommendation I.70)
- I.75** **The legal basis for the operation of Cedars should be clear.** (repeated recommendation I.71)

## Section 2. Respect

### Accommodation

#### Expected outcomes:

**Detainees live in a safe, clean and decent environment. Detainees are aware of the rules, routines and facilities of the unit.**

**2.1** *The centre was well designed to meet the needs of children and families, providing a good overall environment. The accommodation was in good order and was comfortable, spacious and appropriate for families and children of all ages. The external environment was attractive.*

**2.2** Families were located together in nine well-equipped, comfortable and spacious self-contained apartments, the smallest of which accommodated two people and the largest up to six people. The furnishings were adapted to suit the specific needs of families, assessed before and at the point of arrival by Barnardo's staff, and depended largely on the ages of the children. Parents had swipe cards to get into their rooms and could move around the centre easily (see activities section). Some apartments were showing small signs of wear and tear, but overall the accommodation was in very good order. There was a well equipped laundry room which detainees could freely use to wash their clothes.

**2.3** Two further apartments, Lavender and Orchid, were used to accommodate families presenting particular welfare concerns. Orchid was designed to house residents at risk of self-harm (see suicide and self-harm section) and most rooms in the apartment had small internal windows with blinds so that staff could more easily undertake welfare checks. Lavender accommodated families who were disruptive and occasionally held people at risk of self-harm (see use of force and single separation section).

**2.4** The communal areas were attractive and clean with plenty of natural light, and brightly decorated with murals and pictures, promoting a child-friendly environment. There was good focus on providing a safe environment for children; for example, there were no sharp corners on furnishings and child safety locks and stair gates were in use. The external environment was attractive and well maintained (see paragraph 3.2)

### Staff–detainee relationships

#### Expected outcomes:

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

**2.5** *Relationships between families and staff from all agencies remained good. The risk of families being overwhelmed by staff attention was mostly managed well. Adults and children at the centre continued to receive an excellent level of individual care and attention. Staff were consistently respectful in their conversations to and about detainees.*

- 2.6** Relationships between families and staff from all agencies working at Cedars were good and detainees received very high levels of care and support. One parent detained at the centre said she had been treated well by staff at Cedars and they had done their best to help her. She described staff taking good care of her child while she was making telephone calls and in interviews.
- 2.7** With so few families in residence at a time, there was a risk of families being overwhelmed by staff attention. Staff were aware of this and it was generally managed well, except in reception (see arrival section). We observed a good response to feedback from one parent who felt there was too much staff attention to their family.
- 2.8** Written records demonstrated consistent good quality interaction between detainees and staff. These records showed that some detainees preferred more staff involvement than others and that staff respected the wishes of the families, for example that children should remain in the apartment with their parents rather than undertake activities with Barnardo's staff. Staff were consistently respectful when talking about detainees or sharing relevant information about them with colleagues.

## Equality and diversity

### Expected outcomes:

**The centre demonstrates a clear and coordinated approach to eliminating discrimination, promoting equitable outcomes and fostering good relations, and ensures that no detainee is unfairly disadvantaged. This is underpinned by effective processes to identify and resolve any inequality. At a minimum, the distinct needs of each protected characteristic<sup>3</sup> are recognised and addressed: these include race equality, nationality, religion, disability (including mental, physical and learning disabilities and difficulties), gender, transgender issues, sexual orientation and age.**

**2.9** *Good efforts were made to understand and meet the individual needs of detainees. Monitoring of equality and diversity was appropriate and used to inform training and the provision of support. There was an adapted apartment for detainees with mobility problems. Telephone interpretation was used appropriately.*

- 2.10** The equality and diversity policy was based on legislation and provided clear guidance for staff. The emphasis was to treat detainees as individuals, and all protected characteristics were covered. The policy was being reviewed at the time of the inspection to ensure its continuing relevance and accessibility to staff and detainees.
- 2.11** The equality and diversity manager also managed religious affairs and chaired a quarterly equality and diversity committee. The committee comprised all agencies working at Cedars, but attendance was sometimes sporadic. Monitoring of the detainee population took place quarterly and was reviewed at the committee meetings. Monitoring data informed an annual review of equality and diversity and were used well to identify areas for staff training. For example, monitoring showed that in 2012 the largest group at the centre had been Muslim women and an awareness session on working with this group had been delivered to staff in 2013. Many of the discussions at the committee centred on improving support for detainees and promoting staff awareness of diversity and equality.

<sup>3</sup> The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

- 2.12** The equality and diversity manager met families, usually early on the day after they arrived, to welcome them and discuss their particular needs. These frequently involved dietary or religious requests which were usually met. An adapted apartment was available for detainees with mobility problems and the rest of the centre was accessible. Records showed that few detainees with physical disabilities were held at Cedars.
- 2.13** One pregnant woman had been held in 2013. She was about 20 weeks pregnant and went to hospital for a scan on her first full day at Cedars. She was removed with her family two days later and there were no indications from staff recollection or documentation of any concerns during her stay at Cedars.
- 2.14** There had been no detainee complaints about equality and diversity since the previous inspection. Staff undertook basic training in equality and diversity as part of their induction. Awareness-raising and refresher training took place during the year. Notice boards displayed information about religious and cultural dates of significance each month and celebrations took place. Two families had observed Ramadan and a small Eid event had taken place.
- 2.15** Many of the detainees were able to communicate in English. Otherwise, telephone interpretation was used well to support detainees who could not understand or speak English well enough to participate fully in discussions.

## Faith and religious activity

### Expected outcomes:

**All detainees are able to practise their religion fully and in safety. The faith team plays a full part in the life of the centre and contributes to detainees' overall care, support and release plans.**

**2.16** *There was good support for detainees' religious and spiritual needs. Detainees had ready access to well equipped facilities for worship and to chaplains.*

- 2.17** The facilities for worship consisted of a small multi-faith chapel and a small multi-faith room, which were both well equipped and had appropriate washing facilities. The rooms were of a suitable size for the detainees accommodated at Cedars. They could use the rooms to pray, to spend time in private or to talk to a chaplain of their faith. The manager of religious affairs met families on their first full day at the centre, showed them the facilities for worship and arranged for them to see a chaplain of their faith if required. Proper sensitivity was shown to those who had changed their faith while in the UK but did not wish this to be known. The centre shared with other centres nearby a team of chaplains representing all the major faiths. Muslims had made up the largest faith group at the centre in 2013.
- 2.18** Chaplains were responsive to families' needs and services were arranged at families' request. It was clear from records that chaplains offered significant support to families, particularly those who were in the most distress about their situation. Support ranged from prayer and religious counsel to sitting and listening to detainees while they explained their problems.

## Complaints

### Expected outcomes:

**Effective complaints procedures are in place for detainees, which are easy to access and use and provide timely responses.**

**2.19** *Complaint forms were available in a range of languages. No complaints about Cedars had been submitted since the previous inspection.*

**2.20** Complaint forms in English and 13 other languages were available in the library. Information on how to complain was available in a similar range of languages. There were two complaint boxes, one shared box for G4S and the Home Office and a separate box for the Independent Monitoring Board (IMB). A child-friendly form was available for children who wanted to raise a concern and a copy of this was included in each welcome pack. Home Office staff checked the shared box and allocated complaints to the relevant agency to address. A test complaint submitted by inspectors was acknowledged later the same day. The IMB checked their box. No complaints had been submitted since the previous inspection. We were told that complaints were replied to in English.

**2.21** Detainees' experience prior to arrival at Cedars had recently been identified and forwarded to the relevant authorities to investigate. Two of these concerning arrest and initial detention had been referred to the professional standards unit of the Home Office and a third had been sent to a local authority and was the subject of a lessons learned review. The results of these investigations were not available during the inspection.

### Recommendation

**2.22** **Complaints should be replied to in the language of the complaint.** (repeated recommendation 2.23)

## Health services

### Expected outcomes:

**Health services assess and meet detainees' health needs while in detention and promote continuity of health and social care on release. Health services recognise the specific needs of detainees as displaced persons who may have experienced trauma. The standard of health service provided is equivalent to that which people expect to receive elsewhere in the community.**

**2.23** *Health care provision was generally good and largely met the immediate needs of detainees. Families had 24-hour access to a nurse and a daily GP clinic. Too few families were able to take responsibility for their own medicines and there was inadequate provision of anti-malarial prophylaxis for pregnant women and adults. Mental health provision for adults was adequate but there was limited contingency planning for children arriving with mental health needs.*

## Governance arrangements

- 2.24** Health services were provided by G4S integrated services and the GP service by Saxonbrook Medical. A clinical lead nurse for the centre had been appointed since our last inspection. The pool of nurses attending the centre regularly included one registered children's nurse who took the lead on children's needs. A health needs assessment for all the Gatwick immigration removal centres had been completed in 2012 but made little reference to the specific needs of families. A new health needs assessment was due to be undertaken shortly after our inspection.
- 2.25** Health was well integrated into wider centre meetings. Nursing staff attended local and external safeguarding meetings and planning meetings, although their contribution was sometimes passive and they did not always identify key health implications for detainees. Policies were largely national organisational policies and some health specific policies relevant to detainees, such as infection control, communicable diseases, blood-borne viruses, information sharing and food refusal, were not accessible to nurses working at the centre. Not all staff had received training in safeguarding children and understanding children's developmental and physical and mental health needs. There was no clinical supervision for nursing staff and some staff had not had regular management supervision. The GPs had a system of clinical supervision and regular appraisal. There were good links with local specialist NHS services for TB and blood-borne viruses to enable appropriate advice to be given to detainees.
- 2.26** The health care rooms were suitably located, furnished and clean and offered appropriate privacy. One room lacked ventilation. Both rooms were reasonably child friendly. Resuscitation kit, including adult and child specific equipment, was checked regularly. All staff had received basic life support training appropriate to the care of adults and children. Healthcare staff had received intermediate life support training. There was emergency access to the local community GP out-of-hours' service.

## Recommendations

- 2.27** **Health care services should be based on the needs of detained families and children. There should be an up-to-date, appropriately focused health needs assessment and staff should receive up-to-date training in safeguarding children and awareness of child development and children's physical and mental health needs.**
- 2.28** **All health care professionals should have regular clinical and management supervision to ensure safe and good clinical practice.**

## Housekeeping points

- 2.29** Nurses should contribute actively to wider centre meetings to support their health advocacy role for families.
- 2.30** Policies should accurately reflect detainees' health needs, particularly in relation to communicable diseases, blood-borne viruses, food refusal, immunisation and information-sharing consent.
- 2.31** Ventilation in the main health care room should be improved.

## Delivery of care (physical health)

- 2.32** Health care staff received a copy of the family welfare form with supporting medical information in advance of a family's arrival at the centre. Nurses told us that they identified health issues that required further information. It was not clear if this was always done before the family arrived. Efforts were made to ensure that staff had access to the personal maternity record of pregnant women and the personal child health record of young children.
- 2.33** All detainees were seen on arrival by a nurse. We observed the health screening of the G family; the nurse was sensitive and thoughtful in her approach but the process was too long and much of the assessment could have been completed the following day (see arrival section). It was coincidental rather than planned that issues of torture and abuse were discussed out of the earshot of the child, and not enough consideration was given to this. We observed the screening of another family where the assessment of the history and risk of self-harm was poor: the nurse asked blunt questions with little attention to how a family in a stressful situation might react.
- 2.34** Families were seen by a GP within 24 hours. The GP assessment of the G family was thorough and sensitive and no sensitive questions were asked in the child's presence. The mother asked to be given the child's medicines to administer herself and this was done. GPs were clear about the completion of Rule 35 documentation (see casework section); we did not see any examples.
- 2.35** Health professionals maintained appropriate privacy and confidentiality in relation to detainees' health information but nurses were always accompanied by an officer to see families in their accommodation.
- 2.36** Electronic records were used; the records we reviewed were appropriately completed and demonstrated satisfactory clinical care for detainees.

## Recommendations

- 2.37 Reception health screening should be sensitive and mindful of the needs of children.**
- 2.38 Detainees should be able to see a nurse without the presence of a detention officer unless a specific risk has been properly identified.**

## Pharmacy

- 2.39** The pharmacy service was provided by Boots at Gatwick Airport. The service was open from 4am to 9pm (10pm in summer). There was limited stock available and no policy or arrangement to ensure that nurses could access medications outside these times. The pharmacist visited monthly to audit stock and prescriptions. Detainees could ask to see the pharmacist but this had never happened.
- 2.40** There was a good in-possession risk assessment and we noted an example of appropriate review when a concern was raised. Despite this, families were rarely allowed to have their medicines in possession except for skin creams. Nurses visited the family accommodation to give medication and were always accompanied by a detention officer. Prescribing was appropriate to the setting with a suitable formulary but included no provision for prescribing to children; the formulary had not been reviewed as requested by the medicines

management committee. There was good provision for translating information about medicines for families.

- 2.41** There was a wide range of patient group directions<sup>4</sup> (PGDs) but they were rarely used except for simple analgesia; a PGD for rectal diazepam (used to control fits and seizures) was not supported by available stock. We were told that childhood immunisations were given only if a child was due for a particular dose during their stay at the centre and parents were given advice about completing any courses of immunisations already started. On removal, children and selected adults with compromised immunity were supplied with 12 days of Malarone (an anti-malarial medication); this included pregnant women. Adults did not receive malaria prophylaxis. All families were provided with mosquito nets. Supplies of prescribed medication were provided.
- 2.42** Drug refrigerators were appropriately checked by the nurses but only when they were present in the suite. An appropriate medicines management committee meeting was attended by relevant stakeholders.

## Recommendations

- 2.43** **Parents should have medication in possession unless individual risk assessment indicates otherwise.** (repeated recommendation 2.35)
- 2.44** **Patient group directions should be used whenever possible to allow more appropriate use of doctor consultation time.**
- 2.45** **Pregnant women should be offered an alternative to Malarone in accordance with National Institute for Clinical Excellence guidelines. Adults travelling to countries where malaria is endemic should be offered malaria prophylaxis in accordance with World Health Organisation guidance on loss of natural immunity.**

## Dentistry

- 2.46** Detainees requiring emergency dental treatment were initially treated by the GP and could be referred to local community emergency dental services if necessary.

## Delivery of care (mental health)

- 2.47** Primary mental health services were delivered by G4S as required and there was access to a weekly psychiatrist adult clinic. Six people had been referred to the primary mental health nurse in the last year and we were told that most were seen for reactive distress and low mood associated with their removal. There were no formal links with local child and adolescent mental health services (CAMHS): a child with a pre-existing referral to CAMHS was due to arrive during our inspection, but did not arrive and there was lack of clarity about how such a situation would be managed.

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<sup>4</sup> Enable the supply and administration of prescription-only medicine by persons other than a doctor or pharmacist, usually a nurse

## Recommendation

- 2.48** Links should be developed with the local child and adolescent mental health service.

## Substance misuse

### Expected outcomes:

**Detainees with drug and/or alcohol problems are identified at reception and receive effective treatment and support throughout their detention.**

- 2.49** *Detainees with substance use needs were not accepted at the centre.*

- 2.50** Detainees with substance use needs were not accepted at the centre but there was provision for symptom relief to be prescribed by the GP if needed.

## Services

### Expected outcomes:

**Detainees are offered varied meals to meet their individual requirements and food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations. Detainees can purchase a suitable range of goods at reasonable prices to meet their diverse needs, and can do so safely.**

- 2.51** *The catering arrangements remained the same and the standard of food available to detainees continued to be of a high standard.*

- 2.52** Catering staff were provided with background information about detainees before their arrival which they used to prepare food that they thought detainees might like. Available food options were discussed with the family when they arrived and they were able to make a choice. Hot food was always available for detainees on admission. The menu was designed to meet the individual requirements and preferences of family members. A wide range of food suitable for children was kept in stock and suitable provision was made for special diets. If a particular item requested was not in stock, it was bought in.

- 2.53** Detainees usually ate together in the canteen. They also had the opportunity to cook for themselves in the well equipped kitchens in their apartments, but few chose to. Healthy snacks, fruit and drinks were available in communal areas throughout the day and catering staff ensured that detainees had access to suitable food 24 hours a day.

## Section 3. Activities

### Expected outcomes:

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

**3.1** *Barnardo's continued to deliver a good range of activities to meet the needs and recreational interests of all detainees. In particular, children engaged well in a series of carefully planned activities which combined play and informal learning. Accommodation and facilities to deliver activities were extensive and of excellent quality. The promotion of cultural diversity through the activities was particularly good.*

**3.2** Families had good freedom of movement around the centre. Each adult received a key card for their own room and for different parts of the premises, including the garden and the outdoor areas which contained two playground areas for children of different ages and a sensory garden. Weather permitting, families were able to eat outside and children's learning and play activities took place outdoors.

**3.3** Several rooms had been designed and equipped for socialising, activities and entertainment. The library and the garden were open and accessible throughout the day until 10pm. Detainees could ask to use library resources, such as the fax machine, after that time.

**3.4** Activities and facilities provided good physical and mental stimulation for children and adults. Barnardo's had compiled a wide range of age-appropriate activities which matched the national curriculum and the Early Years Foundation syllabus. Children were occupied in activities throughout the day for a period suitable for their age. The information that Barnardo's received on the educational needs of the young people arriving at the centre had improved since the last inspection.

**3.5** Planned activities consisted of a well balanced mixture of play, writing and reading as well as sports and physical exercise. Time was set aside at the end of the evening for more relaxed activities such as watching a film or reading together. Many activities centred on working with crafts which encouraged children to explore their creativity.

**3.6** Older children could undertake activities that afforded them appropriate opportunities to express their emotions. Children were well supported by staff during these activities to help them develop coping strategies for the stress, apprehension and anxiety related to their removal and the journey ahead. Many children wrote an account of their time at the centre as a useful tool to reflect on their experience and to communicate their fears to staff who supported them with compassion.

**3.7** The promotion of cultural diversity through activities was excellent. Many activities promoted positive images of the country the families were being removed to, helping children to begin thinking about their destination. Barnardo's placed great emphasis on creating awareness of different languages, national flags, animals, and religious festivals and typical crafts. Many displays around the centre served as a platform to showcase the children's work and to promote the concept of the global citizen.

- 3.8** Barnardo's had also designed and promoted well a curriculum of activities for adults involving manual crafts, English language lessons and visits to the library and the gym. However, staff felt that, due to their short stay, most adults were occupied in dealing with the logistics and legal matters surrounding the family's return to their country and not all undertook other activities. Detainees had access to television, books, newspapers and DVDs in a range of languages. Each apartment was equipped with a television and DVD player so that families could watch television together in privacy. A larger communal room was also available for families to watch television together or play one of the many board games.
- 3.9** A wide range of age-appropriate DVDs included an adequate selection in different languages. Two digital tablets were available to residents to play games and to download electronic books, but not to download films in foreign languages. Detainees could borrow music CDs from the centre by requesting a list from staff.
- 3.10** The accommodation and resources for activities were excellent and there was a youth lounge where children could play games, including sports and snooker. The technology for playing games was comprehensive and up to date and support workers participated if necessary. There was a range of musical instruments, many indigenous to other countries, which provided opportunities for children to explore cultural diversity through music.
- 3.11** The designated fitness provision met the needs of all detainees and placed a good emphasis on safety. The gym was a small but adequate room which contained modern, well maintained equipment, including a range of cardiovascular equipment, a cross trainer, a selection of weights and an exercise bike. Every detainee wishing to use the gym facilities underwent a health screening to identify any health concerns. These were appropriately assessed by the health care department which suggested coping mechanisms for health problems while exercising. The multi-sensory room used visual, sound and light effects very effectively to provide a secluded and relaxing environment which both adults and young children enjoyed.

### Housekeeping point

- 3.12** A list of the music CDs available in the centre should be displayed so that this recreational resource can be used easily.

## Section 4. Preparation for removal and release

### Welfare

#### Expected outcomes:

**Detainees are supported by welfare services during their time in detention and prepared for release, transfer or removal before leaving detention.**

**4.1** *Social visiting times were good. The visits area was welcoming but small and afforded little privacy. Telephone provision was generally good. There was free access to a fax, the internet and email but not to social networks or Skype. Support for families released from the centre was good. Pre-removal planning was good, with considerable attention paid to welfare and post-return needs. An overseas escort that we observed was generally well managed; a second, failed removal was generally handled well by staff, but there were some areas for improvement.*

**4.2** Support for families released from the centre was good. They were given the means to return home, often accompanied by a Barnardo's worker to help them to reach their destination safely, and some who were released later in the evening were provided with a hotel room for the night. Food packs were provided.

**4.3** Detainees were able to keep their mobile phone in the centre if it had no camera, or they were provided with one. However, one detainee had no working phone overnight (see arrival section). There was free access to a fax machine, and to the internet and email, although some sites were unnecessarily blocked, including some that could help detainees with their cases (see legal rights section). The centre used filtering software to block sites. A manager could ask the G4S IT help desk to unblock a site but this took 48 hours: too long given the short time that detainees were held at the centre. There were no notices advising detainees that sites could be unblocked. There was no access to social networking sites or Skype, both primary mechanisms for young people to maintain contact with each other.

**4.4** The number of social visits was low, at 24 during 2013. Social visiting times remained good, from 9am to 9pm, and booking was straightforward. Visitors were able to bring in property for detainees. The visits area remained bright and welcoming, with a good range of play equipment, but was located next to the staff reception desk and afforded little privacy. We observed the G family having a social visit; one member of staff watched the family from the desk throughout the visit, which was disproportionate to the risk the family posed. The visits room was small and could not comfortably accommodate more than one family. Public transport information was displayed on a notice board and travel links to the centre were good. The centre was served by Gatwick detainee visitors' group but there was very little demand for their services.

### Overseas escorts

#### The G family

**4.5** We observed the removal of the G family from collection at Cedars to Nairobi airport in Kenya on a scheduled commercial flight. Staff held a planning meeting before their departure

to consider key issues such as the provision of clothing and suitcases, of which there was a good supply, health needs and immediate needs post removal. The family was given the Barnardo's email address and telephone number to provide feedback post return if they wished.

- 4.6** Five Tascor overseas escorts, who had not received any specific safeguarding training, and one medic contracted from Taylormade Healthcare, travelled with the family. The journey time from Cedars to Nairobi was 14 hours. The team leader had most relevant information about the detainees. Person escort records (PERs) and a care plan for the child were started and added to throughout the journey. The escorts' handcuffs were kept out of sight of the family in hand luggage. To avoid unnecessary attention, all escort staff dressed informally, but the medic wore a fleece with a red cross and the word 'Medic' on the sleeve throughout the journey to Nairobi. This was unnecessary, particularly during the flight.
- 4.7** The senior escort and the medic entered the small reception area at Cedars initially and only after they had introduced themselves to the family did two female escorts enter to engage with the child while the mother completed formalities. The medic received a confidential handover from centre health care staff. Barnardo's had produced a helpful individualised information pack about Kenya containing details of hotel accommodation, public transport, the cost of living in Nairobi, and relevant support agencies. The mother was given a cash card pre-loaded with £150 which could be taken from any ATM in Kenya to assist with immediate needs and a safe journey to the family's final destination. A hotel in Nairobi had been pre-booked for two nights for the family, and the mother was given the requisite amount of local currency to pay for this. Food packs were provided for the journey. Barnardo's had put together a personalised bag with the child's name painted on the front containing age-appropriate toys and books which the child was able to take with her.
- 4.8** The mother was discreetly searched at Cedars out of sight of the child, who was only required to walk through a decorated security portal. The mother was advised that any time she was in an outside area during the escort she would need to be held by the arm. This was done discreetly by a female escort linking arms with her while walking to the coach, but it was unnecessary given that she was completely calm and compliant (see recommendation I.57). The child was taken by the hand by another female escort. The same linking of arms and hand holding (which resulted in mother and child being separated) took place whenever the family were off the coach.
- 4.9** Staff had undertaken use of force training but not on its use in confined areas like an aircraft. If allegations of assault made by detainees during removal attempts were supported by medical evidence, it was not Home Office policy to delay the removal while the complaint was investigated.
- 4.10** The escort coach was clean and comfortable, with a toilet and plenty of space for property to be carried. A female escort accompanied the detainees to the toilet and did not allow the toilet door to be fully closed; this was relaxed during the flight (see section on escort vehicles and transfers). The boarding of the coach initially felt crowded, with escorts in the aisle on boarding, an escort filming nearby and two escorts with the detainees. Once seated, the escorts were less intrusive. One escort filmed the removal intermittently from Cedars to boarding the aircraft. The reason for this was properly explained to the family, as was the complaints procedure. The mother had access to her own phone from leaving Cedars to boarding the aircraft and was free to make calls as needed.
- 4.11** The coach left Cedars at 1pm and at 3.20pm arrived at the baggage check area which was at a separate location to that for standard passengers. Security procedures took 20 minutes, after which the family travelled to Cayley House, an airside short-term holding facility, arriving at 4.10pm. The detainees were accommodated in the family room where there was a child's play area and refreshments were provided. At 5.15pm the family left Cayley House

for transfer to the aircraft. There was a delay boarding the aircraft because of another (unconnected) escorted detainee, who the senior escort had not been made aware was on the same flight. At 6.10pm the family were seated towards the rear of the aircraft, boarding by the rear stairs before the other passengers boarded. They were seated only two rows in front of the other escorted detainee who was considered a security risk and boarded in handcuffs. There was a risk that the child may have been distressed by the handcuffs. Other passengers were staring at this detainee, which negated the considerable efforts made by escorts not to draw attention to the family.

- 4.12** The aircraft departed on time at 7pm. Overall the removal was well managed; escort staff were polite and respectful at all times and the child remained at ease in their company throughout the journey. On arrival the family disembarked without any attention being drawn to them, and made their own way through the airport.

## The J family

- 4.13** We also observed the attempted removal of the J family to Colombo in Sri Lanka. The escort team comprised nine staff (three females and six males) and a medic, and they were thoroughly briefed. However, it was noted that the family welfare form was an unwieldy document consisting of 49 pages, which made it difficult to identify quickly the removal plan and the care needs of the family. The senior escort had overlooked the need for an interpreter for the mother, although by chance it transpired that an escort spoke Tamil and was able to converse with the family.
- 4.14** Family escorts introduced themselves to the family and were polite and respectful, but the small reception area was very crowded with 11 members of staff and the family. Pre-removal planning was good, and included the provision of a cash card pre-loaded with £200 to assist with transport costs and other immediate needs on arrival at Colombo. However, there were some inconsistencies with this removal: nobody had explained to the family that elements of the journey would be filmed, and the team leader's handcuffs, although kept in a pouch, were on occasion clearly visible to the family; no light touch restraint was used on either parent when leaving Cedars, although it was used on both when boarding the plane which angered and further distressed the otherwise compliant detainees (see use of force section). During the coach journey the care given to the family was generally good. However, some staff were sending texts on their mobile phones and discussing personal texts they had received, which was inappropriate. The medical section of the PERs had not been completed to identify risks.
- 4.15** Passing through the dedicated baggage security area took a long time, and the small area was very crowded and hot, causing the mother to become increasingly agitated. The family transferred to Cayley House for a short time; the senior escort decided not to use the smaller family room and used an adjacent room, where the family sat at a fixed table in the middle of the room with 10 members of staff looking in at them. Other detainees in the facility were also looking in, which was particularly inappropriate given the presence of two children. The team leader left the facility to make ticket arrangements, which were lengthy and chaotic because specific seats had not been booked for the escorts and the family to be seated together at the rear of the plane. The family reboarded the coach for transfer to the aircraft before the team leader had returned. A decision was made by the escorts to seat the parents separately on the coach despite their compliance.
- 4.16** By the time the family began boarding the aircraft at 8.42pm it was virtually full with passengers for the scheduled 9pm take off. The father boarded first, followed by the mother who was by this time very emotional. Both were seated in separate rows, flanked by escorts. The two children refused to get off the coach and the mother began screaming and tried to

leave her seat to return to her children. Escorts handcuffed her and took both parents off the aircraft quickly. The escorts dealt with this difficult situation reasonably well. The mother reboarded the coach in handcuffs, which would have been distressing for the children.

- 4.17** By boarding the parents first, the children were left without an appropriate adult present, which presented a safeguarding issue. The senior escort was not aware of any safeguarding policy or protocol. No physical force was used on the children to get them to leave the coach, and the officers remained calm and did not raise their voices. However, they made a number of inappropriate suggestions to persuade the children to board, such as 'if mummy goes, you are going to be very lonely' and 'there's nothing to stop you coming back [if you go]'. The younger child did not appear distressed or to understand what was happening. It was difficult to assess the impact on the older child who was quiet and resolute. At one point she said that if the family returned, her father would be killed. Barnardo's' assessment had been that she was withdrawn and taking on her parents' problems.
- 4.18** When the family were back on the coach, and their luggage had been retrieved, they were returned to Cayley House. During this journey escorts were reassuring and showed no hostility towards the detainees for what had happened. Staff completed use of force reporting forms. The family were granted temporary admission to the country.

## Recommendations

- 4.19 Families should have access to all reasonable websites, especially those which may assist their cases, social networks and Skype. They should be told that they can request the unblocking of websites and centre staff should be able to unblock sites quickly.**
- 4.20 The visits area should afford detainees and their visitors privacy and should accommodate several families simultaneously.** (repeated recommendation 4.12)
- 4.21 If allegations of assault made by detainees during removal attempts are supported by medical evidence, the removal should be delayed while the complaint is investigated.** (repeated recommendation 4.11)
- 4.22 All family escort staff should undertake safeguarding training, which should be refreshed regularly, and they should be familiar with safeguarding policy and protocols.**
- 4.23 Children should be in the presence of either their parent/carer or an appropriate adult at all times during a removal, and should not be subject to untrue or inappropriate persuasion by staff.**

## Housekeeping points

- 4.24** All escort staff, including medics, should dress informally to avoid drawing unnecessary attention to families being removed.
- 4.25** Ticketing and seat booking arrangements should ensure that specific seats have been reserved for the escort party in advance of the removal.
- 4.26** Overseas escorts should be coordinated effectively to ensure that children are not at risk of witnessing restraint used against other detainees on the same flight. Senior escorts should be aware of other detainees being removed on the same flight.

## Section 5. Summary of recommendations and housekeeping points

The following is a listing of repeated and new recommendations, housekeeping points and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report, and in the previous report where recommendations have been repeated.

### Main recommendation

To the Home Office

- 5.1** Home Office enforcement teams should conduct arrests as sensitively, calmly and quietly as possible. All elements of the arrest should be approved by the Independent Family Returns panel and should protect the welfare of children. Any deviation from the approved plan should be reported promptly to the panel. (S40)

### Recommendations

To the Home Office

#### The use of force and single separation

- 5.2** Separation should be governed by clear rules. (1.58)

#### Casework

- 5.3** The Home Office should ensure that local immigration teams are consistent in their approach to detention. (1.74, repeated recommendation 1.70)
- 5.4** The legal basis for the operation of Cedars should be clear. (1.75, repeated recommendation 1.71)

#### Preparation for removal and release

- 5.5** If allegations of assault made by detainees during removal attempts are supported by medical evidence, the removal should be delayed while the complaint is investigated. (4.21, repeated recommendation 4.11)

### Recommendation

To the Home Office, escort contractor and centre manager

#### Escort vehicles and transfers

- 5.6** Detainees should have constant access to a telephone and their numbers while detained so that they can contact legal advisers, family and friends. (1.9)

## Recommendation

To the Home Office and centre manager

### Safeguarding children

- 5.7** The risk of female genital mutilation (FGM) should be systematically considered as a safeguarding concern, and there should be an understanding that FGM may be highly prevalent in specific communities in countries which overall exhibit a low prevalence. (1.46)

## Recommendations

To the escort contractor

### Escort vehicles and transfers

- 5.8** The collection of all detainees by escorts should be timely and should adhere to the removal plan. (1.10)

### Removal and release

- 5.9** All family escort staff should undertake safeguarding training, which should be refreshed regularly, and they should be familiar with safeguarding policy and protocols. (4.22)
- 5.10** Children should be in the presence of either their parent/carer or an appropriate adult at all times during a removal, and should not be subject to untrue or inappropriate persuasion by staff. (4.23)

## Recommendations

To the escort contractor and centre manager

### Safeguarding children

- 5.11** The local workshop approach to safeguarding training should be extended to include Tascor escort staff. (1.43)
- 5.12** The scope of the guidance and procedures to safeguard children should be extended to cover safe arrival at the centre and at the onward destination. (1.45)

## Recommendations

To the centre manager

### Early days in detention

- 5.13** The reception process should be undertaken quickly, particularly for those families who have undertaken long journeys and/or arrived late at night, and staff should avoid overwhelming families with attention on arrival. (1.17)

### Self-harm and suicide prevention

- 5.14** All staff who may have sole, direct contact with detainees should carry ligature knives. (1.29)

### Safeguarding children

- 5.15** A standard approach towards 'learning lessons' should be adopted by all agencies at the centre. (1.44)

### The use of force and single separation

- 5.16** Force and separation should only be used for the minimum time, and detainees should not be subject to light touch restraint by escort staff without an individualised risk assessment. (1.57)
- 5.17** The cool-down room should be furnished and decorated. (1.59)

### Complaints

- 5.18** Complaints should be replied to in the language of the complaint. (2.22, repeated recommendation 2.23)

### Health services

- 5.19** Health care services should be based on the needs of detained families and children. There should be an up-to-date, appropriately focused health needs assessment and staff should receive up-to-date training in safeguarding children and awareness of child development and children's physical and mental health needs. (2.27)
- 5.20** All health care professionals should have regular clinical and management supervision to ensure safe and good clinical practice. (2.28)
- 5.21** Reception health screening should be sensitive and mindful of the needs of children. (2.37)
- 5.22** Detainees should be able to see a nurse without the presence of a detention officer unless a specific risk has been properly identified. (2.38)
- 5.23** Parents should have medication in possession unless individual risk assessment indicates otherwise. (2.43)
- 5.24** Patient group directions should be used whenever possible to allow more appropriate use of doctor consultation time. (2.44)
- 5.25** Pregnant women should be offered an alternative to Malarone in accordance with National Institute for Clinical Excellence guidelines. Adults travelling to countries where malaria is endemic should be offered malaria prophylaxis in accordance with World Health Organisation guidance on loss of natural immunity. (2.45)
- 5.26** Links should be developed with the local child and adolescent mental health service. (2.48)

## Welfare

- 5.27** Families should have access to all reasonable websites, especially those which may assist their cases, social networks and Skype. They should be told that they can request the unblocking of websites and centre staff should be able to unblock sites quickly. (4.19)

## Visits

- 5.28** The visits area should afford detainees and their visitors privacy and should accommodate several families simultaneously. (4.20, repeated recommendation 4.12)

## Housekeeping point

To the Home Office

### Legal rights

- 5.29** The Home Office should record data concerning the duty advice rota, including whether the detainee required advice and the time of appointments. (1.66)

## Housekeeping points

To the escort contractor

### Escort vehicles and transfers

- 5.30** Detainees should be allowed to close the toilet door fully during escort, subject to individual risk assessment. (1.11)

### Preparation for removal and release

- 5.31** All escort staff, including medics, should dress informally to avoid drawing unnecessary attention to families being removed. (4.24)
- 5.32** Ticketing and seat booking arrangements should ensure that specific seats have been reserved for the escort party in advance of the removal. (4.25)
- 5.33** Overseas escorts should be coordinated effectively to ensure that children are not at risk of witnessing restraint used against other detainees on the same flight. Senior escorts should be aware of other detainees being removed on the same flight. (4.26)

## Housekeeping points

To the centre manager

### Early days in detention

- 5.34** Security regulations should be commensurate to the risk posed by individual families. (1.18)

### Self-harm and suicide prevention

- 5.35** An ACRT assessor should always be available when reviews need to be carried out. (1.30)

### **The use of force and single separation**

- 5.36** Documentation should explain the reasons for separation in detail and the individual risk factors that made separation necessary. (1.60)

### **Health services**

- 5.37** Nurses should contribute actively to wider centre meetings to support their health advocacy role for families. (2.29)
- 5.38** Policies should accurately reflect detainees' health needs, particularly in relation to communicable diseases, blood-borne viruses, food refusal, immunisation and information-sharing consent. (2.30)
- 5.39** Ventilation in the main health care room should be improved. (2.31)

### **Activities**

- 5.40** A list of the music CDs available in the centre should be displayed so that this recreational resource can be used easily. (3.12)



## Section 6. Appendices

### Appendix I: Inspection team

Hindpal Singh Bhui	Team leader
Colin Carroll	Inspector
Beverley Alden	Inspector
Ian Macfadyen	Inspector
Angela Johnson	Inspector
Martin Kettle	Inspector
Deri Hughes-Roberts	Inspector
Gary Boughen	Inspector
Fiona Shearlaw	Inspector
Louise Finer	Senior Policy Officer
Nicola Rabjohns	Health services inspector
Ian Craig	Care Quality Commission
Sue Melvin	Pharmacist
Maria Navarro	Ofsted



## Appendix II: Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made, organised under the four tests of a healthy establishment. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

### Safety

#### **Detainees are held in safety and with due regard to the insecurity of their position.**

*At the last inspection in 2012, detainees reported positively about escorts overall but families complained about their treatment at the point of arrest. There was good preparation for families arriving at the centre and detailed advance information was communicated to appropriate staff. The arrivals area was welcoming and the arrivals process was well managed. Detainees said they felt safe. Those at risk of self-harm were well managed. A strong child-centred culture had been developed in the centre. Safeguarding and child protection procedures were well understood by all staff. Where force had been used it was usually minimal. However, it had been used to effect the removal of a pregnant woman, posing an unacceptable risk to the unborn child. Force had also been used against children. Detainees were given good access to legal assistance. On-site immigration staff were accessible. There were apparent inconsistencies in the decision to detain families. Outcomes for detainees were reasonably good against this healthy establishment test.*

#### **Main recommendation**

Force should never be used to effect the removal of pregnant women or of children. It should only ever be used in relation to such vulnerable groups in order to prevent harm. (HE.40)

**Achieved**

#### **Recommendations**

At the point of initial arrest parents should have adequate time to prepare themselves and their children for their journey, and UKBA teams should conduct the arrest as sensitively, calmly and quietly as possible. (I.8)

**Not achieved**

The handover from arrest teams to escorts should be conducted in a private location out of public view. (I.9)

**Achieved**

Escort staff should remain calm, polite and respectful at all times. (I.10)

**Achieved**

Families should only be transported in appropriate and spacious vehicles, and held on them for the minimum possible time. (I.11)

**Achieved**

Removal plans should be adhered to, and any deviations should be fed back promptly to the independent family returns panel. (1.12)

**Not achieved**

The reception process should be undertaken quickly and all relevant staff should be familiar with completing reception procedures. (1.19)

**Partially achieved**

Key information should be available in an appropriate range of languages and formats including notices, booklets and DVDs. (1.20)

**Achieved**

UKBA should ensure consistent quality of family welfare forms. (1.45)

**Achieved**

'Lessons learned' meetings should be held promptly. (1.44)

**Not achieved**

Separation should be governed by clear rules and staff should be aware of how to record its use. The unit should be less stark, with some furniture and decoration. (1.57)

**Not achieved**

Paramedics on escorts should focus on their primary duties and not operate hand-held cameras. (1.56)

**Achieved**

UKBA should ensure that local immigration teams are consistent in their approach to detention. (1.70)

**Not achieved** (recommendation repeated, 1.74)

The legal basis for the operation of Cedars should be clear. (1.71)

**Not achieved** (recommendation repeated, 1.75)

## Respect

**Detainees are treated with respect for their human dignity and the circumstances of their detention.**

*At the last inspection in 2012, accommodation was high quality and designed around the needs of children. Relationships between staff and families were very good. Diverse needs were met appropriately through an individualised approach. Faith provision was good. Complaints were well investigated. The standard of food was high and parents could cook for their families. Families had easy access to health care. Provision for those with mental health problems was limited. Outcomes for detainees were good against this healthy establishment test.*

## Recommendations

Parents should have medication in possession unless individual risk assessment indicates otherwise. (2.35)

**Not achieved** (recommendation repeated, 2.43)

A health needs assessment should be undertaken, including a mental health needs assessment. Appropriate access to adult, child and adolescent mental health services should be available. (2.36)  
**Partially achieved**

All clinical staff should receive training in child-specific care and treatment. (2.37)  
**Achieved**

Parents should be able to discuss their medical needs with health care staff in confidence. (2.38)  
**Partially achieved**

All relevant health care information should be received before families arrive on site. (2.39)  
**Achieved**

Complaints should be replied to in the language of the complaint. (2.23)  
**Not achieved** (recommendation repeated, 2.22)

## Activities

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

*At the last inspection in 2012, facilities and resources for activities were excellent. The library was well stocked, attractive and easy to use. Activity planning was age appropriate and tailored to individuals. We observed children engaged fully with a range of semi-structured activities, and purposefully occupied. Outcomes for detainees were good against this healthy establishment test.*

## Recommendation

All family welfare forms should contain detailed information on previous educational history and attainment. (3.10)

**Achieved**

## Resettlement

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

*At the last inspection in 2012, families received good support to prepare for removal or release. Families could have daily visits, but the visits room lacked privacy. Access to telephones, email, fax and internet were all good. Removal plans were not always received or fully implemented. Useful country information packs were provided to all families. Efforts were also made to contact support organisations in destination countries. A good range of clothing was available for those who needed it. Grants were regularly provided to help detainees meet immediate needs on arrival and make their way to final destinations. Post-removal follow-up information was limited. Outcomes for detainees were good against this healthy establishment test.*

## Recommendations

The centre should be informed of the views of the independent family returns panel prior to removal of the family. (4.9)

**Achieved**

Escort staff should be fully briefed on removal plans and any deviations should be fed back to the family returns panel. (4.10)

**Partially achieved**

If allegations of assault made by detainees during removal attempts are supported by medical evidence, the removal should be delayed while the complaint is investigated. (4.11)

**Not achieved** (recommendation repeated, 4.21)

Detainees should retain their mobile phones during removal unless an individual risk assessment determines otherwise. (4.13)

**Achieved**

The visits area should afford detainees and their visitors privacy and should accommodate several families simultaneously. (4.12)

**Not achieved** (recommendation repeated, 4.20)

Children should be able to access social networking sites. (4.14)

**Not achieved**