Report on an announced inspection of

Harmondsworth Immigration Removal Centre

17–21 July 2006

by HM Chief Inspector of Prisons

ISBN-13: 978-1-84726-105-2
ISBN-10: 1-84726-105-1

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

Introduction

Harmondsworth is the largest immigration removal centre (IRC), holding around 500 men. Around 2,000 people each month pass through its reception area, at all hours of the day and night. Most will spend only a short time there; though some can spend months or even years there. Over recent years, the centre has experienced a major disturbance, and an apparently self-inflicted death.

It is therefore of considerable concern that this inspection found an establishment that was not performing sufficiently well against any of our tests of a healthy custodial environment. At the heart of the centre's problems were the relationships between custody officers and detainees, together with an over-emphasis on physical security – which was more appropriate to a high security prison than a removal centre run under rules that require 'secure and humane detention under a relaxed regime'.

Over 60% of detainees said they had felt unsafe at Harmondsworth. This was much higher than the comparator for other centres. More worryingly, the main fear was of bullying by staff: 44% of detainees (compared to 28% in other IRCs) said they had been victimised by staff. In structured interviews, five of the 10 most common concerns about safety related directly to staff behaviour. Detainees described custody officers as 'aggressive', 'intimidating', 'rude' and 'unhelpful', especially to those without English – though they found senior officers better, and were extremely complimentary about education staff. Some staff also expressed concerns to us about language and behaviour they had witnessed from colleagues. We ourselves saw relationships that were often distant, and evidence of a lack of care or understanding of detainees' situations and anxieties.

We attributed these poor relationships, which were worse than any we have seen elsewhere, at least in part to the centre management's over-emphasis on physical security and control. Many of the rules and systems would have been considered over-controlling in a prison, let alone a removal centre. Detainees were unable to have basic possessions, such as tins, jars, leads for audio equipment and nail clippers. Their movements were strictly controlled. Use of force was high, as was the use of temporary confinement in segregated conditions – sometimes as a response to poor behaviour rather than for reasons of security or safety as specified in the Detention Centre Rules. The incentives scheme operated rather as a punishment system, sometimes depriving detainees of basic entitlements, such as the ability to attend religious services.

By contrast, the systems that should exist to support detainees were underdeveloped. Suicide and self-harm work was weak, in spite of the efforts of a good and committed coordinator. Reviews did not involve healthcare, support plans were poor, and night staff had limited access to ligature cutters. Most worryingly, a so-called action plan, to deal with problems identified by the inquiry into the recent self-inflicted death, had been shared with neither the suicide prevention team nor the staff in the centre. It was a purely bureaucratic exercise which had had no impact on the centre's practices. Equally, the complaints system was distrusted and ineffective. It was not sufficiently confidential and tracking systems were ineffective. This was of particular concern as a third of complaints were about staff, and some that raised serious allegations had not been investigated properly.

There were, of course, pockets of good practice in the centre. Some staff, and particularly the senior custody officers, were interacting well with detainees. The work of the chaplaincy team and the education department was extremely good, and greatly valued by detainees. Unfortunately, those staff felt much less valued by the centre's managers. Some healthcare

provision was also good, though there was an over-reliance on GPs, and insufficient nursing and particularly mental health support.

This is undoubtedly the poorest report we have issued on an IRC. Harmondsworth is not an easy place to run, and the serious disturbance it had experienced had clearly affected the confidence of managers and staff. However, it had been allowed to slip into a culture and approach which was wholly at odds with its stated purpose, and inimical to the proper care and treatment of detainees. This is not primarily the fault of staff, some of whom were trying, without adequate support, to do a good job. It is essentially a problem of management, and it is of some concern that this had not been fully identified and resolved earlier by the contractor and the Immigration and Nationality Directorate.

Anne Owers September 2006
HM Chief Inspector of Prisons

Fact page

Task of the establishment
To hold immigration detainees, including asylum seekers, whose applications are being considered under fast-track procedures.

Location
Longford, West Drayton

Contractor
UKDS (United Kingdom Detention Service)

Escort provider
Global Solutions Ltd

Number held
17 July 2006: 481

Operational capacity
501

Last inspection
14–17 February 2005

Brief history
Harmondsworth opened in September 2001 and closed in mid-2004 following a disturbance that followed the death of a detainee. It reopened in October 2004. Extensive building work has been undertaken since 2003, including the installation of a sprinkler system following the fire at Yarl's Wood immigration removal centre (IRC). Originally holding families as well as single men and women, at the time of inspection Harmondsworth held single male adults only.

Description of residential units
Accommodation is made up of two, three and four-bedded rooms. There are another 20 secure single rooms to hold detainees removed from normal location in accordance with Detention Centre Rule 40 (removal from association), and six for detainees confined under rule 42 (temporary confinement).

Healthy establishment summary

Introduction

HE.1 The concept of a healthy prison was introduced in our thematic review *Suicide is Everyone's Concern* (1999). The healthy prison criteria have been modified to fit the inspection of removal centres. The criteria for removal centres are:

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

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

Activities – detainees are able to be purposefully occupied while they are in detention

Preparation for release – detainees are able to keep in contact with the outside world and are prepared for their release, transfer or removal.

HE.2 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 (IRCs). Rule 3 sets out the purpose of centres as being to provide for the secure but humane accommodation of detainees:

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

HE.3 The statutory instrument also states that due recognition will be given at IRCs to the need for awareness of:

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

Safety

HE.4 The reception was busy and unwelcoming. First night procedures were basic and many detainees felt unsafe on their first night. Suicide and self-harm procedures needed improvement, including learning from previous incidents. There was little indication of bullying among detainees and anti-bullying procedures were satisfactory. However, many detainees felt victimised by staff. Use of force was high but well documented. Temporary confinement and loss of association did not always appear properly justified. Detainees needed better access to legal advice and more information about progress with their immigration cases. The centre was not performing sufficiently well against this healthy establishment test.

HE.5 The reception was open constantly and dealt with approximately 2,000 movements in and out of the centre each month. Detainees no longer had to wait on vans in queues. However, the quality of information that arrived with them, including those who came from prisons, continued to be poor and this made initial risk assessment difficult. Many detainees were negative about their reception experience. Few received a free telephone call on arrival, and in our survey only 30%, against a comparator[1] of 57% for IRCs, said that they were treated well there. Many said that some staff had a disrespectful attitude. During property checks, some legal documents were confiscated arbitrarily and inappropriately.

HE.6 At the time of the inspection the removal centre was full, as it had been for some months, and there was little opportunity for staff to make a thorough assessment of individual detainees before they were allocated their accommodation. New arrivals were not allocated to any designated area of the centre, although there were plans to change this. First night procedures comprised basic checks on the wings and were difficult for detainees without good English. In our survey only 39%, compared with 51% in other IRCs, said they had felt safe on their first night.

HE.7 The induction arrangements were fragmented and inadequate. A video was shown in reception, which some detainees found useful, but an information booklet was no longer distributed as it was out of date. Induction staff had to track down new arrivals on the wings and give them a brief outline of essential rules. Although the staff had the appropriate skills, the resources were too limited for the task.

HE.8 The action plan produced in response to the report of an inquiry into an apparent self-inflicted death appeared to be simply a bureaucratic response, as it had not been discussed with suicide prevention staff. Centre staff were unaware of its contents and could not therefore learn any lessons. There were regular reviews of detainees identified as at risk of self-harm, but these were not always multidisciplinary, made little use of appropriate interpreters and support plans were often unspecific. Monitoring of those at risk was too predictable and there was an emphasis on recording observations rather than interactions. Staff access to ligature cutters was too restricted. The suicide prevention liaison officer made good monthly reports that identified some of these problems, but little action had been taken. We were concerned that a plan for four senior detainee custody officers (DCOs) to share this

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

work would dilute responsibility for it. The suicide prevention meetings did not examine individual cases and had no detainee or external agency representation. There was no free Samaritans telephone or peer support. Although food refusal was monitored, any resulting action was unclear.

HE.9 There was little evidence that bullying between detainees was a significant problem, although there had been a rise in the number of assaults. In our survey significantly more detainees than the comparator said that they had felt unsafe in the centre, and that it was staff who were the bullies – 44% compared to 28% in other IRCs said they had been victimised by staff. There was a clear anti-bullying policy for detainees and generally good monitoring of alleged bullies and their victims. However, some documentation was in poor order and there was little positive support for victims.

HE.10 Staff were well trained in control and restraint (C&R), although use of force appeared high compared to other centres. Documentation was completed well, with full accounts of incidents. Temporary confinement under rule 42 of the Detention Centre Rules had been authorised 129 times since January 2006, a quarter for more than 24 hours. All those confined were routinely strip-searched. The regime was very basic and not satisfactory for those who had self-harmed and needed support. Removal from association under rule 40 was also used extensively and had been authorised 440 times in 2006. Requests for temporary confinement and removal from association did not always give the full circumstances and background. Some of the removals from association appeared to be a response to poor behaviour rather than for the security or safety reasons specified by the rules. Those held under rule 40 could normally associate with others in the unit but there was little to do. Rooms were well equipped but those on the standard level did not have telephones to receive incoming calls.

HE.11 Detainees on the fast-track asylum processing scheme received some legal advice, and there was a pilot scheme by the Legal Services Commission to provide legal advice surgeries. However, these sessions were available to relatively few and many continued to have insufficient access to good quality specialist advice. Recent initiatives to identify foreign national ex-prisoners, where there was doubt about whether they had been considered for deportation, had increased the need to improve legal advice services.

HE.12 Although casework had become more complex, the on-site immigration team had been reformed and now comprised mainly administrative workers with a loss of the expertise of experienced immigration officers. In one case a detainee's grant of bail had been held up by delays in conveying the decision by Immigration and Nationality Directorate (IND) caseworkers and a lack of understanding by the on-site team. The contract monitor and her team spent much time chasing responsible caseworkers from external immigration teams, and many detainees complained of ignorance and confusion about the reasons for their detention and the progress of their case. This caused substantial distress. The IND documentation we examined indicated poor monitoring and explanation of case progress.

Respect

HE.13 Living conditions were clean but basic. Relationships between detainees and custodial officers were very poor. Meals and the range of goods in the shop did not properly acknowledge detainees' needs and preferences. Systems to promote diversity were underdeveloped. Faith provision was reasonable but detainees on the standard regime could not attend communal worship. Complaints procedures were poor and some serious allegations against staff were not fully investigated. Rules and security procedures were unnecessarily restrictive. The incentives and earned privileges (IEP) system was based on sanctions rather than rewards. Healthcare was generally satisfactory, except that there was little provision to meet mental health needs. The centre was performing poorly against this healthy establishment test.

HE.14 Residential units and individual rooms were clean but institutional. There were no formal compatibility assessments for sharing rooms and detainees said it was difficult to change to take account of preferences. Rooms had telephones for incoming calls but not all detainees had keys to their rooms. Rooms were very hot at night. Exercise yards were open all day until late but association facilities on the living units were poor. There were too many unnecessary restrictions on the possessions that detainees were allowed. Access to showers and toilets was good but many were poorly ventilated. Some were out of order and we were told this was because a refurbishment programme was underway, though we did not see any work being done during the week of inspection. There was little information displayed on wings and most of this was in English only.

HE.15 Detainees had poor perceptions of staff at Harmondsworth. In our survey only 37% said that most staff treated them with respect, against a comparator of 73%, and only 31% said there was a member of staff they could turn to for help with a problem, compared to 62%. Although we observed some good staff–detainee interactions, DCOs were mostly distant from detainees, which reflected a culture of procedural rather than dynamic security. Staff often used surnames alone when they addressed detainees, and both staff and detainees gave us many examples of disrespectful language used to and about detainees. We were told that DCOs treated men who did not speak English particularly badly. Detainees were more positive about their relationships with senior DCOs, and very positive about education staff.

HE.16 Detainees were dissatisfied with the quality and variety of the food. In our survey only 23% said the food was good or very good, against a comparator of 36%, and 55% said it was bad or very bad. There were poor arrangements to consult detainees and involve them in the provision of culturally appropriate food. In a recent small survey by the cultural and religious affairs liaison officer (CRALO), 56% of respondents said the quality of food was poor but no action had been taken as a result. Meal times were reasonable and the dining halls were clean, although small. There was a limited range of goods in the shop, and a lack of culturally appropriate items. In our survey only 20% said the shop sold a wide enough range of goods, against a comparator of 46%.

HE.17 There was a recently published diversity policy with an emphasis on race and culture and some reference to disability and sexual orientation. There had been some improvements in displaying information in a range of languages, and promotion of

cultural events continued to be good. There was little use of the telephone translation service, and an over-reliance on staff to interpret. The CRALO was active and provided good informal support. However, there was little strategic oversight of diversity issues, and informal systems were weak and lacked monitoring by race or nationality. The complaints system was little used and the procedures inhibited detainees from reporting racist incidents. Records of investigations lacked detail. Detainees were not represented on the race relations management team, which also did not involve external community organisations.

HE.18 Faith facilities were good with four separate areas to cater for different religious groups. Many detainees attended religious services, but there were unacceptable blanket restrictions on communal worship for those on standard regime. This appeared to breach the centre's contractual responsibilities. We had some concerns that the world faith manager had been discouraged from carrying out his pastoral role after inappropriate intervention from external IND officers. The respective relationships and responsibilities of the world faith team needed to be better integrated and supported.

HE.19 Detainees had to request application and complaint forms from staff, who often completed them on their behalf. In our survey only 15% of respondents, against the comparator of 41%, said it was easy or very easy to get a complaint form. Only 45 of the 155 complaint forms issued since January 2006 had been returned and there was no way of tracking them, which left opportunity for abuse. A third of all complaints were about staff. Although replies were prompt, some were not addressed directly to the complainant and some had not been properly investigated, including those that raised serious allegations against staff. Few detainees were aware of how to contact the Independent Monitoring Board (IMB).

HE.20 Harmondsworth imposed some restrictions that were inconsistent with the purpose of a removal centre and not necessary to maintain a safe and secure environment. Detainees complained to us about petty rules about prohibited items, restrictive movement requirements, and ad hoc and arbitrary restrictions applied inconsistently by staff.

HE.21 The security department operated well with some good systems but residential staff put a disproportionate emphasis on security, which had a negative effect on detainees. Detainees escorted to hospital were routinely handcuffed. Public protection systems were underdeveloped.

HE.22 The IRC-detainee compact was not provided in translation and was not explained at induction. The scheme operated as a sanction rather than an effective rewards system. Some incentives for detainees on enhanced status, such as unrestricted visits, education and communal worship, should not have been treated as privileges.

HE.23 A good multi-language healthcare assessment tool was used for new arrivals. A reasonable range of visiting health professionals provided specialist services, and detainees had swift and easy access to a GP seven days a week. In contrast, there was an underprovision of nurses and of mental health services. There was limited health promotion and other information in foreign languages. Some healthcare staff spoke other languages, but there was very little use of the telephone translation service. The centre had good links with the primary care trust communicable disease nurse but no contact at a strategic level or links with external community mental

health teams. Healthcare staff had not received training in dealing with victims of torture, and received little feedback from IND on identified cases.

Activities

HE.24 The education provision offered some good opportunities, but for only a minority of detainees, and access arrangements were too inflexible and inefficient. There continued to be no work opportunities for detainees and there were insufficient activities to occupy them. Library access was limited. Physical education (PE) provided important and welcome activity but some of the facilities were too cramped. The centre was not performing sufficiently well against this healthy establishment test.

HE.25 Education, library and other activities took place in a dedicated area, which could occupy up to 120 detainees. However, detainees had to attend a whole session of over three hours, which was too inflexible and was inefficient. Participation varied considerably. Although it was good in the afternoon and some evenings, with up to 100 attending, it was much lower in the mornings. There were no educational opportunities for detainees in the healthcare centre or those removed from association. Detainees said that the education classes were good respite from concern about their situation. They contrasted the good relationships with education staff with their poorer experiences of officers on the units. Education staff felt the importance of their role in the centre was undervalued.

HE.26 Detainees' engagement in learning was good in all classes, and there was effective use of competitions to motivate and provide incentives. They received good individual attention from teachers, who had appropriate interpersonal skills and subject expertise. Provision was good in art and craft classes, and satisfactory in English for speakers of other languages (ESOL) and information technology. The games room in education had a good range of facilities but was noisy and too cramped. Formal arrangements to improve the quality of education were weak, and there was little monitoring of participation to help planning. Promotion of education provision to detainees was poor, with an absence of interpreters and written information in languages other than English.

HE.27 Paid or voluntary work was still not permitted in the centre. This severely limited activities for detainees and opportunities to occupy their time. A provision to exempt detainees from the national minimum wage had been included in recent legislation but had yet to come into force.

HE.28 Access to the library was inflexible and limited to detainees prepared to spend long sessions in the education area. It was not possible for detainees to make a quick visit to look up information or change books. The stock was good but there was no direct internet access for the librarian or detainees.

HE.29 Detainees had satisfactory access to PE but only 15% in our survey, compared with 30% in other IRCs, said they could get to the gym three or more times a week. There were enthusiastic staff who made good efforts to provide a range of team sports and activities. The sports hall was adequate but facilities for outdoor activity were very cramped, as was the gymnasium.

Preparation for release

HE.30 Clear signage to the centre was still needed for social and other visitors. Detainees had reasonable opportunities for visits but identity checks for visitors were too restrictive. There was good access to telephones but no email or internet access. There was only limited welfare work to support and help detainees on release. The centre was not performing sufficiently well against this healthy establishment test.

HE.31 The centre continued to lack clear signposting and was difficult to find. This problem had been identified in a death in custody investigation at the neighbouring IRC and at our previous inspection. Not only was this inconvenient for visitors, it was critical for emergency services. During our inspection an ambulance inadvertently went to the neighbouring IRC, as Harmondsworth is not signposted. Identification checks for visitors were restrictive and inflexible, and too many were turned away as a result. The visits area was clean but unwelcoming, with few posters or artwork and no system for visitors' feedback. Although more respondents to our survey than the IRC comparator said they could get a visit, significantly more also said they and their visitors were treated badly by visits staff.

HE.32 Detainees were positive about their access to telephones and mail services, and responses to our survey in these areas were generally significantly better than other IRCs. However, the inability to receive calls in the education area was a disincentive to attendance there, although a telephone was being installed to address this. There was still no email or internet access for detainees. Detainees could fax legal correspondence through the information centre. This was a useful and well-used resource but there were unnecessarily rigid limits on the number of pages that could be faxed at a time.

HE.33 There were no formal arrangements for welfare work to help detainees keep in touch with their families in the UK or abroad and prepare for release. There was some limited work by the CRALO, administrative staff in the information centre and world faith staff, but this was a key gap in service provision. The level of outside support was limited and was primarily delivered through the voluntary London Detainee Support Group. There was considerable scope to extend the range of services provided through stakeholder networking.

HE.34 Almost 60% of the centre's detainees went on to be removed from the country. The procedures were audit-driven, with an emphasis on ensuring men left quickly and quietly, but there were no formal systems to help detainees prepare for release. The few detainees granted temporary release were given a taxi to the nearest tube station and a travel warrant, but there was no systematic provision of financial assistance for those released without any means and many detainees had very little cash. Just over a quarter of detainees left Harmondsworth to transfer to other IRCs, but they were given little information to explain the move.

Main recommendations

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

HE.36 The centre should monitor notifications issued under rule 35 of the Detention Centre Rules, including allegations of torture, following transmission to the IND case holder. IND should review the case and respond promptly.

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

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

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

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

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

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

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

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

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

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

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

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

Section 1: Arrival in detention

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

1.1 Detainees reported a negative experience of arrival at Harmondsworth. In our survey less than a third felt well treated by reception staff, less than a fifth had been offered a free reception telephone call, and only 39% felt safe on their first night, all of which were well below the IRC comparator[2]. Information provided to detainees was poor and inconsistent. Reception staff followed unpublished instructions and sometimes inappropriately withheld detainees' documents, including those relevant to their legal proceedings.

Escort vans and transfers

1.2 Detainees said they were generally treated well by escorts. Group 4 Securicor (G4S) was the main escort provider contracted by the Immigration and Nationality Directorate (IND). Some who had arrived from the North of England said that they had stopped on the way, usually at Campsfield House in Oxfordshire, for a comfort break. Detainees often did not know why they were transferred and whether this meant anything for the progress of their case. Some detainees had had an initial uncomfortable period in a police station awaiting transfer to an immigration removal centre (IRC), with no access to immigration staff. A detainee who spent three days in a London police station said he was not allowed a free telephone call and no immigration officer arrived to deal with his queries. He persuaded the police doctor to contact his brother, who then took steps to find a solicitor. His IS91 detention authority form did not record his stay in police custody.

1.3 We saw some vans that were to take detainees to their consulates in London for interview to obtain a travel document. Not all detainees cooperated with this process. Escort staff said that they normally escorted the detainee into the consulate, and an immigration officer was also usually present. However, they could not understand any exchanges between the detainee and consular staff in their own language, and were unaware of any written protocol defining their powers or responsibilities inside diplomatic offices of foreign countries.

1.4 If a detainee reported ill treatment by escort staff, reception healthcare staff recorded this and noted and photographed any marks, and IND was informed. If the detainee wished to complain, police were informed. We were told that such complaints were rare and we found only one such complaint four months previously. The outcome was not recorded as the detainee had moved on.

Reception

1.5 In a significant improvement since the last inspection, escort vehicles no longer queued routinely to enter the centre. However, reception staff continued to work under pressure. The centre received people 24 hours a day, seven days a week, and handled 2,000 movements a month. Its target was to receive escort vehicles within 15 minutes of arrival and to process new

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

arrivals within two hours. This pressure may have been a factor in detainees' poor experience of reception. In our survey only 30% of respondents said they were treated well or very well in reception, significantly worse than the IRC comparator of 57%. Only 47% thought the initial search was conducted in a sensitive way, against a comparator of 64%. Detainee ratings were also low in most other responses about reception.

1.6 Some detainees complained that their documents, including legal documents, were taken from them unreasonably. The prohibited items list displayed said only that detainees could not keep passports and identity documents. We checked the papers taken from one young man returning from court and found law reports relevant to his case. Reception staff explained that they had been told to retain any documents that might be of interest to IND or that might be subversive, but they had no written policy explaining the scope or justification for this.

1.7 The holding rooms and reception area were clean. Information was displayed on the walls and available in a short leaflet. A video about the centre was shown to waiting detainees. Many found this useful. However, the *Rough Guide to Harmondsworth*, which described life in general at the IRC in more than 20 languages, was not given out routinely as it was out of date. We were told there were plans to revise and republish it.

1.8 Drinks and hot food were available. A clean, well-equipped shower and bathroom and basic fresh clothing were available to those in need, particularly those held initially in a police station without a change of clothes or shower. Soap and other toiletries were given to new arrivals, but they were not allowed to keep any opened toothpaste or toiletries they had brought with them.

1.9 Arrangements for free telephone calls on arrival were unclear, and staff had differing views about who got one. Detainees generally only had a free call if they arrived without money, or with less than £1. The free call consisted of a staff member telephoning the number given and leaving the IRC number for the recipient to telephone the detainee, rather than new arrivals being given a free telephone call to let family, friends and legal advisers know where they were. In our survey only 18% of respondents said they had a free telephone call on arrival, significantly below the IRC comparator of 59%.

1.10 The documentation that arrived with detainees was often uninformative, with little to help staff place them safely in shared rooms. While this lack of information was understandable for those who had only recently come to the attention of the authorities, it was also the case for those who previously served a prison sentence, who made up more than 20% of the population. Some had been released and were complying with licence conditions but were detained when they had reported as required. As the centre was full, there was limited scope to allocate new arrivals according to risk or preference. When a risk was perceived, detainees were placed initially in one of the single rooms designated for removal from association (see paragraph 8.12). Reception staff were aware of the need to keep a close eye on any detainee subject to present or recent self-harm monitoring. These detainees were likely to be sent to the healthcare department.

1.11 Healthcare staff were on duty around the clock and saw all detainees as they arrived. They had useful multilingual questionnaires, but use of a telephone interpreting service at any stage of reception was rare. There were not enough immigration staff to see all new arrivals.

1.12 Detainees who arrived with money were discouraged from keeping more than £50 to spend in the centre shop. From their day of arrival, detainees had an allowance of 86p a day (£6.02 a week) paid into their accounts. A reduced rate of 57p a day (£3.99 a week) was paid to those on standard regime.

First night

1.13 In our survey only 39% said they felt safe on their first night, against the IRC comparator of 51%.

1.14 There was a system to identify new arrivals to custody officers on change of shift. Names were listed in the unit book and any issues were discussed during shift handover. We saw some staff who made an effort to help new arrivals. However, this was not easy if the detainee had little English and no one was available to translate as detainee custody officers (DCOs) worked their way through a checklist of information about facilities and the regime. As detainees could move freely within their units, DCOs could not always find new arrivals to check if they were all right.

1.15 Two half-time, non-uniformed staff shared the induction post. They spent much of their time explaining the basics which should have been covered on the first day. This was not surprising given that the *Rough Guide* induction booklet was no longer routinely issued, and the limited ability of DCOs to explain regime information to non-English speakers. The induction staff had relevant experience, interest and commitment but had virtually no resources and no room available to them. They received the daily list of arrivals – one described a Monday morning list of up to 98 new arrivals over the weekend. They then had to track down the new detainees on the units and give them one-to-one explanation, often in a busy corridor where they were interrupted by other detainees who recognised them as amenable sources of advice. The induction staff had got a few paragraphs of essential information translated into a few languages, and had identified some bilingual detainees able and willing to help, if they could be found. But they said it was difficult to provide information, for example about education activities, when detainees were ignorant about their more basic needs.

1.16 There were plans to place all new arrivals on one wing and to restrict movement in the middle of the night.

Recommendations

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

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

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

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

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

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

Section 2: Environment and relationships

Residential units

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

2.1 The residential units were clean, but looked very institutional. Detainees' rooms were also mainly clean, but spartan, and there was no real opportunity for them to personalise them. Association facilities were poor. Detainees had good access to showers, toilets and laundry facilities, although some equipment was broken.

Accommodation and facilities

2.2 There were four main residential units on three levels linked by a central corridor. The units were clean, but very institutional. Landings and corridors were painted the same colour and looked identical. Cleaning was carried out by a contract cleaning company and communal areas were kept clean. Outside areas were also clean and free of litter.

2.3 Most detainees shared rooms, to which most had their own key. Some detainees had to share keys with roommates because they had been lost by previous residents and not replaced. There were no formal risk or compatibility assessments, although we were told that staff tried to match up roommates as best they could. Room swapping was generally discouraged, but allowed in exceptional circumstances.

2.4 Detainees' room windows did not open and there were many complaints about the high temperature, particularly at night. During a night visit we found some rooms, including staff offices, that were exceptionally hot, which was an uncomfortable living and working environment. Most rooms were clean and tidy but very impersonal. Detainees were not allowed to display any pictures or photos or personalise their rooms with items such as duvet covers and curtains. We were told that some notice boards had been bought but had not been fitted. Detainees had telephones for incoming calls in their rooms. This facility was not available for those on standard regime or in the secure units, who also did not have keys to their rooms. Movement around the site was restricted and detainees were not allowed to associate on wings or exercise yards other than their own.

2.5 Some information was displayed on notice boards on the units but this was not very comprehensive and mainly in English only. There were some quiet rooms, which contained some information, although these were also spartan and unwelcoming.

2.6 Association facilities were poor. There were four exercise yards, which were open during the day, but no unit provision apart from board games or cards. There were TV rooms on the landings but these were poorly designed, lacked proper seating and were very bare and shabby. An association room in the education department was better equipped and had pool tables. This was well used, but was the sole such facility in the establishment.

Clothing and possessions

2.7 Detainees wore their own clothes. If they did not have two full sets of clothes they qualified for a 'destitution' allowance. There were laundries on every unit to which detainees had good access. Some had broken equipment, which needed repair. Despite these arrangements, which seemed reasonable, only 30% of respondents to our survey, against an IRC comparator of 64%, said they could get enough clean, suitable clothing.

2.8 The volume of possessions held by detainees was very low. There was no list of items that they could have in possession in their rooms, although a draft one was in preparation at the time of the inspection. However, there was a 'banned items' list. This included items such as nail clippers and leads for audio equipment, which was excessively restrictive and disproportionate to any risk. Detainees were also not permitted to bring in unsealed toiletries from other establishments. This policy was more restrictive than that adopted by most prisons, and inappropriate for a detention centre.

Hygiene

2.9 There were showers and toilets on every residential landing, and detainees had free access to them. Most were reasonably clean, although some shower curtains were dirty and needed replacing. Ventilation in the showers was poor and some were consequently very damp and smelly. Some showers and toilets were out of order and needed replacement or repair. Managers were aware of these issues and were in the process of refurbishing the showers at the time of the inspection.

Recommendations

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

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

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

2.13 There should be more association facilities, including on living units.

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

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

Housekeeping points

2.16 Detainees should be allowed to personalise their rooms and display photographs.

2.17 Detainees should be allowed to bring in toiletries bought in other establishments.

2.18 All detainees should have their own room keys.

2.19 Notice boards should be fitted in detainees' rooms.

Staff-detainee relationships

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

2.20 Most detainees felt the majority of staff did not treat them with respect. We received reports of rude or dismissive language from staff, and observed distant relationships and a lack of engagement by detainee custody officers (DCOs) in particular.

2.21 In our survey only 37% of detainees said that most staff treated them with respect, against an IRC comparator of 73%. Similarly, only 31% said there was a member of staff they could turn to for help if they had a problem, against a comparator of 62%. Staff were often required to work in different units, and told us that it was difficult for them to develop knowledge of and relationships with the detainees for whom they were responsible.

2.22 We observed DCOs who were mainly distanced from detainees, and saw little positive interaction. Senior officers and centre managers engaged more with detainees, but had not effectively communicated the need for more involved and respectful relationships to most officers. Poor staff–detainee relationships appeared to contribute to and result from a pervasive culture, of procedural security emphasising surveillance and monitoring from a distance. The importance of dynamic security, which acknowledges the crucial contribution of positive interactions and relationships between staff and detainees to safe and secure custodial communities, had been neglected.

2.23 Staff routinely used surnames alone when they addressed detainees, and we observed staff who entered detainees' rooms without knocking. We were given many examples – by staff as well as detainees – of rude language used to residents, and were told that people who spoke little English were treated particularly badly. Some reported that they were treated 'like animals'. One detainee commented: 'No manners, talk to you like shit. Red badges [senior officers] are okay, everyone else is really bad. Treat you like you are nobody. They have a stinking attitude.'

2.24 Significantly more detainees than the comparator for the IRC estate said that they had experienced victimisation by staff (see paragraph 5.3), and there was evidence that serious allegations of staff mistreatment were not being followed up. One detainee complained of 'Excessive force used, intimidating behaviour with 3-4 guys marching up the corridors', while another stated that 'The first thing they say to you when you come in here is don't mess about or we'll make life difficult for you here.'

Recommendations

2.25 Staff should not address detainees by surnames alone.

2.26 Staff should not enter detainees' rooms without knocking.

Section 3: Legal rights

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

3.1 Although there had been some improvement in access to legal advice at Harmondsworth, many detainees complained of a lack of understanding of their legal position. There was inadequate independent legal advice and limited access to the immigration team, which had lost experienced staff.

3.2 Many detainees were confused about their immigration status, especially those who felt most at home in the UK, had lived here since childhood and had established family and social networks. Some had been transferred to detention at the end of a prison sentence while others had been suddenly detained after release. They felt that the basis for their detention, and what was likely to follow, had not been properly explained to them. Their nationality and immigration status were sometimes uncertain, not least to them, and detention restricted their ability to investigate these issues. It was not just the detainees who were confused.

3.3 Detainees who needed explanation could not always get this from on-site immigration staff because of recent changes in staffing and role (see paragraph 4.2). Detainees were not seen routinely on their arrival and had to send any inquiry by written application.

3.4 A common problem for detainees was how to get advice from a specialist immigration solicitor. The library had lists of specialist solicitors provided by the Immigration Law Practitioners' Association. Detainees and staff said that solicitors often failed to respond to numerous faxed requests for help because they were not able to take on new cases. Some detainees said that relatives had paid significant amounts for legal help, even though most appeared to be eligible for means-tested legal aid.

3.5 For the minority of detainees subject to fast-track asylum processing, duty solicitors were allocated by rota and funded by the Legal Services Commission, subject to legal aid criteria. The asylum application refusal rate was 98%, and many duty solicitors withdrew at this stage. Just over half of detainees had had legal representation for their appeal in the previous three months. The Legal Services Commission had taken steps to address the advice shortfall by setting up a legal advice surgery. This provided ten half-hour slots on two days a week, for which detainees put their name on a list in the library. The list was generally full, with a one-week wait at the time of our inspection. This scheme was welcome, but had yet to be evaluated.

3.6 We were concerned about the lack of help with bail. A detainee who had just returned from an unsuccessful bail hearing, at which he was unrepresented, showed us the document given to him by the court following refusal which said: 'Served with ICD 0350 notice of asylum claim to be refused under S.72 and given 28 days to 14/7 for rebuttal of notice.' He had no idea what it meant and neither did we.

3.7 Centre staff faxed detainees' letters to solicitors and other legal documents without charge, but these were limited to ten pages. If their documents had more pages, they had to return the next day to fax another ten. We queried this interference with legal correspondence, and the restriction was removed during the inspection.

3.8 Legal visits were available on mornings, afternoons and evenings seven days a week. Detainees generally had no problems accessing telephones, although they had no direct internet or email access.

3.9 The library had a reasonable legal reference section, including current textbooks on immigration law and procedure. Home Office and Amnesty International country information was held but, because staff had limited access to an internet terminal, it was not easy for detainees to obtain other background material. Library staff kept a stock of photocopied bail application forms and guidance from Bail for Immigration Detainees.

3.10 Following guidance revised by IND in early 2006, removal directions were issued to detainees at least 48 hours before implementation. (See main recommendation HE.45)

Section 4: Casework

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

4.1 The increasing complexity and lengthening stay of Harmondsworth's population were not reflected in diligent communication and review by external Immigration and Nationality Directorate (IND) case holders. The IND contract monitor, who had a largely inexperienced staff, continually had to prompt case holders to review detainees' cases.

4.2 As in other IRCs, the on-site immigration team was being reformed. Experienced immigration officers had been replaced by basic administrative grade staff. Instead of direct involvement in casework, the role of immigration staff inside IRCs was to be that of messenger between detainees in the centre and the external IND case holding offices responsible for their case. This meant that the team leader, in addition to her other tasks as contract monitor, was training and supervising eight recently recruited administrative officers, most with little experience of immigration law and process.

4.3 At the same time, the on-site team still had to monitor and prompt case progress, as there were many examples where external IND case holders had failed to pursue detainee casework vigilantly. In one case during the inspection, a detainee's surety telephoned to query why he had not been released following a successful bail application. In fact the detainee was not released until four days after the grant of bail. No one had sent the centre a copy of the court order, and the IND case holder appeared to be unaware of the situation. It was left to the centre's inexperienced immigration staff to deal with the case, and they were initially out of their depth.

4.4 The on-site immigration staff seemed to be more alert to the need for diligent review than the external case holders. We saw some files where monthly reviews were missing, or which were identical despite changes in circumstances which should have been addressed, or where nothing had happened until prompted by the Harmondsworth team. In one case a detainee had been held for 19 months, following a short sentence for possession of drugs. He had no apparent prospect of imminent release since his consulate was not prepared to issue a travel document. His file recorded that he was literally banging his head on the wall. His documented history of psychiatric problems and self-harm, including a medical report, were not addressed in the detention reviews, and these were issued only erratically.

4.5 Given the number of incidents of poor case management that we found, we were concerned about the ability or leverage of inexperienced administrative officers on site to respond to the circumstances of detainees over time.

4.6 Although the on-site team was not yet able to see all detainees, it had displayed team staff names and photos around the centre to encourage understanding of their role and contact. This enabled detainees to approach them as they walked about the centre. Their advice to detainees included how to make a bail application.

4.7 The needs of the population detained at Harmondsworth had become more complex, partly because of the recent intake of foreign nationals who had served a custodial sentence at some stage. This included longstanding UK residents, some who had lived in the UK since childhood, whose nationality and immigration status were not always clear. They were

detained while their immigration history remained to be clarified, rather than following such clarification. As any decision to deport would be subject to appeal rights, removal was not imminent.

4.8 The recent intake also included European Union citizens detained following a custodial sentence. These included a young Irishman who had lived in the UK for many years, with a partner and child. He had been detained for two months following a short custodial sentence, despite some health problems and a history of self-harm. It was not clear that full consideration had been given in these cases to the requirements of European Union law.

4.9 At our previous inspection the longest period in detention had been five months. During this inspection we found a detainee who had been held for two years, and 22 had been detained for more than six months just in Harmondsworth. No information was available for 2005 or 2006 about average duration of detention. Harmondsworth records showed duration of stay at the centre, but this was not always the first place of detention. Managers said the average duration of stay had risen from about two weeks to six weeks.

4.10 A minority of the population were held for fast-track processing. Harmondsworth had a separate immigration team dedicated to interviewing and determining asylum applications, with any appeal heard at the on-site hearing centre. Not all could be removed at the end of the determination process, as some awaited travel documents. After three or four weeks the fast-track team was likely to pass the case to another IND office, the management of detained cases unit. The fast-track detainees had reduced to about a fifth of the population, and had been replaced by some foreign national former prisoners whose cases would take much longer to resolve.

4.11 In the previous three months, of those leaving the centre, 57% had removal directions, 28% were transferred to another place of detention, 10% were granted temporary admission or release subject to conditions, and 5% were released on bail.

Section 5: Duty of care

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

5.1 There was little indication of significant bullying among detainees. The reported level of bullying by staff was much higher than in other centres. Significantly more detainees than elsewhere said they felt unsafe, and said that 'staff behaviour' and 'aggressive body language' were prominent reasons for this. Suicide and self-harm procedures needed improvement. The centre's response to a recent investigation into a self-inflicted death had been inadequate and there was no evidence of effective food refusal procedures.

Bullying

5.2 In our survey about a third of detainees said they had been insulted or assaulted by other detainees, which was comparable with other IRCs. This finding was not supported by evidence from our group interviews or discussions with detainees, who suggested that bullying between detainees, was not significant. However, the centre's figures showed a rise in both detainee on detainee and detainee on staff assaults. Out of a total of 33 recorded assaults in 2005, 11 had been detainee on detainee, as were 22 of the 53 assaults recorded in the first six-and-a-half months of 2006. This required ongoing monitoring.

5.3 The level of victimisation by staff reported in our survey was much higher than in other centres – 44% compared to 28%. Structured interviews with detainees confirmed this finding. In our survey 61% said they felt unsafe in the centre, which was significantly higher than the IRC comparator of 49%. In-depth follow-up interviews with detainees about their perceptions of safety (see appendix IV) revealed that immigration cases and lack of information were the most common causes of such insecurities. However, 'staff behaviour', 'aggressive body language' and 'lack of trust in staff' were also prominent reasons.

5.4 There was a thorough and clear anti-bullying policy, although this was not based on a needs analysis or consultation with the detainee population. The policy focused on the need to monitor and support bullies and victims for the short periods they were expected to remain in the centre. Bullies were also managed through the incentives and earned privileges (IEP) scheme.

5.5 One anti-bullying log and a victim support log were open at the time of our inspection. Eighteen bullying incidents, involving 37 detainees, had been recorded in the first six months of 2006. Monitoring logs were opened on identified bullies and victims and were generally completed regularly while the detainees concerned remained at the centre. We sampled nine forms. In one the victim log had been mislaid by staff and was not completed at all in the five days it was open. There was also a lack of active support for victims. In one case, a victim revealed that he had not attended education to avoid being bullied. Staff accepted this and took no further action to help the victim attend education.

5.6 Four senior detainee custody officers (DCOs) were the anti-bullying coordinators and met weekly with a residence manager to review cases. Because they shared responsibility, it was not clear who took the lead for anti-bullying. Anti-bullying meetings took place monthly, but

attendance was poor, discussions were generally perfunctory, and detainee representatives were not invited.

5.7 Communication between the security department and the anti-bullying coordinators was good. We sampled some security information reports (SIRs) with an element of bullying, and incident report forms had been completed in every case.

5.8 There was a freephone anti-bullying line, and the number for this was widely advertised in the centre. However, the recorded message was not welcoming and did not explain any subsequent action or support available to victims. Very few messages had been left.

Self-harm and suicide

5.9 Four senior DCOs shared responsibility for suicide and self-harm prevention work, but one had lead responsibility and was the recognised suicide prevention liaison officer. She was due to leave her post and the work was to be divided up again between four senior DCOs. We had concerns that this would dilute responsibility for this work.

5.10 The suicide prevention committee met monthly. Meetings were well attended, although there was no detainee or outside agency representation. The centre had previously had some contact with the local Samaritans, but they had not attended any meetings during 2006.

5.11 The minutes of meetings did not indicate meaningful discussion of general issues or specific cases. Action points were not systematically followed up at subsequent meetings. Following an apparently self-inflicted death in the centre in January 2006, a draft investigation report by the Prisons and Probation Ombudsman had been received in April 2006. The acting director had drawn up an action plan to address this report, but had done this without the knowledge or involvement of the suicide prevention coordinator or the suicide prevention committee. None of the staff we spoke to were aware of the report or the action plan, and there was no evidence that learning points had been taken up or shared with staff. The action plan seemed to have been drawn up as a bureaucratic necessity rather than genuinely to improve the care of vulnerable detainees. This tragic incident appeared to have had no impact on practices in the centre.

5.12 The suicide prevention liaison officer presented monthly reports to the committee and, although these were thorough and outlined many important issues that needed attention, little effective further action was taken by managers. One example was that detainees were charged the standard call rate for what should have been a freephone number to the Samaritans. This issue had been raised in February 2006 but had still not been resolved by July.

5.13 The centre used the Prison Service F2052SH (self-harm monitoring) system for managing those at risk of self-harm, although the assessment, care in custody and teamwork (ACCT) approach was due to replace it. The centre had managed 326 open F2052SHs during the first six months of 2006. According to the log book, most had been opened in other centres and were closed within three days of detainees arriving at Harmondsworth. The remainder were normally closed within two weeks. There had been 44 incidents of self-harm during the same period. We were told that these relatively high numbers were because Harmondsworth had 24-hour healthcare and other centres saw it as a safe destination for vulnerable detainees.

5.14 There were three open F2052SH forms at the time of our inspection. The records indicated a heavy emphasis on monitoring alone rather than positive interaction between staff and

detainees. Monitoring was also at predictable times, usually at exactly the same minutes past the hour.

5.15 There were regular F2052SH reviews, usually by DCOs and senior officers. Most were not multi-agency. In a random sample of 21 forms, only three reviews had world faith representatives and only eight had healthcare representatives. This was partly because other departments were not routinely informed of reviews, which often took place at short notice. Support plans were generally unspecific about the action to be taken and by whom. When forms were closed, there was often a lack of information about why that decision had been reached, and in some cases no information at all. There was minimal use of interpreters and no professional interpreters were used at reviews. Detainees were used inappropriately to interpret for other detainees.

5.16 We used a telephone interpreting service to interview a detainee who spoke no English, had mental health problems and said he had been tortured in his home country. He had spent a period in hospital and had also refused food for four days. He said that he had been treated well by staff, who had asked another detainee to explain the centre regime to him. However, this person had apparently explained very little and did little to reduce his anxiety. The detainee had initially been frightened and distressed, which could have been alleviated with active staff attention and use of formal interpretation.

5.17 We were concerned to find during our night visit that only senior officers carried ligature knives. This meant that there would almost inevitably be delays in cutting down anyone who attempted to hang themselves. Furthermore, none of the DCOs we spoke to on the night visit knew that ligature shears were available in the suicide prevention kits provided in all offices.

5.18 Staff at the servery noted the names of any detainees who did not take lunch or dinner, but not those who failed to take breakfast. We were told that a log was opened on any identified food refusers, but no such logs could be found during the inspection, and there was no central record. Consequently there was no evidence of any further action taken following identification of food refusal, although healthcare staff were given clear procedures in the event of referrals.

5.19 There was annual suicide prevention refresher training for staff. The centre had recently run a distance learning exercise for staff on suicide and self-harm prevention, which had yet to be evaluated.

5.20 There was no buddy scheme in place and no evidence that this had been considered, although detainees had requested such a scheme in a detainee consultative meeting.

Health and safety

5.21 There was a dedicated fire, health and safety officer and a comprehensive health and safety policy. Fire risk assessments and nearly all health and safety risk assessments were up to date. Fire evacuation signs were displayed throughout the centre. Although these were available in 21 languages, they were displayed in only a few languages. Staff attended regular fire safety training and received annual refresher training.

Recommendations

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

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

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

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

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

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

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

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

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

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

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

5.33 Reviews for those at risk of self-harm should be multi-disciplinary and support plans should specify the action to be taken and by whom.

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

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

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

5.37 A buddy scheme should be set up.

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

Diversity

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

5.39 The diversity policy emphasised race and culture. Detainees received good informal support on race and cultural matters from the cultural and religious affairs liaison officer (CRALO). However, formal procedures were generally weak with a poor and underused complaints system. Record keeping was poor, there was no active involvement by relevant outside bodies, and there was very limited input from detainees. There was little use of professional interpreting services.

5.40 A diversity policy had recently been published. This was clearly written and outlined staff obligations under relevant legislation. The policy emphasised race and culture, although it also referred to disability and sexuality.

5.41 The CRALO had the lead responsibility for all race related matters. He was an experienced custody officer and spoke nine languages. The post was full-time and the CRALO was supported by four part-time assistants. He delivered training on race and cultural awareness to all new recruits. Training feedback forms suggested that new staff were challenged about their assumptions and made to think about race and culture issues.

5.42 The CRALO had a high profile in the establishment and visited all the residential areas daily. Detainees could raise concerns, which were recorded in one of the nine CRALO books in the centre. The CRALO dealt with most of these day-to-day matters informally.

5.43 More serious issues relating to race were dealt with initially through the complaints system. A detainee with a serious complaint had to ask a custody officer for a general application to request a confidential race relations complaint form. The application was sent to the complaints clerk who sent a numbered form to the detainee in a sealed envelope. The detainee completed and returned this form in a sealed envelope to the complaints clerk, following the standard complaints procedure. The clerk noted this and passed the complaint to the CRALO. This was an exceptionally bureaucratic process that required some persistence to follow through. We were not surprised that the level of reporting was extremely low, with around three or four complaints logged a month.

5.44 Record keeping for race related complaints was poor. Apart from the limited records kept by the complaints clerk there was no centralised log of race related complaints. It was therefore impossible to tell what stage of the process complaints had reached. The CRALO carried out the investigations, but the level of detail in these reports varied considerably. The documentation was poorly organised, which made it difficult to understand how investigations were dealt with and their outcomes.

5.45 There was a monthly cultural and religious affairs committee (CRAC) meeting, chaired by the deputy centre manager. These meetings were normally well attended by residential and operations managers as well as representatives from the security, world faith, catering and contract compliance departments. There were no representatives from outside bodies or the detainees.

5.46 The CRALO produced a summary report for the CRAC meetings, which provided the main agenda items. These reports contained useful information, particularly the organisation of cultural events. CRAC discussions on statistical information were very basic and mainly identified the majority nationality, which at the time of the inspection was Jamaican. As full records of race related activity were not maintained, it was not possible to monitor any patterns or trends.

5.47 The CRALO had recently introduced a survey of detainee views about various race and cultural matters. This initiative was carried out ad hoc, without full support from other staff.

5.48 Promotion of cultural events was good. The CRALO published an annual programme, in conjunction with the world faith team, with at least one special event a month to celebrate festivals or feast days.

5.49 Some information was produced in a range of languages. The internal detainee grievance form and information about the role of the CRALO were displayed in the residential areas in nine languages. The CRALO maintained a list of staff who could assist in interpreting for detainees, and this was updated monthly and circulated widely. Although this was useful for basic practical matters, this system was over-used as the primary resource for interpreting. The telephone interpreting service had been used only 11 times in the previous six months, which was very low for the size of the population held and the complexity of their problems.

Recommendations

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

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

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

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

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

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

Faith

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

5.56 The chaplaincy team catered well for the religious and spiritual needs of detainees. Detainees generally had good access to facilities, but there had been a gap in provision of services by an imam. There were unacceptable blanket restrictions on communal worship. The chaplaincy team needed support to develop its pastoral role and to be better integrated into the daily life of the centre.

5.57 The world faith manager was a Christian minister and his assistant was a Sikh minister. Both these posts were full-time. The rest of the chaplaincy team were part-time ministers, including an imam and a Hindu priest. Ministers from a range of faiths could attend the centre if requested. The chaplaincy team met once a month. It was a well organised, functional group and members worked well together.

5.58 The facilities for detainees to practise their faiths were good. There were four separate, well-equipped areas: a mosque, church, chapel and world faith room. The accommodation was on the world faith corridor, a quiet, peaceful area. The main religions for detainees were Islam and Christianity.

5.59 There were regular weekly services for the major religions, which were well attended with normally between 30 and 50 detainees at each of the two Christian services. There had been a gap of six weeks before our inspection when no imam visited the centre. Previously between 70 and 100 people had regularly attended Friday prayers. A new imam had been appointed. In our survey only 26% of respondents, compared to the IRC comparator of 36%, said they had access to a minister within 24 hours of reception.

5.60 A detainee had to put his name on a list on the unit to attend a religious service, although this could be done shortly before the service started. The system of fixed movements deterred some individuals from attending and the centre's timetable meant that a detainee had to choose between going to a religious activity or education.

5.61 Detainees on standard status, in the segregation unit and on secure location were not permitted to attend communal worship. Although a member of the world faith team tried to see these detainees daily, they did not have the resources for formal one-to-one sessions. Such sessions only took place if detainees made special requests, and seldom happened. This blanket restriction for certain categories of detainee was both unacceptable and also potentially in breach of the centre's contract.

5.62 The chaplaincy team ran classes such as Compass, a programme of 11 sessions on basic Bible study open to all detainees. The team also carried out basic pastoral work to support detainees and help them maintain links with the outside world. The world faith manager was keen for his team to become more involved in this work, but there had been disagreements with centre managers and immigration staff about the role and independence of pastoral work. This needed to be clarified.

5.63 The chaplaincy team was not well integrated in the establishment. For example, it was often invited to F2052SH reviews for those at risk of self-harm at too short notice for chaplains to attend.

Recommendations

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

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

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

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

Section 6: Healthcare

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

6.1 The healthcare department provided a 24-hour nursing service with an impressive inpatient facility. The healthcare environment was very good and, despite nursing shortages, there was a good range of primary care services. Many visiting health specialists held regular clinics and there was no significant waiting list for any speciality. There was overprovision of GP services and not enough nurse-led intervention. Medicine management was good, as was dental provision. Mental health services were very limited with little primary care. The few registered mental nurses were generally employed on generic nursing duties, and there were no counselling services.

Environment

6.2 All healthcare functions, except reception, were carried out in the main department. This was on two floors, with primary care on the lower floor and inpatients on the upper. Secure double doors divided the floors into two areas. Both floors were spacious, well accommodated and bright and all areas were clean and tidy, with contract cleaners on site every day. The primary care accommodation had appropriately equipped offices and clinical areas that provided a safe and confidential area for patients, and a good working environment for staff.

6.3 The waiting room was at the entrance to the department, was an adequate size with comfortable chairs and had good visibility from the main corridor. There was a selection of health promotion leaflets in various languages. Treatment and consulting rooms were appropriately equipped and had a good level of privacy. There was a comprehensive set of emergency equipment, including a defibrillator, in the nurses' office. This was fully functional and fit for purpose, and was checked twice a day with records logged. All staff had been trained in its use.

6.4 The dispensary was large and fit for purpose. There were sufficient lockable storage cupboards, which were in order with no excess stock. Named medications were stored separately and the cupboards were clean and tidy. There were pharmacy refrigerators, and medicines were stored at the correct temperature and daily records maintained. Controlled drugs were stored correctly in a secure cabinet, and the controlled drugs register completed in line with legislation. Medicines were administered to patients through a secure hatch on the main corridor, but there was no hood for patient confidentiality when they collected their medications.

6.5 The dental surgery was large, air conditioned and well equipped with a good range of lockable cupboards and work surfaces. All instruments were held securely. Dental x-ray equipment was checked regularly and there were sufficient specialist dental instruments provided. There was no x-ray warning light outside the surgery and officers sometimes entered while x-rays were taken, which was a health and safety hazard. There was a general x-ray room next to the dental surgery, which was large and well equipped with an adjacent small developing room. All x-ray equipment was monitored by the Mobile Radiology Service.

6.6 The inpatient area was large and well equipped. When our inspection began this had 21 beds in three six-bedded dormitories, two single en suite rooms and a safe room. A planned reduction in beds during our inspection reduced this to one dormitory and the safe room, with additional office space. This dormitory was large, bright and well equipped, with hospital beds, lockers and comfortable chairs. Oxygen and suction equipment was in place and patients had access to television and the telephone.

6.7 Although the bathroom had been designated for disabled patients, neither the shower nor bath was suitable. The shower had a raised tray and the bath was very small and fixed to two walls. The room needed significant refurbishment and additional equipment to make it suitable for people with disabilities.

6.8 A further room was used as a day room. Although this was large and bright, it too needed to be refurbished to make it fully functional. Additional accommodation included another toilet for people with disabilities and an office area. No drugs were held in the inpatient area.

6.9 A dedicated medical room was in the reception area, close to and clearly visible from the main reception desk. The room was fit for purpose and had privacy for new arrivals. An alarm bell was appropriately sited and there was sufficient equipment for the nurse who worked there. There was a computer for staff to make entries directly into the in-house computerised patient clinical records system.

Records

6.10 All clinical records were maintained on the in-house system. There was ongoing work to introduce an IND-wide patient information management system. We sampled several clinical records, which were contemporaneous and had appropriate entries. All patient interventions were recorded. Although there was no link with NHS systems, the system used provided a legible and timed record of patients. Medical records went with a detainee if he was transferred to another IRC.

6.11 The dentist made handwritten notes for his own records and these were transferred to the computer system so that any healthcare worker could access dental notes.

6.12 Medicines charts were computerised and had a photo of the patient for identification. All medicines were entered on to the charts at the time of administration and were reviewed once a month by the visiting pharmacist.

Staffing

6.13 The healthcare manager was a registered general nurse (RGN) with previous experience in the NHS and prison healthcare and who had been in post since the centre opened.

6.14 Medical staff were employed by UKDS. Four qualified GPs held regular clinics and were in the centre from 7.30am until 6.30pm Monday to Friday and for three hours on Saturday and Sunday. The same doctors provided all out-of-hours cover. Two GPs had a special interest in substance use.

6.15 There were 22 nursing posts, including the manager, eight of which were vacant. There were also six healthcare assistant (HCA) posts, all of which were filled. Most nurses were general nurses, some had additional qualifications such as learning disabilities and there were two registered mental nurses (RMN). The skill mix was in favour of general nurses and the two

RMNs had little or no time to practise their specialism as the bulk of their work was as general nurses.

6.16 Agency nurses were used frequently as were the IRC's own bank nurses. There were two permanent agency nurses and two bank nurses, who were all security-cleared and held keys. Twenty-four hour nurse cover was provided through three trained nurses and two HCAs during the day, and two trained nurses and a HCA at night. There was also a nurse 'on call' system to cover unpredicted sickness or other emergencies. Recruitment was difficult because of the high living costs and competition from the many NHS and private healthcare facilities in the local area.

6.17 A full-time senior administrative officer provided clerical support, assisted by one of the HCAs who divided her time between the two roles. Staff appeared committed to their roles and willingly worked extra shifts to support the service. Many spoke foreign languages, including Russian, Polish, French and Indian languages. All staff had an induction programme and annual appraisals. Clinical supervision was in place, but there was little uptake by staff. Professional training was supported where appropriate. There were staff meetings every two months, which were generally well attended.

6.18 Detainee custody officers (DCOs) were allocated to healthcare every day between 8am and 8.30pm to supervise detainees and accompany them to and from the department. The system worked well and relationships between healthcare staff and the DCOs were good.

Delivery of care

Primary care

6.19 In our survey only 21% of respondents rated the quality of healthcare as good or very good, against the IRC comparator of 35%. It was difficult to isolate the cause of their dissatisfaction. Detainee groups said it was difficult to access medication, although our survey showed that 33% could access medication they were taking before they were detained, which was better than the IRC comparator of 26%. There was no specific consultative group where detainees could discuss healthcare issues, but the manager did attend the general consultative group.

6.20 The healthcare department was extremely busy, and involved in some way in the more than 40 detainee movements in a 24-hour period. Healthcare staff told us that they were usually informed the day before a detainee left the centre, but there were times when they were not. This could have implications for any detainee on medication and meant that documentation did not always accompany them. Similarly, detainees arrived from other establishments without any medical documents. In such cases there were attempts to retrieve documents from the sending establishment.

6.21 Healthcare staff saw new arrivals in the reception area for a detailed health screen and offered them an appointment with the doctor. In our survey only 6% said they were offered an interpreter during their assessment, against the comparator of 16%. If the detainee did not speak English an NHS/British Red Cross multilingual phrase book was available in over 20 languages and some staff did speak other languages. The use of the telephone interpreting service was minimal, and we were told this was because of budget costs. The assessment tool covered all essential health questions, including a dental assessment, to ensure those in discomfort were seen quickly. Detainees were given a healthcare information leaflet, available in several languages.

6.22 All detainees who arrived with medication automatically saw the doctor to have their medication reviewed and rewritten. Any who needed to see a health professional was referred immediately.

6.23 New arrivals were asked if they had been subject to torture in their country of origin. If so this was documented on their records and an appointment made for them to be examined by the doctor. In the year to June 2006, 131 detainees reported they had been tortured. All were referred to the GP, but only 85 attended their appointments. With the detainee's permission, the doctor completed a report of torture form and forwarded this to the centre manager. Rule 35 of the Detention Centre Rules required healthcare staff to notify the centre manager if a detainee's health was likely to be injuriously affected by detention, including if he may have been the victim of torture, and the centre manager was to notify IND. Healthcare staff were unsure about what happened next. Since January 2006, 57 reports of torture had been forwarded to the centre manager, but we were told that no responses had been received. Healthcare staff had still not received any specific training in the management of patients who had been tortured, although this had been a recommendation in two previous inspections. We were told that training was hard to identify nationally, but Harmondsworth was due to host an estate-wide symposium on this subject later in 2006.

6.24 Detainees who arrived with injuries attributable to a failed removal were seen by a nurse, who completed an injury form if needed. The injuries were treated accordingly after he was examined by the GP. Entries were made on the clinical record, and detainees were advised that they could report the matter to the police.

6.25 Access to GP clinics was excellent, but GPs saw many patients who could have been dealt with by nurses trained in minor illnesses or as nurse practitioners. GPs held clinics every day, including weekends. There were 24 appointments available each weekday and up to 12 at weekends. During June 2006, 545 detainees had attended GP clinics and 91went to nurse clinics.

6.26 There was no formal application process. Detainees told their unit officer that they wanted to see the doctor and the officer contacted healthcare staff, who gave them an appointment. All patients were assessed by nurses initially and referred on to the GP if necessary. No triage algorithms were used. Nurses relied on their professional judgement to assess patients as none had any formal training in the management of minor illnesses.

6.27 Nurses also carried out brief informal assessments at medication times, when detainees often asked to see the doctor. In this case they were given an appointment for the next day and detainees were always seen within 24 hours of reporting unwell.

6.28 Detainees held in the segregation and secure units were seen daily by the GP. A nurse brought over any medications if these were required.

6.29 Medicines were administered from the dispensary at 8am, 11.30am, 2pm and 7pm every day, and could be administered at 10pm if necessary. Detainees who did not hold their medication in possession went to the healthcare department for their medication and received this on presentation of their centre photo identity card.

6.30 Approximately 60% of medication was held in possession and there were efforts to increase that rate. Subject to risk assessment, in-possession medication was given for up to one month. Detainees kept their medicines in their rooms.

6.31 DCOs supervised all medication times and detainees generally waited in an orderly fashion, although some complained that the 7pm medications took a long time. This was because many – sometimes up to 40 – came for their medication then, though they should have collected it in the morning. Detainees were encouraged to take responsibility for their own medication and were guided on how and when to collect it. Those who did not collect their medication were reminded twice by healthcare staff.

6.32 Pharmacy items were supplied by a local pharmacy. The service was good and ordered items were returned three times a week, or quicker if requested. The pharmacist visited monthly to check stock and reconcile prescriptions. Prescriptions were faxed to the pharmacy daily, with the originals sent to them when the items had been supplied. All pharmacy stock was checked weekly. A prescribers' committee had been established and membership included medical and nursing staff, the pharmacist and a senior security officer. The committee was reviewing patient group directives to enable nurses to deal with the more common complaints.

6.33 There had been an increase in the numbers of detainees who required drug and alcohol detoxification. Nine detainees had required detoxification in the previous month. This had followed a change in the population (see paragraphs 4.7 and 4.8). Two of the GPs had a special interest in substance use management and had written protocols for drug and alcohol detoxification. No nursing staff were trained in substance use.

6.34 Visiting health professionals included an optician who came twice a month and a chiropodist who came on request. There were no lengthy waiting lists for these specialists.

6.35 Because of the transient population, nurse clinics were demand led. Named nurses monitored patients individually. They saw those with high blood pressure, diabetes or other long-term illnesses regularly and recorded progress on their clinical records. The management of such patients appeared well structured and in line with clinical guidelines. Condoms were available from healthcare on request.

6.36 Patients who needed physiotherapy were sent to Hillingdon Hospital for treatment. Gym staff saw detainees who needed remedial gym and treated them accordingly. Healthcare staff had good relationships with the gym and the catering department. Extra food was available for patients with, for example, diabetes. One of the HCAs had been trained in aromatherapy and acupuncture and treated patients with stress-related anxieties and migraine. Detainees said they found this very beneficial, especially for the stress of waiting for decisions about their future.

6.37 There were clear food and fluid refusal procedures in healthcare. Detainees who missed meals for two days were seen by a nurse and their weight, blood pressure, pulse and urinalysis recorded. They were reviewed regularly and referred to the doctor if their health deteriorated. Where necessary, they were admitted to the inpatient unit. However, there was no central log of food and fluid refusers (see paragraph 5.18 and recommendation 5.36).

6.38 The dentist held a day clinic every Tuesday, accompanied by his dental nurse. He increased the sessions where necessary to meet demand and there was no waiting list. New arrivals were asked during the reception health assessment if they needed to see the dentist, and an appointment was made for the next visit. Attendance for appointments, 90%, was reasonably good. Up to 22 patients were treated on each visit. Routine treatment and advice on oral health promotion was given. The dentist provided no formal out-of-hours care but gave advice over the telephone if necessary. The GPs and nurses provided pain management and, if unresolved, used local NHS facilities for emergency dental treatment.

6.39 The healthcare department had good relationships with local NHS providers and two detainees were allowed to attend outpatient clinics every day, one in the morning and one in the afternoon. Doctors' referral letters to external specialists were faxed to clinics and appointments for treatment were generally arranged within the month. This expedited access to NHS clinics. Patients referred to the genito-urinary medicine clinic at Hillingdon Hospital were normally seen at the next available clinic. A few appointments had been cancelled due to lack of escorting staff. Patients with serious health problems, such as HIV, were managed sensitively by healthcare staff with specialist support from the genito-urinary medicine clinic. Those detainees with urgent outstanding NHS appointments were, wherever possible and appropriate, kept at Harmondsworth until their appointment.

6.40 Contact with the primary care trust public health department was very good and the healthcare manager liaised frequently with the communicable disease lead nurse who provided specialist advice on the management of patients.

6.41 Detainees released from Harmondsworth into the community were seen the day before they left, wherever possible. They were given a short health check and any appropriate medications for up to a week. However, they were not given a letter for their GP outlining their medical care while at the centre, unless they requested this.

6.42 One evening during the inspection healthcare staff called an ambulance for a patient with chest pain. The ambulance went to Colnbrook IRC next door, instead of Harmondsworth. Fortunately, this delay had no serious impact on the patient's condition in this instance, although it might have had very serious consequences. We understood that this was not the first time this happened, as there were no signs to indicate the location of Harmondsworth IRC.

6.43 We observed this patient's transfer to the ambulance and were surprised that he was handcuffed throughout. Healthcare staff did not ask for the handcuffs to be removed and told us that handcuffing patients transferred to hospital was official policy. It was clear that this patient did not need to be handcuffed. His medical condition meant it was not needed and, with three escort staff and two paramedics, there was little risk of escape. We were also told that the healthcare manager had sometimes intervened and argued strongly that cuffs should not be used, and had met resistance to this. It was unacceptable that clinical advice was not taken into account.

Inpatients

6.44 There was one inpatient at the time of the inspection. He had an infectious condition and therefore was isolated. There were good cross-infection control procedures and he was well cared for. His care plan was updated regularly and there were good contemporaneous entries.

6.45 There was no published regime for inpatients. The facility was used only as a last resort as patients were managed on the wings wherever possible. If the inpatient's English was limited they could feel very isolated. The ward was always staffed by a trained nurse and a GP saw any inpatients daily.

Mental health

6.46 Mental health services were extremely limited. We were told that few detainees needed specialist mental healthcare and those who did were seen regularly by a GP and the psychiatrist. There was no structured primary mental health service and the two RMNs had little time to practise their speciality. A visiting forensic psychiatrist from Broadmoor Hospital

held one session every Saturday and generally had three or four patients under his care. No detainees had ever been sectioned under the Mental Health Act.

6.47 There was a reliance on detainees with mental health needs being identified during the reception screening. They were seen by the GP as soon as possible and, if appropriate, referred to the visiting psychiatrist. Patients were managed on the units wherever possible, so that they could be supported by fellow detainees. Many detainees were anxious about their future, but were unable to access help easily. There were no counselling services, although healthcare staff and the chaplaincy did what they could to provide support. We were told that this was because the average length of stay at Harmondsworth was just days. However, the average stay had increased significantly and many detainees had been there for much longer (see paragraph 4.10). Staff were reluctant to rekindle events that could make the detainee feel worse if they were transferred or removed. There was no mental health awareness training for discipline staff.

6.48 Any new arrivals considered to be at risk of suicide and self-harm were placed on an F2052SH (self-harm monitoring) form. If there were concerns about their mental health they were admitted to healthcare for close observation. We were told that all detainees placed on an F2052SH were seen by a doctor within 24 hours, but this was not always the case. Healthcare staff told us that they attended all reviews they knew about but were not always told when a review took place. This meant that important and relevant information was not always passed on between the groups (see paragraph 5.15).

Joint work with NHS

6.49 Hillingdon Primary Care Trust was the local health authority. There was no contact with the trust at a strategic level, despite efforts by the healthcare manager and the clinical director. However, there were helpful and beneficial links with the lead nurse and the communicable disease link nurse.

6.50 The healthcare manager was a member of the IRC healthcare steering group and the Harmondsworth clinical governance committee.

Recommendations

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

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

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

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

6.55 A counselling service should be available to all detainees.

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

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

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

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

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

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

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

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

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

Housekeeping points

6.65 A privacy hood should be installed over the medicine hatch in healthcare.

6.66 Detainees should have lockable boxes for their medication in their rooms.

6.67 An x-ray warning light should be installed outside the dental surgery.

Good practice

6.68 *Detainees did not have to submit a written application to use the healthcare service.*

6.69 *The initial health assessment for new arrivals included dental health.*

6.70 *Referrals were faxed to NHS facilities, which reduced the waiting time for appointments.*

Section 7: Activities

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

7.1 The education provision was good but access arrangements were inefficient, leading to poor take-up of some sessions. Operational management was sound but formal arrangements to improve quality were weak. The curriculum did not include short courses for detainees who had brief stays at the centre. There was inadequate monitoring to assist planning. There was no internet access, and no paid or voluntary work. The library was an adequate size, but access was limited. The gymnasium was small and unsuitable for the number of detainees who used it.

Education and skills training

7.2 The centre provided education, games and a library in a suite of rooms in morning, afternoon and evening sessions during weekdays, and more restricted opportunities on weekend mornings. Participation varied considerably. At full capacity on weekday sessions, the 120 places could cater for around a quarter of the detainee population of about 500. Not enough places were available at other times, with a maximum of 80 on four nights a week and 60 on Friday evening and weekend sessions. Take-up was good in the afternoon and some evenings, but generally lower in the mornings. The range of education classes was adequate. Access to education for detainees in healthcare or removed from association was unsatisfactory and limited to the provision of books, newspapers and videos.

7.3 Engagement in learning was good in all classes. Detainee-staff ratios were generally favourable. Detainees received good individual attention from teachers and learning assistants, and often worked in teams of two or three. They worked conscientiously and with concentration for sustained periods. Many said the education classes provided respite from the worry about their situations. Relations between detainees and education staff were good. Detainees commented favourably on the mutual respect within the education department, and contrasted it with their treatment by detainee custody officers (DCOs).

7.4 The centre made good use of competitions to motivate and provide incentives to detainees. All areas of education regularly held competitions with small cash prizes for the winners, and detainees responded to these with enthusiasm. Competitions were often imaginative and required detainees to use skills learned in their classes. For example, detainees in computer classes produced posters for the 2012 London Olympics.

7.5 Standards of work in art and craft classes were good and detainees with no previous experience of beadwork produced attractive items. Learning and teaching were good. Planning of activities was effective, and detainees could complete some projects in a single session or over a longer period. Staff worked imaginatively to provide a good range of activity, but were restricted by the centre's prohibition on the use of common art materials, such as clay. The art room was large enough and equipped appropriately.

7.6 English for speakers of other languages (ESOL) learning was organised flexibly. New arrivals received an appropriate simple initial assessment to determine their language proficiency. They received packs of learning worksheet materials graded according to their language level

for use in classes and independent study. In classes detainees worked individually or in pairs, closely monitored and supported by ESOL staff. Staff also provided some group sessions. Although detainees made useful progress in vocabulary and grammar, classes did not concentrate sufficiently on developing their spoken English. They rarely used computer-based learning materials as part of their programmes.

7.7 Information and communication technology (ICT) provision was carefully structured. Computer hardware and software was generally satisfactory, and provision had recently been increased to cater for high levels of demand. Most learners worked towards nationally recognised qualifications in ICT, while a few followed more advanced centre-devised modules. Learners worked individually following instructions in workbooks, with good tutor support. The language in many of the workbooks was too complex for detainees with limited English, and the topics rarely reflected their needs or interests. Few learners completed qualifications and most left the centre before they could complete all the assignments needed. The curriculum did not include appropriate short courses for detainees on short stays. Internet access was not available. Learners did not routinely learn to use common web-based applications, such as email.

7.8 A games room in the education area was heavily used. A good range of facilities included play station consoles, table football, keyboards with headphones, and a wide range of board games. However, the room was very noisy and too cramped for the large number who used it. The most popular activities, such as pool, were oversubscribed.

7.9 The education team was enthusiastic and positive about its work with detainees. The staff had the appropriate interpersonal skills and subject expertise, and operational management was sound. The education manager and subject coordinators attended recently initiated meetings with representatives from publicly run and privately run IRCs to exchange good education practice.

7.10 Formal arrangements to improve quality were weak. Managers did not routinely observe learning sessions to develop staff practice. The centre did not use a self-assessment process to identify areas of strength or underdevelopment. There were careful records of attendances at education, but data on take-up of provision was not collated or analysed effectively to establish the number who attended education or any differences in participation by nationality or ethnic group.

7.11 Senior management support for education was weak. Staff felt that senior managers undervalued the role and importance of education provision in engaging detainees purposefully at Harmondsworth. Support for staff to improve their qualifications and skills was narrow and mainly confined to encouragement to follow publicly funded teacher training courses. Staff access to the internet and email communication with colleagues was inadequate, and was only available in the education manager's office.

7.12 The regime in which education was offered was inflexible. Detainees could only go to the education area at the start of a session. Although they could move between classes, the games room and the library, they could not leave the area before the session ended, which during the daytime lasted three and a half hours. Attendance at education precluded access to telephone calls, breaks outdoors and, on some days, taking part in physical Education (PE) as well as attendance at religious services (see paragraph 5.60). Security-imposed restrictions on common learning resources limited the education curriculum significantly.

7.13 Arrangements to inform detainees about education were unsatisfactory. Most new arrivals received brief verbal information in English about education as part of their induction in

residential areas. Arrangements for interpretation were inadequate. Detainees were rarely supplied with written information in English or other languages. Posters and displays that promoted activities in the centre were not translated into other languages.

7.14 A recent legal provision to exempt detainees from the minimum wage had yet to come into force. Neither paid nor voluntary work was permitted in the centre.

Library

7.15 The library was in the education area. It was adequately sized for the volume of demand at most times. However, evening and weekend opening was too limited, at two evenings a week and weekend mornings only. Access was inflexible, and detainees who wished to use the library only briefly during the day had to remain there or elsewhere in the education area for the full three and a half hour session.

7.16 The library had an extensive and wide-ranging stock of fiction and non-fiction in over 30 languages. Bilingual dictionaries covered a similar range of languages, and included loan as well as reference copies. The provision of newspapers and magazines was satisfactory. The education manager reviewed data on the centre population monthly, and used this effectively to buy material to meet changing demand. Videos and music CDs were also available in a good range of languages, and detainees made extensive use of the eight audio CD players in the room to listen to music. The availability of legal texts was adequate. However, there was no direct access to the internet for additional materials, and detainees had to make written requests to library staff to obtain this.

7.17 Staffing arrangements were insufficient. Staff levels were sometimes too low, and staff were not qualified librarians or library assistants.

Physical education

7.18 Access to PE was satisfactory, and there were appropriate rotas to enable all detainees to participate. Staff were enthusiastic and most had specific basic qualifications and a range of useful experience. They made good efforts to provide a range of team sports and activities to meet detainees' preferences, and held competitive activities with cash rewards to motivate and enthuse them.

7.19 The sports hall allowed a satisfactory variety of activity. However, facilities for outdoor team sport were cramped, and significantly limited what was offered. The gymnasium was small and unsuitable for the number of detainees who used it. The equipment was poorly spaced and potentially unsafe when the room was full. Footwear provided was poor and clothing for those who needed it was inadequate. There were no showers or changing facilities.

7.20 Initial induction was brief and was not extended for those who stayed in the centre for longer periods. Links with healthcare were not sufficiently developed. The centre had improved its range of data and information on those who used the facilities. It had introduced pictures of activities into questionnaires on detainees' preferred activities to better reach those with poor English. However, arrangements to improve take-up by specific nationalities or ethnic groups were not well developed.

Recommendations

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

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

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

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

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

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

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

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

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

Section 8: Rules and management of the centre

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

8.1 There were too many unnecessary rules and restrictions and a disproportionate emphasis on security. Detainees placed in temporary confinement were routinely strip searched. Public protection procedures were underdeveloped. The IEP scheme operated on sanctions rather than rewards, and detainees' removal from association was not always justified on grounds of security and safety. Levels of use of force were relatively high, but documentation was completed to a good standard and planned interventions were videoed. The applications and complaint system was fundamentally flawed and detainees had little confidence in it. Few detainees were aware of the Independent Monitoring Board (IMB).

Rules of the centre

8.2 Detainees complained to us about what they perceived as petty rules imposed by staff. We also found many examples of rules imposed with little justification (see for example paragraphs 7.12 and 9.7). There was also a blanket ban on detainees having lighters or matches and they continually had to request lights from staff. This was annoying for staff and demeaning for detainees. Security restrictions on property entering the establishment were also extremely tight and hard to justify. New arrivals were not allowed to retain any toiletries already opened. We could not understand why this rule was applied to detainees transferred from other detention centres or from prisons (see paragraph 2.8 and housekeeping point 2.17).

8.3 General rules were explained in the *Rough Guide to Harmondsworth* and the incentives and earned privileges (IEP) compact in English only. However, many detainees complained that they had not been given a copy of the guide (see paragraph 1.7) and the IEP compact was in English only.

Security

8.4 The security committee met monthly and was routinely attended by the centre manager and senior managers from all departments, as well as the police liaison officer. The security department was staffed by a security manager and his deputy, two administrative grade staff who carried out intelligence analysis and three officers who worked there regularly. Other staff were briefed on security matters through an information board in the staff briefing room. There was a monthly meeting with designated liaison officers from all areas.

8.5 Procedurally the security department operated well. Staff were active in obtaining information on any former prisoners and recording security markers where appropriate. These markers took account of detainees' behaviour in other IRCs and prisons and were used to assess their risk. It was not uncommon, however, for detainees to be received from prisons with little or no background information, and it could take security staff several days to gather this. Despite the good systems in the security department itself, there were many restrictive rules, many of which appeared disproportionate to the risk and disadvantaged detainees unfairly (see paragraph 8.2).

8.6 The security department received about 35 security information reports (SIRs) a week, which was a big decrease on the previous year but still a reasonable level. SIRs were processed promptly and efficiently. There were searches of communal areas every eight weeks. Room searches were intelligence-led only, which was appropriate for the population. Strip searches were also intelligence-led, except for detainees placed on rule 42 of the Detention Centre Rules (temporary confinement) who were strip searched routinely with no risk assessment.

8.7 The centre did not carry out any telephone or mail monitoring, although it held detainees who had served prison sentences for sexual or harassment offences. There were five detainees at the time of inspection who had served custodial sentences for sexual offences, including offences against children. There were no procedures to identify and restrict child visitors to such detainees or monitor their risk in the centre. These gaps had potential implications for public safety.

Rewards scheme

8.8 The centre operated an IEP scheme with enhanced and standard tiers. All detainees started off on enhanced, but this level included some basic entitlements rather than privileges – such as access to education, faith provision and unrestricted visits. Sanctions included detainees being locked in their rooms between 8.30pm and 7am, the weekly allowance reduced from £6 to £4, and telephones removed from rooms, which restricted their incoming calls. The compact was in English only and did not state that some sanctions applied, such as removal of access to education or faith provision. The IEP scheme was not explained to new arrivals during the induction session we observed.

8.9 There were 20 detainees on standard level during our inspection, and there had been between 30 and 65 a month in the previous six months. They were located on one of the main units (A unit) unless they had been removed to rule 40 (removal from association) or 42 rooms for other reasons. They remained on standard for at least a week before their status was reviewed by a residential manager and several senior custody officers. Detainees were routinely reduced to standard level for refusing to leave the centre to board flights. This was inappropriate given that the centre's role was to be a neutral custodian, not to punish detainees for their lack of compliance with the Immigration and Nationality Directorate (IND).

8.10 The scheme was not monitored by detainees' nationality or ethnicity and so it was not possible to establish any patterns in the application of warnings. Possible abuses of the scheme could not, therefore, be identified. Detainees said that staff constantly used the possibility of an IEP warning as a threat or to exercise power arbitrarily.

Discipline

8.11 Indiscipline was dealt with through warnings under the IEP system or rule 40, which were both used extensively. Rule 40 was used for detainees who had misbehaved to the point that an IEP warning was not considered sufficient and also to monitor detainees with security markers from other IRCs or from prisons (see paragraph 8.5).

8.12 There were 20 designated rule 40 rooms in the establishment – four on a secure landing on B unit and eight each on two secure landings on D unit. All rule 40 rooms were clean and well equipped with normal wooden furniture, an en suite shower, television (for those on enhanced IEP level only) and telephone for incoming calls. Each secure landing had a communal television room.

8.13 Rule 40 was used extensively and had already been authorised on 440 occasions since January 2006. Initial authorisation was given by one of the centre managers, and further authorisation was required from the IND contract monitor for periods exceeding 24 hours. Rule 40 restrictions could not be imposed for more than 14 days. Detainees placed on rule 40 were given written reasons, but these were in English only. There was no published regime for rule 40 detainees.

8.14 There were 12 detainees held under rule 40 at the time of our inspection. In some cases the manager's request for continued confinement did not give a full explanation. Some use of rule 40 appeared to be simply a response to poor behaviour rather than being necessary to maintain security and safety. We saw no published avenues of appeal for detainees held on rule 40.

8.15 Detainees on rule 40 were normally allowed to associate with each other between 7.30am and 10.30pm and were otherwise locked in their rooms. Except for the television, there was little to occupy them, although they did get daily access to time in the open air. These detainees were not allowed to attend communal religious services (see paragraph 5.61), although those on the enhanced IEP level were allowed to attend PE.

8.16 If detainees misbehaved on rule 40 they could be placed on 'top lock', with a second lock to their room that the occupant could not override. A centre manager could give authority for this for periods of four, 12 or 24 hours. Further permission was required for any increase in the initial period authorised.

8.17 Smoking was permitted in the communal television room and during outside exercise. Detainees were not allowed to smoke in their rooms. This was a problem for some of those locked up for nine hours at night.

8.18 Detainees on rule 40 were visited daily by the required personnel, including the IND contract monitor, duty manager, medical officer and world faith manager. Staff completed observation sheets and the standard of entries were generally good.

8.19 Some detainees had been banned from PE or education following alleged poor behaviour. However, there was no written policy about such bans and no apparent safeguards, such as the right to appeal.

Use of force and single separation

8.20 Control and restraint (C&R) training was given a high priority and over 150 staff had received refresher training in the previous 12 months.

8.21 There had been 107 use of force incidents in 2006. Although the location of these incidents was routinely monitored, managers did not appear to use this information. For example, 36% of all incidents had involved detainees on rules 40 or 42, a high proportion that needed analysis. The number of incidents appeared slightly higher than at other IRCs, particularly as they all involved the use of C&R. If the levels of use of force in 2006 continued for the rest of the year, they would exceed the total of 141 incidents in 2005 (which included eight non-C&R incidents).

8.22 Planned C&R removals were videoed and tapes kept for evidential purposes. We viewed two such videos. Staff had acted professionally, and in both incidents all the staff involved had identified themselves to the camera. This was particularly useful as it was otherwise difficult to

identify staff in protective clothing. Use of force documentation was generally completed to a good standard. Staff statements gave a full account of the incident and their involvement. Injury to detainee forms (F213) had been filed appropriately with all use of force documentation.

8.23 Detainees who were violent or refractory were placed on rule 42 and held in one of two designated rooms on B wing or four designated rooms on D wing. These cells had fixed furniture, were clean and had ample natural light. Managers had to make a case to apply rule 42 to the IND contract monitor, who was responsible for considering and, where appropriate, approving such requests. Detainees were given written reasons but these were in English only.

8.24 Rule 42 had been authorised 129 times since January 2006, which appeared high. On at least 33 occasions a detainee had been held for more than 24 hours. The actual figure was probably higher as the register was incomplete. It was clear from some records that some detainees had been held under rule 42 for a considerable time after they had become compliant.

8.25 All detainees held under rule 42 were routinely strip searched without any risk assessment (see paragraph 8.6) and normally issued with sterile clothing. There was no published regime for those held under rule 42. The regime provided was basic, although detainees did have daily access to showers, exercise and telephones. Incoming calls could be arranged by prior appointment.

8.26 We observed one detainee held under rule 42 following a self-harm incident in which he had become violent and threatening. Application of rule 42 was understandable in view of his behaviour and the threat posed. However, it was evident that the initial level of threats and violence had since abated. This detainee was under constant staff watch through the observation port in the cell door. We saw little evidence that staff had tried to engage with him. Rule 42 was generally an inappropriate option for managing individuals during periods of crisis.

8.27 As with those held on rule 40, those on rule 42 received the required official visitors and good duty manager, medical officer and world faith leader records were kept.

Complaints

8.28 New arrivals were not always properly informed of the arrangements for making applications or complaints. We saw some information about complaints on the residential units but this was difficult to find and in English only.

8.29 Detainees had to request application forms from the unit office. Applications were not logged and there were no monitoring arrangements. Staff did not pursue unanswered applications and generally only became aware of unresolved applications when the detainee raised this.

8.30 Complaint forms were not freely available. Detainees had to complete an application form, which was forwarded to the complaints clerk who issued the form with an envelope. The completed complaint form had to be given to unit staff to hand to the complaints clerk. We were concerned that such a system could be open to abuse, particularly as, owing to detainees' lack of English, it was not uncommon for unit staff to complete complaint forms on their behalf. Of the 155 complaint forms issued in 2006, only 45 had been returned to the complaint clerk. A third of all complaints were about staff.

8.31 Staff were used in the first instance to interpret complaints in foreign languages. We were told that where this was not possible the telephone interpreting service was used. However, there

was very little use of this service at Harmondsworth (see paragraph 5.49). Replies to complaints were prompt but we found some written in the third person, which was disrespectful, and others, including serious allegations against staff, that had not been fully investigated.

8.32 Detainees were very negative about the complaint system. In our survey only 15%, significantly below the IRC comparator of 41%, said it was easy to get a complaint form, and only 8% against 16% felt that complaints were handled fairly.

8.33 The work of the IMB was not explained on induction. In our survey only 4% of respondents, against the comparator of 19%, said that it was easy to contact the IMB. Although photographs of IMB members were displayed in several locations, and the IMB had its own secure application boxes, many detainees were unaware of the IMB or its role.

Recommendations

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

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

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

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

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

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

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

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

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

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

8.44 The establishment should have a published policy explaining the circumstances in which physical education (PE) and education bans can be imposed on detainees.

Reasons for any bans should be recorded and detainees should have clear avenues of appeal.

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

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

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

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

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

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

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

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

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

Housekeeping point

8.54 Replies to complaints should be individual responses to the detainee and not written in the third person.

Good practice

8.55 *Staff involved in a planned control and restraint (C&R) intervention identified themselves to the camera for the video record. This was particularly useful when they wore protective clothing, which made identification difficult.*

Section 9: Services

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

9.1 Detainees were extremely negative about the food and the consulting arrangements were poor. There was daily access to an on-site shop, although its range of goods was restricted and, as with meals, did not properly take account of detainees' needs and preferences.

Catering

9.2 There was a small, clean and well-maintained central kitchen behind the servery on D wing. Meals were prepared by catering staff and were sent on trolleys to the seven serveries. Detainees took meals in dining halls next to the serveries. These were small, and although they did not have enough seats to accommodate everyone at the same time, detainees could collect their meals over a one-hour period. The dining halls were clean, but plain and unwelcoming. Meals were served at appropriate times.

9.3 Detainees pre-selected their meals 24 hours in advance. The menu cycle was repeated every four weeks, although there was some repetition within this cycle. There were three choices of hot meal for lunch and dinner, plus potato, rice and a vegetable option. There were pictures of different foods on the serveries to help detainees make their choices. Food comments books were not freely available on the serveries. After some searching, some books were found in cupboards, but the detainees were not aware of them and, tellingly, they contained no comments. We were told that food comments books used to be provided on the serveries but were withdrawn because some people wrote abusive comments.

9.4 We received many complaints from detainees about the food, mainly about the lack of choice and portion sizes, although the food we sampled was of reasonable quality. In our survey only 23% of respondents said the food was good or very good, against an IRC comparator of 36%. The common complaint was that rice and chicken were served at every meal, although the centre told us that when alternatives had been tried these had been even more unpopular. We were also told that the centre had previously responded positively to feedback on menu choices. Although the centre was aware of detainees' general negativity, it was not doing enough to respond to these perceptions.

9.5 A catering manager sometimes attended the regular detainee committee meetings. However, there had been no formal catering surveys of detainees. The cultural and religious affairs liaison officer (CRALO) had recently started bi-monthly surveys of detainees' views of catering. However, these lacked depth, were unsystematic and involved only a few detainees. The first survey just asked detainees whether they thought the quality of the food was good or poor. Over half said it was poor, but nothing was done with this information. The most recent survey had asked detainees for suggestions about how their cultural needs could be better met. This had produced a wide range of responses, although these had not yet been forwarded to the catering manager.

Centre shop

9.6 There were three shops in the centre, and detainees had two hours' access to the shop each day. The times when the shop opened on each wing varied daily, and although there were some regime clashes this was not seen as a serious problem. Detainees could also use the vending machines in the TV rooms at any time.

9.7 The shop's product list was small, and detainees could only really buy basic confectionery, tobacco items and some toiletries. They were not permitted to buy fruit or other perishables, tinned goods or items in glass bottles, as these had been banned by the security department. This seemed unnecessarily restrictive, as these items are available in many prisons. The range of specific items for black and minority ethnic detainees was also poor. In our survey, only 20% of respondents, against an IRC comparator of 46%, said the shop sold a wide enough range of goods.

9.8 There was no consultative forum for detainees to suggest items to be stocked in the shop. Although there was a regular detainee committee meeting, recent minutes showed that when detainees raised issues about the shop they were advised to raise these through the CRALO's bi-monthly survey on shop goods. As well as misunderstanding the role of the committee meeting, this response was also not helpful as most detainees would not have had the opportunity to participate in the CRALO's very small survey. Those who had been surveyed had suggested items they would like to see stocked. The CRALO had forwarded this information to the shop manager but had not yet had a response.

9.9 Any profits made by the shop were held in a general purpose fund. This fund was used for monthly vouchers in education and the gym, where they were given as incentives for detainees, to fund the games consoles in the visits hall, and to buy ad hoc items, such as computers. Authority from the centre manager and IND were required to approve any expenditure from this fund, although there was no formal committee to oversee spending and no detainee involvement in the process.

Recommendations

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

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

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

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

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

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

Section 10: Preparation for release

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

10.1 Welfare provision for detainees was minimal. The lack of signposts outside the centre made it difficult for visitors to find. The visits area was unwelcoming, and the checks on visitors were restrictive and inflexible. Detainees had poor views of treatment by visits staff, and there were no procedures for visitors to express their views. Detainees had good access to telephones and mail, and most found these services easy to use. There were no formal procedures for dealing with vulnerable individuals during their transfer, discharge or removal or to help them prepare for these eventualities.

Welfare

10.2 Although detainees needed access to basic welfare support for matters such as recovery of property, accommodation and outside contacts, there were no formal arrangements for welfare work and limited support from staff in the centre and visiting agencies.

10.3 The cultural and religious affairs liaison officer (CRALO) visited every residential area each day to collect written referrals, mostly relating to race relations, but occasionally had more general requests for addresses or telephone numbers. The administrative staff in the information centre provided a similar service, but said their role had been more effective previously when they had dealt with detainees face-to-face and it was more difficult to resolve queries satisfactorily now they were office-based. The chaplaincy team also carried out welfare work, although received no encouragement for this (see paragraph 5.62).

10.4 External support for detainees was primarily through the London Detainees Support Group. This voluntary organisation had about 80 visiting volunteers who provided valuable emotional and practical support for detainees. The coordinator of the group met managers at the centre about twice a year. He suggested that working relationships had improved over the previous 12 months. However, his example of this was that volunteers now normally waited about 30 minutes before they could see a detainee, whereas previously they had been kept waiting much longer. He suggested that custody staff referrals to the group on behalf of detainees would be positive.

10.5 Our survey results in this area were very poor. Only 13% of respondents said they had received a visit from a community group or volunteer visitor, against the IRC comparator of 22%. Centre managers suggested that it was difficult to engage community-based stakeholders to participate in collaborative work. They cited poor attendance at events that they had convened in the centre. It was clear that the working relationships between the establishment and relevant agencies in the community needed to be strengthened and extended to improve the level of support available to detainees.

10.6 The few detainees who were granted temporary release were given a travel warrant. Most detainees who left were removed. There was no preparation for release and those unexpectedly detained had to rely on a friend or relative to collect and bring in their property.

Visits

10.7 There was no signposting at the entrance to the centre, which was inconvenient for visitors and potentially critical for emergency services (see paragraph 6.42 and main recommendation HE.37).

10.8 Visitors had identity checks in the small visitors' centre and were required to produce two proofs of identity – a specified photo identification and a document with a name and address, such as a utility bill. The criteria for valid identification were difficult to understand. Some posters in the visitors' centre only referred to a passport or a driving licence, although many visitors had neither. The proof of address requirement was difficult for visitors from abroad or who lived in rented accommodation without personal utility bills. We were told that stubs from an airline ticket would be considered in lieu of an address, which was confusing and not publicised as an acceptable form of identification.

10.9 The identity check policy was unrealistic and unduly restrictive but was closely adhered to. We were told by visits staff that approximately one visitor in 15 was turned away because they did not have the specified identification. During the inspection a detainee subject to the F2052SH (self-harm monitoring) process did not receive a visit because his partner could not supply the required identification. Although she showed alternative proof of identity, and had travelled some distance, she was turned away at the gate. By the time a manager was persuaded to rectify the situation, the visitor had left and the detainee did not receive a visit until two days later.

10.10 Before they were admitted, visitors also had to provide a biometric finger scan. When this was completed they could leave their personal property in a locker. Adult visitors were given pat down searches before the visit, but young people under 16 were not subject to this. All detainees received a rub down search before and after the visit.

10.11 The visits area was clean and functional. The toilet facilities were good and there was a well-equipped baby changing area. There were three vending machines, which sold a selection of hot and cold drinks and snacks. Children could play in a small recreational area. The visits hall was austere and the few posters displayed were usually in English only. There was a tired-looking display of detainees' art in one corner.

10.12 Visits took place every day between 2pm and 9pm.They could last for two hours or more each session and staff exercised their discretion about the length of the visit. This meant that, apart from the weekend when the visits hall was busy, visits could continue for several hours or even for the whole session.

10.13 Staff were instructed to allow detainees to embrace their visitors at the beginning and end of a session only. While it was appropriate for staff to intervene when they considered that public decency had been breached, blanket restrictions on contact between families and detainees at other times were not acceptable.

10.14 Survey results about visits arrangements were poor. Only 23% of respondents felt that they and their visitors were treated well by visits staff, against the IRC comparator of 39%. There was no complaints system specific to the visits area, and no comments book for visitors.

Telephones

10.15 Detainees had good access to telephones. They had handsets for incoming calls in their rooms. There were nine pay telephones in each of the residential units with unrestricted access. Detainees could use coins or buy cheaper telephone cards from the shop. Staff sometimes allowed detainees without money to make free calls.

10.16 Detainees on standard regime were not allowed to receive incoming calls, and we received complaints from outside agencies that had had great difficulty in attempting to contact such detainees. This measure was unduly restrictive and unacceptable.

10.17 Detainees did not have direct access to email facilities or to the internet.

Mail

10.18 All detainees received one free letter a week for private use and had unlimited free mail for legal correspondence. They could send faxes free of charge to legal advisers through the information centre. This was a well-used service that dealt with up to 100 queries a day, but there were restrictions on the amount of material that could be sent at any one time (see paragraph 3.7).

Removal and release

10.19 In the three months before the inspection, 57% of detainees were removed, 28% transferred and 15% received temporary admission or bail. Removal and release was an audit-driven process, with a strong emphasis on ensuring that detainees left the centre quickly and quietly. Staff had to complete the necessary documentation promptly to comply with time targets.

10.20 We spoke to detainees with removal directions who had generally been given two or three days' notice. However, staff in the reception area said that many detainees had not received written removal directions.

10.21 Managers told us that staff took care in the management of detainees identified as potentially violent or disruptive, particularly those with a history of difficult to manage behaviour. This usually involved a discussion between staff working in reception and the security department, and the use of additional staff. There appeared to be no multidisciplinary care plans or full risk assessments. We were told that there were usually three or four cases a month when a detainee refused to leave the centre voluntarily. In these circumstances the immigration authorities were notified and they arranged for a special escort. Since January 2006 there had been two or three occasions where detainees were not prepared to cooperate with these special escorts and had to be placed on transport forcibly. We found no written plans relating to these situations. There were no formal procedures for dealing with vulnerable individuals during their transfer, discharge or removal.

10.22 Detainees released into the community were given a taxi to the nearest underground station or a travel warrant. There was no systematic provision of financial assistance to those released without any means, although most detainees had very limited means – 53% had less than £1 in their account and 42% had between £1 and £5.

Recommendations

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

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

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

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

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

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

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

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

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

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

Section 11: Recommendations, housekeeping and good practice

The following is a listing of recommendations 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.

Main recommendations

To the director general, IND

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

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

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

To IND and the centre manager

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

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

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

To the centre manager

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

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

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

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

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

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

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

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

Recommendations — To the director general, IND

Arrival in detention

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

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

Healthcare

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

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

Recommendations — To the centre manager

Arrival in detention

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

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

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

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

Environment and relationships

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

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

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

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

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

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

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

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

Duty of care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Healthcare

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

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

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

11.61 Healthcare staff should receive specific training in the identification and management of detainees who have been tortured. Such training should be part of the induction programme and updated regularly. (6.56)

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

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

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

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

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

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

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

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

Activities

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

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

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

11.73 There should be suitable arrangements to improve the quality of education, including regular self-assessment of the provision and structured observation of tutor performance. (7.24)

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

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

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

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

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

Rules and management of the centre

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Services

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

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

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

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

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

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

Preparation for release

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

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

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

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

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

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

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

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

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

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

Housekeeping points

Environment and relationships

11.115 Detainees should be allowed to personalise their rooms and display photographs. (2.16)

11.116 Detainees should be allowed to bring in toiletries bought in other establishments. (2.17)

11.117 All detainees should have their own room keys. (2.18)

11.118 Notice boards should be fitted in detainees' rooms. (2.19)

Healthcare

11.119 A privacy hood should be installed over the medicine hatch in healthcare. (6.65)

11.120 Detainees should have lockable boxes for their medication in their rooms. (6.66)

11.121 An x-ray warning light should be installed outside the dental surgery. (6.67)

Rules and management of the centre

11.122 Replies to complaints should be individual responses to the detainee and not written in the third person. (8.54)

Examples of good practice

11.123 Detainees did not have to submit a written application to use the healthcare service. (6.68)

11.124 The initial health assessment for new arrivals included dental health. (6.69)

11.125 Referrals were faxed to NHS facilities, which reduced the waiting time for appointments. (6.70)

11.126 Staff involved in a planned control and restraint (C&R) intervention identified themselves to the camera for the video record. This was particularly useful when they wore protective clothing, which made identification difficult. (8.55)