Report on an unannounced inspection of the

short-term holding facility at

Heathrow Airport Terminal 1

by HM Chief Inspector of Prisons

30 September 2014

Glossary of terms

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Fact page

Task of the establishment
To hold individuals and families who are of interest to the UK Border Force.

Location
Heathrow Airport Terminal 1 (airside).

Name of contractor
Tascor

Number held during inspection
2

Last inspection
11 April 2011

Escort provider
Tascor

Overview

Heathrow is the world's busiest airport for international passenger traffic. The short-term holding facility at Terminal 1 is managed by Tascor (formerly Reliance) on behalf of the UK Border Force. The facility is mainly used to hold passengers who have been denied entry at the border and are awaiting removal, or people detained pending further inquiries.

In the previous three months, 616 detainees had been held in the facility for an average of six hours 30 minutes. Eighty-four had been held for more than 12 hours, and nine for more than 24 hours, including one detained for 36 hours. Forty-nine children were held, of whom 15 were unaccompanied. The average length of detention for accompanied children was seven hours 30 minutes, and six hours 40 minutes for unaccompanied children. The youngest unaccompanied child was eight years old. During our inspection, two single males were held in the main holding room.

About this inspection and report

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

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

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of detainees, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. The tests have been modified to fit the inspection of short-term holding facilities, both residential and non-residential. The tests for short-term holding facilities are:

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

Inspectors kept fully in mind that although these were custodial facilities, detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes.

Summary

Safety

S1 At our inspection in 2011, we made 17 recommendations in relation to this healthy establishment test, four of which were achieved, one partially achieved and 10 not achieved. We were unable to inspect two recommendations relating to escort vehicles and transfers into or from the holding room as none took place during the inspection. However, one incident report that we looked at indicated that poor planning and coordination by the Detainee Escorting and Population Management Unit (DEPMU) had led to an elderly detainee with mental health problems spending too far too long in an escort van.

S2 There was not always a female detainee custody officer (DCO) on duty, and male and female detainees could not always be held separately. Detainees were not provided with mobile phones for use in the holding room. Not all DCOs had received self-harm prevention training. Border Force staff identified and recorded risks correctly on documents authorising a detainee's detention (IS91).

S3 Forty-nine children had been held over the previous three months. DCOs had been on safeguarding children training, but were not aware of a Tascor safeguarding policy. The family room was small but adequately equipped. Some DCOs routinely gave children a rub-down search, which was inappropriate, and documentation did not give adequate detail when such a search took place on the basis of suspicion. Child care plans were generally good. The Border Force safeguarding and trafficking (SAT) team had improved its links with social services, but was not regularly on duty at night time, and there were no social workers on site at the airport. Border Force managed the case of a potential child victim of trafficking poorly and inefficiently. It took too long to transfer asylum-seeking families with children from the airport to initial accommodation, and unaccompanied minors were in the holding room for too long. Children were interviewed in the same interview rooms as adults.

S4 Force was rarely used against detainees, and the documentation for the one recent use demonstrated good efforts by staff at de-escalation and provided some assurance that the force used was proportionate.

S5 In the previous three months, over 600 detainees had been held in the facility for an average of six hours 30 minutes. Detainees were given written reasons for their detention but in English only. Detainees could not freely use a fax machine or access email to communicate with legal representatives. Tascor staff had inappropriately admitted detainees without an IS91, the legal authority to detain. We were not assured that detention was always kept to a minimum period.

Respect

S6 At our inspection in 2011, we made five recommendations in relation to this healthy establishment test, of which one was achieved, three were not achieved, and one was not possible to inspect.

S7 The environment was clean but shabby, and not suitable for long or overnight stays. There were no showers or adequate sleeping facilities and no tables for detainees to eat at. DCOs had access to a medical triage telephone line and airport emergency services.

S8 DCOs were polite and respectful to detainees, but their name badges were not easily legible. They had not had any diversity training. Detainees could practise their faith while in the holding room. Staff told us that disability care plans were used, but none had been completed in the previous three months. Professional telephone interpreting services had been used 37 times from the beginning of June 2014 to the end of August. There was no hearing loop facility, and no information in Braille.

S9 Complaint forms were freely available and the complaints box was emptied regularly. Contact details for the Independent Monitoring Board (IMB) were not displayed. Catering arrangements were adequate.

Activities

S10 At our inspection in 2011, we made one recommendation in relation to this healthy establishment test, which was not achieved.

S11 There was enough to occupy detainees held for a short time but not for detainees held for longer periods - in the previous three months, 84 detainees had been held for more than 12 hours. Detainees could not go outside, and the facility lacked natural light. Detainees were not allowed to smoke, and no nicotine patches or gum were available.

Preparation for removal and release

S12 At our inspection in 2011, we made two recommendations in relation to this healthy establishment test, which were not achieved.

S13 Detainees were not permitted to have visitors. They were not able to access email, Skype or social networks routinely to communicate with friends, family or legal representatives. Immigration removal centre (IRC) information cards were available for detainees transferring to further detention. There was no clothing at the holding room for those requiring it, although some was available at the Cayley House STHF on the Heathrow site.

Section 1. Safety

Escort vehicles and transfers

Expected outcomes:
Detainees under escort are treated safely, decently and efficiently.

1.1 We were unable to inspect escort vehicles or transfers into or from the holding room as none took place during the inspection. However, we found that a 63-year-old detainee had spent over two hours on an escort van being transported to the Harmondsworth immigration removal centre (IRC), which is next to the airport. The relevant incident report showed that he had been violent and disruptive in the holding room and that his behaviour might have been indicative of mental illness. After he was restrained, DEPMU decided to move the detainee to the nearby Colnbrook IRC. The detainee left the facility at 8.20pm and arrived at Colnbrook at 9.40pm, only to be refused entry as the centre was full. He was then taken to Harmondsworth IRC, next door to Colnbrook, where he was admitted at 10.30pm, two hours and 10 minutes after leaving the holding room. He was placed in the segregation unit on arrival. Given the detainee's mental state and age, more should have been done to ensure he was transferred swiftly.

Recommendation

1.2 Transfers should be properly planned and coordinated to ensure that detainees do not spend excessive periods on escort vehicles.

Arrival

Expected outcomes:
Detainees taken into detention are treated with respect, have the correct documentation, and are held in safe and decent conditions. Family accommodation is suitable.

1.3 There were two detainees already in the holding room when we arrived, but none were brought in during the inspection. The holding room was open 24 hours a day, seven days a week, and was staffed by two detainee custody officers (DCOs), who said that a female DCO was on duty for most, but not all, shifts. A rub-down search was usually undertaken by an officer of the same sex as the detainee and, in the absence of a female DCO, female detainees were searched by a male officer using a wand only (but see paragraph 1.17).

1.4 Detainees were not permitted to keep mobile phones with cameras and internet access. However, they were not routinely provided with an alternative mobile phone for use in the holding room with their SIM card. This restricted their ability to call friends, family or legal representatives as they could only tell them (via a free phonecard or the office telephone) the number of the payphone in the holding room for incoming calls.

1.5 A basic detention information leaflet was freely available to detainees in 16 languages. DCOs said they offered all detainees food on arrival (see paragraph 1.57), and toiletry packs were available to those who required them.

Recommendations

1.6 **A female detainee custody officer should be present at the holding room whenever a woman is detained there and for the duration of her detention**. (Repeated recommendation 1.12)

1.7 **Detainees should be given a mobile phone when in the holding room to contact friends, family and legal representatives.**

Bullying and personal safety

Expected outcomes:
Detainees feel and are safe from bullying and victimisation.

1.8 Women could only be held separately from men if no families were held in the second smaller holding room. Staff said that it was possible to move some detainees to the nearby Cayley House STHF, but this could not always be guaranteed. They told us that they had recently let a female detainee sit in the staff office after she was harassed by a male detainee, who was subsequently moved to Cayley House himself.

1.9 DCOs had a reasonably good view of the main holding room from their office. Areas outside their line of sight were covered by CCTV, which they could monitor from the staff office.

Recommendation

1.10 **Women detainees should always be offered the opportunity to be held in a separate room from unrelated men.** (Repeated recommendation 1.35)

Self-harm and suicide prevention

Expected outcomes:
The facility provides a safe and secure environment which reduces the risk of self-harm and suicide.

1.11 DCOs opened a 'suicide and self-harm' warning form for detainees at risk of self-harm. Risk information was identified and recorded correctly on IS91s (authority to detain documentation completed by Border Force officers) or, if the detainee was transferred from another place of detention in the UK, from the person escort record (PER). The warning forms accompanied detainees when they left the facility. Some detainees arriving from IRCs or prisons were supported through self-harm prevention case management procedures. DCOs said they would review the case management booklets and record observational entries as required.

1.12 One of the two members of staff on duty had recently received self-harm prevention training as part of an initial training course. The second, more experienced, officer had not received recent training. Both DCOs carried anti-ligature knives.

Recommendation

1.13 **All detention staff should have regular training in the prevention of self-harm.**

Safeguarding (protection of adults at risk)

Expected outcomes:
The centre promotes the welfare of all detainees, particularly adults at risk, and protects them from all kinds of harm and neglect.[1]

1.14 DCOs were not aware of a Tascor safeguarding adults policy. If they had concerns that a detainee might be at risk, they referred the case to a Border Force officer. Alternatively, they said they would open a disability care plan (see paragraph 1.51).

Recommendation

1.15 Through liaison with the local authority and other relevant bodies, Tascor should develop a national safeguarding adults policy, and all relevant staff should be familiar with this.

Safeguarding children

Expected outcomes:
The facility promotes the welfare of children and protects them from all kinds of harm and neglect.

1.16 In the previous three months, 49 children had been held – 34 accompanied and 15 unaccompanied. Accompanied children were held for an average of seven hours and 30 minutes, with the longest detention 22 hours and 45 minutes. Unaccompanied children were held for an average of six hours and 40 minutes, with the longest detention 21 hours and 20 minutes. The youngest unaccompanied child was eight years old.

1.17 The DCOs on duty during our inspection had recently taken part in a one-day safeguarding course run by the children's charity Barnardo's, which they found helpful. One DCO told us they routinely gave children a rub-down search instead of using a wand only, even if there was no specific intelligence to justify this, which was inappropriate. Before our inspection a five-year-old boy had been rubbed down. His care plan claimed the search was justified because 'of suspicion of parents passing things to him'. The care plan did not specify what things were suspected or whether the search had found anything.

1.18 DCOs completed child care plans for all children entering the holding room, accompanied or unaccompanied. The plans contained good basic information about the child but did not comment on their mood. Instead observational entries were made on the Tascor computer system, 'Recos'. Children were interviewed in the same interview rooms as adults, but with a 'responsible adult' present (an independent person who checks on the interests of the child under interview).

1.19 A member of the Border Force safeguarding and trafficking (SAT) team was detailed to work on every early or late shift. However, they were not routinely allocated to the night shift. The SAT team member advised and guided fellow Border Force officers on handling children or trafficking cases. SAT team members had recently completed a four-day training course with Hillingdon social services, the National Crime Agency, the Border Force intelligence

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

unit and the police, and had been addressed by a former victim of trafficking. However, not all SAT team members had completed tiers two and three of the Home Office's 'Keeping Children Safe' training. Unlike at Gatwick Airport, there were no social workers permanently based at Heathrow, which caused delays, especially out of hours (see the example below). Members of the SAT team met social services fortnightly to discuss recent cases. The Disclosure and Barring Service had recently carried out enhanced checks on the SAT team members. Despite these developments, we identified some shortcomings in children's casework.

1.20 Border Force had managed the case of a potential child victim of trafficking poorly. The 16-year-old girl was travelling on a US passport, but had left there when she was two and was brought up in an African country. She arrived at the immigration control desk with a British woman. Border Force officers were suspicious of the relationship between the two, detained the child and allowed the woman to proceed through the control. Directions were set to remove the child to the USA, even though she had not lived there for 14 years and did not speak English. Border Force contacted the US Department for Homeland Security to let them know the child was being removed. She was escorted from the holding room for the flight but the removal failed due to a ticketing problem. DCOs returned the child to the holding room. Removal directions were reset for the following morning and it was only at 2am on 11 September, some 16 hours after she was first detained, that Border Force made a referral to the national referral mechanism[2] for potential victims of trafficking. Despite this, removal directions remained in place and were only cancelled when the child told a Border Force officer that she did not want to travel to the USA. She was finally picked up by a social worker almost 34 hours after arriving at the airport. Following the child's release, the Home Office's competent authority[3] found reasonable grounds to believe the child was a victim of trafficking, and she was temporarily admitted to the UK for 45 days. The attempted removal to the US, the delay in placing the child in social services care and delay in referring her to the national referral mechanism indicated a lack of focus on promoting the child's best interests and welfare.

1.21 It took too long to transfer asylum-seeking families with children from the airport to initial accommodation. One family with two children were detained for seven hours and 45 minutes, released at 3.15am for 10 hours and re-detained for a further 15 hours. The family were finally released at 4.10am after spending 22 hours and 45 minutes in detention. Another asylum-seeking family with three children was held for 21 hours and 15 minutes before they were taken to initial accommodation.

1.22 Some unaccompanied minors also spent too long in detention. One 15 year old was held for 21 hours and 20 minutes before being granted temporary admission into the care of social services. A 16 year old was held for a total of around 20 hours after an unsuccessful attempt to remove him. He was finally released and processed through the 'new asylum model'. Two eight-year-old unaccompanied minors spent seven hours and 30 minutes in the holding room.

[2] Put in place in the UK in April 2009 to identify, protect and support victims of trafficking.

[3] Under the national referral mechanism, first responders refer to one of two 'competent authorities' to decide if the person is a victim of trafficking - the UK Human Trafficking Centre or the Home Office Immigration and Visas; see: http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism

Recommendations

1.23 **A member of Border Force's safeguarding and trafficking team should always be on duty, including night shifts.** (Repeated recommendation 1.52)

1.24 **Border Force, through discussion with Hillingdon social services, should ensure delays in transferring children into the care of social services are significantly reduced.**

1.25 **Children should be interviewed in a child-friendly environment.** (Repeated recommendation 1.53)

1.26 **All members of the SAT team should receive tiers two and three of the Keeping Children Safe training.** (Repeated recommendation 1.51)

1.27 **Children should only be detained in very exceptional circumstances and for a minimum time.**

1.28 **Potential victims of child trafficking should be referred to social services and the national referral mechanism without delay. Removal directions should not be set while a competent authority is making a reasonable grounds decision.**

Use of force

Expected outcomes:
Force is only used as a last resort and for legitimate reasons.

1.29 In the previous 12 months, force was used on three occasions. The last incident occurred in August 2014. The associated documentation for this case showed that DCOs had gone to considerable lengths to avoid using force by talking to the detainee to comply with their requests. In another case, a detainee was restrained after trying to escape from the facility. The third case involved a 63-year-old man who might have been suffering from a mental illness (see paragraph 1.1). The documentation assured us that the use of force was necessary and proportionate in all these cases. A Tascor manager reviewed the documentation. All DCOs were up to date with their control and restraint training.

Legal rights

Expected outcomes:
Detainees are fully aware of and understand their detention. Detainees are supported by the facility staff to exercise their legal rights freely.

1.30 The detainees held during our inspection had been given written reasons for their detention (IS91R) but in English only. Border Force staff said they explained the contents of the notices with an interpreter if necessary.

1.31 Notices in the holding rooms promoted the Civil Legal Advice helpline, which detainees could call to get contact details of immigration solicitors. However, there was no guarantee that detainees would receive legal advice after using the helpline. Detainees could not freely use a fax machine or access email, which might have impeded communication with their legal representatives.

1.32 The telephone numbers of five embassies were displayed by the payphone. Detainees transferring to IRCs were able to see an immigration adviser, and those claiming asylum were referred to an immigration representative.

Recommendations

1.33 **Written reasons for detention (IS91R) should be issued in a language the detainee can understand.** (Repeated recommendation 1.21)

1.34 **Detainees should be able to send legal documentation to representatives confidentially and quickly.** (Repeated recommendation 1.23)

Casework

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

1.35 In the previous three months, 616 detainees had been held, some on more than one occasion. The average length of detention was six hours and 30 minutes, and the longest was 36 hours.

1.36 The form authorising detention (IS91) for those held during our inspection was completed correctly. However, Tascor staff occasionally admitted detainees without an IS91, the legal authority for them to hold people. Although this was for short periods while Border Force officers completed the forms, this was inappropriate.

1.37 The detainees we spoke with had claimed asylum and understood why they were being detained, but were unsure what would happen next.

1.38 We were not assured that detention was always kept to a minimum period. For example, shortly before our inspection, a Dominican Republic national was held for 36 hours and a Syrian national for almost 25 hours. These were unreasonable lengths of time to hold people without access to adequate sleeping and washing facilities, natural light or fresh air.

Recommendations

1.39 **Detainees should not be held in the holding room before the written authority to detain (IS91) has been issued.** (Repeated recommendation 1.31)

1.40 **Border Force officers should confirm that detainees understand how their case is being handled and what will happen to them next.** (Part repeated recommendation 1.32)

1.41 **Detention should be kept to a minimum period and detainees should not be held for unreasonable lengths of time without access to sleeping and washing facilities, fresh air or natural light.**

Respect

Accommodation

Expected outcomes:
Detainees are held in a safe, clean and decent environment.

1.42 The holding room consisted of a staff office, small kitchen area, main holding room (see photographs, Appendix III), five interview rooms, a family room and a locked baggage storage room. The environment was clean but shabby looking and felt very institutional.

1.43 The holding room was not suitable for long or overnight stays (see recommendation 1.41). There were two fixed semi-reclined 'lounger' type seats but these were not adequate sleeping facilities for detainees spending long periods there. There were no showers; detainees were escorted to Cayley House if they wanted to shower, but this was time consuming and depended on staff availability. Blankets and pillows were available and had been provided to the detainees we saw. There were separate toilets for men, women and people with disabilities, which were clean, and sanitary products were freely available for women. There were no tables for detainees to eat at, and we saw the two detainees balancing very hot microwave meals on their laps.

1.44 The family room was small (see photographs, Appendix III), and adequately equipped with a TV and a range of children's toys. As it was located within the main holding room, children had to pass non-related adults to access it. Windows in the room were frosted for privacy but created a claustrophobic atmosphere. There was a fold-down, baby changing table in the disabled-access toilet, but its safety strap was broken. A travel cot, baby food, nappies and baby wipes were available, but there was no high chair. DCOs had petty cash to buy additional food from airport shops if required.

1.45 There was no dedicated health care provision on site, but DCOs could call a medical triage telephone line for advice – for example, to allow a detainee to take medication – or the airport emergency services if required.

Housekeeping points

1.46 Detainees should be able to eat hot meals at a table.

1.47 A high chair should be made available, and the safety strap on the baby changing table in the disabled-access toilet should be replaced.

Positive relationships

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

1.48 DCOs were polite, respectful and helpful to detainees (for example, they permitted them into the kitchen area to choose the food they wanted). The officers wore an identification card on a lanyard around their neck, but the writing was very small and their name and status were not clearly displayed.

Housekeeping point

1.49 DCO name badges should clearly display their name and status.

Equality and diversity

Expected outcomes:
There is understanding of the diverse backgrounds of detainees and different cultural backgrounds. The distinct needs of each protected characteristic, including race equality, nationality, religion, disability, gender, transgender, sexual orientation, age and pregnancy, are recognised and addressed.

1.50 The DCOs we spoke to told us they had not had any recent diversity training and were not familiar with all the protected characteristics or their duties under the Equality Act 2010.

1.51 Prayer mats and religious books were freely available, a sign on the wall indicated the direction of Mecca, and DCOs were familiar with the requirements of Ramadan. A poster gave information on the airport chaplaincy and how to contact them. Staff told us they completed a care plan for detainees with a disability, but none had been completed in the previous three months and there were none available at the holding room for us to inspect. Staff were aware of the designated telephone interpreting service and how to use it, and it had been used 37 times from the beginning of June 2014 to the end of August. There was no hearing loop facility, and no information in Braille.

Recommendations

1.52 DCOs should receive training in all aspects of diversity, including the wide-ranging backgrounds of, and particular issues faced by, detainees in the immigration system.

1.53 Information should be provided in Braille for those requiring it, and a hearing loop facility should be available.

Complaints

Expected outcomes:
Effective complaints procedures are in place for detainees which are easy to access and use, in a language they can understand. Responses are timely and can be understood by detainees.

1.54 We were not provided with any information about complaints submitted in the last year. Detainees could make a formal complaint using the standard Home Office complaint forms, which were available in a range of languages in a folder next to a secure complaints box. The box was emptied regularly by immigration staff (we posted a test complaint and staff responded to it the next day). Complaints were sent to a central Home Office department to be dealt with. Child-friendly complaint forms were available in the family room, and were dealt with in the same way

1.55 A poster displayed photographs of Independent Monitoring Board (IMB) members but there were no instructions on how to contact them. They visited the facility regularly.

Housekeeping point

1.56 Independent Monitoring Board contact details should be displayed in the holding room.

Catering

Expected outcomes:
Detainees are offered varied meals to meet their individual requirements. Food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

1.57 Catering provision was adequate. A range of microwave meals, including halal and vegetarian options, and sandwiches was available, and detainees could help themselves to snacks, fruit and hot and cold drinks in the holding room.

Activities

Expected outcomes:
The facility encourages activities to preserve and promote the mental and physical well-being of detainees.

1.58 There were enough activities for detainees held for short periods, including books, magazines and newspapers in a range of languages, and a television. A handheld DVD player and selection of DVDs were available on request. There were suitable activities for children (see paragraph 1.44). However, detainees held for longer periods could not go outside to exercise in the fresh air, and the facility lacked natural light (see recommendation 1.41). Detainees were not allowed to smoke, and no nicotine patches or gum were available.

Preparation for removal and release

Expected outcomes:
Detainees are able to maintain contact with the outside world and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property. Families with children and others with specific needs are not detained without items essential to their welfare.

1.59 Visitors were not permitted in the holding room, as it was airside. Detainees could not routinely access email, Skype or social networks to inform friends and family of what was happening or to communicate with legal representatives (see paragraph 1.31). Information cards with the address and telephone number of IRCs were available for detainees transferring to further detention. There was no clothing at the holding room for those requiring it, although DCOs said there was an easily accessible and plentiful supply at Cayley House.

Recommendations

1.60 **Detainees should have supervised access to the internet, including email, Skype and social networks.**

1.61 **Arrangements should be made to allow visitors to see detainees.** (Repeated recommendation 1.75)

Section 2. Recommendations and housekeeping points

Recommendations — To Home Office

2.1 Transfers should be properly planned and coordinated to ensure that detainees do not spend excessive periods on escort vehicles. (1.2)

2.2 A member of Border Force's safeguarding and trafficking team should always be on duty, including night shifts. (1.23, repeated recommendation 1.52)

2.3 Border Force, through discussion with Hillingdon social services, should ensure delays in transferring children into the care of social services are significantly reduced. (1.24)

2.4 Children should be interviewed in a child-friendly environment. (1.25, repeated recommendation 1.53)

2.5 All members of the SAT team should receive tiers two and three of the Keeping Children Safe training. (1.26, repeated recommendation 1.51)

2.6 Children should only be detained in very exceptional circumstances and for a minimum time. (1.27)

2.7 Potential victims of child trafficking should be referred to social services and the national referral mechanism without delay. Removal directions should not be set while a competent authority is making a reasonable grounds decision. (1.28)

2.8 Detainees should not be held in the holding room before the written authority to detain (IS91) has been issued. (1.39, repeated recommendation 1.31)

2.9 Border Force officers should confirm that detainees understand how their case is being handled and what will happen to them next. (1.40, part repeated recommendation 1.32)

2.10 Detention should be kept to a minimum period and detainees should not be held for unreasonable lengths of time without access to sleeping and washing facilities, fresh air or natural light. (1.41)

Recommendations — To the facility contractor

Arrival

2.11 A female detainee custody officer should be present at the holding room whenever a woman is detained there and for the duration of her detention. (1.6, repeated recommendation 1.12)

2.12 Detainees should be given a mobile phone when in the holding room to contact friends, family and legal representatives. (1.7)

Bullying and personal safety

2.13 Women detainees should always be offered the opportunity to be held in a separate room from unrelated men. (1.10, repeated recommendation 1.35)

Self-harm and suicide prevention

2.14 All detention staff should have regular training in the prevention of self-harm. (1.13)

Safeguarding (protection of adults at risk)

2.15 Through liaison with the local authority and other relevant bodies, Tascor should develop a national safeguarding adults policy, and all relevant staff should be familiar with this. (1.15)

Legal rights

2.16 Written reasons for detention (IS91R) should be issued in a language the detainee can understand. (1.33, repeated recommendation 1.21)

2.17 Detainees should be able to send legal documentation to representatives confidentially and quickly. (1.34, repeated recommendation 1.23)

Equality and diversity

2.18 DCOs should receive training in all aspects of diversity, including the wide-ranging backgrounds of, and particular issues faced by, detainees in the immigration system. (1.52)

2.19 Information should be provided in Braille for those requiring it, and a hearing loop facility should be available. (1.53)

Preparation for removal and release

2.20 Detainees should have supervised access to the internet, including email, Skype and social networks. (1.60)

2.21 Arrangements should be made to allow visitors to see detainees. (1.61, repeated recommendation 1.75)

Housekeeping points

2.22 Detainees should be able to eat hot meals at a table. (1.46)

2.23 A high chair should be made available, and the safety strap on the baby changing table in the disabled-access toilet should be replaced. (1.47)

2.24 DCO name badges should clearly display their name and status. (1.49)

2.25 Independent Monitoring Board contact details should be displayed in the holding room. (1.56)

Section 3. Appendices

Appendix I: Inspection team

Beverley Alden	Inspector
Colin Carroll	Inspector
Sarah Cutler	Inspector

Appendix II: Progress on recommendations from the last report

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

Safety

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

Recommendations

Staff escorting detainees through public areas and on aircraft should avoid drawing attention unnecessarily and have due regard to the dignity of detainees, especially if they are in restraints. (1.2)
Unable to inspect

Escorting staff should not give immigration advice to detainees but should signpost detainees to accredited legal advisers. (1.3)
Unable to inspect

A female DCO should be present in a holding room whenever a woman is detained there and for the duration of her detention. (1.12)
Not achieved (recommendation repeated 1.6)

Written reasons for detention (IS91R) should be issued in a language the detainee can understand. (1.21)
Not achieved (recommendation repeated 1.33)

The UK Border Agency should negotiate with the Legal Services Commission to allow detainees access to the police station telephone immigration advice service. (1.22)
Not achieved

Detainees should be able to send legal documentation to representatives confidentially and quickly. (1.23)
Not achieved (recommendation repeated 1.34)

Detainees should not be held in the holding room before the written authority to detain (IS91) has been issued. (1.31)
Not achieved (recommendation repeated 1.39)

Immigration officers should use interpretation services as soon as possible to communicate with newly arrived detainees who do not speak English. Immigration officers should confirm that detainees understand how their case is being handled and what will happen to them next. (1.32)
Partially achieved (second part repeated, recommendation 1.40)

Women should always be offered the opportunity to be held in a separate room from unrelated men. (1.35)
Not achieved (recommendation repeated 1.10)

Assessment, care in detention and teamwork (ACDT) booklets should be used for those at risk of self-harm or suicide. (1.40)
Not achieved.

DCOs should carry anti-ligature knives. (1.41)
Achieved

All members of the children and young person's team should receive tiers two and three of the Keeping Children Safe training. (1.51)
Not achieved (recommendation repeated 1.26)

A member of UKBA's children's and young person's team should always be on duty, including night shifts. (1.52)
Not achieved (recommendation repeated 1.23)

Children should be interviewed in a child-friendly environment. (1.53)
Not achieved (recommendation repeated 1.25)

Immigration officers should be aware of and refer potential victims of trafficking to the national referral mechanism. (1.54)
Achieved

A female DCO should be present in a holding room whenever an unaccompanied child is detained there and for the duration of his or her detention. (1.55)
Achieved

Displayed information about detention should be available in the most common languages spoken by detainees. (1.68)
Achieved

Respect

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

Recommendations

Detainees held at the facility for substantial periods or overnight should be able to take showers. (1.13)
No longer relevant

Detainees should not be held for substantial periods or overnight without adequate sleeping facilities. (1.14)
Not achieved

Telephone interpretation should be used to communicate with detainees who cannot speak fluent English. (1.17)
Achieved

All staff should receive regular refresher training in diversity issues. (1.59)
Not achieved

Disability care plans should be detailed and state specifically how a detainee's additional needs will be met. (1.60)
Unable to inspect

Activities

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

Recommendations

Detainees should not be held for substantial periods without access to exercise in the fresh air. (1.62)
Not achieved

Preparation for removal and release

Detainees are able to maintain contact with the outside world and be prepared for their release, transfer or removal.

Recommendations

Detainees should have access to the internet and be able to send and receive emails. (1.74)
Not achieved

Arrangements should be made to allow visitors to see detainees. (1.75)
Not achieved (recommendation repeated, 1.61)

Appendix III: Photographs

Main holding room

Family room

Family room