Report on an unannounced inspection of the short-term holding facility at

# Manchester Airport

by HM Chief Inspector of Prisons

13 January 2016

#### **Glossary of terms**

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#### Fact page

# Fact page

#### **Task of the establishment** To hold immigration detainees for up to 24 hours.

**Location** Manchester Airport, Terminal 2

Name of contractor Tascor

Last inspection 13-14 May 2013

**Escort provider** Tascor

## Overview

Manchester Airport is the UK's third busiest airport in passenger numbers and the largest outside London. The short-term holding facility (STHF) is in Terminal 2, next to the arrivals hall, and is run by the private contractor Tascor on behalf of the Home Office. Many detainees arrived directly from flights and were held after being refused entry to the UK.

In the previous three months, the total number of detainees held at the facility was 124,<sup>1</sup> of whom 77% were male, and the average age was 32 years old.<sup>2</sup> The majority of detainees, 91%, were travelling individually. Detainees originated from 32 different countries, the most common being Pakistan (24%), Albania (17%), United States (11%) and Iran (10%).

The average length of detention was four hours and 34 minutes,<sup>3</sup> with the longest single period of detention at 45 hours and 25 minutes. Nine per cent of detainees were held for over 12 hours during a single period of detention, and 1% for over 24 hours. Almost a quarter of detainees, 23%, had been held at the facility more than once.

No unaccompanied children had been held at the facility during the previous three months. The total number of accompanied children held was six, the youngest of whom was four years old and the oldest was 17. The average length of detention for accompanied children was 14 hours and 33 minutes, with the longest single period of detention for accompanied children at 20 hours and 30 minutes, which was too long.<sup>4</sup>

On the day of inspection there were two detainees in the holding room, both men. An Independent Monitoring Board had regular oversight of the facility.

Individual detainees within the dataset were identified using a port reference number (PRN). From the 156 detention events recorded, details of a PRN were available in 155 cases.

 $<sup>^2</sup>$  With ages ranging from 4 to 71 years (median age 31) (N=123).

<sup>&</sup>lt;sup>3</sup> The median length of the detention events logged was three hours (N=156).

<sup>&</sup>lt;sup>4</sup> With a median time of 11 hours and 34 minutes.

# 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

- SI At our inspection in 2013, we made 13 recommendations in relation to this healthy establishment test, three of which were achieved and 10 not achieved.
- S2 Most detainees' journeys were short; they had usually been detained straight from a flight or came from the neighbouring Pennine House short-term holding facility (STHF). Searching was undertaken in an open area with no privacy. Detainees were unable to make telephone calls until approved to do so by Border Force staff; one detainee had been unable to make any calls since arriving in the holding room at 9pm the night before our inspection. The same detainee, who said he was diabetic, had not been screened by health care staff; he had arrived without his medication and had not taken any for the previous two days.
- S3 Men and women were held together in a single holding room, which could be intimidating for women. Staff could not recall any instances of bullying. We were able to speak to one of the detainees in the holding room, who said he felt safe. The incidence of self-harm was low. Detainee custody officers (DCOs) had not undertaken safeguarding adults training, and most were not familiar with trafficking indicators or the national referral mechanism.<sup>5</sup>
- S4 Not all DCOs had had recent safeguarding children training. We were told that cases of detainees claiming to be minors were rare. There was a room available for families and unaccompanied minors, managed by Border Force staff, although records showed it was not used often; its purpose and governance arrangements were unclear. Unaccompanied children were cared for in the room by a member of the airport chaplaincy or airline staff. The Border Force officers were unaware if such staff had been cleared by the Disclosure and Barring Service (DBS), and there was no requirement for them to be trained in safeguarding.
- S5 Use of force was rare in the holding room. Detainees were no longer handcuffed when they were transferred from the holding room to the neighbouring residential facility Pennine House. All DCOs had been trained in the Home Office Manual for Escorting Safely (HOMES).
- S6 Information on advice and support agencies was displayed in several languages. Staff told us they faxed documents to legal representatives on behalf of detainees, who could retain legal papers. We were not assured that interpreting services were always used when required.
- S7 DCOs were sometimes asked to look after people in interview rooms who had not yet been detained, which was not appropriate.

<sup>5</sup> Put in place in the UK in April 2009 to identify, protect and support victims of trafficking.

### Respect

- S8 At our inspection in 2013, we made three recommendations in relation to this healthy establishment test, all of which were not achieved.
- S9 The environment in the STHF was clean but austere, with no natural light or access to fresh air, and was unsuitable for overnight stays. It was also cold. Staff were polite and courteous to detainees but their interaction was functional.
- S10 DCOs we spoke to told us they had not had any recent diversity training. Detainees were able to practise their faith in the holding room but were unable to use a prayer room nearby. We were not assured the complaints box was emptied daily. The only hot food available was a selection of unappealing long-life microwave meals.

### Activities

- SII At our inspection in 2013, we made one recommendation in relation to this healthy establishment test, which was not achieved.
- S12 Activities were suitable for short stays only.

### Preparation for removal and release

- S13 At our inspection in 2013, we made one recommendation in relation to this healthy establishment test, which was not achieved.
- S14 No visits were permitted. Detainees had no access to the internet, which was a disproportionate restriction.

## Section 1. Safety

### Escort vehicles and transfers

#### **Expected outcomes:**

#### Detainees under escort are treated safely, decently and efficiently.

1.1 Most detainees' journeys to the facility were short; they had usually been detained directly from flights or came from the neighbouring Pennine House residential short-term holding facility (STHF) either for interview by Border Force officers or in readiness for a flight. Those going to and coming from Pennine House were no longer routinely handcuffed through the airport security checkpoint.

### 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.

- 1.2 The facility was open 24 hours a day, seven days a week. It was staffed by four detainee custody officers (DCOs) and we were told that male and female officers were usually on duty together. If the gender mix was not balanced, staff could be brought over from Pennine House. Officers said they would not accept a detainee without written authority to detain them (an IS91 document).
- **1.3** Detainees were given a rub-down search in an open area as there was no designated private space. Detainee property was kept in a storage area. A small stock of spare clothing and hygiene packs was kept on site, and since our last inspection a wet room had been added, enabling detainees to shower if desired.
- 1.4 Detainees were not permitted to make any telephone calls until approved to do so by Border Force officers, which was usually after they had been interviewed. While this was not unreasonable per se, it relied on interviews taking place quickly. However, one detainee we spoke to had been unable to make any calls since arriving in the holding room at 9pm the previous night, as he was still waiting to be interviewed. The Border Force officer dealing with the case told us there was no reason why the detainee should have been prevented from making calls.
- 1.5 There was no health care provision in the holding room, but DCOs were able to call a medical advice line. The same detainee we spoke to above, who said he was diabetic, had not had a health screening. He had arrived without his medication and had not taken any for the previous two days, which was potentially dangerous. Despite this, DCOs had not called the advice line and Border Force staff were intending to place him directly back on to a flight.

#### Recommendations

**1.6** Detainees should be searched in a suitable private area. (Repeated recommendation 1.7)

- 1.7 Detainees should be offered a free telephone call on arrival, and have further access to a telephone to contact family, friends and legal representatives.
- **1.8** Detainees should have access to appropriate health care provision.

### Bullying and personal safety

#### **Expected outcomes:**

#### Detainees feel and are safe from bullying and victimisation.

- 1.9 There was a large observation window between the holding room and the staff area, which enabled staff to supervise the holding room at all times. There were closed-circuit television (CCTV) cameras with recording facilities. DCOs could not remember any instances of bullying or intimidation. Detainees we spoke to said they felt safe in the facility.
- 1.10 Women and men were held together in the single holding room, which some women might have found intimidating. Female DCOs were on duty during our inspection. We were told if a female was particularly vulnerable she could be placed in the vulnerable detainee holding room under the supervision of Border Force. This room, which had opened since our last inspection, was also available for families and unaccompanied children (see paragraph 1.21). However, records indicated that it was used infrequently; in fact, only once in the previous three months, even though there had been families held in the main holding room. We were not assured the room had a clear purpose that all staff understood. Governance arrangements were unclear, as those held in the new room were not subject to an IS91 (authority to detain) document. In addition, DCOs did not supervise this room, although it had CCTV coverage and Border Force staff made hourly welfare checks. However, Border Force staff were not trained in safer custody and there were no safer custody procedures. There were risks with the most vulnerable detainees being looked after by the least experienced staff. (See also paragraph 1.14, and recommendation 1.39.)

#### Recommendation

**1.11** The purpose of the vulnerable detainee room should be clarified and governance arrangements, including legal and practical implications, made clear and robust.

### Self-harm and suicide prevention

#### **Expected outcomes:**

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

**1.12** Staff could not recall any incidents of self-harm. They told us they would open a suicide and self-harm warning form if they had concerns about a detainee, but this was rare. Not all staff had received recent training in suicide and self-harm prevention for detainees at risk of suicide or self-harm. All staff carried anti-ligature knives.

#### Recommendation

**1.13** Staff should receive up-to-date training in suicide and self-harm prevention. (Repeated recommendation 1.12)

### Safeguarding (protection of adults at risk)

#### **Expected outcomes:**

# The centre promotes the welfare of all detainees, particularly adults at risk, and protects them from all kinds of harm and neglect.<sup>6</sup>

- 1.14 DCOs we spoke to were aware of the general vulnerability of detainees and the need to keep them safe in the facility, but had little understanding of the concept of adult safeguarding and had received no training on this. There was no policy for managing vulnerable adult detainees, no care planning arrangements for them and no agreed procedures for managing victims of alleged or suspected abuse.
- 1.15 One staff member had some limited awareness of trafficking indicators, but others had none. No staff were aware of the national referral mechanism for reporting suspected victims of trafficking. We were told Border Force would deal with any trafficking issue before detainees were placed in the care of DCOs. Staff had some awareness of safeguarding issues regarding female genital mutilation.
- **1.16** We were told that if a female detainee was particularly vulnerable, for example, if it was thought she had been trafficked, she could be placed under the care of the immigration team in the vulnerable detainee holding room (see paragraph 1.10).

#### Recommendations

- 1.17 A policy for managing vulnerable detainees should be developed in liaison with the local director of adult social services and the local safeguarding adults board. (Repeated recommendation 1.14)
- 1.18 Staff should be trained in the identification of trafficking victims and concerns relating to trafficking should be shared by DCOs with Border Force staff at the earliest opportunity.

### Safeguarding children

#### **Expected outcomes:**

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

- 1.19 No unaccompanied children had been held at the facility in the previous three months. The total of accompanied children held was six, the youngest of whom was four years old. The average (mean) length of detention for accompanied children was 14 hours and 33 minutes, with the longest single period of detention being 20 hours and 30 minutes, which was too long. Two children had been held for over 12 hours; none were held for over 24 hours. Detainees travelling as a family unit were nine times more likely to be detained for 12 hours or more compared with those travelling individually.
- **1.20** DCOs underwent enhanced level Disclosure and Barring Service (DBS) checks. Not all had received recent training in safeguarding children. All children were required to have a

<sup>&</sup>lt;sup>6</sup> We define an adult at risk as a person aged 18 years or over, 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. 'No secrets' definition (Department of Health 2000).

childcare plan, although Tascor were only able to supply us with plans for four of the six held. Plans consisted largely of a simple questionnaire and tick boxes, which helped identify issues, but did not encourage active, tailored planning for a child's welfare. One merely noted that a father had said his child had a mental illness and was no longer taking medication, without recording any consequential actions. The child was held for over 11 hours which was excessive, particularly for a child who may have been suffering from mental illness.

- 1.21 Since the last inspection, a vulnerable detainee holding room had been opened (see paragraph 1.10). This was not part of the holding facility and was managed by Border Force rather than Tascor staff. Unaccompanied children and those with families, and some vulnerable female detainees, could be released from the custody of Tascor and placed in this room. If an unaccompanied child were placed there, an airport chaplaincy or airline staff member would sit with them and act as a 'responsible adult'. The immigration team was unaware if chaplaincy or airline staff used for this purpose were DBS cleared, and there was no requirement for them to be trained in safeguarding children. (See recommendation 1.39.)
- 1.22 Border Force's local safeguarding and trafficking team was responsible for children's cases or advised colleagues handling children's cases. Efforts had been made to check team members to the DBS enhanced level but some checks were outstanding. Team members received advanced training on safeguarding children. The team knew about its duties to safeguard and promote the welfare of children. Staff had good awareness of trafficking issues, and some children and adults had been referred to the national referral mechanism. Some detainees were granted the 'recovery and reflection' period of 45 days as it was considered likely that they were victims of trafficking. During this period a person cannot be removed from the UK; the aim is to give the victim time to recover and escape the influence of traffickers and/or to take an informed decision on cooperating with the authorities. The Home Office was aware of the dangers of re-trafficking, and some had their mobile phones removed.
- 1.23 Interagency liaison through the local children's safeguarding board had been lacking, but was being relaunched at the time of the inspection. There was an out-of-date memorandum of understanding setting out the responsibilities of the Home Office, social services and the Greater Manchester Police, which did not contain definite timescales for referral responses, but which was being revised. There had been no unaccompanied minors held in the facility in the previous three months, and we were told that cases of unaccompanied detainees arriving and claiming to be minors were rare. However, we were told that when such circumstances arose, there could be significant delays in social services staff attending the airport due to competing demands and the fact that it regarded the airport as a relatively safe environment for children. We were told it was particularly difficult to persuade social services to take responsibility for 16- and 17-year-old children.

#### Recommendations

- 1.24 Children's care plans should be purposeful; they should set out tailored planning which protects and promotes the welfare and safety of children while in detention.
- 1.25 All staff who have contact with children in detention should have an enhanced level Disclosure and Barring Service (DBS) check and receive regular safeguarding children training.

1.26 The memorandum of understanding between the Home Office and Manchester social services should contain defined timeframes for referral responses. (Repeated recommendation 1.27).

### Use of force

#### **Expected outcomes:**

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

1.27 All staff had been trained in the use of force and de-escalation techniques in 2015. DCOs could not remember the last time force had been used, and such use was rare. Staff told us that an airline pilot would be unlikely to accept a passenger if force was required to board them. In this situation, removal directions were usually rescheduled for a later date so that the detainee could be accompanied by overseas escort officers. Detainees from the nearby Pennine House STHF were no longer routinely handcuffed as they passed through airport security (see paragraph 1.1).

### 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.

1.28 A notice beside the telephone in the holding room promoted the Civil Legal Advice helpline in different languages. The helpline provided details of organisations offering asylum seekers legal aid. Detainees who had lawyers could keep in touch with them by fax and telephone, although access to the latter could be delayed (see paragraphs 1.4 and 1.58 and recommendation 1.7). Staff were willing to fax documents from the DCOs' office to lawyers. Detainees could not communicate with their lawyers by email (see recommendation 1.60), and legal visits were not permitted because the holding room was airside.

### Casework

#### **Expected outcomes:**

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

- 1.29 In the previous three months, the number of detainees held at the facility totalled 124, of who 77% were male, and the average (mean) age was 32; 91% of detainees were travelling individually. Detainees originated from 32 different countries, the most common being Pakistan (24%), Albania (17%), United States (11%) and Iran (10%). The average length of detention was four hours and 34 minutes, with the longest single period of detention being 45 hours and 25 minutes, which was too long. Nine per cent of detainees had been held for over 12 hours during a single period of detention, and 1% for over 24 hours. Almost a quarter of detainees, 23%, had been held at the facility more than once.
- 1.30 Detainees were given a copy of the reasons for their detention (document IS91R) but in English only. Border Force practice here, as elsewhere, was for the reasons for detention to be explained to non-English speakers through an interpreter. However, we were not assured that this always happened. One detainee held during the inspection had the reasons read to

him in English, which he could not understand. An interpreter was used for subsequent interactions with both Tascor and Border Force staff.

1.31 Border Force staff questioned detainees in interview rooms next to the facility. DCOs told us that Border Force staff sometimes left individuals unaccompanied in interview rooms and asked them to 'keep an eye on them'. DCOs were uneasy about this practice, as it was not clear under whose custody the individuals fell.

#### Recommendations

- **1.32** The Home Office should progress cases speedily to ensure that detainees are held for the minimum time. (Repeated recommendation 1.33)
- **1.33** Detainees should be provided with written reasons for their detention in a language they can understand. (Repeated recommendation 1.34)
- 1.34 The legal and practical implications of detaining people in interview rooms should be clarified by the Home Office and Tascor. (Repeated recommendation 1.35)
- **1.35** Professional interpreting should be used to communicate with detainees who cannot understand English.

# Respect

### Accommodation

#### **Expected outcomes:**

#### Detainees are held in a safe, clean and decent environment.

- **1.36** Detainees were frequently held overnight or after long flights. The facility comprised a single holding room, a staff area and storage room. Next to the staff area were several interview rooms used by Border Force staff. The holding room was clean, but cramped and dingy, with no natural light. It was also cold and staff could not control the temperature, which was set centrally in the airport. It was not suitable for lengthy detentions. (See also recommendation 1.57.)
- 1.37 In addition to fixed chairs, the holding room had a hard reclining chair and a large beanbag. There was no space where people staying overnight could sleep, although pillows and blankets were available. Separate male and female toilets adjoined the holding room and were appropriately screened, with sanitary supplies and a baby changing facility in the women's toilet. A shower had been fitted since our last inspection.
- 1.38 Since the last inspection, a 'vulnerable detainee' holding room had been opened (see paragraph 1.21). However, the governance of this room was not clear as detainees held there were not in the custody of Tascor. In addition, it was clear from the records that children and families were still held overnight in the main holding room (see paragraph 1.10).

#### Recommendation

1.39 Women, families and children should be detained in separate and appropriate accommodation with supervision from suitably trained staff.

#### Housekeeping point

**1.40** Staff should be able to control the temperature at the facility to ensure that it is comfortable.

### 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.

- 1.41 Staff were courteous and polite to the detainees held during our inspection, and those we spoke to were positive about their care. It was evident staff would readily assist detainees on request, but they remained mainly in the staff office and did not regularly go into the holding room to check on detainees. As a result, their interaction with those held was mainly functional.
- **1.42** Staff wore identification cards but their names and status were too small to read clearly, and some cards were concealed underneath fleece jackets and could not be read at all.

#### Recommendation

#### **1.43** All DCOs should be proactive in engaging with detainees.

#### Housekeeping point

**1.44** Staff should wear clearly legible name badges.

### 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.

- 1.45 DCOs had undertaken diversity training as part of their initial training course but none we spoke to had received any refresher training. Despite this, the more experienced staff demonstrated an awareness of diversity issues and cultural differences.
- **1.46** Detainees could practise their religion; copies of the Bible, Qur'an and prayer mats were freely available, and the airport chaplaincy could be contacted on request. However, detainees were not permitted to use a prayer room next door to the holding room, a regulation which DCOs said had been set by Border Force staff.
- **1.47** Care plans were opened for detainees with disabilities, although DCOs could not recall the last time one was needed. Detention staff were unaware of any policy for the management of transgender detainees, and those we spoke to had not had any experience of such detainees.
- 1.48 We were not assured that interpreting services were always used when required (see paragraph 1.30 and recommendation 1.35). We requested data confirming the number of times telephone interpreting had been used in the previous three months, but this had not been provided at the time of writing. The only available data were for the period July to September 2015 and showed that telephone interpreting had been used 11 times, which was low for the numbers passing through the facility. The range of languages requested included Kurdish, Arabic, Vietnamese and Albanian.

#### Recommendation

#### 1.49 Staff should receive ongoing equality and diversity training.

#### Housekeeping points

- **1.50** Detainees should have access to the neighbouring prayer room.
- **1.51** There should be policies and procedures for the management of transgender detainees, and all staff should be familiar with these.

### 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.

- 1.52 Complaint forms in a variety of languages were freely available. The complaints box was emptied by a Border Force Higher Officer who visited the facility daily and who was responsible for sending complaints to the central detention services complaints unit to be processed. However, we were not assured that the box was emptied daily as it took a week to receive a response to a test complaint form we submitted during the inspection.
- **1.53** We requested data from detention services on the number of complaints and their outcome, but were advised that these were not available.

#### Housekeeping point

**1.54** The complaints box should be emptied daily.

### 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.

1.55 Snacks and some fruit were available in the holding room. A drinks dispenser was freely accessible for hot and cold drinks. In the absence of a freezer, the only hot food available was a selection of unappetising long-life microwave meals. A small range of sandwiches was also available. We were told that staff could use petty cash to buy food in the airport for detainees with special dietary needs.

# Activities

#### **Expected outcomes:**

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

1.56 The activities available were suitable for short stays only. Detainees had access to a small television in the holding room. There was also a small selection of books and newspapers, some in non-English languages. A range of DVDs, including some for children, were kept in the DCOs' office. A variety of children's toys, books and colouring books were also available. Detainees could not go outside into the fresh air.

#### Recommendation

1.57 Detainees held for more than a few hours should have access to the fresh air.

# 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.

- 1.58 Visitors were not allowed at the facility because it was airside. Detainees were permitted to keep their mobile phone if it had no camera or internet access, or could borrow a suitable phone from staff. A payphone in the holding room could receive incoming calls, although it had no privacy hood. However, there were delays in detainees' access to telephones (see recommendation 1.7). Detainees had no access to the internet, which was an inappropriate restriction.
- **1.59** A number of information cards were available with basic details about other centres where detainees might be transferred.

#### Recommendation

1.60 The internet should become a meaningful resource for communication, information and recreation for detainees at all immigration facilities. Detainees should have access to all documents and websites, including email, social networking sites and Skype, unless an individual risk assessment indicates otherwise.

#### Housekeeping point

**1.61** The payphone in the holding room should have a privacy hood.

# Section 2. Recommendations and housekeeping points

### Recommendations

### To the Home Office

- **2.1** All staff who have contact with children in detention should have an enhanced level Disclosure and Barring Service (DBS) check and receive regular safeguarding children training. (1.25)
- **2.2** The memorandum of understanding between the Home Office and Manchester social services should contain defined timeframes for referral responses. (1.26, repeated recommendation 1.27)
- **2.3** The Home Office should progress cases speedily to ensure that detainees are held for the minimum time. (1.32, repeated recommendation 1.33)
- 2.4 The internet should become a meaningful resource for communication, information and recreation for detainees at all immigration facilities. Detainees should have access to all documents and websites, including email, social networking sites and Skype, unless an individual risk assessment indicates otherwise. (1.60)

### **Recommendation** To the Home Office and facility contractor

**2.5** The legal and practical implications of detaining people in interview rooms should be clarified by the Home Office and Tascor. (1.34, repeated recommendation 1.35)

### Recommendations

To the facility contractor

### Arrival

- 2.6 Detainees should be searched in a suitable private area. (1.6, repeated recommendation 1.7)
- **2.7** Detainees should be offered a free telephone call on arrival, and have further access to a telephone to contact family, friends and legal representatives. (1.7)
- 2.8 Detainees should have access to appropriate health care provision. (1.8)

### Bullying and personal safety

**2.9** The purpose of the vulnerable detainee room should be clarified and governance arrangements, including legal and practical implications, made clear and robust. (1.11)

### Self-harm and suicide prevention

**2.10** Staff should receive up-to-date training in suicide and self-harm prevention. (1.13, repeated recommendation 1.12)

#### Safeguarding (protection of adults at risk)

- **2.11** A policy for managing vulnerable detainees should be developed in liaison with the local director of adult social services and the local safeguarding adults board. (1.17, repeated recommendation 1.14)
- 2.12 Staff should be trained in the identification of trafficking victims and concerns relating to trafficking should be shared by DCOs with Border Force staff at the earliest opportunity. (1.18)

#### Safeguarding children

**2.13** Children's care plans should be purposeful; they should set out tailored planning which protects and promotes the welfare and safety of children while in detention. (1.24)

#### Casework

- **2.14** Detainees should be provided with written reasons for their detention in a language they can understand. (1.33, repeated recommendation 1.34)
- **2.15** Professional interpreting should be used to communicate with detainees who cannot understand English. (1.35)

#### Accommodation

**2.16** Women, families and children should be detained in separate and appropriate accommodation with supervision from suitably trained staff. (1.39)

#### **Positive relationships**

2.17 All DCOs should be proactive in engaging with detainees. (1.43)

#### Equality and diversity

2.18 Staff should receive ongoing equality and diversity training. (1.49)

#### Activities

2.19 Detainees held for more than a few hours should have access to the fresh air. (1.57)

### Housekeeping points

- **2.20** Staff should be able to control the temperature at the facility to ensure that it is comfortable. (1.40)
- 2.21 Staff should wear clearly legible name badges. (1.44)
- **2.22** Detainees should have access to the neighbouring prayer room. (1.50)

- 2.23 The complaints box should be emptied daily. (1.54)
- **2.24** There should be policies and procedures for the management of transgender detainees, and all staff should be familiar with these. (1.51)
- 2.25 The payphone in the holding room should have a privacy hood. (1.61)

# Section 3. Appendices

# Appendix I: Inspection team

Beverley Alden Deri Hughes-Roberts Inspector 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

Handcuffs should only be applied to detainees transferring between the residential and nonresidential facilities if justified by an individual risk assessment. The Home Office should liaise with airport authorities to resolve this issue. (1.2) **Achieved** 

Detainees should be searched in a suitable private area. (1.7) **Not achieved** (recommendation repeated, 1.6)

Detainees should be able to shower. (1.8) Achieved

Detention custody officers should routinely carry anti-ligature knives. (1.11) **Achieved** 

Staff should receive up-to-date training in suicide and self-harm. (1.12) **Not achieved** (recommendation repeated, 1.13)

A policy for managing vulnerable detainees should be developed in liaison with the local director of adult social services and the local safeguarding adults board. (1.14) **Not achieved** (recommendation repeated, 1.17)

Families and unaccompanied minors should not be held in the holding room. (1.24) **Not achieved** 

All detainee custody officers should receive up-to-date safeguarding children training. (1.25) **Not achieved** 

Home Office staff who have contact with children should receive an enhanced level Criminal Records Bureau (CRB) check. (1.26) **Not achieved** 

The memorandum of understanding between the Home Office and Manchester social services should contain defined timeframes for referral responses. (1.27) **Not achieved** (recommendation repeated, 1.26)

The Home Office should progress cases speedily to ensure that detainees are held for the minimum time. (1.33)

Not achieved (recommendation repeated, 1.32)

Detainees should be provided with written reasons for their detention in a language they can understand. (1.34) **Not achieved** (recommendation repeated, 1.33)

The legal and practical implications of detaining people in interview rooms should be clarified by the Home Office and Tascor. (1.35) **Not achieved** (recommendation repeated, 1.34)

### Respect

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

#### Recommendations

The holding room should be redecorated and regularly refurbished, as required. (1.41) **Not achieved** 

Women, families and children should be detained in separate and appropriate accommodation. (1.42) **Not achieved** 

Staff should receive routine refresher training in all aspects of the diversity policy and procedures. (1.47) Not achieved

### Activities

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

#### Recommendation Detainees held for more than a few hours should have access to fresh air and somewhere to smoke. (1.54)

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.

#### Recommendation Detainees should have access to the internet. (1.57) Not achieved