

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

Capital Building, Liverpool

by HM Chief Inspector of Prisons

22 March 2016

Glossary of terms

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Fact page

Task of the establishment

To hold immigration detainees following arrest or reporting and before transfer to residential detention

Location

Capital Building, Liverpool

Name of contractor

Tascor

Last inspection

2 May 2012

Escort provider

Tascor

Introduction

Capital Building in Liverpool is the centre of the Home Office immigration operations in Liverpool. The building houses UK Visas and Immigration caseworkers, an immigration compliance and enforcement (ICE) team and a reporting centre. Approximately 120 people a day attend the reporting centre to comply with the conditions of their temporary admission to the UK. Caseworkers interview about seven individuals a day concerning their applications to remain in the UK as the spouse of an EU national.

The short-term holding facility on the ground floor is used to hold individuals who have been arrested in the community by the ICE team, detained after attending the reporting centre or following the rejection of their EU spouse application. Detainees are held in the facility before transfer to a residential detention facility and ultimate removal from the UK.

The private company Tascor runs the facility on behalf of the Home Office. The facility is open 9am to 5pm, three days a week: Monday to Wednesday one week and Wednesday to Friday the next. The facility has two holding rooms separated by an office used by the two detainee custody officers who staff the facility. On the day of our inspection, three detainees were held. The Independent Monitoring Board visits the facility regularly.

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. Our reports are usually based on the 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 detention¹

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.

¹ Non-residential STHFs are unsuitable for long stays and detainees should not be held in them for more than a few hours. This limits what activities can or need to be provided. We will therefore report any notable issues concerning activities in the accommodation and facilities section.

Summary

- S1 At our inspection in 2012, we made 10 recommendations, six of which were achieved and four were not achieved.
- S2 Escort vans were appropriately equipped. Person escort records were completed for Tascor escorts. The routine removal of detainees' belts was a disproportionate security measure. Detainee custody officers (DCOs) were reassuring and sensitive to detainees' needs on arrival. Detainees had good access to telephones.
- S3 Male and female detainees could be held separately. DCOs had good oversight of the holding rooms but there was a blind spot in the closed-circuit television coverage of the smaller holding room. Two detainees had tried to harm themselves during the previous six months. DCOs had taken appropriate action to keep these detainees safe. DCOs did not carry anti-ligature knives.
- S4 DCOs had used force on four occasions during the previous six months. In one incident they managed a disruptive young detainee poorly. Records described the chaotic and unsuccessful use of de-escalation and restraint techniques. Immigration Enforcement officers routinely wore stab vests in the facility. DCOs were unaware of any adult safeguarding policy. Planning for the transfer of a detainee with a disability from the facility to Morton Hall was good but DCOs did not open a disability care plan while he was in the facility.
- S5 Detainees could keep in touch with their legal representatives by fax and telephone. Notices promoted the services of the Civil Legal Advice helpline which gave detainees details of publicly funded legal advisers. Detainees were held with the correct authority to detain (IS91) and served with the reasons for their detention, notice of removal and bail forms. Sixty detainees had been held during the previous three months for an average of just under three and a quarter hours.
- S6 The holding rooms were clean and in a good state of repair but were untidy and lacked natural light. Toilets were not properly screened. Provision of food was adequate for short stays. Detainees could not go outside into the fresh air or watch television. There was not enough foreign language reading material.
- S7 DCOs understood the needs of detainees and offered support sensitively. Detainees could complain in writing but we were not confident that complaint boxes were emptied every day. Prayer mats were stored disrespectfully and copies of the Bible were not held.
- S8 Detainees were transferred from the facility through a back door of Capital Building to escort vehicles waiting in an enclosed car park. Members of the public could not observe detainees leaving the facility and boarding vans. DCOs no longer handcuffed detainees on departure but instead linked arms with detainees for the short distance between the back door and the escort vehicle.
- S9 Detainees could not access the internet or email.

Section 1. Safety

Arrival

Expected outcomes:

Detainees under escort are treated safely, decently and efficiently. Detainees taken into detention are treated with respect, have the correct documentation, and are held in safe and decent conditions.

- I.1** Most detainees arrived at the facility after attending the reporting centre. Others were picked up in the community by the immigration compliance and enforcement team or were detained after being interviewed by a caseworker concerning their application for leave to remain as the spouse of an EU national. No detainees arrived at the facility during our inspection. The van that we inspected was adequately equipped. Person escort records were used for all Tascor transfers to and from the facility.
- I.2** Two detainee custody officers (DCOs), one male and one female, staffed the facility from 9am to 5pm, three days a week. If someone was detained outside these hours, they stayed on or, on rare occasions, Immigration Enforcement officers supervised detainees when Tascor staff were not present.
- I.3** Detainees were given a rub-down search on arrival. One detainee's belt was removed when there was no suggestion of risk, which was disproportionate. We were told that this was routine. Property was tagged in front of detainees and bags were left in the DCOs' office. Detainees' cash was also taken, which was unnecessary.
- I.4** A DCO gave new arrivals a brief induction and asked basic questions about their welfare. DCOs were reassuring and sensitive to the needs of detainees, for example, explaining to those being transported to Pennine House that they would not be deported that day and that they could have visits when they were taken to an immigration removal centre.
- I.5** A free phone was available in each holding room for detainees to call families and solicitors. We saw detainees make numerous phone calls. A pay phone in each holding room allowed incoming calls.

Recommendation

- I.6 Detainees should only have belts and other items of clothing removed following an individual written risk assessment.**

Keeping detainees safe

Expected outcomes:

Detainees feel and are safe from bullying and victimisation. The facility provides a safe and secure environment which reduces the risk of self-harm and suicide. The centre promotes the welfare of all detainees, particularly adults at risk, and protects them from all kinds of harm and neglect. Force is only used as a last resort and for legitimate reasons.²

- 1.7** Male and female detainees could be held separately. During the previous three months, 87% of detainees had been male and 13% female. Staff could not recall having to defuse friction between detainees but said they would talk to detainees to calm tensions and, if a holding room was free, move one of the detainees. DCOs had good oversight of both holding rooms through large windows in their office. CCTV cameras did not cover the whole of the smaller holding room and left a blind spot. CCTV footage was recorded onto a hard drive which could only be reviewed by managers.
- 1.8** DCOs had undertaken training in the Home Office Manual for Escorting Safely and received refresher training every six months. The training package covered the use of force.
- 1.9** During the previous six months, two detainees had tried to harm themselves, one by placing a cord from his hooded jacket around his neck and another by putting the cord from the pay phone around his neck. In both cases, DCOs applied minimal force to prevent the detainee from harming himself. Details of the incidents were recorded in suicide and self-harm warning forms which accompanied the detainees to the next place of detention. Two anti-ligature knives were stored in the DCOs' office but the DCOs did not carry knives.
- 1.10** Force had been used on two other occasions during the previous six months. In one case, Tascor had intelligence that a detainee could be particularly disruptive and he was placed in handcuffs for the short journey from the holding room to the escort vehicle. The detainee objected that he was being treated like a criminal and force was used to apply the handcuffs. The detainee resisted and staff struggled to apply the handcuffs. He was placed on the escort vehicle where the handcuffs were removed.
- 1.11** In the second case, the management of a disruptive young detainee who did not speak English was chaotic and poorly handled. He was agitated at being detained and started to damage the holding room. Two DCOs and two escorts were involved in the incident which continued for about three hours. The detainee threw a screen across the room and removed a chair that had been fixed to the floor. Staff tried unsuccessfully to calm him and to place him in a waist restraint belt. Attempts were made to apply handcuffs and the detainee bit a DCO's hand. The detainee claimed his wrist was broken when handcuffs were applied, a paramedic was called and an x-ray of the detainee's wrist at hospital showed that it was not broken. The detainee was then transferred to Morton Hall immigration removal centre (IRC). Records of the incident showed that de-escalation techniques were not used effectively, staff were not confident in applying restraint techniques and no single officer was in charge of managing the incident which continued for too long. A manager reviewed the paperwork but concluded that no further action was required. This was a missed opportunity to learn lessons from a poorly managed incident.

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

- I.12** Immigration Enforcement officers routinely wore stab vests in the holding rooms when interviewing detainees without an individual risk assessment. This was a disproportionate security measure compared with other facilities where staff do not wear protective clothing.
- I.13** Tascor staff had a general awareness of detainee vulnerability but did not know of a Tascor safeguarding adults policy or the national referral mechanism. They reported any concerns about an at-risk adult to an Immigration Enforcement officer and to Tascor managers. A detainee using crutches following a back injury had been held on the day of our inspection but before we arrived. Planning for his transfer to Morton Hall appeared good: a doctor, two medics and private ambulance accompanied the regular escort vehicle and crew to the IRC. DCOs did not open a disability care plan while the detainee was in the facility.

Recommendations

- I.14** **Closed-circuit television should cover the blind spot in the smaller holding room.**
(Repeated recommendation I.18)
- I.15** **DCOs should carry anti-ligature knives.**
- I.16** **DCOs should use de-escalation techniques. Only the minimum amount of force should be applied as a last resort and for no longer than necessary. Managers should learn and disseminate lessons from use of force incidents.**
- I.17** **Immigration Enforcement officers should only wear stab vests when interviewing detainees who have been arrested in the community or following an individualised risk assessment.**
- I.18** **There should be an effective policy and procedures for managing at-risk detainees safely, with which staff should be familiar.**
- I.19** **The care of detainees with disabilities should be planned and documented.**

Legal rights and casework

Expected outcomes:

Detainees are fully aware of and understand their detention. Detainees are supported by the facility staff to exercise their legal rights freely. Detention is carried out on the basis of individual reasons that are clearly communicated. Detention is for the minimum period necessary.

- I.20** Detainees could contact their solicitors freely and fax documents to them. Notices in English and 10 other languages promoted the services of Civil Legal Advice. Detainees calling this service were signposted to immigration solicitors with a contract to provide publicly funded legal advice. Detainees transferring to an IRC would be entitled to half an hour's free legal advice at the centre.
- I.21** Detainees were held with the correct authority to detainee (IS91). DCOs confirmed that they never accepted a detainee into their custody with no IS91. An Immigration Enforcement officer served relevant legal documents on the detainee on arrival, including a notice of removal, information on bail rights, bail application forms and the reasons for detention (IS91R).

I.22 During the previous three months, 60 detainees had been held for an average of three hours 14 minutes. The longest period of detention was seven hours 10 minutes.

Respect

Accommodation and facilities

Expected outcomes:

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

- I.23** The facility consisted of two holding rooms, separated by the DCO office. They were clean and in good repair but untidy and lacking natural light. The smaller room was equipped with a toilet for detainees with disabilities. There were sanitary items and a bin for their disposal. The room was sparsely furnished with a table and four chairs fixed to the floor. Attempts had been made to soften the environment with some posters but overall the environment was institutional.
- I.24** The larger holding room had additional fixed furniture and four rows of benches. There was a pillow and two blankets. Staff said that detainees lay across a row of seats to sleep during the day. There were separate toilets for men and women. Toilet doors were lockable but staff were able to unlock them from the outside if they became concerned for a detainee's safety. Toilets in both rooms were clean but lacked seats and lids. There was a four-inch gap at the bottom of the door of each toilet. Both rooms had water fountains. Copies of a generic information leaflet were displayed in each, with the information translated into 15 languages. No hygiene packs were available.
- I.25** If detainees arrived with medication, staff could obtain advice from a telephone medical advice and triage service provided by Tascor. In an emergency, they would call an ambulance.
- I.26** Detainees held for short stays were provided with adequate food. They were offered food and drinks on arrival and at regular intervals during their stay from a selection of sandwiches and ambient microwave meals. There was also a supply of fresh fruit. There was less choice for vegetarians than we usually see. We were told that staff could use petty cash to buy food for detainees with special dietary needs.
- I.27** Detainees could not go outside and there were still no working televisions. Board games and two portable DVD players were available but we were not confident that these were offered to detainees regularly. There were a few newspapers and magazines, some in foreign languages, but all were out of date, some by several months. There were a few books, most of which were in English.

Recommendations

- I.28 Detainees should not be held for significant periods without access to exercise in the fresh air.**
- I.29 Reading material should be available in a range of languages.**

Respectful treatment

Expected outcomes:

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

- I.30** Two detainees were held in the facility at the time of the inspection (a third was transferred before we arrived). DCOs interacted with detainees sensitively, offered support and understood their needs. DCOs wore name badges on lanyards, but the writing was too small to be easily identified.
- I.31** Detainees could submit written complaints. Complaint forms in English and other languages were freely available and could be submitted in secure boxes in each holding room. The complaints box was not emptied regularly. We submitted a dummy complaint on the day of our inspection but the Home Office did not confirm receipt until six weeks later.
- I.32** DCOs had received diversity and equality training during their initial training course. A care plan had not been opened for a detainee with a disability held earlier in the day (see paragraph I.11). Copies of the Qur'an were available, but not the Bible or other religious texts. Prayer mats were not stored respectfully. They were bundled up next to a pile of old newspapers and magazines in the large holding room and had been left on the table in the smaller room.

Recommendations

- I.33** **Staff should wear badges with their names clearly legible.** (Repeated recommendation I.12)
- I.34** **The complaints box should be emptied every day the holding room is occupied.**

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.

I.35 We observed two detainees being taken from the facility to an escort vehicle for transfer to Pennine House residential short-term holding facility outside Manchester Airport. The transfer was handled well: detainees were briefed in advance about where they were going and reassured that they were not being removed from the UK that day. They were given a small credit-card sized card with contact details and a map of their next place of detention. Detainees leaving the facility were no longer routinely handcuffed as they were taken to escort vehicles. A DCO linked arms with the detainee (a guided hold) from the back door of Capital Building to the escort vehicle which was parked in a semi-secure area. We were told this was standard practice. The short walk to the escort vehicle did not pass through public areas.

I.36 Detainees could not receive visitors, but family and friends could deliver property. Detainees had good access to family and solicitors on the free phone line. Incoming calls could be taken on the pay phones in each holding room. DCOs answered calls after detainees had left and we heard them offering contact details and reassurance to family members. Detainees could not use the internet or email.

I.37 The stock of clothing was inadequate.

Recommendation

I.38 Detainees should have access to the internet, including email, social networking sites and Skype, unless an individual risk assessment indicates otherwise.

Section 2. Recommendations

Recommendations

To the Home Office

Keeping detainees safe

- 2.1** Immigration Enforcement officers should only wear stab vests when interviewing detainees who have been arrested in the community or following an individualised risk assessment. (1.17)

Accommodation and facilities

- 2.2** Detainees should not be held for significant periods without access to exercise in the fresh air. (1.28)

Respectful treatment

- 2.3** The complaints box should be emptied every day the holding room is occupied. (1.34)

Preparation for removal and release

- 2.4** Detainees should have access to the internet, including email, social networking sites and Skype, unless an individual risk assessment indicates otherwise. (1.38)

Recommendations

To the facility contractor

Arrival

- 2.5** Detainees should only have belts and other items of clothing removed following an individual written risk assessment. (1.6)

Keeping detainees safe

- 2.6** Closed-circuit television should cover the blind spot in the smaller holding room. (1.14, repeated recommendation 1.18)
- 2.7** DCOs should carry anti-ligature knives. (1.15)
- 2.8** DCOs should use de-escalation techniques. Only the minimum amount of force should be applied as a last resort and for no longer than necessary. Managers should learn and disseminate lessons from use of force incidents. (1.16)
- 2.9** There should be an effective policy and procedures for managing at-risk detainees safely, with which staff should be familiar. (1.18)
- 2.10** The care of detainees with disabilities should be planned and documented. (1.19)

Accommodation and facilities

2.11 Reading material should be available in a range of languages. (1.29)

Respectful treatment

2.12 Staff should wear badges with their names clearly legible. (1.33, repeated recommendation 1.12)

Section 3. Appendices

Appendix I: Inspection team

Colin Carroll
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.

The UK Border Agency should promptly transfer detainees to their final destination, especially in prearranged arrest operations involving families. (1.16)

Achieved

Escort vehicles should be kept clean. (1.2)

Achieved

Closed-circuit television should cover the blind spot in the smaller holding room. (1.18)

Not achieved (Recommendation repeated, 1.14)

Detainee custody officers (DCOs) should complete incident reports for significant events such as detainees being taken to hospital. (1.20)

Achieved

DCOs should receive regular annual suicide and self-harm prevention training. (1.21)

Not achieved

DCOs should receive training in safeguarding and promoting the welfare of children. (1.24)

Achieved

Detainees subject to control and restraint techniques should be seen by a health care practitioner as soon as possible after restraint is removed. (1.30)

Achieved

Respect

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

Staff should wear badges with their names clearly legible. (1.12)

Not achieved (Recommendation repeated 1.33)

Reading material in foreign languages should be available. (1.27)

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.

Detainees should only be handcuffed following an individual written risk assessment. (1.41)

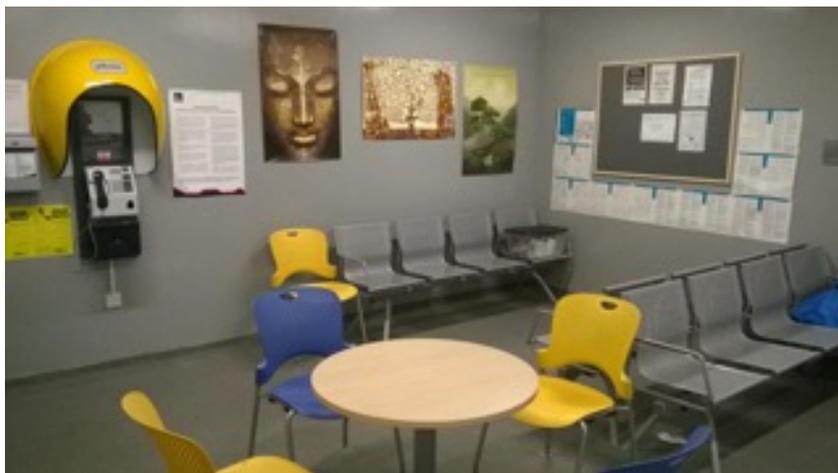
Achieved

Appendix III: Photographs

Large holding room



Large holding room



Smaller holding room

