

Report on an unannounced inspection of

**Family detention, Tinsley
House Immigration Removal
Centre**

by HM Chief Inspector of Prisons

3–5, 9–12 & 16–20 April 2018

This inspection was carried out with assistance from colleagues at the General Pharmaceutical Council and in partnership with the following bodies:



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Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: <http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/>

Introduction

The pre-departure accommodation (PDA) at Tinsley House Immigration Removal Centre holds people being returned under the family returns process when other attempts to remove them have failed, usually for no more than five days. It is adjacent to a unit that holds families arrested at the border, usually for one night before they are returned on flights the next day. This unit was not used at all during the inspection and the report therefore refers mainly to the PDA. The two units are managed by the same staff and have similar specifications. Our last inspection of the PDA was in 2016 at the now closed Cedars facility. The Tinsley House border returns unit was last inspected in 2014. At this inspection, these two facilities were inspected together.

Attempts to remove the small number of detained families were largely unsuccessful and the unit was being used even less frequently than its predecessor. In the 11 months that it had been opened, 19 families had been detained in the pre-departure accommodation and only four of them were eventually removed. This was troubling given the harmful effect that arrest and detention inevitably has on children who witness their parents becoming very distressed; during the inspection, children saw their parents being physically restrained.

Putting this considerable issue aside, staff provided an impressive level of care and support to families, who, despite their difficult situations, were very positive about the way they were treated and helped by staff. Given the increase in stress and deterioration in health outcomes that can accompany open-ended detention in the adult detention estate, it was good that detention was strictly time-limited. Most families were released or removed within three days. Border return families usually left within 24 hours. There had been little use of force, but we identified some shortcomings in the management of one incident. Safeguarding procedures were well developed and staff, who were given the chance to report to us in confidence, did not raise any concerns.

Cedars provided good care and an excellent environment for detained families and children but was closed as a result of its limited use and high expense. The new unit was located in a more restricted space in the grounds of the removal centre and could not fully replicate the welcoming, open environment of Cedars. Nevertheless, it was well designed, families could move around it easily and use a small but attractive outside space. They were kept entirely separate from the population in the adult centre. Efforts had been made to ensure that the walls and fences outside were not easily visible once families were inside. Activities were planned well to help distract children from their situation and families had enough to do for the short time they were held.

The welfare team, which included three social workers, had a good child-centred approach, which families appreciated. They were assisted by the charity Hibiscus Initiatives, which provided help to those being removed. The careful planning and tailored care for families that we saw before had been maintained. It was a surprising omission that problems with internet access for families had not been identified or resolved.

The PDA at Tinsley House has in most respects maintained the standards set by its predecessor. Nevertheless, detaining families is very costly and carries a considerable human impact, especially for children. The bar for detaining children with their families has rightly been set high. However, the routine failure of detention to achieve the objective of removal suggests that it could be set still higher, and careful strategic consideration should be given to the purpose served by pre-departure accommodation in light of the findings of this report. In the meantime, staff from all agencies were providing an impressive level of care to detained families.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

June 2018

Fact page

Task of the establishment

The detention, care and welfare of families subject to immigration control prior to their removal from the UK. Families may be detained for up to 72 hours in the pre-departure accommodation but this period may be extended to one week, with ministerial authority. The border returns accommodation usually detains families for no more than one night.

Certified normal accommodation and operational capacity of pre-departure accommodation

Detainees held in the pre-departure accommodation at the time of inspection: 9

Certified normal accommodation: 8

Operational capacity: 10

Certified normal accommodation and operational capacity of borders accommodation

Detainees held at the time of inspection: 0

Certified normal accommodation: 5

Operational capacity: 6

Notable features from this inspection

19 families had been detained in the pre-departure accommodation since it had opened in June 2017. Only four had been removed.

1,300 families had been removed through the family returns process without the use of detention since the previous inspection.

10 families had been detained in the border return apartment since June 2017.

Force had been used twice in the unit since it had opened.

Name of contractor

G4S

Key providers

Escort provider: Tascor

Health service commissioner and providers: NHS England, G4S Medical Services Ltd

Learning and skills providers: G4S

Location

West Sussex

Brief history

In June 2017, two new family detention facilities opened at Tinsley House, replacing the Cedars pre-departure accommodation and the Tinsley House unit that had previously been used for families arrested at the border and needing overnight accommodation before a return flight. The two units were managed by the same staff and adjacent to each other. There was no mixing of the families detained in the two units. The final stage of the family removal process, including detention in pre-departure accommodation, is intended as a last resort if options such as assisted voluntary return have failed.

Short description of residential units

There were two distinct units: the designated pre-departure accommodation, which had two apartments holding families being returned under the Home Office's family returns process; and a single apartment used for families arrested and detained at the UK border and requiring overnight accommodation before taking a return flight. The apartments varied in size from one to two bedrooms. Families could also use a separate kitchen, dining room, living area and a garden.

Names of centre managers

Sarah Newland (Tinsley House)

Lee Hanford (Director, Gatwick IRC)

Independent Monitoring Board chair

Anne Duffy

Last inspection

Pre-departure accommodation: 4–26 April 2016

Border returns accommodation: 1–12 December 2014

About this inspection and report

- A1 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.
- A2 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.
- A3 All Inspectorate of Prisons reports include a summary of an establishment's performance against the model of a healthy establishment. The four tests of a healthy establishment are:
- | | |
|--|--|
| 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 destination country and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property. |
- A4 Under each test, we make an assessment of outcomes for detainees and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the Home Office.
- **outcomes for detainees are good against this healthy establishment test.**
There is no evidence that outcomes for detainees are being adversely affected in any significant areas.
 - **outcomes for detainees are reasonably good against this healthy establishment test.**
There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.
 - **outcomes for detainees are not sufficiently good against this healthy establishment test.**
There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.

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

A5 Although this was a custodial establishment, we were mindful that detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees:

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

A6 The statutory instrument also states that due recognition will be given at immigration removal centres to the need for awareness of:

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

A7 Our assessments might result in one of the following:

- **recommendations:** will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections
- **examples of good practice:** impressive practice that not only meets or exceeds our expectations, but could be followed by other similar establishments to achieve positive outcomes for detainees.

A8 Five key sources of evidence are used by inspectors: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

A9 Since April 2013, all our inspections have been unannounced, other than in exceptional circumstances. This replaces the previous system of announced and unannounced full main inspections with full or short follow-ups to review progress. All our inspections now follow up recommendations from the last full inspection.

A10 All inspections of immigration removal centres are conducted jointly with Ofsted or Education Scotland, the Care Quality Commission and the General Pharmaceutical Council (GPhC). This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

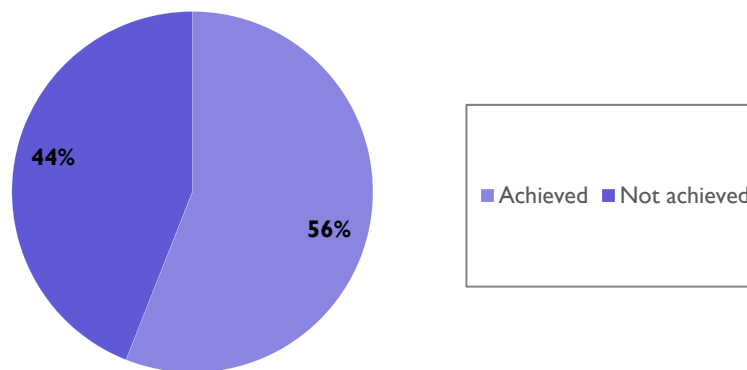
This report

- A11 This explanation of our approach is followed by a summary of our inspection findings against the four healthy establishment tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees*. The reference numbers at the end of some recommendations indicate that they are repeated, and provide the paragraph location of the previous recommendation in the last report. Section 5 collates all recommendations and examples of good practice arising from the inspection. Appendix II lists the recommendations from the previous inspection, and our assessment of whether they have been achieved.
- A12 Details of the inspection team and the detainee population profile can be found in Appendices I and III respectively.

Summary

- S1 We last inspected family detention at Tinsley House Immigration Removal Centre in December 2014, alongside the inspection of the adult centre. We made four recommendations about family detention, and at this inspection all four had been achieved.
- S2 We last inspected pre-departure accommodation (PDA) in 2016, at the now closed Cedars unit. In June 2017, the new PDA opened at Tinsley House Immigration Removal Centre. At our 2016 inspection, we made 25 recommendations. At this follow-up inspection we found that 14 of those recommendations had been achieved and 11 had not been achieved.

Figure 1: Pre-departure accommodation, Tinsley House Immigration Removal Centre, progress on recommendations from last inspection (n=25)



- S3 Since our last inspection, outcomes for detainees stayed the same in all healthy establishment areas apart from Safety and Preparation for removal and release, which had declined. Outcomes were good in Respect and Activities and were reasonably good in Safety and Preparation for removal and release.

Figure 2: Pre-departure accommodation, Tinsley House Immigration Removal Centre healthy establishment outcomes 2016 and 2018¹



¹ Please note that the criteria assessed under each healthy establishment area were amended in 2018. Healthy establishment outcomes reflect the expectations in place at the time of each inspection.

Safety

- S4** *Immigration enforcement and escort staff carried out arrests and transfers to the unit reasonably well. Nevertheless, the arrests were traumatic for children and families, and the majority ended without a successful removal. Staff prepared for the arrival of families well. The unit was safe and adults and children were safeguarded during their stay. Staff did not communicate sufficiently well with community agencies to inform them about vulnerable families being released. Unit staff rarely used force or separation. Access to legal assistance was reasonable and detainees could contact Home Office staff easily. **Outcomes for detainees were reasonably good against this healthy establishment test.***
- S5** *At the last inspection in 2016 we found that outcomes for detainees in Cedars were good against this healthy establishment test. We made 12 recommendations about safety. At this follow-up inspection we found that six of the recommendations had been achieved and six had not been achieved².*
- S6** We observed the arrests of two families. They involved more than eight people in uniforms wearing stab vests and heavy boots entering a family's home early in the morning. During the first arrest, staff were unsuccessful in their efforts to obtain an interpreter and used telephone interpretation instead. This made communication difficult.
- S7** One arrest was particularly traumatic because restraint was used on the father and, briefly, on his eldest child. In the other arrest, the father was told he could ring his lawyer at a nearby reporting centre, but this promise was not kept. He was only allowed to phone his solicitor once he had boarded the coach to begin his journey towards Gatwick. The time from arrest to the point that the family went to their apartment was over 15.5 hours.
- S8** Immigration enforcement vans transported one of the families to Tinsley House. These vehicles were smaller and less comfortable than Tascor coaches that were normally used, but the journey was reasonably short.
- S9** Preparations for the families' arrival were comprehensive; staff received information in advance and representatives from all departments attended planning meetings. Staff were welcoming and activities for children were planned in advance. The arrivals process was less formal and quicker than at our last inspection of family detention.
- S10** There was a suitable policy in place to tackle bullying if it occurred and staff supervised detainees well. There had been no reports of bullying or violence since the unit had opened. It was unusual for more than one family to be detained at any one time. The two families held during the inspection said they felt safe. There was an up-to-date safeguarding adults policy.
- S11** Detainees at risk of self-harm or suicide were well cared for. Six detainees had been subject to assessment, care in residence and teamwork (ACRT) processes since the centre opened, all of them adults. Only one incident of self-harm had occurred: a detainee deliberately pulled her own hair, but no injury was caused. Three detainees had been placed on a constant watch and had been managed sensitively. In several cases, staff did not communicate well enough with community services in the UK or in receiving countries to inform them that a detainee was at risk of self-harm and suicide. Staff did not routinely inform community services of detainees' self-harm risks even if they had required constant supervision.

² See also Progress on recommendations from the Tinsley House Immigration Removal Centre report, 2014 (Appendix II).

- S12 Centre staff were trained in restraint techniques for use against children and adults. They had used force and separation on two occasions; it was used proportionately, although one incident was handled less professionally than the other.
- S13 A suitable, clear safeguarding policy covered children. Staff understood their responsibilities. The structures for managing safeguarding were sound – internal meetings took place every other month, while external safeguarding meetings were held quarterly. Attendance, although reasonable, was less consistent than at the previous inspection. Representatives from West Sussex Children’s Services continued to attend the external meetings and relationships between Tinsley House staff and the local authority were good. The safeguarding lead member of staff passed on concerns that had been identified to local authorities. There had been no formal complaints about the centre since it opened.
- S14 Detainees could exercise their legal rights. They could contact legal representatives freely using mobile phones and had good access to a duty solicitor scheme. They could also contact legal representatives through fax, as well as during legal visits.
- S15 Detention was strictly time limited. The longest stay had been just over four days (102 hours). All but four periods of detention were for less than 72 hours. Families arrested at an airport but not subject to the family returns process, were placed in an adjacent ‘border returns’ apartment. They were held for short periods – the longest stay among this group was 26 hours. Ten such families had been detained since June 2017.
- S16 Home Office family engagement managers continued to promote voluntary return and offered families assistance that could help them avoid detention. Since our previous inspection of family detention at the Cedars unit in April 2016, over 1,300 families had been returned having not been detained. The number of successful removals following detention remained very low – only four families had been successfully removed in the 11 months the unit had been open.
- S17 Detained families had very good access to Home Office staff. The induction and exit interviews we observed were reasonable, although detainees found it difficult to understand what was being said because of the use of jargon and euphemisms.

Respect

S18 *Relationships between staff from all disciplines and detained families were good. The food was reasonable and families could cook for themselves. No complaints had been submitted since the centre had opened. The accommodation was well designed and met families’ needs. Interpretation facilities were routinely used. Faith provision was good. Health care provision was good. **Outcomes for detainees were good against this healthy establishment test.***

S19 *At the last inspection in 2016 we found that outcomes for detainees in Cedars were good against this healthy establishment test. We made seven recommendations about respect. At this follow-up inspection we found that four of the recommendations had been achieved and three had not been achieved³.*

S20 The interactions we observed between staff and detainees were good. No families were detained in the border returns apartment during the inspection. Staff continued to

³ See also Progress on recommendations from the Tinsley House Immigration Removal Centre report, 2014 (Appendix II).

demonstrate a respectful and caring attitude towards detainees, which was reflected in meetings we observed and the documents we saw. Complaint forms were freely available in a range of languages and a dummy complaint we submitted received a swift response.

- S21 The accommodation catered well for the small number of families detained. The apartments and communal living areas were well designed. The unit was clean, brightly decorated and maintained to a high standard. Families had access to a well-kept outside garden and all areas were well-equipped and had resources for children. Families in the border returns apartment usually stayed for short periods. They did not have access to the same communal facilities as those being removed under the family returns process. The latter could use a dining room, living area and a room with games consoles and music equipment. On arrival, they had access to an adequate selection of microwave meals in addition to a range of drinks and snacks. Detainees could order food to cook in the clean and well-equipped communal kitchen although in practice this rarely happened. There was an over-reliance on the use of frozen convenience food.
- S22 There was an up-to-date equality and diversity policy. Interpretation was generally by telephone, although Home Office staff often used a face-to-face interpreter. Staff who spoke Urdu and Punjabi were frequently on duty, while another spoke Arabic. A 21-week pregnant woman had previously been detained with her partner and sons aged eight and 11, before being released. The unit had facilities for those with disabilities – the bathroom had a low bath with suitable rails and a call bell.
- S23 Faith provision was good. Prayer and worship materials for the main faiths were available in the reasonable multi-faith room. Muslim and Christian chaplains were available every day and others visited on request. Halal food was stored separately, but not all halal and non-halal utensils were separated.
- S24 Families had ready access to health care services and a nurse saw them promptly on arrival. A reception template for children was not age appropriate. A handover of pertinent medical information was undertaken and a GP follow-up took place within 24 hours. Detainees continued to have access to their prescribed medication, unless it had been discontinued by the GP due to an identifiable risk.

Activities

S25 *Families were free to move around the unit and had access to a good range of recreational and learning resources. The welfare team planned activities to meet the needs of individual children. The library provided a good service. Fitness facilities were limited. **Outcomes for detainees were good against this healthy establishment test.***

S26 *At the last inspection in 2016 we found that outcomes for detainees in Cedars were good against this healthy establishment test. We made no recommendations about activities⁴.*

S27 Detained families were able to move freely around the units where they were held. They could use a reasonable outdoor space on request. Activities met the needs of family members and were designed to distract children from the negative aspects of being detained. Staff produced a brief activity and learning plan for each family member. Activity plans for

⁴ See also Progress on recommendations from the Tinsley House Immigration Removal Centre report, 2014 (Appendix II).

children and adults were simple but appropriate. Pictures and simple written descriptions were used effectively to ensure it was clear what activities the centre was suggesting.

- S28 The unit's good range of recreational and learning resources were up-to date and in excellent condition. There were books in a number of languages other than English. Detainees had no access to a gym or fitness equipment. Members of staff worked closely and flexibly with children throughout their stay. Staff routinely reflected on and reviewed activities following each family's departure and made improvements.

Preparation for removal and release

S29 *Hibiscus Initiatives provided detainees with valuable support and advice on destination countries for the small number of families who were removed from the UK. The unit provided families with the means to travel home and staff accompanied them when required. Detainees could contact the outside world at any time by phone. However, families could not use the internet and there was still no access to social media or video calls. Visiting arrangements and facilities were good. **Outcomes for detainees were reasonably good against this healthy establishment test.***

S30 *At the last inspection in 2016 we found that outcomes for detainees in Cedars were good against this healthy establishment test. We made six recommendations about preparation for removal and release. At this follow-up inspection we found that three of the recommendations had been achieved and three had not been achieved⁵.*

- S31 Detainees could contact their families by phone at all times and receive visitors every day. However, they could not use the internet, something that was not known to some staff and managers. Even when the internet point was working, families still had no access to Skype or social media sites. Visitors could use a free minibus service from Gatwick Airport. Visits could take place in the reception area or dining room – both were bright and welcoming.
- S32 The welfare team, including three social workers, had maintained the positive child-centred approach we found at the previous facility. Staff also provided practical help purchasing suitcases and clothing if required. Families who were released were provided with the means to travel home and were often accompanied by staff.
- S33 Staff from the charity Hibiscus Initiatives worked with families to address their concerns about destination countries, and provided information packs on potential destinations. However, little information was available on the region or town families would be living in when families were transferred to a third country (of which they were not a national).

Main concern and recommendation

- S34 Concern: The arrest, detention and attempted removal of families from the UK was harmful to children but was often ineffective. Children were woken early in the morning by arrest teams and escorted on long journeys before being detained in an unfamiliar environment with their parents who were often visibly distressed. Some children had witnessed their parents being restrained, but after this traumatic process, nearly 80% of families were simply released.

⁵ See also Progress on recommendations from the Tinsley House Immigration Removal Centre report, 2014 (Appendix II).

Recommendation: The Home Office should analyse why so many removals fail, with a view to reducing the unnecessary and harmful detention of children and families.

Section 1. Safety

Arrival and early days in detention

Expected outcomes:

Families⁶ travelling to and arriving at the centre are treated with respect and care. Risks are identified and acted on. Families are supported on their first night and given an effective induction. They are welcomed into safe and decent conditions. Due regard is given to the specific needs of children.

- I.1 Families continued to find the arrest process distressing. We observed two arrests – both involved a team of more than eight people in uniforms, wearing stab vests and heavy boots, entering a family’s home at about 7am. While in both cases Home Office immigration enforcement teams used interpretation, communication was difficult and families were confused about what was happening. The teams included a health care member of staff who checked on the family throughout the process. (See case study: S family.)
- I.2 Despite the arrest being a distressing and high-risk process where force was often used, Home Office immigration enforcement teams did not routinely use body-worn video cameras to safeguard staff and detainees during arrests and transfers to the facility.
- I.3 During one arrest, the father became aggressive after being told what was happening and he was restrained in front of the rest of his family. The oldest child became upset and tried to kick a television and was also restrained for a short period. Arresting officers took some time to gain control of the father who was eventually taken to a cellular vehicle. In both cases the use of force was proportionate.
- I.4 The families could pack their belongings and prepare some breakfast. One family was promised that they would be able to speak to a legal representative when they arrived at the local immigration enforcement office. When they arrived, they were denied the opportunity. (See case study: S family.)
- I.5 The escort contractor Tascor transferred one family to Tinsley House while Home Office immigration enforcement staff transferred the other. Tascor’s vehicle was more comfortable and the family could use pillows and blankets. The escorting team was better prepared with food and drinks and the vehicle made several stops for hot food and drinks (see case study: S family). In contrast the Home Office arrest team vehicle was cramped and unable to accommodate the health care member of staff who travelled in another vehicle. Officers only had water on board. However, this was offset in part by the much shorter journey of less than four hours.
- I.6 Staff continued to prepare well for the arrival of families. Planning meetings were held before the arrival of each family, during which Home Office, custody, health care and welfare staff considered information on the families’ previous involvement with the family returns process. The family welfare forms were detailed and contained useful information, including on academic achievements, interests and previous children’s services involvement. The welfare team used the information to tailor activities to individual children.
- I.7 On arrival, detained families received a mobile phone and could transfer any numbers they needed. This meant they continued to have access to friends, family and legal representatives throughout their detention.

⁶ The term ‘families’ is used here in a broad sense and may, for example, include unmarried and same sex couples.

- 1.8** We observed the arrival of these two families during the inspection. In both cases, the family were welcomed by custody, welfare and health care members of staff. A metal detecting wand was used to search children, and adults underwent a pat down search. The searching process was carried out respectfully. Welfare staff immediately focused on the children and offered them access to pre-planned activities, while the parents went through the reception process. The initial interview to assess the families' risks and needs involved the use of interpretation. Interviews took place in the same area as the children's activities. A nurse received a handover from escorting staff and assessed the health needs of both families. In both cases the family apartment, consisting of a living area, shower room and two bedrooms, was very well prepared, comfortable and clean. Staff prepared a meal for both families on arrival. Although it was comprehensive and swifter than at the previous facility, the reception process remained lengthy, which was particularly frustrating for one family who were taken off the vehicle at 9.55pm after being arrested at 7.15am and experiencing an 11-hour coach journey. (See case study: S family.)
- 1.9** The family apartment contained a welcome pack containing information about the facility. However, most information was only available in English.

Case study: S family

- 1.10** *The S family consisted of a father, mother, eight-year old boy, five-year old girl and 15-month old baby boy. We attended the immigration compliance and enforcement (ICE) team briefing. The operation was planned in detail. Efforts had been made to find an interpreter but none had been willing to attend the arrest (although one agreed to attend the handover to Tascor). The accommodation provider had given the team a set of keys to the property.*
- 1.11** *The arrest team comprised nine officers and a medic. Two other officers were outside with equipment to enable a forced entry should that have been necessary. They were not needed and had no contact with the family. The team arrived at 7.15am and knocked loudly on the door, shouting, 'Immigration please open the door'. After about a minute or two, the team used the keys it had received to enter the property. The children were sleeping and Mr and Mrs S were in their pyjamas. The parents were taken to the living room. Officers stayed with the children in their bedrooms. The lead officer spoke to the family using a telephone interpreter. Communication was difficult and the parents were upset and shocked. They were arrested and asked to get themselves and their children dressed. They appeared confused and were slow to comply. An officer said, 'We can do this the easy way or the hard way.' The lead officer advised Mr and Mrs S that once they got to the short-term holding facility they could phone their lawyer. They got dressed, dressed the children, packed their belongings and made breakfast. A large number of officers were in the flat. Two were assigned to each parent and they followed them around the property. The team and the family left the property at 8.20am.*
- 1.12** *The family was driven in two vehicles to a short-term holding facility. Mrs S and the three children were in a vehicle fitted with child seats and a baby seat. Mr S was in a larger vehicle.*
- 1.13** *The family arrived at the short-term holding facility at 8.45am. After the handover and paperwork were dealt with, the ICE team handed custody over to the Tascor team, comprising nine escorts (four women and five men) and a medic. The Tascor lead staff member briefed the family on what would happen next and asked some risk questions. A face-to-face interpreter arrived and was used by the Tascor lead staff member. Mr S asked to phone his lawyer but was told he could only use the phone once he got on the bus. He became upset as he had been told he could make a phone call on arrival at the short-term holding facility. This needlessly escalated the situation.*
- 1.14** *At about 9.10am, the Tascor team discovered that the baby seat did not fit on the coach. No alternative coach was available. At 10.10am, it was announced that the baby would travel without a*

travel seat. The parents had a rub down search and staff used a metal detecting wand to search the children and baby. The father was taken to the coach using a light touch hold. Boarding was video recorded. The Tascor team wore smart casual clothing rather than uniforms. Once on board, the father called his solicitor with the aid of the interpreter. The coach left at 10.43am, stopping for refuelling at about 11.10am when the family was given hot drinks. It stopped again at 2.20pm for a meal, and again at 7.20pm for hot drinks. The family was offered snacks and cold drinks throughout the journey, and could use pillows and blankets. The children became bored but watched DVDs (in English) and the officers played games and sang songs with them.

- 1.15** The coach arrived at Tinsley House at 9.28pm but the family did not disembark until 9.55pm. The family was welcomed by a manager, two family care officers, a welfare officer and nurse. The parents were given a rubdown search and the children had a metal detecting wand waved over them. The welfare officer offered the children colouring books and toys. An officer used a telephone interpreter to assess the family's risks and welfare needs. Mr and Mrs S were tired and frustrated, and Mrs S was also tearful. A nurse checked the family's health needs. At 10.50pm, the family was shown to the apartment, more than 15.5 hours after their arrest.

Recommendations

- 1.16 Home Office immigration enforcement arrest teams should wear body cameras during the arrest of families.** (Repeated recommendation 2.19)
- 1.17 Escorting teams should have food and drink for detainees.**
- 1.18 The initial reception process should be undertaken quickly, especially if families are tired or have had long journeys, with non-essential processes undertaken after the family have rested.** (Repeated recommendation 1.17)

Safeguarding adults and personal safety

Expected outcomes:

The centre promotes the welfare of families and protects them from all kinds of harm and neglect and reduces the risk of self-harm and suicide. Families are protected from bullying and victimisation and the use of force is proportionate to the need to keep detainees safe. Force is never used against children unless it is to protect them or others from immediate harm.

- 1.19** Families were kept safe. There was an anti-bullying policy in place and staff supervised detainees well. It was very unusual for more than one family to be detained at the same time and there had not been any allegations of bullying since the new unit had opened. Families we spoke to said they felt safe despite being extremely anxious about their immigration status. There had been no violent incidents since the unit had opened.
- 1.20** The unit had an up-to-date safeguarding adults policy and detained adults were protected from neglect while they were there. Those requiring extra support could receive it from onsite social workers and other welfare staff. Links with West Sussex local authority were good and there was a clear policy for referring adults at risk of harm or neglect. Welfare and custody staff we spoke to knew how to make a referral. (See also paragraph 1.41.)

Self-harm and suicide prevention

- I.21** Since June 2017, six assessment, care in residence and teamwork (ACRT) case management documents were opened to manage detainees at risk of suicide or self-harm. No children had been subject to an ACRT. As at the previous inspection, most ACRTs were established because detainees were threatening to self-harm if they were removed from the UK. We found that staff provided good care to those at risk of self-harm.
- I.22** There had been one incident of self-harm since June 2017. An adult detainee had pulled her own hair; she did not require medical treatment. Over the same period three detainees had been placed on a constant watch. In most cases a member of staff was in the apartment with the detainee. We saw staff implement constant watches sensitively. All apartments contained windows through which staff could observe detainees less intrusively. The self-harm and suicide prevention policy advised staff to use discretion when detainees were using the toilet or shower and shower screens had been frosted to improve privacy. In all cases, constant watches remained in place until the detainee was released to their home address in the UK. However, self-harm risk information was not routinely communicated to community services in the UK or receiving countries, even where detainees had been constantly supervised up to the point of release.
- I.23** ACRT documentation was reasonably good and demonstrated that staff interacted well with detainees. However, required observations did not always take place and some of the action outlined in care maps was generic. Daily management checks took place and had identified some of these shortcomings. Telephone interpreting was used when required. Clear processes were in place to manage detainees who refused to eat or drink.
- I.24** All custody staff carried ligature knives but some other staff did not. It was unusual for other staff to enter an apartment without a member of custody staff present, but as at the previous facility, valuable time could have been lost if a detainee applied a ligature and was found by a member of staff who did not have immediate access to a cut down tool.
- I.25** G4S staff were trained in restraining children and adults. Force was not used on pregnant women or children to effect removal. Use of force had only been used twice since the pre-departure accommodation (PDA) had opened at Tinsley House. Both incidents took place during the inspection. In the first instance, force was used to separate a parent from his family after he had been aggressive in front of his children on more than one occasion, hitting furniture in the apartment. The incident was managed well – welfare staff encouraged the children and other parent to move to another location before a team of staff used force to move the aggressive detainee to the separation room.
- I.26** Staff did not manage the second incident as well and their lack of use of force experience was apparent. During an attempted removal, they tried to move a mother who was refusing to leave the centre (see case study: T family.)
- I.27** While force was rarely used by Tinsley House staff, detained families were more often subject to force by arrest teams and escort staff during removals. We observed the detention of two families including four adults and five children at the PDA over the three-week inspection. The families were subject to six incidents, in which force was used on four detainees, including a 13-year-old boy (see paragraph I.3). Four of them were carried out by arrest teams or escort staff. Three adults were placed in mechanical restraints (waist and leg restraint belts) and an adult and child were restrained in their house in front of the rest of the family. Neither family was successfully removed from the UK. (See main recommendation S34.)

- I.28** Adult detainees had been separated on two occasions since the new PDA had opened (both incidents were during the inspection). In both cases men were separated to prevent them from exhibiting aggressive or erratic behaviour in front of their children. The separation room was adequate for short stays and contained a toilet and shower room.

Case study: T family

- I.29** *The T family consisted of a mother, father and two children – a boy aged 13 and a girl aged eight. The Tascor team and coach arrived at 2am. The centre manager directed the Tinsley House side of the operation. An Independent Monitoring Board member was also present. The centre manager provided the Tascor lead staff member with a good briefing. They planned to take the father, who was separated from the rest of the family, to the coach first, then the mother, and finally the two children. All the property was stowed in the coach.*
- I.30** *The Tascor lead staff member went to the separation room and calmly introduced himself to the father. Mr T remained on the bed, facing the wall, shaking continuously. At 2.26am he started making retching sounds. Three male escort staff were in the room. They wore ordinary clothes and shoes. One wore black leather gloves.*
- I.31** *An interpreter worked with the nurse, who stayed with Mr T and talked with him. At one point the centre manager asked anyone who did not need to be in the separation room to leave. Twice the nurse loudly asked Mr T to ‘calm down’ and ‘behave yourself’.*
- I.32** *The Tascor escorts searched him half-sitting on the bed, and applied a waist restraint belt in the secure position. He would not stand, and a leg restraint was fitted. He did not physically resist at any point. At 2.33am the escorts carried him in a calm and controlled way through the reception area and out to the coach. A Tascor member of staff filmed the operation, which was carried out quickly and efficiently. An experienced Punjabi-speaking Tascor officer contributed well to its effectiveness.*
- I.33** *At 2.40am, Mrs T sat in the doorway of the apartment in the PDA. She refused to stand or walk. Four staff were around her. They tried to help her to a standing position. For most of this time, Tinsley House staff talked across each other at Mrs T, confusing the situation. One of them said: ‘If you do not stand up you may feel pain’ but we did not see pain compliance used. Mrs T remained passive and it took some time for staff to gain control. During this time staff shouted at Mrs T. One said: ‘You’re a grown lady. This is not good for your children.’*
- I.34** *At 2.45am, Tascor staff took over. They applied a waist restraint belt. She was carried to the coach. Halfway there, her legs were lowered so she could walk, but she did not. The three female Tascor escorts were calm and competent in the use of force, the lead person talked to Mrs T calmly throughout.*
- I.35** *At 2.50am a male and female member of welfare staff saw the two children. The male officer spoke Punjabi and talked to them in a low, calm voice, trying to persuade them to go to the coach. The process was handled well. The girl did not interact, following her brother’s lead. At 2.58am, the boy started to talk, but would not move.*
- I.36** *At 3am the centre manager decided to end the attempt. Mrs T was brought from the coach. She complained about pain in her wrist and was seen by the Tascor medic and a Tinsley House nurse as soon as she entered the unit.*
- I.37** *Mr T, who was still shaking and unresponsive in the back of the coach, was told several times through the interpreter, that if he could be calm and interact with his wife and children in a reasonable way, he could re-join them. He continued to shake and remained unresponsive. At 3.45am, Mr T was carried from the coach to the PDA. The leg restraint, which had been removed in the coach, was re-applied. Back in the separation room, he continued to lie shaking on the bed, and was put on constant supervision. The nurse and medic saw him on arrival.*

Recommendations

- I.38 Information regarding a detainee's risk of suicide and self-harm, and other welfare concerns, should be communicated with community agencies on release.**
- I.39 All staff who may have sole, direct contact with detainees should carry ligature knives.** (Repeated recommendation I.27)
- I.40 Managers should ensure staff are confident and competent in using restraint techniques.**

Safeguarding children

Expected outcomes:

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

- I.41** A comprehensive safeguarding policy covering children was in place. It contained guidance on welfare concerns, allegations against staff, female genital mutilation and preventing radicalisation. Structures in place for safeguarding children were reasonably good and regular internal and external safeguarding meetings were held. Staff had a good relationship with West Sussex Children's Services (WSCS), but WSCS staff attendance at quarterly external meetings was less consistent than at the previous inspection, which reduced the effectiveness of external scrutiny. Internal safeguarding meetings took place every two months and discussed the care of each detained family. Staff training remained a standing agenda item and those working with families received safeguarding training.
- I.42** The welfare manager was the lead member of staff for safeguarding. We found that appropriate referrals were made to the local authority multi-agency safeguarding hub (a single point of entry for all referrals concerning a child or young person), but the lack of a safeguarding log and failure to record action at the time it was taken made it difficult to track what had been done and caused delays in the process. In addition, it was not always clear if all welfare concerns were communicated to the responsible community agencies in the UK or overseas (see recommendation I.38).
- I.43** There had been no allegations about Tinsley House staff but there was a process in place to investigate allegations, which included consulting the local authority designated officer.
- I.44** In the first few months of the PDA's operation, managers had carried out exercises to establish what lessons could be learned after each family had left the facility, which was positive and helped improve practice.

Legal rights

Expected outcomes:

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

- I.45** Detainees were informed of their right to legal advice and Home Office and PDA staff encouraged them to contact legal advisers throughout their detention. Detainees were asked if they had legal representation during their Home Office induction interview. The duty solicitor scheme was well promoted among those who did not have a legal representative or

who wanted to change legal representatives. Detainees could contact their legal representative by phone or fax. Legal visits arrangements remained sufficient.

- I.46** We saw cases in which Home Office staff advised families to make legal challenges at several stages in the process and there was no evidence that detainees were prevented from contacting solicitors. Of the 19 families that had been detained, five were released following a legal challenge.
- I.47** Family detention remained limited to 72 hours or a week with ministerial approval. The longest stay for families being removed was just over four days (102 hours) and all but four periods of detention were for less than 72 hours. Stays for families in the border returns accommodation were generally shorter – the longest stay for this group was 26 hours.
- I.48** Home Office staff continued to promote the option of returning voluntarily and in many cases offered families assistance to do this so they could avoid detention. Since our inspection of Cedars PDA in April 2016 the number of families entering the family returns process had declined steadily. The proportion of successful removals remained similar over this period and over 1300 families had been removed.
- I.49** The number of successful removals following detention remained very low; only four of the 19 detained families had been successfully removed in the 11 months since the PDA had been open. This made detention an exceptionally resource-intensive process. (See main recommendation S34.)
- I.50** During detention families had very good access to Home Office staff and the induction and exit interviews we observed were reasonable. However, we watched interviews where jargon and euphemisms were used, making it difficult for detainees to understand what was being said.
- I.51** The standard of interpretation was variable and we saw an interpreter take another call during a meeting in which a distressed woman was being told that she and her family would be removed from the country by force if necessary. Home Office staff challenged the interpreter when this happened.

Section 2. Respect

Staff–detainee relationships

Expected outcomes:

Families are treated with respect by all staff, with proper regard for the uncertainty of their situation and their cultural backgrounds. Complaints and feedback procedures are effective.

- 2.1 Many of the staff had transferred from the previous pre-departure accommodation at Cedars and the good relationships we observed at the previous inspection remained. We observed staff attempt to gain the confidence of detained families who were mistrustful of the returns process.
- 2.2 Home Office, custody, welfare, health care and Hibiscus Initiatives staff consistently attended a daily meeting and ensured that those working with detainees were well briefed on what had recently happened and the plans for the day ahead. Custody, welfare and Hibiscus Initiatives staff were respectful when interacting with families and discussing them in meetings. While detainees we spoke to complained about their situation and were resistant to being removed, they reported that staff were helpful and treated them well. The welfare team made skilful attempts to interact with children on arrival and throughout their detention.
- 2.3 The welcome pack in the apartment contained details about making a complaint and forms for contacting the Home Office, welfare team and Independent Monitoring Board. Most information was in English only. No complaints had been submitted since the pre-departure accommodation (PDA) had opened. Complaint forms were freely available in a range of languages and the dummy complaint submitted during the inspection was answered at 6.30am on the following day.

Accommodation and facilities

Expected outcomes:

Families are held in a safe, clean and decent environment. They are offered varied meals according to their individual requirements.

- 2.4 The facility at Tinsley house was well designed but significantly smaller than the previous centre at Cedars. It contained two (compared with 11) apartments. The adjacent border returns accommodation was designated for families detained by immigration officers on arrival in the UK. The number of apartments was adequate for the small number of families held.
- 2.5 Families were detained together in apartments that were well equipped, comfortable and in good repair. A useful welcome pack contained written information about the PDA and the family returns process, but it was only available in English. Staff adapted the equipment and toys to the children's age and families' interests. Apartments contained a shower room, living area and bedrooms as well as a place to prepare hot and cold drinks.
- 2.6 Communal areas were brightly decorated, clean and in good repair. There was a dining room, games and music room, multi-faith room, library and living area, as well as a clean and well-equipped kitchen. A wide range of play and entertainment facilities was also available. Outside space was pleasant, but much smaller than at the previous facility and it felt more

enclosed. Families could move around the facility freely and could use the outside space on request.

- 2.7** On their first night at the PDA, families could choose from a range of adequate microwave meals and convenience foods, such as pizzas, chips and frozen vegetables. From the following morning, they could order ingredients and cook meals for themselves, but very few detained families took up this offer. This meant there was an over reliance on frozen and convenience food. Families were offered, and had free access to, a range of snacks, including fruit and they could make a hot drink at any time during their detention.
- 2.8** Families staying in the border returns apartment could not use many of the communal facilities, which was an unnecessary restriction. This was offset in part by their shorter stay in detention.

Recommendations

- 2.9** **Welcome packs should be available in languages that detainees understand.**
- 2.10** **Families in the border returns unit should have equal access to communal space during their detention.**

Equality, diversity and faith

Expected outcomes:

There is a clear approach to promoting equality and diversity, underpinned by processes to identify and resolve any inequality or discrimination. The distinct needs of detainees with protected and any other minority characteristics are recognised and addressed. Detainees are able to practise their religion. The multi-faith team plays a full part in centre life and contributes to the overall care and support of detainees.

- 2.11** The centre's equality and diversity policy had been updated, although it still needed to be finalised and signed off. There was an equality and diversity manager for the family detention units and they were included within the scope of equality reporting work across Tinsley House and Brook House immigration removal centres (IRCs), but received almost no distinct mention in monthly reports, other than a record of whether any pregnant women had been held. There had been no discrimination-related complaints since the facility had opened.
- 2.12** Staff generally used a telephone interpretation service if needed. A face-to-face interpreter was generally used during immigration enforcement interviews on detainees' arrival and in preparation for their departure. A member of staff spoke Urdu and Punjabi and was often used; another spoke Arabic fluently. There were books and DVDs in a number of languages other than English.
- 2.13** A 21-weeks pregnant woman had been detained shortly before the inspection, along with her sons, aged eight and 11, and her partner. Two pregnant women had been held in September 2017. They had all had been released. They appeared to have received adequate care during their detention.
- 2.14** There was sufficient provision for those with disabilities – the bathroom was equipped with a low bath with suitable rails and a call bell.

- 2.15** Faith provision was good. The multi-faith room contained a washing facility for Muslims and a full selection of books and prayer material for the main faiths. The lead chaplain worked independently from the adult Tinsley House IRC and separate, specific services were provided for families' faith needs. A Muslim and Christian chaplain were always available through the IRC, and ministers of other faiths visited on request. Halal food was kept separately. Not all utensils used for halal food were stored separately from those used for non-halal food.

Recommendation

- 2.16** Halal and non-halal cooking utensils should be stored separately to meet faith requirements.

Health services

Expected outcomes:

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

The inspection of health services was jointly undertaken by the Care Quality Commission (CQC)⁷ and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. *The CQC found there were no breaches of the relevant regulations.*

- 2.17** On reception, a nurse carried out a health screening for all individual family members and reviewed all medical information that accompanied detainees. However, the screening tool did not have an appropriate template for children. All detainees were also seen by a GP within 24 hours of their arrival and usually on their first day at the unit. Information about health services in languages other than English was not readily available.
- 2.18** During their stay, families had constant access to a health care practitioner and a specialist mental health team was also available to provide support. Staffing levels were not increased when the family accommodation re-opened, and health staff in Tinsley House IRC still supported both families and detainees in the adult centre. Nevertheless, we found detainees' needs were met and during the inspection we saw them receive prompt access to secondary health care when a medical concern arose.
- 2.19** A draft health needs assessment had been created and was expected to inform future health provision. Clinical governance arrangements were sound and risks and areas for improvement were recognised. Services were monitored through audits, managerial supervision and oversight from the clinical lead staff member.
- 2.20** All health care staff had undertaken safeguarding children training appropriate for their roles and were competent practitioners with experience of working with families. There were no specialist paediatric nurses, but the team had undertaken child health modules and understood developmental milestones. Given families were only held for short stays, staff had a suitable skillset. Age-appropriate emergency resuscitation equipment was available and

⁷ CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: <http://www.cqc.org.uk>.

practitioners were trained to deliver adult and paediatric life support. Staff also received awareness training on trauma-informed care (care for people who have experienced trauma) and all medical staff had undertaken specific training on producing rule 35 assessments⁸.

- 2.21** Detainees with recognisable mental health conditions requiring specialist secondary support were not admitted to the PDA. If family members presented as acutely mentally unwell, a review of their detention would take place. Detainees continued to have access to their prescribed medication, unless it had been discontinued by the GP due to an identifiable risk.
- 2.22** We were advised that detainees with substance use treatment needs were not admitted and health screening identified any potentially hidden needs to prevent them from being admitted. Forward, the provider of psychosocial support for detainees with substance misuse problems, was available to provide information, guidance and harm reduction advice, but the service was rarely required.

Recommendations

- 2.23 An age-appropriate template for use with children should be introduced as part of the reception screening process.**
- 2.24 Information about health services should be available in multiple languages and accessible formats.**

⁸ Rule 35 of the detention centre rules requires that the Home Office be notified if a centre doctor considers that a detainee's health will be injuriously affected by continued detention or the conditions of detention; if a detainee may have been a victim of torture; or if a detainee has suicidal intentions.

Section 3. Activities

Expected outcomes:

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

- 3.1 Families held as part of the family returns process could move around the pre-departure accommodation (PDA) freely. Access to outdoor space was limited to prevent children playing outside unsupervised from being harmed. However, staff opened the doors to the small garden area when asked.
- 3.2 Activities provided adults with something to do as well as mental stimulation. They were designed to distract children from dwelling on the negative aspects of being detained through learning and recreation.
- 3.3 Activities were tailored to the individual family. PDA staff produced a brief activity and learning plan for each family member. It formed part of the support plans they prepared based on pre-arrival information from the Home Office.
- 3.4 Plans setting out suggested activities for children and adults were simple, but appropriate. Activities for adults mainly included recreational pursuits, such as playing card games or sewing. Those for children included a mix of learning, physical activity and entertainment options. For example, one plan suggested study in the resource room in the morning, play on equipment in the garden in the afternoon and using an electronic games machine in the evening.
- 3.5 A good range of recreational and learning resources was available. Resources were up to date and in excellent condition. A room in which detainees were received when they arrived was very well equipped with play activities for small children and a TV screen for older children, keeping them occupied while adult family members completed arrival documents.
- 3.6 Facilities in an activity room for children were very good. They included a good range of musical instruments, such as a guitar and key board, a play station, DVDs and games. The room was furnished appropriately to resemble a living room.
- 3.7 A small resource room had suitable education materials, such as primary key stage and GCSE handbooks. It provided a small range of novels and light fiction in English, as well as books in other languages and in braille. It had a modest but good range of books for children of different ages, as well as a standalone computer and booklets on common removal destination countries. However, there was no access to the internet or email. (See paragraph 4.1 and recommendation 4.4.)
- 3.8 Fitness facilities were limited. Detainees had no access to a gym or adult fitness equipment. Outdoor fitness activities were confined to a limited range for children. Wii-based activities were available indoors for all age groups, as were yoga and zumba tapes and mats.
- 3.9 Members of staff worked closely and flexibly with children throughout their stay. They provided effective help with the learning elements of the child's activity programme, responded to requests, and willingly varied plans. For example, staff supplied practice tests for a child about to sit a school entrance examination, when they were asked to.
- 3.10 Staff routinely reflected on and reviewed activities following each family's departure and made improvements. For example, they purchased additional football resources for young boys who were detained.

Section 4. Preparation for removal and release

Communications

Expected outcomes:

Families are able to maintain contact with the outside world using a full range of communications media.

- 4.1 On arrival detained families received a mobile phone and could transfer any phone numbers from existing devices. Families could make calls at any time and communicate by fax, but there was no access to email. During the inspection, and for an uncertain period beforehand, families did not have access to the internet because of a connection fault that had not been addressed. Some staff were unaware that the internet connection was faulty and action had not been taken by staff who were aware to resolve the issue. Even when the internet point was working, detained families could not use social networking sites or internet video conferencing services such as Skype.
- 4.2 Visiting arrangements were good and could be organised at short notice. Information about visits was provided in each apartment, including details about public transport to Gatwick Airport. A free minibus service was provided from the main terminal building to the centre. Visitors could bring in property for detainees.
- 4.3 Visiting facilities were good. Visits took place either in the dining room or reception area. Both areas were comfortable and staff ensured play equipment was available in either room while visits were taking place. The facilities would have been cramped if more than one family had been detained and a visit booked, but this would rarely have been the case. Pre-departure accommodation (PDA) staff could observe the visiting areas unobtrusively.

Recommendation

- 4.4 **Families should have access to the internet, including social networks and Skype.**

Leaving the centre

Expected outcomes:

Families are prepared for their release, transfer or removal. Families 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.

- 4.5 The welfare team maintained the positive child-centred ethos of the previous facility. The team consisted of 13.5 staff, although one post was vacant during the inspection. They included a manager, four team leaders – three of whom were social workers – four welfare workers, four Hibiscus project workers and administrative support. The team was sufficient to deal with the throughput of the PDA and staff had a clearly defined role that was distinct from family custody staff.
- 4.6 The team provided good support focused on improving the families' experience of removal. For example, they provided clothing and luggage if necessary, as well as personalised bags for children and activities for the journey. They persistently attempted to interact with all

families and gave parents and children several opportunities to access support during their short time at the facility.

- 4.7** Most families – nearly 80% – were released from detention and were not removed from the UK. In these cases, welfare staff allowed families to make their way home, providing staff to accompany them to ensure they reached their destination safely, unless the family specified they did not want this. Detainees who were due to be released late at night could sometimes defer the release until morning and stay overnight in the facility or stay in hotel accommodation and travel home in the morning. Families often accepted hotel accommodation.
- 4.8** Justice charity Hibiscus Initiatives employed four staff to help prepare families for life in destination countries. They reassured families and provided them with practical information. All families received a written pack containing this information. Where families were removed to a third country (of which they were not a national), the information was generic because not enough guidance about the region or town the family would eventually live in was available.
- 4.9** We observed two attempted removals, both of which failed. Both removal plans included the contingency of separating one parent from the rest of the family during the day before the attempted removal (see paragraph 1.28). There was now a system in place to record the number of times that children had been separated during the removal process. Since the centre had opened there had been no record of a separation of a child from a parent during arrest, detention or removal.

Section 5. Summary of recommendations and good practice

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

Main recommendation

To the Home Office

- 5.1** The Home Office should analyse why so many removals fail, with a view to reducing the unnecessary and harmful detention of children and families. (S34)

Recommendations

To the Home Office and escort contractors

Arrival and early days in detention

- 5.2** Home Office immigration enforcement arrest teams should wear body cameras during the arrest of families. (1.16, repeated recommendation 2.19)
- 5.3** Escorting teams should have food and drink for detainees. (1.17)

Recommendations

To the centre manager

Arrival and early days in detention

- 5.4** The initial reception process should be undertaken quickly, especially if families are tired or have had long journeys, with non-essential processes undertaken after the family have rested. (1.18, repeated recommendation 1.17)

Safeguarding adults and personal safety

- 5.5** Information regarding a detainee's risk of suicide and self-harm, and other welfare concerns, should be communicated with community agencies on release. (1.38)
- 5.6** All staff who may have sole, direct contact with detainees should carry ligature knives. (1.39, repeated recommendation 1.27)
- 5.7** Managers should ensure staff are confident and competent in using restraint techniques. (1.40)

Accommodation and facilities

- 5.8** Welcome packs should be available in languages that detainees understand. (2.9)
- 5.9** Families in the border returns unit should have equal access to communal space during their detention. (2.10)

Equality, diversity and faith

- 5.10** Halal and non-halal cooking utensils should be stored separately to meet faith requirements. (2.16)

Health services

- 5.11** An age-appropriate template for use with children should be introduced as part of the reception screening process. (2.23)
- 5.12** Information about health services should be available in multiple languages and accessible formats. (2.24)

Communications

- 5.13** Families should have access to the internet, including social networks and Skype. (4.4)

Section 6. Appendices

Appendix I: Inspection team

Hindpal Singh Bhui

Colin Carroll

Martin Kettle

Angus Mulready-Jones

Steve Eley

Malcolm Irons

Joanne MacDonald

Alastair Pearson

Team leader

Inspector

Inspector

Inspector

Health services inspector

Care Quality Commission inspector

Care Quality Commission inspector

Associate Activities Inspector

Appendix II: Progress on recommendations from the last report on pre-departure accommodation

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

Safety

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

At the last inspection, in 2016, an observed arrest was carried out well by immigration enforcement staff, but several recent complaints about arrest teams were under investigation. In some cases, Tascor escorts lacked sensitivity to the distress of families. At Cedars, preparation for arrival of families remained very good. The centre provided a safe environment and those at risk of self-harm were well supported. Safeguarding and child protection procedures remained a high priority for all centre staff and were well managed. Force had not been used in the centre since the last inspection. There had been some use of restraints during escorts; it was usually justified and subject to appropriate governance, but one incident was poorly recorded. Separation had not been used at all in the previous two years. Detainees had reasonable access to legal assistance. Fewer families were detained and most were released. On-site immigration staff were accessible. Outcomes for detainees were good against this healthy establishment test.

Recommendations

Health care information should only be shared more broadly with centre staff if it is directly relevant to the care of a detainee during their stay, or demonstrates potential risks to staff or the detainee.

(1.16)

Achieved

The initial reception process should be undertaken quickly, especially if families are tired or have had long journeys, with non-essential processes undertaken after the family have rested. (1.17)

Not achieved (recommendation repeated, 1.18)

All receiving staff should be aware of documented risks, understand the significant impact of impending removal, and take responsibility for comforting distressed detainees when required. (1.18)

Achieved

Managers should ensure that constant observations strike an appropriate balance between decency and safety. (1.26)

Achieved

All staff who may have sole, direct contact with detainees should carry ligature knives. (1.27)

Not achieved (recommendation repeated, 1.39)

Tascor staff should take part in multi-agency safeguarding training and be aware of the specific safeguarding concerns that may arise at Cedars or during arrests. (1.40)

Not achieved

Allegations concerning the behaviour of staff towards children should be referred to the local authority designated officer (LADO). (1.41)

Achieved

The risk of female genital mutilation (FGM) should be systematically considered as a safeguarding concern at all stages of the family returns process. If necessary, referrals should be made to local authorities to ensure that appropriate risk assessments are carried out. (1.42)

Not achieved

Recordings of use of force incidents should provide a complete picture of the whole incident to provide assurance of proportionality. (1.58)

Achieved

Only the minimum number of staff needed for security and safety should be positioned around a detainee during escort. (1.59)

Not achieved

Staff should check compliance at regular intervals to minimise the length of time that restraints are used. (1.60)

Achieved

In all cases, detention should only be used as a last resort and for the minimum time possible. (1.74)

Not achieved

Respect

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

At the last inspection, in 2016, the physical environment remained excellent and had in some respects improved. Relationships between staff and families were very good. Interpretation was usually used appropriately. Facilities for worship were good. There had been no complaints since the last inspection. Food was adequate. Health care provision was good and had improved. Outcomes for detainees were good against this healthy establishment test.

Recommendations

Home Office immigration enforcement arrest teams should wear body cameras during the arrest of families. (2.19)

Not achieved (recommendation repeated, 1.16)

Complaints should be replied to in the language in which the complaint is made. (2.20)

Not achieved

Health information literature should be readily available in the languages that are most common in the centre. (2.29)

Not achieved

Nursing staff should be trained in child development and basic health needs such as minor illnesses. (2.30)

Achieved

All health care professionals should have regular clinical and management supervision to ensure safe and good clinical practice. (2.31)

Achieved

Adult detainees with limited English should be offered interpretation during health care consultations. (2.37)

Achieved

Regular prescribing audits and stock checks should be reported to the medicines management meeting (currently the clinical quality meeting) to ensure safe and clinically effective prescribing and management of medicines. (2.43)

Achieved

Activities

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

At the last inspection, in 2016, the range of activities continued to meet the needs of detainees of all ages. Leisure and activity areas in the centre were very well equipped. Children could take part in a series of planned activities that combined play and learning. The library and gym were good resources. Outcomes for detainees were good against this healthy establishment test.

Recommendations

None

Preparation for removal and release

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

At the last inspection, in 2016, pre-removal support was good and those released were also given appropriate help. Visiting times were good. There was reasonably good access to email and the internet, but the ongoing Home Office restriction on social media was excessive. Each of the three overseas escorts we attempted to observe were cancelled. Outcomes for detainees were good against this healthy establishment test.

Recommendations

Information about removal should only be withheld from detainees as a last resort and based on a justifiable risk. (4.3)

Achieved

Families should have supervised access to social networks and Skype. (4.7)

Not achieved

The visits area should afford privacy to detainees and their visitors. (4.8)

Achieved

A record should be kept of the number of approved removal plans which include the option to separate children from their parents, and the number of times this option has been exercised. (4.12)

Achieved

Reasonable discretion should be applied if detainees being released late at night ask to stay overnight at Cedars before going home. (4.13)

Achieved

If allegations of assault made by detainees during removal attempts are supported by medical evidence, the removal should be delayed while the complaint is investigated. (4.14)

Not achieved

Progress on recommendations from the Tinsley House Immigration Removal Centre report, 2014

Main recommendations

Border Force should consider alternatives to detention before holding families with children at Tinsley House. This consideration should be fully recorded on the detainee's casework information database record. (S37)

Achieved

The Home Office should reassess the role of the unit. The name of the unit should reflect its function. Which detainees are deemed suitable for the unit should be robustly governed to manage risks safely for all those held on the unit. (S38)

Achieved

Recommendations

Escort arrangements for families should be based on the needs of any children involved, and female escort staff should be used to facilitate this if necessary. (5.18)

Achieved

A plan should be produced for each detainee held in the family unit outlining the support they will be offered and, where necessary, steps to be taken to maintain the safety and wellbeing of all detainees. (5.19)

Achieved

Appendix III: Photographs



Reception area



Corridor



Activities area



Family bedroom



Garden

Appendix IV: Detainee population profile

Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

Population breakdown by:

(i) Age	No. of men	No. of women	No. of children	%
Under 1 year	0	0	3	4.41
1 to 6 years	0	0	21	30.88
7 to 11 years	0	0	9	13.24
12 to 16 years	0	0	4	5.88
16 to 17 years	0	0	1	1.47
18 years to 21 years	1	1	0	2.94
22 years to 29 years	0	5	0	7.35
30 years to 39 years	4	9	0	19.12
40 years to 49 years	5	4	0	13.24
50 years to 59 years	1	0	0	1.47
60 years to 69 years	0	0	0	0
70 or over	0	0	0	0
Total	11	19	38	100

(ii) Nationality Please add further categories if necessary	No. of men	No. of women	No. of children	%
Afghanistan	4	3	8	22.06
Albania	0	3	5	11.76
Algeria	0	0	0	0
Angola	0	0	0	0
Bangladesh	0	0	0	0
Belarus	0	0	0	0
Cameroon	0	0	0	0
China	0	2	3	7.35
Colombia	0	0	0	0
Congo (Brazzaville)	0	0	0	0
Congo Democratic Republic (Zaire)	0	0	0	0
Ecuador	0	0	0	0
Estonia	0	0	0	0
Georgia	0	0	0	0
Ghana	0	0	0	0
India	1	2	2	7.35
Iran	1	1	3	7.35
Iraq	3	4	10	25
Ivory Coast	0	0	0	0
Jamaica	0	0	0	0
Kenya	0	0	0	0
Kosovo	0	0	0	0
Latvia	0	0	0	0
Liberia	0	0	0	0
Lithuania	0	0	0	0
Malaysia	0	0	0	0
Mauritius	1	1	2	5.89
Moldova	0	0	0	0
Nigeria	0	2	3	7.35
Pakistan	0	0	0	0
Russia	0	0	0	0
Sierra Leone	0	0	0	0
Sri Lanka	1	1	2	5.89
Trinidad and Tobago	0	0	0	0
Turkey	0	0	0	0
Ukraine	0	0	0	0
Vietnam	0	0	0	0
Yugoslavia (FRY)	0	0	0	0
Zambia	0	0	0	0
Zimbabwe	0	0	0	0
Other (please state)	0	0	0	0
Total	11	19	38	100

(iii) Religion/belief Please add further categories if necessary	No. of men	No. of women	No. of children	%
Buddhist	0	0	0	0
Roman Catholic	1	2	4	10.29
Orthodox	0	0	0	0
Other Christian religion	1	4	6	16.18
Hindu	0	1	1	2.94
Muslim	4	7	18	42.65
Sikh	5	4	7	23.53
Agnostic/atheist	0	0	0	0
Unknown	0	0	0	0
No religion	0	1	2	4.41
Total	11	19	38	100

(iv) Length of time in detention in this centre	No. of men	No. of women	No. of children	%
Less than 1 week	11	19	38	100
1 to 2 weeks	0	0	0	0
2 to 4 weeks	0	0	0	0
1 to 2 months	0	0	0	0
2 to 4 months	0	0	0	0
4 to 6 months	0	0	0	0
6 to 8 months	0	0	0	0
8 to 10 months	0	0	0	0
More than 10 months (please note the longest length of time)	0	0	0	0
Total	11	19	38	100

(v) Detainees' last location before detention in this centre	No. of men	No. of women	No. of children	%
Community	11	19	38	100
Another IRC	0	0	0	0
A short-term holding facility (e.g. at a port or reporting centre)	0	0	0	0
Police station	0	0	0	0
Prison	0	0	0	0
Total	11	19	38	100