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

Becket House

by HM Chief Inspector of Prisons

18 June 2019

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 an immigration removal centre.

Location
60–68 St Thomas Street, London, SE1 3QU

Name of contractor
Mitie Care and Custody

Last inspection
6 January 2015

Escort provider
Mitie Care and Custody

Introduction

Becket House remains one of the Home Office's busiest reporting centres and is used by immigration enforcement teams and Home Office caseworkers. It is no longer routinely used for handling asylum claims.

Approximately 700 people attend the centre each day to comply with the conditions of their temporary admission into the UK. Of these, around two are detained in the short-term holding facility on the ground floor of the building. An additional number are brought to the facility by immigration enforcement teams after been picked up in the community.

The secondary search area (SSA) mentioned in our last inspection report remained. Individuals could now ask to leave, but were still subject to restriction of liberty without any form of documented authorisation. The governance of this area remained inadequate and the conditions there were poor. In the previous three months, 18 people had remained in the SSA for more than four hours, with the longest being for seven hours and 13 minutes.

Facilities and conditions in the holding rooms remained as at the time of the previous inspection, with a lack of opportunity for detainees to spend time in the open air and insufficient activities available to occupy them for more than a few hours. Detainee custody officers were polite and courteous when dealing with detainees but some security processes remained disproportionate. In the previous three months, 257 detainees had been held, with some continuing to spend too long in the facility waiting for onward transport. During the inspection, we saw one couple spend nearly 12 hours at the facility, which was excessive. The average length of stay in the holding facility was four hours and 28 minutes.

An Independent Monitoring Board had recently begun to undertake routine visits to the facility.

About this inspection and report

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

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

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

> **Safety** – that detainees are held in safety and with due regard to the insecurity of their position
>
> **Respect** – that detainees are treated with respect for their human dignity and the circumstances of their detention[1]
>
> **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 2015, we made 23 recommendations, six of which we found at this inspection were achieved, one partially achieved, 15 not achieved and one that we were unable to inspect.

S2 The short-term holding facility was used to hold people who had been detained following attendance at the reporting centre and those who had been arrested in the community by an immigration compliance and enforcement team.

S3 The facility consisted of two holding rooms, enabling unrelated male and female detainees to be held separately. The rooms were reasonably clean and in good decorative condition. However, one room had no natural light.

S4 Detainees received a rub-down search by a DCO of the same sex and could make a telephone call but were not able to retain their own mobile telephones if they had an integral camera.

S5 Catering arrangements were adequate, and DCOs could buy items for special diets from nearby shops. Detainees did not have access to the open air and there was nowhere to smoke or vape. Some security processes were disproportionate.

S6 Four detainees were held during the inspection. DCOs interacted reasonably well with them and attempted to put them at ease. They expressed frustration at the frequent delays in onward transfer experienced by detainees, which unnecessarily lengthened the day for detainees and added to their anxiety and stress.

S7 Detainees could practise their religions, but access and facilities for those with disabilities were limited. All medication was routinely removed from detainees, without the advice of a health care professional, which potentially disrupted their continuity of care.

S8 DCOs carried anti-ligature knives but had not received refresher training in self-harm prevention. They demonstrated limited knowledge about safeguarding and adults at risk in detention. Children were not detained at the facility.

S9 All staff were up to date with their HOMES[2] training. There had been two use of force incidents in the previous 12 months.

S10 Complaint forms were available in a variety of languages but were not prominently displayed. One complaint had been submitted in the previous 12 months.

S11 Detainees could communicate with friends, family and lawyers by telephone but not by fax or email, and they could not use the internet. Visitors were not allowed into the facility and property could not be dropped off for detainees.

S12 Individuals continued to be held in the secondary search area. Although they were now able to leave, they had to ask for the door to be unlocked. We were not satisfied that sufficient governance was in place.

S13 Detainees being transferred to further detention could board escort vehicles in relative privacy. However, there were long waits for escort vehicles, and guiding holds were routinely applied to detainees as they left the centre.

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2 Home Office Manual for Escorting Safely training, which includes use of force.

Section 1. Safety

Arrival and early days in detention

Expected outcomes:
Detainees travelling to and arriving at the facility are treated with respect and care. Risks are identified and acted on. Induction is comprehensive.

1.1 The short-term holding facility (STHF), on the ground floor of Becket House reporting centre, was run by Mitie Care and Custody staff on behalf of the Home Office. It was open seven days a week, from 9am to 7pm. Staff told us that they often had to stay beyond 7pm, mostly for short durations, while waiting for escort vehicles to collect detainees. Staffing comprised a minimum of three staff, and always included a female detainee custody officer (DCO).

1.2 Detainees arrived either after reporting at the centre or after arrest in the community. A couple who had been detained by an immigration compliance and enforcement (ICE) team on the day of the inspection spoke positively about their treatment, stating that they had been offered the opportunity to have a shower and to pack their belongings. During their relatively short journey to Becket House they had also been offered water.

1.3 Arrested detainees were brought directly into the STHF staff area via a secure street-level car park and then escorted into the main building, where they were interviewed and processed by enforcement staff. Once this was complete, they were handed over to Mitie Care and Custody DCOs in the STHF.

1.4 We saw some risk and health needs information being communicated by enforcement staff to DCOs but it was limited and imprecise, particularly in the case of one diabetic detainee (see paragraph 1.42).

1.5 Some security procedures were disproportionate. For example, although detainees were not routinely handcuffed between disembarking from vans and entering the building, enforcement officers held their arms, which was unnecessary practice and not based on an individual risk assessment (see also paragraph 1.53 and recommendation 1.56). Immigration enforcement staff routinely wore stab-proof vests when interviewing detainees who had been picked up by the ICE team, and arrest-trained staff routinely carried handcuffs and extendable batons. Searching arrangements were also excessive, with some detainees being searched up to five times in one day.

1.6 Reception and induction arrangements were adequate. Staff followed a standard induction checklist, which covered basic issues relating to property, food and drink, and available facilities. Detainees received a rub-down search by a DCO of the same sex. Belts were routinely removed from detainees regardless of individual risk. Toiletry packs were available on request, but staff did not sufficiently promote their availability.

1.7 Detainees were allowed to make telephone calls to their family, friends and legal advisers (see also paragraph 1.45). Staff told us that professional telephone interpreting services would be used if necessary, or a Home Office interpreter brought in if they were available.

Recommendations

1.8 Handover information between immigration enforcement staff and detainee custody officers (DCOs) should be comprehensive and include all areas of identified risk and mitigating actions taken.

1.9 Security processes, including the removal of clothing from detainees, and the frequency of searching, should be based on an individual written risk assessment.

Safeguarding adults and personal safety

Expected outcomes:
The facility promotes the welfare of all detainees and protects them from all kinds of harm and neglect. The facility provides a safe environment which reduces the risk of self-harm and suicide. Detainees are protected from bullying and victimisation, and force is only used as a last resort and for legitimate reasons.

1.10 DCOs were not aware of the Mitie Care and Custody 'safeguarding vulnerable adults at risk' standard operating procedure or the Home Office's 'adults at risk of harm in detention' policy. They were able to describe their duty of care towards detainees in general terms but discussions of potential vulnerability were limited to self-harm and suicide. One vulnerable adult warning form had been completed in the previous year, after a management quality assurance check.

1.11 Staff had not heard of the national referral mechanism for potential victims of trafficking but said that they would inform their own manager and immigration enforcement staff if they had any information or concerns about a specific detainee.

1.12 Posters in the holding rooms promoted the telephone number of a helpline for victims of modern slavery. The posters were displayed in English and several other languages. A separate poster promoted a helpline to report female genital mutilation, although this was displayed only in English.

1.13 Men and women were still held together in the secondary search area (SSA),[3] although the Chief Immigration Officer (CIO) on duty during the inspection said that they would take additional precautions if they were aware of a person with a particular vulnerability. A single security guard remained responsible for their care but, unlike DCOs, was not accredited to hold detainees,[4] had not been trained in self-harm and suicide prevention procedures and did not carry an anti-ligature knife.

1.14 During the previous three months, 81% of detainees in the STHF had been male and 19% female. The facility consisted of two holding rooms, enabling unrelated male and female detainees to be held separately. Although there was a glass partition between the two holding rooms (see section on accommodation and facilities), there were window blinds in place which could be drawn to provide privacy.

1.15 DCOs had good oversight of the designated holding room for men but there were some blind spots in the room for female detainees. However, these were covered by closed-circuit television cameras, which were in place in both rooms. DCOs said that there were rarely

[3] A single room with limited seating, and used predominantly as a waiting area for people who had reported to the centre but were now to be interviewed for further information or, potentially, detention.

[4] Under section 154 of the 1999 Immigration and Asylum Act, the Home Secretary can certify that a detainee custody officer is a fit and proper person and has received appropriate training. Section 155 states that only certified detainee custody officers can discharge custodial functions.

issues between detainees but if they arose, they would speak to them, to try to defuse any tensions.

1.16 Mitie Care and Custody had a national self-harm and suicide prevention standard operating procedure but staff did not have a copy of it and could not remember the last time that they had received self-harm prevention training. They were aware of the requirement to fill out a self-harm and suicide warning form if a detainee self-harmed or presented a risk of self-harm.

1.17 We reviewed incident paperwork that had been submitted over the previous year. One report related to the detention of a person, in November 2018, who told staff that he had consumed alcohol that day, had a history of alcoholism and had suffered a recent seizure. However, of concern, it appeared that taking custody of the detainee had been the main focus of the ongoing conversation between immigration enforcement staff and DCOs, and not the detainee's well-being or consideration of his risk factors and suitability for detention. One detainee had self-harmed in the previous year, using a blade. Incident reports demonstrated minimal use of force by staff to prevent the detainee from further self-harming, and to retrieve the blade. DCOs carried anti-ligature knives and had completed first-aid training.

1.18 DCOs were regularly refreshed in their HOMES[5] training. They carried rigid-bar handcuffs, and three sets of waist and leg restraint belts were kept in the staff area and checked weekly. In the previous 12 months there had been two uses of recorded force. One related to DCOs who had restrained a detainee to prevent him further hurting himself. Paperwork was accurately completed and indicated proportionate and reasonable use of force. The other incident involved the use of force by escort staff. The detainee was handed over to them under restraint by immigration enforcement staff. The reasons for this initial restraint were not documented and escort staff paperwork was not consistent, with one quoting the detainee as stating, 'he not happy but will comply', while another described him as 'argumentative' and threatening to 'kill all English people'. These inconsistencies had not been identified in management checks.

Recommendation

1.19 DCOs should have a broad understanding of vulnerability and risk, including an awareness of the relevant Home Office and Mitie Care and Custody safeguarding adults policies in place.

Safeguarding children

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

1.20 At the time of the previous inspection, children had not been held in the STHF but could be held in the SSA if they had accompanied an adult reporting in. During the inspection, the CIO confirmed that they would not detain an individual if suitable care arrangements could not be made for an accompanying child. In addition, in a change since the previous inspection, adults with children were not held in the SSA but in a 'family room'. In reality this was a standard interview room with a few toys. The CIO told us that all immigration enforcement officers had been trained to level 2 in the Home Office's 'Keeping children safe' course.

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5 Home Office Manual for Escorting Safely training, which includes use of force.

Legal rights

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

1.21 The SSA was now used mainly for people waiting to be interviewed after reporting to the centre. Individuals were locked into the room without being issued with any detention paperwork. We were told that individuals could now ask to leave the room and there was a poster displayed advising individuals of this. However, this was only in English and they had to inform the supervising security guard, who would then contact a Home Office manager to facilitate this. We were not satisfied that sufficient governance was in place. In the previous three months, 18 people had remained in the SSA for more than four hours, with the longest being for seven hours and 13 minutes.

1.22 Immigration enforcement officers issued detainees with relevant legal documents at the point of detention. These included an IS91 authority to detain document, a notice of removal, information on bail rights and an associated application form. This paperwork was entirely in English but we were told that professional telephone interpreting services were used if needed. We spoke to two detainees. One said that he had been offered the use of professional telephone interpreting services, while the other told us that he had not been offered the same opportunity, understood little of what enforcement staff had told him and had merely 'signed where he was told to'.

1.23 DCOs were clear that they would not accept a detainee into their care without an IS91 form; however, these forms were not always completed accurately. We examined two IS91 documents, for a married couple who had been arrested and escorted to the reporting centre together. The time of initial detention was noted as 8am in one IS91 document, and 6am in the other.

1.24 The holding rooms contained a few notices, in various languages, promoting a telephone number for the Office of the Immigration Services Commissioner, which could provide help to detainees in locating a registered immigration adviser. However, the Civil Legal Advice helpline was not promoted. A copy of the STHF rules was available in both holding rooms.

1.25 Legal representatives were unable to visit detainees. Detainees had no access to a fax machine (see paragraph 1.46); they could maintain contact with their legal representatives by telephone, but not always in private. Those subsequently transferred to immigration removal centres (IRCs) would be able to seek legal advice through Legal Aid Agency-funded duty advice surgeries.

1.26 During the previous three months, 257 detainees had been held, for an average of four hours and 28 minutes. The longest period of detention had been 10 hours and 31 minutes.

Recommendations

1.27 People should be able to leave the secondary search area freely.

1.28 The details and telephone numbers of advice agencies and solicitors should be displayed in the holding rooms, in a variety of languages.

Respect

Accommodation and facilities

Expected outcomes:
Detainees are held in a safe, clean and decent environment. They are offered varied meals according to their individual requirements. The facility encourages activities to promote mental well-being.

1.29 The SSA was relatively clean, but overall conditions were poor. It contained fixed seats, lockers to store property, a water fountain and some magazines. No television was provided and there were no other activities available to occupy people waiting to be interviewed. There was no toilet in the room, so people had to ask the security guard to be let out to use the nearby facilities.

1.30 The STHF was largely unchanged since the previous inspection, and consisted of two small holding rooms with a small staff area. Both rooms were clean and in good repair but the smaller one, designated for women, had no natural light. Both rooms contained several fixed seats, some blankets and pillows, a water fountain and a payphone. Efforts had been made to soften the environment by displaying plastic flowers and some wall art. There was one toilet in each room; both were clean but they lacked seats and lids. There were sanitary products freely available in the smaller room. Toilet doors were lockable but staff could unlock them from the outside if they became concerned for a detainee's safety.

1.31 Detainees were provided with adequate food, with a small selection of crisps, biscuits, long-life croissants and carton drinks freely available in the holding rooms. DCOs offered them microwave meals, including halal and vegetarian options, and hot drinks. There was a limited range of meals for vegans but no fruit was provided. DCOs confirmed that they could buy items for special diets from nearby shops, if required, using petty cash. There were no tables for detainees to eat or drink at; we were told that they were provided with the cardboard sleeves from their microwave meals to use as makeshift trays.

1.32 For short-stay detainees, there were some activities to occupy them but these were inadequate for anyone being detained for more than a few hours. Each room contained a television and a few newspapers, magazines and books, some of which were in foreign languages. Most of the newspapers and magazines were out of date. Detainees did not have access to the fresh air or anywhere to smoke or vape.

1.33 Management checks of the facility were undertaken but were infrequent (in the visitors' logbook for June 2019, there were only five recorded visits from Home Office staff over four different days). However, DCOs told us that records were likely to be inaccurate as Home Office staff did not always sign in.

Recommendations

1.34 Toilets should have a seat and lid.

1.35 Detainees spending more than a few hours at the facility should be allowed time in the open air.

Respectful treatment

Expected outcomes:
Detainees are treated with respect by all staff. Effective complaints procedures are in place for detainees. There is understanding of detainees' diverse cultural backgrounds. Detainees' health care needs are met.

1.36 Four detainees were held during the inspection. We observed DCOs engaging reasonably well with detainees. They were polite and courteous, and tried to put them at ease. They were sensitive to detainee concerns and expressed their frustrations to us about the often long delays in onward transfer experienced by detainees (see also paragraph 1.50).

1.37 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. However, the forms were not prominently displayed, being kept in an information folder, which held only one complaint form. Some literature in this folder was inaccurate and referred to the 'yellow' complaints box, which was actually grey.

1.38 The CIO told us that they emptied complaints boxes weekly. We submitted a dummy complaint on the day of the inspection but the Home Office had yet to confirm its receipt, four weeks after the inspection. One complaint had been submitted in the previous 12 months, regarding a lost passport, but we were not provided with the response.

1.39 DCOs said that they completed disability care plans when required, but the holding rooms were in any event inadequate for those with disabilities; for example, there were no suitable toilets.

1.40 There were no separate quiet or faith rooms but detainees could practise their religions. Holy books and prayer mats were stored respectfully. DCOs had a basic understanding of equality and diversity issues but could not recollect having attended or completed any training or awareness sessions.

1.41 In the previous three months, the most common countries of origin for detainees held were India (12%), Bangladesh (11%) and Ukraine (11%). Staff were aware of the professional telephone interpreting service, but records showed that it had been used on only 15 occasions in the previous 12 months, which seemed surprisingly low given that 257 detainees had been held in the previous three months alone.

1.42 DCOs removed all medications from detainees on arrival, including those that had been prescribed to them. DCOs said that they would not administer any medication, but would contact immigration enforcement staff to do so. We observed an instance where immigration enforcement staff provided DCOs with a basic and imprecise verbal handover regarding a detainee's specific health issues. He was diabetic and DCOs confirmed with him that he needed his medication; he was then taken to get it. This matter could have been clarified by the immigration staff before the detainee's medication was removed, avoiding confusion and potential to disruption of the detainee's continuity of care.

Recommendations

1.43 There should be adequate facilities to support detainees with disabilities, including limited mobility.

1.44 There should be arrangements to ensure that detainees have adequate and prompt access to medical services, including their own medication to manage long-standing conditions.

Preparation for removal and release

Communications

Expected outcomes:
Detainees are able to maintain contact with the outside world using a full range of communications media.

1.45 Detainees could maintain reasonably good contact with the outside world by telephone but not by any other means of communication. Although detainees were not permitted to retain their mobile phones if they had a camera, they could still use them outside the holding rooms under staff supervision. Alternatively, they could make use of an available cordless phone that they could take into the holding room with them. Replacement mobile phones were not provided. A payphone in each holding room accepted incoming calls, but did not have a privacy hood.

1.46 Detainees did not have access to the internet, email or social media. A fax machine in the staff area had not worked since the change in contract provider.

Recommendation

1.47 Detainees should be able to contact people outside the facility easily by fax, video calling, email and social networks, and should be able to access the internet.

Leaving the facility

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

1.48 Visitors were not allowed into the facility, and friends and family were unable to leave property for detainees. DCOs told us that, in exceptional circumstances, they would facilitate the handing out of essential property– for example, car or house keys – to a detainee's family or a friend.

1.49 DCOs did not always inform detainees promptly of their onward transfer destinations, and did not routinely give them the available wallet-sized information cards displaying the address and telephone number of the relevant IRC.

1.50 Escort arrangements were not effectively coordinated, with evidence of adverse outcomes for detainees. During the inspection, we met a married couple who had been arrested in the community by an ICE team at 5am that day. They had been transported, processed and located in the STHF by approximately 8am, but were not collected for transport to Yarl's Wood IRC until 7.40pm. This unacceptably long delay was likely to have added to the stress and anxiety that both detainees were already experiencing.

1.51 By contrast, an escort vehicle arrived to take two detainees to Tinsley House IRC before either of them had been fully processed. This led to escort staff having to wait for the second detainee for approximately 45 minutes. In their subsequent haste to depart, they did not

facilitate this detainee's request to use his phone before transfer, and he was told that he would have to wait until he arrived at Tinsley House IRC.

1.52 The escort vehicle we examined was clean, free of graffiti and had adequate space to store detainees' property. Crisps, water and croissants were available for detainees during their onward journeys to IRCs.

1.53 The car park in which the escort vehicles parked offered reasonable privacy, although the public would have been able to see in through the street-side metal fencing. Detainees were not routinely handcuffed when being taken to escort vehicles, but guiding holds were used unnecessarily.

1.54 On leaving the facility, most male detainees were taken to either Brook House or Tinsley House IRCs, located near Gatwick Airport, and female detainees to Yarl's Wood IRC, in Bedfordshire.

Recommendations

1.55 **Detainees should be transferred promptly to removal centres.** (Repeated recommendation 1.69)

1.56 **Escort staff should not hold detainees by their arms when leaving the facility, unless justified by an individual risk assessment.**

Section 2. Summary of recommendations and good practice

Recommendations To the Home Office

Arrival and early days in detention

2.1 Handover information between immigration enforcement staff and detainee custody officers (DCOs) should be comprehensive and include all areas of identified risk and mitigating actions taken. (1.8)

Legal rights

2.2 People should be able to leave the secondary search area freely. (1.27)

Recommendations To the Home Office and facility contractor

Arrival and early days in detention

2.3 Security processes, including the removal of clothing from detainees, and the frequency of searching, should be based on an individual written risk assessment. (1.9)

Communications

2.4 Detainees should be able to contact people outside the facility easily by fax, video calling, email and social networks, and should be able to access the internet. (1.47)

Recommendations To the escort contractor

Leaving the facility

2.5 Detainees should be transferred promptly to removal centres. (1.55, repeated recommendation 1.69)

2.6 Escort staff should not hold detainees by their arms when leaving the facility, unless justified by an individual risk assessment. (1.56)

Recommendations

To the facility contractor

Safeguarding adults and personal safety

2.7 DCOs should have a broad understanding of vulnerability and risk, including an awareness of the relevant Home Office and Mitie Care and Custody safeguarding adults policies in place. (1.19)

Legal rights

2.8 The details and telephone numbers of advice agencies and solicitors should be displayed in the holding rooms, in a variety of languages. (1.28)

Accommodation and facilities

2.9 Toilets should have a seat and lid. (1.34)

2.10 Detainees spending more than a few hours at the facility should be allowed time in the open air. (1.35)

Respectful treatment

2.11 There should be adequate facilities to support detainees with disabilities, including limited mobility. (1.43)

2.12 There should be arrangements to ensure that detainees have adequate and prompt access to medical services, including their own medication to manage long-standing conditions. (1.44)

Section 3. Appendices

Appendix I: Inspection team

Kam Sarai	Inspector

Appendix II: Progress on recommendations from the last report

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

Safety

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

Recommendations

The secondary search area should not be used as a place of detention. (S17)
Not achieved

Immigration enforcement officers should not hold detainees by their arms inside Becket House unless justified by individual risk assessment. (1.4)
Not achieved

Detainees should be taken off Immigration Enforcement vans and booked into the STHF promptly. (1.9)
Achieved

Detainees should not be subjected to repeated searches inside Becket House. (1.10)
Not achieved

Clothing and other items should be removed from detainees only on the basis of individual risk assessment. (1.17)
Not achieved

All staff should understand and follow emergency protocols. (1.18)
Achieved

All detainee custody officers (DCOs) should carry anti-ligature knives. (1.19)
Achieved

Tascor and the Home Office should develop a national safeguarding adults policy, and all relevant staff should be aware of this. (1.21)
Partially achieved

Detainees should be able to fax documents to legal representatives on request from the fax machine in the holding area, reducing unnecessary delays and anxiety. (1.29)
Not achieved

Standard information on the IS91R reasons for detention form should be in a range of languages. (1.30)
Not achieved

Respect

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

Recommendations

There should be routine supervision of the facility by senior immigration staff to check that conditions of detention are appropriate, casework is properly progressed and detainees are kept informed. These visits should be recorded. (1.40)
Not achieved

DCOs should respond to detainees' requests promptly. (1.44)
Achieved

Immigration enforcement staff should interact with detainees respectfully. (1.45)
Not achieved

Staff should receive regular training in diversity that takes account of the particular experiences of asylum seekers and refugees. (1.50)
Not achieved

Complaints forms should be complete and easy to read. (1.53)
Achieved

The complaints box should be emptied every day by immigration enforcement staff. (1.54)
Not achieved

Responses to complaints should be fair and impartially address the issues raised. (1.55)
Unable to inspect

Vegetarian sandwiches and healthy snacks should be available, and detainees with special dietary needs should be informed that they can request alternative food. (1.59)
Achieved

Hot food should be served safely on trays or tables. (1.60)
Not achieved

Detainees held for more than a few hours should have access to the open air. (1.64)
Not achieved

Preparation for removal and release

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

Recommendations

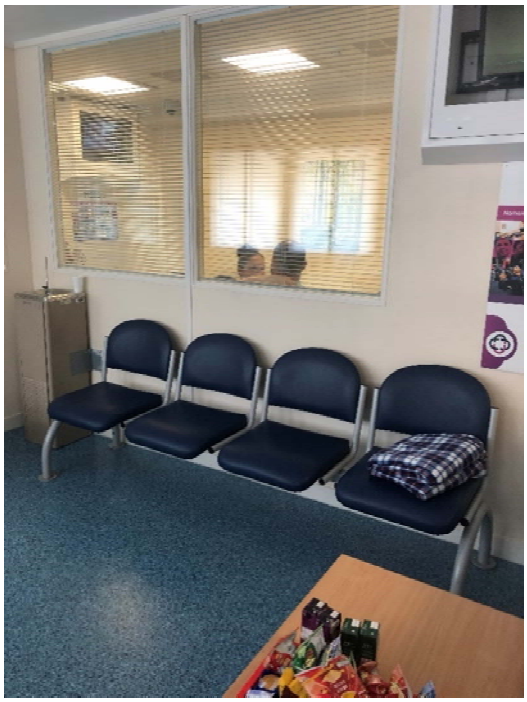
Detainees should be transferred promptly to removal centres. (1.69)
Not achieved (recommendation repeated, 1.55)

Detainees should be able to receive visitors. (1.70)
Not achieved

Arrangements should be in place to allow detainees to recover or arrange for the disposal of their property and detainees should be informed of this. (1.71)
Not achieved

Appendix III: Photographs

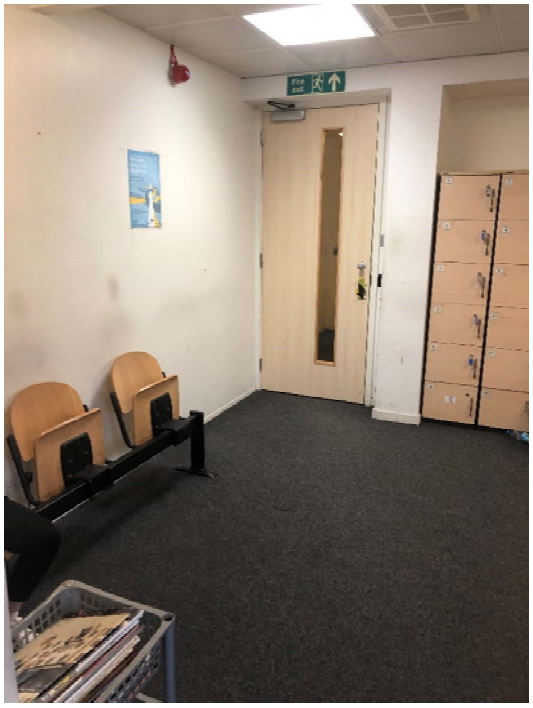
Men's holding room



Men's holding room

Women's holding room

Women's holding room



Secondary search area