Response to Independent Chief Inspector of Borders and Immigration: call for evidence for the Second Annual Inspection of 'Adults at Risk' in Immigration Detention

by Her Majesty's Chief Inspector of Prisons

Introduction

1. We welcome the opportunity to submit evidence to the Independent Chief Inspector of Borders and Immigration (ICIBI) for the second annual inspection of 'Adults at Risk' in Immigration Detention.

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose role is primarily set out in section 5A of the Prison Act 1952. This role includes reporting on conditions for and treatment of those in immigration removal centres (IRCs) and Short-Term Holding Facilities (STHFs). HMI Prisons is a member of the UK's National Preventive Mechanism (NPM), which was established pursuant to the UN Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) and which focuses on the prevention of torture and other ill-treatment.

3. Our response to this call for evidence is based on our findings from three inspections of IRCs published during the period 1 April 2019 – 30 September 2020, covering Colnbrook, Brook House, and Morton Hall. Our response also includes findings from an inspection of STHFs published in June 2020. These inspections are carried out against our *Expectations* for immigration detention or STHFs respectively, which are the independent criteria by which we assess the treatment and conditions of those held in these settings. Our *Expectations* were drawn up following extensive consultation and are based on and referenced against international human rights standards.[1] Inspections consider outcomes for vulnerable detainees, including whether the Adults at Risk policy operates effectively.

4. The first part of our response focuses on those detained in IRCs and covers Rule 35 reports, support to vulnerable detainees and the identification of adults at risk. We also comment on what works well in IRCs. During our IRC inspections, we speak to staff and detainees, and assess evidence provided by the Home Office and IRC provider – including data on the number and level of adults at risk being held; safeguarding policies; and documentation of care plans for vulnerable adults. We also review a sample of case files and relevant documentation – including Rule 35 reports and detention reviews – to assess case progression and whether the Home Office can evidence that it has reviewed the impacts of maintaining detention. We note that we inspect outcomes for those in detention and therefore do not inspect casework relating to the work of the Detention Gatekeeper.

5. The second part of our response considers those detained in STHFs. Due to the short-term nature of detention at these facilities, our inspections focus on Border Force's ability to identify vulnerable adults and provide effective safeguarding for the duration of their detention.

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[1] The Expectations can be found at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/immigration-detention-expectations/.

6. Finally, our response includes findings from our 'Short Scrutiny Visits' (SSV) to four IRCs in May 2020. SSVs were introduced following the outbreak of COVID-19 and allowed HMI Prisons to provide independent scrutiny of places of detention without placing an undue burden on inspected establishments and while adhering to the principle of 'do no harm'.[2]

1. Immigration Removal Centres

1.1. Detention Centre Rule 35

7. Rule 35 of the Detention Centre Rules requires the centre's medical practitioner to report to the Home Office about any detainees whose health may be injuriously affected by detention; those who are suicidal; or those who may have been the victim of torture. During our full inspections, we review a sample of 10 Rule 35 reports. Some repeated concerns arise from these reviews.

8. In our submission to the ICIBI's first annual inspection of adults at risk in immigration detention, we noted that inspections had found concerns about the use and quality of Rule 35 reports in IRCs, including that they were rarely submitted in cases where detainees expressed suicidal ideation, and were often not of sufficient quality to allow case workers to make fully informed decisions. We continued to report these concerns in subsequent inspections.

9. In the three subsequent IRC inspections, we found that Rule 35 reports were rarely used in cases that did not involve torture, thereby reducing safeguards for detainees with serious health issues or those who expressed suicidal ideation.

   'Despite a higher level of self-harm than at the last inspection, and nearly a hundred constant watches in the previous six months, no Rule 35 reports had been completed on suicidal ideation.'[3]

10. We often found that Rule 35 reports lacked detail, or did not adequately explain the reasoning behind conclusions, meaning they were not of a sufficient quality to allow case workers to make fully informed decisions on whether detention should be continued.

    'We reviewed in detail 10 Rule 35 reports and their replies, all of which related to torture. They were not good enough. They gave a judgment on consistency with the alleged method of torture, but lacked detail. Doctors gave judgements on the consistency of scarring with the detainee's account but the reasoning behind these judgements was not clear. The assessment in one report comprised a single sentence. Not all reports explored the likely impact of further detention. Assessment of psychological trauma was limited. Five reports documented evidence of poor mental wellbeing such as anxiety, low mood, insomnia, nightmares and flashbacks but gave no assessment of whether the detainee had posttraumatic stress disorder.'[4]

11. We also found that the Home Office often maintained detention even when they accepted the Rule 35 report as evidence of torture, citing immigration history as a countervailing factor against release. For example, at Colnbrook IRC, inspectors reviewed nine cases where Rule 35 reports were accepted as evidence of torture, but detention was maintained in all but one of

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[2] The full methodology can be found at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/03/Short-scrutiny-visit-briefing-document-for-IRCs-for-website.pdf.

[3] Paragraph S9, Report on an Unannounced Inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons, September 2019.

[4] Paragraph 1.20, Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre by HM Chief Inspector of Prisons, April 2019.

these on grounds that immigration factors outweighed the presumption to release.[5]

12. Finally, at Colnbrook IRC, we found that a psychiatrist who worked with detainees suffering from significant mental health issues was prevented from submitting Rule 35 reports, due to a rule stating that only GPs could do so. This restriction was depriving some of the most vulnerable detainees of an important safeguard.[6] This did not appear to be an issue at other IRCs.

1.2 Assessment, Care in Detention and Teamwork Plans (ACDTs) and Care Plans for Vulnerable Detainees

13. IRC staff produce 'Assessment, care in detention and teamwork' (ACDT) documents in cases where there are concerns that a detainee is at risk of self-harm or suicide. These documents are designed to help to monitor detainees, and identify appropriate interventions to support their wellbeing.

14. Vulnerable detainees can also be given individual supported living plans (care plans) – based on risk assessment - which should record their needs, as well as any necessary adjustments or planned interventions.

15. We found that the completion of documentation and the implementation of both ACDTs and care plans was inconsistent across the IRC's inspected. At Colnbrook IRC, 'the quality of opened vulnerable adult care plans was good and better than we usually see,'[7] and 'ACDT procedures were carried out well, with comprehensive entries giving a clear picture of the detainee's frame of mind while on the residential unit.'[8] However, at Brook House IRC:

    > 'The quality of ACDT documentation was not good enough. Assessments and reviews were timely but care maps frequently lacked detail, case reviews were not sufficiently multidisciplinary and some post-closure reviews were not completed. ACDT observations were regular but did not always demonstrate enough meaningful engagement.'[9]

    Care plans at Brook House 'were good in theory but…were not completed well enough to be a helpful tool for staff to care for detainees.'[10] At Morton Hall IRC 'care plans lacked focus and some staff did not understand what their purpose was.'[11]

16. Furthermore, not all detainees who needed a care plan had one. For example, at Colnbrook IRC:

    'Only 10 had been opened in the previous six months and five detainees assessed at the highest level of risk had no plan.'[12]

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[5] *Ibid.,* Paragraph 1.21.
[6] *Ibid.,* Paragraph 1.19.
[7] *Ibid.,* Paragraph 1.13.
[8] *Ibid.,* Paragraph 1.26.
[9] Paragraph S10, Report on an Unannounced Inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons, September 2019.
[10] *Ibid.,* Paragraph S7.
[11] Paragraph S8, Report on an Unannounced Inspection of Morton Hall Immigration Removal Centre by HM Chief Inspector of Prisons, March 2020.
[12] Paragraph 1.13, Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre by HM Chief Inspector of Prisons, April 2019.

1.3 Identifying Adults at Risk and Sharing Information

17. In our previous submission to the ICIBI, we noted that we had found it difficult to obtain accurate data regarding the number of adults at risk being held, which resulted in concerns about how well adults at risk were being identified, cared for and released when detention should not be maintained. The lack of reliable data also raised concerns about how effectively the Home Office and detention providers shared information and worked together to identify vulnerable adults and implement appropriate care.

18. Our subsequent inspection findings suggest that this has improved at some IRCs, but not across the board. For example, at Colnbrook IRC, staff working for the detention provider – Mitie – had poor awareness of the Adults at Risk policy, and joint working to identify and record vulnerable detainees was poor, which resulted in unreliable data on the number of adults at risk detained at the centre:

    'Home Office records showed 40 detainees at the two higher levels of risk, whereas Mitie only had a record of 21. We could not therefore be confident that targeted support was provided to all vulnerable detainees.'[13]

19. However, at Brook House IRC, staff from the Home Office and the detention provider were working effectively to identify adults at risk, and strong practices were in place to support information sharing and case reviews:

    'Joint working between the Home Office, G4S and health care to identify vulnerable adults was good. The Home Office and G4S each had nominated officers who ensured that accurate records were kept of adults at risk. These records were checked for consistency at the weekly adults at risk meeting.'[14]

20. At Morton Hall IRC, although centre staff had improved at identifying adults at risk, 'detainee custody officers were not sufficiently aware of the fact that detention was likely to cause harm to detainees assessed at level 3.'[15]

21. In all three IRCs, centre staff held regular multi-disciplinary review meetings, where adults at risk and detainees on ACDTs were discussed. However, attendance at these meetings was not always adequate. For example, at Morton Hall IRC, there was insufficient direct input from Home Office case owners at these meetings,[16] and at Colnbrook 'minutes showed that meetings were useful and suitably focused on adults at risk. However, Mitie staff had not attended in recent weeks nor received the minutes.'[17]

1.4 What Works Well in IRCs

22. Across the three IRCs, we found that relationships between staff and detainees were positive. At Morton Hall, 73% of detainees responding to our survey reported that staff treated them with respect always or most of the time and we found that most staff understood the

[13] *Ibid.*, Paragraph 1.12.
[14] Paragraph 1.15, Report on an Unannounced Inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons, September 2019.
[15] Paragraph S8, Report on an Unannounced Inspection of Morton Hall Immigration Removal Centre by HM Chief Inspector of Prisons, March 2020.
[16] *Ibid.,* Paragraph 1.11.
[17] Paragraph 1.11, Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre by HM Chief Inspector of Prisons, April 2019.

complexities of working in an IRC and empathised with detainees.[18] At Brook House, 72% of detainees reported staff treating them with respect always or most of the time, and in addition, nearly all interviewed detainees said they were treated well or very well by centre staff.[19] However, there were some concerns reported by staff about poor attitudes among healthcare staff at Brook House.[20] At Colnbrook, 80% of detainees responding to our survey said that most staff treated them with respect and most staff reported that staff-detainee relationships were a real strength of the centre.[21]

23. Home Office staff in IRCs often demonstrated good awareness of the National Referral Mechanism and modern slavery. As was reported in our previous submission, IRC custody staff's knowledge of the National Referral Mechanism was poorer. However, staff at Morton Hall and Colnbrook said they would report cases involving suspected trafficking to a manager or the Home Office.[22]

24. At Colnbrook, Home Office caseworkers dialled in to 'complex case meetings' – we noted this as positive practice which helped staff to focus on reviewing complex cases involving vulnerable adults.[23]

2. Short-Term Holding Facilities

25. HMI Prisons published an inspection of STHFs managed by Border Force in June 2020. The Adults at Risk policy applies in STHFs, but Border Force officers we spoke to were unaware of basic features of the policy.[24]

26. We found that there was no process for Border Force to open care plans for vulnerable detainees and no special monitoring arrangements for care plans that were in place.

    'Many ports had no means of recording the care provided to detainees. Where recording was undertaken, it was generally poor and provided little evidence of care given to detainees, beyond the offer of food and drink.' [25]

27. In addition, some detainees who had been identified as vulnerable were held for too long – we noted two cases of pregnant women being detained for long periods of time.[26]

28. While staff stated that the incidence of self-harm was low in STHFs, we also found that there were no processes to plan for the care of detainees considered to be at risk of self-harm. Risk information was recorded in brief on the document authorising detention (IS91). However,

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[18] Paragraph 2.3, Report on an Unannounced Inspection of Morton Hall Immigration Removal Centre by HM Chief Inspector of Prisons, March 2020.
[19] Paragraph 2.2, Report on an Unannounced Inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons, September 2019.
[20] *Ibid.,* Paragraph 2.3.
[21] Paragraph 2.2, Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre by HM Chief Inspector of Prisons, April 2019.
[22] *Ibid.,* Paragraph 1.9.
[23] Paragraph 1.11, Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre by HM Chief Inspector of Prisons, April 2019.
[24] Paragraph 1.9, Report on a national inspection of the Short-Term Holding Facilities in the UK managed by Border Force by HM Chief Inspector of Prisons, June 2020.
[25] *Ibid.,* Paragraph 1.14.
[26] *Ibid.,* Paragraph 1.15.

unlike in privately run facilities, staff did not use more extensive suicide and self-harm warning forms to inform ongoing care of detainees or convey risks to escort staff.[27]

3. COVID-19 Response in Immigration Removal Centres

29. In May 2020, we visited four IRCs in a series of one-day SSVs. SSVs employed a reduced methodology which aimed to capture the institutional response to the COVID crisis and describe the day-to-day experience of detainees and staff. SSVs considered only those *Expectations* essential to the safety, care and basic rights of those detained. SSVs did not allow for the exhaustive triangulation of evidence that characterises full inspections, but still allowed us to consider how IRCs were supporting vulnerable detainees, including under the Adults at Risk policy.

30. We found that while numbers of detainees in the detention estate overall had reduced significantly, levels of assessed vulnerability in all centres were high – 40% of those still detained were identified as Level 2 or 3 adults at risk. Those assessed to be Level 3 adults at risk were predominantly categorised this way because they met the criteria for shielding.[28]

31. Despite this high level of assessed vulnerability for those who remained in detention, many had been held for long periods at a time when the prospect of removal appeared remote. However, processes for supporting and reviewing the detention of the most vulnerable detainees were in place – in all centres, ACDT and other care planning processes continued to be delivered.[29]

32. Levels of self-harm were low, with the exception of Harmondsworth, where levels of self-harm had not fallen in line with the reduced population.[30]

33. Vulnerable detainees, including adults at risk and those at risk of self-harm, were reviewed regularly in all centres, including at weekly multi-disciplinary meetings – ACDT and care planning processes were still operating. We were told that the Home Office was closely monitoring the cases of all Level 3 adults at risk.[31]

34. The reduced numbers in IRCs meant that centres were able to deliver relatively open regimes.[32]

35. The completion of Rule 35 reports and Home Office responses were generally timely, although we found a small number of lengthy delays. At Morton Hall IRC, the temporary lack of a GP had meant that one assessment had taken five weeks to complete. Across the four IRCs visited, we found a large variation in the rate at which Rule 35 reports resulted in release – from 16% to 61%, although the reasons for this variation were unclear. On average, from January 2020, 47% of Rule 35 reports had resulted in release, a much higher proportion than we found in full inspections during 2019. [33]

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[27] *Ibid.,* Paragraph 1.17.

[28] Paragraph 1.12, Report on Short Scrutiny Visits to Immigration Removal Centres by HM Chief Inspector of Prisons, May 2020.

[29] *Ibid.,* paragraph 1.14.

[30] *Ibid.,* Paragraph 1.11.

[31] *Ibid.,* Paragraph 1.14.

[32] *Ibid.,* Paragraph 1.3.

[33] *Ibid.,* Paragraph 1.10.

Conclusion

36. Many of the issues identified in our submission to the ICIBI's previous inspection of Adults at Risk in immigration detention still persist, and we continue to find high numbers of vulnerable detainees in IRCs despite the Adults at Risk policy's stated aim of reducing vulnerability in detention. We also continue to find that some vulnerable detainees do not receive the care and support they need while in detention. However, the detention estate's response to COVID-19 has demonstrated some good practice, with vulnerable adults being monitored and assessed regularly at the time of our SSVs.

37. I hope that you find this information useful and should you require anything further, please do not hesitate to contact me.

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