



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

Western Jet Foil, Lydd Airport and Manston

by HM Chief Inspector of Prisons

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Contents

Introduction.....	3
What needs to improve at these short-term holding facilities	4
About Western Jet Foil, Lydd Airport and Manston short-term holding facilities.	6
Section 1 Summary of key findings.....	7
Section 2 Leadership.....	11
Section 3 Safety	12
Section 4 Respect.....	18
Section 5 Preparation for removal and release.....	30
Section 6 Summary of priority and key concerns.....	32
Appendix I About our inspections and reports	34
Appendix II Glossary	36

Introduction

This report mainly covers inspections of the new detention facilities at Western Jet Foil (WJF) in Dover and a larger facility at Manston. Inspectors also visited Lydd airport holding room, although nobody had been detained there for several months. These facilities all held people who had arrived on small boats after undertaking often precarious sea crossings from France.

Our two previous inspections of the reception facilities in Kent, in September 2020 and November 2021, were highly critical of detention sites that were badly equipped to meet their purpose and where detainees were experiencing unacceptably poor conditions. It is, therefore, pleasing to report that considerable improvements had been made to both infrastructure and processes.

Nevertheless, substantial problems and challenges remained. Some aspects of governance were weak, especially in safeguarding and health care, and inconsistent practices affected detainees' welfare and dignity. For example, some were not allowed access to mobile phones to let their families know they were safe, and in some parts of the site they were, inexplicably, not even allowed to close toilet doors fully.

Most detainees spent short periods at WJF before moving to other sites, principally Manston, where more than 4,000 people had passed through in the previous three months. However, once at Manston, the length of detention was far too long, often more than 24 hours and sometimes far in excess of this. The longest recorded detention of a child was 48 hours, which was unacceptable. The marquee accommodation was well equipped, but only for short waits. It was particularly disappointing once again to see exhausted detainees forced to sleep on floor mats between rows of seats or on wooden benches. Much more accommodation was available at Manston, but it was as yet unstaffed and did not have proper sleeping facilities. Detainees could not go outside for fresh air regardless of the length of detention.

Overall, this report identifies a number of continuing and significant concerns, but it also recognises that the Home Office and its contractors have made creditable progress since our last inspection of the arrangements for people arriving across the Channel in small boats. The size of the accommodation, the plans we saw to improve leadership oversight and coordination and increase staff numbers meant that there were clear pathways to resolving these problems.

Charlie Taylor
HM Chief Inspector of Prisons
August 2022

What needs to improve at these short-term holding facilities

During this inspection we identified 14 concerns, of which six should be treated as priorities. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **Exhausted detainees were regularly held for more than 24 hours in non-residential accommodation.**
2. **Professional interpretation was used inconsistently, with the exception of the screening interview.**
3. **Governance of health care processes was weak.** Medevent's management of controlled drugs was particularly poor and breached standards for the safe storage of medicines. The care pathway lacked coordination or clinical leadership and there were no policies, protocols or governance of clinical standards.
4. **Detainees' vulnerability was not always recorded to inform subsequent assessments.** Detainees with disabilities and trafficking victims were held at Manston, but no detainees had been designated as adults at risk.
5. **Some children were detained for too long.** The documented average length of detention for unaccompanied children was 27 hours and the longest was 48 hours.
6. **The governance of security clearances and training of staff at Western Jet Foil and Manston sites was weak.** There was no single co-ordinated database of the security clearance or disclosure and barring service (DBS) status of all staff working on the sites and it was not possible to determine if all staff had had undergone relevant checks or appropriate training to work with children and vulnerable adults.

Key concerns

7. **Data collection was inconsistent and fragmented.** The total length of detention from arrival at WJF to departure from Manston was not recorded and data on the number of referrals made to the National Referral Mechanism were not consistent or complete.

- 8. The lack of single leadership oversight and consistent coordination of agencies at Manston and between Manston and the other sites presented risks to the vulnerability and welfare of detainees.**
- 9. Detainees were searched too many times and not always with sufficient sensitivity by Home Office staff.**
- 10. Mitie Care and Custody induction interviews were held in noisy booths where staff and detainees struggled to hear and understand each other, and interpretation was not always used where needed.**
- 11. Records did not adequately show whether the use of force and restraints were proportionate.**
- 12. Detainees at the screening building were not allowed to use toilets in private.**
- 13. Detainees did not have adequate access to phones.** A stock of mobile phones at Manston were not routinely offered and some detainees' request for a phone was refused with no explanation.
- 14. Detainees were given very little information about the next steps when leaving Manston.**

About Western Jet Foil, Lydd Airport and Manston short-term holding facilities

Role of the facilities

These facilities primarily held migrants who had arrived from France on small boats after undertaking sea crossings across the Channel. Western Jet Foil and Lydd Airport functioned as initial points of entry where people underwent initial health checks and were given an opportunity to change out of wet clothes. Manston was a short-term holding facility where immigration documents were issued and some detainees started the asylum screening process.

Location

Western Jet Foil is in Dover, Kent. Lydd Airport is in Lydd, East Sussex. Manston is close to the village of Manston, Kent.

Name of authority or contractor

Western Jet Foil: Home Office and Interforce

Lydd Airport: Home Office

Manston: Home Office, Mitie Care and Custody, Interforce, and MTC

Escort provider

Home Office and Interforce

Date of last inspection

This was the first inspection of all sites.

Section 1 Summary of key findings

Progress on recommendations

- 1.1 None of these facilities had previously been inspected.

Safety

- 1.2 The arrival procedure at Western Jet Foil (WJF) was organised and swift, but there was not enough use of interpreting. Home Office staff searched detainees twice in an open area and we observed some staff who were abrupt and impatient during the search, including with children.
- 1.3 After arrival at Manston, detainees were searched for a third time, which was excessive, although the searches undertaken by Mitie Care and Custody staff were conducted in private and with sensitivity. Staff were welcoming and gave detainees comprehensive written information in a range of languages. However, induction interviews were held in a noisy area where staff and detainees struggled to communicate with each other.
- 1.4 Detainees with identified vulnerability were usually not sent to Manston, but a small number were processed there during the inspection period due to traffic disruption at Dover preventing the use of WJF. This included wheelchair users, at least one person with severe mental health problems, and trafficking victims. Despite this, no detainees had been designated as adults at risk under the Home Office policy and potentially critical information about vulnerability was not available to decision makers at subsequent stages of the asylum process. The sparsely completed vulnerable adult warning forms gave little assurance that needs were being met. The Home Office could not provide consistent or full data about the number of referrals made to the National Referral Mechanism.
- 1.5 WJF and Manston were both well-ordered and calm environments, where staff provided a high level of supervision. Recorded violence, non-compliance and self-harm were all rare and detainees we spoke to did not express concerns about personal safety at either site. However, at Manston we saw exhausted detainees held for more than 30 hours become very frustrated at the time it was taking to be transferred to a place where they could sleep properly. Use of force and restraints was also rare but records did not adequately show whether it was proportionate.
- 1.6 Forty children had been held at Manston from April to June 2022, five of whom were unaccompanied. The documented average length of detention for unaccompanied children was 27 hours and the longest was 48 hours, which was far too long. At the time of the inspection, the temporary closure of WJF resulted in more people than usual being

held at Manston pending age assessments. They had to wait for up to 12 hours to see social workers.

- 1.7 The average length of detention for accompanied children was reasonable at just under four hours and the longest nine hours. Child care plans showed little or no evidence of meaningful engagement with children, nor a focus on welfare needs. It was positive that social workers at WJF provided advice on cases involving children and potentially vulnerable adults and we saw some good work by Border Force staff who identified trafficking concerns. Although there was only one holding room at Lydd, suggesting that children would be held in the same area as adults, we were told by the Home Office that discrete areas for receiving children, family groups, and other vulnerable categories were in effect when the facility was operating.
- 1.8 Home Office data showed that, in the three months to June 2022, 4,161 people had passed through Manston and 636 had been held for more than 24 hours. The longest time of detention at Manston was more than 70 hours, which was unacceptable for a non-residential facility. The total recorded time that detainees were held was inaccurate in all cases as Home Office data did not include the period that people were held at WJF or Lydd, nor waiting periods at Manston before IS91s (authority to detain notification) were issued. The quality of immigration paperwork and the process for issuing it had improved: IS91 documents were now routinely completed properly and detainees were issued with IS91R documents, with interpreting and translation services used to explain them to detainees. Basic information about detainees' right to legal representation was displayed in holding rooms at Manston but not at the other sites.

Respect

- 1.9 The two reception areas at WJF were adequate for short stays. However, the toilets were dirty. They also had no lids or seats. The Home Office stated that this was due to accommodating the sanitary practices of other cultures and to reduce the risk of injury which could occur were seats and lids to be broken as a result of squatting rather than sitting on toilets. Sanitary products were not freely available. The Lydd site consisted of a single bare holding room, but it had not been used in the previous eight months.
- 1.10 At Manston, the marquees were clean, well ventilated, in good condition and comfortable for short stays. However, a lack of trained Mitie staff to supervise other marquees meant that adult males were crowded into a single facility and exhausted detainees slept on floor mats between the rows of chairs. They were not allowed to go into the fresh air despite some very lengthy stays.
- 1.11 Toilets and showers in most of the marquees were in good condition, but the baby changing facility was in a dirty mobile toilet. Sanitary products were freely available in the Mitie holding areas only. Detainees at the screening building were not allowed to use toilets in private, which was undignified and unnecessary.

- 1.12 There was a good stock of clothes for detainees and children at WJF and Manston and property was stored safely. Adequate food was provided, but hot meals consisted largely of unhealthy fried food that did not meet all dietary requirements. In the Mitie marquees at Manston, there were plenty of freely available cold snacks and drinks.
- 1.13 Communication between staff and detainees at WJF was largely polite but limited and professional interpreting was rarely used. At Manston, there was similarly little interaction between staff and detainees during the initial processing stages, with security staff standing around detainees to guard them. There was a more welcoming environment when detainees were taken into Mitie custody and we saw particularly good staff engagement in the children and families' marquee.
- 1.14 Health care services delivered by paramedics at WJF and Lydd included appropriate basic health assessment, early detection of immediate health needs and emergency care. There was no use of interpreting services, making it difficult to identify all but obvious health needs. On arrival at Manston, migrants could access two well-staffed paramedic services provided by Medevent and IPRS Aeromed. The Medevent clinic could deal with most emergency health needs and emergency transport vehicles were on site, but governance of controlled drugs was poor and breached standards for the safe storage of medicines.
- 1.15 A more detailed and personalised health assessment was undertaken by Aeromed staff if particular health concerns had been raised by Medevent, although we found examples of poor communication between the two services. The care pathway lacked coordination or clinical leadership to govern the standard and quality of care. There were no on-site policies, protocols or governance relating to clinical standards.

Preparation for removal and release

- 1.16 Detainees' phones were removed and stored in property bags at WJF and Lydd, with no opportunity for detainees to record phone numbers. Most detainees leaving WJF were transported to Manston in clean and appropriately equipped coaches.
- 1.17 Despite the availability of a stock of mobile phones at Manston, it was difficult for detainees to make phone calls because the phones were not routinely offered. Some detainees who asked for them were refused with no explanation, while others had to wait for several hours. Some detainees were clearly upset at not being able to contact family members to tell them that they were safe. There was no internet access or payphone.
- 1.18 Departure from Manston was managed by two subcontractors with assistance from the military. During the previous three months, the majority of detainees received their initial asylum screening interview at Manston and were then transported to hotel accommodation. The remainder were taken to other immigration detention facilities or bailed

to special 'screening hotels' where they were required to complete their asylum interviews. These hotels were not detention facilities.

- 1.19 Detainees were not told where they were going until they boarded the coach at Manston, nor were they given information about their onward accommodation. Interpreting was not routinely used and it was not explained to detainees that they could not access their belongings before or during the journey, which caused some confusion in the departures that we observed.

Notable positive practice

- 1.20 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.
- 1.21 Inspectors did not find any examples of notable positive practice during this inspection.

Section 2 Leadership

- 2.1 Leaders had greatly improved infrastructure and procedures for reception of migrants at the south coast. At the time of our visit, both Western Jet Foil (WJF) and Manston could cope reasonably well with moderate to high numbers staying for short periods, and more when fully staffed. However, while the management of detainees through Western Jet Foil appeared swift, leaders had not yet succeeded in avoiding long waits at the non-residential Manston facility.
- 2.2 Data collection by individual agencies and across agencies was inconsistent and fragmented, which made it impossible to get a full picture of detainee outcomes from the start to the end of the process. In particular, data did not show the total length of detention from arrival at WJF to departure from Manston and the Home Office could not provide us with important information relating to vulnerability, such as the total number of National Referral Mechanism referrals and outcomes.
- 2.3 There was no single leadership oversight or coordination of agencies at WJF or Manston. While staff worked reasonably well together on the ground, this presented risks, for example in terms of emergency contingency planning and communication of important information relating to detainee vulnerability and welfare between agencies. Another consequence of a lack of central coordination was that good practices developed in one part of the operation were not shared well enough. For example, the good quality conditions in the Mitie Care and Custody marquees were not replicated in areas such as the initial processing marquee and the screening unit at Lancaster House. Leaders were aware of these problems and we were told that there were continuing efforts to achieve more effective oversight and cooperation.
- 2.4 There had been considerable leadership efforts to increase the number of staff, but this remained a problem that was directly affecting detainee care at Manston. For example, while some marquee accommodation was overcrowded, other marquees were unused because of a lack of trained detention staff.
- 2.5 Leaders had ensured basic health provision at both the main sites, but overall governance of health care processes was poor.

Section 3 Safety

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

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.

- 3.1 Detainees arrived in Dover tired after dangerous and often harrowing journeys on small boats from France. They were either picked up at sea or after landing on beaches around Kent.
- 3.2 The arrival process was organised and swift. Detainees disembarked from the boat in groups of 10 and walked up a jetty escorted by two military staff. They were then taken by bus on the short journey to Western Jet Foil (WJF).
- 3.3 On entering WJF, detainees were taken into a marquee tent where they received a basic health screen (see paragraph 4.24). Children and families were appropriately prioritised at this stage. Detainees were given dry clothes and searched with a handheld metal detector.
- 3.4 Detainees were then taken to a large portacabin where they waited on benches to be arrested formally by Border Force staff. There was little use of interpreting and most communication involved gestures, including when staff were asking for ages. Border Force staff made some use of telephone interpretation and translations to inform people of their arrest in their presumed language, but it was clear that some detainees had not fully understood what was happening.
- 3.5 Detainees were then searched in full view of others, including rub-down searches of women and children. Some staff were abrupt and impatient, including with children. We observed one member of Border Force staff pulling a young child by the arm with no explanation to start the rub-down search. The parent of another young child was instructed via gestures to remove the child's earrings despite the child experiencing pain and distress as the parent struggled to do this.
- 3.6 After arrest and searches, detainees were placed into another holding area. Single adult males and families and children went to different areas, where they were provided with food and drink while they waited for the coach to take them to Manston. Detainees were not told during their time at WJF what would happen to them next.
- 3.7 On arrival at Manston, all detainees waited on benches in the same area to have their fingerprints taken and the IS91 served (authority to detain notification). They were guarded by Interforce staff who did not

speak to them. Single women and families should have been seated separately from unrelated adult men, but this did not happen consistently for reasons that were unclear.

- 3.8 After formal processing, most detainees were moved to the Mitie induction marquee. Although Mitie staff and the environment in the marquee were welcoming, migrants were searched for a third time, which was excessive. The search was, however, conducted in private and with sensitivity.
- 3.9 Folders of comprehensive information were provided in appropriate languages. Mitie staff interviewed detainees using an induction checklist, which included questions about trafficking and modern slavery. These interviews were held in noisy adjacent booths, which afforded little privacy. Telephone interpreting and handheld translation devices were not always used when needed and, in any event, staff and detainees struggled to hear and understand each other. Two women disclosed that they had been trafficked during the Mitie interview. One of the staff who conducted the interview was sensitive and caring but frustrated at the inappropriate environment and lack of privacy for such a sensitive interview.
- 3.10 Detainees were then moved into the designated family marquee or into one for single adult males, where they had access to showers, toiletries, food and drink.

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.

- 3.11 Most detainees with identified vulnerability were not sent to Manston, but a few who were part of family groups had been held there, as it is Home Office policy not to split family groups unless absolutely necessary. This included wheelchair users, a detainee with severe mental illness who had been held before our inspection, and several victims of trafficking who were identified at Manston during our inspection. We spoke to Home Office and Mitie staff who had basic awareness of these detainees but could not provide evidence of co-ordinated care planning or specialist support in these cases.
- 3.12 There was an appropriate Mitie safeguarding policy at Manston and the Home Office 'Adults at Risk in Immigration Detention' policy also applied. We were not provided with safeguarding policies for other agencies working with detainees at Manston and could not confirm whether they adopted a similar level of safeguarding responsibility. We were told that the Home Office was undertaking work to ensure consistency across the policies and operating procedures used by

different agencies working at Manston, but this had not yet been completed.

- 3.13 After arrival at Manston, there were several opportunities for detainees to disclose vulnerability, including during when fingerprints were taken and immigration paperwork served by Home Office staff, and during the Mitie induction interview (see paragraph 3.9). However, the asylum screening interview was the first opportunity for many detainees arriving at Manston to disclose vulnerability in confidence with the use of professional interpreters. This could be many hours after arrival and some detainees were not screened at Manston at all (see paragraph 3.36).
- 3.14 Information about vulnerability was not always clearly recorded and communicated among the various agencies at Manston. There was no shared local database and no robust oversight to make sure that information was communicated. It was not, therefore, always clear if appropriate action had been taken, information shared with other agencies or where responsibility lay for detainees' future care or progressing their case. There was little formal governance of safeguarding and no evidence of multi-agency meetings to review safeguarding data or complex cases and drive improvement. Home Office staff were developing a 'logistics cell' so that information could be recorded centrally and shared more readily, but this was in its infancy at the time of our inspection.
- 3.15 Mitie had opened 35 vulnerable adult warning forms at Manston since the site had become operational, which accounted for less than 1% of detainees who had been held there. The sample that we reviewed predominantly involved physical health concerns rather than other vulnerability and were poor. They did not demonstrate engagement with detainees and contained little evidence of their needs or care planning. Observations were not always completed.
- 3.16 Home Office data showed that no detainees had been designated as adults at risk at Manston despite individuals with significant health issues and experience of trafficking passing through the facility. This resulted in potentially critical information about vulnerability not being made clear to decision-makers at subsequent stages of the asylum process.
- 3.17 The Home Office was not able to provide consistent data on the number of referrals to the National Referral Mechanism (NRM, see Glossary) that had been made from Manston. During our inspection, we were given several different figures and agency staff who conducted asylum screening interviews told us that these were all much lower than the number of referrals they recalled making.
- 3.18 There was a calm and well-ordered environment at Manston and detainees were supervised by staff at all times. We saw some Mitie staff engaging with detainees to make sure they were comfortable and no detainees whom we spoke to expressed concerns about their personal safety. However, we saw some exhausted detainees who had

been held at Manston for almost 30 hours, who became very frustrated at the time it was taking to be transferred to a location where they could sleep properly.

- 3.19 Staff from all agencies said that incidents involving violence and non-compliance were very infrequent and that there had been no incidents of self-harm. Home Office staff had used force on six detainees at WJF during the previous three months and handcuffs had been used in five of these cases. The log indicated use of pain compliance techniques, but there was no formal procedure for locally recording the use of force at WJF. The Home Office stated that force was reviewed based on centralised records, but we received no evidence of scrutiny of the use of force.
- 3.20 There had been four recorded uses of force at Manston since the site became operational, two involving Mitie staff and two Border Force staff. These were recorded using different systems by Border Force and Mitie staff. Records gave an account of events but did not adequately justify the proportionality of the force used or the use of handcuffs. In one case, there was no risk assessment to justify the use of handcuffs when escorting a sick detainee to hospital. In another, it was unclear why a detainee remained in handcuffs for 10 minutes after being removed from the scene of an altercation with another detainee.
- 3.21 There was no comprehensive log of incidents, nor evidence of incidents being reviewed to identify learning or areas for improvement.

Safeguarding children

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

- 3.22 The governance of security clearances and disclosure and barring service (DBS) checks on staff at WJF and Manston was weak, with no central record of clearances of staff. We were unable to determine if all staff had had clearance to work with children and vulnerable adults. Most Mitie staff had the appropriate clearance and we were told that they would not be able to work with detainees until this had been completed. Home Office Detention and Escorting Services (DES) staff who were in the process of applying for DBS clearance were still allowed to work at the sites. We were told that some Interforce staff were allowed to work at Manston before the security checks they were required to have had been completed. Despite repeated requests, we received no information about the security clearance or DBS status of any Interforce or military staff at either site, although they both came into regular contact with children and vulnerable adults.
- 3.23 If unaccompanied detainees said they were under 18 and had documentation to prove this, they were transferred to the Kent Intake Unit (KIU). Those without the appropriate documentation were given an initial age assessment by immigration staff and trained social workers.

In the three cases involving minors that we looked at, all were processed quickly and appropriately at WJF.

- 3.24 Social workers at WJF provided advice on cases involving children and potentially vulnerable adults. Similarly, we saw good work by Border Force staff who identified trafficking concerns and referred them to colleagues and social workers for further investigation.
- 3.25 Mitie had a generic safeguarding children policy but other agencies who regularly came into contact with children were unable to provide us with a policy, despite several requests.
- 3.26 Forty children had been held at Manston from April to June 2022, five of whom were unaccompanied. The documented average length of detention for accompanied children was reasonable at just under four hours and the longest was nine hours. The average length of detention for unaccompanied children was 27 hours and the longest was 48 hours, which was excessive. Data on the time of detention did not include time spent waiting to be processed.
- 3.27 On one day of the inspection, WJF was temporarily closed because of long tailbacks at the Port of Dover and some unaccompanied children instead came straight to Manston. Six of them were involved in age disputes and waited for up to 12 hours in the first holding marquee where they tried to sleep on benches while waiting for social workers to arrive.
- 3.28 Although families with children and women on their own were prioritised, the process before movement to the Mitie marquee could be slow. We observed a woman trying to take care of her toddler and breastfeed her other child in full view of other detainees.
- 3.29 The family marquee was a pleasant environment suitable for families, and we observed Mitie staff showing a caring and helpful manner.
- 3.30 Child care plans showed little or no evidence of meaningful engagement with the children, nor a focus on welfare needs.

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.

- 3.31 The Home Office did not keep accurate data on the time detainees spent at WJF.
- 3.32 Once migrants had completed reception procedures and been arrested they were told they were not free to leave WJF. The lack of interpreting during the processing stage left many migrants unaware of what was happening to them and unable to give consent to being searched and receiving a COVID-19 test before they were arrested.

- 3.33 Home Office data showed that, during the three months to June 2022, 4,161 people had passed through Manston, 437 of whom had been recorded as being held for more than 24 hours. The average time of detention at Manston was 14 hours 56 minutes. The longest recorded period of detention was more than 70 hours, which was much too long for a non-residential facility.
- 3.34 However, records of time in detention were not accurate because they only started when detainees were given IS91 documentation at Manston. The records did not include time spent waiting at WJF or Lydd, nor time waiting to be processed and served with immigration documents at Manston. We saw detainees waiting at Manston for several hours to be processed. This gave a misleading picture of the total length of detention.
- 3.35 The quality of immigration paperwork and the procedure for issuing it had improved since our previous inspection of facilities in Dover. IS91 documents were now routinely completed properly and detainees were issued with IS91R documents which explained the reasons for their detention. These documents were issued in English, but we did see interpreting being used to explain the documents. In contrast to the serving of immigration papers at Manston, the process for collecting biometrics and serving paperwork was smooth and organised.
- 3.36 Home Office data showed that screening interviews were carried out with most detainees while they were at Manston. However, a considerable minority were bailed to temporary hotel accommodation without screening. This was more common during busy periods. The Home Office was not able to provide data on the number of people who were screened at Manston and the number who left the site unscreened.
- 3.37 Full, face-to-face screening interviews were conducted at Manston and professional telephone interpreting was routinely used when necessary. Records of these interviews had been promptly added to online Home Office records in the sample of cases that we reviewed. Overnight screening was no longer taking place, but detainees were still unable to rest properly because of the lack of sleeping facilities. Interviews were conducted remotely with detainees who were transferred to hotels for screening.
- 3.38 Basic information about detainees' right to legal representation and how to report poor quality representation was displayed in holding rooms at Manston, but only in English. We did not see any detainees being informed about their legal rights or directed to this information. A list of legal representatives and their contact details was also displayed, but there was little space at Manston for detainees to meet or call their legal representatives in private if they wished. There were no records of visits to the site by legal representatives. Mobile phones were available for detainees to make calls once they had been issued with their immigration papers, but they were not routinely offered and could have hindered communication between detainees and legal representatives (see paragraph 5.2).

Section 4 Respect

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

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.

- 4.1 Western Jet Foil (WJF) comprised two holding areas, a marquee for initial medical checks and searches and a second for immigration processing and further searches. Both consisted of wooden benches to sit on while waiting and were adequate for short stays.
- 4.2 The initial arrival marquee had two separate searching areas: one for single men and unaccompanied minors over 13, and another for single women and families. It was well stocked with clean, dry clothes, including for children, and supplies of nappies and baby food. Detainees were escorted to the outside toilet blocks, which were dirty.



Supplies for children at WJF

- 4.3 The second marquee was larger and searching took place in an open area, which did not allow privacy (see paragraph 3.5). After they had been processed, single women and families could wait in a separate area in which there were toys and games for small children. The toilets in this marquee were metal and did not have lids or seats.



Toilets at WJF

- 4.4 There was no dedicated baby changing area in either marquee and sanitary products were not freely available. There was no private area for mothers to breastfeed their children.
- 4.5 Food provision at WJF was adequate. An on-site catering team prepared hot meals of fried food which did not meet all dietary requirements. Dry snacks were provided, including for children.
- 4.6 Lydd airport was not occupied at the time of our inspection. There was one holding room for all detainees with fixed chairs and wooden benches and it was well ventilated. There was a separate area for detainees to change into dry clothes, with pop-up tents for privacy. There were separate male and female toilets, but no baby change or shower facilities.
- 4.7 The marquees at Manston were clean, well ventilated and in a good condition. They were comfortable for short stays, but not suitable for sleeping. We saw adult male detainees sleeping on floor mats between the rows of chairs, with pillows and blankets provided. In the arrival marquee before they were placed in Mitie custody, we saw detainees sleeping on wooden benches. The family marquee was decorated to a good standard, with welcoming wall art and soft furnishing for families and children. There was a separate baby changing area and breastfeeding room, although an open window afforded limited privacy.



Marquee 6 – Dove – leaving marquee



Marquee 5 – open baby change

- 4.8 The single adult male marquee was overcrowded and several other marquees had not yet been opened because of a shortage of trained Mitie staff. Detainees at Manston had no access to fresh air during their stay, despite the fact that many were held for more than 24 hours.
- 4.9 A mobile detention unit in a coach was based at Manston but was not in operation at the time of our inspection.
- 4.10 Toilets in most of the marquees were in a good condition. A cleaning team was on site seven days a week to support the upkeep of the toilets and the rest of the facilities. However, the temporary toilets in the arrival marquee and the processing area were in a poor state. Detainees who needed to use a baby changing facility could either do so in full view in a marquee or in a dirty mobile toilet, which was not acceptable. Sanitary products were freely available in the Mitie holding areas but had to be requested from staff elsewhere, which was not appropriate. No women's toilets were available in the building used to conduct screening interviews and men were not allowed to close toilet doors. This was excessive and at odds with all other parts of the site where they were able to use toilets in private.



Portaloo with baby change



Marquee showers

- 4.11 The shower facilities were small but in a good condition and basic toiletries were provided. Detainees only had access to showers once they had been processed through the Mitie induction, which could be hours after their arrival at Manston. There was no separate area in the family marquees for men, women and children to shower, although the showers did have locks.
- 4.12 There was a good stock of clothing for detainees and children and property was now being processed efficiently and stored safely before being returned to the detainee when they left the centre.
- 4.13 The family marquee offered a good range of toys and activities for children of all ages and we saw staff playing with the children, which was good. Adult men in the other marquees had access to board games, cards and DVDs and staff were participating in this with them.



Family marquee play area

- 4.14 Dry snacks and water were available at all three sites and hot food was served by on-site caterers at WJF and Manston between 7am and 6pm. The food was basic fast food with Halal meat, but no healthy options were available. Allergies, dietary requirements and cultural preferences were not considered. In the Mitie marquees at Manston, plentiful cold snacks, drinks and baby food were freely available at all times of the day.



Baby food available in marquee



Cold snacks in the family marquee

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.

- 4.15 Professional interpreting was rarely used at WJF and it was not always clear that detainees understood the process. We saw staff and other detainees being asked to interpret. Communication between staff and detainees was limited but generally polite.
- 4.16 We observed sensitive interactions between staff and migrants in the waiting area for women, unaccompanied minors and families. However, a toddler was separated from his mother to be examined by a paramedic in front of unrelated adult men. We also saw abrupt and impatient interactions during searches (see paragraph 3.5).
- 4.17 There was no quiet area or prayer room at WJF and no religious items were provided.
- 4.18 Professional interpreting was also poor at Manston and records indicated limited use. It was not always used during induction interviews with detainees despite the availability of handheld translation devices. We observed staff speaking to detainees in English even when they were unable to understand. Notice boards had some translated material on topics including human trafficking, but some information leaflets were only available in English.
- 4.19 We did not see any interaction at Manston between Interforce staff and detainees during the initial processing stages. Interforce staff said the purpose of their role was to guard the detainees. Staff did not engage with detainees and used numbers instead of detainees' names. We were told that recruitment issues at Mitie had resulted in Interforce staff with no detention training managing some of the marquees during busy periods.
- 4.20 When a detainee was taken into Mitie custody, there was a more welcoming atmosphere and, while the use of interpreting was still poor, we observed much more friendly interactions. Staff were engaged in activities with detainees and children. Some staff were managing movement in and out of the marquees, but an electronic system was to be installed to allow staff more time to interact with detainees.
- 4.21 Complaint boxes and forms were available once the detainee was in Mitie custody. Information on how to make a complaint was contained in the induction leaflet. No complaints had been received recently and the boxes were marked as 'suggestion' boxes with the box in the family marquee left unlocked. This was confusing for detainees. There was no clear oversight of the process.

- 4.22 Each marquee had prayer rooms which could hold two detainees at a time. The rooms were useful but could become noisy when the marquees were full. Prayer mats and religious books were provided in some rooms, but we saw one marquee with no religious materials.
- 4.23 Detainees who were wheelchair users had been held in Manston on two recent occasions. Personal emergency evacuation plans (PEEPs) were no longer used and had been replaced by vulnerable adult warning forms (see paragraph 3.15). None of the marquees was suitable to accommodate detainees in wheelchairs and no adaptations had been made. The induction process did not cover all protected characteristic groups (see Glossary), including disability.

Health care

- 4.24 New arrivals received a basic health screening assessment in the reception area of WJF, carried out by a paramedic team from Medevent. The medical area was clean and bright but lacked privacy. The screening included assessing any immediate pain or injuries, asking women if they were pregnant, conducting basic tests for temperature, blood pressure and COVID-19 and asking detainees if they took any medication. The screening process was conducted efficiently but the process resembled a production line where things happened to detainees with no explanation, although staff were polite.
- 4.25 The health screening we witnessed, described by the Home Office as triage, was conducted in the public area with no access to interpreting services and in front of young male detainees. Staff relied too much on using gestures or images on cards to communicate.
- 4.26 After screening had been completed, detainees were moved to another location at WJF which included a purpose-designed clinical facility with two treatment rooms, one of which doubled as a consultation room and shower facility for those arriving with fuel burns. The condition of this room was poor and there was no screen in the shower area. Medical equipment and medicines in the room were out of date. We observed detainees, including children, being assessed and treated in the public area rather than the designated clinical treatment rooms.
- 4.27 Detainees who tested positive for COVID-19 at WJF were located in a portacabin away from the main holding area. The facility was basic but provided access to fresh air and toilet facilities. On the day of the inspection, one detainee testing positive for COVID was transferred to the isolation facility and was treated respectfully throughout. One member of Border Force staff went to great lengths to make sure the detainee was aware of his situation using telephone interpreting services.



COVID-19 isolation cabin at Manston

- 4.28 A portable defibrillator was available in the main WJF holding areas. We were advised that an ambulance was usually on site but on the day of the inspection the vehicle was being repaired. We were told there was good cooperation between local ambulance services and hospitals and that all staff had been trained in advanced life support. There were no records to verify this or to confirm compliance with practice standards and protocols, but the Home Office stated that Immigration Enforcement staff undertake a 12-month refresher course of arrest skills and emergency life support.
- 4.29 On admission to Manston, detainees were clinically assessed by paramedic services. Medevent staff provided continuity of care during this initial stage of the arrivals process. Medevent operated a purpose-built clinical facility in the grounds at Manston and, at the time of the inspection, three ambulances were on site equipped to deal with most emergency health needs.
- 4.30 The Medevent clinic was clean and there was scope for a range of treatments and examinations. However, medicines management was poor and we raised immediate concerns about the lack of controls for recording, documentation and storage of controlled drugs. Oversight of the maintenance of emergency equipment was poor. Some equipment was out of date and no audit records, policies or procedures were available to guide staff and their practice.

- 4.31 After processing by immigration officials, the care of detainees passed to staff from IPRS Aeromed for continuing paramedic support at Manston. This well-staffed paramedic team was available 24 hours a day and there were effective arrangements with local hospitals for immediate transfer in a medical emergency.
- 4.32 Health needs identified at this stage were captured on IS91 documents. However, the Aeromed team was not always alerted to key risks, including the identification of women or children who may have been trafficked and in need of a more detailed health assessment.
- 4.33 The clinical room operated by Aeromed staff was poorly equipped, with only basic equipment to treat minor ailments. There were no guiding policies or procedures for staff to deliver consistent care. The room was poorly ventilated and not designed to offer a clinical service.
- 4.34 Compliance with completing health care assessments was good but access to on-site policies or protocols relating to clinical standards was poor. The quality of the assessment varied and use of interpreting services during clinical consultation was poor. There was no senior clinical oversight of the standard and quality of care delivered at Manston.
- 4.35 Facilities for the management of detainees with COVID or other infectious diseases were poor. Detainees were placed in a claustrophobic portacabin with no clear responsibility assigned for managing their care. Paramedic staff were unsure of any guidance, policy or procedure for the management of infectious diseases.

Section 5 Preparation for removal and release

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

Communications

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

- 5.1 Detainees' phones were removed and stored in property bags at WJF and Lydd, with no opportunity for detainees to record phone numbers or to retain their SIM cards. Detainees were not able to access their phones while at Manston.
- 5.2 Induction materials at Manston described the availability of mobile phones to make urgent calls and that detainees were allowed to use their own SIM cards. There was a stock of mobile phones in each marquee for this purpose, but the phones were not routinely offered and some detainees who asked to make a phone call were refused. Others had to wait several hours to make a requested call. Detainees whom we spoke to were clearly upset at not being able to contact family members to tell them they were safe (see paragraph 3.38).
- 5.3 There was no internet access or payphone in any of the facilities, and nowhere to make private phone calls to legal representatives.

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.

- 5.4 Most detainees leaving WJF were transported by coach to Manston, while unaccompanied minors and other vulnerable people went to the Kent Intake Unit (KIU). The coaches were clean and air conditioned and snacks and bottled water were provided for the journey.
- 5.5 Two subcontractors managed the process of leaving Manston, with assistance from the military. During the previous six months, 72% of detainees had been bailed and transported to hotel accommodation, including some who were placed in 'screening hotels' to complete initial asylum interviews (see paragraph 3.36). These hotels were not detention facilities. Any detainee who was not bailed to a hotel went to immigration detention, either a short-term holding facility or an immigration removal centre.

- 5.6 The bail documents that we saw were only provided in English. Detainees we spoke to did not know where they were going or what would happen next and had little understanding of their bail conditions.
- 5.7 During the departures that we observed, detainees were not told where they were going until just before boarding, or in some cases while on board the coach. There were some inconsistencies in the departure process, for example we observed some single men receiving an additional search on leaving and asked to sign papers they did not understand. Interpreting was not routinely used, although we saw some women and families being shown translated information on handheld devices. Very little information was provided about onward destinations or sources of support in the community.
- 5.8 We observed sensitive interactions between staff and families with children leaving the facility. However, we saw little evidence that additional support needs were checked before detainees left Manston, including consideration of welfare needs or vulnerability that may not have been detected during the screening process.
- 5.9 The return of property was managed efficiently, although it was not explained to detainees that they could not open or access their belongings during the journey. This caused some confusion in the departures that we observed, particularly for those who could hear their mobile phones ringing in the bags as they were placed in the hold.

Section 6 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

Priority concerns

1. **Exhausted detainees were regularly held for more than 24 hours in non-residential accommodation.**
2. **Professional interpretation was used inconsistently, with the exception of the screening interview.**
3. **Governance of health care processes was weak.** Medevent's management of controlled drugs was particularly poor and breached standards for the safe storage of medicines. The care pathway lacked coordination or clinical leadership and there were no policies, protocols or governance of clinical standards.
4. **Detainees' vulnerability was not always recorded to inform subsequent assessments.** Detainees with disabilities and trafficking victims were held at Manston, but no detainees had been designated as adults at risk.
5. **Some children were detained for too long.** The documented average length of detention for unaccompanied children was 27 hours and the longest was 48 hours.
6. **The governance of security clearances and training of staff at Western Jet Foil and Manston sites was weak.** There was no single co-ordinated database of the security clearance or disclosure and barring service (DBS) status of all staff working on the sites and it was not possible to determine if all staff had had clearance or appropriate training to work with children and vulnerable adults.

Key concerns

7. **Data collection was inconsistent and fragmented.** The total length of detention from arrival at WJF to departure from Manston was not recorded and data on the number of referrals made to the National Referral Mechanism were not consistent or complete.
8. **The lack of single leadership oversight and consistent coordination of agencies at Western Jet Foil and Manston presented risks to the vulnerability and welfare of detainees.**

9. **Detainees were searched too many times and not always with sufficient sensitivity by Home Office staff.**
10. **Mitie Care and Custody induction interviews were held in noisy booths where staff and detainees struggled to hear and understand each other, and interpretation was not always used where needed.**
11. **Records did not adequately show whether the use of force and restraints were proportionate.**
12. **Detainees at the screening building were not allowed to use toilets in private.**
13. **Detainees did not have adequate access to phones.** A stock of mobile phones at Manston were not routinely offered and some detainees' request for a phone was refused with no explanation.
14. **Detainees were given very little information about the next steps when leaving Manston.**

Appendix I About our inspections and reports

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, secure training centres, immigration detention facilities, police and court custody and military detention.

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 tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For short-term holding facilities the tests are:

Safety

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

Respect

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

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.

(Note: One of our standard tests is 'purposeful activity'. Since they provide for short stays, there is a limit to what activities can or need to be provided. We will therefore report any notable issues concerning activities in the accommodation and facilities section.)

Inspectors keep fully in mind that although these are custodial facilities, detainees are not held because they have been charged with a criminal offence and have not been detained through normal judicial processes.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for detainees. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are

summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Inspectors use key sources of evidence: observation; discussions with detainees; discussions with staff and relevant third parties; documentation; and, where appropriate, surveys. 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.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

This report

This report provides a summary of recommendations made and notable positive practice identified during the inspection. There then follow sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees* (Version 4, 2018) (available on our website at <https://www.justiceinspectors.gov.uk/hmiprisons/our-expectations/immigration-detention-expectations/>). Section 5 summarises the areas of concern from the inspection. Section 6 lists the recommendations from the previous full inspection and our assessment of whether they have been achieved.

Inspection team

This inspection was carried out by:

Hindpal Singh Bhui	Team leader
Tamara Pattinson	Inspector
Chelsey Pattison	Inspector
Rebecca Mavin	Inspector
Ali McGinley	Inspector
Karen Wilson	Health care inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: <http://www.justiceinspectors.gov.uk/hmiprison/about-our-inspections/>

Adults at risk policy This Home Office policy sets out what is to be taken into account when determining whether a person would be particularly vulnerable to harm if they remained in detention.

National Referral Mechanism (NRM) A framework for identifying and referring potential victims of modern slavery and making sure they receive the appropriate support. It is the responsibility of immigration staff in the KIU to refer detainees held there for consideration under the NRM.

Protected characteristics

The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

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