Notable positive practice

1.42 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.

1.43 Inspectors found seven examples of notable positive practice during this inspection.

1.44 Health care staff asked women a range of gender-specific questions during the induction process, including about female genital mutilation and pregnancy, which allowed those concerned to be identified and referred to appropriate support services. (See paragraph 3.9)

1.45 The Home Office's detention engagement team was providing a good level of service. Engagement officers had manageable caseloads and a good understanding of the cases they were responsible for, and detainees were able to meet their engagement officer in person regularly. (See paragraphs 2.8 and 3.47)

1.46 Living conditions were much better than in other IRCs. Communal areas and detainees' rooms were large, clean and well ventilated. (See paragraphs 4.4 and 4.6)

1.47 Health care staff made exceptional efforts to use interpreting services and provided translated information, including care plans, so that patients fully understood their treatment. (See paragraphs 4.49 and 4.69)

1.48 The delivery of bespoke training for detention officers to enable care for women with complex needs, with integration of key points in the women's vulnerable adult care plan, gave officers a meaningful plan with which to work and increased their understanding of the psychological needs of the woman. (See paragraph 4.65)

1.49 The development of culturally sensitive materials encouraged detainees to participate in therapy by integrating health care into their personal and cultural frames of reference. (See paragraph 4.69)

1.50 Hibiscus had good working relationships with the women, providing support both in detention and after release. Through the facilitated returns scheme, it provided 'start-up' funds for women who were setting up their own business, and kept in touch after removal to another country. (See paragraph 6.18)

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for detainees. (For definition of leader, see Glossary.)

2.1 Good leadership helps to drive improvement and should result in better outcomes for detainees. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 The decision to open a new immigration removal centre (IRC) for women in a location far from main centres of population, and where it was difficult to recruit staff, and especially managers, with relevant experience, had created many challenges for those leading the centre.

2.3 Most leaders were motivated to set an example of positive care for detainees, and staff and detainees said that they were visible around the centre. A positive tone was set by a pleasant environment, freedom of movement and mainly caring staff, but most leaders at all levels lacked sufficient knowledge of, and operational experience in, the immigration detention context and they had not been given sufficient support to develop their knowledge and skills. There was some evidence of insufficient supervision to make sure that all staff complied with professional standards.

2.4 Many managers were new to leadership responsibility at the appropriate level. Some support had been given by Mitie Care and Custody managers from other sites in the early stages, but this had not been sufficient to embed proper oversight across a range of operational areas. The governance of use of force was a conspicuous example; although the use of force was rare, some unapproved and risky techniques, and some inappropriate language, had been used by staff, including a manager.

2.5 Leaders had not grasped the importance of structured governance processes. They did not make sure that operational data were collected and used to guide planning, for example on incidents of violence or physical force. We were told that key meetings – for example, about safety or vulnerable detainees – took place regularly, but in many cases there was no record of the meetings, with the result that decisions or actions could not be reliably tracked and followed up.

2.6 The specific needs of women were not reflected in many of the published policies, which were often drawn from generic material relating primarily to male detention centres. Some staff did not show sufficient awareness of the needs of women in this context, or of a trauma-informed approach in response to their specific vulnerabilities.

2.7 Many areas of day-to-day detainee well-being were not being affected negatively by these deficits, mainly because of the large staff-to-

Reception area

3.4 The initial screening in reception was not private. We observed women being asked sensitive questions near to other detainees. There were two rooms available where interviews could have taken place and it was unclear why these were not used. Interpreting services were not used enough, despite a detainee repeatedly saying that she spoke little English. Questions about vulnerabilities were asked by health care staff during their initial screening, which took place in a private room away from reception. Detainees did not wait long for their reception screening.

3.5 Detainees were checked at least three times during their first night and 91% of respondents to our survey said that they had felt safe on their first night in the centre, in comparison with 59% in other immigration removal centres. There was no dedicated first night accommodation, as the building work had not been completed. Women were welcomed by staff on the main units and shown to their rooms. We saw no use of interpreting services during this process.

3.6 Induction was completed within 48 hours of arrival, but this was unstructured and detainees were unsure when they would be seen and by whom. Records were poor and it was not clear which agencies had visited women when they first arrived.

were being supported through this process were positive about the care they received. Most women on an ACDT received this support because of concerns related to the impact of detention and the removal process.

3.20 Most ACDT documentation was inadequate and there was little quality assurance. Care maps were not always tailored to the individual and most target setting was generic. Daily records focused mainly on observations rather than conversations with the women, and telephone interpreting services were not always used when needed. Paperwork for women who had left the centre, including ACDT documents, was disorganised.

3.21 The Home Office was informed of risk information from case reviews, but they were not recorded in sufficient detail. It was not uncommon for different people to take the role of case manager in successive ACDT case reviews, and we saw a woman having to repeat information about herself in a meeting because a new person was acting as the case manager. In addition, too often the meetings were not multidisciplinary. Mental health workers attended case reviews and offered good support, but onsite Home Office staff rarely took part. Weekly adults-at-risk and complex case meetings discussed ACDTs along with other standing agenda items, but the monthly safer detention meetings were not recorded and data were not analysed.

3.22 Since the opening of the centre, only one woman had refused food or fluids. The documentation in this case was incomplete and there was no evidence of case reviews or of support having been provided.

3.23 Constant supervision, in the cases of highest risk, was usually completed on the residential units, as two rooms designed for this purpose were in the building that remained incomplete (see also paragraph 4.9). The documentation of those on constant supervision was weak, and did not always clarify when a woman was on this process. We saw staff not interacting with the women and failing to maintain observations while, using electronic devices and talking among themselves. We saw a male staff member completing a constant supervision, along with two female staff despite the records of the detainee concerned highlighting the presence of males as a self-harm trigger for this woman.

Safeguarding children

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

3.24 There was a thorough child safeguarding policy and staff had received appropriate training. No women had been subject to age dispute cases since the opening of the centre.

3.25 Women with children were identified on reception, including those who were living in the UK. Although staff were aware of those who had children, limited work was being done to support these individuals.

Personal safety

Expected outcomes: Everyone is and feels safe. The centre promotes positive behaviour and protects detainees from bullying and victimisation. Security measures and the use of force are proportionate to the need to keep detainees safe.

3.26 In our survey, 15% of respondents said that they currently felt unsafe, and 45% that they had felt unsafe at some point during their time at the centre. Most to whom we spoke told us that they felt safe in the centre and no detainees said that staff made them feel unsafe.

3.27 Assaults and intimidatory behaviour were rare, but structures and processes to make sure that victims were supported and protected, and that perpetrators received support to change their behaviour, were weak. The anti-bullying and violence reduction policies were not tailored to the specific situation and needs of women in immigration detention.

3.28 Data and record-keeping relating to violent and antisocial behaviour were poor. We were told that there had been two assaults on detainees by other detainees and one assault on staff in the previous six months, but managers were unable to provide any relevant paperwork.

3.29 Records also indicated that during this time seven detainees had been monitored for antisocial or violent behaviour. When we requested the paperwork for these, we were provided with only two examples. These were of poor quality and lacked sufficient investigation. Entries made by staff were mainly observational and provided no evidence of meaningful interaction to support detainees to change their behaviour. Similarly, the documentation intended to support the two victims of antisocial behaviour was inadequate.

3.30 We were told that the safer community team met monthly, but there was no evidence of this as there were no records, nor an action plan to drive improvements.

Security and freedom of movement

Expected outcomes: Detainees feel secure. They have a relaxed regime with as much freedom of movement as is consistent with the need to maintain a safe and well-ordered community.

3.31 Detainees were never locked in their rooms. They were able to move freely around the grounds for 14 hours per day, and around their units at all times.

3.32 During the previous six months, 217 security information reports had been submitted. Reports were not always analysed and processed quickly and it was not clear what consequent actions had been identified or whether they had always been completed. There were no efficient systems for processing them quickly, or for agreeing and tracking actions in response to them.

3.33 The policy was for strip-searching to be undertaken only as a result of intelligence, and none had yet taken place.

3.34 Handcuffing of detainees during external escorts was based on an individual risk assessment, which was appropriate, but in some cases the paperwork was poorly completed. For example, information about risk or important health care issues was sometimes missing.

3.35 There was no evidence of substance misuse, and in our survey, no respondents said that it was easy to get drugs in the centre.

3.36 All room searches were based on specific intelligence. Checks and searches of the perimeter, communal areas and activities took place regularly.

3.37 Corruption prevention work was adequate. Allegations of inappropriate conduct were investigated by senior managers and acted on appropriately.

3.38 In some cases where a referral should have been made to the Home Office Professional Standards Unit, this had not been done; examples included inappropriate use of force on a detainee and derogatory remarks made about a detainee, recorded on body-worn camera (see case studies at paragraph 3.41).

Use of force and single separation

Expected outcomes: Force is only used as a last resort and for legitimate reasons. Detainees are placed in the separation unit on proper authority, for security and safety reasons only, and are held in the unit for the shortest possible period.

3.39 Records indicated that force had been used eight times during the previous six months. Footage was not available for all the incidents, despite the good availability of body-worn cameras. Record keeping of the use of force was poor, with no systematic process for collating all footage and paperwork after an incident.

3.40 Governance and quality assurance arrangements for use of force were weak. Although all incidents were reviewed by Mitie managers and the Home Office, the reviews were inadequate, and had failed to identify several serious failings in the application of force. It was not clear whether all use of force was on every occasion both proportionate and necessary. We observed derogatory comments being made by staff about a detainee, some risky use of techniques in the application of force, an apparent absence of de-escalation, lack of empathy and of overall incident management. It was clear from the footage that other detainees in the centre had witnessed these incidents, with no follow-up support provided.

3.41 Discussions on use of force took place as part of the security meetings, but minutes were poor and did not demonstrate evidence of scrutiny or lessons learned, and there was no associated action plan to support improved outcomes in this area.

Case study 1

A woman aged 38 was required to leave the centre for a removal flight, but she was passively resistant – refusing to go with the staff, but offering no violence or aggression. After a struggle, she was brought to the ground in the communal area of the unit. There was a lot of shouting over one another by staff. She repeatedly complained that she was in pain and that her neck was hurting, but staff continued to struggle with her using unapproved and risky techniques, particularly around the head and neck area, albeit only for a very brief period. They appeared not to use de-escalation techniques sufficiently. The woman was handcuffed, unusually, with two interlinking sets. An officer and a senior manager were overheard to make derogatory remarks about the detainee. Health care staff talked to her and tried to calm her down. Staff decided to carry her, but their lifting technique was poor – the staff were struggling and the woman was in pain. Her head was not properly supported, and one member of staff held her neck, until someone asked them not to. The use of the handcuffs while she was being carried also caused her considerable pain. A member of the health care team was able to persuade her to walk to reception. The

incident was witnessed by other detainees. The woman did not leave the centre and was not removed on the flight.

3.42 During the previous six months, removal from association had been used four times. The average length of stay was 21.5 hours. In the paperwork we examined, the centre's decision to separate detainees was not properly justified. For example, separation under Rule 40 had been used three times for the same detainee, who had been identified as an adult at risk level 2 by the Home Office, but this was not acknowledged in the paperwork and there was no record that alternatives to separation had been considered.

3.43 There was some evidence that separation had been used punitively and not for the shortest time possible. For example, paperwork stated that the detainee was located to the unit 'to calm down', and on body-worn camera footage staff could be heard telling them that they would be there for 24 hours.

3.44 The Rule 42 unit (for the temporary confinement of violent and refractory detainees) had not been used since the opening of the centre. The two cells designed for use in these circumstances, not yet commissioned for use, were very bare.

Rule 42 accommodation

Living conditions

4.4 Living conditions were generally good, and much better than in other immigration removal centres (IRCs). Outside areas were clean and pleasant. There was little planting to enhance the environment, although a 'welcome' mural had recently been painted. There was not enough outside seating.

Outside area

4.5 During the inspection, two residential units were in use. They were bright, clean and spacious. All women responding to our survey said that the communal areas of their unit were clean.

4.6 Most of the accommodation was in single rooms. All single and double rooms were large and clean. In contrast to some purpose-built IRCs, windows could be opened. Rooms were generally well equipped, had a television and were adequately furnished, with lockable cupboards. All had separate showers and toilets. Women had their own room keys.

A double room

4.7 All those who responded to our survey said they had clean sheets every week. Mattresses were thin and laid on a solid wooden base.

4.8 Laundry facilities were in good order. In our survey, almost all respondents said that they normally had enough clean, suitable clothes for the week. The centre provided tracksuit tops and bottoms, and underwear, for women who needed them. There was only a small stock of other clothing, donated by local charitable organisations.

4.9 The site had started to receive detainees in December 2021, before building work had been completed. This meant that some services and activities were based in a temporary location, and others (see paragraph 5.1) were yet to open at all. Building work was not due to be completed until 2023.

Detainee consultation, applications and redress

4.10 There were few complaints – just 18 in the six months to the end of July 2022, and they were generally handled well. Despite the low number, three responses had been late. In our survey, 90% of respondents said that they knew how to make a complaint, and 90% of those who had made a complaint said that it had been dealt with fairly. Most complaint responses showed thorough investigation. Replies

in which unit staff used hand gestures or spoke loudly in attempts to make themselves understood (see also paragraph 6.19).

4.29 Health care and Home Office DET team staff made good use of professional telephone interpreting (see paragraph 4.49), but we were not satisfied that other staff always used this when necessary. Telephone interpretation was not recorded as having been used in some assessment, care in detention and teamwork (ACDT) reviews for women with little understanding of English. In a reception safety interview, staff failed to use interpretation when it was needed (see paragraph 3.4). A woman was discharged whose record stated that interpretation was needed, but it was not used even though she told staff that she did not understand them (see paragraph 6.19).

4.30 Several detainees were not in the same residential unit as others who spoke their language. More needed to be done to minimise the social isolation of some, with regular recorded checks using interpretation.

4.31 Helpfully, about two-thirds of operational staff were women. However, few of the Mitie operational policies were tailored to a female population. Some staff did not show sufficient awareness of the needs of women, or of a trauma-informed approach in response to their specific vulnerabilities. For example, the scarcity of social visits had a negative impact: few detainees received any visits, and no children had visited any detainee (see paragraph 6.5).

4.32 A small number of women lived with physical disabilities and some appropriate adjustments were made. In our survey, the three women who reported having a disability said they were getting the support they needed.

4.33 There was a well-equipped room with adaptations for someone with mobility difficulties. We were told that, if needed, a peer supporter would be allocated to help them with daily needs. There was little structured oversight of such arrangements.

4.34 Despite some good support from the mental health team, staff said that they found it difficult to help with women with more serious mental health conditions. They had little awareness of neurodiversity and could not say whether any neurodiverse women had been detained.

4.35 There was some appropriate provision for LGBT women.

Faith and religion

4.36 Good, supportive chaplaincy staff spoke with detainees in every part of the centre. In our survey, respondents were positive about respect for their religion. Employed and volunteer chaplains covered most of the religions represented, although leaders had not yet been able to recruit a Buddhist faith leader.

4.37 Facilities for worship were adequate, but the chapel and mosque were too small to accommodate increased numbers in the future. Each unit

training had been completed, with plans to introduce further IRC-related training, such as understanding Rule 35 reports (see Glossary) and completing person escort records. All staff were encouraged and supported to take part in further development.

4.46 Health care staff across all services attended clinical supervision. There were arrangements for peer reviewing, and the handovers included learning from each other. Staff said that they felt supported by managers and knew who to report to if they needed help.

4.47 Spectrum was holding monthly patient forums to gauge satisfaction with the service, which was proving constructive. In our survey, 95% of respondents said that the quality of health services was very or quite good.

4.48 The health centre was new, purpose designed and contained the dental surgery as well as clinical rooms. It was an exceptional clinical space that met infection prevention compliance standards. A snagging problem with incorrect locks, unresolved since opening, was fixed during the inspection.

4.49 Clinical in-confidence information was stored on SystmOne (the electronic clinical record). Care plans were subject to clinical audit and those we sampled were of good quality. Health care staff made exceptional efforts to use interpreting services, and took time to discuss treatment options with patients and to provide reassurance.

4.50 There was a suitable policy to manage infectious diseases, under which an outbreak of COVID-19 had been successfully managed.

4.51 The centre had not published a strategy to promote health and well-being, although some discussions had taken place to create one. There was a good health promotion strategy, with regular events. During the inspection, a health promotion afternoon in the gym was reasonably well attended by detainees and some staff. General health screening, in line with national programmes – for example, chlamydia, tuberculosis and blood-borne viruses – was offered to new arrivals as indicated clinically.

4.52 Women-specific health screening was available, including breast and cervical screening, with access to gynaecology and visiting midwifery services if needed. Immunisation and vaccination clinics, such as for COVID-19, MMR and influenza, took place, in line with the national public health schedule.

Primary care and inpatient services

4.53 The primary care service was staffed 24 hours a day, with a nurse providing overnight cover who was available to receive any late arrivals. There were clear processes for out-of-hours GP and emergency cover.

4.54 Around 11 detainees each week were screened by nurses on arrival at the centre. A comprehensive secondary health assessment followed on

information with patients on where to get further help and support in their area, if released into the UK.

Mental health

4.63 Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust and the Rethink Mental Illness charity ('Rethink') integrated their work to deliver highly valued mental health services. In our survey, all relevant respondents said that they had been helped with their mental health problems. Patients we met said that they were satisfied with their care.

4.64 Mental health practitioners (MHPs) offered services from Monday to Friday and included nurses, a psychiatrist and psychological well-being practitioners. They were well led, trained and supervised, and they were co-located with Spectrum staff within the health centre. Communications were excellent, with MHPs contributing effectively to health centre and prison meetings, including contribution to vulnerable adult care plans (VACPs) and ACDT care coordination.

4.65 Bespoke training was being delivered by MHPs to detention officers, to enable them to support individual women with complex psychological needs. Key points arising from the training were included in the VACP, so that staff could relate training to expected practice.

4.66 TEWV and Rethink standard operating procedures had been carefully adapted for use in an IRC, and about 60% of the population were in receipt of MHP care. Every detainee admitted to the centre was reviewed for the need for such care, the women had open access and there were no waiting lists.

4.67 Treatment interventions were solution-based and included art therapy, cognitive and dialectical behavioural therapies (see Glossary) and counselling. Patients with serious mental illnesses received regular support from MHPs. Interventions had to be adapted for short periods of detention. For example, eye movement desensitisation and reprocessing (EMDR; see Glossary) was offered in flash technique format (see Glossary), as women might not have stayed long enough to benefit from a full course of EMDR.

4.68 Thought was being given to delivering therapy in groups – for example, anxiety management or sleep hygiene – which could be more efficient than one-to-one treatment. There was not yet suitable dedicated accommodation for psychological group therapies.

4.69 We saw impressive written materials on mental health, composed in culturally sensitive ways to encourage participation in therapy. For example, the introduction to mental health services booklet was available to all, but a version to assist Muslim detainees, developed with the Muslim chaplain, to integrate the receipt of care into an Islamic context, was also available. Materials were also translated into languages other than English as necessary, including care plans, which were shared with patients.

Section 5 Activities

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

Access to activities

5.1 The number of activity places was sufficient for the current population of the centre, and 55% of respondents to our survey said that they had enough to do to pass their time. Each accommodation unit provided a range of recreational materials, such as games, puzzles and art materials, but there were insufficient programmed activities. This was largely because building work was still ongoing, so that important facilities such as the shop, café and cultural kitchen were not yet available. Most activities took place in the regimes building, which was in good condition, clean and well lit.

5.2 Managers had not yet produced a plan for the development of activities, but a new team had begun to consider this. To inform their plans, managers had improved the collection and reporting of data on participation and had carried out two detainee surveys. Some of the resulting suggestions were being implemented; for example, a range of distance learning courses was being made available on in-room televisions in response to requests for more activities during the evenings.

5.3 All detainees were shown around the facilities as part of their induction. There was no assessment of their educational needs. The range of education opportunities was too limited: there were only two education classes, with a maximum attendance of around 12, which was not enough for the expected population of the centre. Managers planned to introduce an additional class, in information technology, soon.

5.4 Detainees had good access to the regime building and outdoor areas (see paragraph 3.31). At weekends, staff organised outdoor activities such as rounders and bowls on the lawn areas around the accommodation units. Education classes were offered for two sessions every weekday. Detainees could attend activities whenever they wanted and there were no waiting lists.

Education and work

5.5 During the inspection, around half of the detainees attended at least one of the education sessions. There were two teachers, one offering an education class in English and mathematics, and the other providing arts and crafts activities. They were well qualified and sensitive to the needs of detainees, developing good rapport and often giving valuable support to women who were worried and distressed about their situation. The low numbers of learners allowed teachers to provide good, individualised tuition.

Section 6 Preparation for removal and release

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

Welfare

Expected outcomes: Detainees are supported by welfare services during their time in detention and prepared for release, transfer or removal before leaving detention.

6.1 Welfare provision was good. The officers were knowledgeable and detainees told us they were helpful and accessible, which was impressive given they had received very little training for the role.

6.2 All detainees received a formal interview on arrival to identify need. There was a further interview 48 hours later, to check that actions had been completed. We were satisfied that these initial interviews met need, but work undertaken by officers and subsequent contact were not sufficiently well documented.

6.3 The welfare team was visible on residential units and in other areas. Welfare officers checked on all detainees daily, and they could visit the welfare office throughout the day.

6.4 There was an active visitors group and a team from the charity Hibiscus provided good support to the women. The remote location meant few other groups attended to give face-to-face support to detainees. Welfare staff also liaised with other support groups, to enable detainees to make telephone and email contact with them.

Visits and family contact

Expected outcomes: Detainees can easily maintain contact with their families and the outside world. Visits take place in a clean, respectful and safe environment.

6.5 Visits were available daily from 9am to 9pm, but there had been very little take-up. No children had visited the centre since it had opened and there was no evidence that the centre encouraged, promoted or supported women to maintain contact with their families.

6.6 The visits area was clean and tidy, but there were no facilities for visitors to buy food or drink and they were prohibited from bringing such items into the centre. There was little provision for children, apart

6.14 Women could send one free personal letter a week and unlimited legal correspondence. Until recently, there had been only one post box, in the activities building, but there were now post boxes in each unit.

6.15 The centre had recently installed WayOut TV, to enhance communication through detainees' televisions, and there were plans to develop the use of this facility.

Leaving the centre

Expected outcomes: Detainees leaving detention are prepared for their release, transfer or removal. Detainees are treated sensitively and humanely and are able to retain or recover their property.

6.16 In the last three months, about half of detainees leaving the centre had been released into the community. Some women had been held for long periods because of a lack of bail accommodation, in some cases for more than three months, which was unacceptable. We were told that two women had been released without accommodation, but this could not be confirmed through lack of record-keeping.

6.17 In our survey, only 35% of respondents said that they felt supported and prepared for release. Leaders told us that preparation for release started when a woman arrived at the centre, but there was insufficient evidence of multidisciplinary working to support this assertion. Records of preparation for release lacked detail and detainees, including those with complex needs, were not well prepared for leaving the centre.

6.18 Women spoke positively about the support from Hibiscus, which continued to help them after leaving detention and removal to another country. We saw examples of women who had left the centre being provided with 'start-up' funds to set up their own business on release and Hibiscus staff were able to keep in touch with some of these after removal to another country. Grants had also been provided for items such as clothing and furniture. Hibiscus worked closely with the welfare team, who saw all women leaving the centre, but the work being done was not always well documented. Mental health services provided an informative booklet for women being released, including details about travel and support services.

6.19 We observed two women being transferred to a short-term holding facility. Interpreting services were not used for one woman because of a technical fault in the device they wanted to use; they could have used telephone interpretation instead, but did not do so. The woman made staff aware that she did not speak English, but this was not acknowledged and staff used hand gestures and spoke loudly (see also paragraph 4.29). She did not know where she was being transferred to and was asked to sign documentation about her stored property in English. The whole experience for the woman was poor. The other woman's transfer was cancelled at the last minute; staff inappropriately informed her in front of other detainees and staff, which

was insensitive in the circumstances. As she had been wrongly registered as discharged on the computer system, she was made to go through the whole new-arrival process again before returning to her room.

Section 7 Summary of priority and key concerns

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

Priority concerns

1. **Systematic governance, action planning, record keeping and quality assurance were deficient across most areas of operational management.** Detainee safety was an example needing priority action.

2. **Those at risk of self-harm or suicide did not receive consistent and well-organised care.**

3. **Use of force was not always carried out professionally, and oversight was lacking.**

4. **Some vulnerable detainees continued to be detained, despite evidence of a deleterious effect on their health and well-being.**

Key concerns

5. **There was insufficient focus on the needs of women in detention, in policy and practice.** Some staff showed insufficient awareness of women's needs.

6. **Many women had long journeys and arrived late at night.**

7. **Detainees were not kept sufficiently safe by thorough processes to address any evidence of intimidatory behaviour, and to support victims.** Data collection was weak and when investigations into alleged incidents took place, they were inadequate.

8. **Separation was not always clearly justified or used for the shortest time possible.** It had sometimes been used punitively.

9. **Staff and managers were not always professional in their interactions with detainees.** Despite the generally good relationships, there were some disrespectful comments, and some behaviour which showed little understanding of detainees' past traumas and present concerns.

10. **Interpreting services were used too little with those who did not know English well.** This was especially an issue at key points such as reception and discharge.

11. **Consultation with detainees, to understand and respond to their needs, was poor.**

12. **Some key facilities were unavailable because of unfinished initial building work.**

13. **There was not enough for women to do.** There was no plan for the development and promotion of the activities provision to meet the needs of an expanding population.

14. **The centre was not doing enough to encourage and support family contact.** Poor mobile phone reception exacerbated the problem.

15. **Some women waited too long in detention,** often because bail accommodation was not available.

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 prisoners/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. For immigration removal centres 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.

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

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

Under each test, we make an assessment of outcomes for detainees and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the Home Office.

Outcomes for detainees are good.
There is no evidence that outcomes for detainees are being adversely affected in any significant areas.

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

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

All inspections of immigration removal centres in England are conducted jointly with the Care Quality Commission. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report provides a summary of our inspection findings against the four healthy establishment tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees* (Version 4, 2018) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/immigration-detention-expectations/). Section 7 summarises the areas of concern from the inspection. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of detainees and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief Inspector
Martin Kettle	Team leader
Deri Hughes-Roberts	Inspector
Rebecca Mavin	Inspector
Steve Oliver-Watts	Inspector
Chelsey Pattison	Inspector
Tamara Pattinson	Inspector
Fiona Shearlaw	Inspector
Rachel Duncan	Researcher
Rahul Jalil	Researcher
Nisha Waller	Researcher
Paul Tarbuck	Lead health and social care inspector
Lynda Day	Care Quality Commission 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.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

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

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except rooms in segregation units, health care rooms or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged rooms, rooms affected by building works, and rooms taken out of use due to staff shortages. Operational capacity is the total number of detainees that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Detention engagement team (DET)
Home Office team responsible for engaging with detainees to update them on progress on their case while detained.

Dialectical behavioural therapy
This is form of psychotherapy that can be useful in treating mood disorders and suicidal ideation, as well as for changing behavioural patterns such as self-harm and substance use.

Eye movement desensitisation and reprocessing (EMDR)
EMDR is a comprehensive psychotherapy that helps individuals process and recover from past experiences that are affecting their mental health and well-being.

Flash technique
Rapid therapy to enable individuals to cope with intrusive thoughts and unacceptable feelings associated with previous trauma.

Hibiscus
A charitable company whose mission is ‘to support and empower vulnerable foreign nationals, Black, minority ethnic and refugees (primarily women), who are affected by the criminal justice system and immigration restrictions’.

Leader
In this report the term 'leader' refers to anyone with leadership or management responsibility in the immigration detention system. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

National referral mechanism
identifies, protects and supports victims of human trafficking.

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

Protection of adults at risk
Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Removal from association (RFA)
Under Rule 40 of the Detention Centre Rules 2001, detainees may be taken from normal location to a separate RFA unit in the interests of safety and security. Rule 42 provides for temporary confinement of violent and refractory detainees.

Rule 35
Rule 35 of Detention Centre Rules requires notification to Home Office Immigration and Enforcement if a detainee's health is likely to be injuriously affected by detention, including if they may have been the victim of torture.

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are:

Detainee population profile

We request a population profile from each centre as part of the information we gather during our inspection. We have published this breakdown on our website.

Detainee survey methodology and results

A representative survey of detainees is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Survey of centre staff

Staff from the centre are invited to complete a staff survey. The results are published alongside the report on our website.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

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