# Detainees under escort: Inspection of escort and removals to

# Zimbabwe

by HM Chief Inspector of Prisons

7–8 September 2022

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# Introduction

Removal charter flights to Zimbabwe were resumed in 2021 after an interval of some years, and this was the first we have inspected. Nine people were removed to Harare, three women and six men. Inspectors spoke with then before departure and monitored the whole journey. Several of those being removed knew very little before embarkation about when and how the journey would take place, many were anxious, and one was given close supervision and support because of the risk of self-harm.

Staff generally treated those being removed with respect and consideration, and those being removed were able to telephone personal contacts and legal advisers freely, but there was some insensitive behaviour by escorting officers. The normal processes for departure from immigration removal centres and transfer were carried out calmly, although the report identifies some room for improvement at points where conditions were cramped or crowded, and there were some long waits on coaches.

The privacy of detainees, and proper separation between women and men, were not always given sufficient priority. Force was used at certain points to secure compliance: proper techniques were used, but it was not always clear whether sufficient priority had been given to de-escalating tensions by other means. Escorting officers refrained from taking hold of a person's arm unless it was necessary.

Home Office staff were present throughout and made themselves more accessible to those being removed than we have sometimes seen. Before landing, the people being removed were given some information on assistance in Zimbabwe, and the disembarkation process went smoothly.

**Charlie Taylor**
HM Chief Inspector of Prisons
October 2022

# What needs to improve

During this inspection we identified six key concerns. 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.

## Key concerns

1. **Not all detainees were aware of the details of their removal.** This included information about collection, departure and arrival times.

2. **Flight manifests and person escort records (PERs) did not always provide consistent information.** PERs had conflicting information and information was not always well recorded.

3. **Women and men were made to share the same coach to the airport, even when risks had been highlighted.** Women were also made to board the aircraft after some men, having to walk past them.

4. **Detainees spent too long on coaches before boarding the aircraft.**

5. **Detainees were not allowed to use the toilets with complete privacy.** This practice was not based on individual risk assessment.

6. **Although some staff referred to detainees by their names, many used their manifest numbers only, which was impersonal.**

# About this escort and removal

**Departure airport**
Stansted

**Destination country**
Zimbabwe

**Destination airport**
Harare

**Escort contractor**
Mitie Care and Custody

**Number of detainees escorted**
Nine

**Number of escort staff**
50

**Health care staff**
Two

**Length of journey**
17 hours 15 minutes (longest)

# Section 1 Summary of key findings

1.1 Nine English-speaking detainees boarded the aircraft – three women and six men – along with 50 escort staff and two paramedics. The number of detainees had reduced in the lead-up to the flight, which caused considerable anxiety for those whose removal directions were cancelled at short notice.

1.2 The staff briefing at Mitie's base in Spectrum House, near Gatwick Airport, was clear and staff were reminded of critical areas, including the risks and vulnerabilities of detainees on the flight.

1.3 All detainees, except one, had been held in immigration removal centres (IRCs) for at least 48 hours before departing. One detainee had been transferred to an IRC the day before the flight. He did not have all his property with him for the flight; he raised this with the the chief immigration officer (CIO) on the aircraft.

1.4 During our interviews with detainees before their removal, we were told that some were not aware of the details of their journey to Zimbabwe, including not knowing when the coach would be arriving to collect them. All detainees had access to a mobile phone to contact their solicitors, although one said he had been unsuccessful in getting representation.

1.5 Searching was proportionate and respectful, but in most cases was done in an area that was overcrowded with staff and cramped.

1.6 One female detainee was placed on constant supervision before leaving the IRC. She was on assessment, care in detention and teamwork (ACDT) case management for risk of suicide or self-harm and a vulnerable adult care plan (VACP). One male detainee travelled on a VACP but there was no evidence that the care plan was followed after he left the centre.

1.7 Force was used twice during the operation, once to carry a woman on to the plane. Two male detainees were already seated on the plane and witnessed this, which was inappropriate. Waist restraint belts were used for two male and three female detainees during the operation, but documentation was weak; it did not show justification for the length of time it was used or whether there were other measures that could have been used. For those not in waist restraint belts, guiding holds were not used, which was an improvement on previous inspections.

1.8 There had been some improvements in entries on person escort records (PERs) from previous flights we have inspected, but there were discrepancies between this document and the flight manifest, including inconsistencies in detainees' medical information. One man who had been deemed a risk to women shared a coach with two female detainees, which was inappropriate.

1.9 Coach commanders showed good support through the processing stages but did not communicate well when a coach broke down on the way to the airport. Detainees continued to spend an excessive time on the coach before boarding the flight, with one detainee spending two hours and 15 minutes on one before it left the IRC. The longest transfer time from boarding the coach to the plane was five hours and 45 minutes.

1.10 We observed generally good interactions between staff and detainees, including staff supporting a woman on a constant watch (see Glossary), but there were examples of insensitive behaviour. Some staff did not use detainees' names but referred to them solely by their manifest numbers. Home Office staff made themselves accessible throughout the process, which was good.

1.11 Sufficient food and drink were provided on the coaches and the aircraft, and all detainees had access to pillows and blankets. Escort staff continued to keep toilet doors on both the coach and the plane slightly ajar when detainees used them, which was an unnecessary intrusion into their privacy.

1.12 Disembarkation was managed effectively and detainees were provided with information on assistance on their arrival in Zimbabwe. A few detainees had raised concerns of being homeless on their return.

## Progress on recommendations

1.13 At our last inspection we made six recommendations about areas of concern. At this inspection we found that one of the recommendations had been achieved and five had not been achieved.

## Notable positive practice

1.14 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which others 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 others could learn from or replicate the practice.

1.15 Inspectors found no examples of notable positive practice during this inspection.

# Section 2 Safety

## Preparation and departure from removal centres

Expected outcomes: Detainees are escorted in safety and due regard is given to individual needs and risks. Removals are conducted in accordance with law. Security and good order are maintained through proportional operational arrangements and force is only used as a last resort.

2.1 Most detainees had stayed at immigration removal centres (IRCs) for at least two nights before the flight. However, the manifest indicated that one detainee had travelled from HMP Maidstone to Colnbrook IRC on the day before.

2.2 Detainees were aware of the date of their removal, but some of the women we spoke to at Colnbrook IRC told us they did not know what time they were leaving the centre or what was going to happen during their journey, which added to their anxiety.

2.3 Four men were held in the care and separation unit (CSU) at Brook House IRC before leaving the centre, owing to a perceived risk by staff that they might not comply. They were not locked into cells and were allowed into the communal areas.

2.4 The staff briefing at the muster point was thorough. They were reminded to make sure they were aware of detainee risks on the flight, along with considering their vulnerabilities and the stresses they might be experiencing.

2.5 We observed the early stages of removal at Brook House and Colnbrook IRCs. We saw good interactions from staff, but the area was very cramped in Colnbrook, with over 16 staff in the room at one time. Health care staff were visible and spoke with each detainee before they left the centre. Two detainees raised concerns about medication and whether they would be able to get this in Zimbabwe.

2.6 The centre staff gave information to detainees about the availability of mobile phones on the coach to call solicitors, family and friends. Detainees were able to record contact numbers from their personal devices before they were stored in their property.

2.7 Two women detainees shared a coach with one man from Colnbrook IRC who was identified as a risk to women; although they were seated separately, this was still inappropriate. Other men being removed had also been identified as a risk to women, but female staff had been allocated to supervise them.

2.8 Coach commanders introduced themselves to each detainee at the centres and showed support through the processing stages. However,

when one of the coaches broke down on the way to the airport, they did not keep detainees or staff updated about what was happening.

2.9 Home Office staff were at both centres we observed and spoke to each detainee, which was positive. The detention and engagement team (DET) at Colnbrook served removal papers to one man who was already on the coach and, although they delivered this sensitively, too many other staff were watching this process.

## Safeguarding adults and personal safety

Expected outcomes: Detainees are escorted in safety with due regard for their vulnerability. Security and good order are maintained through proportionate operational arrangements and force is only used as a last resort.

2.1 Searching was proportionate and respectful, and staff engaged detainees in informal conversation, but the areas used in Colnbrook, and for most of the time in Brook House were too crowded and cramped.

2.2 Health care staff in Colnbrook were called to see a woman while force was used to effect her removal. There were concerns as she was unresponsive and health staff checked her before force was used again. She was later told her removal was cancelled. Another female detainee was placed on constant supervision before leaving the centre after being assessed as at high risk of self-harm, triggered by her impending removal. This remained the case throughout the operation, while she was also on assessment, care in detention and teamwork (ACDT) case management for risk of suicide or self-harm and a vulnerable adult care plan (VACP). One male detainee travelled on a VACP but there was no evidence that the care plan was followed after he left the centre, since no entries were made by escorting staff on the care plan record.

2.3 Waist restraint belts were used for two men and three women during the operation. They were removed from one of the men and one of the women before boarding the aircraft. Restraints were removed from another woman before the aircraft began take off. One man had his restraint moved relatively quickly after the aircraft had taken off, but the paperwork did not show why it had stayed on until then, as the detainee had offered no physical resistance. The remaining woman was in the waist restraint belt for three hours; it had been applied after she refused to move on the aircraft steps and it was only removed when authorised by security staff. Documentation again did not show justification for the length of time it was used.

2.4 Force was used on one female on the aircraft steps and she was carried to her seat. Two male detainees had already boarded the plane and witnessed this, which was inappropriate. Health care staff spoke to the woman once she was seated and again later in the flight, but

documentation of these interactions was inadequate. There was no evidence that other measures had been taken to engage the woman before the waist restraint belt was applied.

2.5 We saw no use of guiding holds, which we have seen previously on other flights, for most detainees who were not in waist restraint belts boarding the plane and for whom no concerns had been raised. They were surrounded closely by staff but walked freely up the steps with no contact being made, which was an improvement on previous inspections.

2.6 We examined records from the previous three removals, which showed that force had been used six times on these operations. In five of these cases, the waist restraint belt had been used, and in one case leg restraints were also used. In two cases, handcuffs were placed on a detainee's wrist for pain compliance, but it was not clear from the paperwork that this was necessary. Additionally, records did not demonstrate that use of the restraint belts was for the shortest time possible, and there was no evidence of alternative measures to engage with detainees to avoid the need for use of force. In one of these removals, force and restraints were used on a detainee who appeared to have had more than one seizure during the removal. The onboard medic had checked him on each occasion and assessed him as fit to travel.

2.7 We reviewed all detainee person escort records (PERs) when they had disembarked. Although there was improvement from previous flights, with some examples of good record-keeping, there were still discrepancies in entries by IRC and escorting staff, including inconsistencies in the medical and risk information recorded in the PER and in the risk assessment in the flight manifest.

## Legal rights

Expected outcomes: Detainees can exercise their legal rights. Removals are conducted in accordance with law.

2.8 Most detainees had access to a solicitor and spoke to them before boarding the plane. One detainee told us that he was unable to get a solicitor in the lead-up to his removal, and that no one had returned his calls.

2.9 All detainees had access to a mobile phone on the coach and plane and we observed many using these before take-off, including calls to their solicitors.

2.10 The Home Office chief immigration officer (CIO) held a surgery to speak to individual detainees on the plane. This took place at the detainee's seat with four security escorting staff present, which was excessive. Four detainees had originally expressed an interest in seeing the CIO when they were asked at the beginning of the flight but two changed their mind when the surgery was held. The meeting with

the CIO was not well documented in the PER of one of the detainees, and it was not clear what support was given.

# Section 3 Respect

## Physical conditions and property

Expected outcomes: Detainees are escorted in decent physical conditions and individual needs are addressed. Detainees are treated with humanity and respect.

3.1 Detainees' property was managed well in the centres before it was loaded on to the coach, and each detainee could check that the correct property was being sent with them. One detainee had not received his property from the prison he was at before his arrival at Colnbrook. Staff advised him to submit a complaint and forms were handed out, but in English only. The detainee did not submit a complaint but spoke to the CIO on the aircraft about his concerns.

3.2 All detainees were offered compression socks for the flight, along with the offer of clothes, which one detainee accepted as he lacked warm clothing.

3.3 The Home Office and escorting staff raised concerns about the stairs used to board the plane, which did not fit well to the entrance of the plane and were poorly lit. Escorting staff were positioned appropriately to manage the safety of those boarding the plane.

3.4 Detainees were provided with cold food and drinks on the coach. Staff handed out more snacks before the coach arrived at Stansted. Hot meals and drinks were provided on the flight, with a suitable vegetarian option. Detainees were offered snacks to take with them as they left the flight, as there was a surplus. Staff and detainees were given blankets and pillows once the plane was airborne.

3.5 Staff continued to stand outside toilet doors on the coach and aircraft when detainees used them, with doors kept slightly ajar. This continued to be an unnecessary intrusion on privacy and was not based on individual risk assessments.

3.6 Some detainees had spent too long on the coach before boarding the flight; one had spent two hours and 15 minutes on a coach before leaving Colnbrook IRC. The longest transfer time from boarding the coach to the plane was five hours and 45 minutes, which happened when the coach from Brook House broke down on route to Stansted.

## 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.

3.7 Treatment of detainees overall was good and we saw some positive examples of escorting staff building rapport with the men and women. However, there were still some cases of inappropriate behaviour from a few staff, including talking about their personal lives with each other when detainees were being processed for departure at the IRC, and cheering when the plane landed in Harare.

3.8 The woman on a constant watch was well supported by three escorting officers at all times. Two officers carried out this duty throughout the flight, which was too demanding when other staff could have taken a turn.

3.9 Staff were advised in the briefing to offer detainees distraction boxes on the coach, but not all did this and some were sceptical about the contents, which included packs of cards, small board games, coloured pencils and paper. All detainees were offered an iPad on the plane to watch films and most took advantage of this offer.

3.10 The Home Office did not assign an interpreter to the operation and staff were told of this during the briefing at Spectrum House. All detainees spoke English fluently and no issues were raised about communicating with staff.

3.11 Escort staff greeted detainees by name at the IRCs but otherwise referred to them by their manifest number at Colnbrook IRC. This was impersonal and did not convey a commitment to the care and welfare of each detainee.

# Section 4 Preparation for reintegration

Expected outcomes: Detainees are prepared for their arrival and early days in the destination country. Any unacceptable behaviour in destination countries is appropriately challenged.

4.1 Most of the detainees said that they had not lived in Zimbabwe for some time, in some cases 20 or 30 years, and several said that they had no family or friends in the country. A few raised concerns about being homeless on their return.

4.2 During the flight, escorting staff gave detainees a leaflet which provided information on assistance available when they arrived in Zimbabwe. It was explained that funds could be supplied for purchase of a SIM card and/or onward transportation, and for assistance with overnight accommodation. A cash grant for temporary accommodation, small business set-up, education or training could also be provided, and detainees were told they would be given more information when they landed in Harare.

4.3 There were no incidents during disembarkation, which was smooth and efficiently managed. Health staff on board returned personal medication and medical notes to the relevant detainees one hour before landing. The women detainees left the plane first, swiftly followed by the men. The handover was conducted by the CIO, and members of the Zimbabwean immigration authorities checked each detainee by their name before they boarded a shuttle bus to the airport.

# Section 5 Summary of key concerns

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

## Key concerns

1. **Not all detainees were aware of the details of their removal.** This included information about collection, departure and arrival times.
2. **Flight manifests and person escort records (PERs) did not always provide consistent information.** PERs had conflicting information and information was not always well recorded.
3. **Women and men were made to share the same coach to the airport, even when risks had been highlighted.** Women were also made to board the aircraft after some men, having to walk past them.
4. **Detainees spent too long on coaches before boarding the aircraft.**
5. **Detainees were not allowed to use the toilets with complete privacy.** This practice was not based on individual risk assessment.
6. **Although some staff referred to detainees by their names, many used their manifest numbers only, which was impersonal.**

# Section 6 Progress on recommendations from the last inspection

## Recommendations from the last inspection

The following is a list of all the recommendations made in the report of our last inspection of an overseas escort to Spain and Portugal on 6 July 2021.

### Safety

Detainees should receive advance information on their removal, including details about collection, departure and arrival times.
**Not achieved**

Home Office staff should be present and visible to detainees during the removal process.
**Achieved**

Flight manifests should contain comprehensive details of the risk factors and vulnerability of detainees at the time of removal.
**Not achieved**

### Respect

Unless an individual risk assessment indicates otherwise, escort staff should allow detainees to use the toilet in complete privacy at IRCs, on coaches and on the aircraft.
**Not achieved**

The time detainees spend on a coach should be monitored and escorts coordinated, to minimise unnecessary waits.
**Not achieved**

Detainees should not solely be addressed by their manifest number.
**Not achieved**

# Appendix I About our inspections and reports

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 monitors the treatment of and conditions for detainees. Escorts are included in this remit. 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 establishment that were first introduced in this Inspectorate's thematic review Suicide is everyone's concern, published in 1999. For inspections of escorts and removals the tests are:

- Safety
- Respect
- Preparation for reintegration

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 providers 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 providers could learn from or replicate the practice.

## This report

This report provides a summary of our inspection findings against the healthy prison tests. There then follow three sections each containing a detailed account of our findings against our *Expectations for immigration detention. 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 5 summarises the areas of concern from the inspection. Section 6 lists the recommendations from the previous inspection and our assessment of whether they have been achieved.

## Inspection team

This inspection was carried out by:

| | |
|---|---|
| Martin Kettle | Team leader |
| Tamara Pattinson | Inspector |
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| Fiona Shearlaw | 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 and separation unit (CSU)**
A unit for detainees removed from association with others on the main residential units, under rule 40 (removal from association) or rule 42 (temporary confinement) of the Detention Centre Rules 2001.

**Constant supervision**
Also known as constant watch, this takes place when the risk of suicide is deemed high and so the detainee is directly observed by a specific officer for 24 hours a day.

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

**Guiding hold**
Where an officer takes hold of a detainee's arm to guide them when walking. This is recorded as a use of force.

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