Report on an unannounced inspection
of short-term holding facilities managed by

Border Force

by HM Chief Inspector of Prisons

9–20 January 2023

Contents

Introduction

These short-term holding facilities (STHFs) hold individuals and families who have been detained at the border by the UK Border Force. The inspection included all those staffed and run directly by Border Force at five airports and 10 seaports which are listed in Appendix II.

While there is still much work to be done to make sure consistent and satisfactory standards are maintained across all the sites, I am pleased to report considerable improvements since our last inspection in March 2020. Then, even the most basic facts about STHF locations and their use were not clear, and we found 'an alarming lack of oversight and accountability'. A programme of action and reorganisation began soon after our report was published, and leadership became more consistent.

This has resulted in much better coordination between the national STHF team and regional operational leaders at Border Force, improved staff training and detailed, consistent standards for all STHFs being set. Data were now collected, but they were not accurate and insufficient use was made of them.

Most of the sites where we found unacceptable physical conditions in 2020 had been rebuilt or refurbished, some quite recently. The notable exception was the Port of Felixstowe and Purfleet Docks, where conditions remained below any acceptable standard.

Children and adults vulnerable to harm did not always receive appropriate or sufficient support or care. There were also inconsistencies in practice between the sites in several areas, notably in assessing and mitigating risks of harm, use of force and searching.

This report describes commendable improvements in leadership and in the standard of provision. Some of the changes have been implemented recently, and much of them remain uneven across the network of relatively small holding facilities, but improvements can now be consolidated, and good, consistent standards achieved at all sites.

Charlie Taylor
HM Chief Inspector of Prisons
February 2023

Summary of key findings

What needs to improve at this short-term holding facility

During this inspection we identified 13 concerns, of which four 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 the Home Office.

Priority concerns

1. **Leaders were not making sure good practice was consistent across all sites**. This covered areas such as identifying and managing risks, induction, treatment of children, use of force and searching.

2. **Data were not being collected reliably enough or used to identify trends so action could be taken.**

3. **Not all detainees with potential vulnerabilities were being identified, and information about their vulnerabilities was not always clearly noted in case files.**

4. **The Port of Felixstowe remained a poor holding facility.** No plan had been confirmed for the refurbishment of the site.

Key concerns

5. **Not all Border Force staff who came into contact with detainees, including minors, had undergone a Disclosure and Barring Service security check.**

6. **Not all use of force was recorded.**

7. **There was a lack of formal well-documented care planning for detainees identified as vulnerable, which could have contributed to their vulnerability.** They included detainees with protected characteristics, for example women and those with disabilities or serious health conditions.

8. **Unaccompanied children were held for too long and for over two hours longer on average than adults.**

9. **Safeguarding processes were not sufficiently robust, which meant children who were vulnerable to modern slavery might not have been identified.**

10. **Legal advice was not readily available to detainees.**

11. **Not all facilities had showers.**

12. **Detainees did not have sufficient activities to keep themselves occupied.** They could not exercise outside, and children's toys were limited.

13. **Not all detainees had access to the complaints process and complaint forms were only in English.**

Progress on recommendations

We last inspected border force short-term holding facilities in 2020 and made 22 recommendations. The Home Office fully accepted 17 of the recommendations and partially (or subject to resources) accepted four. It rejected one of the recommendations.

At our last inspection, we made 22 recommendations. At this inspection we found that four of those recommendations had been achieved, six had been partially achieved and 12 had not been achieved. Most of those not achieved were in the area of safety; in most of these cases there had been progress, but not enough to meet the recommendation in full. For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 5.

Notable positive practice

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.

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

Section 1 Leadership

1.1 There had been considerable improvements in leadership, management and coordination since the previous inspection. In 2020, leadership at national level had been inadequate partly through successive temporary postholders in key roles. However, it had now become more regularised and consistent, with more permanent managers in post. Operational guidance had been improved and consolidated into a single document, available to all sites.

1.2 Operational practice in key areas such as safeguarding had improved, but there were still inconsistencies between sites, and our findings showed a number of examples of insufficiently good practice in areas such as risk identification and management, induction, treatment of children, use of force and searching.

1.3 Border Force national leaders now had frequent contact with regional managers responsible for everyday operations. They also met regularly with regional detention leaders, and attendance at these meetings was now good.

1.4 Data gathering had improved, and every site forwarded monthly returns to Border Force National Operational Headquarters. There was still some way to go to make sure that data were reliable and consistent or to make use of data to identify trends so action could be taken.

1.5 Training for staff had improved – safeguarding training was provided across all sites, and a caseworker training package was delivered to over 1500 Border Force staff.

1.6 A programme to upgrade the holding rooms, with newly built premises in some cases, was in progress but had been too slow in a number of locations. The new facilities were well designed. The programme was not yet complete, and some sites remained unsuitable.

1.7 Working relationships between Border Force and the respective port authorities were positive. Independent Monitoring Board oversight was now in place for all sites.

Section 2 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.

2.1 Home Office records showed that 811 detainees had been held across all 14 sites in the six months leading to the inspection, Bristol Airport being the most frequently used facility. However, information provided by the Home Office did not tally with local records in all cases, and there was evidence that its data underreported the number of arrivals at some sites. None of the facilities were permanently staffed, but there were sufficient staff at all sites for holding rooms to be opened 24 hours a day if a detainee arrived.

2.2 Detainees arrived at airport facilities after disembarking from commercial flights. At seaports, some detainees arrived as passengers in cars or on foot, but others were found concealed in lorries or containers or in insecure freight areas having left the vessel on which they had travelled.

2.3 IS81 documentation, which provides immigration officers with the legal authority to hold a person, was generally issued promptly after they were first stopped. At airports, detainees were usually identified in the border control area and walked to the holding room. At seaports, detainees who arrived concealed in lorries were often found further away from the holding room and were generally transported in cellular vans. The vehicles we saw were in good condition. There was some inconsistency in the use of handcuffs on detainees who were found in insecure areas, and at some facilities, older children were routinely handcuffed. (See also paragraphs 2.18 and 2.23.)

2.4 At most facilities, adult detainees were given a rub-down search and were also searched using a metal detecting wand. At Leeds Bradford Airport, detainees were not routinely searched – searching took place on a risk-assessed basis. At some seaports, detainees were searched twice while in Border Force custody, both at the point of detection and once they had arrived at the facility. We were told that the first search aimed to discover any weapons or sharp objects and the second was for any documentation or items which might help establish a detainee's identity or means of travel. There was almost always a female officer on duty to search female detainees.

2.5 We found differing practices in the searching of children, particularly at seaports. We were told younger children would only be searched using a wand, but at some sites older children were routinely given rub-down searches without a risk assessment having been carried out.

2.6 IS91 documentation, which legally authorises formal detention, was not always being issued to individuals promptly. At Tilbury Docks, for example, we reviewed cases in which IS91 documents had only been issued after several hours in Border Force custody.

2.7 Detainees at all sites received some form of induction, which involved using professional telephone interpretation when needed. At most sites staff were now using a standard induction checklist, which outlined key processes that needed to be completed, but we did not see it being used at every facility. At most facilities, the induction process involved a brief initial interview to establish detainees' immediate needs or risks. However, documentation was not always clear about the depth of the interviews or whether detainees were asked about prominent risks, such as trafficking or their mental health.

2.8 Detainees' property was bagged and stored securely but not always fully listed or recorded.

2.9 Not all facilities at seaports had showers available, despite some detainees arriving cold and dirty after long journeys. However, basic toiletries were provided at all sites, and seaports had clean clothing for detainees who needed it.

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.

2.10 All Border Force staff had received basic safeguarding training, and there were several officers at each facility who had completed enhanced Safeguarding and Modern Slavery (SAMS) training. SAMS-trained officers were not rostered on every shift, but staff could contact regional and national safeguarding teams for advice when necessary. (See also paragraph 2.27.) It was a concern that not all staff who came into contact with detainees had undergone Disclosure and Barring Service security checks.

2.11 Posters displaying information about safeguarding issues, such as trafficking and female genital mutilation, were displayed at most sites, and some displayed information about safeguarding helplines.

Information posters on safeguarding at Portsmouth

2.12 Detainees were well monitored at all sites, and, in most cases, we saw evidence of regular observations recorded in paperwork, although they did not always indicate that meaningful interactions had taken place. Most facilities had space for women and children to be held separately from unrelated men, but at some this involved holding them for long periods in an interview room or another space that was not suitable.

2.13 Staff we spoke to had a general understanding of the National Referral Mechanism (NRM) process (see Glossary), and 41 referrals had been made in the previous year across all sites. However, some sites had not made any referrals, and in some cases the records appeared to show evidence that would justify a referral being made, but it was not. For example, a family who arrived at Poole Ferry Terminal who appeared to have been dropped off at the facility was not referred. (See also paragraph 2.25.)

2.14 Border Force was subject to the national Home Office adults at risk in immigration detention policy (see Glossary), but many staff we spoke to only had a vague understanding of the policy and some had not heard of it at all. Only 17 detainees had been determined to have been adults at risk in the year leading to the inspection, despite many arriving clandestinely after dangerous journeys involving potential trafficking, and many being asylum seekers claiming to have suffered persecution. Four adult detainees had been referred to local authority social services in the previous year, after Border Force officers identified care needs.

2.15 Where vulnerabilities were identified, staff recorded them on the Home Office's online systems. However, we did not see evidence of care planning or additional monitoring for those who had been identified as

vulnerable, and case files we reviewed did not always adequately record vulnerabilities. Where care was recorded in case files, it was often brief and did not demonstrate that meaningful interactions had taken place beyond offering food and drinks or taking note of the times when detainees slept.

2.16 Self-harm was rare across all facilities, and three incidents had been recorded in the year leading to the inspection. On one occasion at Tilbury, a detainee who had threatened to self-harm and who had sustained injuries during his journey was handcuffed during a hospital escort, with no evidence of a risk assessment having taken place. There was no formal process in place to plan the care of detainees who were at risk of self-harm, and Border Force officers would simply note any identified risks in brief on the IS91 document authorising detention. Staff did not carry anti-ligature knives at all sites.

2.17 During an incident at Tilbury, two men self-harmed after being found concealed on a ship. As they did not have leave to enter the UK and did not claim asylum, Border Force staff agreed that they should be kept in a locked room on board the vessel until it left on the following day, and they could be removed. This decision did not appear to factor in their self-harm or their potential vulnerability. Records showed that the two detainees went on to escape and carry out further self-harm using a sharp object they had found in the room, which required hospital treatment. While it was legal for Border Force to prevent the two men from disembarking the ship, the incident raised questions about whether their evident vulnerabilities had been considered.

2.18 Handcuffing practices varied across the sites. At airports, handcuffs were not generally used. However, at seaports we were told most detainees were routinely handcuffed because of open port areas and potential flight risks. (See also paragraph 2.3.)

2.19 Most detainees were compliant, and violence and the use of force were rare, but there was evidence of underreporting. Home Office records showed that force had been used 49 times across all sites in the year leading to the inspection. Most incidents involved the use of handcuffs, but as most detainees who arrived at seaports were routinely handcuffed, there was reason to believe that the actual figure was higher. Batons had been drawn on two occasions in the six months leading to December 2022, but we found evidence of a third incident that had not been included in Home Office figures. From current records, the use of restraint techniques appeared to be proportionate and justified, but we saw evidence of restraint being used at East Midlands Airport, which had not been recorded in the figures we were given.

Safeguarding children

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

2.20 In the six months to the end of November 2022, 83 children were held, 30 of whom were not accompanied by an adult relative. Documentation suggested that Border Force staff appropriately believed detainees who said they were children.

2.21 Better data was collected on the detention of children, but it was incomplete and there was little evidence that it was analysed to help plan future action. Children were still held for too long. A 15-year-old unaccompanied boy was the longest held at 27 hours 17 minutes, and eight unaccompanied children had been held overnight. Unaccompanied children were held for longer than adults – eight hours and 23 minutes on average, compared with six hours and 10 minutes.

2.22 None of the facilities maintained comprehensive data on the timeliness of referrals to local authority social services or response times, an important factor that affected the length of child detention. Border Force did not always contact social services departments as soon as staff became aware that they were dealing with an unaccompanied child. There were delays of up to two hours in cases we looked at. A log of social services response times was only kept at Tilbury. It showed delays of between three and seven hours for a release address to be provided.

2.23 There remained significant inconsistencies in practice, for example, in the searching and handcuffing of children. In some facilities, children were routinely given a rub-down search. In others, children were searched with an electronic device and only subject to a further search if the device indicated that there was a concealed item. In several centres, older children were sometimes handcuffed. At Harwich International Port and Poole Ferry Terminal, children were never handcuffed. (See also paragraph 2.3.)

2.24 We saw documentation showing how Border Force staff at Tilbury took a child to foster accommodation in handcuffs. When questioned, staff there told us that all detainees, including children, were risk assessed for the use of handcuffs while being escorted to release accommodation. The use of handcuffs for this purpose was disproportionate and unacceptable. (See also paragraph 2.3.)

2.25 We were told that all Border Force staff who had contact with detainees had completed Home Office training on keeping children safe. Staff were aware of when and how to refer cases to social services and, where there were concerns about modern slavery, they knew they should make referrals through the NRM. (See also paragraph 2.13.)

2.26 Unaccompanied children were generally offered a free telephone call to speak to family and a legal representative, but they seldom took up this

offer. At the Port of Felixstowe, calls were not offered, and in one concerning case, a child threatening to harm himself was refused a phone call until a social worker arrived.

2.27 We were not satisfied that safeguarding processes were robust enough to identify children who were vulnerable to modern slavery. All children had a full welfare interview to identify their immediate needs and trafficking concerns, but they sometimes did not take place until several hours after a child arrived. There were not enough SAMS-trained officers (see paragraph 2.10). Children were not always interviewed in the presence of a responsible adult who could support them. In a minority of ports, social workers acted in this capacity, and in others, port staff were asked to sit in on interviews. There was no routine provision for detained children to have access to a legal adviser under a 'duty' system as in some other forms of custody and, in some facilities, information and access to free legal advice was very limited or non-existent (see paragraph 2.38).

2.28 Welfare interviews were variable. In some cases, we saw trafficking risks being identified and acted on. In others, the interview record appeared cursory, and we saw some where questions intended to identify trafficking concerns were not asked. Some case files documented the rapid removal of children who did not receive the support of a responsible adult and had declined the offer of contacting a legal representative.

2.29 Border Force did not open care plans for children. Records of the care of children were variable and, in some cases, provided little evidence of meaningful interactions with children.

2.30 Some facilities offered better conditions for children than previously. However, others still had only one holding room, and children could be held with unrelated adults in an interview room or other inappropriate location. In Felixstowe, we were told of one instance where a child was held in a car for at least half an hour while a more suitable location was found. (See also paragraphs 3.1 and 3.2.)

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.

2.31 The collection of data had improved since our last inspection. Border Force now kept holding room logs in all facilities. They provided key information about those detained, including the amount of time they were held. Data were being collected and collated for all sites, although we found discrepancies between locally held information and data kept centrally. We did not see any indication that data were being analysed to identify concerning patterns or trends that might inform responsive action.

2.32 The data indicated that detainees could be held for substantial periods, sometimes in very poor conditions. On average, in the previous six months, detainees were held at the facilities for over six hours. The absence of data for a similar period during our last inspection meant that we were not able to make an exact comparison, although partial and inexact data for a three-month period indicated that, at that time, the average length of detention was over eight hours.

2.33 Many detainees were still held for long periods including, in some instances, overnight. Thirty-five detainees had been held for over 18 hours, 12 of whom had been held for more than 24 hours. The longest detention had been for over 32 hours.

2.34 On average, men were held for nearly six and a half hours, while women were held about an hour less (five hours and 18 minutes.) On average unaccompanied children were held the longest of all (eight hours and 23 minutes) which mainly reflected delays in making necessary arrangements with social services to provide ongoing care.

2.35 Detainees were initially held under IS81 documentation while enquiries were made, and documents were usually issued promptly. However, there were sometimes delays in issuing subsequent documentation that continued to provide the authority to detain (IS91/IS91R forms). Although a phone application was sometimes used to translate these detention authority documents for detainees, it was unsatisfactory that they were never professionally translated. We were told that the contents were explained to detainees using telephone interpretation as necessary.

2.36 There had been instances where detainees, even if they had undertaken arduous journeys, were woken up and interviewed at night, which was not appropriate. Use of telephone interpretation for interviews was good, but centrally compiled data about its use was not consistent with local records.

2.37 Although relevant safeguards were being applied, they were not always implemented with sufficient rigour to assure us that detainees who feared persecution were identified. In one case at Newhaven Port, the detainee's responses in a brief Border Force interview suggested that he feared persecution in his country. This was not explored further, and he was not informed of the right to claim asylum. He was removed less than an hour later. We were also concerned that some children who arrived at Tilbury, who had not sought advice and were interviewed without a responsible adult being present, were removed having not claimed asylum.

2.38 There was no access to a detention duty legal advice service in any of the facilities and information about legal advice varied between locations (see paragraph 2.27). Most facilities provided contact details for local providers accredited by the Office of the Immigration Services Commissioner, but a list displayed at Harwich was for the wrong region. Some facilities displayed only the contact numbers of national

organisations. The ability of detainees to contact legal advisers also varied (see paragraph 4.2).

2.39 The Independent Monitoring Board was now providing oversight of the facilities, having recently been able to establish a complete network of regional boards.

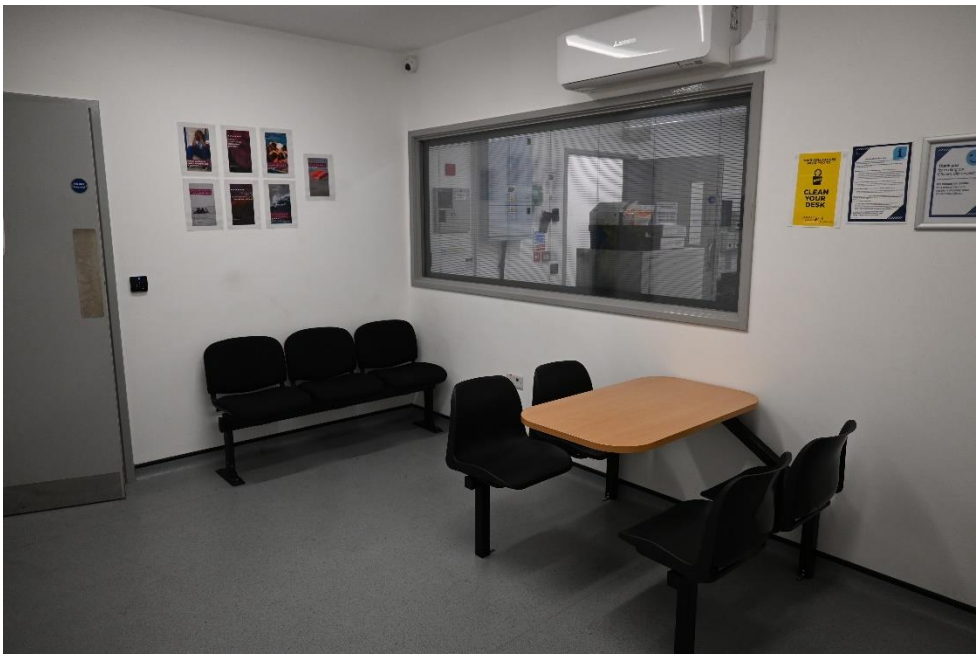
Section 3 Respect

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

Accommodation and facilities

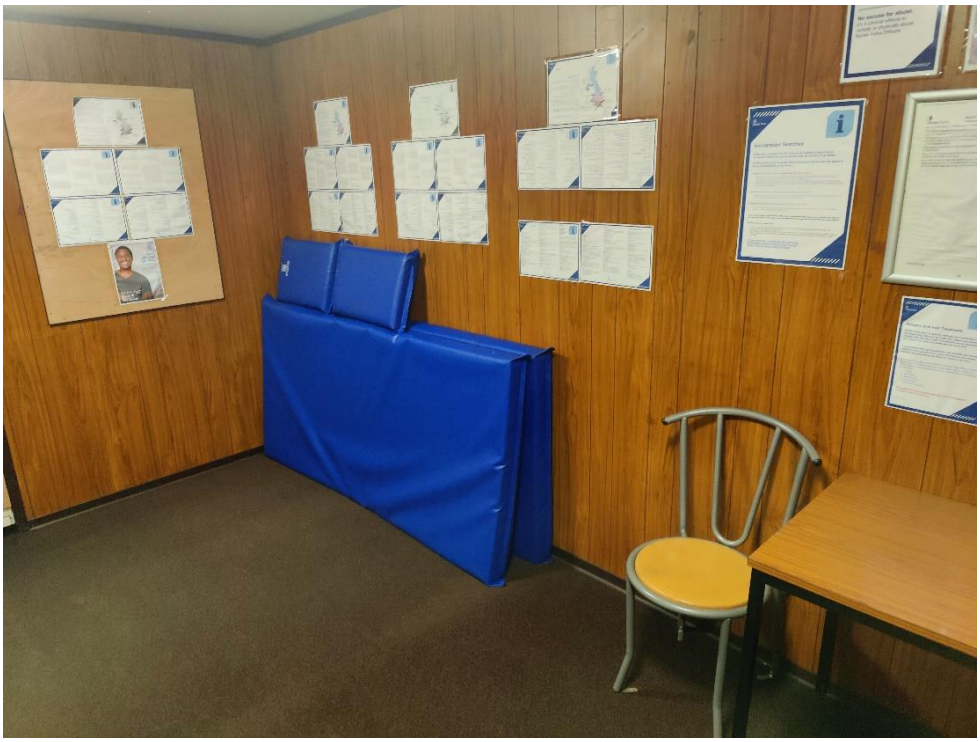
Expected outcomes: Detainees are held in a safe, clean and decent environment. They are offered varied meals according to their individual requirements. The facility encourages activities to promote mental well-being.

3.1 Since the last inspection, some facilities had been greatly improved, including Newhaven Port and Tilbury Docks, and conditions for detainees were much better. Hull Port no longer held detainees in a disused Border Force dock hall and had a new facility, which consisted of one holding room and three interview rooms. However, conditions at some seaports were still very poor and oppressive, such as at the Port of Felixstowe and Purfleet Docks. The building used at Immingham Docks had been a freight examination shed, which was a completely unacceptable environment in which to hold detainees. However, the facility had recently been refurbished and conditions were now suitable.



New holding room at Tilbury

Holding room exterior at Felixstowe with portable chemical toilet

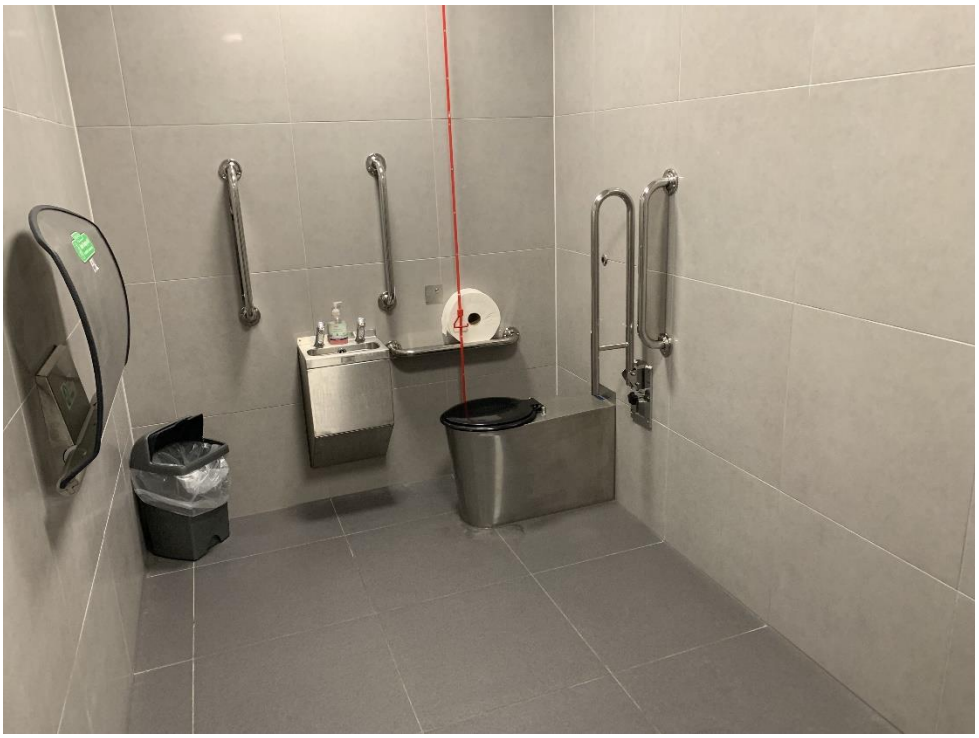


Holding room at Felixstowe

3.2 Most Border Force facilities only had one holding room, making it difficult to accommodate men, women and children separately. Staff said they would find an alternative room to make sure detainees were separated where required. Detainees were mostly supervised through observation windows and they could catch staff's attention in an emergency. Most facilities were well ventilated, with heating systems in

place, but none had a dedicated outdoor area so detainees could have access to fresh air, even when they had been detained for several hours. Few of the facilities had natural light, particularly those in airports.

3.3 Toilets across all the facilities were mainly clean and well kept, except at Felixstowe and Purfleet (a new facility was due to open at Purfleet shortly after our visit). The portable chemical toilet at Felixstowe had no hand-washing facilities, which was not appropriate. In two of the ports – Hull and Felixstowe – detainees' privacy was unnecessarily undermined by staff waiting outside the toilet while detainees used them, with the door slightly ajar. Not all facilities had showers, which was poor given the journeys some detainees had made. Those that did, had facilities that were in good condition, providing access for those with mobility difficulties.



Clean adapted toilet area at Bristol airport

3.4 Clean clothing was available at seaports, but not at all the airports, where it was rarely needed. Mattresses, most of which were too thin, as well as blankets and pillows were also available, but other than at East Midlands Airport, which provided a pop-up bed, detainees would have to use them on the floor or a bench, if available. None of the facilities were suitable for overnight stays.

Holding room with pop-up bed at East Midlands

3.5 The furnishings in the holding rooms were mainly bare and austere. Some Border Force information was displayed on the walls, and, in most cases, posters on safeguarding with details about support and advice were visible. Aberdeen Airport and Newhaven provided soft seating as a good alternative to the fixed table and chairs found in other facilities.

Aberdeen airport holding room with soft furnishings

3.6 A limited range of ready meals was available at all facilities with some sites, such as Hull, specifically catering for different dietary requirements, which was good. Some staff told us if detainees were held for longer periods, they could order food and, in some airports, they were able to buy fresh food from outlets in the terminal. Snacks were readily available, including biscuits and noodles, as were hot and cold drinks.

Food for different dietary requirements at Hull

3.7 Most sites had books in a few different languages and young children's toys were available, most of which were in a good condition, but they were too limited. Only a small number of facilities had a television in the holding room. In general, the facilities were not sufficient for those staying for many hours.

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.

3.8 Only one detainee was held for a short time during our inspection, and we were unable to observe any staff interactions. All Border Force staff we spoke to were positive and respectful about detainees. They understood their situations and the legal aspects of detention.

3.9 Professional interpretation was used well across all sites throughout the different stages of detention. Some areas held local records, but they did not always match the national database and did not capture all the occasions when it was used.

3.10 There had been no formal complaints at any of the facilities in the previous 12 months. Confidential complaints boxes were available, but not all of them were accessible to detainees or clearly marked. In the new facilities in Immingham and Killingholme Port, the boxes were in the staff area. Forms remained in English only and were not available

in other formats. There was evidence of detainees being provided with out-of-date information, for example in Aberdeen, where email addresses were used that had been withdrawn some time ago. Information on the Independent Monitoring Board was available in the holding rooms.

3.11 Religious artefacts and texts were available at all sites, although at Cardiff International Airport, staff to whom we spoke were not aware of the provision. Facilities such as at Leeds Bradford Airport and Hull had boxes available with a wide range of religious materials, stored respectfully. There were no dedicated prayer rooms in any of the facilities, except for Bristol Airport, where it was bare and being used to store mattresses. Staff at most sites said they would try and find an empty room for detainees to pray in.

3.12 Protected characteristics (see Glossary) were not routinely identified on a detainee's induction and no monitoring took place. Staff would often ask for a detainee's age, nationality and religion, but nothing further, which meant that some adults at risk might not have been identified during those early stages. Most sites had good access and adaptations for those with mobility difficulties, except for Felixstowe and Purfleet, where the facilities remained poor and unsuitable. There was no individual care planning for detainees with disabilities to help them with any specific needs while in the care of Border Force.

3.13 All facilities almost always had sufficient female officers available to support detained women. Basic toiletries, sanitary products and babies' nappies were readily available, but not all facilities had single sex toilets or washing facilities. Home Office data showed two pregnant women were held in the facilities in the previous six months at Bristol and Cardiff. Both were identified as adults at risk. They had spent lengthy periods in detention – one nine hours and 24 minutes and the other seven hours and 25 minutes.

Health care

3.14 There was no onsite health provision at any facility. In some locations, such as Bristol, staff would make sure a first aider was working on each shift. Fully stocked first-aid kits were available, including defibrillators, and staff would call 111 or 999 if they needed medical assistance, such as advice on a detainee's medication. Medical advice was not always sought when required, for example at Immingham, where a detainee outlined concerns with their health on arrival, which was not followed up. We saw evidence of good local multi-agency arrangements in the event of mass arrivals in ports, including at Hull.

Section 4 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.

4.1 Detainees' phones were removed and stored with their property at most of the facilities. At many locations detainees could, under supervision, access and write down numbers they needed from their own phone.

4.2 When they were not allowed to retain their own phone or if they did not have one, detainees were generally allowed to use landlines or officers' work mobile phones to contact family members, friends, or legal representatives. However, at some facilities these calls were not routinely offered. In cases we reviewed there was some evidence of telephones being offered to detainees to allow them to contact family members. Detainees were not able to access their phones or make any calls while at Felixstowe.

4.3 There was no internet access in any of the facilities, and Harwich International Port continued to be the only site with a payphone. Detainees were allowed to keep their phones at a few sites and could access personal email accounts and social networks.

Pay phone at Harwich

4.4 Information about the Independent Monitoring Board was readily available to detainees, but generally in English only. Detainees were not allowed to receive personal visits at any of the facilities because of security restrictions at the port or airport.

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.

4.5 Staff in some facilities said that detention was often extended because of waits for transport, which was usually outside Border Force control. As at the last inspection, these delays occurred when detainees were being transferred to an immigration removal centre, when they had to wait several hours for an escort contractor to arrive. Delays were also reported for asylum seekers bailed to alternative accommodation, who often had to wait for taxis supplied by a housing provider to transport them to their accommodation. Staff at some facilities said when delays occurred, they assisted in transporting the detainee where possible to minimise their time in detention.

4.6 Other than at Poole Ferry Port, person escort records were not used to share risk information when transferring detainees to other custodial establishments. It was not clear if risk information was being adequately communicated by other means, although we were told that the risk assessment carried out as part of the IS91 process (which legally authorises formal detention) would often contain relevant information.

4.7 Except at the Port of Felixstowe, detainees who were due to be released, transferred or removed could inform family, friends and legal representatives.

4.8 Detainees being transferred to further detention were told why this was necessary, but they were not always given information about the centre to which they were being transferred. For those being released, no information was provided about sources of support in the community other than at Hull, where leaflets in a few different languages were available with contact details for national and local support groups.

4.9 Detainees' property was returned to them on release or removal, or travelled with them to a further place of detention.

Section 5 Progress on recommendations from the last report

The following is a list of all the recommendations made in the last report, organised under the four tests of a healthy establishment.

Safety

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

Recommendations

Border Force should undertake a comprehensive national audit and assure itself and the public that all sites of detention are identified, properly equipped and consistently managed, and that local staff are given adequate support and guidance.
Partially achieved

Accurate data should be kept on the number of people detained and the length of their detention. This information should be used, in part, to help reduce the lengths of stay in detention.
Not achieved

All detainees should be given a formal structured induction to ensure their initial needs in the holding facility are met.
Partially achieved

Border Force managers should ensure that all cases referred to the National Referral Mechanism are recorded, and that referrals are analysed to inform trends and patterns of trafficking.
Not achieved

Border Force officers should explain the dangers of clandestine entry to detainees being removed from the UK.
Not achieved

Border Force officers should complete records that evidence the care offered to detainees.
Not achieved

Border Force officers should promptly assess and meet the needs of vulnerable detainees, such as pregnant women, who should be swiftly transferred or released.
Not achieved

Border Force officers should complete warning forms for detainees who may be at risk of suicide or self-harm. The warning forms should accompany detainees to their next place of detention.
Not achieved

Handcuffs should only be used where there are clearly identified risks, documented in use of force paperwork, to ensure accountability and proportionality.
Not achieved

Border Force should keep centralised records of children's detention, including the response times of children' social services, and monitor these to identify trends and patterns in the governance of child detention.
Not achieved

Unaccompanied minors being removed from the UK should receive a welfare interview with a responsible adult present, have access to legal advice and be given the opportunity to make a telephone call.
Not achieved

Child detainees should only be transported in cellular vans or handcuffed in very exceptional circumstances, and only following a risk assessment.
Not achieved

Respect

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

Recommendations

All facilities should provide accommodation that is clean, well equipped, suitable for men, women, unaccompanied children and families, and accessible to those with mobility difficulties or disabilities.
Partially achieved

Detainees should be offered a suitable range of food and drink that is readily available and meets their individual needs.
Achieved

Detainees should have sufficient activities to occupy themselves, and access to the fresh air.
Not achieved

Border Force staff should use professional telephone interpreting services throughout all stages of their engagement with detainees, especially during initial welfare checks.
Achieved

Detainees, including those who do not speak English, should have effective access to a confidential complaints process.
Not achieved

Detainees should have access to relevant artefacts to practise their religion.
Achieved

Female detainees should only be searched by female staff.
Achieved

Facilities should identify detainees' protected characteristics on their arrival to ensure their needs can be quickly identified and addressed.
Partially achieved

Preparation for removal and release

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

Recommendations

All detainees should be able to make telephone calls to family, friends or lawyers.
Partially achieved

Detainees leaving the STHFs should be advised about what is going to happen to them next, in a language they understand, and be informed about relevant support agencies they could approach for assistance.
Partially achieved

Appendix I About our inspections and reports

HM 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, 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 outlines the priority and key concerns 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.justiceinspectorates.gov.uk/hmiprisons/our-expectations/immigration-detention-expectations/). Section 5 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:

Martin Kettle	Team leader
Deri Hughes-Roberts	Inspector
Rebecca Mavin	Inspector
Chelsey Pattison	Inspector
Christopher Rush	Inspector
Fiona Shearlaw	Inspector

Appendix II Locations

Airports

Aberdeen Airport

Aberdeen Airport in Dyce, just outside the city of Aberdeen, opened in 1934. It had approximately three million passengers in 2019, to destinations across the UK and the rest of Europe.

Bristol Airport

Bristol Airport in North Somerset opened in 1957. Almost nine million passengers travelled through it in 2019, making it the eighth busiest airport in the UK. It serves the UK and the rest of Europe.

Cardiff International Airport

Cardiff International Airport is in the Vale of Glamorgan. It had 1.6 million passengers travelling through it in 2019. It is the busiest airport in Wales and owned by the Welsh government. It serves the UK and the rest of Europe.

East Midlands Airport

East Midlands Airport is close to Castle Donington in northwest Leicestershire. The airport carries over four million passengers a year in the UK and the rest of Europe. After Heathrow, it is the UK's busiest air cargo hub.

Leeds Bradford Airport

Leeds Bradford Airport, the largest airport in Yorkshire, is in Yeadon, in the city of Leeds in West Yorkshire. Four million passengers pass through it annually.

Seaports

Port of Felixstowe

The freight-only port at Felixstowe in Suffolk has been in existence since 1875 and was the first UK port to receive container traffic. In 2018, it was the sixth busiest port in England, handling 28 million tonnes of cargo. It is the busiest container port, taking around half of the UK's containerised freight.

Harwich International Port

Harwich International Port is a freight and passenger port on the south bank of the River Stour near Harwich, in Essex. It is opposite the port of Felixstowe. The ferry terminal services the Hook of Holland and several cruise liners during the summer months.

Hull Port

King George Dock at the Port of Hull is a passenger and freight terminal located at Kingston upon Hull in East Yorkshire. It is home to regular ferry services to

both Rotterdam and Zeebrugge and processes around 10 million tonnes of freight each year.

Immingham Docks

Immingham freight terminal near Grimsby in Lincolnshire is the busiest freight-only terminal in the UK, handling 55 million tonnes of cargo from across the world in 2019.

Killingholme Port

Killingholme is a freight terminal located on the south bank of the Humber estuary, near Grimsby in Lincolnshire. Ferries operate to the Hook of Holland, Rotterdam and Zeebrugge. The freight terminal is part of the larger Immingham facility.

Newhaven Port

Newhaven is a ferry and freight port at the mouth of the river Ouse in East Sussex. Up to three ferries per day arrive from Dieppe.

Poole Ferry Terminal

Poole Ferry Terminal handles both passenger and freight ferries, with the addition of cruise liners. The terminal handled 800,000 tonnes of cargo in 2019. Passenger ferries serve destinations to France and the Channel Islands.

Portsmouth Docks

Portsmouth international ferry terminal is both a freight and passenger port with regular ferries to France, Spain, the Channel Islands and the Isle of Wight. Portsmouth handled 3.5 million tonnes of freight in 2018.

Purfleet Docks

Purfleet is a freight-only port on the bank of the River Thames near Purfleet in Essex. Along with Tilbury and several other ports, it makes up the Port of London, the second biggest in the UK, handling 53 million tonnes of cargo in 2019.

Tilbury Docks

Tilbury is a freight-only port on the bank of the River Thames near Tilbury in Essex. It is 22 nautical miles east of London, making it part of the major port for the capital, and handles mainly container traffic. Tilbury, Purfleet and several other ports make up the Port of London, the second biggest in the UK handling 53 million tonnes of cargo in 2019.

Appendix III 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/

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 STHFs 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).

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

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