Report on an unannounced inspection of

Tinsley House Immigration Removal Centre

by HM Chief Inspector of Prisons

17 April – 5 May 2023

Contents

Introduction 3

What needs to improve at Tinsley House Immigration Removal Centre 5

About Tinsley House Immigration Removal Centre 7

Section 1 Summary of key findings.. 9

Section 2 Leadership 11

Section 3 Safety 13

Section 4 Respect... 23

Section 5 Activities.. 38

Section 6 Preparation for removal and release... 41

Section 7 Progress on recommendations from the last full inspection reports 45

Appendix I About our inspections and reports 53

Appendix II Glossary 57

Appendix III Further resources 59

Appendix IV Summary of detainee interviews.............................. 60

Introduction

Tinsley House Immigration Removal Centre (IRC) is a modern facility adjacent to the runway at Gatwick Airport. Operated by Serco since May 2020 it has been managed jointly with the nearby Brook House as Gatwick IRC. Although the centre is capable of holding up to 162 almost exclusively adult male detainees, operational capacity had been reduced to below 100 at the time of our inspection, with just 50 men detained. We were told this reduction was a consequence of staff shortages among the on-site Home Office Detention Engagement Team; we found that it had been reasonably successful in ensuring a realistic work/resource balance. The centre also provided a separate, small pre-departure facility, which had been used very rarely in the last three years.

The centre remained a generally stable facility, a notable achievement considering recent disruptions to operations. Lately, Tinsley had been re-purposed as bail accommodation and latterly as an immigration short-term holding facility (STHF), only returning to use as an IRC in late 2022. We last inspected it in 2018 when we reported reasonably good outcomes for detainees in three of our healthy establishment tests and good outcomes in preparation for removal and release. At this inspection, while outcomes in preparation for removal and release had slightly deteriorated, we judged outcomes in all four tests to be reasonably good.

We found a safe and respectful centre, where violence was rare, and when it did occur, was not often serious. Facilities and access to services were generally satisfactory and mainly predicated on respectful staff-detainee relationships, reflecting a positive institutional culture. Leadership was strong and provided good direction; this, in turn, was leading to improvements, although there was some sense that Tinsley House was considered merely an annex to the larger Brook House. The disaggregation of institutional data would be a useful first step in the process of better understanding the distinctive needs of the centre.

Beyond this, our findings suggested there was a need to speed up processes and decision-making in relation to those facing removal, while also making sure there was better support for those detainees – more than half – who were ultimately released into the community. Linked to these issues, we found that medical assessments concerning those thought to be victims of torture (Rule 35) lacked clarity and depth. The promotion of equality was limited and while we found some useful facilities in education, the library and gymnasium, the potential of the latter two was not being fully realised and relatively few detainees were making use of them.

This was a good inspection of a well-led and respectful IRC. We identify some issues of concern in our report, which we hope will assist with ongoing improvement.

Charlie Taylor
HM Chief Inspector of Prisons
June 2023

What needs to improve at Tinsley House Immigration Removal Centre

During this inspection we identified eight key 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 HMI Prisons.

Priority concerns

1. **Casework, including decision-making and obtaining travel documentation for detainees' removal, was often not progressed promptly.** Many were not released on bail despite long delays and barriers to removal.

2. **Most Rule 35 assessments** (see Glossary) **contained insufficient detail, some reporting was vague and most made no clear finding on the likely impact of detention on detainees' health.** Detention engagement team (DET) staff no longer monitored the timeliness of Home Office responses and there was evidence of some excessive delay.

3. **Interpreting services were not used consistently with those who did not know English well.** Translated documents were available but not routinely issued to detainees when required.

4. **Fair treatment was not being promoted through effective use of data or consultation with members of minority groups.**

Key concerns

5. **IT problems meant staff could not access a reliable report of detainees assessed to be at risk in any immigration removal centre.** Staff in Tinsley House were not aware of all detainees assessed to be at risk.

6. **The provision of education was limited and oversight was weak**. There was no monitoring of education attendance, measuring of progress or professional development of teachers.

7. **The library was poorly organised and lacked oversight.** There were still no systems to manage borrowing, monitor use or replenish stock. The range of books in the library did not meet the needs of the detainees.

8. **The needs of those leaving the centre were not always met.** There were delays in securing bail accommodation, and the needs of

vulnerable detainees and those released homeless were not systematically assessed and addressed.

About Tinsley House Immigration Removal Centre

Task of the establishment
To detain men subject to immigration detention, and families prior to their removal from the United Kingdom.

Certified normal accommodation and operational capacity (see Glossary)
Detainees held at the time of inspection: 50
Baseline certified normal capacity: 162
In-use certified normal capacity: 162
Operational capacity: 97

There was a temporary cap on capacity due to understaffing in the local Home Office team.

Population of the centre
- Around 40 new detainees received each month in the previous three months.
- 51% of those held had previously completed a prison sentence.
- Around a third of the population were Albanian nationals.
- Three detainees had been in immigration detention for longer than one year.

Name of contractor
Serco

Escort provider: Mitie
Health service commissioner and provider: NHS England; Practice Plus Group
Learning and skills provider: Serco

Location
Gatwick Airport

Brief history
Tinsley House has the capacity to hold 162 men and a suite to accommodate families denied entry to the UK, as well as a pre-departure accommodation (PDA) facility for up to two families, and the Borders suite to hold women and families overnight before they were returned to the airport from where they had come. The centre was used periodically as bail accommodation and as a short-term holding facility during the COVID-19 pandemic, and resumed use as an IRC in November 2022. Since May 2020, Tinsley House has been managed jointly with the nearby Brook House IRC as Gatwick IRC.

Short description of residential units
Bedrooms accommodate between two and six men, with communal showers and toilets on each residential corridor. The PDA could accommodate up to two families, and the Borders suite up to five people.

Name of centre manager and date in post
Steve Hewer, May 2020

Changes of centre manager since the last inspection
Phil Wragg, in post until May 2020

Independent Monitoring Board chair
Neil Beer

Date of last inspection
3-19 April 2018

Section 1 Summary of key findings

Outcomes for detainees

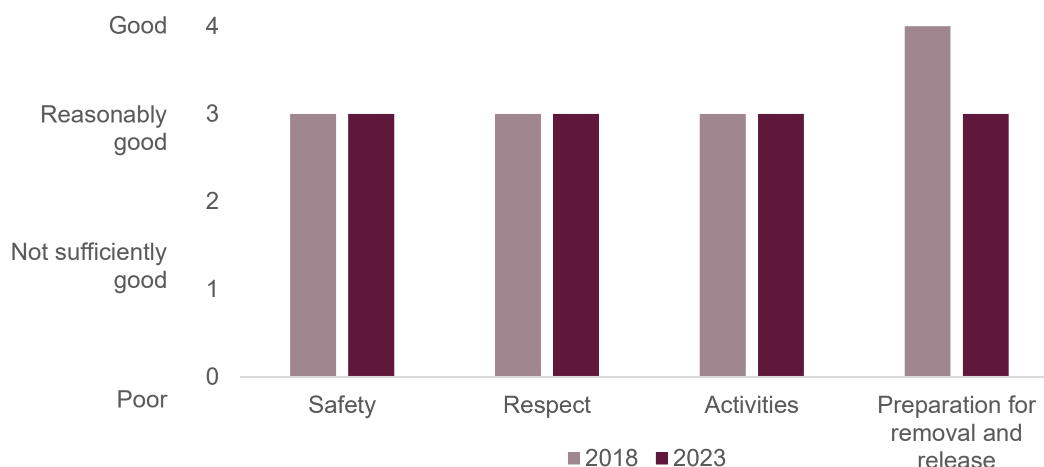
1.1 We assess outcomes for detainees against four healthy establishment tests: safety, respect, activities, and preparation for removal and release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of Tinsley House IRC, we found that outcomes for detainees were:

- reasonably good for safety
- reasonably good for respect
- reasonably good for activities
- reasonably good for preparation for removal and release.

1.3 We last inspected Tinsley House in 2018. Figure 1 shows how outcomes for detainees have changed since the last inspection.

Figure 1: Tinsley House Immigration Removal Centre healthy establishment outcomes 2018 and 2023



Progress on key concerns and recommendations

1.4 At our last inspection in 2018, we made 50 recommendations, two of which were about areas of key concern. The immigration removal centre fully accepted 37 of the recommendations and partially (or subject to resources) accepted nine. It rejected four of the recommendations.

1.5 At this inspection we found that one of our recommendations about areas of key concern had been achieved and one had not been achieved, both in the area of safety. While the centre had achieved a recommendation on disproportionate restriction on detainees' freedom

of movement, a recommendation on monitoring rule 35 reports had not been achieved.

1.6 In 2018, we also conducted a separate inspection of the family pre-departure accommodation at Tinsley House and made 13 additional recommendations, one of which was about an area of key concern. The IRC fully accepted nine of these recommendations and partially accepted three. It rejected one of the recommendations. We also inspected these recommendations at this inspection, apart from the key concern in the area of preparation for removal and release.

1.7 For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

1.8 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 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for detainees. (For definition of leaders, 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.

2.1 Tinsley House immigration removal centre (IRC) has had a reasonably positive institutional culture for several years, reflected in our previous inspections. Some managers and staff who have served Tinsley House for a number of years have helped to preserve this, with an atmosphere of relative informality and a more open regime than at many IRCs. Leaders were confident in their day-to-day roles.

2.2 These benefits of continuity have been challenged, however, by a rapid sequence of changes to the institution's purpose over the last three years. This has seen Tinsley being used first as bail accommodation and then as a short-term holding facility. The switch back to full IRC status began suddenly in November 2022 and was only confirmed in January 2023. Since then, the deployment of staff has been gradually returning to the configuration needed for full operation as an IRC. At the time of inspection, most of the features of an IRC had been restored, but there was still some way to go in delivering improvements, for example, in education, and in diversity and inclusion.

2.3 Staff at Tinsley House felt, with some justification, that the attention of senior managers in Gatwick IRC (which managed both Tinsley House and the nearby Brook House) was primarily on Brook House. We judged that the next stage in work towards a creative and positive regime at Tinsley was likely to need specific attention to it as a discrete site with its own potential. There was already some good collaborative working, including the work of the security team with other departments.

2.4 Data on some key aspects of the operation of Tinsley House, including activities and equality issues, were not well used to drive improvement, particularly when they were not separated from the figures for Brook House. An exception was the health care service, where data were well used, including some that were Tinsley-specific, and where the head of health care gave a strong lead with a clear focus on quality and improvement.

2.5 Leaders gave attention to the staff culture. A long-term project was under way across Gatwick IRC, with academic guidance, to increase a sense of participation and build an atmosphere of community among all staff (see paragraph 4.4).

2.6 Governance was not always sound in areas of safety, such as safeguarding and management of behaviour. Despite the small number of incidents, it was the responsibility of leaders to keep the framework of oversight robust.

2.7 Local Home Office staff were well engaged with detainees and with the running of the centre. The detention engagement team (DET) was working hard to deliver a good service in spite of staffing pressures. Frustrations with the slowness of immigration processes, particularly in finding bail accommodation for those due for release, related mainly to factors beyond the control of local managers.

2.8 The pre-departure accommodation (PDA) for families had been used once, just before our inspection, after a long interval. While this level of activity was not sufficient for us to draw solid conclusions about the PDA's readiness to deliver good care, its leadership was committed, with the welcome addition of social work input.

Section 3 Safety

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

Arrival and early days in detention

Expected outcomes: Detainees travelling to and arriving at the centre are treated with respect and care. Risks are identified and acted on. Detainees are supported on their first night. Induction is comprehensive.

3.1 There had been 125 arrivals at the centre in the previous three months, which was far fewer than in the same period before our previous visit. Most arrivals were from prisons, police stations or holding rooms at immigration reporting centres.

3.2 Many detainees continued to arrive at the centre at night; between January and March 2023, 47 of the 125 had arrived between 10pm and 6am. Most detainees were dealt with promptly once they arrived in reception, and staff told us they would prioritise any who were vulnerable, but on one busy day we saw some detainees wait over three hours before they were processed and taken to their rooms. However, all those who responded to our survey said they were treated well by reception staff.

3.3 The reception area was clean and adequately furnished with comfortable sofas and a TV, and also had toilet facilities and refreshments. An informative booklet was available in different languages and gave a brief overview of the centre, but professional telephone interpreting was not always used with those who understood little English. Detainees could not have a shower in reception but could readily do so once they were taken to their room. Clean clothes were provided to those who needed them.

Tinsley House reception

3.4 Detainees were checked at least three times during their first night, and 75% of respondents to our survey said that they had felt safe on their first night there. There was no dedicated first night accommodation, with detainees lodged directly into rooms on the main corridors. Some detainees were given a centre induction tour as soon as they arrived at their rooms, but for those arriving very late, this should have been left until the morning when they were rested.

3.5 The induction processes we observed with welfare staff were adequate but could have provided detainees with more detail on the support they could offer. Interpreting services were sometimes used where required, but translated documentation was not always made available.

Safeguarding

Expected outcomes: The centre promotes the welfare of all detainees and protects them from all kinds of harm and neglect. The centre provides a safe environment which reduces the risk of self-harm and suicide. Detainees at risk of self-harm or suicide are identified at an early stage and given the necessary care and support.

Safeguarding of vulnerable adults

3.6 The centre had a whistleblowing policy and staff knew how to raise concerns through Serco's confidential corporate helpline. There had been no calls to the helpline in the last 12 months and no concerns raised on the centre's safeguarding helpline. No allegation of staff misconduct had been referred to the Home Office's Professional

Standards Unit in the last 12 months. The Home Office convened very regular professional standards meetings with Serco to oversee this area of work.

3.7 Custodial staff we spoke to had limited understanding of adult safeguarding, modern slavery or the policy on adults at risk. Serco had made no adult safeguarding or modern slavery referrals in the last 12 months. In the same period, Home Office staff had made 39 modern slavery referrals.

3.8 Local records showed that four detainees were assessed by offsite Home Office caseworking teams at level 2 of the Home Office's adults at risk in detention policy because there was professional or other evidence that they were at risk. None were assessed at level 3, the highest level of risk, indicating there is additional evidence that detention is likely to cause the detainee harm.

3.9 Although recorded levels of vulnerability were relatively low, ongoing problems with the Home Office's detainee case management system meant there was no ready access to a reliable report of detainees assessed to be at risk in any immigration removal centre. We were not, therefore, satisfied that staff based in any centre were aware of all detainees assessed to be at risk. In one case, a detainee with post-traumatic stress disorder (PTSD) and depression was held for over three months in Tinsley House without onsite Home Office, custody and health care staff knowing that he had previously been assessed as a level 3 adult at risk. In consequence, no vulnerable adult care plan was opened for him and his case was not discussed at the weekly vulnerable residents meeting. His vulnerability was finally recognised about four months later, after he was discovered researching how to take his life.

3.10 In the previous six months, there had been 25 rule 35 reports (concerning special illnesses and conditions, including torture claims – see Glossary). Twenty-four of the reports concerned torture, and one was opened because the staff suspected a detainee of having suicidal intentions. Home Office data showed that 12 of the 24 reports considered had resulted in the release of the detainee.

3.11 We reviewed a sample of 10 rule 35 reports; nine concerned torture and one suicidal intention. GP assessments generally contained insufficient detail and some findings were vague. GPs did not explore some key allegations of torture with detainees, nor did they always record findings on how significant scarring might have been caused.

3.12 Reports consistently addressed the psychological impact of torture, which was an improvement on findings in our last inspection. However, most made no clear finding on the likely impact of detention on detainees' health. The health care provider had recognised that there were some weaknesses in rule 35 reporting, and there were appropriate plans to address this (see paragraph 4.50).

3.13 Rule 35 reports were considered by an offsite Home Office casework team. Detention engagement team (DET) staff no longer monitored the timeliness of the team's responses and there was evidence of some unacceptable delay. In one case, it took over 10 weeks for the Home Office to reply to a report that a detainee had been tortured. In another, the Home Office took three weeks to respond to a report for a suicidal detainee who had been discovered researching how to take his life (see paragraph 3.9).

3.14 The Home Office accepted evidence of torture in seven out of the nine torture cases in our sample. These detainees were assessed at level 2 of the adults at risk policy (see paragraph 3.8). No detainees were released as a result of this assessment. Detention was maintained in four cases because it was considered that negative immigration factors outweighed the detainees' vulnerability. Three detainees were released before consideration of the report. In one of these cases, the Home Office unfortunately refused to consider the report and assess the evidence of torture because of the release.

3.15 The Home Office considered that two reports of mistreatment did not fall within its definition of torture. In one case this was justified as there was no evidence the detainee had suffered harm. The other involved a man who had been trafficked to the UK and was mistreated, possibly severely. The Home Office did not consider that this report met the definition of torture because the GP's account of the mistreatment was unclear. Normally, under Home Office policy, such a report would have been referred back to the GP with a request for greater clarity.

3.16 Three vulnerable adult care plans had been opened in the last six months for detainees assessed to be at risk. Plans generally documented good multidisciplinary care planning with the detainee. Observations also showed some good support for detainees, although night-time observations for detainees who presented no self-harm risk were unnecessary and intrusive.

3.17 There was consideration of the needs of more vulnerable detainees in the vulnerable residents meeting, although meetings would have had greater value if Home Office caseworkers had more often taken part. It was good that a Serco-employed social worker was available to assist more vulnerable detainees, and to support the consideration of cases in the vulnerable residents meeting.

Self-harm and suicide prevention

3.18 The level of self-harm was low. In the previous six months, there had been six self-harm incidents involving two detainees. However, there were concerning features in the case of a segregated detainee, as he had repeatedly attempted to ligature himself while on constant watch due to his self-harm risk. The investigation of these incidents was not thorough and did not consider them in sufficient detail to learn lessons.

3.19 The centre re-opened as an IRC in November 2022 with the short notice transfer of 59 detainees from Harmondsworth following a

disturbance there. About six had been on assessment, care in detention and teamwork (ACDT) case management for risk of self-harm in Harmondsworth, but this documentation was never forwarded to Tinsley House.

3.20 In the previous six months, 12 ACDT documents had been opened, with the Home Office notified appropriately. Case reviews took place in a confidential setting and were no longer interrupted by other staff.

3.21 ACDT assessments were mostly reasonable, but some lacked detail. Some care plans were weak, but planning was better in more recent cases. Health care staff consistently attended case reviews, which contributed to good consideration of risk. However, reviews were undermined by poor attendance of DET staff, since immigration and detention were key factors in all the cases that we reviewed. Staff observational entries generally showed good engagement with the detainee.

3.22 Five detainees had been placed on constant watch in the last six months. There was a need to make sure that the reasons and evidence justifying such decisions were recorded correctly and taken fully in to account. The care suite provided a reasonable environment to look after such detainees.

3.23 Thirteen detainees had been monitored for food and fluid refusal in the last six months. There were appropriate arrangements for the care of such detainees, and clinical records now demonstrated good health care support.

3.24 No calls had been made to the centre's safer communities helpline in the last six months. We left a test message left on the helpline and the response was prompt.

3.25 The Samaritans had not been visiting the centre since the outbreak of the pandemic, but there were advanced plans for their volunteers to resume visiting to give face-to-face support to detainees. Detainees could make free phone calls to the Samaritans on phones provided by the centre.

Safeguarding children

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

3.26 The policy for safeguarding children was adequate, but managers were no longer attending meetings with West Sussex safeguarding children board. Staff received training in child protection in their initial training course. Although staff assigned to work in the pre-departure accommodation (PDA) received enhanced initial training, they were not receiving refresher training.

3.27 There were appropriate arrangements to safeguard children held in PDA. Shortly before the inspection, the PDA was used for a family for the first time in three years. An attempt to remove the family directly from the community had failed, and three children, aged 5, 4 and 2, were detained with their mother for almost a week before they were released (see also paragraphs 4.54 and 6.21).

3.28 The centre had contingency plans if a detainee claimed to be a child. In the last 12 months, five unaccompanied detainees had said they were children. All were held while the centre was operating as a residential short-term holding facility, and all had previously been assessed as adult by immigration officers. They included three Sudanese detainees who arrived in the centre together. Brief notes of the age assessments stated the detainees 'did not present as significantly under 18 yrs old' and that their 'demeanour, general presentation, and emotional responses would indicate that they are either very close to being adult or ranged 18 to early 20s'. This suggests that the assessors failed to apply the correct legal test for 'abbreviated' age assessments and give the detainees the benefit of the doubt (under Home Office policy, the detainees should have been treated as children unless their physical appearance and demeanour very strongly suggested they were significantly over 18). They were held for a week before taken into care by West Sussex social services following the intervention of Gatwick Detainees Welfare Group. Two were subsequently assessed as being children; the third was appealing the assessment that he is adult.

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.

3.29 The centre remained fundamentally safe and calm, and violence was rare. There had been seven incidents in the last six months – three assaults on detainees and four on staff. All were low-level incidents, and none had resulted in any injuries. Staff had handled these incidents appropriately.

3.30 Data on violence were recorded, but as it was so infrequent it was difficult for managers to identify meaningful trends. Individual incidents were discussed at the monthly safer communities meeting, and suitable action had been taken when necessary. At the time of the inspection, the centre was rolling out a new anti-bullying and violence reduction policy, which contained appropriate measures.

3.31 In our survey, 17% of detainees said they felt unsafe, which was fewer than at other IRCs and the previous inspection. In our detainee interviews, no participants raised any concerns about safety or abusive behaviour; in our survey 90% said they had never experienced abuse

from other detainees, and 100% that they had never experienced abuse from staff.

3.32 At the time of our inspection, 51% of detainees were former prisoners, which was higher than we usually see in IRCs. This had not led to heightened levels of violence or poor behaviour, and detainees mixed without problem.

3.33 Detainees were given clear rules on how to behave in the centre, in their own language. Perpetrators or victims of violence were managed through tackling antisocial behaviour (TAB) documents. Two of these had been opened in the previous six months, but their use had been inconsistent. TABs had not been opened after all incidents and, when they were, they were not used to facilitate investigation and support. The TAB documents did not allow for target setting or meaningful engagement to improve behaviour, and were being phased out in favour of an improved system for managing behaviour.

3.34 Detainees who displayed persistently poor behaviour could be moved to Brook House, which provided a more secure environment. Records showed that this was not done disproportionately, and that transfers due to challenging behaviour had been appropriate.

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.

3.35 Detainees' freedom to move around the centre had improved since the last inspection – they now had access to communal facilities from 7am to 10pm, but were restricted to their corridor for two 30-minute roll checks throughout the day. Detainees were never locked in their rooms and could move around the residential corridors at night and during roll checks.

3.36 Security remained well managed and generally proportionate, and incidents were infrequent. The centre had received 276 security incident reports in the previous six months, and these were processed promptly. It was positive that staff from the security department had been actively engaging with other staff to encourage them to submit intelligence.

3.37 Security information was analysed at monthly meetings that covered both Brook House and Tinsley House. Although security incidents were less common at Tinsley, information about the centre fed into risk assessments and actions. A small group of managers continued to meet to review any intelligence on possible staff corruption, but there had been no serious concerns at Tinsley House.

3.38 Detainees were given rub-down searches on arrival and before any visits or meetings with Home Office staff or legal representatives. No

detainees had been strip-searched in the previous six months. It was positive that room searches were now conducted on an intelligence-led basis, as opposed to routinely.

3.39 It was also positive that detainees leaving the centre on escorts to hospital were no longer routinely handcuffed. In the last six months, only around half of detainees on escorts had been cuffed following a risk assessment. There had been one attempted escape during an escort in December 2022, but this had not led to the use of disproportionate practices.

3.40 Drugs and alcohol were not prevalent in the centre. There had been three finds in the previous six months, all of which were handled appropriately. There was a suitable policy to address any substance misuse.

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.

3.41 There had been 10 uses of force in the previous six months, all of which were unplanned. They were all low-level and involved guiding holds to defuse altercations or to prevent a detainee from self-harming. In the video footage of these incidents we viewed, force was justified, and was used briefly and proportionately.

3.42 Body-worn video cameras were used in almost all incidents and showed staff making good efforts to de-escalate situations, although this was sometimes undermined by not using interpreting. In some instances, large numbers of staff responded to relatively minor incidents without making a positive contribution, thus hindering efforts at de-escalation.

3.43 Governance of the use of force was appropriate. Centre managers and the Home Office reviewed all incidents within 24 hours and were able to flag any immediate concerns. Monthly use of force meetings, which included Brook House, also reviewed footage and identified any areas for improvement. Most of the documentation we reviewed was adequately detailed and timely.

3.44 Separation under rule 40 (removal from association in the interests of security or safety) had been used three times in the previous six months, for an average of around 17 hours. Records showed reasonable justification in all cases, but some were imprecise and did not always fully explain why alternatives were not suitable. Reviews for detainees held on rule 40 were multidisciplinary and included input from health care staff. The room used to hold detainees on rule 40 separation was in good condition.

3.45 Centre policy stated that detainees separated under rule 40 could be offered limited access to the regime during roll check periods, but logs showed that this had not happened in all three recent cases. Temporary confinement under rule 42 had not been used in the last six months.

Legal rights

Expected outcomes: Detainees are fully aware of and understand their detention, following their arrival at the centre and on release. Detainees are supported by the centre staff to freely exercise their legal rights.

3.46 The Home Office detention engagement team (DET) was very understaffed and stretched – the centre's operational capacity had been reduced on account of this. However, it was able to provide a suitable level of service to the reduced number of detainees held at Tinsley. All detainees were given an induction by Home Office staff, received monthly updates on their immigration cases and could see a member of the team on request. The DET also facilitated a weekly surgery. In our survey, only 33% of detainees said that the Home Office were keeping them informed about their case, but when we spoke to detainees most told us that this was due to a lack of progress by caseworkers rather than the unavailability of the DET.

3.47 At the outset of our inspection, the longest period a detainee had been held at Tinsley House was 165 days. The average cumulative time spent in detention, including time spent in other centres, was 79 days, which was higher than we usually see. Three detainees had been held for over a year, with the longest held for 444 days, which was unacceptably long. Home Office managers recognised that the available data on time held in detention were not reliable, and we could not be confident that the average length of cumulative detention provided was accurate.

3.48 We examined the cases of 10 detainees to assess the effectiveness and efficiency of Home Office caseworking and identified several common issues. Many detainees faced long waits for bail accommodation, with some exacerbated by poor communication between the Home Office and the probation service. In one case, a detainee had been bailed in July 2022 pending the identification of a suitable address, but he remained in detention because of delays.

3.49 Some cases had been greatly delayed while the Home Office attempted to secure travel documents that would allow a detainee without a passport to be removed to their home country. In others, detained asylum casework had been slow. We found examples of detainees with significant barriers to removal, such as judicial reviews with no set timescales, and nationals of countries where return processes were currently suspended who continued to be held. This was despite minimal likelihood of removal in a reasonable timescale and, in many cases, despite the Home Office's case progression panel

recommending their release. Many detainees told us that slow case progression was a major frustration to them.

3.50 Detainees could access free legal advice through the Detained Duty Advice Service. Two sessions a week took place, all now face-to-face. Provision was good, but many detainees were dissatisfied as legal representatives chose not to take on their cases. The centre's welfare team was active in supporting detainees to find a new representative when this happened.

3.51 The library provided a small range of legal textbooks, although not all of these were up to date. The computers in the library allowed detainees to access several useful websites, which were helpfully pinned to the home page for ease of access.

3.52 The video-link technology in the centre was broken, so that detainees who had bail hearings were unable to use it and had to dial in on a telephone, which was inappropriate. We were told that this would be fixed shortly.

Section 4 Respect

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

Staff-detainee relationships

Expected outcomes: Detainees are treated with respect by all staff, with proper regard for the uncertainty of their situation and their cultural backgrounds.

4.1 Relationships between staff and detainees were a real strength of the centre. The reduced population now held gave staff more opportunity to develop relationships with detainees. In our survey, all detainees said most staff were respectful, and none reported any adverse behaviour from staff.

4.2 We observed positive interactions between staff and detainees throughout the inspection across all staff groups, whether supervising and engaging in activities, talking with detainees or making sure basic requests were actioned. Detainees whom we interviewed described most staff as polite and respectful.

4.3 While detainees were not allocated their own named officer to keep in touch with them, officers held meetings with each detainee twice in their first month of arrival and then monthly, while exploring their welfare and personal circumstances. Records demonstrated that these meetings were frequent and that staff took the time to address the issues raised. In our survey, 91% of detainees, compared with 55% at our previous inspection, now said that they had a member of staff to turn to for help.

4.4 An in-depth and innovative project had been established in collaboration with ‘the appreciative partnership’ (a ‘positive psychology’ consultancy), with the aim of developing a positive detention culture. This involved a large proportion of staff in discussion and data collection, and while it was too early to trace clear effects, the level of engagement by leaders and staff, and the emergence of some early data, were encouraging.

Daily life

Expected outcomes: Detainees live in a clean and decent environment suitable for immigration detainees. Detainees are aware of the rules and routines of the centre. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair. Food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

Living conditions

4.5 Living conditions were generally good. Communal areas were clean, and 96% of respondents to our survey confirmed that communal and shared areas were normally clean. Outside areas were well maintained and pleasant.

Corridor in the IRC

Outside area with football goals

4.6 Ventilation remained a problem and the temperature in detainees' rooms was often too hot, made worse by non-opening windows. During our inspection, a few rooms were taken out of service because of temperature problems.

4.7 Most of the accommodation was in rooms on two corridors, containing two, four or six beds. These were generally well equipped and in a reasonable condition. Lockable cupboards were available, but storage space was often limited.

Typical room

4.8 There were separate showers and toilets on the corridors. These were in good condition and appropriately screened, but the drains smelled foul. In our survey, 96% of respondents said they could have a shower every day.

4.9 Association areas were adequate and recreational equipment, including some limited gym equipment, was available (see paragraph 5.1).

4.10 The corridors were often noisy at night. In our survey, 73% of detainees said it was quiet enough to sleep at night, which was better than 42% in our 2018 survey, but some told us about noisy behaviour by residents that was not challenged by staff.

4.11 Detainees were issued with clean bedding on arrival. The laundry area was freely accessible to detainees and was adequate and well maintained. In our survey, 92% of respondents said that they normally had enough clean, suitable clothes for the week.

4.12 Detainees’ property was stored securely in reception when they arrived; 81% of respondents in our survey said they could get access to their property when they needed it, compared with only 45% at our last inspection.

4.13 The family rooms in the Borders suite and pre-departure accommodation were welcoming and bright, and a range of activities were available to keep children occupied and entertained.

Family detention accommodation

Family detention accommodation

Detainee consultation, applications and redress

4.14 Wing forums were held every week, giving detainees on each corridor the opportunity to provide feedback on topics such as food, regime and activities, shop, accommodation and staff-detainee relationships. However, they were not always well attended. Minutes of the meetings were not always sufficiently detailed: they were displayed on a notice board and available via the detainee electronic information kiosks, but only in English. Monthly resident consultative committees were held and chaired by the deputy director of the centre, although the numbers attending varied.

4.15 There were few complaints – just nine in the five months since the centre had reopened as an IRC – and they were generally handled well. In our survey, 90% of those who had made a complaint said that it had been dealt with fairly, compared with 25% at the previous inspection. Most responses to complaints showed thorough investigation. A regular meeting to review and quality-assure complaints had recently been introduced, but it did not consider equality issues.

4.16 Complaint forms in a variety of languages were freely available, but required updating. Although there were complaint boxes on the corridors and in the library, they were not readily identifiable.

Residential services

4.17 The food was adequate and plentiful, and it was served at appropriate times. A four-week menu cycle was operating, and specialist diets could be catered for in conjunction with the health care department. In our survey, 80% of detainees said the food was good.

4.18 All meals offered a hot option. Detainees had to eat their meals in the communal dining room. Catering staff attended the weekly wing forums and consultative committees to address any concerns and, where possible, this led to changes in the menu.

4.19 The kitchen was clean and the equipment was mostly in good working order. As at our previous inspection, however, halal and non-halal food continued to be stored together inappropriately.

4.20 There were limited options for detainees to cook for themselves. They had access to hot water, and a microwave oven was available in the shop. There were toasters in the dining room, but access to them was restricted to mealtimes. Detainees could cook food from their culture in the 'cultural kitchen', which was equipped with ovens, hobs and microwaves and was now available seven days a week, but it was underused. The catering department supported this valuable resource by providing a range of ingredients.

Cultural kitchen

4.21 The shop continued to provide a good service and offered a variety of products, including fresh fruit, but some detainees complained they could not purchase vapes; this was said to be due to the sensitivity of the centre's fire alarm system. The centre facilitated online shopping, provided there were no security restrictions.

Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality and diversity, underpinned by processes to identify and address any inequality or discrimination. The distinct needs of detainees with protected and any other minority characteristics (see Glossary) are recognised and addressed. Detainees are able to practise their religion. The multi-faith team plays a full part in centre life and contributes to detainees' overall care and support.

Strategic management

4.22 The centre needed to do much more to understand and respond to the diverse needs of detainees. Strategic management of equality work remained underdeveloped. Senior staff had been appointed to lead work on each protected characteristic, but this had not yet produced any positive results and no forums had been held.

4.23 There was an equality policy and action plan; monthly diversity and inclusion meetings were held, but were poorly attended. Data were collected and analysed on a few key areas, such as use of force, but only covered the previous month's activity, which lacked a rigorous approach to detecting any disproportionate outcomes.

4.24 An assistant director led the centre's equality work, supported by two liaison officers, and there was a cycle of activity to support the celebration of key diversity and inclusion events, but the noticeboard advertising these events and other information was in English only. There were no detainee equality representatives. There had been no complaints involving allegations of discrimination in the previous five months.

Protected characteristics (see Glossary)

4.25 Health staff and Home Office DET staff made good use of professional telephone interpreting, but we were not satisfied that other staff always used this when necessary. For example, it was only used in other parts of the centre twice in January 2023 and eight times in February. In our survey, 43% of respondents said that they understood spoken English and 50% that they understood written English. Some staff had access to hand-held interpreting devices that they used to communicate with detainees, but this was not always successful (see paragraph 6.4). Much useful information had been translated into the most common languages, but this was not always issued to detainees and many notices throughout the centre were still in English only.

4.26 The centre was unable to tell us if it had held any detainee with a physical disability in the previous five months as it incorrectly believed that this information was confidential and could not be shared by health care colleagues. In our survey, 33% of respondents considered themselves to have a disability. There was no adapted accommodation

for detainees with a physical disability, but staff said individual support was provided where required.

4.27 One-fifth of detainees responding to our survey said they were gay, bisexual or other sexual orientation: this was more than were known to the centre. A constructive and individualised approach had been taken to the recent care of a transgender woman.

4.28 Six women and a family had been held in the last few months in the Borders and PDA. These self-contained units allowed women to be held separately from the male population. Just under 40% of staff across the Gatwick IRC (comprising Tinsley House and Brook House) were women.

Faith and religion

4.29 Committed and supportive chaplaincy staff made themselves available to speak with detainees across the centre. In our survey, 96% of detainees said that they had a religion, 86% said their religious beliefs were respected and 63% that they could speak to a chaplain of their faith in private. There was now a full-time religious affairs manager for the whole of the Gatwick IRC, and almost a full team of religious chaplains, pending vetting for one recruit.

4.30 Since our previous inspection, the multi-faith room had been adapted to allow two services to take place at the same time in privacy. There was good provision for the most common faiths, with weekly communal worship, and detainees had free access to the chapel and multi-faith room during association.

4.31 The chaplaincy worked well with equality and catering staff to promote the celebration of religious festivals, and appropriate arrangements had been made for Ramadan and Eid.

Health services

Expected outcomes: Health services assess and meet detainees' health needs while in detention and promote continuity of health and social care on release. Health services recognise the specific needs of detainees as displaced persons who may have experienced trauma. The standard of health service provided is equivalent to that which people expect to receive elsewhere in the community.

4.32 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) (see Glossary) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies.

Governance arrangements

4.33 NHS England (NHSE) had commissioned Practice Plus Group (PPG) to provide health care services at both Tinsley House and Brook House

since September 2021. PPG subcontracted some services, including GP sessions to a regular agency.

4.34 NHSE monitored the contract by regular data submissions, review meetings and onsite quality visits. Quarterly partnership board meetings and monthly local quality delivery board meetings were well attended by key stakeholders, including Serco, NHSE and Home Office representatives, with a focus on pertinent issues to improve and enhance the service. The procurement process for a new health needs analysis had started, with one planned for 2024.

4.35 The service was well-led by a knowledgeable and experienced manager, supported by a caring and conscientious staff group who worked across both sites. There was a primary care nurse and usually a health care assistant at Tinsley House 24 hours a day, with other teams visiting regularly. Detainee access to services was prompt with minimal waiting times. The health team had shown flexibility and coped well with the changes of function of the centre when it returned to being an IRC in November 2022.

4.36 Clinical governance arrangements were effective, and areas for improvement and risks were appropriately identified. There was a low level of clinical adverse events at Tinsley House, with only eight incidents in the last six months. Staff we spoke to were aware of how to report incidents via Datix, the electronic reporting system. They were fully investigated and any lessons learned were shared with staff. There was a regular programme of audits, which had resulted in the implementation of improvements.

4.37 The patient engagement lead had established a monthly patient forum and met detainees who had any concerns to try to resolve them. Patient feedback was collated and reviewed monthly to inform service delivery.

4.38 There was a dedicated confidential health complaints system. There had been only one complaint during the last six months and it was appropriately managed. Face-to-face resolution meetings were held and telephone interpreting services used when needed, but printed information was only in English, which was a gap (see paragraph 4.43).

4.39 Infection control standards were adequate and regular cleaning was undertaken by Serco staff. The main clinic room required some refurbishment: this had been raised with Serco and at the quality delivery board and the service was awaiting resolution. Clinical equipment was calibrated annually.

4.40 SystmOne, the electronic clinical record system, was used by all health staff. Patient records were written comprehensively and in line with expected standards.

4.41 Training records indicated a good uptake of mandatory training for most staff and included level 3 adult and children safeguarding training. There were opportunities for professional development, which staff

were encouraged to take up, with regular access to supervision and managerial support.

4.42 Registered clinical staff were trained in immediate life support and had access to suitable and regularly checked equipment, which was in good order. In an emergency, officers would collect the nearest emergency bag so that health care staff could focus on attending to the patient.

4.43 Telephone interpreting services were used regularly for health consultations when needed, but there was limited health promotion information displayed or available in languages other than English. The service had identified this as a deficit and had started to address it.

4.44 Although there was no centre-wide approach to health promotion, the service was organising a health and well-being day to raise the profile at Brook House and then at Tinsley House. Detainees were offered access to screening for blood-borne viruses and other immunisation programmes and travel advice, but uptake was low despite encouragement and investigation of ways to increase it. Barrier protection was available, but not advertised. We were informed that detainees could smoke cigarettes but could not access vapes (see also paragraph 4.22). This meant that detainees who had vaped either gave up or started smoking cigarettes, which was more harmful to health. Smoking cessation services were available but uptake was low.

4.45 Communicable diseases were managed well and the team had good links with the UK Health Security Agency and local TB services.

Primary care and inpatient services

4.46 Detainees received a full health care screen on arrival and appropriate referrals were made to other services, such as the mental health team. All detainees were offered a GP appointment within 24 hours of their arrival.

4.47 The health team shared pertinent information with the centre and promptly highlighted any risks. This included informing the Home Office of any notable changes in the health of detainees by completing the required risk assessment form to review the appropriateness of detention.

4.48 Detainees had open access to a nurse clinic each day for services such as wound care and treatments for minor ailments. We observed detainees visiting each day and being seen immediately or after a very short wait. A GP visited every afternoon and there was a minimal wait, with routine appointments available either the same day or next.

4.49 There was good joint working between primary care nurses, health care assistants and GPs. Primary care staff made GP appointments for detainees when required and informed them when to attend. Assessments under rule 35 (see Glossary) were carried out within two to three days, and reports were prepared and shared with the Home

Office promptly. The reports varied in their quality and detail (see paragraphs 3.11 and 3.12). PPG had recognised this and had developed training material, which was a positive initiative. This had been implemented recently and all GPs had now attended. The quality of the reports was re-audited regularly to see if improvements had resulted from the training.

4.50 There were pathways to provide care and treatment to patients with long-term conditions such as asthma or diabetes. While the need for this service was low, such patients had a care plan and received annual reviews and medication to help manage their condition.

4.51 There were short waits for other services, such as the optician and physiotherapist, with detainees able to request these appointments through a paper form or by seeing a member of the health care team. External hospital appointments and escorts were well managed, and none had been cancelled in the previous six months due to a lack of escort staff.

4.52 If detainees arrived without an NHS number, they could now arrange for one to be issued, which had helped with registering detainees with a GP surgery before release. A nurse saw all detainees before they left the centre and gave them a copy of their medical records and at least two weeks' medication if they were on prescribed medicines.

4.53 A nurse saw the one family who had been in the PDA since the start of the pandemic promptly on arrival, and they were seen daily by the nurse and GP (see paragraph 3.27). They also had access to a mental health nurse. Since the last inspection, an age-appropriate reception template for children has been created but was not yet in use, although the screening was age-appropriate. All female detainees were offered a pregnancy test.

Mental health

4.54 The mental health team was based at Brook House and visited Tinsley House daily. There were some vacancies in the team, but they were covered by regular agency nurses and had not affected detainees' prompt access to the team.

4.55 The mental health team comprised a mental health social worker who was the team leader, experienced mental health nurses and a regular locum psychiatrist who attended Brook House weekly and visited patients at Tinsley House when needed. A psychologist was due to start to address the gap in psychology and counselling services, with a plan to employ a psychology assistant.

4.56 Referrals were received from custody staff, the primary care team, substance misuse team and detainees themselves. Referrals were triaged daily and prioritised by clinical need with assessments taking place promptly. Urgent referrals were seen within 24 hours and routine ones within five days.

4.57 At the time of the inspection, the service was supporting four detainees with regular sessions. Written records were of a good standard and all had care plans and risk assessments. During the previous six months, the team had completed 102 assessments and had attended and supported detainees on ACDT management. Health care staff participated in the vulnerable residents meeting and had been involved in creating vulnerable adult care plans.

4.58 Many detainees experienced anxiety and altered mood because of their detention and possible removal. The team offered support through psychologically informed approaches to address mild to moderate problems, which included guided self-help, coping strategies and short-term interventions.

4.59 Detainees with severe illness or psychosis were not admitted to the centre; if such problems emerged, they might be transferred to Brook House where more staff were based, or have a review of their detention. Complex patients could be discussed at the weekly team meeting with the psychiatrist and at the weekly multidisciplinary team meeting with representatives from all teams, which was valued by staff.

4.60 Detention staff received mental health awareness training during their induction and as part of their mandatory training.

4.61 No detainees at Tinsley House had required a transfer to a secure hospital bed under the Mental Health Act in the previous 12 months.

Substance misuse treatment

4.62 A joint agency substance misuse strategy covered supply reduction, and any issues were discussed at the monthly security committee meeting attended by the substance misuse team leader and health staff. There was little evidence that illicit drugs were prevalent in the centre.

4.63 All new arrivals were screened by a registered nurse for any substance misuse issues and referred to the team. Any detainee requiring alcohol detoxification or opiate substitution therapy would have been diverted elsewhere, including to Brook House, depending on clinical presentation.

4.64 The psychosocial substance misuse team provided a weekly drop-in session for detainees at Tinsley House and attended more frequently when needed. The demand for the service was very low, with no one receiving support from the team at the time of the inspection. In the last six months, the team had received 11 referrals and had responded swiftly to them.

4.65 Custody staff and health professionals could refer detainees and detainees could also refer themselves.

4.66 The team had information on harm minimisation and specific drug information in various languages, but none was displayed around the centre, which was a gap.

Medicines optimisation and pharmacy services

4.67 Medicines were stored securely, and staff ensured that patients received them when required. There were regular checks and audits to make sure that stock medicines remained in date and that staff were completing medicines records correctly. There was no record of medicines kept in two medicine stock cupboards, which meant that there was limited assurance that they were being used safely. Once we identified this, the service said it would rectify this.

4.68 Controlled drugs were not kept at Tinsley House because of a lack of appropriate storage and other security measures. Anyone requiring controlled drugs would go to Brook House.

4.69 Most patients had their medication in possession. Staff administered the medicines three times a day and contacted any patients who did not attend to collect them. Patients were notified when their in-possession medicines had arrived and had lockable storage in their rooms in which to keep medicines. Orders were placed with the supplying pharmacy and delivered the next day, apart from weekends and bank holidays. Arrangements could be made for emergency deliveries out of hours if necessary. Detainees now had access to a regular pharmacist-led clinic.

4.70 The provider had patient group directions to guide staff in providing some medicines and over-the-counter remedies without the need for a prescription. Staff were aware of these, and they were available for reference online.

4.71 Medicines in-possession risk assessments were completed for all detainees on arrival. A medicines reconciliation usually took place within 24 hours if a detainee had arrived with some medication.

4.72 The provider produced a monthly prescribing report that identified the most prescribed medicines at Tinsley House. This was discussed during medicines management meetings to identify any themes and patterns of prescribing, which helped to detect any issues.

4.73 Regular audits of medicines management were carried out by the regional pharmacist. Any issues identified were rectified and any learning from medicines incidents was shared.

Oral health

4.74 There was no onsite dental suite at Tinsley House, but a mobile dental service had been introduced in February 2023, funded by NHSE commissioners. This had greatly improved detainees' access to dental services and reduced pressure on primary care services. The mobile unit was managed by Community Dental Services, with Time for Teeth providing the dental treatment, and visited the centre fortnightly.

Detainees had access to the standard range of NHS treatments, such as fillings, extractions and dental X-rays. The dentist could prescribe pain relief and antibiotics.

4.75 Detainees could request appointments by completing a paper form or seeing a member of the primary care team, who would book an appointment. There were short waits for routine services, with appointments available within two to three weeks.

4.76 Community Dental Services arranged for the servicing of equipment on the mobile unit and we saw records that these were up to date. We were not able to see the unit during the inspection, but Time for Teeth staff commented that it was well maintained and they had not experienced any problems. Decontamination of reusable equipment was carried out on site.

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 centre offered a range of activities, including education, work, cultural cooking, a library, a gym and recreational areas. All activities were voluntary, and many detainees did not feel the need to take up work or education. In our survey, 55% of detainees said that they had enough to do.

5.2 Detainees had access to recreational areas and outside spaces for 13 and a half hours a day, with activity areas, such as education and the library, open for just under 10 hours. Outside these times, detainees were confined to residential corridors; it was positive that detainees were not locked in their rooms.

5.3 The outside courtyard was well presented, with an opportunity to sit and relax or use outdoor exercise equipment.

5.4 A cultural kitchen (see paragraph 4.20), available to use via an application, allowed small groups of detainees to cook and share food. The facility was good, but take-up was low; we saw it being used only once during the inspection.

5.5 There was a reasonable timetable of recreational activities available seven days a week, including various activities and competitions. However, the promotion of activities was limited to posters. In sessions we observed, activities staff engaged well with detainees.

5.6 Leaders did not record participation effectively for most activities, which meant they could not monitor whether the current provision met the needs of detainees.

Education and work

5.7 Provision for education was limited to English for speakers of other languages (ESOL) and art, similar to the last inspection. However, the two now took place in a shared classroom where previously there had been two separate spaces; this was not conducive to a good learning environment. Only one teacher was available at each session and was expected to support learners in both subjects, which was not appropriate. Leaders did not advertise which teacher would be in the classroom, so that detainees were not aware until they attended. There was a lack of consistency in the provision of teachers: for example, there could up to five different teachers at the centre within a week.

5.8 Leaders had no systems to monitor the education provision. Data were combined with those for Brook House, and Tinsley's education data

use was not separated, which meant leaders were not aware how frequently detainees were using the facility. During our inspection, attendance appeared to be low. There were also no systems to monitor the quality of the education delivered or the professional development of teachers.

5.9 There was no measurement of outcomes for detainees attending education; this was left to individual teachers to record on each individual detainee's learning plan. The learner’s files we reviewed showed learning plans were in place for less than half of detainees engaging in education, and most of these plans were poor, not setting learning objectives or monitoring progress.

5.10 The quality of teaching we observed was good, and teachers adapted well to the different skill mixes in the classroom. In our survey, a third of detainees reported using the education facility, and 86% of those who did attend said it was helpful.

5.11 A ‘virtual’ college had been introduced since the last inspection; this was a positive initiative that allowed detainees to gain some qualifications, for example in food hygiene or barista training online. However, take-up had been low and in the last three months, only three courses have been completed. The computers were not based in the classrooms, so detainees were not able to seek advice easily from education staff if needed.

5.12 The centre had sufficient paid work for the reduced population; 35 posts were available, and a third of detainees were employed. The method to obtain work was quick, with applications taking between 24 and 48 hours to process. Each detainee received an induction and completed a work compact. The level of pay remained low at £1 an hour for most jobs. It was positive that no detainees had been prevented from working by the Home Office, other than for legitimate behavioural reasons.

Library provision

5.13 Access to the library was good; it was open seven days a week, including in the evening. Most of the officers deployed to work in the library had no expertise in library work and so they did not have a good enough knowledge of the resources available, and could not help detainees use them.

5.14 The range of books did not meet the needs of the detainees; as an example, there were only four books in Albanian, which was the commonest language at the centre. There were no ‘easy-read’ books for detainees learning English, and there were some gaps in non-fiction provision, including health and well-being. The library held a wide range of DVDs, but detainees had no access to a DVD player. Reference material included a range of foreign-language-to-English dictionaries and books on immigration law.

5.15 The number of computer terminals for detainees had reduced from 12 at the last inspection to five, with only four working at the time of the inspection. Detainees valued the use of IT as it allowed them access to essential information, but they could not use social media.

5.16 Overall, the library was poorly organised and lacked oversight, and there were still no systems to manage borrowing, monitor use or replenish stock.

Fitness provision

5.17 There were good fitness facilities at the centre, consisting of a sports hall, an outdoor sports field and a small gymnasium. In addition, the outside courtyard had fixed exercise equipment. While most of the equipment was in reasonable condition, there were no free weights in the gym.

5.18 Access to the gym was good; in our survey, 80% of detainees said they could go to the gym as often as they wanted to. The gym was open for just under 10 hours a day, with structured activities such as badminton and football in addition.

5.19 The gym was not always monitored by a qualified staff member; only two activity officers had a formal gym qualification (and were a shared resource across the two centres) and, as a result, many detainees were using the gym without having completed a formal induction, which was potentially unsafe.

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 The welfare team helped detainees with a wide range of issues. Twelve staff worked between the centre and nearby Brook House with usually two available at a time, which was sufficient for the currently reduced population. The welfare office was open throughout the day and in the evenings, seven days a week, and detainees could and did come to see the team about a range of concerns.

6.2 At our last inspection, we commented positively on the fact that all the welfare team had achieved level 1 accreditation by the Office of the Immigration Services Commissioner, which enhanced their ability to provide information and direct detainees to sources of support. Only four of the team now had such an accreditation, though there were plans to address this.

6.3 The welfare team interviewed every detainee within a day of their arrival as part of their induction, gathering relevant information and identifying needs. However, the induction interviews we observed did not provide the detainees with enough information about the support that could be provided by the service (see paragraph 3.5).

6.4 The welfare staff did not always use professional interpreting when it was necessary. We observed that they often relied on translation software to convey general information to detainees, but this was not effective in helping them to understand and respond to specific concerns, and it was apparent that detainees did not always understand the information provided.

6.5 Information leaflets on a range of topics were available to detainees in several languages. The ‘house rules’, which contained useful information about life in the centre, were available in 22 languages. The intranet, which was accessible to detainees through the computers in the library, had also highlighted links to useful information about agencies that could provide relevant information, advice and support.

6.6 The welfare team was well connected with other providers. Of particular note, Bail for Immigration Detainees (BID) undertook a

monthly surgery at the centre. There was particularly good cooperation with Gatwick Detainees Welfare Group (DWG), who operated a weekly drop-in for detainees and made an important contribution to their welfare in the centre.

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.

6.7 There was good provision for social visits to detainees. They could be scheduled every afternoon or evening, and bookings could be made by phone, email or via an online booking form. The Gatwick DWG provided volunteers to visit detainees, mostly because they could not receive visits from friends or family.

6.8 A minibus provided free transport to and from the railway station at Gatwick Airport. This was well publicised during the booking process and was very much appreciated by the visitors to whom we spoke. There was no dedicated visitors' centre, so arriving visitors were processed in the main reception area. Visiting adults were subject to a rub-down search while children were searched with a wand in an unscreened area.

6.9 In our survey, 88% of detainees said that staff treated their visitors with respect, and we found staff to be welcoming and helpful. We observed that there were some inconsistencies of approach to visitors between front desk staff. For instance, although we were told that while adult visitors should be given a wristband, young children did not have to wear one, we observed staff putting a wristband on a toddler.

6.10 The visits hall was small, allowing a maximum of six simultaneous visits. Because of the wide range of times available to visit this was currently sufficient. Although there was a colourful and welcoming children's play area that was well stocked with toys and games, the rest of the hall was drab and needed brightening up.

6.11 Detainees were subject to relatively strict restrictions on physical contact during visits. Staff told us that they only tolerated physical contact at the start and end of the visits and that visitors were expected to sit opposite the detainee. Given the nature of the centre, these restrictions were excessive.

Communications

Expected outcomes: Detainees can maintain contact with the outside world regularly using a full range of communications media.

6.12 Detainees were not allowed to have smartphones at the centre but were issued with mobile phones with basic functions, and these were well used. They were given £5 phone credit on arrival and could top this up. Detainees wanting to call family members abroad were given a phone card with credit or could use the phones in the welfare office.

6.13 Detainees were given the opportunity to post a weekly free letter, including internationally, and they were able to send and receive faxes. They could make video calls on either of two laptop computers that were set up in private rooms. This provision was popular with detainees, but the computers were very small and therefore not ideal for video calling.

6.14 The computers in the library allowed detainees to browse the internet and access their email accounts, but there were not enough for this purpose and social media sites were still blocked (see paragraph 5.15). They were able to print out relevant paperwork.

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.

6.15 Although the welfare team undertook good work with detainees from their arrival to their departure, there was no systematic approach to make sure that their pre-departure needs had been addressed.

6.16 In the previous three months, 63% of detainees leaving the centre had been released into the community. They all left with a summary of their medical records and up to a month's supply of medication, were often provided with contact details for local support organisations, and those needing them were given clothes and suitable bags.

6.17 Some of those released were vulnerable. Although information was shared at the weekly vulnerable residents meeting, no multidisciplinary meetings had been convened to plan specifically for the safe release of individuals with complex risks or needs since the centre had reopened as an IRC. Leaders said that none had been assessed as needing this form of additional release planning.

6.18 Some detainees had been released homeless, but data on the number were unreliable. Apart from clothes, the centre could not provide anything to those released in such circumstances, though Gatwick DWG and others sought to source other support. Because of a lack of

suitable accommodation, some detainees granted bail continued to be detained for lengthy periods extending to several months.

6.19 Some detainees were transferred to other centres, usually at short notice. They were not always told the reason for the transfer.

6.20 Detainees being removed had access to country information packs through the welfare office. Reserve lists for charter flights continued to be used, which caused detainees unnecessary distress. During our inspection, several detainees were scheduled to be removed. Those to whom we spoke knew little about the arrangements for their departure and were waiting to leave early in the afternoon, even though they were scheduled to depart the centre in the early hours of the next morning.

6.21 Shortly before the inspection, the pre-departure accommodation was used for a family for the first time in three years, when a previous attempt to remove them direct from the community had failed (see paragraph 3.27). The mother had declined to take a pregnancy test on arrival and had been assessed as fit to fly, but while in detention she reported feeling unwell and tested positive for pregnancy. Despite this, the Home Office decided to proceed with removal. Attempts to do so were abandoned and the family released when the mother locked herself in a toilet and refused to leave. A meeting was convened shortly afterwards to identify lessons from the case.

Section 7 Progress on recommendations from the last full inspection reports

Recommendations from the last full inspection of IRC

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, 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.

At the last inspection, in 2018, too many detainees were transferred to the centre overnight. Processes during detainees' early days were not sufficiently thorough. The centre provided a safe environment and there was very little evidence of violence, although a significant minority of detainees said they felt intimidated by staff. Some staff said they would not raise safeguarding concerns. There were weaknesses in the rule 35 process, which was not used in all relevant cases and was not sufficiently effective in protecting vulnerable detainees. The level of self-harm was low and support was good. Security was generally well managed, but some restrictions, including limiting detainees' ability to move freely around the centre, were disproportionate. There was little use of force or the separation unit. Legal support was reasonable and relatively few detainees were held for long periods. On-site immigration staff provided detainees with an improving service. Outcomes for detainees were reasonably good against this healthy establishment test.

Key recommendations

The centre should monitor rule 35 reports to ensure they are submitted when necessary. Reports should contain sufficient detail to inform a proper assessment of the vulnerability of the detainee. Home Office responses should be timely. Where evidence of torture is accepted, detention should only be maintained in exceptional circumstances that are documented on file and explained in writing to the detainee, their legal representatives and the doctor.
Not achieved

Security procedures and limitations on detainees' ability to move freely around the centre should remain proportionate to a detainee population. Any restrictions should be focused and based on risks and clear evidence.
Achieved

Recommendations

There should be a time limit on the length of detention
Not achieved

All casework, including substantive decision making, should be progressed promptly.
Not achieved

Detainees should never be transported at night except for urgent operational reasons
Not achieved

Reception processes should be prompt and efficient, ensuring that detainees' immediate vulnerabilities, needs and risks are assessed during a private interview. Key information should be conveyed to residential staff and other departments.
Achieved

Managers should ensure that centre staff understand and feel comfortable using whistleblowing procedures. Reporting lines should allow staff to provide information quickly
Achieved

All staff in contact with detainees should be familiar with adult safeguarding, modern slavery and adults at risk practice.
Not achieved

There should be effective multidisciplinary care planning for adults at risk.
Partially achieved

The centre should have an up-to-date local policy on the care and management of detainees refusing food or fluid.
Achieved

Messages left through the confidential safer community helpline and email services should receive a prompt response.
Achieved

ACDT case reviews and meetings between staff from the Samaritans and detainees should take place in private and should not be disturbed.
Achieved

Sustained efforts should be made to investigate negative perceptions of safety held by some detainees and appropriate action should be taken.
Achieved

Use of force meetings should take place regularly. They should analyse use of force data specifically for Tinsley House as well as monitor trends and set appropriate action.
Achieved

Professional interpretation should be used for all immigration interviews where the detainee is not fluent in English.
Achieved

The library should stock up-to-date immigration law text books and country of origin information reports. Legal support websites should not be blocked.
Partially achieved

Detainees should receive a copy of their bail summary by 2pm the day before the bail hearing.
Achieved

Respect

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

At the last inspection, in 2018, staff-detainee relationships were good. The living accommodation was clean and in good order, although rooms were more cramped than at the previous inspection, which was particularly an issue given that detainees were more restricted. Equality and diversity work was underdeveloped. Faith provision was good. Complaints were usually managed effectively. The food was satisfactory but did not cater for a culturally diverse population. Health care provision was reasonable, but some staff did not communicate with detainees well enough, and support for those with low level emotional needs was underdeveloped.
Outcomes for detainees were reasonably good against this healthy establishment test.

Recommendations

Complaints requiring investigation by the professional standards unit should be passed immediately to that department for investigation.
Achieved

Staff should knock and wait for a response before entering rooms, except in emergencies
Not achieved

Managers should monitor and assess the impact of regular redeployment on relationships in the centre.
Achieved

Detainees should be consulted to understand any concerns about the behaviour of staff and action should be taken to address those concerns.
Achieved

Detainees should have well ventilated rooms where they can rest and sleep in reasonable comfort.
Not achieved

Complaints should receive a response within published timescales.
Achieved

Special and religious diets should be effectively catered for, and food should be correctly stored.
Partially achieved

Consultation should lead to action that addresses detainees' dissatisfaction with the food.
Achieved

Detainees should have significantly more access to the cultural kitchen
Achieved

The under-reporting of detainees' protected characteristics should be investigated and addressed
Partially achieved

Diversity monitoring should facilitate the identification and investigation of trends in detainee outcomes
Partially achieved

Specific forums should be established for detainees with protected characteristics
Not achieved

Detainees of all faiths should be able to pray in the multi-faith room without being unduly disturbed.
Achieved

There should be enough health care staff to meet detainees' needs
Achieved

A formal memorandum of understanding should be agreed with the Home Office and local authority, describing how detainees with social care needs will be supported
No longer relevant

Detainees making a complaint should initially be addressed face-to-face whenever their language of choice is not English and written responses should be in an accessible format
Achieved

A 'whole centre' approach to health promotion should be introduced. It should cover screening and immunisation and offer readily available appropriate information in accessible formats, including in the main written languages of the detainee population.
Not achieved

The centre should introduce an effective booking system that allows detainees to make an appointment easily
Achieved

There should be sufficient staffing capacity to meet the health needs of the population and counselling services should be provided

Partially achieved

Detainees should have access to pharmacy-led clinics
Achieved

Protocols for authorising non-prescribed medicines should be comprehensive to ensure compliance with legislation, and prescribing audits should be undertaken.
Achieved

Activities

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

At the last inspection, in 2018, there was a good range of activities and recreational facilities. Access was more limited than at the previous inspection. Less than half of detainees in our survey said they had enough to do to fill their time at the centre. Education was delivered well. There was a reasonable number of paid roles, but not all were filled. The library provided an accessible service but the range of books and other resources was very limited. The fitness provision was generally good.
Outcomes for detainees were reasonably good against this healthy establishment test.

Recommendations

Cover arrangements for staff absences should be in place to ensure the consistent and safe delivery of a range activities.
Partially achieved

Data on activities should be collected and analysed to identify trends in the use of all facilities and participation by different groups of detainees. The information should be used to improve participation, planning and promotion to attract higher interest and attendance
Not achieved

The centre should establish effective quality improvement systems.
Not achieved

Rates of pay should be raised to encourage more detainees to apply for paid work at the centre and compliance with the Home Office should not be a pre-requisite for obtaining work.
Not achieved

Effective systems should be in place for borrowing books and checking and renewing stock.
Not achieved

Sports and activities staff should have instructor or coaching qualifications. They should supervise the gym more closely to ensure detainees are safe and complete a gym induction before they use equipment.
Not achieved

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.

At the last inspection, in 2018, welfare support was excellent, although pre-discharge work was not systematic. The provision for visits was generally good and support from the visiting group was good. Detainees could use the internet easily, but not social media or Skype, and too many legitimate websites were blocked. Detainees had good access to phones, but faxing could be difficult. Outcomes for detainees were good against this healthy establishment test.

Recommendations

A formal system of assistance should be introduced to ensure that detainees are able to reach their final destination safely
Not achieved

Detainees being transferred to other places of detention should be given sufficient notice of the move
Not achieved

Rules in the visits hall should be proportionate to the detainee population. Appropriate physical contact between detainees and their visitors should be allowed, and young children should not be required to wear wristbands or lanyards.
Not achieved

Visitors should be given information about what to expect at the centre before they arrive
Achieved

Detainees should have access to social networks, Skype and all other legitimate websites.
Partially achieved

Detainees' needs should be assessed systematically, and as far as possible addressed, before they leave the centre.
Not achieved

Recommendations from the 2018 inspection of pre-departure accommodation at Tinsley House

The Home Office should analyse why so many removals fail, with a view to reducing the unnecessary and harmful detention of children and families.
Not inspected

Home Office immigration enforcement arrest teams should wear body cameras during the arrest of families
Not inspected

Escorting teams should have food and drink for detainees
Not inspected

The initial reception process should be undertaken quickly, especially if families are tired or have had long journeys, with non-essential processes undertaken after the family have rested.
Achieved

Information regarding a detainee's risk of suicide and self-harm, and other welfare concerns, should be communicated with community agencies on release
Achieved

All staff who may have sole, direct contact with detainees should carry ligature knives.
Achieved

Managers should ensure staff are confident and competent in using restraint techniques.
Partially achieved

Welcome packs should be available in languages that detainees understand.
Partially achieved

Families in the border returns unit should have equal access to communal space during their detention
Achieved

Halal and non-halal cooking utensils should be stored separately to meet faith requirements.
Achieved

An age-appropriate template for use with children should be introduced as part of the reception screening process.
Partially achieved

Information about health services should be available in multiple languages and accessible formats.
Not achieved

Families should have access to the internet, including social networks and Skype
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 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.

Outcomes for detainees are reasonably good.
There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for detainees are not sufficiently good.
There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for detainees are poor.
There is evidence that the outcomes for detainees are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for detainees. Immediate remedial action is required.

The tests for immigration detention facilities take into account the specific circumstances applying to detainees, and the fact that they are not being held for committing a criminal offence and their detention may not have been as a result of a judicial process. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees: in a relaxed regime; with as much freedom of movement and association as possible consistent with maintaining a safe and secure environment; to encourage and assist detainees to make the most productive use of their time; and respecting in particular their dignity and the right to individual expression.

The statutory instrument also states that due recognition will be given at immigration removal centres to the need for awareness of the particular anxieties to which detainees may be subject, and the sensitivity that this will require, especially when handling issues of cultural diversity.

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.

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 outlines the priority and key concerns from the inspection and our judgements 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 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:

Martin Lomas	Deputy Chief Inspector
Martin Kettle	Team leader
Rebecca Mavin	Inspector
Chelsey Pattison	Inspector
Deri-Hughes Roberts	Inspector
Chris Rush	Inspector
Fiona Shearlaw	Inspector
Donna Ward	Inspector
Charlotte Betts	Researcher
Emma King	Researcher
Alexander Scragg	Researcher
Joe Simmonds	Researcher
Maureen Jamieson	Lead health and social care inspector
Matthew Tedstone	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.

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

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).

Rule 35 reports
Detention Centre Rule 35 provides that:

(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
(2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those

suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.
(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.
(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.
(5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care.

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 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.

Appendix IV Summary of detainee interviews

Every detainee at Tinsley House was offered a confidential individual interview with an inspector. Nine agreed to be interviewed, of six nationalities. The interviews were semi-structured and were held during the week of 17 April 2023. What follows is a brief summary of the key messages that emerged. The opinions of interviewers are not included, and this represents only the views of interviewees. These interviews were used as one source of evidence to inform the rounded judgements made by inspectors in the body of this report. The principal objectives were to identify concerns about safety and safeguarding of individual detainees, and to deepen inspectors' understanding of the culture in the centre. The detainees we spoke to were self-selecting and the findings below should be seen as supplementing our detainee survey findings (see Appendix IV). We followed up any allegations of concern and have reported on outcomes in the main body of the report where we were able to corroborate the allegations.

Key themes from the nine detainee interviews

Some were dissatisfied with how their immigration case and their detention were being handled.

Several of the interviewees said that the Home Office team did not keep them up to date about their cases. One said he had been seen by someone from the Home Office immediately before this interview, during which he had been issued with a letter in English, the detail of which had not been explained to him. Five raised concerns about the length of time either they or others had been held at the centre.

Interviewees described mainly respectful treatment and behaviour from staff, but also gave examples of less constructive attitudes.

Most said that staff treated them well or reasonably well and they were polite in their exchanges. A few, however, said they felt that staff did not treat them well enough; one gave the example that they did not always use interpretation services when it would have been helpful. Another said that young staff did not know how to speak to or engage with older detainees and one said that a few staff were 'just rude' or ignored the detainees. None had seen any of the staff behaving in a clearly inappropriate way.

At least half indicated that they were confident about how to make a complaint if required but a few were unaware of the complaints process; they said they had had no need to ask about it. One said that another man had not showered for over a month and staff were doing nothing to resolve the situation, but he was not willing to identify the person.

As at the last inspection, a few interviewees said that staff had told them that if they misbehaved, they would be transferred to Brook House.

Those interviewed said that they felt safe in the centre, although it was not free of drugs.

All of those interviewed said that they felt safe in the centre and, when asked to rate it, judged that safety in the centre was either good or very good. They all said that staff respond appropriately to incidents involving detainees.

Most detainees said it was hard to get drugs in the centre, but two indicated it was easy to access them and one detainee said that staff brought drugs in. A few mentioned that a detainee had been found in possession of drugs a few days earlier and as a result had been moved to Brook House.

Some expressed dissatisfaction with health care delivery.

Four of those interviewed raised concerns that their physical and mental health needs were not being met. Two said that they saw a health care professional in reception but had not seen any since. One said this was in spite of advising staff that he was on the wrong medication.

One man stated he had been at Tinsley for two weeks and had requested to see a doctor on several occasions but kept getting fobbed off. Another who had been resident for five months said he had waited a long time to see a dentist, while a third indicated that he did not think his friend was receiving enough support for his mental health.

There were mixed opinions of the facilities at the centre.

Several of the detainees reported good access to activities such as the gym, pool tables, play stations and also books in their own languages, albeit a small selection.

Some said there was an insufficient choice of food, and that portion sizes were not always adequate (e.g. too much dry rice served with a little curry); while others indicated that there was a good variety of food. One complained that he was not allowed to eat in his room after being at the gym.

One man complained that an Indian TV channel had been withdrawn; and another they were not allowed to purchase or use vapes in the centre, which had led him to start smoking again.

Crown copyright 2023

This publication, excluding logos, is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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/

Printed and published by:
HM Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England

All images copyright of HM Inspectorate of Prisons unless otherwise stated.