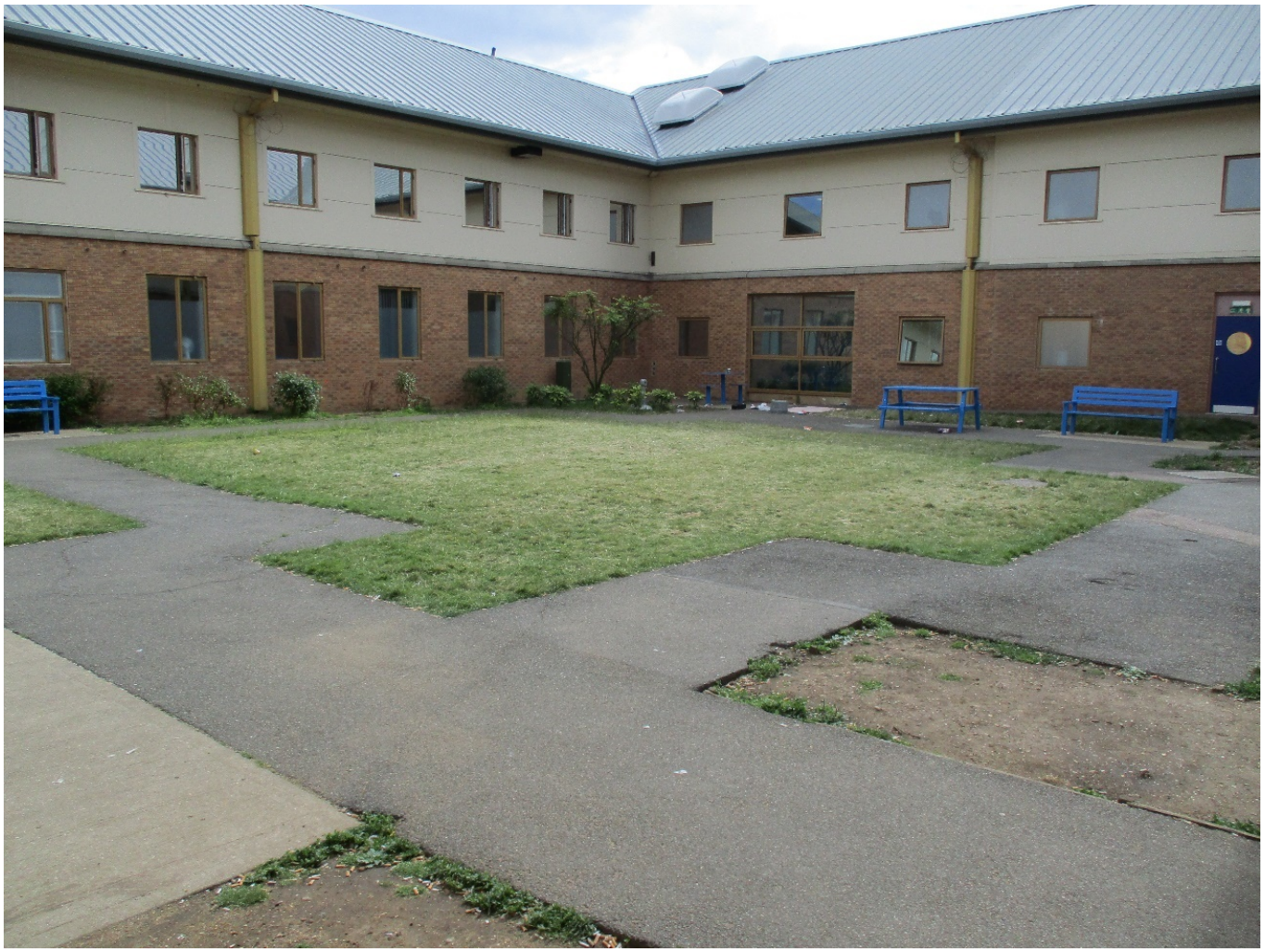
Report on an unannounced inspection of

Yarl's Wood Immigration Removal Centre

by HM Chief Inspector of Prisons

12–14 June, 3–6 July 2023



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Introduction

Yarl's Wood is an immigration removal centre (IRC) located near Bedford which, since 2007, has been operated on behalf of the Home Office by Serco. At the time of our inspection there were 347 detainees, of whom about 40 were women held on a separate wing.

This inspection is our first at the centre since 2017. During that time it has faced the impact of COVID-19, changes to its function, and latterly a concerted indiscipline which led to the escape of 13 detainees. The centre was calm during the inspection but there was a tangible change in atmosphere from our previous visit. There were more detainees, more protests and more evident frustration, fuelled by longer periods of cumulative detention without enough progress on immigration cases: 32 people had been detained for over six months and eight for over a year. Our assessments of a healthy establishment evidenced the deterioration. At this inspection the provision of activity had clearly worsened, and of even greater concern, safety outcomes were no longer sufficiently good.

Late or out of hours arrival remained the experience of many new to the centre, especially women, who were often transferred long distances. Yarl's Wood held far more women than the main designated women's centre at Derwentside, which was well-resourced but poorly located. Reception and welfare assessments were reasonable, although induction procedures were inconsistent.

Violence was uncommon, but nearly half of men and about a quarter of women still told us that they felt unsafe. Interviews with detainees suggested the more numerous national groupings and the prevalence of former prisoners may have added to some anxieties, and this was probably not helped by the way petty rule breaking was overlooked. Serco's middle managers were offering staff useful support but needed to be clearer and more consistent with them about the maintenance of standards.

Use of force was infrequent and usually low level, and oversight was generally reasonable, but we were troubled to find that at least one example of potentially dangerous practice by staff during an incident had not been identified by managers. We were also concerned about the blurring of accountability for the oversight and application of separation before charter removals.

There was little self-harm, but many detainees responding to our survey indicated that they had felt depressed at the centre, and the lack of information relating to immigration case progression was often cited as contributory factor in self-harm case management documentation. Some detainees whose release had been agreed in principle continued to be held for long periods due to a lack of approved bail accommodation. One detainee, for example, was held for almost eight months awaiting suitable accommodation.

We saw mainly good relationships between staff and detainees, and living conditions were mostly good; these were both especially so on the women's unit. However, the rising population had highlighted the limitations of the

centre’s infrastructure. The atmosphere was often frenetic, detainees congregated in corridors because of a lack of association space, the men’s yards were not clean, and the women’s yard was overlooked by a male unit and some women had been intimidated as a result. There were weaknesses in health care governance and detainees waited too long for a Rule 35 appointment. Access to general amenities was adequate but the food was fairly poor and the limited use of self-catering facilities was a missed opportunity.

Detainees were unlocked for most of the day and evening and could move freely around the centre's activity and outside areas. That said, there was a limited range of activity which was not well promoted, and many detainees described feelings of boredom alongside the anxieties of detention. Education offered a useful but narrow curriculum and of the 100 paid jobs available, only a third had been taken up. The library and gym were more popular but access to the latter was still restricted following the escape. The activities on the women’s unit were more popular.

The welfare team was highly valued by detainees, although more easily accessed by the men than women. Support for family contact was also good and had improved since our last inspection with the introduction of a Skype link. Over half of detainees leaving the centre were released into the community, but data kept on this by the Home Office and Serco was inconsistent and some detainees were being released homeless, including individuals identified as having complex needs. Arrangements to address these concerns were not yet effective.

The centre was operationally well led and staffing resources had kept pace with the rising population, although this was not true of the less well-staffed Home Office teams. Weaknesses in data-sharing meant that Serco staff did not always know the vulnerabilities of the detainee population. Overall, while the experience for most detainees was currently adequate, we left Yarl’s Wood concerned about deteriorating outcomes in a centre that was having to manage a complex and larger population of detainees, who were held for longer periods.

Charlie Taylor
HM Chief Inspector of Prisons
July 2023

What needs to improve at Yarl's Wood Immigration Removal Centre

During this inspection we identified 15 key concerns, of which five 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. **The Home Office was unable to provide the centre with accurate data, undermining its ability to care for the most vulnerable detainees.**

2. **Many detainees had been illegitimately located in the separation unit pending charter removals**. This was not based on individual risk nor subject to appropriate oversight, as would have been required if they had been held under Rule 40.

3. **Case progression was often slow and detainees were held for long periods despite little prospect of removal in the near future, which contributed to frustration and instability in the centre.**

4. **Patient safety was compromised by poor health care record-keeping, weak incident reporting and ineffective oversight by health care managers.**

5. **Women had worse access to some services than men, and the inherent risks of co-location were highlighted by the intimidation of women in a yard overlooked by a male residential unit.** Yarl's Wood continued to hold more women than the dedicated but poorly located women's centre at Derwentside.

Key concerns

6. **Many detainees who were granted bail continued to be held at the centre because of a lack of approved accommodation.**

7. **Potentially dangerous control and restraint techniques had not been identified on review and health care staff had failed to refer an alleged assault to Serco or the Home Office for investigation.**

8. **Some detainees lacked mental capacity and were assessed as unfit for detention but were still in detention for long periods.**

9. **Many Rule 35 reports were of poor quality and did not provide adequate assessment of the impact of continuing detention on detainees' health.**

10. **The quality and variety of food were inadequate and the cultural kitchens were underused.**

11. **Detainees did not receive a full range of health care provision because of gaps in staffing, particularly in mental health and psychosocial services.**

12. **Health care risk assessments for hospital escorts were completed poorly. Health care staff failed to consider proportionality of handcuffing and wrongly assumed that detainees should be in restraints unless assessed out of them.**

13. **There was poor take-up and ineffective promotion of education provision.**

14. **The men's activity areas lacked rooms suitable for association and informal pastimes and men tended to congregate in crowded corridors.**

15. **The mobile phone signal in most of the centre was poor, especially in detainees' rooms**. This limited detainees' ability to make calls when they were locked in their rooms at night.

About Yarl's Wood Immigration Removal Centre

Task of the establishment
The immigration removal centre holds men and women detained to facilitate their removal from the UK. The short-term holding facility holds men and women for periods not exceeding seven days pending initial checks, removal from the UK or transfer to long-term immigration detention.

Certified normal accommodation and operational capacity (see Glossary)
Detainees held at the time of inspection: 347
Baseline certified normal capacity: 410
In-use certified normal capacity: 410
Operational capacity: 410

Population of the centre
- The centre held detainees from 48 countries. At the outset of the inspection, 35% of detainees were Albanian nationals.
- 12% of detainees were women.
- 20% of detainees had spent time in prison.
- 30% of detainees had been held at Yarl's Wood for less than a week, but 4.5% of the population had been at Yarl's Wood for more than six months.
- During the six months before the inspection, 27% of detainees held in the centre had been removed from the UK and 65% had been released into the community.

Name of contractor
Serco

Escort provider: Mitie

Health service provider: Northamptonshire Healthcare NHS Foundation Trust (NHFT)

Health Service commissioner: NHS England (East of England)

Learning and skills providers: Serco

Location
Milton Ernest, Bedfordshire

Brief history
Yarl's Wood is located near Bedford and has been operated by Serco since 2007. For most of that time, it has been the UK's main immigration removal centre (IRC) for women. In May 2020, the centre became a short-term holding facility (STHF), primarily accommodating men who had arrived on the south coast via small boats. In January 2021, the centre was refurbished to accommodate predominantly male IRC detainees alongside a small number of STHF spaces. In March 2023, the female IRC unit was refurbished to allow it to operate independently of the male centre.

Short description of residential units
Avocet Unit – male IRC accommodation
Dove Unit – male IRC accommodation
Crane Unit – induction unit for men held under IRC rules
Nightingale Unit – self-contained female accommodation
Bunting Unit – self-contained short-term holding facility

Name of centre manager and date in post
Michael Guy: May 2020 to date

Changes of centre manager since the last inspection
Steve Hewer: until May 2020

Independent Monitoring Board chair
Paul Harris

Date of last inspection
5–16 June 2017

Section 1 Summary of key findings

Outcomes for detainees

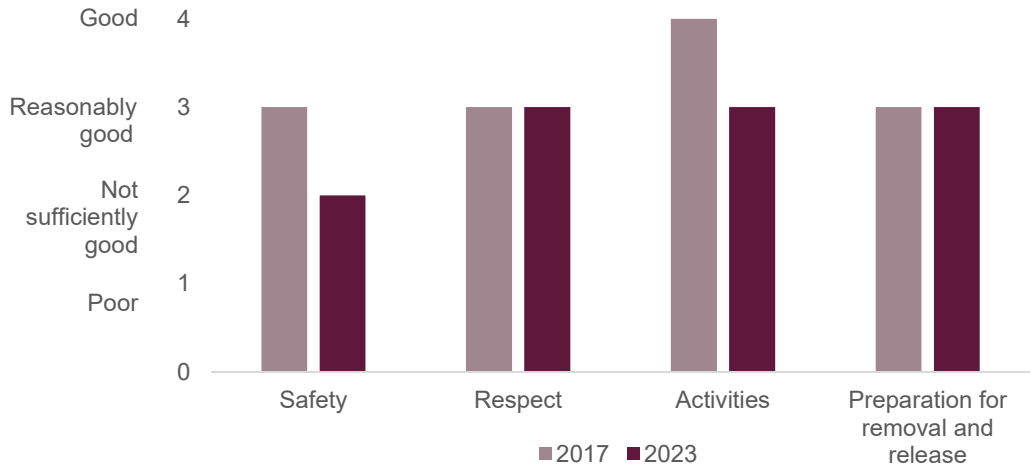
1.1 We assess outcomes for detainees against four healthy establishment tests: safety, respect, activities and preparation for removal and release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of Yarl's Wood Immigration Removal Centre, we found that outcomes for detainees were:

- not sufficiently good for safety
- reasonably good for respect
- reasonably good for activities
- reasonably good for preparation for removal and release

1.3 We last inspected Yarl's Wood in 2017. Figure 1 shows how outcomes for detainees have changed since the last inspection.

Figure 1: Yarl's Wood Immigration Removal Centre healthy establishment outcomes 2017 and 2023



Progress on key concerns and recommendations

1.4 At our last inspection in 2017, we made 44 recommendations, five of which were about areas of key concern. The immigration removal centre fully accepted 35 of the recommendations and partially (or subject to resources) accepted four. It rejected five of the recommendations.

1.5 At this inspection we found that two of our recommendations about areas of key concern had been achieved and three had not been achieved. While the centre had achieved recommendations concerning the number of female staff and the management of the pharmacy,

recommendations concerning support for those leaving the centre, the length of time people were held in detention and the timeliness of the Rule 35 process had not been achieved. For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

1.6 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

1.7 Inspectors found one example of notable positive practice during this inspection.

1.8 Since the women's unit had re-opened, the centre had consistently staffed it with an all-female staff group in an effort to help women feel safer and more comfortable in the centre (see paragraph 3.83).

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.

2.2 Home Office leaders had not provided Serco with accurate data about the detained population. The data did not, for example, show current detainee risk levels or the outcomes of Rule 35 reports (see Glossary). This undermined the centre's ability to assess and meet the needs of the most vulnerable people it held.

2.3 Home Office leaders had not made sure that case progression was sufficiently swift for the many detainees held for long periods with no release date and little prospect of removal. The resulting insecurity and frustration negatively affected the atmosphere and stability of the centre.

2.4 Home Office and HMPPS leaders had made no tangible progress on resolving the longstanding problem of delays in probation accommodation checks, which meant that many detainees were still held despite being granted bail. Senior level meetings were planned but had yet to take place at the time of the inspection.

2.5 A new detention engagement team (DET) manager was improving its work with the centre by ensuring more consistent attendance at key meetings. The DET had been under-resourced until recently, but it had maintained a reasonable level of contact with detainees and diligently passed on the information that it held.

2.6 The fact that women continued to be held at Yarl's Wood in far greater numbers than at the dedicated and well-resourced women's IRC at Derwentside presented an emerging leadership challenge. The Home Office needed to keep many women at Yarl's Wood for case progression reasons and women were also unwilling to travel so far from their existing support networks.

2.7 Leadership of safer custody was purposeful and had, for example, helped to make sure that case management of detainees identified as being at risk of self-harm was consistent. However, safer detention meetings did not provide consistent oversight and the work was hampered by the lack of Home Office data on detainees' risks and needs.

2.8 Serco leaders had responded to the larger detainee population by increasing the number of frontline detainee custody officers (DCOs)

and taking action to upskill managers through a management development programme. While DCO recruitment was reasonably effective, retention remained a challenge and there was still a shortfall in staff numbers.

2.9 DCOs generally described unit managers as supportive, but some staff required more assertive management and guidance to help them to engage confidently and proactively with detainees. In particular, staff were not sufficiently encouraged to promote the underused activities.

2.10 Operational leadership of the effective welfare work was good, but leaders had not identified the need for more consistent provision in the women's unit.

2.11 Health care leaders had not recognised the clinical risks created by poor record-keeping and incident reporting. They were not sufficiently focused on addressing governance and performance concerns.

Section 3 Safety

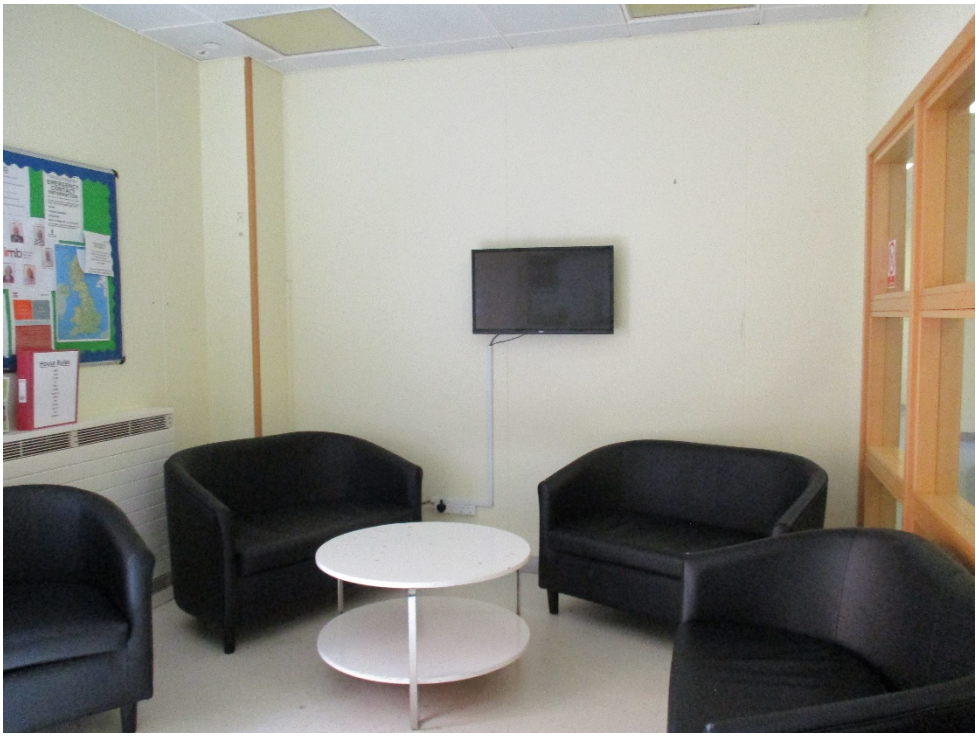
Detainees are held in safety and with due regard to the insecurity of their position.

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 Too many detainees continued to arrive at the centre through the night, including some from other immigration removal centres (IRCs). During the previous week, over a third had arrived between 10pm and 6am. Women were particularly likely to have had very long journeys from Derwentside IRC. Escort vehicles were in good condition and detainees told us they had adequate comfort breaks during their journey.

3.2 An average of about 60 detainees arrived each week, although the number of arrivals varied considerably depending on the scheduling of charter flight removals. Men and women had separate reception areas, which were welcoming and included outdoor space on the men's side. Waiting rooms displayed useful information, although in English only on the men's side. Detainees were offered drinks and cold food and were searched in private.



Reception waiting area

3.3 Serco staff interviewed detainees about sensitive issues in the busy reception area, which was not conducive to disclosure. This was particularly concerning given that many detainees, including those coming from prisons, arrived with very little information about their risks and vulnerability.

3.4 The reception process was quick and efficient and anyone known to be vulnerable was prioritised. Staff were welcoming and we saw them helping detainees to resolve problems such as obtaining phone numbers. Telephone interpreting was used regularly and some staff were able to speak to detainees in their own language. Detainees whom we interviewed and surveyed were generally positive about the reception staff and process.

3.5 Most male detainees were located on Crane induction unit following their arrival, but the unit did not have the capacity to accommodate all new arrivals. Women went directly to the Nightingale unit. The rooms that we saw were in good order and detainees were given bedding, clothing and a basic hygiene pack. Staff were aware of the location of new arrivals and checked on them twice during their first night in the centre.

3.6 Induction was timely but varied in extent and quality. Not all detainees received useful information and a full tour of the centre. Induction materials were translated, but the induction booklet was out of date.

3.7 All detainees received a more extensive and consistently helpful welfare induction, which gave staff the opportunity to provide further information and help detainees resolve immediate problems. Detainees also spoke to the Home Office detention engagement team (DET) within 48 hours of arrival. This was sometimes by telephone because of a shortage of staff, which reduced the quality and value of the interview.

3.8 Detainees being held under short-term holding facility (STHF) rules went through a similar reception process, which generally took less time as not all the induction questions were relevant for detainees held for short periods.

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

3.9 There was a high level of assessed vulnerability in the centre. During the previous six months, two detainees had been transferred to hospital as a result of severe mental illness. Several more had been identified

as level 3 Adults at Risk which meant the Home Office considered that detention was having an adverse effect on their health or well-being.

3.10 There had been changes in the Home Office processes and online systems and they were not routinely sharing important information such as outcomes of Rule 35 reports (see Glossary) and National Referral Mechanism (NRM) referrals (see Glossary), and updated information on Adults at Risk (see Glossary). As a result, centre staff were not always aware of the identity or needs of the most vulnerable detainees, which undermined their ability to plan and deliver appropriate care.

3.11 Local records provided by health care staff suggested that 234 Rule 35 reports had been submitted to the Home Office during the previous six months, all involving claims of torture. No Rule 35 reports concerning physical illness or suicidal ideation had been submitted during this period, despite the fact that 27 detainees had been subject to constant watch because of an imminent risk of self-harm (see paragraph 3.20). Most reports that we reviewed did not provide adequate assessment of the impact of ongoing detention and it was not possible to establish from the available data how many had resulted in release.

3.12 We sampled 10 Rule 35 reports on claims of torture and in nine cases the response from the Home Office had been timely. In four cases, the Home Office accepted that detainees' experiences met the definition of torture, but none of these detainees was released.

3.13 There had been 173 referrals to the NRM in the previous six months. Some detainees continued to be held despite being recognised as victims of trafficking or modern slavery.

3.14 Staff from the centre, health care and the Home Office discussed detainees who had been identified as vulnerable at a weekly 'individual needs' meeting. This was a useful forum for planning care in complex cases and we saw examples of detainees who had been identified being supported. There were no data to indicate whether all vulnerable detainees were discussed.

3.15 The Serco safer custody team was small but purposeful and worked well in supporting detainees at risk. The team had a good understanding of which areas required attention, but their action plan was out of date and did not reflect the proactive work that we saw (see paragraph 3.25).

3.16 During the previous six months, 81 vulnerable adult care plans (VACPs) had been opened. Almost all involved health conditions and few referred to other forms of vulnerability. Observations indicated a good level of support and day-to-day care, but most VACPs did not include adequately detailed plans or interventions or consider detainees' individual risks.

3.17 Allegations of staff impropriety were properly investigated and two members of staff had left the centre in the last six months following substantiated allegations. Nearly all staff who responded to our survey

said they knew about whistleblowing processes, but a small number said they would not report concerns because they felt that confidentiality would not be maintained.

Self-harm and suicide prevention

3.18 The number of recorded self-harm incidents was low. There had been 21 in the last six months, two of which involved women. Two detainees had required treatment in hospital, although both were discharged on the same day.

3.19 In our survey, 84% of detainees said they had felt depressed while in the centre and 44% said they had felt suicidal. Lengthy and indefinite detention and the lack of information about immigration case progression were the main causes of distress for many detainees whom we interviewed and were the reasons given for opening every assessment, care in detention and teamwork document (ACDT) in our sample.

3.20 Staff had opened 71 ACDT documents in the last six months. Twenty-seven detainees whose risks were considered the greatest were placed on constant supervision, usually for less than one day. Female officers were appropriately responsible for the constant supervision of women.

3.21 There was more consistent ACDT case management than we usually see. Case review documentation generally showed reasonable engagement by custodial staff with detainees about their risks. However, health care and Home Office attendance at reviews was poor and their written contributions were too brief to contribute meaningfully to the assessment of risk. ACDT assessments and care planning were generally adequate, but there was often no record of whether care plan actions had been completed. Records did not always demonstrate sufficient meaningful day-to-day engagement by unit staff with detainees.

3.22 The support of specific detainees of concern, including those on an ACDT, was discussed at the weekly vulnerable detainee meeting. There was good attendance by health care and local Home Office staff, which provided some mitigation for weaknesses in the case review process. The Kaleidoscope counselling service (see paragraph 3.112) also provided good support to large numbers of detainees with lower-level mental health and emotional support needs. However, there were no peer support workers and the local Samaritans were no longer visiting the centre.

3.23 The supported living facility provided a reasonable environment for supporting detainees struggling to manage on normal location. Reasons for locating detainees in the facility were now documented.

3.24 A food and fluid monitoring log was opened for detainees missing six or more meals over a three-day period. Four logs had been opened in the last six months. Most were closed relatively quickly and there was no record of any detainee suffering continuing ill effects.

3.25 There was no local suicide and self-harm prevention strategy and action planning was too limited. The safer detention committee collected and analysed appropriate data, but meetings were not always well attended and there was little minuted discussion of data.

Safeguarding children

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

3.26 No children had been held in the centre during the previous year. During that time there had been seven age dispute cases, all of which involved detainees held under STHF rules who were later determined to be adults.

3.27 Processes for caring for detainees whose age was disputed were sound: care plans were opened to monitor their welfare and they were placed in single rooms. The centre maintained good links with the local authority.

3.28 Staff who oversaw visits to the centre took suitable action to make sure that children were safeguarded, including monitoring visits so that detainees with probation restrictions were placed in different areas.

3.29 A quarter of detainees who responded to our survey said that they were responsible for a child in the UK and several detainees told us they had children in their home countries. Detainees were asked during the reception process if they had children, but there was little proactive support or encouragement for detainees to maintain contact with them.

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.

3.30 There was little physical violence in the centre. During the previous six months, there had been 13 assaults of which four had been on staff and nine on detainees. Most assaults were low level, with few resulting in injury and no detainee had required hospital treatment.

3.31 Nonetheless, 41% of men and 23% of women responding to our survey said they felt unsafe in Yarl's Wood. In our confidential interviews, detainees generally said they were physically safe, but some explained that they felt intimidated by the more numerous national groups and others felt unsafe around ex-prisoners. A recent protest against detention had also affected some detainees (see paragraph 3.36) and many others were affected by the uncertainty of their immigration case (see paragraph 3.19).

3.32 During our interviews, no detainees said they had been assaulted by other detainees or staff and no staff in our survey said they had seen any physical mistreatment of detainees. However, an allegation by a detainee of an assault by immigration officers had been mishandled by health care staff (see paragraph 3.49). Otherwise, there was evidence of appropriate investigations in response to allegations of staff impropriety.

3.33 Some women had been upset by the comments shouted at them when they were in the yard outside the women's unit. The area was overlooked by a male residential unit, highlighting the inherent problems of holding women and men in the same centre.

3.34 There was widespread rule-breaking in the centre, especially smoking indoors. During the previous six months, 150 detainees had been formally monitored for bullying or antisocial behaviour under the 'tackling antisocial behaviour' process. However, it was not clear why many documents in our sample had been opened and there was little or no evidence that their behaviour had been discussed with detainees. There were no case reviews and action plans were missing or did little to address poor behaviour. There was no record that any actions had been completed.

3.35 There was no local strategy or action planning to reduce violence and little action was taken in response to the limited range of data on violence and poor behaviour presented to the safer detention meeting (see paragraph 3.25).

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.

3.36 There had been recent protests against detention and the lack of immigration case progression. The most serious incident had taken place in April 2023 when 51 detainees had gathered in the gym and refused to return to their cells. Free weights were used to break out of the gym and into the sports field. Some detainees had forced their way to the perimeter fence and 13 had escaped, although all were subsequently apprehended. The Prisons and Probation Ombudsman had started an investigation into the incident.

3.37 Measures introduced in response to this concerted indiscipline included restrictions for the vast majority of detainees who had had no part in the disturbance. These included the removal of free weights from the gym and limiting the number of detainees attending the sports hall to 10. These measures needed to be kept under review.

3.38 More than 700 security information reports had been submitted in the last six months. The security team was working individually with staff to improve the quality of reports, which were not always good enough.

Monthly strategic intelligence reports set out appropriate actions to address key threats, but these were not discussed at the security committee meeting and were not disseminated well enough to staff.

3.39 The monthly security committee meeting was not always well attended and, while monthly security reports included some useful data, they were not analysed over time.

3.40 Physical security had been increased when the role of the centre was changed to a mixed male/female IRC. Changes included the installation of additional CCTV, razor wire and prison-style cell doors and vented windows.

3.41 With the exception of Bunting unit, male detainees were still locked in their cells overnight, which was not appropriate. They had courtesy keys to their cells and risks could have been managed by sufficient night staff. Otherwise, detainees had reasonable freedom of movement in the centre.

3.42 The focus on staff corruption was adequate. During the previous six months, the centre had upheld two complaints that staff had sexually harassed detainees. In the first case, a male officer was found to have harassed a female detainee, and in the second a female officer was found to have harassed a male detainee. Both members of staff resigned while the complaints were being investigated.

3.43 Management and authorisation of strip-searching and closed visits had improved and neither was commonly used. However, health care did not provide sufficient information on the use of restraints for hospital escorts to inform the risk assessment and we were not satisfied that all decisions to use restraints were justified.

3.44 Very few detainees whom we interviewed were aware of illegal drugs in the centre. Some useful work had been done to address drug supply, but there was no up-to-date supply reduction policy. Managers were working to introduce a more co-ordinated, multidisciplinary approach to supply reduction.

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.

3.45 Force had been used 69 times in the previous six months, including twice with women. Most incidents entailed minimal force, such as guiding holds and pushes. Use of force documentation was well managed and generally demonstrated reasonable justification.

3.46 All use of force was reviewed by a senior manager and the Home Office compliance team separately checked all footage.

Multidisciplinary reviews were being planned. Home Office reviews were not always timely and there had been considerable delays in reviews of the footage by Serco. However, no reviews were outstanding at the time of the inspection. We were concerned to find a case of potentially dangerous staff incompetence when applying control and restraint techniques, which had not been identified on review. Centre leaders were informed of this case.

3.47 The recordings showed good examples of staff engaging well with detainees and de-escalating incidents. However, it sometimes took too long to gain control of the detainee and it was evident that staff lacked experience. Body-worn cameras were not always used when necessary, which was a failing.

3.48 The Home Office Professional Standards Unit (PSU) had substantiated one complaint involving poor control and restraint techniques in the last six months. In another case, a staff member had been suspended pending the outcome of an internal investigation which was the subject of a separate PSU management review.

3.49 We were not satisfied that all appropriate matters were referred to the PSU. A detainee told us that his finger had been broken by immigration arrest officers. He had reported this to health care staff who had documented his injuries but took no further action, failing to report it to the Home Office or Serco for investigation.

3.50 Use of force meetings were held regularly with good attendance, but minutes indicated limited discussion of monitoring data.

3.51 During the previous six months, 144 detainees had been separated in the control and separation unit (CSU) under Rule 40 (removal from association) and 10 under Rule 42 (temporary confinement). The average time that detainees had spent in separation was not excessive: six hours under Rule 40 and two hours under Rule 42. Separation under these provisions was appropriately justified and overseen in most cases. However, the exceptional circumstances required to separate people in crisis were not always sufficiently recorded and there was little documented reintegration planning.

3.52 During the same period, 69 detainees had been separated for charter removal for an average of more than 13 hours. This had been justified by reference to Rule 15, an administrative provision requiring accommodation to be certified as fit for habitation. This Rule did not confer power to separate detainees nor was the separation of these detainees based on individual risk or subject to appropriate oversight as required by Rule 40.

3.53 At least two psychotic detainees who were not fit for detention had been held in the CSU under Rule 40. One of these was a man who was held for a total of 28 days and the other a woman who lacked mental capacity (see paragraph 4.53).

3.54 The separation unit was in reasonable decorative condition, but cells were austere. There was no separate CSU for women and there had been at least one occasion when a woman had been held in the CSU at the same time as a man.

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.

3.55 The Home Office could not provide accurate figures on the time that detainees had spent in detention but even the lowest reliable estimates were concerning. The data indicated that the average cumulative time spent in detention, including time spent in other centres, was 74 days and potentially considerably longer. At least 32 people had been detained for more than six months and at least eight people for over a year.

3.56 The Home Office DET had been short-staffed but had continued to hold regular surgeries on the units and meet detainees promptly to discuss their cases. The team had had more than 4,000 engagements with detainees during the previous six months. However, some paperwork had been served by post and not all bail summaries had been served on time.

3.57 Most detainees we spoke to said that it was straightforward to meet a member of the DET, but they were often unable to provide them with a meaningful update on their case. Many detainees did not have a good understanding of important aspects of their case progression.

3.58 We sampled 16 cases on the Home Office online casework system. In nine of these cases, the detainees had previously served prison sentences but only four had been served with a deportation order before their prison sentence had concluded. In each of these four cases the detainees had made further representations to the Home Office and their removal had had to be deferred.

3.59 Monthly updates in our sample were generally timely but often showed little meaningful progress. Casework was often slow, especially for detained asylum-seekers, and applications for emergency travel documents also delayed progress. In one case, a man had been detained for 10 months but the Home Office remained unsure of his nationality and there was no timescale for obtaining an emergency travel document. In another case, a man had claimed asylum nine months previously but remained in detention despite no decision on his claim.

3.60 Some detainees whose release had been agreed in principle continued to be held for long periods because of a lack of approved bail accommodation. One detainee was released during our inspection almost eight months after bail had been granted.

3.61 We found several examples of detainees who had continued to be held despite the Home Office recognising that they were unfit for detention. During our inspection, a woman who was deemed too unwell to be detained or released into the community was transferred to another centre, despite efforts to locate a suitable hospital placement for her. In another case, a man whom the Home Office had deemed to be at the highest level of vulnerability had been detained for more than a year despite being recognised as a victim of torture. He was released during our inspection.

3.62 The Detained Duty Advice Service operated four days a week and 638 face-to-face sessions had taken place during the previous six months. Waiting times were short, but some detainees had to speak to several legal representatives before finding one who would take their case. The centre facilitated visits from legal representatives efficiently and 113 had taken place during the previous six months. There was no private area for detainees to video call their legal representatives.

3.63 The legal visits area was large enough to accommodate asylum interviews and bail hearings and there was also a courtroom in the centre where bail hearings took place. A small private room in the visits area was fully equipped for detainees to have medico-legal assessments.

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 We saw mainly positive relationships between staff and detainees, especially on the women's unit. In our survey, 67% of detainees said staff treated them with respect all or most of the time compared with 88% at other centres. Detainees whom we interviewed described staff as friendly and respectful, although there were also a few reports of rude or unhelpful attitudes.

4.2 There was no longer a personal officer scheme (see paragraph 6.1), but 77% of detainees responding to our survey said they had a member of staff they could turn to for help if they had a problem.

4.3 Staffing levels had increased in line with the larger population and staff retention was improving. However, there were many inexperienced staff and some struggled with managing a sometimes more challenging population who were detained for longer. Detainee custody officers often did not challenge minor misbehaviour such as detainees smoking inside and, in our staff survey, some staff were concerned about the lack of professionalism shown by newer colleagues (see paragraph 3.34).

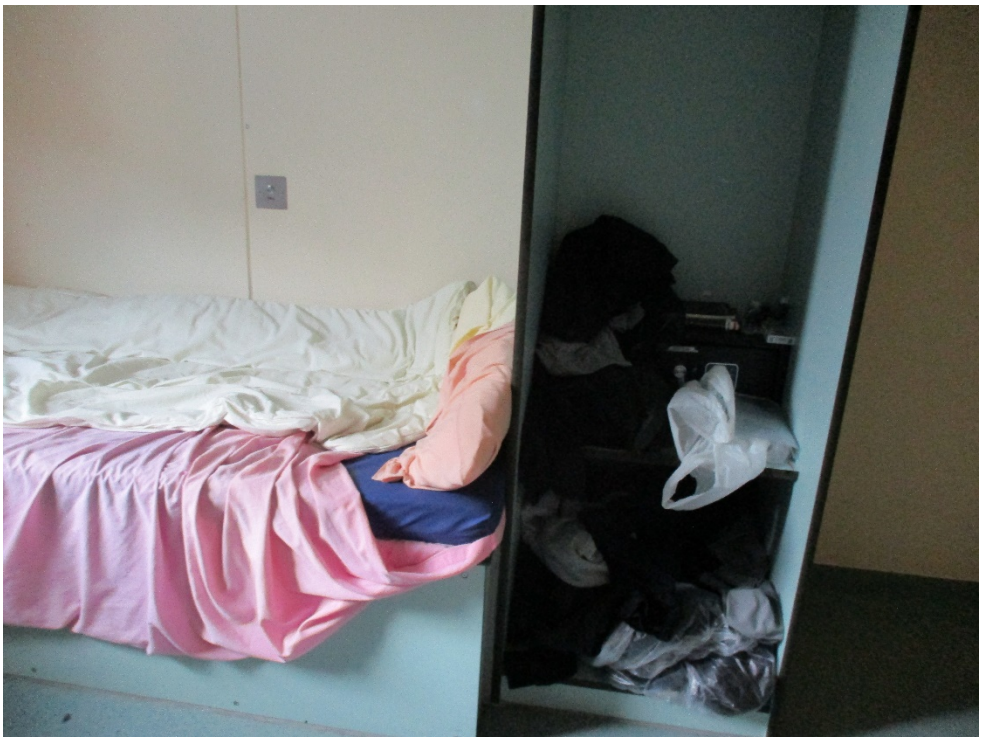
Daily life

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

4.4 Living conditions were generally good, especially in the women's unit, but the men's accommodation had become more like a prison since the installation of cell doors and non-opening sealed windows with air vents. Most cells were shared and were reasonably well equipped with a television, small lockable safes, tables and cupboards, although

these had no shelves. All cells had separate shower and toilet areas and detainees had courtesy keys.



Adapted cell with lack of shelving

4.5 The increase in detainee numbers had highlighted the limitations of the infrastructure in the centre. There was limited communal space and many people congregated in narrow corridors (see paragraph 4.4). Units could be noisy and only a third of those responding to our survey said it was quiet enough to sleep at night.

4.6 The exercise yards were well used but had limited seating and could become crowded. The central courtyard (pictured on the cover of this report), which was a popular meeting place, was run down and not always clean. The exercise yard for women was more attractive and welcoming, but it was overlooked by male accommodation (see paragraph 3.33).

Nightingale exercise area

4.7 Detainees were issued with clean bedding on arrival and the laundry areas were easily accessible and well maintained. There was a good stock of clothing in the centre if detainees required it.

Detainee consultation, applications and redress

4.8 Resident information action committee meetings were held separately for men and women every month and gave detainees the opportunity to provide feedback on topics such as food, accommodation, activities, the shop and visits. However, attendance was inconsistent and issues raised were often not actioned. Minutes of the meetings were displayed on a notice board in English.

4.9 During our interviews, most detainees were confident about complaining if required but some were concerned about the perceived impact on their case. Despite this, considerably more complaints had been raised in the previous six months than at our previous inspection (82 compared to 24) and about 14% of these were fully or partially upheld. Complaints were investigated well, replies were informative and polite and the findings were reasonable. However, a small number of complaints about the conduct of officers had been inappropriately investigated by staff of the same grade.

4.10 Complaint forms in a variety of languages were freely available but were not up to date. Complaint boxes were available on each unit, but not always readily identifiable.

Residential services

4.11 In our survey, only 38% of detainees said the food was very or quite good and it was the most common complaint raised in our interviews. The food that we tasted had too many carbohydrates and did not reflect the cultural diversity of the population well enough. Special diets were catered for well.

4.12 No detainee surveys on the menu were carried out and catering staff had not attended any recent resident information action committee meetings. There was little evidence that food concerns raised at these meetings or in the food comments books on the residential units were addressed.

4.13 Detainees could eat in communal dining areas which were well used and had microwaves for detainees to use. Cultural kitchens were available for both men and women to cook for themselves and their friends. In spite of their popularity, they were often closed because of staff shortages (see paragraph 4.6).

Nightingale cultural kitchen

4.14 The shops had a reasonable range of goods but there were few healthy food options because, we were told, there was no storage space. Detainees could buy on-line goods 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

4.15 The equality action team (EAT) was energetic and proactive. An assistant director led the centre's equality work supported by an experienced manager and a diversity officer, although the latter was often redeployed. A cycle of activity supported the celebration of equality, diversity and inclusion events, but it was advertised on noticeboards in English only. The centre could not provide figures on attendance. No detainee equality representatives were in post.

4.16 Monthly EAT meetings were often poorly attended. Data were collected and analysed on a few key areas, such as discrimination incidents, but only covered the previous month's activity. Detainees were not allowed to attend any part of these meetings, which was an unnecessary restriction.

4.17 Several senior staff members had been appointed to lead work on each protected characteristic (see Glossary) and some forums had been held on age, disability and religion. These varied in quality and attendance.

4.18 Twenty-nine complaints involving allegations of discrimination had been submitted in the year to date which were monitored by the equality action team (see paragraph 3.79).

Protected characteristics (see Glossary)

4.19 Reception and welfare staff made good use of the professional interpreting service, but use across the centre appeared low at 243 occasions in the last month. This was partly mitigated by the fact that many staff spoke other languages and used their language skills generously. However, some key occasions to use interpreting were missed, for example when explaining bail conditions, which risked misunderstanding. Much useful information had been translated into common languages. Some noticeboards displayed material in different languages, but too many were in English only.

4.20 Just under half the operational staff were women and it was positive that leaders had now made sure there was an all-female staff group in the women's unit. In our interviews, women tended to report more positively than men across a range of issues. They had access to the

same services as men, but in some cases the level of access was more restricted (see paragraph 5.13).

4.21 There were three adapted cells for people with disabilities, two for men and one for a woman. Good individual support had been provided in the cases that we reviewed. During our night visit, not all staff were aware of detainees in their care who might need support to leave the unit during an emergency.

4.22 A quarter of detainees responding to our survey said they were gay, bisexual or of other sexual orientation, although only about 8% of detainees had disclosed this to the centre. Detainees who disclosed these protected characteristics were given one-to-one support by the diversity officer. A constructive and individualised approach had been taken to the care of transgender people.

Faith and religion

4.23 In our survey, 81% of detainees who responded said their religious beliefs were respected. Chaplaincy staff were supportive and visible in the centre. There was now a full team of religious ministers and efforts were being made to reinstate some volunteers whose vetting had expired during the COVID-19 pandemic.

4.24 There was good provision for the most common faiths with weekly communal worship and detainees had free access to the attractive and well-maintained faith rooms during association periods.

4.25 The chaplaincy worked well with equality and catering staff to promote the celebration of religious festivals and appropriate arrangements had been put in place 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.

4.26 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. The CQC issued 'requirement to improve' notices following the inspection (see Appendix III).

Governance arrangements

4.27 Northamptonshire NHS Foundation Trust (NHFT) was responsible for primary care, mental health and psychosocial health care services. NHFT subcontracted GP services to DrPA Secure Healthcare

Solutions. Kaleidoscope provided counselling and Time for Teeth delivered dental services. Central and North-West London NHS Trust (CNWL) delivered pharmacy services. Commissioners monitored the contract through monthly meetings, assurance visits and independent reviews. An NHS England quality review visit had last been completed in March 2022, before the award of the current contract which had not yet been followed up.

4.28 A health and social care needs assessment had been used to inform service delivery but had been compiled without the use of local data which limited the scope for analysis of trends or patient needs.

4.29 Partnership working between Serco, the Home Office and NHFT was not always effective and sometimes led to adverse outcomes for patients. For example, where patients had acute mental health needs and a hospital bed was required, partners did not always work together to make sure this was accessible to the patient.

4.30 Quarterly partnership board meetings were well attended but oversight and monitoring of some aspects of governance were ineffective, including incident reporting and record keeping. Female detainees received the majority of their health care in Nightingale unit where staff attended for up to 90 minutes in the morning.

4.31 Local governance meetings were well attended by all providers. However, there was poor reporting of incidents and potential risks to patient safety could not be readily identified or addressed.

4.32 There were vacancies in primary care, mental health, administration and psychosocial services as a result of which health care managers were drawn into clinical delivery, which took them away from their management responsibilities. We were advised that at least two nurses were on site 24 hours a day.

4.33 Mandatory training was being completed and professional development was encouraged. Staff had regular clinical supervision and had received safeguarding supervision from NHFT specialists which supported safer practice.

4.34 Health staff were good at notifying the Home Office through the appropriate channels of any changes in circumstances or deterioration in health. However, they received limited feedback and their clinical judgement was not always accepted.

4.35 We found considerable gaps in some aspects of record-keeping and health care leaders had limited insight into the risks this posed. The minutes of multidisciplinary meetings about patients with complex needs, or those who had failed to attend for their medication at the correct time, were not in the electronic clinical records. This was contrary to national guidance and presented a risk to patient safety and care. We raised these concerns with the head of health care and steps were taken to address the issue.

4.36 The team had received 30 complaints in the previous six months. Responses that we sampled were timely, fully addressed the concerns raised and were respectful in tone. Staff saw detainees face to face, using telephone interpreting when needed. Patients were informed of how to escalate their complaint if they were unhappy with the outcome. Specific health care complaint boxes were not properly identified on the units and detainees were using the centre boxes, which compromised patient confidentiality.

4.37 The health care centre was accessible, bright and clean, but some fixtures, such as taps, did not meet infection control standards. Emergency bags and defibrillators were checked daily. Officers' knowledge of emergency codes was inconsistent, but ambulances had been called promptly when necessary.

4.38 There was no overarching health promotion strategy to support a joint approach between the centre and health care, but NHFT followed the national calendar of health promotion events. Health promotion information was displayed in a range of languages in the main health centre, but in the women's unit information was in English only.

4.39 Blood-borne virus screening was offered at reception and patients could be referred to local specialist clinics if required. A range of age-appropriate health screens and vaccinations was offered routinely, including sexual health support and access to barrier protection. The health team had actively promoted vaccinations to the younger population and uptake had improved. Health care staff provided information and carried out procedures such as blood pressure and blood glucose monitoring on the units, which was good.

4.40 A patient who had tested positive for TB had been released on bail and we noted good follow up with a community specialist TB nurse to ensure continuing care.

4.41 Many detainees reported respectful and prompt treatment from health care staff and we observed some patient and kind interactions. However, only 51% of the detainees in our survey said that health care services were good. Patient feedback was provided in surveys but there were no regular health forums. A 'You said: We did' noticeboard in the health care department gave some feedback to patients.

Primary care and inpatient services

4.42 Detainees received a satisfactory private health screen on arrival and appropriate referrals were made. Women had access mostly to female staff and notices were displayed in different languages about the availability of a chaperone in all health care areas. The daily triage clinics were well attended and travel vaccinations were offered on request.

4.43 There was a suitable range of primary care services and acceptable waiting times. However, although waiting times for a Rule 35 (see Glossary) appointment had been reducing, they still took approximately

nine days, which was too long. Rule 35 reports varied in quality and lacked management oversight.

4.44 Urgent GP appointments were available and staff could call 111 for out-of-hours advice. The high number of appointments which detainees failed to attend was being monitored and ways of improving this were being explored. Nurse-led long-term conditions clinics were in place and lead roles had been identified, but some nurses were awaiting additional training. Not all patients had care plans to support management of their condition.

4.45 No pregnant detainees were held at the time of our inspection and we were advised that they would not be held in the unit. Pregnancy tests were offered at reception.

4.46 Referrals were made to hospital specialists as required and we were advised that health care and Serco worked well together to make sure that patients were able to attend. Health care risk assessments in detainee escort records were poorly completed and did not guide escort staff adequately. Health care staff had not received training on completing the risk assessment. We were concerned to find that they were not considering the proportionality of handcuffing and that their starting assumption was that a patient would be handcuffed. This was inappropriate.

Mental health

4.47 Mental health services were delivered by NHFT with Kaleidoscope offering counselling to patients with lower-level needs such as anxiety. The service operated from Monday to Friday, 9am to 5pm with primary care staff covering urgent need out of hours. Staffing levels were fragile: two mental health nurses dealt with all new referrals, seeing patients on their caseload and attending multidisciplinary meetings such as ACDT reviews. They were also covering some primary care tasks such as monitoring patients who were refusing food and fluids. The centre was receiving more patients with complex mental health needs, especially from prisons, which was placing increased demand on the service.

4.48 Despite these challenges, staff completed routine initial assessments within five days and urgent assessments within two days. A new registered mental health nurse had been recruited and was awaiting clearance. As a result of the short stays in detention of most patients, staff only maintained small caseloads and patients were seen regularly for reviews. Patients also had quick access to a clinical psychologist and assistant psychologist who provided valued support to patients managing trauma. Staff were dedicated and committed and knew their patients well.

4.49 The service operated a stepped care model and five patients were on the care programme approach for more severely unwell people at the time of the inspection. Patients could move between NHFT and Kaleidoscope services dependent on need. The two teams met

regularly to discuss patient care and worked well together. Kaleidoscope provided valued support to patients requiring counselling and also offered a relaxation group. This service was due to transfer to NHFT after the inspection and it was unclear how it would be staffed.

4.50 At the time of the inspection, there was no wait for a psychiatry appointment but waiting times fluctuated as the population changed. One session a week was delivered, although an additional session could be provided if needed.

4.51 Some records were detailed but others were brief and staff did not always have enough time to complete good quality entries. Care plans were not always in place where needed and those that we reviewed were basic and not person-centred.

4.52 Patients requiring health checks relating to mental health medicines were referred to the primary care team for blood tests and ECGs and these were carried out in a timely way. The mental health team leader was also the neurodiversity lead and NHFT was in the process of developing a neurodiversity pathway.

4.53 Only one patient had transferred directly from the centre to a secure hospital during the past year. This had taken more than two months, which was outside the 28-day timeframe, and included a long period in the CSU. Another patient who lacked mental capacity also spent time in the CSU and was transferred to another IRC during the inspection against the advice of health care staff who were seeking a secure hospital bed (see paragraph 3.53). Some patients left the centre without notification to health care staff, which could lead to delays in the transfer of continuing treatment to another provider. When staff had sufficient notice, they tried to make arrangements for the transfer of care to community providers, including those in other countries. When this was not possible, staff provided patients with a written summary of the care they had received at the centre.

Substance misuse treatment

4.54 The GPs provided clinical substance misuse treatment to a small number of patients (five at the time of the inspection). No psychosocial provision was available, but the recent contract allowed for two new posts which had yet to be filled.

4.55 All patients were screened for substance misuse needs during the reception process and prescribing was undertaken for those withdrawing from alcohol or opiates. Patients who were already receiving methadone prescribed elsewhere could continue with it subject to verification. Recognised screening tools were used to assess anybody who was showing withdrawal symptoms and observations were undertaken for the first five days.

4.56 All patients were placed on a methadone reduction programme, but records did not demonstrate that this was explained to patients or what action was taken should a patient not wish to reduce their dosage

further. The GP saw patients every Thursday for a review, but there was little support for patients who might be struggling between these meetings.

Medicines optimisation and pharmacy services

4.57 Medicines were dispensed remotely by a community provider and there was a short time lag before pharmacy staff received them. Stock was used to cover this gap whenever possible, which was good.

4.58 In-possession risk assessments were present for most patients, but many were not adhered to and reasons for the deviation were not recorded. We raised this with the head of health care who told us that it was being addressed.

4.59 Prescribing and administration were recorded on the electronic clinical record and the current in-possession risk assessment was easy to see. Medicines were administered three times a day. The queues for collection of medicines were usually supervised by officers and provided a degree of privacy. There was provision for night-time administration.

4.60 Suitable medicines were available to treat minor ailments. Patient group directions (which enable nurses to supply and administer prescription-only and pharmacy-only medicines) were limited but included permethrin for scabies treatment which was appropriate.

4.61 Controlled drugs were well managed. Medicines were stored and transported securely and cold-chain medicines were kept in suitable, monitored fridges.

4.62 There was limited clinical supervision of the medicines management service. There was no pharmacist oversight of prescribing and no pharmacist contribution to the reviews of patients who had missed more than three doses or had more complex treatments. The pharmacy technicians attended weekly meetings to discuss these cases, but they had limited clinical knowledge. The overall care of patients did not include a pharmacist's input into monitoring the blood tests required.

Oral health

4.63 NHSE commissioned Time for Teeth to deliver emergency dental services. An experienced dentist and dental nurse provided two sessions a week and offered further treatments when possible. Oral health advice was given during the session and telephone interpreting services were used. Health promotion leaflets were available in a few languages with work in progress to produce more.

4.64 Patients were seen within seven days and appointments for female and male detainees were facilitated at different times. The team was flexible and any urgent need was prioritised. Pain relief and antibiotics were prescribed by the dentist or the primary care team when needed.

4.65 The service kept a log of patients who did not attend their appointments. These patients were followed up with a phone call and a letter and rebooked if still required.

4.66 The dental facility was small but well equipped and met infection prevention and control standards. There was no separate decontamination room, but the clean and dirty areas were clearly signed and there was good adherence to safe cleaning practices.

4.67 Equipment was serviced and maintained appropriately. Governance arrangements were good and dental staff were suitably trained and supervised. Patients gave positive feedback about the service they had received.

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 detainees had reasonably good freedom of movement (see paragraph 3.41). They were unlocked for more than 12 hours each day and could move freely around the activity areas during morning, afternoon and evening sessions, totalling about 10 hours a day. However, detainees were not permitted to visit residential units other than their own, which restricted their social contact.

5.2 Access to outdoor areas was good. Each accommodation unit had an enclosed garden equipped with fixed exercise equipment and outdoor seating. The women's unit garden had attractive planting and facilities for outdoor games. There was one outside area where detainees from all the male units could meet, but it was overused and did not have enough seats.

5.3 Activities were not well promoted with little translated information and attendance was poor. Staff organised one-off events such as bingo competitions and film nights, but there was no regular or structured programme of activities for detainees. Only 24% of detainees who responded to our survey said they had enough to do to fill their time.

5.4 The men's activity areas were too small for the numbers now detained at the centre. There were not enough indoor places for detainees to meet, so they gathered in the corridors which became uncomfortably crowded. The centre had a good stock of pastimes such as board games, but they were little used because there was nowhere to play them. The association and games rooms on the men's accommodation units were uninspiring, poorly furnished and with few recreational facilities.

5.5 The women's association area was better. Located outside the accommodation unit, it was less crowded and provided a reading area, internet access room, hair and beauty salon, shop and a small recreation room. The hairdressing salons in the men's and women's areas were well equipped and popular with detainees.

5.6 There were cultural kitchens in both the women's and men's areas, which allowed groups of detainees to prepare meals from their own national dishes with support from trained staff. These sessions were popular and provided very good purposeful activity but were cancelled too often because of staff shortages (see paragraph 3.76).

5.7 Access to the internet was reasonably good. The computer room was open every day, providing 30 terminals with fast internet access. Places were available during most of the day, but the room became

crowded in the evening sessions. Detainees could access legitimate websites without restrictions, but use of social media was blocked.

Education and work

5.8 Education classrooms in the women's and men's units were comfortable and easily accessible and classes were provided every day. The two teachers were appropriately skilled and experienced and gave a friendly welcome to prospective learners. The curriculum focused on teaching English which was appropriate for the population, many of whom had little command of the language. Teachers also offered tuition in basic mathematics and ICT. However, attendance was poor, with less than 25 learners registered, and most sessions were attended by only two or three detainees.

5.9 Teachers carried out a simple initial assessment with new learners to determine their level of ability in English. They had developed a good range of learning materials and worksheets to suit different levels of ability. These were supplemented by one-to-one tuition and use of teaching resources on the electronic white board.

5.10 The very low numbers attending restricted the range of techniques that teachers could use to add interest to classes. There was little interaction between learners in most sessions. Detainees' progress was recorded on individual learning records, which showed that some made considerable improvements in their understanding of English.

5.11 There were six computers in the men's classroom, which detainees could use to study on-line courses, including a level 2 award in food hygiene which was the only accreditation offered by the centre. In the women's unit these courses were available on the IT room computers.

5.12 Art and craft sessions were also offered each day. There was an art room in the men's unit and classes were held in the association area on the women's unit. Detainees enjoyed creative activities and developing new skills, including painting, model-making and printing on T-shirts. However, the art room was too small and the numbers attending were low. The tutor was enthusiastic but had to cover both women's and men's classes and was sometimes redeployed. There was little activity in the art room when the teacher was not present.

5.13 Classroom provision was not monitored by managers to make sure that it was of good quality and met the needs of detainees. There was no procedure to observe teaching, deliver feedback and identify possible improvements. Managers collected data on attendance but had not carried out a review of the curriculum, despite the low take-up of education.

5.14 About 110 paid work roles were available for detainees. At the time of the inspection, only 35 were filled, but records showed that up to 70 detainees had been employed in recent weeks. The pay rate of £1 per hour was a considerable disincentive for many detainees. During the

previous six months, 16 detainees who had applied for jobs had been prevented from working by the Home Office.

5.15 Notices promoting paid work opportunities in different languages were displayed on the main corridor. Applications were dealt with efficiently and detainees were given an information pack, including health and safety information and a job description. This was only available in English, but staff told us they would have it translated when necessary.

5.16 Most jobs were cleaning or kitchen roles, but detainees could also apply to work as peer supporters and as assistants in the library and hairdressing salons. Those wishing to work in the kitchen or on food serveries were required to complete an on-line training course in food hygiene. There was no other training or recording of the skills detainees developed through their work.

Library provision

5.17 There was good access to the library which was located in the men's activity area and was open every day. It was efficiently managed by a staff member who had completed a library training course. There was a reasonable stock of library books, films and CDs in the women's association area. These were regularly refreshed from the main collection and women could request specific items.

5.18 The book stock was well matched to the needs of the population. There were more than 7,000 books, including a high proportion in languages other than English. The librarian ordered new titles each month, based on feedback from users and data on the nationalities of detainees held at the centre. Detainees could also borrow from an extensive range of films on DVD and music CDs.

5.19 The library held copies of immigration legislation and had recently purchased a good collection of up-to-date legal textbooks for reference. Both women's and men's libraries provided daily newspapers in English and four other languages.

5.20 There was no activity to develop detainees' reading. The library was too small to provide spaces for study or for events to promote reading such as book clubs or promotions. The two available seats were reserved for detainees making Skype calls. These were poorly located and did not afford privacy for those making calls (see paragraph 5.14).

Fitness provision

5.21 The centre had good sports and games facilities, but the outdoor artificial turf pitch was temporarily out of use because of recent security concerns. Similarly, the large sports hall, which was normally used for a wide range of activities, was restricted to football and basketball games for a maximum of 10 players. Despite these restrictions, activities staff organised regular tournaments and events to encourage participation.

5.22 The gym had a small cardiovascular exercise room with three treadmills and seven other exercise machines. The fitness equipment

was in good condition, but the room was quite cramped and poorly ventilated. Four more machines were located in the corridor outside.

5.23 Male detainees had good access to the facilities. They could use the exercise room whenever they wished during the day, except for an hour when it was reserved for female detainees. Both men and women could book the sports hall for games.

5.24 New detainees were shown how to use the equipment safely, but this induction was not translated into languages other than English. There was no routine communication with health care staff to ensure that detainees were medically fit to use the facility, but Serco was informed if a detainee could not participate. Most activities staff were appropriately qualified to work in the gym, but some were still working towards their qualification.

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 was well resourced, dedicated and highly valued. Staff completed a thorough welfare induction of every new arrival within 24 hours, assessing support needs and helping to address any issues, including property retrieval, contacting families and providing information for release. Some members of the team could speak different languages, which was appreciated by the detainees, and telephone interpreting was also well used. Plans to establish regular key working sessions had been hindered by cross-deployment of welfare staff to cover staff shortfalls elsewhere in the centre.

6.2 The welfare office offered a welcoming environment, with several information leaflets in different languages on support and available services. The visitors' room was decorated with soft furnishings and was used for events and drop-in services for the men. The number of welfare contacts was high, but not all detainees were seen before release and outstanding needs were not always met (see paragraph 5.20).

External visitors room

6.3 Male detainees could drop into the office seven days a week throughout the day and most evenings, but access to welfare services was considerably worse for women. Welfare staff visited the women's unit for two hours a day but did not advertise their presence and had neither a dedicated room nor computer access.

6.4 The welfare team had made good links with support organisations in the community, such as the Red Cross and MIND. Bail for Immigration Detainees attended the centre once a month and Hibiscus were on site four days a week, a charity offering a helpful return, resettlement and welfare service for men and women. Beyond Detention offered valuable emotional and practical support to all detainees, both in the centre and on release, and the drop-in sessions that they held three times a week were well attended. They also delivered a visiting befriender service, although take-up of this was low (see paragraph 5.5).

Visits and family contact

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

6.5 The availability of visits was good, with sessions seven days a week between 2pm and 5pm and 6pm to 9pm. In our survey, 37% of detainees said they had received a visit from family or friends at the centre, compared to 17% in other immigration removal centres. Detainees we spoke to were positive about the provision of visits. A

well-established befriender service was available through the organisation Beyond Detention, but the take-up of this was low and the centre did not actively identify and encourage those who might benefit from the service.

6.6 The visitors' centre was in good condition. It was clean and spacious, with snacks and drinks available to buy from two vending machines. Visitors did not spend long in this area and were processed efficiently through to the visits hall. We observed staff who were friendly and helpful when checking in visitors and property they had brought in for detainees.

6.7 The visits hall was a large and comfortable room. There was a small area with facilities for children of all ages, including board games and PlayStations, and the outdoor seating area was pleasant. No hot meals were available, but visitors could buy snacks and drinks from the vending machines. A small shop had also been set up for detainees in the visits area, selling items more cheaply than the vending machines.

Visits hall

6.8 Detainees who were identified as having additional risk factors were managed well by visits staff and measures to safeguard children were in place (see paragraph 3.28). There were two closed visits rooms which, at the time of the inspection, were used for two detainees under restrictions because of evidence that drugs had been passed during visits. These restrictions were reviewed each month.

6.9 Visitors were able to complete a questionnaire in different languages to provide feedback about the centre. However, the comments received were not translated and analysed. Most of the information and notices in this area were in English only.

6.10 A free bus service was available between the train station and the centre, which was good. This had to be pre-booked, but an out-of-date bus timetable had confused some visitors whom we spoke to.

6.11 Support was not routinely offered to detainees who were separated from their children and families. Detainees were asked during the reception process if they had children, but unless they specifically asked for support to maintain family ties, none was offered (see paragraph 3.29). Leaders were aware of this issue and the welfare department was working to rectify it.

Communications

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

6.12 All detainees had access to a mobile phone, which was good, and residents were issued with £5 on arrival, which they could use to buy credit in the shop. The mobile phone signal in most of the centre was poor, particularly in some detainees' rooms. They were, therefore, unable to make any calls to families, friends or legal representatives when they were locked in overnight (see paragraph 3.41).

6.13 Skype had been made available since our last inspection and the take-up was good. The men had good access to eight Skype terminals seven days a week from morning to evening. Women had considerably less access to this service. There was only one Skype terminal on their unit with limited availability because the room was used by the education department.

6.14 Most computers available to the men lacked privacy, particularly in the library where detainees had to cover the screen so it could not be seen by other library users (see paragraph 4.20). A further six Skype terminals in the visits hall afforded slightly more privacy.

6.15 The computer rooms were popular in the men's and women's areas and access to the internet and fax machines was good. The rooms were open for 9.5 hours a day, seven days a week, and staff were available to help detainees use these facilities. Computers could be used for access to personal email accounts and leisure purposes, but social networking was still unnecessarily prohibited.

6.16 Detainees could send one free personal letter a week and unlimited legal correspondence. All mail coming into the centre was routinely drug tested and we observed all detainees collecting their post having to open their mail in front of a staff member, which was excessive. Senior leaders addressed this during our inspection.

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.

6.17 During the previous six months, centre records showed that half the detainees leaving the centre were released into the community. Some had spent considerable time in detention. However, Home Office and Serco data on this were inconsistent and we could not establish an accurate number of men and women being released from the centre.

6.18 We found evidence that some detainees were being released homeless, although there were no records of the number. We found an example of a detainee, identified as an adult at risk and with complex needs, being released with no fixed abode. In another case, a detainee had been given bail subject to the tagging system but had been released with no address for the tag to be applied. The release plans for some vulnerable detainees were discussed at the weekly individual needs meeting, but outstanding needs were not always addressed and it was not always clear if actions were completed.

6.19 The length of detention for some detainees was extended for several months because there was no suitable accommodation (see paragraph 3.60). If a detainee was subject to licence conditions in the community, there was evidence of delays by the Probation Service in completing relevant checks on the suitability of accommodation.

6.20 Men and women had separate discharge areas, both of which were in good condition. The welfare team did not see every detainee before release and, although they provided a useful release booklet with information on support services, this was only available in English. We observed the release of two women for whom interpreting was not used when it would have been beneficial. Detainees were asked to complete a resident discharge questionnaire, which was available in different languages, but no meaningful analysis was carried out and comments received were not translated.

6.21 It was regular practice for detainees who were being removed on a charter flight to be taken to the care and separation unit before leaving the centre. There was no individual risk assessment and their access to services, such as welfare drop-in sessions, was restricted (see paragraph 3.52).

6.22 The centre provided transport to the nearest train station for those being released and issued travel warrants to their destination. Charities, including Beyond Detention and Hibiscus, provided support, including clothing and information on release areas, and health care staff ensured that detainees had access to their medical records before leaving the centre.

Section 7 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

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 2017, outcomes for detainees were reasonably good. Outcomes for detainees were now not sufficiently good against this healthy establishment test.

Key recommendations

There should be a strict time limit on the length of detention. (S35)
Not achieved

Rule 35 assessments should be completed within 24 hours. Reports should provide clear, objective and detailed professional assessments, including on evidence of PTSD. Responses should be prompt. Where professional evidence of torture is accepted, the exceptional reasons leading to the decision to maintain detention should be provided, in detail. Rape should be considered a form of torture for the purpose of Rule 35. (S36)
Not achieved

Recommendations

Detainees should not be subject to long delays before transfer to Yarl's Wood. They should never be transported during the night except for urgent operational reasons. (1.3)
Not achieved

Reception should not be staffed by a lone male officer and women should be screened by female nurses in reception. (1.11)
Achieved

Night-time welfare checks should be fully explained to detainees in a language they understand, and they should be conducted by staff of the same gender. (1.12)
Partially achieved

Induction should take place on the day following reception. Key information should be given to detainees in accessible, written formats. (1.13)
Partially achieved

When managers conclude that there is no need for an external investigation of a detainee's allegation, a clear rationale for their decision should be recorded. (1.21)
Achieved

Managers should document the reasons why detainees are held in the supported living facility and the rooms adjacent to health care. (1.28)
Achieved

Safeguarding adults training should be delivered to all staff and should include raising awareness of trafficking, torture and the national referral mechanism. There should also be a single comprehensive list identifying detainees considered vulnerable, with effective multidisciplinary oversight and, where appropriate, care planning. (1.37)
Not achieved

Detainee custody officers and all other relevant staff should complete necessary safeguarding children training. (1.42)
Achieved

Male staff should not search women's rooms. (1.50)
Achieved

Closed visits should only be imposed when there is evidence that a detainee has abused visits. There should be regular documented reviews of the related intelligence. (1.51)
Achieved

All strip-searches should be accurately recorded and sufficient justification should be demonstrated. (1.52)
Achieved

All use of force incidents should be reviewed by managers and learning points should be shared with staff. (1.61)
Achieved

All operational staff should be able to apply control and restraint techniques confidently and competently. (1.62)
Not achieved

The separation unit should only be used to accommodate detainees under Rule 40 or Rule 42. All Rule 40 and 42 records should fully justify the need for separation. Detainees subject to assessment, care in detention and teamwork procedures should only be separated in exceptional circumstances which are clearly documented in separation records. (1.63)
Not achieved

The centre should explore the reasons for fewer non-English speaking detainees having a solicitor. (1.70)
Achieved

The library should be stocked with up-to-date legal text books. (1.71)
Achieved

Bail summaries should contain all relevant information, including details of why a detainee has been assessed to be at risk in detention. Summaries should be given to the detainee by 2pm on the working day before their bail hearing. (1.72)
Not achieved

Respect

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

At the last inspection in 2017, outcomes for detainees were reasonably good. Outcomes for detainees remained reasonably good against this healthy establishment test.

Key recommendations

More female staff should be recruited to ensure that at least 60% of staff in direct contact with women detainees are women. (S37)
Achieved

Robust governance of health services should ensure safe and effective medicines management, including establishing an effective medicines management committee and checking professional credentials. Unqualified pharmacy staff should be supported and should not be given responsibility beyond their competence. Detainees should receive their medicines in a timely manner. (S38)
Achieved

Recommendations

Graffiti in Bunting unit and across the centre should be removed and dealt with swiftly if it reappears. (2.7)
Achieved

All staff should receive the training that helps them to recognise and respond appropriately to the particular vulnerabilities of a female detainee population, including in cultural awareness and the specific backgrounds and experiences of detainees. (2.13)
Achieved

At least 60% of staff in direct contact with women detainees should be women. (2.14)
Achieved

There should be sufficient staff on units at all times. Units should never be left without any staff presence. (2.15)
Achieved

Strategic planning for diversity should consider the specific needs of the population at Yarl's Wood, set objectives and clearly set out how these will be achieved. (2.19)
Not achieved

Diversity monitoring should facilitate the identification and investigation of trends in detainee outcomes across all the protected characteristics. (2.20)
Partially achieved

All detainees who identify as having a disability should be assessed and receive necessary support while at the centre, including the assistance of a paid detainee carer if required. (2.26)
Partially achieved

With the exception of medical in confidence issues, the centre should be aware of all complaints made to ensure managers have a good understanding of detainee concerns. (2.34)
Achieved

There should be more seats outside the medication area for detainees to wait for their medication. (2.51)
Achieved

All clinical environments should be accessible only to health care staff and should comply with infection control standards. (2.52)
Partially achieved

An effective monitoring system should be in place to ensure that all emergency resuscitation equipment is in good order. (2.53)
Achieved

The in-possession policy should be adhered to, prescribing should follow local guidelines and there should be effective monitoring of prescribing trends to provide assurance of safe outcomes for detainees. Medicines should be stored safely. (2.68)
Achieved

The food menu and the range of goods available for detainees to purchase should reflect the diverse needs of the population. (2.86)
Partially 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 2017, outcomes for detainees were good. Outcomes for detainees were now reasonably good against this healthy establishment test.

Recommendations

Information should be displayed to remind detainees of safe working protocols when using computers that are used by other people. (3.7)
Achieved

Managers should observe training activities to assure the quality of the training delivered by tutors, visiting staff and volunteers. (3.14)
Not achieved

More paid work opportunities should be made available for male detainees on the family unit. (3.17)
No longer relevant

The librarian should be qualified in library management. (3.21)
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 2017, outcomes for detainees were reasonably good. Outcomes for detainees remained reasonably good against this healthy establishment test.

Key recommendation

The welfare department should see all detainees being released from the centre to address outstanding needs and signpost detainees to community support where required. (S39)
Not achieved

Recommendations

The visits hall play area should contain a good range of toys and games for children of all ages. (4.5)
Achieved

Subject to risk assessment, detainees should have access to video calling and social media. (4.9)
Partially achieved

All detainees requiring it should be provided with the financial means to reach their final destination safely. (4.15)
Achieved

Links with a broad range of community organisations should be developed, including gender-specific services. Centre staff should work closely with these organisations to address the support needs of detainees who have experienced abuse, rape, violence or other forms of exploitation. (4.16)
Achieved

Only detainees who volunteer to do so should be placed on a reserve list. (4.17)
No longer relevant

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
Hindpal Singh Bhui	Team leader
Deri Hughes-Roberts	Inspector
Rebecca Mavin	Inspector
Chelsey Pattison	Inspector
Steve Oliver-Watts	Inspector
Fiona Shearlaw	Inspector
Emma King	Researcher
Alexander Scragg	Researcher
Samantha Rasor	Researcher
Grace Edwards	Researcher
Sarah Goodwin	Lead Health and Social Care Inspector
Maureen Jamieson	Health and Social Care Inspector
Matthew Tedstone	Care Quality Commission Inspector
Mark Griffiths	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/

Adults at Risk
A Home Office policy aimed at identifying vulnerable individuals held in immigration detention.

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.

National Referral Mechanism
A framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

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

Rule 35
Rule 35 of detention centre rules requires the Home Office to be notified if a detainee's health is likely to be injuriously affected by detention, including if they may have been the victim of torture.

Appendix III Care Quality Commission Requirement Notice

Care Quality Commission (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

The inspection of health services at Yarl's Wood Immigration Removal Centre was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/working-with-partners/). The Care Quality Commission issued 'requirement to improve' notice/s following this inspection, which is published on our website.

Provider

Northamptonshire Heathcare NHS Foundation Trust

Location

Yarl's Wood Immigration Removal Centre

Location ID

RP1Z1

Regulated activities

Treatment of disease, disorder or injury and diagnostic and screening procedures.

Action we have told the provider to take

This notice shows the regulations that were not being met. The provider must send CQC a report that says what action it is going to take to meet these regulations.

Regulation 17 (1)(2)(a)(b)(c)

1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.
2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to:

a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

How the regulation was not being met

Systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Systems and processes were not operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Systems and processes were not operated effectively to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

In particular:

- Clinical record keeping was not of an acceptable standard with some entries being very brief and not explaining the care and treatment provided. Records relating to PRN medicines (medicines to be taken 'as required') given to patients did not explain what the medication was being given for.
- GP Rule 35 reports lacked detail and did not always provide a clear recommendation.
- Discussions of patient care in multidisciplinary team meetings and medication missed dose meetings were not entered on to patient records meaning that important information about patient care was not available to other clinicians.
- Record-keeping audits had not identified shortfalls or ensured that remedial action was taken to improve standards.
- Care plans were not always in place for patients when required. Where care plans were in place, they were basic and not person centred.
- Incidents were not always being reported which meant that investigations into those incidents were not carried out and opportunities to share learning were missed.
- There were limited opportunities for patients to provide feedback about the service because there was no dedicated healthcare forum and limited healthcare attendance at the IRC residents forum.

- Staffing challenges meant that the head of healthcare had to cover some clinical activity which detracted from their ability to focus on managerial and strategic work.

Appendix IV Summary of detainee interviews

Every detainee at Yarl's Wood was offered a confidential individual interview with an inspector. A few had either left the centre or did not want to be interviewed when inspectors went to see them, and we eventually conducted 47 interviews, including 17 with interpretation. We also issued an invitation, through various voluntary and community groups, for recently released detainees to speak to us. No detainees were referred to us through this route. The interviews were semi-structured and were held from 12–14 June 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 V). 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.

Key themes from 47 detainee interviews

Most detainees were treated well on arrival, but some had very long waits in police cells

The vast majority of detainees said they had been treated well or reasonably on arrival, although those who spoke little English were more critical. A few detainees had been held for periods of up to 36 hours in police stations before being transferred to Yarl's Wood. One man said he had been in a dark police cell for over 24 hours and felt like he had been 'losing his mind' before he was transferred to the IRC.

Lengthy detention and lack of information about cases caused distress to many

Uncertainty about release date, long periods in detention, a lack of information from the Home Office and feeling like they were in a prison were common concerns cited by detainees. Some said this had led to depression and panic attacks, several detainees were crying during interview. Some detainees who wanted to return to their own countries were frustrated at the time it was taking to arrange their removal. One detainee who had already been in detention for 14 months in total said: 'It feels like they kidnapped me, I'm away from my friends and my family. My brain still hasn't processed the fact that I'm in detention.'

Most detainees felt physically safe

Most detainees felt physically safe and none reported being assaulted either by other detainees or staff. Most had either not seen any fights or conflicts between others or said that staff dealt with incidents quickly. Very few were

aware of drug use or had seen any problem associated with drugs. However, although most felt that other detainees behaved appropriately in the centre, some described feeling intimidated by the more numerous national groups and some felt unsafe around ex-prisoners.

Some detainees had also been afraid for their safety during a recent protest against detention when a fire was started. They said they were locked in their cells while smoke was drifting in and could not get staff to respond to their alarm bells. A few other detainees mentioned personal health care issues as making them feel unsafe.

Most detainees found staff respectful and helpful

Detainees usually described staff as respectful and friendly, and a few were very complimentary about the efforts staff made to engage with them. However, some felt that staff were not always proactive enough in helping them and a few were described as being rude or shouting at detainees. Some detainees felt they were targeted because of their ethnicity.

Detainees were worried about complaining formally in case it affected their case

While most detainees were confident about complaining if they had to, many had little confidence in the system or were worried about the impact of complaining on their cases. Several said they were more comfortable complaining verbally to staff rather than putting things in writing.

There were mixed reports about the support from health care staff

Some detainees were very positive about the care provided for both physical and mental health needs, describing, for example, compassionate health care staff and good mental health support from a psychologist. However, others complained of long waits for appointments, and a few said they had received poor treatment or lack of appropriate medication.

Food was the main source of complaint and activities were the most commonly mentioned positive

Many detainees complained about quality and cultural variety of the food, and a few said they could not or would not eat it. Most appreciated the cultural kitchen, but they said access was too limited and sessions were often cancelled. The main positive aspects of the centre mentioned by detainees were activities, including the gym, education and work, and the visits facilities.

Appendix V Further resources

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

Detainee population profile

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

Detainee survey methodology and results

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

Survey of centre staff

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

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

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

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