Report on an unannounced short follow-up inspection of

Dungavel House Immigration Removal Centre

31 July – 2 August 2012

by HM Chief Inspector of Prisons

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Introduction

Dungavel House is an immigration removal centre (IRC) for male and female foreign nationals being removed from the UK. Since our last inspection, the government has confirmed that children will no longer be held at the centre. It is the only IRC in Scotland. In our previous report we described it as 'the best IRC we have inspected'. At this inspection, we were pleased to find that the centre had built on its strengths and made sufficient progress against our recommendations in three of the four healthy establishment areas.

Improvements had been made to an already very safe environment. The care of detainees during their first days at the centre had improved. Despite many exhausting overnight journeys and the absence of prison files arriving with detainees from Scottish prisons, detainees were safe. Reception had been relocated to a bigger and more suitable unit. Male detainees were housed on a new dedicated first night unit and received regular checks on their well-being. We were pleased to find that non-English speakers received help to deal with the frustrations of detention, and that female detainees could receive counselling. However, the UK Border Agency did not always attend case reviews for detainees in crisis. Not all detainees were able to consult their lawyers in private. An age-dispute policy had been developed with assistance from South Lanarkshire social services.

We witnessed excellent relationships between staff and detainees – an enduring strength of the centre. Female detainees still did not have access to single or double rooms, which was unsettling, especially during the early days. Attempts had been made to improve some inadequate accommodation on one of the male units but further work was needed. The centre's equality policy required more procedural guidance but identification of detainees with disabilities had improved. A helpful online diversity training package was available to staff. Complaints were dealt with respectfully and addressed issues raised but a separate system for health care complaints was required to protect medical confidentiality. The health centre had relocated to a much more suitable environment and there were more nurse-led clinics. A third of frontline staff had undergone mental health awareness training but we were disappointed to find a lack of training to identify and treat torture survivors.

Activities for detainees had improved. The already high-performing learning and resources centre (LRC) had upped its game even further. All detainees received a briefing from the LRC team and a works opportunities coordinator ensured that job vacancies were quickly filled. Paid work opportunities had increased. The centre had proactively worked with the Scottish Qualification Authority to provide more certified and higher-level courses. Teaching was better than at the previous inspection, with more varied, individualised and interactive methods used to engage detainees.

Less progress than in other areas had been made in preparing detainees for release. Assistance for those served with removal directions at weekends had improved. While the needs of detainees being removed were assessed, those being transferred or released were not all routinely assessed. Detainees were often given little notice of transfers and many did not know the reasons for the transfer. Detainees whose removal was enforced did not receive formal assistance with the journey from the airport to home in their country of origin.

Dungavel remained a safe and respectful centre, with good activities to engage detainees. With the exception of preparing detainees for release, the centre had not rested on its laurels but had actively worked to improving outcomes for detainees. Improvements in reception, health care, teaching and work places were particularly welcome, as was the introduction of a first night centre and interventions to help detainees overcome the frustrations of detention.

Nick Hardwick **September 2012**
HM Chief Inspector of Prisons

Fact page

Task of the establishment
The detention, care and welfare of people subject to immigration control.

Location
Strathaven, South Lanarkshire

Name of contractor
GEO Group UK Ltd

Number held
173

Certified normal accommodation (CNA)
217

Operational capacity
217

Last inspection
21–25 June 2010

Brief history
Dungavel House Immigration Removal Centre was formerly a hunting lodge for the Duke of Hamilton. It was used as a hospital during two World Wars, after which it became a training college for the Coal Board (Bevin's boys), and then an SPS low-category prison. It became a detention centre in 2001, the contractors being Premier Detention Services. In 2004, Serco bought out Premier and in 2006, G4S won the contract to run Dungavel. In 2011, GEO was awarded the contract.

Name of centre manager
John McClure

Escort provider
Reliance

Short description of residential units
The male accommodation consists of single and double rooms, and dormitories (capacity 203). Female accommodation consists of dormitories (capacity 14).

Health service commissioner and providers
Commissioner: NHS Lanarkshire
Providers: Primecare

Learning and skills providers
Scottish Qualification Authority

IMB chair
Richard W Bett

Section 1: Summary

Introduction

1.1 Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, immigration detention facilities and police custody.

1.2 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.

1.3 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2010 and assess the progress achieved. All full inspection reports include a summary of outcomes for detainees against the model of a healthy establishment. The four criteria of a healthy establishment are:

Safety – that detainees are held in safety and with due regard to the insecurity of their position

Respect – that detainees are treated with respect for their human dignity and the circumstances of their detention

Activities – that the centre encourages activities and provides facilities to preserve and promote the mental and physical wellbeing of detainees

Preparation for removal and release – that detainees are able to maintain contact with family, friends, support groups, legal representatives and advisors, 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.

1.4 Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress. Inspectors draw up a brief healthy establishment summary setting out the progress of the establishment in the areas inspected and giving an overall assessment against the following definitions:

Making insufficient progress
Overall progress against our recommendations has been slow or negligible and/or there is little evidence of improvements in outcomes for detainees.

Making sufficient progress
Overall there is evidence that efforts have been made to respond to our recommendations in a way that is having a discernible positive impact on outcomes for detainees.

Safety

1.5 At the last inspection in 2010, we judged that outcomes for detainees against this healthy establishment test were good. We made 17 recommendations in this area, of which eight had been achieved, two partially achieved and seven had not been achieved. We have made two further recommendations.

1.6 Some detainees were still subject to overnight journeys and excessive moves around the detention estate. The number of detainees who had been held in police stations for long periods before arriving at the establishment had decreased, although there were still some instances of this, with one detainee being held for more than 29 hours. Detainees transferring from Scottish prisons arrived without their prison files, although steps were taken to assess risk from other sources.

1.7 Reception and first night arrangements had improved greatly. The reception area was now much bigger, well ventilated and fit for purpose. The new dedicated first night unit enabled staff regularly to check the well-being of male detainees. Female detainees were accommodated in one of two dormitories, which some found unsettling.

1.8 An intervention to help non-English speakers overcome the frustrations of detention had been introduced, although this initiative was not sufficiently well promoted. The UK Border Agency (UKBA) still did not routinely attend assessment, care in detention and teamwork (ACDT) reviews, even though immigration uncertainty was often a trigger for such anxiety.

1.9 Facilities for legal visits remained inadequate, with detainees often unable to consult their legal representatives in private. Internet access to, and printing of, legal documents had improved.

1.10 The rewards scheme generally operated consistently. Downgrading to the standard level was rare but based on a pattern of behaviour and not automatically applied to those removed from association.

1.11 Temporary confinement under Rule 42 was properly used and authorised. The average time spent in temporary confinement under Rule 42 had reduced.

1.12 UKBA provided detainees with written information on bail processes in a range of languages but did not give them a bail application form at their induction interviews. UKBA and health care logs recording Rule 35 reports were consistent.

1.13 A local written procedure for handling age disputes had been developed with close involvement from South Lanarkshire children's social services department.

1.14 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Respect

1.15 At the last inspection in 2010, we judged that outcomes for detainees against this healthy establishment test were good. We made 20 recommendations in this area, of which 13 had been achieved, two partially achieved and four had not been achieved. One recommendation was no longer applicable. We have made three further recommendations.

1.16 Women still did not have access to a non-smoking association room or single and double bedrooms. Improvements had been made to the poor accommodation in Loudoun House. However, these two rooms lacked blinds and remained stuffy. Detainees still did not have room keys but had lockable cupboards in their rooms. Access to the laundry in Loudoun House had improved.

1.17 History sheets were regularly updated and staff made more use of telephone interpreters than at the time of the previous inspection.

1.18 The diversity policy remained largely a statement of intent and there was insufficient procedural guidance. Most staff working with detainees had completed the 'acting inclusively' online training. Staff used telephone interpreters when necessary in ACDT reviews. Detainees with disabilities were effectively identified on arrival.

1.19 Detainees were more aware of the complaints system. However, complaints about clinical issues were still not processed through separate health care channels to ensure confidentiality. Replies generally addressed the issues raised adequately, were respectful and were written in simple, clear language.

1.20 The health care environment had improved and there were more nurse-led clinics. Over a third of all uniformed staff had been trained in mental health first aid. However, a mental health professional did not deliver the training. Health services staff had not been trained to recognise and treat signs of torture. Female detainees could receive dedicated counselling facilities.

1.21 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Activities

1.22 At the last inspection in 2010, we judged that outcomes for detainees against this healthy establishment test were good. We made four recommendations in this area, of which all had been achieved. We have made no further recommendations.

1.23 The number of work opportunities had increased by over 50%, to 64 positions. The learning resource centre (LRC) had introduced more opportunities for higher-level learners and a broader range of certified programmes. The Scottish Qualification Authority (SQA) had recently approved English for speakers of other languages (ESOL) and information and communication technology courses at access level. There were plans for the LRC manager to become an SQA verifier, which would enable the centre to offer additional certified programmes. Teaching had improved and staff used more interactive teaching methods.

1.24 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Preparation for removal and release

1.25 At the last inspection in 2010, we judged that outcomes for detainees against this healthy establishment test were good. We made four recommendations in this area, of which one had been achieved and three had not been achieved. We have made no further recommendations.

1.26 The welfare needs of those who received removal directions at weekends were better catered for than at the time of the previous inspection. However, the welfare team did not routinely see

all detainees being transferred or released. Some detainees being transferred to other centres were not given sufficient notice, reasons for transfer or written information about the destination centre. Forcibly removed detainees did not receive formal assistance with travel from the airport of arrival to their final destination.

1.27 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient progress against our recommendations.

Section 2: Progress since the last report

The paragraph reference number at the end of each recommendation below refers to its location in the previous inspection report.

Main recommendations (from the previous report)

2.1 **Detainees arriving from prisons should always be accompanied by their prison files. (HE.41)**

Not achieved. Most ex-prisoners arrived with their prison files, but not those coming from Scottish prisons. This did not leave the centre completely devoid of risk information as the movement order usually provided some detail, and staff contacted the sending prison for further details if required. The UK Border Agency (UKBA) was in consultation with the Scottish Prison Service to address the problem.
We repeat the recommendation.

2.2 **The centre's diversity policy should cover all strands of diversity including the needs of women and detainees with disabilities. (HE.42)**

Partially achieved. The local diversity policy gave a statement of intent which covered all diversity strands. This, supported by the in-house and computer training (see recommendation 2.30), gave staff a reasonable understanding of equality and diversity matters. However, there was no written guidance for staff on how to deal practically with diversity issues faced by detainees.

Further recommendation

2.3 The centre's diversity policy should include written guidance for staff on dealing practically with the range of diversity issues faced by detainees.

2.4 **Detainees should have more opportunities for paid work or volunteering. (HE.43)**

Achieved. Opportunities for paid work had increased from 42 to 64 paid positions. Detainees worked in a variety of roles, including as gardeners, caterers, peer supporters, multi-faith assistants, teaching assistants, hairdressers and laundry assistants. The learning resource centre staff inducted all new arrivals and briefed them on work and education opportunities. Approximately 107 work place inductions had taken place in each month of 2012 to date. A member of staff now acted as a works opportunities coordinator and ensured that health, security and UKBA checks were conducted. Details of detainees eligible for work were placed on a database, to which detention custody officers (DCOs) across the centre had ready access, and which they used to fill job vacancies.

Recommendations – safety

Escort vehicles and transfers

2.5 **Detainees should not be subjected to exhausting overnight journeys. (1.6)**

Not achieved. Overnight journeys continued to be a problem. In the detainee records there were numerous cases showing evidence of this, including seven detainees leaving the centre for Pennine House at 1.30am and two arriving from Pennine House at 3.45am.
We repeat the recommendation.

2.6 **Detainees should not be subject to excessive moves around the detention estate. (1.7)**

Not achieved. We saw records of detainees who had been moved to several places in a short space of time, including one who had travelled from Pennine House to Campsfield House to Heathrow to Campsfield House to Dungavel in just over two weeks.
We repeat the recommendation.

2.7 **Detainees should be held in police cell accommodation for the shortest possible time. (1.8)**

Not achieved. We looked at a number of files of detainees who had been held at a police station before arriving at Dungavel. Most had spent only a few hours in police cells but there were some exceptions, most notably a detainee spent 29.5 hours in a police cell, which was excessive.
We repeat the recommendation.

Early days in detention

2.8 **The reception area should be large enough for purpose and the reception waiting rooms should be well ventilated. (1.15)**

Achieved. The former family unit had been refurbished and converted into the new reception area. It was larger than the previous reception accommodation. The two waiting rooms for new arrivals were well ventilated; those for detainees leaving the centre were smaller and had no windows. However, the detainees we observed leaving spent little time in the rooms, and were permitted to leave the door open and walk in the corridor.

2.9 **Night staff should be informed of the location of detainees spending their first night at the centre and be required to make regular checks on their well-being. (1.23)**

Achieved. Dedicated first night accommodation had been introduced in a small unit at the end of Loudon House which was locked off and separated from the unit during the night. Night patrols checked on all detainees in this accommodation on each patrol throughout the night.

Bullying and suicide and self-harm

2.10 **Interventions should be developed to help non-English-speaking detainees deal with the frustrations of detention. (4.12)**

Achieved. Health services staff had set up anxiety and stress reduction groups for non-English-speaking detainees to help deal with the frustrations of detention. Copies of the course content had been translated into several different languages and there was evidence that some use was made of detainee interpreters to help to facilitate sessions. However, courses were not well advertised and many detainees we spoke to said that they were unaware of the service.

2.11 **UKBA staff should attend ACDT reviews. (4.13)**

Not achieved. Formal case management arrangements were generally effective and the quality of assessment, care in detention and teamwork (ACDT) documentation was good. Attendance at reviews by centre staff who knew the personal circumstances of the detainee was better than we usually see but attendance by UKBA staff was rare.
We repeat the recommendation.

Safeguarding (children)

2.12 **A written procedure for handling age dispute cases should be agreed between the onsite contact management team, G4S, health care and South Lanarkshire social services. (4.19)**

Achieved. A procedure had been developed and incorporated into the safeguarding policy, led by health care services for the centre and in partnership with social services. Social services confirmed that the local agreement was for two social workers, one from the children's team and one from the adult team, to conduct a Merton-compliant age assessment in all age-dispute cases unless a previous assessment was located. The number of age disputes was low, with UKBA records indicating only one in the previous year.

Rewards scheme

2.13 **Access to the internet, to a mobile phone and to paid work should not be forfeited through reduction to the standard IEP level. (7.23)**

Not achieved. As at the time of the previous inspection, detainees on the standard level of the incentives and earned privileges (IEP) scheme automatically lost the use of their mobile telephone, were not given access to the internet and were not allowed paid work.
We repeat the recommendation.

2.14 **Downgrade to standard level should always be on the grounds of behaviour and not on the grounds of separation alone. (7.24)**

Achieved. Written documentation showed that the scheme was implemented consistently across the centre, and detainees were seldom given warning notices. All were on the enhanced level and there was no evidence that any detainee had been downgraded because he or she had been segregated.

The use of force and single separation

2.15 **The authorisation of separation under Rule 40 or 42 should be signed in person by a senior manager. (7.25)**

Achieved. Records we examined showed that authorisation documentation for separation was always signed by a senior manager.

2.16 **Detainees placed in temporary confinement under Rule 42 should leave this accommodation as soon as they cease to be violent or refractory. (7.26)**

Achieved. Temporary confinement under Rule 42 had been used twice between January 2012 and the time of the inspection. Segregation in these cases had been justified and ended as

soon as the detainee had ceased to be violent. The length of stay in both cases had been less than two hours.

Legal rights

2.17 **Detainees should be able to download and read important documents attached to emails and from the internet. (3.8)**

Partially achieved. Detainees could now open and print important legal documents in PDF format, including country-of-origin reports, case law and bail application forms. However, detainees could not open Word documents such as witness statements or legal letters. This could have impeded communication with legal representatives.

Further recommendation

2.18 Detainees should be able to download important documents in Word format attached to emails and from the internet.

2.19 **There should be sufficient consultation rooms, fitted with telephones, for solicitors to meet detainees in private. (3.9)**

Not achieved. There were still only two consultation rooms for legal visitors. If these were full, detainees consulted their legal representatives in the visits hall. We saw and heard a detainee being interviewed by his solicitor in the visits hall. This lack of confidentiality may have inhibited detainees from fully disclosing details.
We repeat the recommendation.

Casework

2.20 **Detainees should be advised of their bail rights and given a bail application form during their induction interviews with UKBA. (3.18)**

Partially achieved. UKBA gave detainees written information on bail rights in English and other languages during their induction interviews. However, detainees did not receive a bail application form (B1).

Further recommendation

2.21 Detainees should be given a bail application form (B1) during their induction interviews with UKBA.

2.22 **Accurate and complete Rule 35 report logs should be kept by the UKBA contact management and health care staff. (3.19)**

Achieved. Logs kept by the UKBA contact management team and health services staff were consistent and complete. A member of the UKBA contact management team signed the health care record to confirm receipt of reports.

Recommendations – respect

Residential units

2.23 **Female detainees should have access to single and double rooms. (2.13)**

Not achieved. Female detainees did not have access to single and double rooms. During the inspection there were five female detainees in two dormitory rooms which could accommodate a maximum of 14. The centre had submitted a funding application to UKBA to construct single and double rooms but this had been unsuccessful. Women said that the large shared accommodation was unsettling on arrival, particularly when a detainee arrived in the middle of the night. Furthermore, they felt strongly that access to smaller rooms and to a non-smoking association room, which they did not have, should be equitable for both male and female detainees.
We repeat the recommendation.

Further recommendation

2.24 Female detainees should have access to a non-smoking association room.

2.25 **The modified accommodation on Loudoun should be properly ventilated and brightened up. (2.14)**

Partially achieved. The modified accommodation (rooms 16 and 17 in Loudoun House) comprised former storage rooms which had been adapted to hold six detainees each. There were no windows but natural light was provided from skylights. The rooms had been recently repainted and were in a good condition and we were told that the ventilation had been improved. However, the rooms were still stuffy and the occupants complained that the rooms were too hot and had poor air quality. There were no blinds on the skylights, which meant that the rooms were light very early in the morning during the summer.

Further recommendation

2.26 Rooms 16 and 17 in Loudon House should be properly ventilated.

2.27 **Detainees should be issued with keys to their rooms. (2.15)**

Not achieved. Although many rooms could be locked from the inside, none could be locked with a key when left unattended. We were told that the centre had unsuccessfully approached UKBA to provide locks and keys. However, the detainees we spoke to did not consider this to be a problem, as they all had lockable cupboards in their rooms so could store possessions securely.

2.28 **There should be sufficient washing facilities for the population of Loudoun. (2.16)**

Achieved. There were three washing machines and three dryers for the building and detainees said that this was sufficient. We saw no queues during the inspection. Many rooms had also been fitted with towel rails adjacent to the beds, to allow detainees to dry clothing and towels properly.

Staff–detainee relationships

2.29 **History sheets in Loudoun House should be completed thoroughly and staff should make regular use of professional interpretation to establish needs and concerns. (2.21)**

Achieved. We inspected a number of history sheets across all residential units. Most had been completed frequently and the latest entries were no more than 10 days old. Some entries were basic but all were legible. We noted little disparity between units. Since the previous inspection, staff in Loudoun had received additional advice about the completion of these documents. All staff were familiar with telephone interpreting services and used them for more formal matters and health issues. Records showed that such services had been used, on average, 65 times a month in the previous six months.

Equality and diversity

2.30 **Staff working directly with detainees should receive training on all strands of diversity. (4.30)**

Achieved. Records confirmed that approximately 95% of the centre staff had undertaken an intranet-based diversity training package called `acting inclusively`. This pass/fail package was monitored by the centre. All staff we spoke to confirmed that they had received the training and were conversant with the content. Many staff had also received in-house classroom-based diversity training.

2.31 **Professional interpretation should be used in all cases involving initial assessment and suicide and self-harm. (4.31)**

Achieved. Staff used professional telephone interpretation when initially assessing detainees in crisis and completing ACDT documents. We saw evidence of this in several ACDT documents we inspected. Staff were clear that they would not use detainees as interpreters in these circumstances.

2.32 **The procedures for assessing disability on admission should be reviewed to ensure that they are effective. (4.32)**

Achieved. All detainees were screened by health services staff on arrival. The procedures for assessing disability had been recently reviewed, resulting in the inclusion of a question on disability in the screening tool. If a detainee identified themselves as having a disability, health services staff initiated a personal emergency evacuation plan, which was shared with other departments.

Complaints

2.33 **A systematic approach should be taken to ensure all detainees are aware of the complaints process. (7.27)**

Achieved. Complaint forms were available on each floor of every residential unit, away from staff offices, and in a range of languages. Information about how to make a complaint was included in the induction programme and in notices on residential units.

2.34 **Complaints about clinical issues should be handled through health care governance channels to protect medical confidentiality. (7.28)**

Not achieved. Medical complaints were dealt with as general complaints. The number of formal complaints about medical issues was low but clinical details could still be included on the forms disclosed to UKBA staff, which would have been inappropriate. We didn't find examples of clinical complaints among the normal complaints but there weren't two separate systems.
We repeat the recommendation.

2.35 **Responses to complaints should be full enough to cover all substantive points raised, but couched in simple, clear language. (7.29)**

Achieved. A nominated UKBA clerk ensured that all complaints were logged and dispatched expeditiously to managers in appropriate areas. The quality of responses to formal complaints was good. All replies we examined were respectful, adequately addressed the issues at hand and were written in simple, clear language.

Health services

2.36 **The physical environment in the health centre should support an appropriate and confidential service for detainees. (5.7)**

Achieved. The health centre had been expanded to include more treatment, individual and group meeting rooms. Attention had been given to patient privacy and dignity so that the environment offered improved confidentiality for patients. Shortly after the inspection, additional building was due to start which would enhance the environment further, ensuring total confidentiality at medication administration times.

2.37 **Health centre staff should be trained to recognise signs of and treat trauma and torture. (5.8)**

Not achieved. Health care staff had not been trained to recognise signs of and treatment for trauma and torture.
We repeat the recommendation.

2.38 **Nurse-led clinics should be introduced to relieve pressure on GPs. (5.20)**

Achieved. There were regular nurse-led clinics, offering primary care triage and treatments, and the management of lifelong conditions such as diabetes and epilepsy. This enabled GPs to concentrate on patients with more complex conditions.

2.39 **Pharmacists should visit the centre regularly and scrutinise the use of medicines. (5.27)**

Achieved. A local pharmacist visited weekly. The head of medicines management for Primecare, the health services provider, visited monthly. Both scrutinised the use of medicines.

2.40 **All SOPs and protocols under review, including the risk assessment and in-possession protocols, should be ratified and put into practice as soon as possible. (5.28)**

Achieved. Standard operating procedures (SOPs) and protocols were appropriately ratified, signed and brought to the attention of staff members.

2.41 **The centre should introduce patient group directions or non-medical prescribers to enhance patient access to appropriate prescription medication in the absence of a GP. (5.29)**

No longer relevant. A cost–benefit analysis for the introduction of non-medical prescribers had been completed in 2011, and had concluded that cost outweighed benefit. A survey of the potential use of patient group directions (PGDs) had been undertaken in 2011. It had been determined that PGDs were not required as access to GPs, which had improved, was adequate to meet the demand for prescribing beyond the over-the-counter remedies available via nurses.

2.42 **Female detainees should have dedicated counselling facilities. (5.39)**

Achieved. There was a new dedicated counselling room in the health care centre and services were available to female clients.

2.43 **Mental health awareness training should be provided for uniformed staff on reception and the residential units. (5.40)**

Achieved. Mental health first-aid training was delivered to uniformed officers, and around 36% had been trained in the previous eight months. Mental health professionals were not involved in delivering the training, which was a missed opportunity to enrich the learning experience.

Recommendations – activities

2.44 **The LRC should introduce more opportunities for higher level learners, including advanced ESOL classes. (6.14)**

Achieved. The range of courses offered by the learning and resource centre (LRC) for higher-level learners had increased. New courses included food hygiene and hospitality. Shortly before the inspection, the LRC had received approval from the Scottish Qualifications Authority (SQA) to offer access levels 3 and 4 courses in English for speakers of other languages (ESOL) and information and communications technology. Plans were under way to offer these subjects at intermediate levels 1 and 2.

2.45 **There should be a broader range of certificated programmes. (6.15)**

Achieved. There was a broader range of certified programmes in ESOL (see recommendation 2.44) and information and communications technology than at the time of the previous inspection. The LRC manager was planning to train as an SQA verifier, which would allow the centre to offer additional certified programmes.

2.46 **Staff should introduce more interactive learning methods into their teaching to improve engagement and develop skills more effectively. (6.16)**

Achieved. Staff used more varied and interactive teaching methods than at the time of the previous inspection, and overall teaching had improved. Staff built on individual detainees' experiences and interests to engage them effectively. The new ESOL teacher used active learning techniques to encourage detainees to think for themselves and focused on individual detainees' interests, strengths and weakness to improve language skills. ESOL attendance had improved.

Recommendations – preparation for removal and release

2.47 **Detainees given removal directions at weekends should be seen and assessed as soon as possible by one of the welfare team. (9.18)**

Achieved. The needs of detainees given removal directions at weekends were better catered for than at the time of the previous inspection. Residential staff were made aware of who had been served removal directions by the on-site immigration team so that they could talk to the detainee and ensure their well-being. Such detainees were also offered the opportunity to see health services staff. The welfare manager emailed pre-removal paperwork to weekend DCOs for them to complete with detainees in his absence, which included referral to the welfare team, who then saw and assessed detainees as soon possible on the following Monday.

2.48 **One of the welfare team should interview detainees before transfer or release to check that they have no outstanding needs. (9.19)**

Not achieved. Although there was a checklist for staff to go through with all detainees being released or transferred, in practice this was only done with detainees being removed from the UK.
We repeat the recommendation.

2.49 **Detainees being transferred should be given as much notice as possible, told the reasons for the transfer and given information about the centre to which they are being transferred. (9.20)**

Not achieved. We spoke to one distressed detainee transferring to another immigration removal centre (IRC), who said that he had only been told late on the previous evening that he was moving, and that his family was travelling a long distance from England to visit him that day. Staff said that it was common for the UKBA's Detainee Escorting and Population Management Unit (DEPMU) to notify the centre in the evening about transfers to take place the following day, and that reasons were not always provided. Although the welfare manager kept a file of information on other IRCs, it was not routinely provided to detainees.
We repeat the recommendation.

2.50 **Removed detainees should receive assistance with travel from the airport of arrival to their final destination. (9.21)**

Not achieved. The welfare team had details for every Red Cross office and a range of other welfare organisations throughout the world, and made efforts to help detainees in need. However, there remained no formal system of financial assistance for detainees requiring it, to ensure that they were able to make their way from the airport of arrival to their final destination after removal. In our groups, some detainees raised this as a concern. UKBA told us that they would fly detainees to an airport as close as possible to their home town.
We repeat the recommendation.

Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Recommendations — To UKBA

3.1 Detainees arriving from prisons should always be accompanied by their prison files. (2.1)

3.2 Detainees should be held in police cell accommodation for the shortest possible time. (2.7)

3.3 Detainees should be given a bail application form (B1) during their induction interviews with UKBA. (2.21)

3.4 UKBA staff should attend ACDT reviews. (2.11)

Recommendations — To UKBA and the escort contractor

3.5 Detainees should not be subjected to exhausting overnight journeys. (2.5)

3.6 Detainees should not be subject to excessive moves around the detention estate. (2.6)

Recommendations — To the centre manager

Early days in detention

3.7 The reception area should be large enough for purpose and the reception waiting rooms should be well ventilated. (2.8)

Rewards scheme

3.8 Access to the internet, to a mobile phone and to paid work should not be forfeited through reduction to the standard IEP level. (2.13)

Legal rights

3.9 Detainees should be able to download important documents in Word format attached to emails and from the internet. (2.18)

3.10 There should be sufficient consultation rooms, fitted with telephones, for solicitors to meet detainees in private. (2.19)

Residential units

3.11 Female detainees should have access to single and double rooms. (2.23)

3.12 Female detainees should have access to a non-smoking association room. (2.24)

3.13 Rooms 16 and 17 in Loudon House should be properly ventilated. (2.26)

Equality and diversity

3.14 The centre's diversity policy should include written guidance for staff on dealing practically with the range of diversity issues faced by detainees. (2.3)

Complaints

3.15 Complaints about clinical issues should be handled through health care governance channels to protect medical confidentiality. (2.34)

Health services

3.16 Health centre staff should be trained to recognise signs of and treat trauma and torture. (2.37)

Removal and release

3.17 One of the welfare team should interview detainees before transfer or release to check that they have no outstanding needs. (2.48)

3.18 Detainees being transferred should be given as much notice as possible, told the reasons for the transfer and given information about the centre to which they are being transferred. (2.49)

3.19 Removed detainees should receive assistance with travel from the airport of arrival to their final destination. (2.50)

Appendix I: Inspection team

Colin Carroll	Team leader
Bev Alden	Inspector
Gary Boughen	Inspector
Gordon Riach	Inspector
Paul Tarbuck	Health services inspector
Peter Connelly	Inspector – Education Scotland

Appendix II: Detainee population profile

Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

(i) Age	No. of men	No. of women	No. of children	%
Under 1 year	N/A	N/A	N/A	
1 to 6 years	N/A	N/A	N/A	
7 to 11 years	N/A	N/A	N/A	
12 to 16 years	N/A	N/A	N/A	
16 to 17 years	N/A	N/A	N/A	
18 years to 21 years	9	0		5
22 years to 29 years	54	3		33
30 years to 39 years	69	1		41
40 years to 49 years	24	0		14
50 years to 59 years	8	1		5
60 years to 69 years	4	0		2
70 or over				
Total	**168**	**5**		**100**

(ii) Nationality Please add further categories if necessary	No. of men	No. of women	No. of children	%
Afghanistan	11	0		6.3
Albania	1	0		0.5
Algeria	3	0		1.7
Angola				
Bangladesh	35	0		20.2
Belarus				
Cameroon				
China	15	2		9.8
Colombia	1	0		0.5
Congo (Brazzaville)				
Congo Democratic Republic (Zaire)				
Ecuador				
Estonia				
Georgia				
Ghana	3	0		1.7
India	39	1		23.1
Iran	3	0		1.7
Iraq	3	0		1.7
Ivory Coast				
Jamaica				
Kenya	1	0		0.5
Kosovo				
Latvia				
Liberia	1	0		0.5
Lithuania				
Malaysia				
Moldova				

Nigeria	4	1		2.8
Pakistan	34	0		19.6
Russia				
Sierra Leone				
Sri Lanka	1	0		0.5
Trinidad and Tobago				
Turkey				
Ukraine	1	0		0.5
Vietnam	2	0		1.1
Yugoslavia (FRY)				
Zambia				
Zimbabwe	1	0		0.5
Other (please state)	9	1		5.8
Total	**168**	**5**		**100**

(iv) Religion/belief Please add further categories if necessary	**No. of men**	**No. of women**	**No. of children**	**%**
Buddhist	4	0		2.3
Roman Catholic	3	1		2.3
Orthodox				
Other Christian religion	21	1		12.7
Hindu	9	0		5.2
Muslim	96	0		55.4
Sikh	24	1		14.4
Agnostic/atheist				
Unknown	11	2		7.5
Other (please state what)				
Total	**168**	**5**		**100**

(v) Length of time in detention in this centre	**No. of men**	**No. of women**	**No. of children**	**%**
Less than 1 week	15	0		8.7
1 to 2 weeks	51	1		30
2 to 4 weeks	37	0		21.4
1 to 2 months	30	3		19.1
2 to 4 months	18	1		11
4 to 6 months	2	0		1
6 to 8 months	9	0		5.2
8 to 10 months	1	0		0.6
More than 10 months (please note the longest length of time)	5 (18 months)	0		3
Total	**168**	**5**		**100**

(vi) Detainees' last location before detention in this centre	No. of men	No. of women	No. of children	%
Community	0	0		
Another IRC	7	0		4
A short-term holding facility (e.g. at a port or reporting centre)	35	2		22
Police station	110	3		64.5
Prison	16	0		9.5
Total	**168**	**5**		**100**