Report on an unannounced follow-up inspection of the non-residential short-term holding facility at:

Sheffield Vulcan House

29 May 2012

by HM Chief Inspector of Prisons

Printed and published by:
Her Majesty's Inspectorate of Prisons
1st Floor, Ashley House
Monck Street

London SW1P 2BQ
England

Contents

Overview 4

The healthy custodial establishment 5

1 Progress on recommendations 7

2 Recommendations 16

Appendix 18

Overview

Vulcan House accommodates the UK Border Agency's (UKBA) reporting centre and enforcement teams for South Yorkshire. Foreign nationals who are subject to reporting restrictions attend the centre at regular intervals. Within the complex and adjacent to the reporting centre is the short-term holding facility (STHF) where those arrested by enforcement teams or detained as a result of reporting restrictions are held before they are transferred to a residential place of detention. The facility operates four days a week from 9am until 4pm and is run on behalf of UKBA by the security firm Reliance.

The holding room is used infrequently, with approximately seven detainees held in each of the three months before our inspection. The average length of detention during this period was exactly three hours. On the day before our inspection, a detainee was held for almost nine hours. It was UKBA's policy not to detain children at the facility. No detainees were held during our inspection. The Independent Monitoring Board visited the facility.

At our previous inspection in 2009, we made 42 recommendations. At this inspection 19 had been achieved, six partially achieved, 15 not achieved and two were no longer relevant.

Sheffield Vulcan House
Inspected: 29 May 2012
Last inspected: 4 February 2009

Inspectors
Colin Carroll
Bev Alden

The healthy custodial establishment

HE.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.

HE.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.

HE.3 The concept of a healthy prison was introduced in this inspectorate's thematic review *Suicide is Everyone's Concern* (1999). The healthy prison criteria have been modified to fit the inspection of short-term holding facilities, both residential and non-residential. The criteria for short-term holding facilities 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 – detainees are able to be occupied while they are in detention

Preparation for release – detainees are able to keep in contact with the outside world and are prepared for their release, transfer or removal.

HE.4 The purpose of this inspection was to follow up the recommendations made in our last inspection of 2009 and assess the progress achieved. Inspectors kept fully in mind that although these were custodial facilities, detainees were not held because they had been charged with a criminal offence and had not been detained through judicial processes.

Safety

HE.5 Escort vehicles had to park some distance from the holding room. Detainees were handcuffed to and from the facility without an individual risk assessment being carried out.

HE.6 Written reasons for detention were only issued in English but telephone interpreters were used to explain them to those who did not speak English.

HE.7 Information on how to contact a legal adviser was available in the holding room. Staff helped detainees with calls to and from their legal representatives. Information about the community legal advice helpline was displayed in the holding room. In the three months before our inspection, 23 detainees had been held for an average of three hours.

HE.8 Detainees were supervised at all times and a large window from the detainee custody officer's (DCO's) office provided clear sight lines into the holding room. Staff used a medical triage service to take advice on detainees' health problems.

HE.9 Belts and scarves were systematically removed from detainees without an individual risk assessment. Staff did not receive regular refresher training in anti-bullying and suicide and self-harm prevention. Not all DCOs carried anti-ligature knives. DCOs were not given feedback or made aware of lessons learned from previous incidents. Suicide and self-harm warning forms could have been opened and accompanied detainees.

HE.10 Force was last used four months before our inspection to prevent self-harm when a detainee banged himself against a wall. Incident reports confirmed that force was necessary, proportionate and used no longer than necessary.

HE.11 Children were no longer held at the facility. Many detentions were planned and helped to avoid unrelated male and female detainees being held together.

Respect

HE.12 The toilet in the holding room was inadequately screened. The toilet door could easily be opened from the outside. Sanitary products were available in the toilet.

HE.13 There was no ongoing formal programme of equality impact assessment. An information booklet in different languages set out the expected standards of behaviour required of detainees. Detainees could make a complaint. The complaints box was emptied every day but none had been submitted in the three months before our inspection.

HE.14 Detainees did not receive hot meals but they were given sandwiches and snacks.

Purposeful activity

HE.15 There was a lack of reading material in languages other than English. Books were not kept in the holding room. Unlike at our last inspection, there was a working television which could play DVDs. Detainees could not exercise in the fresh air.

Preparation for release

HE.16 Detainees could easily make and receive phone calls. DCOs completed person escort records for detainees leaving the facility; they detailed current risks and accompanied the detainee to the next place of detention. In the three months prior to our inspection, 83% of detainees were transferred to an immigration removal centre, 13% taken to Pennine House residential short-term holding facility and four per cent released.

Section 1: Progress on recommendations

Recommendations to the facility contractor

Escorts, vans and transfers

1.1 Vehicles collecting detainees should be able to park adjacent to the holding area. (1.7)
Not achieved. The building remained unchanged since the last inspection, with escort vans parking in a small loading bay some distance from the holding room, which was accessible through staff corridors in the reporting centre. This may have increased risks should a detainee have been removed using force.
We repeat the recommendation.

1.2 Once a decision has been made to detain someone, he or she should be transferred to a residential facility promptly. (1.8)
Achieved. The majority of detainees spent very little time in the holding room before being transferred elsewhere. Although on the day before our inspection two detainees had been held for seven hours and almost nine hours, staff told us that this was because of flooding at the destination immigration removal centre (IRC), which meant that an alternative centre had to be found.

1.3 Logs should be completed for each day that the facility is open, recording the length of time that a detainee is held; when there are no detentions, this should be recorded. Logs should always record the transfer location. (1.9)
Achieved. Holding room logs recorded detainees' details, time of arrival and departure, length of detention and transfer location. The logs also recorded when there were no detentions or when the holding room was closed. Records were sent to head office for collation. A separate diary recording similar details was also kept at the request of the Independent Monitoring Board (IMB).

Additional information

1.4 The security firm Reliance was contracted to manage the facility and to operate escorts. Most detainees were brought to the holding room from the reporting centre in the same building. There were no detainees or vehicles at the facility during the inspection.

1.5 All detainees, excluding pregnant women, were handcuffed when being moved from the holding room to the escort vehicle. This was not subject to an individual risk assessment and detainees had to walk through a staff corridor to reach the vehicle bay.

1.6 We were told that the holding room was sometimes used to facilitate a comfort break for detainees en route to other places of detention. When this occurred, escorting staff contacted the facility in advance to ensure that the holding room was free.

Further recommendation

1.7 Handcuffs should only be used if justified by a written individual risk assessment.

Arrival and accommodation

1.8 The number of staff escorting detainees across from the reporting centre should depend on a risk assessment. (1.18)
Not achieved. Detainees brought into the holding room from the reporting centre were escorted by three immigration officers. This was not based on an individualised risk assessment, but the practice at our last inspection of using two police officers and two immigration staff no longer occurred.

1.9 Detainees should have access to health services and be able to speak with a medical professional in full privacy. (1.19)
Partially achieved. Detainees had no face to face access to health service professionals unless there was an emergency, in which case they would call 999 and request an ambulance. A medical triage helpline was available and the number displayed in the office. Staff used it to take advice on giving detainees access to their prescribed medication. We were told that detainees could speak directly to a health professional via the triage helpline but staff could not recall this happening. Staff's close proximity to the office telephone meant that detainees would have been afforded little privacy (see further recommendation 1.14).

1.10 Toilet facilities should be properly screened from the holding room. (1.20)
Not achieved. The toilet cubicle remained unchanged from our last inspection and did not have a full length door. This was particularly inappropriate when more than one detainee was being held.
We repeat the recommendation.

1.11 Cushioned seating should be available. (1.21)
Achieved. Cushioned seating had been added to the four fixed chairs.

1.12 The environment should be more welcoming and have posters in different languages, including details of the diversity, disability and complaints policies. (1.22)
Achieved. Details of the diversity, disability and complaints policies were displayed in the holding room in 16 languages. Brightly coloured posters were displayed, although most were more appropriate for children than adults.

1.13 The pay telephone should accept incoming calls, and detainees should be able to make calls in privacy. (1.23)
Partially achieved. The payphone accepted incoming calls but did not have a privacy hood. An additional telephone in the staff office could be used by detainees by passing it through a small hatch in the wall. This afforded little privacy.

Further recommendation

1.14 The payphone should have a privacy hood and detainees should be afforded privacy when making calls.

1.15 Detainees with no means to fund their own calls should be given free calls. (1.24)
Achieved. Staff told us detainees without their own funds were free to use the office land line as much as they needed to.

1.16 Evacuation instructions should be displayed in the holding room in a range of languages. (1.25)
Not achieved. Evacuation instructions were not displayed but staff told us that they went

through evacuation procedures with detainees on arrival. The layout and size of the facility meant evacuation options were limited.

Additional information

1.17 The facility was open four days a week from 9am until 4pm and was staffed by one male and one female detainee custody officer (DCO). The facility was closed one working day a week, although this varied from week to week. A chief immigration officer decided which day the holding room would be closed. Many detentions were planned and DCOs generally knew who would be arriving a week in advance, which meant that they could avoid holding unrelated male and female detainees. As many detainees were detained following attendance at the reporting centre, they often had little or no property. Family and friends were permitted to leave property at the front desk and DCOs would collect it.

1.18 An observation window between the office area and the holding room allowed for good supervision by staff, and CCTV footage covering the facility was monitored by Home Office security staff based outside but within Vulcan House. Detainees were not permitted to keep belts or scarves while in the holding room due to the risk of self-harm, although shoelaces were not removed. This was a blanket policy and not applied on the basis of individual risk assessment.

Further recommendation

1.19 Detainees should retain all items of clothing, including shoelaces, unless individual written risk assessment indicates otherwise.

Positive relationships

1.20 All staff should wear name badges. (1.28)
Achieved. DCOs wore legible name badges.

1.21 The door between the office and the holding room should be left open, on a risk-assessed basis. (1.29)
Not achieved. The door between the office and the holding room was kept shut when detainees were held. This inhibited staff-detainee interaction.
We repeat the recommendation.

Legal rights and casework

1.22 Written reasons for detention should be issued in a language that the detainee can understand. (1.33)
Not achieved. Detainees were issued with written reasons for detention in document IS91R, which the UK Border Agency (UKBA) issues, but this was in English only. UKBA used interpreters to explain the reasons to detainees who did not understand English.
We repeat the recommendation.

1.23 General information about legal rights, including how to apply for bail and how to find a competent, qualified legal representative, should be freely available to detainees in a range of common languages. (1.34)
Partially achieved. A notice in English and other languages promoted the Community Legal Advice helpline. Information was also provided regarding the immigration paperwork served on

detainees. Staff told us how they had helped a detainee the day before our inspection to make contact with a firm of immigration lawyers. There was no information at the facility regarding bail; however, we were told that detainees being transferred to residential detention would be able to obtain relevant information there.

1.24 Detainees without means should be allowed to make as many free telephone calls as necessary to their legal advisers. (1.35)
Achieved. Staff told us that they would facilitate free calls to detainees' legal advisors. The payphone in the unit received incoming telephone calls.

Additional information

1.25 Staff told us that detainees were able to retain legal documents served by immigration officers, for example, those containing written reasons for their detention (through document IS91R) and removal directions. Legal representatives were not able to visit detainees in the facility; however, most were held only for a few hours before being transferred to a residential place of detention where visits could take place.

Casework

1.26 The holding room logs for the previous three months (February – April 2012) indicated that 23 detainees had been held, an average of approximately seven a month. The average length of detention was shorter than we normally find in short-term holding facilities (STHFs) at three hours. Children were no longer held at the facility as a matter of policy.

Duty of care

1.27 Detainee custody officers (DCOs) should receive regular refresher training in anti-bullying and suicide and self-harm prevention. (1.39)
Not achieved. DCOs did not receive regular anti-bullying training. They were alert to intimidation between detainees and would act to diffuse tensions. A workplace coach had provided DCOs with one off training on suicide and self-harm prevention, but this was not repeated regularly.
We repeat the recommendation.

1.28 DCOs should carry anti-ligature knives. (1.40)
Partially achieved. Of the two DCOs, only one carried a ligature knife.
We repeat the recommendation.

1.29 The locking mechanism on the door of the holding room should be replaced with a system allowing staff to open the door from both sides. (1.41)
Achieved. The door could now be opened with a key from inside the holding room. Home Office security staff in Vulcan house held the keys and only issued them to DCOs when a detainee was being held.

1.30 Detention officers should be aware of lessons learned from previous incidents. (1.42)
Not achieved. DCOs were not given feedback or made aware of lessons learned from previous incidents.
We repeat the recommendation.

Bullying

1.31 Detainees were supervised at all times. A large window in the DCOs' office provided clear sight lines into the holding room. CCTV cameras covering the holding room were monitored by Home Office security staff in Vulcan House. Detainees could easily summon help from staff if necessary.

Suicide and self-harm

1.32 DCOs would open a warning form where a detainee was at risk of suicide or self-harm. The warning forms were similar to those used by escorts contracted by the National Offender Management Service to transfer prisoners. Staff would also record risk information on person escort records (PER) and communicate risks to escort staff verbally. Self-harm incidents were recorded on general incident report forms and forwarded to Reliance's headquarters.

1.33 The last self-harm incident occurred four months before our inspection. After being held for about two and half hours, the detainee started shouting and banging himself against the wall. DCOs entered the holding room by which time the detainee had thrown himself to the floor and was banging his head on the floor. DCOs attempted to restrain the detainee who bit himself and attempted to bite an officer. The detainee was placed in handcuffs but continued to try to bite staff. DCOs talked to the detainee in an attempt to de-escalate the situation. The detainee eventually calmed down and was taken to a local police station. Paperwork was completed correctly and confirmed that force was necessary, proportionate and used no longer than was necessary. The detainee was examined by a nurse.

Childcare and child protection

1.34 There should be clarity about whether there are any circumstances in which children, or those whose age is in dispute, might be held in the facility. (1.54)
Achieved. Both UKBA and Reliance staff were clear that children were no longer held in the facility.

1.35 DCOs should receive regular refresher training in child care and child protection issues. (1.55)
No longer relevant. Children were no longer held at the facility.

1.36 Children's toys should be regularly checked for damage and cleaned. (1.56)
No longer relevant. Children were no longer held at the facility.

Diversity

1.37 The diversity and disability policies should be displayed in the holding area in a range of languages. (1.62)
Achieved. Diversity and disability policies were clearly displayed in English and a range of other languages.

1.38 Detainees' nationalities should be monitored and telephone interpreting services should be used as needed. (1.63)
Achieved. Detainees' nationalities were recorded in the daily logs. Staff told us that they were familiar with using a professional interpreting service, for which contact details were

prominently displayed in the office. The telephone in the DCOs' office was fitted with two handsets. This allowed staff to speak to detainees using a telephone interpreter without having to pass a single handset to and fro.

1.39 All local policies should be impact assessed, looking at how they affect different groups in different ways: such as women, people with disabilities, older people and those from different ethnic and nationality groups. (1.64)
Not achieved. There was no ongoing formal programme of equality impact assessment.
We repeat the recommendation.

1.40 The Qur'an and Bible should be on a bookcase in the holding room and should not have to be requested. (1.65)
Not achieved. The Qur'an, a prayer mat and a compass were available as was the Bible, but they were kept in a cupboard in the staff office and detainees had to ask for them.
We repeat the recommendation.

Additional information

1.41 DCOs received diversity training as part of an initial course. One DCO had undertaken a refresher course in the previous year, but the other had not had any additional training since 2009, prior to the Equality Act 2010.

1.42 The toilet in the holding room had not been adapted for disabled detainees. There was a staff disabled toilet located near the facility on the same floor, but detainees were not allowed to use it. DCOs told us that they had refused to accept disabled detainees because of the lack of suitable facilities.

Further recommendation

1.43 Reasonable adjustments should be made to the holding room toilet so that it can be used by detainees with mobility problems.

Activities

1.44 Newspapers, magazines and books which reflect the main languages spoken by detainees should be available and should be reviewed regularly. (1.69)
Partially achieved. One daily English newspaper and two weekly foreign language newspapers were available, along with a range of English magazines. Reading material was selected according to availability rather than to reflect the languages spoken by detainees.

Further recommendation

1.45 Reading material in a range of languages should be available in the holding room.

1.46 Books and other reading material should be stored on a bookcase in the holding room, so that detainees do not need to request them from staff. (1.70)
Partially achieved. Newspapers and magazines were freely available. Five old books were kept in a cupboard in the staff office.
We repeat the recommendation.

1.47 The television should be operational. (1.71)
Achieved. The television now worked and showed Freeview. DVDs could also be viewed.

1.48 A stock of suitable DVDs, in a range of languages, should be available. (1.72)
Not achieved. A small selection of DVDs were available and all were in English.
We repeat the recommendation.

1.49 Detainees should have access to fresh air. (1.73)
Not achieved. Detainees were unable to access fresh air. While most detainees were only held for short periods, some had been held for longer (see above) without access to exercise in the fresh air.
We repeat the recommendation.

Facility rules

1.50 Rules and expected standards of behaviour should be available in a range of languages and displayed in the holding room. (1.79)
Achieved. An information booklet setting out basic information, rules and expectations was available in the holding room in 16 languages.

Additional information

1.51 Force was last used four months before our inspection (see the section on suicide and self-harm).

Complaints

1.52 The complaints box should be clearly marked. (1.82)
Achieved. The complaints box was clearly marked and visible.

1.53 Information about how to complain should be displayed in the holding room in a range of languages. (1.83)
Achieved. Complaints forms in English and 15 other languages were available in the holding rooms. The forms contained information concerning how to complain. Pens were freely available. The box was emptied by the chief immigration officer on her daily checks of the facility. No complaints had been submitted in the three months prior to our inspection.

Additional information

1.54 As well as lodging formal complaints, detainees could complete Reliance feedback forms or suggestion forms. Child friendly complaints forms were available in English and 15 other languages. As children were no longer held in the facility, they no longer needed to be displayed.

1.55 Detainees had access to 'Confide', a confidential telephone service through which detainees could report issues relating to their treatment. Information could then be fed back anonymously to Reliance. While the service was well promoted, it was not clear what outcomes detainees could expect from the service.

Housekeeping points

1.56 The child friendly complaint forms should not be displayed as long as children are not held at the facility.

1.57 The purpose of the Confide telephone service should be explained to detainees.

Services

1.58 When a detainee's stay spans a period of several hours, a hot meal should be provided. (1.88)
Not achieved. There were no resources within the facility to provide hot meals. On one occasion in the past, staff had purchased a hot meal from the staff canteen in Vulcan House for a vegetarian detainee who could not eat the sandwiches in the holding room. However, this provision was ad hoc and subject to the DCO's discretion.
We repeat the recommendation.

1.59 Sanitary products should be available in the toilet area and detainees should not have to ask for them. (1.89)
Achieved. A box containing sanitary products was inside the toilet cubicle for detainees to access.

Preparation for release

1.60 Detainees should be able to receive visitors. (1.94)
Not achieved. Detainees could not receive visitors at the facility. However, given the normally short stays, visits were very unlikely. Those being detained at an IRC would be able to receive visitors. Detainees could receive property delivered to the centre by friends or family.

1.61 Detainees should be given more detailed information about the IRC they are going to. (1.95)
Not achieved. As at our last inspection detainees were given a small card with a map and contact details of their next place of detention.

1.62 Detainees should be able to make a free telephone call to legal representatives and family to let them know where they are going immediately before departure. If there are evidenced security concerns, staff should inform family and legal representatives. (1.96)
Achieved. Detainees were able to use the pay phone to contact family and legal representatives before their departure. Staff told us that they would assist detainees without funds to make calls before leaving the facility.

1.63 Detainees who pose particular risks to themselves or others should have a care plan drawn up before leaving the facility. (1.97)
Achieved. DCOs completed PERs for detainees leaving the facility. The records contained a section detailing current risks. A warning form was completed for those at risk of suicide or self-harm. The warning form contained information on the nature of the risk, actions taken to ensure safety and observations. The PER and warning form accompanied detainees when they left the facility.

1.64 Detention planning should ensure that police custody is only used in exceptional circumstances. When a detainee is transferred to a police cell, the logs should record why. (1.98)
Achieved. At our last inspection approximately a fifth of all detainees were taken to a police station. This was no longer the case. In the three months before this inspection 23 detainees were held at the facility, 83% of whom were transferred to an IRC. Thirteen per cent were taken to Pennine House residential STHF and one detainee was released.

Additional information

1.65 Hygiene packs and clothing were available for detainees who required them.

Section 2: 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 the facility contractor

Escorts, vans and transfers

2.1 Vehicles collecting detainees should be able to park adjacent to the holding area. (1.1)

2.2 Handcuffs should only be used if justified by a written individual risk assessment. (1.7)

Arrival and accommodation

2.3 Toilet facilities should be properly screened from the holding room. (1.10)

2.4 The payphone should have a privacy hood and detainees should be afforded privacy when making calls. (1.14)

2.5 Detainees should retain all items of clothing, including shoelaces, unless individual written risk assessment indicates otherwise. (1.19)

Positive relationships

2.6 The door between the office and the holding room should be left open, on a risk-assessed basis. (1.21)

Legal rights and casework

2.7 Written reasons for detention should be issued in a language that the detainee can understand. (1.22)

Duty of care

2.8 Detainee custody officers (DCOs) should receive regular refresher training in anti-bullying and suicide and self-harm prevention. (1.27)

2.9 DCOs should carry anti-ligature knives. (1.28)

2.10 Detention officers should be aware of lessons learned from previous incidents. (1.30)

Diversity

2.11 All local policies should be impact assessed, looking at how they affect different groups in different ways: such as women, people with disabilities, older people and those from different ethnic and nationality groups. (1.39)

2.12 The Qur'an and Bible should be on a bookcase in the holding room and should not have to be requested. (1.40)

2.13 Reasonable adjustments should be made to the holding room toilet so that it can be used by detainees with mobility problems. (1.43)

Activities

2.14 Reading material in a range of languages should be available in the holding room. (1.45)

2.15 Books and other reading material should be stored on a bookcase in the holding room, so that detainees do not need to request them from staff. (1.46)

2.16 A stock of suitable DVDs, in a range of languages, should be available. (1.48)

2.17 Detainees should have access to fresh air. (1.49)

Services

2.18 When a detainee's stay spans a period of several hours, a hot meal should be provided. (1.58)

Appendix

Holding room