



# **Annual Report of the Independent Monitoring Board at Yarl's Wood IRC**

**For reporting year  
1 January 2024 to 31 December 2024**

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## **Introductory sections 1 – 3**

### **1. Statutory role of the IMB**

#### **1.1 Statutory Role in the IRC**

The Immigration and Asylum Act 1999 requires every immigration removal centre (IRC) to be monitored by an independent board appointed by the Secretary of State from members of the community in which the IRC is situated.

Under the Detention Centre Rules, the Board is required to:

- monitor the state of the premises, its administration, the food and the treatment of detained persons
- inform the Secretary of State of any abuse that comes to their knowledge
- report on any aspect of the consideration of the immigration status of any detained person that causes them concern as it affects that person's continued detention
- visit detained persons who are removed from association, in temporary confinement or subject to special control or restraint
- report on any aspect of a detained person's mental or physical health that is likely to be injuriously affected by any condition of detention
- inform promptly the Secretary of State, or any official to whom authority has been delegated, as it judges appropriate, any concern it has
- report annually to the Secretary of State on how well the IRC has met the standards and requirements placed on it and what impact these have on those in its custody.

To enable the Board to carry out these duties effectively, its members have right of access to every detained person and every part of the IRC and all its records.

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty designed to strengthen protection for persons deprived of their liberty. The protocol recognises that such persons are particularly vulnerable and aims to prevent their ill-treatment through establishing a system of visits or inspections to all places of detention. OPCAT requires that states designate a National Preventive Mechanism to carry out visits to places of detention, to monitor the treatment of and conditions for detained persons and to make recommendations for the prevention of ill-treatment. The IMBs are part of the United Kingdom's National Preventive Mechanism.

#### **1.2 Statutory role in the RSTHF**

The Yarl's Wood Independent Monitoring Board is appointed by the Home Secretary to monitor and report on the welfare of persons in a residential short-term holding facility (RSTHF) through observation of their treatment and of the premises in which they are held.

The Board conducts its work in line with the Short-Term Holding Facility (STHF) Rules 2018, which place the day-to-day operations of STHFs on a statutory footing. Part 7 of the Rules sets out the responsibilities of the Independent Monitoring Board (referred to in the Rules as the Visiting Committee). The Board has unrestricted access to every detained person and all immigration detention facilities and to most records. IMB members have access, at all times, to all parts of the facility and can speak to detained persons outside of the hearing of officers. They must consider any complaint or request which a detained person wishes to make to them and make enquiries into the case of any detained person

whose mental or physical health is likely to be injuriously affected by any conditions of detention. The IMB must inform the RSTHF manager about any matter which they consider requires their attention. and report to the Secretary of State about any matter about which they consider the Home Office needs to be aware.

The Board's duties also include the production of an annual report covering the treatment of detained persons, the state and administration of the facility, as well as providing any advice or suggestions it considers appropriate. This report has been produced to fulfil that obligation.

## **2. Description of the establishment**

Yarl's Wood IRC ('the centre') is a purpose-built establishment for the detention of single men and women under immigration legislation. The centre is managed on behalf of Home Office Immigration Enforcement (HOIE) by Serco.

During 2024, the establishment has been used as an IRC for men and women and an RSTHF for men who are housed under IRC rules. The maximum capacity of the centre is 444 persons; 376 male IRC, 58 female IRC and 10 male RSTHF. These are housed in five units: Avocet, Bunting, Crane and Dove for males and Nightingale is a stand-alone unit for females. Most of the accommodation is in ensuite twin rooms, although single rooms are provided when necessary. All units provide access to a garden area.

The care and separation unit (CSU) is used for IRC rules 40 and 42 and comprises 10 single rooms. There are also two rooms in the supported living facility (SLF): one single and one double. Since 2018, these have sometimes provided more relaxed and temporary accommodation for those detained people requiring a greater level of support, as well as for those who struggle to cope on a main unit.

In 2024, the number of detained men leaving the centre was 3,197 (2,872 in 2023) and the number of detained women leaving the centre was 1,736 (657 in 2023). This represents a 40% increase in the 2023 population of the centre. There was an average monthly occupancy of 339, with a maximum of 388 persons in December 2024<sup>1</sup>.

Onsite healthcare is provided by Northamptonshire Healthcare NHS Foundation Trust (NHFT), commissioned for the centre by NHS England.

The Home Office detention engagement team (DET) communicates with detained persons and helps them understand their cases and detention. During 2024, drop-in surgeries were held on each unit by the DET team and in the visits hall. Detained persons have been contacted by phone as well as having face-to-face meetings in the legal corridor and on units. The Home Office Detention Services (DES) compliance team is responsible for all onsite commercial and contract monitoring.

The welfare office also runs daily surgeries to support detained persons and further services are supplied by external organisations: Hibiscus, who advise on resettlement; the Red Cross, who help trace families; and Bail for Immigration Detainees (BID), which advises on bail applications. Beyond Detention provide emotional and practical support both to detained persons in the centre and post-detention in the community. Finally, the UK Lesbian and Gay Immigration Group support detained persons who are lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more.

Spiritual support and counselling for pastoral purposes are provided by the religious affairs team, with representatives from all the main faiths. If not a regular visitor, then arrangements are made for specific faiths. Educational opportunities are provided by the contractor.

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<sup>1</sup> Data source: Serco.

### **3. Key points**

#### **3.1 Background to the report**

The throughput of the centre has increased by 40% since 2023. The Bunting unit is now fully integrated into the male accommodation regime, along with the other male units.

#### **3.2 Main findings**

##### **Safety**

- The levels of violence at Yarl's Wood over the course of 2024 are similar to those in 2023. There have been many altercations between detained persons and there continues to be physical and verbal assaults on both female and male officers.
- The level of violence can be directly attributed to the proportion of the detained persons that are TSFNOs (Time Served Foreign National Offender), which has, at times, been more than 50% of the male population. There also continues to be a high level of stress and anger, particularly amongst the men, at the length of time they have been kept in detention. This in turn has contributed to the levels of violence, along with poor mental health.
- The Board has observed and commends the efforts of officers to diffuse potential altercations and engage in mediation between residents.
- There was one major incident during the year when the command suite was opened. The Board attended the incident and saw that it was very well managed. The incident was concluded without damage to the building and there were no injuries to staff and detained persons. Lessons have clearly been learned from the five major incidents in 2023. However, the fragility of the centre's fabric remains with potential risks resulting from such incidents.
- The Board has commented on a potential safeguarding exposure in having both male and female detained persons in the Care and Separation Unit (CSU) at the same time. It would be appropriate to have separate CSU accommodation for both males and females.
- The centre continues to experience detained persons arriving with mental health issues, including those transferred from the prison estate. The Detention Gatekeeper should be more robust in its safeguarding purpose of protecting vulnerable people from being detained.
- Information coming from prisons about the mental health and vulnerability of men being transferred to Yarl's Wood should be improved. There is poor information sharing that creates unnecessary risk in ensuring the safety and wellbeing of detained persons and increases the work for the staff, both Serco and healthcare.

##### **Fair and humane treatment**

- The Board has seen that detained persons are treated fairly and humanely by staff.
- The Board has seen that the CSU has been used appropriately by staff and commends the approach and efforts to return detained persons as quickly as possible to normal association.
- The CSU has been used to house detained persons with significant mental health problems, often for weeks at a time until a mental health bed has been found. The CSU is safer than other locations, but it is not an appropriate place for someone experiencing severe mental health problems.
- When Nightingale was being prepared to reopen as a women's unit, the Board was concerned that it might be easy for the men on Crane unit to have visual access to

the women. Some mitigation has taken place, but there are still some complaints that the women receive unwelcome comments and cat calls from the men.

- Women have been unfairly threatened by officers with use of force if they refuse a transfer to the Derwentside IRC, when the transfer has been for administration purposes. The Home Office and Serco management have both stated that they do not support the use of force and such threats by officers should not be made.

## **Health and wellbeing**

- The healthcare team has been well staffed during the year.
- A range of health awareness sessions has been provided throughout the year on issues such as hepatitis and blood pressure. Smoking cessation sessions were given to support the ban on smoking in the centre which was brought in during the year.
- The Board continues to be concerned about the number of persons detained with significant mental health problems. The Board is pleased to report that the responsibility for referral for specialist treatment has been assumed by NHFT, which should give improved management of the referral process. The Board notes that this is against a backdrop of a shortage of mental health beds generally.
- Healthcare is hindered in its work by detained persons arriving with a lack of medical history and who require treatment. Medication cannot be prescribed until their medical records are obtained or they are assessed by a GP.

## **Preparation for return or release**

- The Board continues to be concerned about the length of time that detained persons, particularly TSFNOs, spend at the centre, leading to frustration and deterioration in their mental health.
- The Board welcomes the increase in the number of Detainee Engagement Team (DET) staff and the resulting increase in surgeries. However, lack of information from case workers continues and the DET staff increase has not noticeably improved casework progression.
- The Board regularly receives complaints from detained persons about the length of time it takes for bail accommodation to be approved with one man saying he had been waiting eight months.

## **3.3 Recommendations**

### ***TO THE MINISTER***

- The Board repeats the recommendation to introduce a time limit for immigration detention. If no time limit is introduced, how does the Minister plan to ensure that the amount of time people are held in detention is decreased?

### ***TO HOME OFFICE IMMIGRATION ENFORCEMENT***

- The Board continues to report that length of stay and frustration with progression of casework continues to be a source of anger and unrest in the Centre. The Board once again recommends that:
  - The removal process for TSFNOs is started in prisons well before their sentence is due to end and in advance of their transfer from prison to the immigration estate.

- The length of stay is reduced by improving the processes related to asylum status/and or removal.
- The process for voluntary returns should be improved/rationalised so that those who wish to leave, do so more quickly.
- The Detention Gatekeeper should be more robust in its safeguarding purpose of protecting vulnerable people from being detained

### **TO THE DIRECTOR/CENTRE MANAGER**

- There have been logistical issues when the CSU unit has been needed to be used by both male and female detained persons. The Board recommends that to avoid such problems, there should be a separate dedicated CSU for female detained persons.

### **TO NHS ENGLAND**

- To encourage external acute psychiatric services to remove psychiatrically ill patients at an early stage.

### **3.4 Progress since the last report**

<b>Issue raised</b>	<b>Response given</b>	<b>Progress</b>
Introduce a time limit for immigration detention.	Recommendation rejected.	
Start the removal process for FNOs in prison before they are transferred to the IRC estate.	FNOs are referred to the HO for deportation immediately following sentencing. HMPPS are working closely with the HO to ensure the Early Removal Scheme (ERS) runs as efficiently as possible.	Statistically, the number of FNO returns has increased by 28% in the year ending June 2024. However, the length of time that FNOs spend in the IRC estate once they have been transferred from prison continues to be a source of frustration and unrest amongst detained persons.
The Board recommends that the culture of professional conduct is maintained through officer's training, inductions and ongoing review of culture.	Accepted	Officers' training is ongoing.
The Board is concerned with the length of time between identification of need and the sourcing of mental health beds for vulnerable persons.	Accepted	The Board acknowledge that the sourcing of beds is not within the control of healthcare at Yarl's Wood.  Significant progress has been made in that all cases will be dealt with by NHFT and that the local community NHS mental health provider for them



		is East London NHS Foundation Trust.
R35 medical reports should be audited and the IMB should have oversight of this process.	Partially accepted.	NHS England accepts the recommendation and has oversight of the audits made by NHFT. The results of these audits can be made available to be shared at the quarterly IRC Partnership Board meeting.

## Evidence sections 4 – 7

### 4. Safety

#### 4.1 Reception and induction

4.1.1 The Board monitors the reception area and has observed staff being calm, helpful and respectful at a time that many detained persons find emotionally difficult. There have been fewer cases of administrative difficulties with paperwork than in 2023 but there are still some cases of detained persons arriving at the IRC from prisons without their medical records. This is a particular problem for detained persons arriving from the Scottish prison estate.

4.1.2 The Board observed arrivals being dealt with in a calm and respectful way by staff who explain clearly the arrivals process that is being undertaken. All arrivals are seen by a member of the healthcare team and are provided with clean towels, bedding and toiletries. If the detained person arrives without spare clothing, this can also be provided. There was an interruption in the provision of clothing that was remedied within a few weeks (see 5.2.6).

4.1.3 The detained persons are then moved to the units where an induction takes place. There is a system of guides appointed from the detained persons to provide ad hoc help as well as pamphlets, which are available in 19 different languages.

#### 4.2 Suicide and self-harm, deaths in custody

4.2.1 There were no deaths in custody during 2024.

4.2.2 There were 57 reported incidents of self-harm during 2024, a significant increase on the 29 incidents reported in 2023. There were also 108 threats of self-harm<sup>2</sup>. Self-harm has varied, from minor scratches to the forearm to self-enucleation of an eye. The latter was carried out after a period of increasing frustration about imminent deportation associated with declining mental health. The individual was on an Assessment Care in Detention and Teamwork (ACDT), which is the process used to manage detained individuals identified to be at risk of suicide or self-harm and constant watch on his unit. Subsequently in the CSU and on constant watch whilst looking away from the door he managed to enucleate his eye. The injury to his eye is permanent. The IMB was present shortly after this episode just before the individual was transferred to hospital. Distress amongst staff was observed as well as emotional numbness in the detainee. Members of the IMB have observed that in cases of self-harm, officers have responded in a proportionate manner and have used the ACDT system, where deemed necessary (see 4.2.4).

4.2.3 There continues to be a high level of stress and anger, particularly amongst men, regarding the length of time they have been kept at Yarl's Wood. There is much evidence that the prospect of indeterminate detention and the length of time and uncertainty in case resolution takes its toll on the detained person's mental health and has resulted in poor sleep, violence, depression, and self-harm.

4.2.4 The number of ACDT cases opened during 2024 was 265, compared with 181 in 2023. There were 164 male ACDT cases (5.2% of the population) and 101 female ACDT cases (5.8% of the population). There were 103 cases of constant supervision ACDT

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<sup>2</sup> Data source: Serco.

cases compared with 70 in 2023. The IMB and senior Serco management regularly monitor the ACDT paperwork, and this appears to be generally of a good standard.

4.2.5 It is evident that the officers respond confidently and proactively both to self-harming incidences and detained persons talking of self-harm. It is the Board's experience to date that appropriate support and supervision is put in place in a timely manner. The number of ACDT cases opened due to threats of suicide or self-harm (108) demonstrates the Serco vigilance in this area (see 6.3.6).

### **4.3 Violence and violence reduction**

4.3.1 There was one major incident during the year when the command suite was opened to manage the incident. The incident was a sit-in, mainly by men on the Dove unit, in protest at their length of stay. Due to the prolonged period of the sit-in, the emergency services were called in, together with the National Tactical Resource Group (NTRG). The incident was relatively quickly concluded with detained persons returning to their rooms and ring leaders of the protest being removed to the CSU. The ring leaders were subsequently transferred to other IRCs.

4.3.2 The IMB attended the incident and observed that it was very well managed. It was concluded with no damage to the fabric of the building and no injuries to staff or detained persons. Lessons have clearly been learned from the five major incidents that were experienced in 2023 and there was much improved communication between the various agencies involved.

4.3.3 There was one logistical issue identified during the major incident in that there was a female detained person in the CSU while the eight male ring leaders were transferred to the CSU. An attempt was made to move the female detained person to the supported living facility, but she would not comply. The Board thinks that to avoid such logistical conflicts in the future there should be a dedicated CSU for female detained persons.

4.3.4 Aggressive or antisocial behaviour has again been notable in the centre during 2024. There were several incidences of damage to the fabric of the centre caused either by angry attacks, or on occasion to provide hiding places for contraband in the partition walls. The most common contraband were mobile phones and hooch. However, the number of incidences has not increased since 2023 and the Serco staff are to be commended for their use of a range management tools that enables a graduated response to angry, frustrated, and potentially violent detained persons.

4.3.5 The centre operates a system of opening tackling anti-social behaviour booklets (TABs). The aim of the TABs is to monitor and reduce tensions and maintain a safe and peaceful atmosphere within the centre and to safeguard the victims from perpetrators. In 2024 a total of 285 TABs were opened, a small decrease of two from 287 in 2023. The IMB were informed that the main reasons for opening TABs were physical/verbal altercations, damage, and non-compliance with centre rules. Violence against staff accounted for seven TABs and in 16 incidents, weapons were found or used.

### **4.4 Detained persons with specific vulnerabilities, safeguarding**

4.4.1 The Board has been concerned throughout the year about the high number of vulnerable persons who are detained at Yarl's Wood, particularly those with mental health complexities, and which places a high level of demand on the healthcare team. There should be greater scrutiny by the Detention Gatekeepers of individuals' mental health to prevent these persons being detained in the first place.

4.4.1 The wellbeing of detained persons identified as vulnerable is managed under vulnerable adult care plans (VACPs) that details the specific needs of the individual and any support or adjustments they require. There were on average 19 VACPs in operation each month, an increase from 12 in 2023, with a total of 228 (153 in 2023). The majority were for mental and physical health issues and reflects the increase in vulnerable persons entering the immigration detention estate. The Board observed adequate records and completed assessments and guidance for staff.

4.4.2 There was a total of two age disputes during 2024 (one in 2023). If there is any suggestion that a detained person is a minor and they have not already been age assessed, then they are released to social services for an age assessment. Whilst this is being arranged the detained person is placed on an age dispute care plan.

4.4.3 A total of 436 individuals were identified as potential victims of trafficking and modern slavery during 2024 (340 in 2023).

4.4.4 Detained persons that are considered especially vulnerable to harm because of their detention are regarded as an 'adult at risk' (AAR). An individual may be regarded as being an adult at risk if they suffer from a medical condition, physical disability or have been the victim of torture or trafficking. There were 329 AAR level one, 240 AAR level two and seven AAR level 3 during 2024 (compared with 16 in 2023).

4.4.5 The Board would like to see integration of ACDT, R35 and AAR policies to enable dynamic risk assessment of the mental health of residents, especially after prolonged detention.

## **4.5 Use of force**

4.5.1 Force was used 156 times against male detained persons (140 in 2023) and 24 times against females (no 2023 data). Of the 156 cases involving men, 92 were spontaneous (99 in 2023) and 44 were planned (41 in 2023). Reasons for the use of force (UoF) include to prevent self-harm, violent outbursts, assaults on staff or other residents, disruption to regime and failure to comply with centre rules. 'Spontaneous' refers to officers intervening between detained people to prevent injury or intervening when a detained person appears to be about to injure themselves or damage property. Time permitting, the Board reviews videos of UoF incidents before most Board meetings and considers that the UoF has been justified and proportionate.

4.5.2 A small number of UOF incidents were subject to complaints and some referred to the professional standards unit. Outcomes of the complaints did not find that UOF was unjustified, but some could have been better handled and lessons learned were put in place.

## **4.6 Substance misuse**

4.6.1 In 2024, there were 176 cases of detained persons suffering from substance misuse that required support from healthcare<sup>3</sup>. Healthcare can conduct routine urine drug screening on new arrivals, but it is not currently mandatory. The Board considers this reduces healthcare's opportunity for early intervention.

4.6.2 There continues to be an element of substance abuse within the centre, especially among detained persons transferring from the prison estate. There have been finds of hooch, which is made in detained persons' rooms and in laundries. There have also been finds of cannabis and other controlled substances during intelligence led searches of

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<sup>3</sup> Data source: Northamptonshire Healthcare NHS Foundation Trust (NHFT).

rooms and officers are diligent in observations during visits to prevent substances being given to detained persons by visitors. Letters and parcels sent to detained persons through the postal service are also monitored and there have been finds of controlled substances. The Board has observed room searches conducted with thoroughness and respect for the detainees.

4.6.3 Healthcare runs a detoxification programme, and medicines are available from the medicines administration point. A total of 39 detained people were on a methadone programme during 2024. There were 389 substance misuse appointments given in 2024<sup>4</sup>.

4.6.4 During the year, the centre successfully introduced a no-smoking policy. The policy was supported by healthcare, which gave 389 smoking cessation courses<sup>5</sup>. Detained persons are allowed the use of vapes in their rooms and outside areas, but not within common areas indoors. The Board has seen the use of vapes indoors and noted that this is tolerated by some officers and enforced by others. To avoid any misunderstanding of policy by detained persons the Board recommends that there should be consistency in application of the policy by staff.

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<sup>4</sup> Data source: Northamptonshire Healthcare NHS Foundation Trust (NHFT).

<sup>5</sup> As above.

## **5. Fair and humane treatment**

### **5.1 Escort, transfer and transport**

5.1.1 The Board monitored two long distance charter removals. Both were well organised and went according to plan.

5.1.2 The Board has previously expressed concern about the unsuitability of nighttime arrivals and departures. In 2024, 1207 men and 831 women arrived between 1900 and 0700 compared with 1062 men and 350 women in 2023. This shows an increasing trend year on year. In departures, 1851 men and 455 women left between 1900 and 0700 hours; again, this raises concerns especially if they are leaving for bail accommodation.

5.1.3 Throughout the year, there were many women who refused to be transferred to Derwentside. One woman complained that she was told that she could be handcuffed if she did not agree to be transferred. The Board questioned this and was told that neither Serco nor the Home Office would support enforced transfers that are for administration purposes. This being the case, the Board questioned why the statement about handcuffing was made to the women and considers such intimidation as inhumane. Serco advised that this was an error relating to an individual staff member, who was subsequently provided with advice and guidance on such transfers.

5.1.4 The Board has reviewed the risk assessments of detained persons sent to hospital. Invariably, detained persons are handcuffed, even under examination and when confined to bed. The Board has questioned Serco about this, and a Home Office instruction has been amended, leading to the use of handcuffs being the default position. The Board considers this practice demeaning and unfair.

### **5.2 Accommodation, clothing, food**

5.2.1 The centre has been operating close to capacity for the year. It is showing signs of wear and tear.

5.2.2 The nature of the population means there has been damage to the centre. For example, display boards were being damaged as soon as they were repaired. The Board continues to question whether the buildings are sufficiently robust to accommodate the current population.

5.2.3 The centre continues to adapt to the changing needs of the estate; the Bunting unit underwent a remodelling to increase capacity with bunk beds being added in each room. The Board notes that this remodelling increased population density and reduced detainees' personal space. The Bunting exercise area was also upgraded with new equipment and an all-weather playing surface.

5.2.4 When the Nightingale unit was being prepared to reopen as a women's unit, the Board was concerned that it might be easy for the men on Crane unit to have visual access to the women. Some mitigation has taken place; filling rooms first on Crane that do not have sight of Nightingale. However, there are still complaints that when rooms are in use that have oversight of the Nightingale garden, the women sometimes receive unwelcome comments and cat calls from the men.

5.2.5 The IMB often receives verbal complaints about the food. A total of 22 detention centre form 9 (DCF9) complaints were received about food. The complaints vary; some say the food is too stodgy, others complain about the quantity. Catering do hold focus groups and change the menu with the seasons. The Board does inspect and taste the food and considers the portions generous, albeit they can be stodgy.

5.2.6 There was one period when the Board was notified that there was a deteriorating situation with the provision of clothing to residents who arrive at Yarl's Wood with only the clothes that they are wearing. Clothing was not being provided and the responsibility was being transferred to Beyond Detention with written requests to provide clothing being made to them by Serco. Anecdotally, the Board was informed that Serco staff had received emails from management telling them not to provide clothes.

5.2.7 The Board wrote to Serco management and was advised that it had made changes to procedures to improve stock control and that the implementation of the change had not gone to plan and errors had occurred. The problem was resolved by management and the Board has not received any more complaints about the issue of clothes.

5.2.8 Good use of the cultural kitchen is made in both Dove unit for the men and Nightingale unit for the women. For many, this is a valuable social activity that allows them to prepare and eat food more to their taste.

### **5.3 Separation**

5.3.1 The CSU is intended to provide basic accommodation for detained individuals who are removed from association under Detention Centre Rules 40 or 42.

5.3.2 There were 218 cases of separation in the reporting year, which is a significant decrease from 2023 (306). Only one person was detained under Rule 42. Forty persons were detained prior to removal. The Board is satisfied this was due to risk assessments following conversations with the detained person and other intelligence.

5.3.3 Detained persons should only be removed from association for reasons of security and safety, both individual and of the centre.

5.3.4 The Board commends the work by the Centre in using de-escalation techniques and changing the regime to reduce the need to remove detained persons from association.

5.3.5 The Board also commends the approach to return as quickly as possible to normal association. It is increasingly common for someone or two persons who have had an altercation to be removed under Rule 40 but then returned to normal association following mediation and/ or time out within a half day.

5.3.6 The Board observed that an increasing number of persons held in the CSU exhibited behaviours suggestive of mental health problems. Eight removals to the CSU were related to mental health issues. Detained persons often must stay there for a significant time, sometimes weeks, until an appropriate mental health bed in a health setting is found. While the CSU is the safest location, it is not an appropriate place for someone experiencing severe mental health issues, both for the impact on their health but also for the other residents and staff.

5.3.7 The Board has commented before on the use of the CSU for both women and men. While the Board appreciate the staff take great care, this year has shown the potential risk of this practice. A female detained resident with mental health issues was in a room in the middle of the unit. An incident took place which resulted in the remaining rooms being filled by men late at night. There was risk in moving her as she was not cooperative but equally it wasn't appropriate for her to be in a room in the middle of a unit filled with men. While the staff did their best, it would be appropriate to have separate CSU accommodation for men and women.

## **5.4 Staff/detained persons relationships**

5.4.1 The recruitment and retention of suitable staff is a constant challenge. During the year, there have been several initial training courses (ITC) for new recruits and the Board commends the appointment of an increasingly diverse staff who bring with them a range of important additional language skills.

5.4.2 The Board received many comments about the kindness of staff and observed many positive and caring interactions between officers and detained persons. To have specific staff on each unit, when possible, helps to establish an atmosphere of understanding and trust.

5.4.3 The Board notes there was often a small number of confrontational detained persons. While the reasons appear to be numerous, the overriding issue was the length of stay and frustration with the HO. At times, this caused tension within the centre.

## **5.5 Equality and diversity**

5.5.1 General information is sometimes available in a range of languages. For example, there are induction pamphlets in 25 languages. There are still gaps in what information is available for detained persons in a language they can understand.

5.5.2 There has been an increase in using graphical images to provide information about the regime, e.g. what time breakfast is served, which is helpful.

5.5.3 Telephonic interpretation services are used regularly. There have been instances of delays while waiting for a suitable interpreter. The Board was present at one multi-disciplinary team meeting (MDT) in CSU where none of the agencies; Serco, HO or Healthcare could get hold of an interpreter. The impact was the MDT was delayed until later that day.

5.5.4 When persons with disabilities were detained, appropriate measures were put in place to support them. All had a personal emergency evacuation plan (PEEP) and appropriate adjustments made.

5.5.5 The centre holds regular focus groups for different populations, both nationality but also for population types and the number of group meetings is given below:

<b>Population type</b>	<b>Number</b>
Age	5
Disability	4
Religious	2
Transgender	2
Sexual orientation	1

5.5.6 The centre has organised events to support tolerance and celebrate diversity including celebrations of Pride, Eid and Black History Month.



## 5.6 Faith and religious affairs

5.6.1 There is a very active religious affairs team, representing most religions. They celebrate significant dates in the spiritual calendars and provide great support by visiting individuals.

5.6.2 As with last year, there is no rabbi and nowhere other than one of the multi-faith rooms, that could be used for acts of worship by those of Jewish faith. To the Boards knowledge, there has not been anyone detained during the reporting year that identified themselves as of Jewish faith.

## 5.7 Complaints

5.7.1 During the reporting year, there were 163 complaints, an increase of seven from the previous year. These complaints were logged on DECS by the DS complaints team; however, there were 45 local resolution cases, which brings the total to 208. This is an increasing trend as 2023 had an increase of 45 from the previous year. The Board is unable to determine the reason, the current population, greater awareness of the complaints system or an increased dissatisfaction with treatment at the centre.

5.7.2 The complaints related to: minor misconduct, professionalism, admin, food, use of force, serious misconduct (assault). Eight Complaints were referred to the professional standards unit (PSU).

5.7.3 The Board is satisfied all complaints were followed up within the target timescales. Outcomes are shown below.

No of DCF9 complaints	208
No of issues (complaints can cover more than one)	Minor misconduct, professionalism, admin, food, use of force, serious misconduct (assault)
Complaints referred to the PSU	7
Complaints referred to agencies outside the centre	0
No of complaints upheld	6
No of complaints partially upheld	3
No of complaints not upheld	154 The outcomes above do not reflect local resolution complaints, the records for which are not held by DES.
No of complaints withdrawn	1
No of complaints under investigation	10

5.7.4 Responses to complaints were detailed, giving reasons for the decision to uphold the complaint or not and outlining the procedure for appealing against the decision.

## **5.8 Property**

5.8.1 There continue to be a small number of problems where detained persons struggle to get access to their property, and this is often when the person has been detained at a police station and their phone is retained for inspection. Property can also be left at a prison when the person is transferred to Yarl's Wood. On most occasions the welfare department can contact the establishment where the property is retained and organise for it to be forwarded.

5.8.2 The Board received one application from a detained person who was incorrectly told by an officer in the welfare department that he must pay for his property to be forwarded from a prison to Yarl's Wood. The Board brought this to the attention of Serco and there has not been a reoccurrence of such incorrect information being given.

5.8.3 The Board has observed over several years that detainees' valuables were placed in bags marked 'HMP' and with a space to add a prisoner number. Yarl's Wood is not a prison and detained persons are not prisoners and treating them as such is demeaning. The Board complained about this several years ago and no action was taken. The Board is pleased to report that following another representation this year, clear plastic bags without HMP labelling have been purchased and are now used for detained persons' valuables.

## **6. Health and wellbeing**

### **6.1 Healthcare general**

6.1.1 The healthcare facility for men is located close to the centre of the building. The facilities include rooms for consultations, clinical treatment and administration. There are no formal inpatient facilities. A separate stand-alone healthcare facility for women with rooms for consultation and treatment is in the Nightingale unit. During rota visits, the Board have observed healthcare facilities to be clean and well maintained. The appointments system appears efficient. Frequently, detention officers escort a detained person as far as the waiting room.

6.1.2 Healthcare is provided by Northampton NHS Foundation Trust (NHFT). Turnover in staff continues albeit at a slow pace. Appointments are available generally within three days with a doctor and same day with a nurse. Appointments with a mental health nurse are on average available within three days and a psychiatrist visits Yarl's Wood weekly.

6.1.3 There are GPs, nurses, mental health nurses and a pharmacist. There is also regular access to a psychologist, a dentist and ophthalmologists. Healthcare regularly attends multi-disciplinary meetings and provide clinical updates to staff.

6.1.4 Healthcare manage their own complaints process. They had 59 (48 in 2023) complaints in the year, seven (14%) of which were upheld. None of these complaints are shared with the IMB on the grounds of medical confidentiality.

### **6.2 Physical healthcare**

6.2.1 All arrivals are offered a physical health screening with a nurse, within two hours of arriving at the centre. If necessary, a VACP is opened during this assessment. All arrivals are offered preventative care services such as HIV testing, hepatitis B and C screening and information on the drug misuse clinic.

6.2.2 Healthcare has at times been hindered in their health assessments by the lack of detained persons' medical history, particularly those arriving from the prison estate or detained at police stations. The records are never provided for detained persons arriving from the Scottish prison estate.

6.2.3 Lack of medical history is a particular problem for detained persons who are on prescribed medication and/or arrive without medication. Healthcare cannot continue their medication until their medical records can be obtained or they are alternatively assessed by a GP. The problem is aggravated if the arrival of the detained persons is late on a Friday or during the weekend. One detained person who was a diabetic arrived without any medication and without their medical history.

6.2.4 If an individual requires specialist care, they are transferred to external services such as at Bedford General Hospital where detention officers normally stay with the detained person as a patient.

6.2.5 Detained persons who are identified as having or suspected of having a contagious disease are isolated either in healthcare or the supported living facility. They are treated there until they are assessed as being fit to rejoin the main population.

6.2.6 The healthcare team has facilitated a range of health awareness sessions throughout the year, providing information on a variety of issues such as hepatitis and blood pressure.

### 6.3 Mental healthcare

6.3.1 The Board acknowledge the high-quality care that is provided by the mental health team working with a high workload of detained persons who present with mental health difficulties.

6.3.2 The Board continues to be concerned about the length of time it takes to obtain a hospital bed for detained persons requiring specialist treatment under the Mental Health Act (MHA). The Board acknowledge that this is not within the control of the Yarl's Wood healthcare team. One obstacle has been that treatment had to be referred to the area health authority from where the detained person came. In some cases, this could not be established. The Board is pleased to report that during the year, responsibility for referral was assumed by NHFT and that the local community NHS mental health provider for them is East London NHS Foundation Trust. This should give healthcare better management of the referral process.

6.3.3 Whilst waiting for a hospital bed, some detained persons have been held in the CSU, in the interests of health and safety, often for weeks, which is clearly inappropriate. Four detained persons were sectioned under the MHA in 2024 (five in 2023).

6.3.4 All other cases of mental illness are managed by in-house mental health professionals. This comprises counsellors, mental health nursing staff and a psychologist with the support of a weekly visit by a psychiatrist. Mental health staff provide treatment including counselling support, the prescription of medication and cognitive behaviour therapy and similar treatments.

6.3.5 Mental healthcare services are in high demand. There were 3832 mental health appointments made in 2024, compared with 2756 the previous year. The average waiting time for appointments is three days to see a counsellor or mental health professional.

6.3.6 In 2024, there were 15 applications made under Rule 35 (1) of the Detention Centre Rules (2001) that requires healthcare practitioners to report the case of any individual whose health is likely to be affected by conditioned detention. There were two applications under Rule 35(2) that requires medical practitioners to report the case of any individual suspected of having suicidal intent and requiring increased supervision. There have been 597 applications under Rule 35(3), which relates to potential victims of torture.

6.3.7 As reported in 2023, the Board is again concerned at the significant difference between the number Rule 35(2) applications and the number of persons placed on ACDT due to their identified risk of suicide or self-harm, two applications of Rule 35(2) versus 108 (see section 4.2.5). The Board is surprised that these numbers are not more closely aligned.

### 6.4 Welfare and social care

6.4.1 Detained persons can book an appointment with the welfare team during the daily open office hours. This service is valued by detained persons and the table below shows the numbers and type of support.

Welfare			
No. of appointments booked	Inductions	Removals' directions consultations	Referrals to other organisations
12514	2673	1336	221

## **6.5 Exercise, time out of room**

6.5.1 Detained individuals are locked in their rooms from 22.00 hours to 7.00 hours. Morning unlock is 7.00 hours until 11.30 hours. Pre-lunch lockdown and roll count is 11.30 hrs. Units are open for free association from 13.00 hrs until 16.30hrs, when pre-evening meal lockdown and roll count is done. After the evening meal, between 18.00 hours and 20.00 hours, the open regime for men is split between units and all detained persons are returned to their room at 21.45 hours for lock up at 22.00 hours.

6.5.2 Outside of these periods, men can freely associate in the residential units, use the gym or take part in the programme of education and activities.

6.5.3 The women's unit is run separately to the male units with similar provision. Women have access to the sports hall at specific times.

## **6.6 Soft skills**

6.6.1 There is a library that is stocked with books, newspapers, DVDs and magazines, all in a sufficient range of languages. The music and art rooms are popular with residents. There are cultural kitchens, which are particularly popular amongst detained persons, as well as a gym, sports hall, arts and crafts room, games room, IT room and football pitch.

## 7. Preparation for return or release

### 7.1 Activities including education and training

7.1.1 The provision of meaningful activities has been inconsistent. The Board noted that in January there was a push in advertising posts of paid activity. These are evidenced on the events calendar and advertised on resident kiosks. This was welcome, as it gives purpose to the day of the detained person, as well as a little extra cash.

7.1.2 The paid activities are in the kitchen, library and cleaning. Detained persons have also been paid to decorate the units. The table below shows the breakdown of paid activities.

Paid activities in 2024 <sup>6</sup>		
		Total for the year
Average age		35
Employed		
Females		32
Males		356
Top three nationalities		
1	Vietnam	
2	Poland	
3	Romania	

7.1.3 It is noteworthy that Albanians do not feature in the top nationalities in paid activities, as they are by far the largest national cohort in the centre, often accounting for 50% of the population.

7.1.4 Educational and training activities in the centre have continued to be patchy. The only certified course now offered is an NVQ1 course in food hygiene, which is completed by persons who wish to work in the kitchens and serveries. Attempts have been made to encourage take up and other available courses were clearly promoted in the classroom. These efforts have had a disappointing response in engagement by detainees

7.1.5 There were 3,418 attendances to classroom lesson in 2024. The men were usually more interested than the women. Staff on the women's unit told the IMB that, anecdotally, the women were usually so concerned about their situation that they were not motivated to engage in learning.

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<sup>6</sup> Data source: Serco.

7.1.6 Differentiated online learning courses (e.g. “virtual college”, ESOL, British Council ESL) are a good idea, but the plans were thwarted when the computer system was not working.

7.1.7 To encourage greater involvement by the detained persons, a teacher organised a very successful spelling competition. However, inhouse certificates to award achievement were less popular.

7.1.8 There are well stocked libraries in all units, offering a range of books, DVDs, newspapers and magazines in several languages.

7.1.9 There was a monthly programme of cultural and social events, which are noted on the events calendar and resident kiosks.

## **7.2 Case management**

7.2.1 The Detained Duty Advice Service (DDAS) should ensure that all detained persons are given legal appointments, either face-to-face or virtually. The Board was pleased to see that some face-to-face appointments were taking place.

7.2.2 Some detained persons told the Board they were unhappy with their solicitor, and could not afford to change, but others did not express dissatisfaction.

7.2.3 The Board welcomes the increased numbers of Detainee Engagement Team (DET) staff. They ran regular well-advertised surgeries on each unit and it was useful for the Board to be able to signpost detained persons to these for advice on their cases.

7.2.4 During the year, 2,754 male detained persons from Yarl’s Wood left the detention estate; 1,238 were removed from the UK, six were granted leave to remain, 1,414 were bailed and 96 left for unspecified reasons<sup>7</sup>. The table below shows the length of stay of male persons leaving detention.

Male detained people leaving the estate <sup>8</sup>	
Length of detention	Numbers leaving
7 days or less	590
7 days to 3 months	1830
3 months to 12 months	323
12 months to 18 months	7
18 months to 24 months	2
24 months to 36 months	1
36 months to 49 months	1
Total	2754

<sup>7</sup> Enforcement Statistics: Refugees and Irregular Migration Analysis (RIMA), Immigration System Statistics & Refugees Analysis & Insight (ISSRAI), Home Office Analysis and Insight.

<sup>8</sup> As above.

7.2.5 During the year, 1,129 female detained persons from Yarl's Wood left the detention estate; 693 were removed from the UK, three were granted leave to remain, 400 were bailed and 33 left for unspecified reasons<sup>9</sup>. The table below shows the length of stay of female persons leaving detention.

Female detained people leaving the estate <sup>10</sup>	
Length of detention	Numbers leaving
7 days or less	461
7 days to 3 months	644
3 months to 6 months	17
6 months to 12 months	6
12 months to 18 months	1
Total	1129

7.2.6 The length of stay figures for 2023 did not give a break down between males and females and a direct comparison cannot be made with 2024. However, a comparison with the raw data shows that lengths of stays are remarkably similar between the two years and time in detention has not reduced.

7.2.7 Length of stay remains a concern and causes a great deal of frustration and distress to those held at the centre. One man, a TSFNO expressed to the IMB his despair at being unable to progress his case ten weeks after arriving from prison. He was not the only person to voice similar feelings to the Board.

7.2.8 At two points in the year, this frustration led some of the men to stage peaceful protests and on one occasion, they demanded to speak to senior HO staff. This resulted in a very welcome approach from DET who ran emergency surgeries over the next few days.

7.2.9 Dissatisfaction and lack of information from caseworkers continues to be a common experience for those detained at the centre. In one notable case, a former prisoner was brought to the centre. He was assessed as an AAR, received mental health support and had a National Referral Mechanism (NRM) referral and support from Medical Justice, yet after nine months he was still in immigration detention. He told the Board that his only contact from his caseworker was the monthly report.

7.2.10 In August, three men were told they were to be released but tagged and that this would happen within 72 hours. One week later, they were still at Yarl's Wood, having apparently been held up by lack of action by their caseworkers. The Board views this as unfair.

### 7.3 Family contact

7.3.1 The centre has a large social visits hall that allows detained persons to receive visitors. The booking system seems to work efficiently and the free transport from Bedford

<sup>9</sup> As above.

<sup>10</sup> As above.



train station is essential for some visitors to be able to reach the centre, which is not served by public transport. There is a small play area for younger children and there are vending machines for visitors to buy snacks.

7.3.2 At various times throughout the year, it was suspected that visitors were passing prohibited items to detained persons. Staff were thorough in following up on any suspicions (see 4.6.2).

7.3.3 The Communications Hub contains computers and fax machines to enable detained persons to communicate with family or their legal advisers. The room is usually fully booked. There are also Skype terminals in the library and the visits hall.

7.3.4 The signal for mobile phones has been inconsistent throughout the year. When combined with occasional computer outages, this has been upsetting for detained persons who could not communicate with family and friends or pursue their cases. The IMB has been told that the phones provided to the detained persons operate on the 2G network, which is no longer supported. There is a pilot scheme at another IRC with phones that operate on a modern network, and if this pilot is successful, it will be introduced at all IRCs. The IMB has been told that staff can authorise residents to use the centre's landlines if required, but the Board has no evidence that detained people are aware of this.

7.3.5 From the Board's observations, there seems to be a tendency to shunt detained women around the immigration detention estate. There were several instances when detained persons, usually women, refused to transfer to Derwentside IRC, saying that it was too far away for their families to visit them. Similarly, one man requested a transfer to Dungavel in Lanarkshire to save his partner an 11hour journey to visit him. It would appear that distance from family is not fully considered when persons are allocated to IRCs.

## **7.4 Planning for return or release**

7.4.1 The Board continues to hear from detained persons that they are frustrated with how long it takes for bail accommodation to be approved. One man said he had been waiting eight months. Another man told the Board that he had been given a bail address in Warwickshire, despite his support network being in Kent.

7.4.2 On another occasion, a man who spoke no English was informed of the address to which he should go, given the money for a train ticket and sent off. There seems to have been little care for the detained person involved in the planning of this release.

7.4.3 The process for returning persons who wish to do so voluntarily seems to operate inconsistently. Many seem confused by it and often tell the Board that they do not understand why they are still detained when they want to leave. In particular, men who have already served their custodial sentence feel they are having to wait a long time while their return is organised.

7.4.4 Several men told the Board that they had applied to return voluntarily but were then told that they had to await the outcome of pending offences. In one case, it was later discovered that there was no offence, so there had been no reason not to return him. This again was unfair.

7.4.5 Several detained persons do not wish to return to their country. Some become very agitated at the prospect and make threats either to resist or harm themselves rather than be returned. The Board have observed staff have reacting empathetically to such threats. Those who threaten resistance are moved to the CSU, usually calmly, well in advance of the removal. They are supported while there and on most occasions the removal is

completed. However, the Board does not consider that the CSU is suitable as pre-departure accommodation.

7.4.6 In the case of those who threaten to self-harm or take their lives, staff open an ACDT document as a means of checking their welfare. When it is known that the receipt of Removal Directions could be a trigger for self-harm, their delivery may be delayed until nearer the departure date.

## 8. The work of the IMB

The Board made weekly rota visits throughout the year, during which members monitored the Centre and dealt with applications from detained persons. Issues were raised immediately with Serco, HO or healthcare, or during monthly Board meetings, as appropriate. Members also monitored charter flight removals, attended committee meetings within the centre when possible or participated remotely by video or telephone conference. Members have also attended multi-disciplinary reviews to ascertain the best care plans for detained persons.

### Board statistics

Recommended complement of Board members	12
Number of Board members at the start of the reporting period	9
Number of Board members at the end of the reporting period	7
Total number of visits to the establishment	161

### Applications to the IMB

Code	Subject	Previous reporting year	Current reporting year
A	Accommodation including laundry, showers	3	1
B	Use of force, removal from association	0	2
C	Equality	0	0
D	Purposeful activity including education, paid work, training, library, other activities	0	0
E 1	Letters, faxes, visits, phones, internet access	0	0
E 2	Finance including detained persons centre accounts	0	0
F	Food and kitchens	0	0
G	Health including physical, mental, social care	2	0
H 1	Property within centre	0	0
H 2	Property during transfer or in another establishment or location	2	2
I	Issues relating to detained persons immigration case, including access to legal advice	20	8
J	Staff/detained persons conduct, including bullying	3	4
K	Escorts	0	2
L	Other	5	3
	<b>Total number of applications</b>	<b>35</b>	<b>22</b>



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