Short thematic report by HM Inspectorate of Prisons

A review of short-term holding facility inspections

2004–2010

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Contents

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Introduction

This report provides a brief overview of the key findings arising from our inspection of UKBA short-term holding facilities (STHFs).

For most of those detained, STHFs are their first experience of detention and they are likely to feel fear, stress and uncertainty. Some will have been refused entry and will be waiting for a return flight. Others will have been picked up from their homes during early morning operations by immigration enforcement teams. An STHF therefore needs to provide a safe and decent environment in which the detainee can use the time available to prepare for their return, release or transfer.

The independent inspection process is an important safeguard for detainees and I am pleased to see that in the period covered by this report, standards have risen. I hope this report will encourage further improvement.

Nick Hardwick
HM Chief Inspector of Prisons

January 2011

1. Overview

1.1 In 2004, HM Inspectorate of Prisons began the routine inspection of short-term holding facilities (STHFs) at ports and reporting centres. These facilities are intended to hold people detained for short periods before removal or after arrival in the UK. They also hold people awaiting transportation to a longer-term place of detention. Most are not designed for overnight stays. By the start of 2010, G4S was contracted or sub-contracted by the UK Border Agency (UKBA) to run all of the UK's short-term holding facilities, except for the facility at Colnbrook. The latter is managed by Serco alongside the adjacent immigration removal centre, for which it doubles as a first days unit. During the period covered in this report, Taylormade Security managed the Harwich facility and Dover Harbour Board managed the Port of Dover facility, though Dover Harbour Board later sub-contracted to G4S. In November 2010, UKBA announced that the re-tendered short-term holding facilities contract had been awarded to Reliance, which will take over from G4S in May 2011.

1.2 People are normally held in short-term holding facilities for two main reasons: during investigations by immigration officers after arrival in the UK, or as a staging post before removal. Most STHFs are located at ports of entry or next to immigration reporting centres. The airport facilities are generally located airside and are therefore particularly inaccessible to the public. Police stations are also regularly used to hold immigration detainees.

1.3 People can be held in residential facilities and police stations for five days before their transfer or release, or seven days if removal directions have been set. Non-residential facilities are unsuitable for long or overnight stays and normally hold people for less than 12 hours, though, as this report shows, some are held for much longer periods. Children and families detained directly after arrival are regularly held in STHFs, usually pending return flights.

1.4 Short-term holding facilities were not inspected on a statutory basis until 2006, when Section 46 of the Immigration, Asylum and Nationality Act 2006 formalised the voluntary oversight that had existed since 2004. The UN's Optional Protocol to the Convention against Torture also came into effect in 2006. All States which ratify the protocol are required to have in place an independent expert body to routinely visit and report on all places of immigration detention in order to prevent inhuman or degrading treatment of detainees. In 2007 the Immigration Detention Expectations were updated to reflect the new formal responsibility. The UKBA has not, to date, published short-term holding facility rules, though draft rules were first issued for consultation in 2005 and again in early 2009.

1.5 The first short-term holding facility report to be published was on a cluster of three of the four residential facilities then open: Harwich (the first facility to be inspected in August 2004), Manchester Airport and Port of Dover. Since 2007, all reports have been published individually and online only, ensuring speedier publication and that individual facilities are clear about the findings which relate to them. This review summarises and reviews the outcomes for detainees found in the 81 STHF inspection reports published in the six years to December 2010 (see Appendix I). By this time, most facilities had been inspected at least three times. Our intention is to chart developments, and we do not make further recommendations relating to individual facilities.

1.6 Since the start of the STHF inspection programme, there has, on the whole, been much improvement in the physical environment in which detainees are held, and in their management and care. A number of facilities that we considered unfit for purpose have been rebuilt or substantially refurbished, and G4S has developed a range of policies to support the humane and welfare-focused approach to detention that we have recommended. A key

positive area across the reporting period has been the decent and respectful approach of many detention staff who have been encouraged by G4S to focus on detainee welfare. The poor staff behaviour found at the busiest holding rooms at Heathrow Airport is a concerning exception rather the rule.

1.7 A few facilities have, as a result of a lack of funding or management focus, shown limited if any progress, even in the most recent inspections. Key recurring concerns include the co-location of unrelated men, women and families; a lack of staff awareness of their responsibilities in relation to children, who continue to be detained frequently in short-term holding facilities; and a lack of information in different languages and too little use of interpretation.

1.8 One of our first recommendations was the appointment of Independent Monitoring Boards to provide more constant oversight. At present, boards are still being appointed to cover all holding facilities, and not all have started routine monitoring. The most established monitoring board, at Heathrow Airport, has been notably effective in driving forward standards in between our inspections.

2. Summary and key findings

2.1 This report summarises the key findings for all reports under the healthy establishment headings which are also used to summarise the findings of individual reports. The concept of a healthy prison was introduced in our thematic review *Suicide is Everyone's Concern* (1999). The healthy prison criteria have been modified for short-term holding facilities as the bulk of information falls under the areas of safety and respect, rather than activities and preparation for release. This is due to the short time (usually less than 12 hours) that detainees spend in facilities. The criteria are as follows:

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.

Safety

2.2 Insufficient attention was sometimes given to ensuring the dignity of detainees during escort, and some were escorted in view of the public, sometimes in handcuffs. The use of handcuffs during escort without adequate risk assessment or obvious need still persists and is noted throughout the six years covered by this report. In some instances, detainees spent excessive periods in escort vans while being transported between detention facilities, often without comfort breaks. The quality of documentation, including risk information, available to escort and facility staff continues to vary. Detainees were often subjected to excessive movements around the detention estate, although less so in more recent inspections. When we began inspecting STHFs in 2004, caged vehicles were used to transport children and families, but by 2009 these had been replaced by more appropriate vehicles without caged compartments. A lack of medical information during escort and on reception was a recurring issue and since 2007 G4S have provided a medical telephone advice line for all STHF staff.

2.3 In most centres staff had good observation of the holding rooms. Inspections usually found that staff were aware of the potential for bullying or unwanted attention and were prepared to confront it where necessary. However, there was a greater risk of intimidation in the many STHFs that did not hold unrelated male and female detainees or, in some cases, even children and families, separately. Since 2005, G4S has issued national core operating procedures covering a range of topics, including the prevention and management of bullying. Awareness of such policies and of their significance to staff roles has been variable and staff do not receive anti-bullying refresher training.

2.4 Many facilities had no recent occurrences of self-harm and there were very few serious incidents. The majority of holding rooms now have a self-harm policy in place, but staff awareness of it has varied and there is no refresher training. All facilities inevitably had some ligature points but ligature knives were not routinely carried in most, risking potentially life-threatening delays.

2.5 Staff in all facilities received regular training in control and restraint techniques, though provision for detainees to be seen by a healthcare practitioner following restraint was not routine. Restraints were rarely used on detainees while in holding facilities and in most cases there was justification because of a risk of self-harm or harm to others. With the exception of the busiest holding rooms at Heathrow Airport, use of force was rare. However, for much of the reporting period, it has often been documented superficially, carelessly recorded or even not recorded at all. It is noteworthy that at Heathrow Airport, we have recently seen progress and some good practice in this regard. At the last inspection (Cayley House 2010), use of force had reduced substantially, completion of documentation was much improved and a sensible harm reduction approach was applied to those escorted in-country. Detainees resisting removal were simply booked for a later removal or overseas escorts were arranged. This avoided the often fruitless escalation of violence and consequent risk of harm to detainees and staff.

2.6 Some positive action had been taken by UKBA to identify and tackle child trafficking, and to minimise the length of detention for children and families. However, a large number of children were still detained, many for long periods, in often unsuitable facilities. There is no transparent UKBA mechanism to show the total number of children detained, their ages and how long they have been held. A G4S child protection policy is now in place. Since 2005, most detainee custody officers (DCOs) have been Criminal Records Bureau (CRB)-checked to the enhanced level, but UKBA staff in contact with children do not routinely undergo enhanced checks. UKBA has implemented mandatory training in child protection, mainly via an e-learning package, which has received mixed reviews from staff. Child protection training for G4S staff only started in November 2010. Some unaccompanied children spent long periods in detention awaiting social services assessment or collection.

Respect

2.7 Most non-residential holding facilities were adequate for short stays but people were regularly held for over 12 hours, and some for more than 24 hours, in rooms with no sleeping facilities. Some holding rooms we inspected were cramped, poorly ventilated and hard to maintain at a comfortable temperature. A considerable number were in need of redecoration, refurbishment or rebuilding and many had improved by the time of our next visit. In many facilities men, women and children were not detained separately, leading to discomfort and sometimes fears about personal safety. The gender ratio of staff was generally appropriate in most facilities and basic information about short-term detention was usually supplied.

2.8 Sanitary protection was available in the majority of facilities but often had to be requested and sanitary disposal bins were often absent. Sanitary products are now freely available in toilet areas. The provision of showers and hygiene packs was good in all residential facilities, but suitable clean clothing has not always been available. Women did not always have a sufficiently separated sleeping area in residential facilities. Advice on health has improved with the provision of a universally available medical triage line in 2007. All residential facilities had some form of nursing provision on site.

2.9 In almost all holding facilities staff demonstrated a sensitive and respectful attitude towards detainees, often displaying a flexible approach in trying to minimise the stressful effects of detention. There were some significant exceptions to this rule: at Heathrow Airport (2007), we identified some particularly poor staff attitudes and behaviour. Other inspections found that interaction between staff and detainees was too limited, with little communication taking place once the reception process was over. Insufficient use of interpretation was a recurring theme.

2.10 Detainees were usually able to retain their legal documents but many did not fully understand how to access legal information and advice or find out about their rights, including the right of appeal when refused entry and the right to apply for bail in some circumstances[1]. Many facilities did not allow detainees to contact their solicitor free of charge. Some allowed faxing but the fax policy was not always clear. Access to legal information has improved over time but telephone numbers for suggested sources of legal advice were generally of little use to short-term detainees. All authority to detain notifications (IS91s) were issued in English only, despite the fact that they contained important information relating to detention. However, interpreters were routinely used by UKBA to explain the reasons for detention. UKBA oversight of holding rooms was inconsistent but has improved over time.

2.11 Few facility staff had received anything beyond initial diversity training. Diversity policies were developed in 2007 but equality impact assessments were rare, despite being a legal duty. Most facilities had appropriate religious items to help detainees to practice their religion during detention. Provision for people with disabilities was generally limited and few facilities were suitable for people with mobility needs. Governance arrangements have improved over time. There is a national G4S lead on disability and staff are now required to complete care plans.

2.12 Complaints were rare and in many instances forms had to be requested and handed back to staff. Some staff were themselves unaware of complaints procedures and complaints boxes were not always opened regularly. Information regarding the complaints system was usually provided in English only.

2.13 The food provided by holding facilities has improved over the period covered by this report, and hot food is now offered, usually in the form of microwave ready meals. In non-residential facilities the quality of food was often poor and unappetising. Staff were generally flexible in attempting to meet special diets. A stock of baby food was usually available.

Activities

2.14 Most reports found that there were insufficient activities to help pass the time. There was generally an inadequate range of translated material in the form of books, newspapers and magazines. Most, but not all, facilities had a working television.

2.15 Provision for younger children was often better. G4S provided some toys, DVDs and other distractions in all holding facilities, but there was less to occupy older children. Only the small number of residential facilities allowed access to the open air during detention and this was available as a matter of routine in only one case.

Preparation for release

2.16 As detainees are usually held for short periods before transfer, removal or release, visitors are unlikely in non-residential facilities and visits are difficult to facilitate for those detainees held in airside holding rooms. Visits were, however, common in the residential holding facilities. Staff in several STHFs were willing to collect property from visitors on behalf of detainees, but these arrangements were generally not systematic.

[1] Port arrivals cannot apply for bail during their first seven days in the UK. Those being removed and held in an STHF following detention at an immigration removal centre can apply if they have been in the UK for more than seven days.

2.17 Few facilities had a process to ensure that detainees could contact family members or a solicitor before release. Very few provided detainees with written reasons for continued detention or information about transfer destinations, unless they were going to an immigration removal centre.

2.18 A number of facilities did not have provision for incoming phone calls. Some did not allow detainees to keep their mobile telephones, regardless of whether they met the UKBA guidelines of no camera or recording equipment. Only one facility has ever offered internet and email access, which was much valued by detainees as a means of keeping in touch with family and legal representatives and keeping up to date with developments in their home countries.

3. Safety

Escorts and transfers

3.1 In most reports, detainees reported positive relationships with escort staff. In several facilities, we noted the efforts to escort detainees away from the public view (Heathrow Terminal 3, 2008; Eaton House, 2007; Gatwick South Terminal, 2007):

"We saw one detainee escorted to a flight to Bangkok, which meant going through a public area. This was done quickly and as discreetly as possible, with care shown towards the detainee.' (Heathrow Terminal 3, 2008)

3.2 In most facilities restraints were not used on a detainee unless it was deemed appropriate through a risk assessment, and with approval from a senior manager. However, occurrence logs in one centre recorded how a mother had been handcuffed on the journey there by immigration enforcement officers, despite being accompanied by her two young children. It was not clear why this was necessary, who had authorised it, or when handcuffs had been removed (Dallas Court, 2007).

3.3 We noted a lack of discretion by some overseas escort staff who unnecessarily drew attention to detainees about to be removed on an aircraft (Detainee escorts and removals, 2009). Detainees have been escorted, sometimes in view of the public, sometimes in handcuffs, without due sensitivity to their embarrassment or to an underpinning risk assessment:

'… detainees were exposed to public gaze throughout (escort to flight), particularly if the DCOs were wearing clearly identifiable fluorescent jackets. DCOs said they also felt uncomfortable and did not believe this was conducive to keeping detainees calm.' (Luton Airport, 2008)

'Managers said that, in general, the decision of whether to apply handcuffs was made on the basis of a risk assessment… However, all detainees… were handcuffed through the security checkpoint. We accompanied two fully compliant detainees, neither of whom presented any obvious risk factors, who were shocked at having to be handcuffed at the checkpoint. Both told us that they felt humiliated and criminalised. Staff thought that this was a requirement of airport security, but the latter told us that it was not, and that they expected staff to conduct individual risk assessments.' (Pennine House, 2010)

3.4 Earlier reports (such as Leeds Waterside Court, 2005) also noted that escort vans did not always have tinted windows, so that members of the public could have a direct view of detainees under escort and sometimes subjected them to abuse. The issue was resolved by escort contractors and clear windows have not been seen in any recent inspections.

3.5 Detainees often reported spending three hours or more in an escort van without stopping for comfort breaks when being transported between holding facilities. It was not unusual for escort records to detail breaks but for detainees to say they had not received them or understood the offer. We saw some limited proactive work to counter this problem: for example, one holding room supervisor monitored escort records for omissions, such as a failure to stop for comfort breaks, and put up notices reminding drivers of such responsibilities (Luton, 2006).

3.6 A lack of medical information during escort was a recurring issue. Medical records are confidential and consequently most information of this nature accompanied detainees in a sealed envelope. At Electric House (2007) a woman arrived with medication and no indication of when this had been issued. This was of particular concern as the woman had also been

identified as being at risk of suicide and self-harm. In 2007 G4S provided staff with a medical triage advice line which has been used to obtain advice on arriving detainees (see accommodation section below).

3.7 In many cases, the IS91 authority to detain did not record all successive places of detention. The omission regularly included police stations, which may have resulted in detention being taken over the seven day limit. There were many examples in available records of detainees being subject to excessive movements around the detention estate. A striking example was at the Port of Dover (2006), where a man had been held in 10 different places of detention over a period of three months. These included three different immigration removal centres (IRCs) on six separate occasions, three STHFs and one police station. This type of movement is disorientating and places an unacceptable strain on individuals, while disrupting their ability to access legal services and maintain contact with families. Such cases are less common now than during early inspections, reflecting efforts by the UKBA to address the problem, but they are still regularly found. For example:

'In the worst case, a detainee had been in seven places of detention in five months, travelling between Torquay police station and Dungavel immigration removal centre (IRC) for no obvious reason.' (Pennine House, 2010)

3.8 Movement orders were generally well completed but their late arrival sometimes delayed transfers and consequently prolonged detention. There have been signs of improvement in IS91 authority to detain forms over time, but they have often lacked detail, and have not adequately recorded risk or special needs. This is particularly problematic in shared facilities where men, women and children can be held together. For example, in Queen's Building (2007) it was noted that the IS91 often recorded 'serious criminal activity' without specifying risk factors. This could have referred to an immigration offence or an offence involving sexual violence. The lack of information meant that custody staff could not properly manage the risks posed by a holding room shared by men, women and children. A more recent example was at the Port of Dover, where:

'… one of our interviewees told us that she had previously attempted to self-harm. Review of her police custody record showed that she had taken an overdose in the past and that police officers had noted that she was upset during her time in their custody. None of this was marked in the authority to detain notification (IS91) risk factors and was not picked up by G4S staff on her initial reception.' (Port of Dover, 2009)

3.9 Most inspected escort vehicles have been found to be clean and tidy, but in many vehicles conditions can be cramped and ventilation poor, especially on long journeys. In some cases we also found that unrelated men, women and children were being transported in the same vehicles (Harwich International Port, 2008; Lunar House, 2007; London City Airport, 2009; Portsmouth Continental Ferry Port, 2009). In others women and children were inappropriately transported in caged vehicles (Edinburgh, 2008; Lunar House, 2007). In 2009, we noted that new vehicles had been appropriately fitted out for families and children (Dover Enforcement Unit, 2009; Port of Dover, 2009) and have been told that this is now routine. No recent reports have found that caged vehicles are used for children and families.

Use of force

3.10 In most facilities, there was little evidence of force being used, the main exception being the holding rooms at Heathrow Airport and the removals unit in particular (initially Queen's Building, replaced by Cayley House in 2009). Where force was used, it was normally appropriate to safeguard detainees or others. Management checks of documentation have

improved recently, and the documentation gives some assurance overall that force is used as a last resort. However, the quality of use of force documentation has varied and, on some occasions, use of force incident reports have lacked detail and/or management oversight. For example, at Queen's Building in 2007, we noted that the incident report file, which included all use of force and control and restraint documentation, was disorganised and confusing. The same incidents were filed in different places, many of the forms lacked clarity or detail and none had an incident report number:

'One incident report recorded the name of a Turkish man but then went on to describe how three Chinese detainees were escorted to a flight in handcuffs too late to board. There was no sign of a use of force form, no indication that handcuffs had been authorised and no evidence that the three detainees were problematic.' (Queen's Building, 2007)

3.11 More seriously, reports were sometimes simply not completed following the use of force, thereby preventing any level of scrutiny (for example, Portsmouth Ferry Port 2009; Waterside Court 2008; Heathrow Terminals 2 and 3, 2007). At Portsmouth Ferry Port (2009) staff said that force was occasionally used on detainees, usually involving the use of arm locks, and that handcuffs were fairly regularly used as a precautionary measure when walking with detainees outside. However, none of this was recorded.

3.12 By the time of our most recent visit to Heathrow, Queen's Building had been replaced by Cayley House (2010), where there had been significant improvements in the way that force was managed (but see section on self-harm). Use of force was much lower than it had been in the previous facility. A commendable change of policy on removals entailed a sensible, harm-reduction approach: rather than attempting to use force and escalating situations, removals were simply rescheduled or overseas escorts booked. Incident reports in general showed appropriate attempts at de-escalation and documentation was completed appropriately. In previous inspections, those declining to board an aircraft or who had in other ways not complied with removal had been routinely placed in separation. It was encouraging to find that it had become very unusual for the separation room to be used unless it was justified by other reasons such as violence or self-harm. This represents significant progress from earlier inspections of the Heathrow holding rooms. During these inspections we had found that the use of force for in-country removals, in particular, was often fruitless, as departures were cancelled and re-scheduled with an overseas escort anyway. In the Cayley House facility, managers took the sensible view that, unless there was exceptional evidence of escape risk, it was not necessary to handcuff detainees routinely within the airside security envelope of the airport. In the new facility, detainees boarding or disembarking from vans were, in any event, contained within a discrete secure area without the need for handcuffs.

3.13 In nearly all facilities staff were trained in control and restraint (C and R) and received annual refresher training, though some facilities did not always have enough staff on duty to carry out formal C and R techniques. In many facilities there was no routine provision for detainees to be seen by a health care practitioner following C and R, although medical attention was available in the event of an emergency. Once again, this pattern has improved in more recent reports.

Duty of care

Bullying

3.14 There have, historically, been few recorded instances of bullying in STHFs. In most centres staff had a good view of the holding rooms and detainees were easily able to attract their attention. Many holding rooms were also monitored by closed-circuit television cameras to

cover any areas out of sight of the supervising staff. Staff were generally aware of the potential for bullying or unwanted attention and managed it where necessary. For example, at Electric House (2009), a risk assessment identified that a male detainee posed a risk to women. In this instance, an unrelated female detainee was located separately in the interview room, with the door open, so she had access to the staff. Among the residential facilities, Port of Dover had a commendable practice in place whereby a 'matron' would sit with women and families during the day time and sleep in the dormitory with them overnight (2006 and 2009).

3.15 However, there were some holding facilities where poor surveillance and blind spots were identified. Most concerning is the fact that most STHFs still do not separate unrelated male detainees from female detainees or even children and families (see child protection section). In Gatwick South (2009) a female detainee was held overnight with an unrelated male detainee whose language she did not speak. Staff had not used an interpreter to communicate with her and she was therefore unable to raise any concerns. When inspectors interviewed her using telephone interpretation the next morning she told us that she had been too frightened to sleep and had positioned herself at the table nearest to the staff window.

3.16 Staff awareness of G4S core operating procedures and policies, and their perception of their significance to their everyday role, varied. G4S staff do not receive training in anti-bullying after completion of initial training.

Suicide and self-harm

3.17 There were few self-harm attempts during short-term detention, particularly in the non-residential facilities, and many inspected holding rooms had no incidences at all. There have been no recorded suicides in STHFs over the last six years. However, some shortcomings have been identified, including problems arising from a lack of risk information. In one case (Becket House, 2009) a detainee who had been refusing food made two attempts to strangle himself, once in the toilets and again on the escort vehicle on the way to Colnbrook:

'The detainee had entered the holding room at 10am but… a movement order had not arrived until 1.5 hours later. This detailed important risk information, including a previous hanging attempt in an IRC and previous food refusal. It was unclear whether this information had been available to holding room staff. The incident reports did not make clear the extent of the injuries caused by the two self-harm attempts.' (Becket House, 2009)

3.18 The ligature points identified in many reports were a particular hazard in the residential facilities where detainees spend longer periods. However, staff rarely carried ligature knives. These were normally in staff offices and, more recently, attached to first aid boxes. In some cases where ligature knives were available, staff were unaware of them or had difficulty obtaining them:

'There had been three self-harm attempts in the previous 15 months. Two self-harm policies had been placed in folders by the reception desk. One was apparently an updated version of the other, but it was not clear which was which. Staff had little awareness of their content. One of the policies clearly stated that ligature knives should be used to cut down any detainee who attempted hanging, but no staff carried them or could locate one. There were a number of ligature points in the holding areas, so this was a potentially serious shortcoming.' (Harwich, 2008)

'Staff were aware of the location of the anti-ligature knife… However, the knife was sealed and not easy to remove. An experienced custody officer cut his finger while attempting to detach it

for inspectors. If it was needed quickly, there could have been crucial delays.' (Dover Enforcement Unit, 2009)

3.19 Detainees were generally, but not always, seen by medical staff after a self-harm incident. Staff training and understanding of suicide and self-harm interventions was often insufficient. As with anti-bullying, there was no refresher training in suicide and self-harm prevention after staff completed their initial training course. The main intervention described by staff was physical restraint but this was not always properly documented and monitored. An incident report from May 2007 described a detainee banging his head against a wall in the holding room and crying. The detainee:

'… started to get worse so officer X held his left arm and officer Y held his right arm. And myself officer Z held his head from the back to protect him from self-harming. C and R was not used but we had to hold him to stop himself from self-harming. After nearly 2 hours he calmed down and spoke to the immigration officer. Escorts came and took him to Colnbrook.'
(Heathrow Terminal 2, 2007)

3.20 In this case, despite the obvious use of force, no use of force incident report was completed and it was debatable from the description given whether formal control and restraint techniques had been applied. Nor was it clear what had happened during the two hours that it apparently took the detainee to calm down. The overall management of incidents was also shown to be inadequate at other inspections. During the Cayley House (2010) inspection a detainee who was showing marked signs of confusion and disturbance was placed in a separate room while staff attempted to calm him down. These attempts were not well managed or coordinated. A considerable number of staff entered and left the room throughout the incident and different people spoke to him in rapid succession. Staff were too close to him, despite the lack of evidence of a risk of actual harm to himself or others, and his obvious desire for space.

3.21 In other cases we noted staff dealing well with situations. For example, in Reliance House (2008), a female detainee was threatening self-harm. On the evidence of the available logs, DCOs dealt with the matter appropriately, increasing observations and bringing their concerns to the attention of UKBA staff. The decision was made to transfer the detainee with three other males. It was fortunate that an alert holding room DCO decided to accompany the woman during transfer, as she tried to self-harm en route.

Childcare and protection

3.22 There are several measures that UKBA and holding room contractors should have in place to ensure that the stressful impact of detention is minimised for both families and young people. In many instances, it is common practice to try to orchestrate planned detentions, where families can be arrested at home and transferred to holding rooms for removal at the last possible moment. For example, the dedicated family team at Waterside Court (2006) conducted a review of a family's circumstances, including making police and social services checks, and undertook all preparation measures such as arranging removal directions in advance to minimise the time a family would spend in detention. This practice was repeated elsewhere across the estate. However, while it reduces time in holding rooms, it does not reduce the stress of detention and there are many circumstances in which it is not possible to anticipate the detention of children and families (for example, when they are detained on arrival in the UK).

3.23 A large number of children continue to be detained in STHFs every year, some for long periods. In 2007, in the five busy holding rooms then open at Heathrow, between 29 and 80

children had been held in each during the previous three months, some for very long periods. A child was held in the Terminal 3 holding room, which is not suitable for overnight stays, for 28 hours without access to fresh air, a bed or a shower. In total, 146 men, 57 women and 12 children had been held there for more than 18 hours during the three month period. At Gatwick South (2009) two children in a family unit were detained for over 31 hours while awaiting a residential detention place and at Gatwick North (2009) of the 42 accompanied minors and six unaccompanied minors held in the previous three months, six had been held for more than 12 hours. In the first inspection of the Terminal 5 holding room at Heathrow Airport in 2010, we found that 66 children had been held in the preceding four months. Ten of them had been detained for more than 18 hours, with the longest detention being 25 hours.

3.24 While in several facilities children and families were held in a separate area, in others there were insufficient or inadequate facilities for holding them separately. In the Heathrow holding rooms children were normally held in the same room as unrelated adults:

'There had been an incident when a man had harassed an unaccompanied 15-year-old girl and another young woman. Staff had challenged the man but had been unable to separate him or the young people for more than a few minutes as there was nowhere else to put them.'
(Heathrow Terminal 3, 2007)

3.25 A new child-friendly room with qualified childminders had been opened for unaccompanied children at Terminal 3 just before the 2007 inspection, but this could separate only a few of the many children held. However, the newly-built Cayley House facility does include a suitable and reasonably welcoming family room (Cayley House 2010). Edinburgh Airport was another severely criticised facility where rebuilding work had taken place by the time of the next inspection to allow for separation of children and families in more appropriate conditions (see accommodation section). Examples of good practice and facilities were highlighted at Luton Airport (2008 and 2010), where a chaplain acted as an appropriate adult for unaccompanied minors, and at Stansted Airport (2006 and 2009), where staff had maximised the use of limited facilities by converting an interview room, which was separate from the main area, into a family room and decorating it appropriately.

3.26 There is no straightforward way of finding out the number of children detained in any one centre, their ages and for how long they had been held. We have been told that UKBA's computer system cannot aggregate the data and subsequently any numerical statements made within inspection reports have been calculated from logs completed by G4S staff and requested by inspectors after the start of inspections. More recently, G4S has been able to computerise some of these logs.

3.27 All facilities have had a G4S child protection policy in place since 2009. The G4S policy includes a code of practice and a flowchart for raising concerns, which was on display in the staff area of most STHFs from 2009 onwards. Despite this, awareness of the policy was variable and in some cases staff said they were unaware of it and of how to raise legitimate concerns about the conduct of colleagues in their treatment of children. No dedicated child protection training had been delivered to G4S staff at the STHFs inspected during the period covered by this report. However, we were told that relevant training had commenced in November 2010. Since 2007, UKBA staff in most facilities have received a basic 'keeping children safe' learning and development e-learning package. The level of training is dependent on the role held by the staff member and levels two and three involve some training workshops. Few centres were found to have an active child protection coordinator. Of the centres that did, most coordinators were found to have undertaken training specific to their role.

3.28 We identified some good UKBA attempts to tackle child trafficking. At Heathrow Airport Terminal 5 (2010), we examined case files of two children arriving with a trafficker. Immigration officers became suspicious as a result of the strange behaviour of the children, and subsequently challenged, arrested and ultimately prosecuted the trafficker. The victims were not referred to the National Referral Mechanism in line with best practice.

3.29 From 2005 onwards, new G4S staff have been subject to enhanced CRB checks, and retrospective checking has taken place to ensure all DCOs hold an up-to-date enhanced CRB status. Surprisingly, it has become apparent more recently that not all UKBA staff in contact with children undergo enhanced checks (for example, Gatwick North, 2009 and Gatwick South, 2009).

3.30 Unaccompanied minors were referred to social services on arrival in the majority of STHFs, as was the case when an individual's age was in dispute. However, some long delays were noted in awaiting assessment or collection by social services staff. A common explanation given was that social services staff considered detention to be a safe location for children and did not therefore give such cases priority. In one case, G4S logs for the previous three months showed that an unaccompanied minor awaiting collection from social services had remained in the holding area for 29 hours and 45 minutes (Stansted, 2009).

3.31 An example of good practice was the on-site social work service established at Gatwick Airport (2009). A dedicated team of social workers allowed relatively quick advice and assessments in cases involving children. One of the team worked at the airport on a rota, providing age assessments or advice on request, and sometimes acting as a responsible adult. The duty social worker saw the duty chief immigration officer in both North and South terminals each day to check whether there were any concerns from the previous night or any children were expected during the day.

4. Respect

Accommodation

4.1 Most holding rooms were suitable for short stays but none of the non-residential facilities were suitable for people held for long periods. Detention for more than 12 hours was not uncommon and we regularly found that people had been held for more than 24 hours in non-residential facilities without adequate washing and sleeping facilities. Foil blankets were often the only means of keeping warm at night.

4.2 In some cases vulnerable people were detained for excessive periods without due consideration for their condition. For example, in Heathrow Terminal 4 (2007), a non-residential holding facility with nowhere to lie down or relax, a woman who was seven months pregnant was detained for 19 hours before being admitted to hospital following assessment by paramedics. In another case, a pregnant woman had been held for 22 hours overnight with only a hard plastic bench to sleep on (Gatwick South, 2007).

4.3 Many holding rooms had poor ventilation and staff found it difficult to maintain a comfortable temperature. At Gatwick South (2009) the temperature was centrally controlled by the airport and could not be adjusted locally. As a consequence, many detainees complained of the cold and some used foil blankets to keep warm. In most STHFs there was no provision to hold men, women and families separately, and unrelated men and women in particular shared holding rooms for long periods of time (see section on bullying). At Lunar House (2009) a female Muslim detainee was uncomfortable about sharing with four male detainees. There were a few examples where families could be held separately and, at Stansted (2009), an effort had been made to create a less austere, more child-friendly environment with attractive paintings and toys. The gender ratio of staff was generally appropriate to receive and search detainees in most, but not all, facilities. In the absence of a female DCO, women and children were usually searched with a 'wand' (metal detector), or not at all.

4.4 Some facilities were in urgent need of redecoration or repair and others were small and cramped, and sometimes exceeded maximum capacity (for example, London City Airport). Most had only fixed hard seats, which were uncomfortable for detainees staying for long periods. Some were simply unsuitable environments for both detainees and even staff (for example, Edinburgh Airport, 2008). In a number of cases, substantial changes had been made by the time of our return, even when initial recommendations had been rejected on the grounds of cost or impracticability:

'Considerable improvements had been made since the last inspection, when we criticised the single, small, shabby holding room, which had seating for just eight, but which sometimes held more. In recent months the facility had been refurbished and expanded to provide three separate rooms.' (Dallas Court, 2007)

'Our last inspection took place shortly after the facility was opened in December 2007 and we found it to be wholly unfit for purpose. At this inspection, new holding areas had been built and conditions had significantly improved.' (Edinburgh, 2010)

'The building incorporated both the refurbished previous accommodation and a new build… In our previous report we mentioned among the priorities for the new premises the need to separate men and women and to allow staff and detainees access to fresh air and daylight. The new build had gone a long way toward addressing the latter two priorities, but accommodation was still not sufficiently separated.' (Pennine House, 2010)

4.5 Information regarding facilities has significantly improved. Before 2007 it was rare to find any translated material in the form of notices, booklets and leaflets. Subsequently, most inspections found copies of the booklet produced by G4S in 15 languages. This provides basic information about short-term detention, though little on individual facilities. Pennine House (previously Manchester Airport) produced its own local and more detailed booklet in various languages. Several facilities still did not routinely display or distribute the generic booklet.

4.6 Most facilities had a stock of baby food and nappies, although this was generally not well advertised and many STHFs did not have a baby changing table. Sanitary products for women were usually available but sometimes had to be requested, often from male staff. G4S responded to the criticism of this undignified and embarrassing procedure by making them freely available in toilet areas in most facilities, though sanitary disposal bins are not always provided:

'Detainees were told to hand any used sanitary towels or nappies to staff in the plastic bag provided. These were then disposed of in a bin in a toilet elsewhere in the building.' (Sandford House, 2008)

4.7 In residential facilities, the provision of showers and hygiene packs was good and women were always afforded a separate sleeping area. However, the lack of full separation from sometimes intimidating male detainees was a problem in some facilities. At Pennine House (2010), the women's accommodation was on the same corridor as the men's. They could not lock their doors and had to pass along the corridor to reach sanitary facilities, dining and association rooms and the telephones. Women were not routinely told before their arrival that they would be sharing the facility with men. At the Port of Dover (2009), the general conditions for the minority of women were worse than for men. Unlike men, they were not allowed to spend time in their bedrooms during the day and their separate association room could become cramped with more than a few people in it. Their toilets and showers were off the same corridor as the men's and they had to go to the main association room if they wanted to get drinks:

'[One woman] had been in the facility for two days and said that some of the men stared at her and/or moved uncomfortably close whenever she went to get drinks… we observed this taking place. She said that she tried to go to the toilet only once a day because the female toilet was on the same corridor as the male toilet and she did not feel safe to use it.' (Port of Dover, 2009)

4.8 Around half of the STHFs did not have single sex toilets, and in several cases toilets were poorly screened. At Heathrow Terminal 5, one of the newest facilities, we found:

'*… separate toilets for men and women, and a further baby change area with a toilet adapted for people with disabilities… All three areas opened directly onto the holding room, separated by a door with a gap of approximately six inches at the top and bottom. The doors did not provide sufficient privacy for detainees using the toilet facilities.'*

4.9 The majority of facilities could provide access to health services or paramedics in the event of an emergency and all G4S-run facilities have had access to a medical triage telephone line since 2007. All residential facilities have some level of nursing provision on site. Manchester Airport/Pennine House has always had a nurse in daily attendance and, by the time of our inspection in 2010, nurse cover was 24 hours a day, seven days a week. Colnbrook has always had access to health care staff from the adjoining removal centre. Harwich International Port (2005) and Port of Dover (2006) did not initially have any arrangements for medical cover. By the time of the inspections in 2008 and 2007 respectively, both facilities had nursing

provision in place, with Port of Dover providing 24-hour cover. Harwich International Port had a nurse in attendance three to four times a week.

Positive relationships

4.10 In almost all holding facilities, a common finding was that most staff demonstrated a sympathetic and respectful attitude towards detainees, often displaying a flexible approach in trying to minimise the stressful effects of detention. For example, in Heathrow Terminal 5:

'All detainees we spoke to said that they had been well treated by detention staff. We observed staff making efforts to calm people who were distressed following immigration interviews, and spending a considerable amount of time talking to detainees when they came into the facility.'

4.11 However, in many facilities there was a lack of positive engagement with detainees and limited use of telephone interpretation that could help to communicate with detainees who spoke little English. This has improved over time, and since 2008 G4S has supplied logs that allow easy monitoring of usage by facility (see diversity section).

4.12 The main exception to the positive staff approach was found at the 2007 inspection at Heathrow Terminal 4 and Queen's Building, where staff routinely referred to detainees as 'bodies' and the holding rooms as 'pens'. This language was clearly inappropriate and dehumanising in nature and reflected and reinforced some unacceptable staff attitudes. In one case a DCO was witnessed aggressively haranguing a passive detainee, stating that he did not 'belong here' and accusing him of 'doing nothing' to help himself over the previous few years. The detainee would not accept that his removal was justified but did not resist physically. He was threatened with being handcuffed despite the fact that he displayed no risk, had no history of difficult behaviour and had made no threats. He was then moved to a side room used for disruptive detainees and had his shoes taken away and kicked out of the room by the officer. By this point he was crying and clearly very distressed, saying that he felt humiliated.

4.13 By the time of our inspections of Cayley House and Terminal 5 in 2010, things had improved substantially but we still found some concerning staff behaviour:

'… a large number of staff regularly congregated in the booking-in area, sometimes creating confusion and tension, and in one case we heard racist comments: two members of staff started to argue with each other about where to place incoming detainees. One officer said to the other, who was Asian, "Should I explain that to you in Indian", causing the Asian officer to become visibly upset and assert that he was British. This matter was being investigated by managers.'

4.14 Some reports found that interaction between staff and detainees was largely functional, with little communication taking place once the reception process was over. In these cases, staff were responsive rather than proactive and there was little obvious engagement with detainees. As a result those detainees who did not speak English were likely to feel isolated.

4.15 In some cases respectful treatment by staff was undermined by an overly restrictive environment. Staff in a number of STHFs kept the door to the holding room open or were even in the room with detainees (for example, London City Airport), encouraging communication and a more relaxed atmosphere. However, others adopted an unnecessarily formal stance. For example, detainees at Lunar House (2009) had to speak to staff and receive refreshments

through a small hatch in the door. This extreme caution was not based on any risk assessment.

Legal rights and casework

4.16 Detainees were usually allowed to retain their legal documents. Many STHFs did not routinely provide information about legal rights while in detention, such as the right to apply for bail or access legal information and advice. Consequently, many detainees we spoke to did not fully understand their legal rights. Language was also a significant barrier. The reasons for detention form (IS91R) were still provided in English only. It listed contact details for the Immigration Advisory Service (IAS) and, before its recent demise, Refugee and Migrant Justice (formerly known as the Refugee Legal Centre), as well as some information about bail rights. However, this was of little use to detainees who did not understand enough English to make sense of the information. For example, at Port of Dover (2009), a man detained for three days was still confused about how he could contact a solicitor because he did not understand any of the information he had been given. The G4S information booklet suggested that detainees should ask staff for information about legal advice, but staff were rarely able to do more than refer detainees to the telephone numbers of advice organisations, and information notices. These were often of little help. The notices commonly included the number for Refugee and Migrant Justice and/or the IAS, but the latter number was usually only for people who could go to IAS offices for appointments, or an answering machine which promised that someone would phone back within 48 hours, by which time detainees would have left the STHF.

4.17 Detainees were not always offered a free telephone call on arrival. Many centres did not allow detainees to contact their solicitor free of charge and when this was allowed it was often not actively or routinely offered. Some facilities allowed detainees to fax documents, or staff did so on their behalf, but this was not always made clear to detainees and staff themselves were not always sure about the policy. Where a fax policy was established it was not always helpful:

'By local agreement, G4S staff did not allow detainees to use their fax machine and instead referred any requests made after completion of the immigration interview to the UKBA… Routing fax requests through the UKBA seemed unnecessarily time-consuming and was likely to cause further anxiety for detainees at an already difficult time. These avoidable delays could also have had an impact on detainees' legal cases, including for one detainee during the inspection who needed to fax documents to legal representatives very quickly as escorts had arrived to put him on a flight scheduled to leave that evening.' (Becket House, 2009)

4.18 Only Pennine House in Manchester allowed access to the internet which could support communication with legal advisors (see section on preparation for release). Most facilities had a copy of the translated Office of the Immigration Services Commissioner (OISC) leaflet containing some basic legal information, but this was not always overtly displayed or routinely offered to detainees. Legal visits were permitted in some facilities, mainly the small number of residential STHFs, although there was not always a suitable, confidential location for them. Port of Dover demonstrated good practice in this area, providing an appropriate interview room and accommodating late night visits if they were urgent.

4.19 All detainees who arrive from abroad and are refused entry are managed by on site UKBA staff. In these cases, immigration staff interview the detainees and explain why entry has been refused. Staff can access the case information database (CID) and check or update any centrally-held information on detainees. However, the degree of information provided for detainees by immigration officers was often minimal. Although immigration staff in many holding rooms had regular oversight, this was not systematic across the STHF estate, and in

some we found that immigration staff were not monitoring the length of stay or providing adequate updates.

4.20 We generally found that UKBA and G4S worked well together and DCOs frequently called on immigration staff to resolve detainees' queries. At Stansted Airport (2006) we noted good practice where DCOs reminded immigration staff if detainees had been awaiting interview for more than two hours. For those detainees who spent more than 12 hours in detention, DCOs would contact the Chief Immigration Officer (CIO) and did so every three hours thereafter. If children were being detained, checks were more regular.

Diversity

4.21 We generally found little evidence of discrimination or intolerance (but see section on relationships), although diversity structures designed to promote equal treatment have been relatively weak. For example, we rarely found equality impact assessments, even though they are a legal duty. Throughout the history of STHF inspections, staff training on diversity has usually been delivered during initial training courses only. There has been no evidence of routine refresher training to promote basic diversity awareness and encourage consideration of issues that have specific relevance to the management of STHFs. Our inspections have sometimes found the need for such training:

'A DCO told us that if he heard a detainee making racist comments he would only act if the victim complained.' (Birmingham Airport, 2010)

'We saw racist graffiti in the DCOs' office. The words "gypsy Irish squatter" were clearly legible on the back of an office chair.' (Luton Airport, 2010)

'Detainees with limited understanding of English could not easily ask questions to obtain information during their detention following their immigration interview. The holding room staff, though sympathetic, tended to rely on sign language. (Gatwick South, 2004)

4.22 The lack of interpretation has been a particular concern. This has improved over the last two years, as evidenced by the logs that G4S now keep showing the use of telephone interpretation in each facility, but our general finding has been of insufficient use by DCOs. In one case the telephone interpretation service had never been accessed, despite certain need, and staff were unaware of the details of any such service (Lunar House, 2009). In a nearby facility, staff were aware of telephone interpretation but records indicated that it had only been used on one occasion in the previous six months (Electric House, 2009). A positive example was provided at London City Airport (2007) which had a three-way telephone installed in the interview room, which was regularly used for interpretation purposes by staff.

4.23 There has been a G4S diversity policy since 2007. Racist complaints are dealt with through the overall complaints system. Neither generic nor specifically racist complaints have ever been common, partly because of the short time that detainees spend in STHFs (see complaints section).

4.24 Most facilities provided religious items such as holy books and prayer mats, although their availability has not always been made clear to detainees. The floor of the Heathrow Terminal 3 holding room (2007) had an inbuilt compass to aid the worship of Muslim detainees. In most facilities we found that notices indicating the availability of religious items were in English only, though many pictorial notices are now in place. Very few facilities could provide a private setting for worship. A few facilities had reasonable contact with nearby chaplaincy services (for

example, Port of Dover, 2010; Luton, 2010) and at one residential facility (Pennine House, 2010) a chaplain visited detainees two to three times a week.

4.25 The basic conditions of most holding rooms would not normally be suitable for people with disabilities, as adjustments such as ramps and accessible toilets are the exception rather than the rule. We noted some very poor practice. For example, a man in one facility had his walking stick removed and was forced to ask another detainee to attract the attention of staff when he needed the toilet as he could not walk unaided (Gatwick South, 2007). At the Port of Dover (2009) a child requiring leg callipers had been held. The facility was unsuitable for those with mobility problems and she had apparently been carried up the stairs by staff. This undignified practice should not have been necessary. There have been improvements in governance and a G4S disability policy was produced in 2007. This includes the requirement to complete care plans which are then sent to the national disability lead for scrutiny. The disability lead is also available for advice at other times. However, some staff have been unaware of either.

Complaints

4.26 Complaints in STHFs are rare. However, it is impossible to say if this properly reflects the standard of care that detainees receive in detention. Most STHF staff have been able to describe the formal complaints procedure but information has often not been provided or clearly displayed for detainees in different languages. London City Airport (2009) provided a positive example, with the formal complaints system advertised in 21 languages on posters clearly displayed in the holding room.

4.27 A recurring weakness was the lack of confidentiality as, in most instances, complaints forms had to be requested from staff, undermining the credibility of the system and discouraging detainees from complaining. With some exceptions (for example in Sandford House, where envelopes were provided), unsealed written complaints had to be handed back to holding room staff.

4.28 In many cases, staff did not understand the complaints system themselves, giving little assurance that detainees were provided with the protection of a properly functioning system which provided the swift resolution that was so essential for people who might not be in the country for long. For example, in Birmingham (2009), while there were locked complaint boxes in both of the holding rooms to provide confidentiality, they were rarely emptied. Immigration staff should have checked them each day during routine visits to the holding room, but when inspectors required one box to be opened, we found a complaint that had lain uncollected for over four weeks. During the inspection of Port of Dover (2009) a complaints box was opened at the request of inspectors and a complaint found which had been placed there a week earlier.

4.29 As part of a new national complaints procedure introduced by UKBA in December 2008, all complaints are sent to a central office for allocation to the appropriate respondent. There has been little evidence of complaints being effectively tracked or monitored at a senior level in UKBA, though G4S produces its own statistics and considers findings at quarterly strategic meetings. It was unclear at many holding facilities how a detainee would receive an answer to his or her complaint.

Services

4.30 All STHFs now provide meals and drink to detainees, but this has not always been the case. Two facilities (Festival Court, 2005; Lunar House, 2004) did not provide any substantial food at

the time of their earlier inspections; in Lunar House, a mother and child were detained for the majority of a day with nothing to eat apart from biscuits. Most holding facilities now provide sandwiches, biscuits and other snacks including fruit, as well as a hot and cold drinks machine with free access. Staff are now required to routinely offer detainees food after reception. An earlier practice in non-residential facilities of offering hot food only after a certain period in detention (taking no account of the fact that detainees may have had long journeys or long periods of interviews before arriving at the facility) has ceased.

4.31 The standard of food has improved. Many earlier inspections documented low quality and limited variety of food. Staff often purchased food for special diets if requested (such as vegan or kosher), but this was sometimes not available. Hot food in non-residential facilities was initially limited to instant noodles. Most now offer 'ambient' long life meals, which are an improvement on instant noodles, but unappetising and unpopular. Where freezers are available the best option is frozen microwave meals, which are now available in many STHFs.

4.32 Most STHFs held baby products, including food and nappies in the holding room, and staff were generally able to purchase any other necessary products from nearby shops. Detainees usually had access to their own cash during detention and could use this for the pay telephone.

5. Activities

5.1 Given the short duration of detention in most STHFs, there was little need for substantial activities, but most inspections found insufficient provision of even temporary distraction. In most facilities, there was inadequate translated material such as books, recent newspapers or magazines to reflect the wide range of nationalities and languages of detainees held. G4S had installed bookcases in most facilities, but the stock generally consisted of free publications acquired by staff and was not necessarily suitable for the mix of people held. At Luton Airport (2010) airlines also donated books (some in different languages) to the STHF that had not been claimed from their lost property. Most STHFs had a working television and a few played DVDs in foreign languages. The situation at Harwich (2008) was not untypical:

'The books and magazines, many of which were brought in by staff, were not managed and many were damaged or defaced. Detainees could watch television, but only English language channels were broadcast.'

5.2 Provision of activities for younger children was generally better, and in recent years G4S has provided colouring packs, toys, some translated children's books, age-appropriate DVDs and hand-held DVD players, and basic hand held computer games. Such provision is less appropriate for older children.

5.3 Very few STHFs allowed access to the open air during detention. The residential facilities were the only exceptions, with the Port of Dover, Pennine House and, to a much lesser extent, Colnbrook allowing regular access. In Pennine House (2010), there was a basic caged area, but it was screened from adjacent roads. This was not the case at Harwich (2010), where the outside exercise facilities were wholly unsuitable:

'The outside area provided was set about 100 feet from the back door and was referred to as the "cage". It was a small space surrounded by high metal fencing that offered no privacy when ships were in harbour... Detainees had also been escorted to the cage in handcuffs… without an individual risk assessment.'

6. Preparation for release

6.1 Detainees in non-residential facilities could not usually receive visitors. Given the short periods most people spent there visitors would not, in any event, be likely, nor would separate visiting facilities be practicable. This was because holding rooms were often located airside and airport security requirements would need to be satisfied. The residential facilities all allowed visitors. When the Manchester Airport residential facility was replaced by the refurbished Pennine House, access no longer required airside access, making it considerably easier for detainees to receive visits. Over 150 visitors had attended in the month prior to the inspection. Pennine House was also well-served by volunteer visitors:

'Volunteers from the Manchester Immigration Detainee Support Team (MIDST) provided regular support to detainees and their visits were well facilitated by the centre. Notices promoting their services were displayed in the main corridor.'

6.2 Generally detainees who did not have their property with them had little opportunity to recover it. Several centres allowed property to be delivered if they could contact someone before transfer, and staff were often helpful if a request was made of them (for example, Sheffield 2009). However, there was little evidence of routine systems for reuniting detainees with their belongings, and this was normally ad hoc and dependent on the flexibility of individual staff.

6.3 Similarly, only a very small number of STHFs had formal or clear procedures in place to allow a detainee to manage their affairs before removal, and this was reliant on individual staff. At the Port of Dover (2007), there was a detailed discharge policy and staff had been issued with instructions that they should check all paperwork, property and the special needs of detainees being transferred out of the port, as well as escort arrangements. Risk assessments prior to transfer did not generally take place, although information was sometimes passed on if the detainee posed a concern.

6.4 Most STHFs now provide detainees with cards for the IRC transfer destination, containing details of its address, telephone number and visiting times, with a map of its location. This allows detainees to pass accurate contact details to families and solicitors. More detailed advance information about IRCs is less common. An exception was at Glasgow Airport (2009) where detainees, who were regularly moved to Dungavel IRC, were shown information booklets about the IRC in different languages. Similarly, at the nearby Glasgow Festival Court (2009) staff made efforts to reassure detainees that they were not being sent to a normal prison.

6.5 We found some practices that paid little attention to family needs, leading to much frustration among detainees. For example, at Manchester Airport (2007) a male detainee who had been detained two days previously (after being held at a police station) was expecting a visit from his family, who were intending to travel from Scotland to Manchester. Before this could happen he was told he was being transferred to Lindholme IRC near Doncaster. His family subsequently changed their plans. The detainee was then told that this transfer had been cancelled and it was now likely, but not certain, that he would be transferred to Tinsley House near Gatwick Airport.

6.6 There was a general lack of communication with detainees through an interpreter after initial sessions with an immigration officer. This undermined the attempts to manage removal or transfer respectfully, despite the efforts of staff. This meant that it was not uncommon for a detainee to be unaware of where they were being taken.

6.7 Not all centres had provision in place to ensure that detainees could contact family members or a solicitor once they were informed of their removal, release or transfer details. UKBA allows mobile phone access as long as phones do not have camera or recording facilities. However, we found variable practice across facilities. In some, detainees without suitable mobile telephones were provided with G4S-owned phones into which they could insert their own SIM cards. However, in others, not only were detainees not informed that they could use suitable phones, but staff themselves were uncertain of the policy and restricted access to communications:

'One of the detainees in the holding room at the time of the inspection wanted to make a phone call to her family, but was not offered her phone (which had no camera on it).' (London City Airport, 2007)

6.8 Many facilities did not have provision for receiving incoming phone calls. In one facility, a young woman had been detained for several hours and thought she was unable to contact the friend who was meeting her on arrival. She did not know that she could ask staff to recover her friend's number from her mobile phone, retrieve her money from her stored property and sell her a telephone card (Heathrow Terminal 1, 2007). Many centres had arrangements to change money in place. Not all centres could securely store detainees' property and in some centres suitcases had to be kept in reception or external corridors. Increasingly, facilities have ensured that detainees without appropriate clothing or only prison issue transparent bags are offered suitable alternatives for removal.

6.9 Only one facility (Pennine House, 2010) has ever provided internet access. Despite rejecting our recommendation for internet access at previous inspections, by the time of our inspection visit in 2010 the facility had provided two computers with internet and email access. This initiative had proven a success, helping detainees to keep in contact with legal representatives and family, and to download legal information and information about their home countries. The computers were freely accessible in the common room and all useful sites were accessible when we checked.

Appendix I

Short-term holding facility inspections 2004–2010

Becket House (2007, 2009)
London

Birmingham International Airport (2005, 2008, 2010)
Birmingham

Calais Seaport (2005)

Cayley House (2010)
Heathrow Airport

Colnbrook (Residential) (2006, 2007, 2008, 2010)*
London

Communications House (2004, 2007, 2009)
London

Coquelles Freight and Tourist (2005)

Dallas Court (2004, 2007, 2010)
Salford

Dover Asylum Screening Centre/Dover Enforcement Unit (2005, 2006, 2009)**
Dover Eastern Docks

Edinburgh Airport (2008, 2010)
Edinburgh

Eaton House (2005, 2007)

Electric House (2004, 2006, 2009)

Gatwick North (2004, 2006, 2009)
Gatwick Airport

Gatwick South (2004, 2006, 2009)
Gatwick Airport

Glasgow International Airport (2005, 2009)

Glasgow Festival Court (2005, 2009)
Glasgow

Harwich International Port (Residential) (2004, 2005, 2008)

Heathrow Airport Terminal 1 (2005, 2007)

Heathrow Airport Terminal 2 (2005, 2007)

Heathrow Airport Terminal 3 (2005, 2007)

Heathrow Airport Terminal 4 (2005, 2007)

Heathrow Airport Terminal 5 (2010)

John Lennon Airport (2006, 2008)
Liverpool

Leeds Waterside (2005, 2008)
Leeds

London City Airport (2004, 2007, 2008)

Lunar House (2004, 2006, 2009)
Croydon

Luton Airport (2005, 2008)

Manchester Airport/Pennine House (Residential) (2004, 2005, 2007, 2010)***

Manchester Airport (2010)****

Port of Dover (Residential) (2005, 2006, 2007, 2009)
Dover Eastern Docks

Portsmouth Continental Ferry Port (2006, 2009)
Portsmouth

Queens Building (2005, 2007)
Heathrow Airport

Reliance House (2006, 2008)
Liverpool

Sandford House (2006, 2008)
Solihull

Sheffield (2009)

Stansted Airport (2006, 2009)
Essex

* After 2006, Colnbrook STHF was inspected at the same time as the adjoining immigration removal centre and subsequent findings were integrated into the reports on Colnbrook IRC published in 2007, 2008 and 2010.

** Dover Asylum Screening Centre had been renamed Dover Enforcement Unit by the time of the 2009 inspection.

*** Manchester Airport Residential STHF was renamed Pennine House following rebuilding work and the first inspection of this facility was in 2010.

**** Manchester Airport non residential facility was opened in 2007 and the first separate report to be published on this facility was in 2010.