Report on the unannounced follow-up inspections of three residential short-term holding facilities:

Manchester Airport

Harwich International Port

Port of Dover

August 2005 – February 2006

by HM Chief Inspector of Prisons

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Background

HM Inspectorate of Prisons agreed to inspect short-term holding facilities, residential and non-residential, which are in the control of the Immigration and Nationality Directorate. Inspection began during the summer of 2004.

This is a report of a follow-up inspection of the three residential holding facilities first inspected during 2004/05 to check progress against previous recommendations.

Residential short-term holding facilities covered in this report:

Manchester Airport, contracted to Group 4 Securicor Limited.
Inspected: 17 August 2005
Inspectors: Jim Gomersall
Eileen Bye
Charlotte Owiredu-Oppong (researcher)
Last inspected: 19-20 October 2004

Harwich International Port, contracted to Abbey Security Ltd.
Inspected: 30 November 2005
Inspectors: Jim Gomersall
Eileen Bye
Last inspected: 20 August 2004

Port of Dover, contracted to Dover Harbour Board.
Inspected: 28 February 2006
Inspectors: Jim Gomersall
Eileen Bye
Last inspected: 18 January 2005

The healthy custodial establishment

HE.1 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 to fit the inspection of short-term holding facilities, both residential and non-residential. The criteria for short-term holding facilities are:

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

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

Activities – detainees are able to be occupied while they are in detention

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

HE.2 Inspectors kept fully in mind that although these were custodial facilities, detainees were not held because they had been charged with a criminal offence and had not been detained through judicial processes.

Safety

HE.3 As at the last inspection, custody staff in all three centres were providing good general standards of care. Each of the centres appeared to be well run and all had good links to their respective local immigration teams but oversight by senior immigration service managers was sporadic and erratically recorded. There was still an absence of the independent oversight found in immigration removal centres but the Independent Monitoring Board national council was formulating plans to address this deficiency.

HE.4 Although the Immigration and Nationality Directorate (IND) policy is not to keep detainees in short-term holding facilities for more than five days (or seven if they are about to be removed), we came across people who had been detained for longer periods in successive short-term holding facilities, including police stations, where conditions were not suitable.

HE.5 While detention of children was rare in these facilities, it remained a possibility and the provision for childcare and child protection was inadequate. Only Dover had a child protection policy and childcare coordinator. Staff likely to be in contact with children had not all been checked to enhanced level by the Criminal Records Bureau at the time of the inspection. Group 4 Securicor (G4S) had begun to do this for new recruits and checks for existing staff were in hand.

HE.6 The décor and fabric of the Harwich facility had deteriorated badly since the last inspection. No remedial work had been done to address the potential ligature points. However, Dover had carried out extensive work to remedy a similar situation found in its last inspection.

HE.7 The incidence of self-harm, bullying and violence was generally low but only Dover had an anti-bullying policy and adequate suicide and self-harm policies that were understood by staff. Staff at Manchester and Dover had some training in the management of self-harm and suicide but staff at Harwich had not. As was found in the last inspection, Harwich custody staff were not trained in control and restraint techniques and were not accredited detainee custody officers. Although there was some provision at Manchester Airport, detainees at the other two centres were not routinely checked by a healthcare professional when force had been used.

HE.8 There was still no designated on site fire officer in any of the centres and, with the exception of Dover, knowledge of evacuation procedures for detainees and/or staff was insufficient. Only Dover had a health and safety policy and had completed workplace risk assessments.

Respect

HE.9 Staff usually wore name badges and appeared to be respectful to detainees in all three centres and the use of first names was common. As at the previous inspection, the routine use of handcuffs when outside the holding rooms at Manchester Airport was a cause for concern.

HE.10 Except in Manchester, there was no information available to detainees about the centres' purpose or the facilities that were available. In both Harwich and Dover, detainees were not given information about how to make a complaint or report a racist incident. None of the centres had completed assessments on the racial and cultural impact of policies and none had a disability policy or designated disabilities officer.

HE.11 Access to telephones was reasonable but privacy was not always possible. The Harwich and Manchester holding rooms allowed detainees to use their own mobile telephones after risk assessment but Dover detainees were not allowed to use their mobiles, even though IND had given general approval.

HE.12 As in the previous inspection, hot and cold meals, drinks and snacks were provided in all three centres.

HE.13 Only Manchester had formal healthcare arrangements, although times of availability were restricted and the healthcare room and facilities were poor. In Harwich and Dover, no detainees were given routine healthcare checks.

Activities

HE.14 There was not enough activity in any of the holding centres and there was still a general lack of reading material in any language available to detainees. Only Dover had a secure yard for outside exercise, although it was sometimes possible for the Harwich staff to take risk-assessed detainees into the fresh air.

Preparation for release

HE.15 As in the previous inspection, there was no procedure in any of the centres that allowed detainees to prepare for release, transfer or removal and there was no

welfare support, except through voluntary agencies and the goodwill of custody and immigration staff. Visitors were allowed at all three centres but detainees were not allowed home to collect possessions or close accounts. Consequently, detainees often had unresolved problems.

Section 1: Progress on general recommendations

1.1 The National Council of Independent Monitoring Boards should be invited to propose a mechanism for regular, independent monitoring of short-term holding centres.

Achieved. The Home Secretary and the IMB National Council had agreed this in principle. The IMB National Council was formulating plans to implement this

Further recommendation

1.2 The National Council of Independent Monitoring Boards should be enabled to implement swiftly the mechanism for regular, independent monitoring of short-term holding facilities.

1.3 There should be regular, documented supervision of each holding room by on-site immigration managers, reporting to senior managers in the Immigration and Nationality Directorate (IND).

Not achieved at Manchester; partially achieved at Harwich and Dover. At Manchester, a chief immigration officer had in the past visited the centre on a daily basis and recorded visits. There had been no recorded visits since 2004 and staff could not recall a senior member of the immigration team visiting for some months.

At Harwich, senior immigration staff visited the holding room every day in addition to helping with queries as they arose. The main purpose of the visit was to check on detainees' welfare but wider issues were sometimes discussed with security staff during frequent contact.

At Dover, an immigration officer from the nearby Dover asylum screening centre (DASC) visited the facility every day and noted the names of detainees listed on the reception board. Only a proportion of the detainees were DASC cases; many others had been detained by local enforcement officers elsewhere and therefore diverse offices were responsible for casework. The officer pursued the responsible immigration office if cases did not appear to be progressing. This was documented at the immigration office but not at the holding facility. There appeared to be no designated officer with responsibility for monitoring use of the facility and detainees' treatment and conditions generally.
We repeat the recommendation

Additional information

1.4 At all centres, we found inadequate records of detainees' custodial history, which often included several places of detention, including police stations.

1.5 At Manchester, of the ten detainees present at the time of the inspection, only one appeared to be a Manchester case. The rest had been brought from other places of detention in England, Scotland and Wales. As before, many had been initially detained in police stations. The nurse on duty commented that detainees coming from police stations were particularly frightened. Detainees present on the day of the inspection were due to be transferred to other removal centres and we looked at some of their IS91 transfer records. One had been first detained in a police station (the duration of which was not recorded but he said he spent one night there),

followed by three nights at Manchester Airport, two nights at Harmondsworth immigration removal centre (IRC), then a further five nights at Manchester. Nine of the last 11 days had been spent in short-term holding facilities. He was due to move to an IRC that evening but did not have removal directions. The pattern for another detainee was similar: first night in a police station, two nights at Manchester Airport, punctuated by a visit to Dungavel IRC of less than a day, returning to Manchester for less than a day en route to Heathrow, where removal directions appear to have failed, a brief stay at Harmondsworth IRC, returning to Manchester Airport where he had spent the last five days. He was due to be transferred to an IRC that evening.

1.6 At Harwich, detainees were brought in by the escort contractor, Group 4 Securicor, or by regional enforcement staff, or by local Abbey Security staff who sometimes collected detainees held at police stations within the region. It was common for people picked up by immigration enforcement officers to be held initially at a police station, although this was not always recorded on their detention record. Documentation belonging to one of the three detainees present reported initial detention in a police station. The second told us he had been detained in a police station but this had not been recorded on his detention authority; the first entry had been made by escorts who collected him to take him to Tinsley House immigration removal centre (IRC). The documentation belonging to the third man had similarly been opened by escorts who collected him to take him to a removal centre but without saying where they collected him from or how long he had been there. Harwich was the second or third place of detention of those present within a period of up to six days.

1.7 IND had recently introduced new detainee transferable documents (DTDs) which contained the core IS91 authority to detain but provided space for more detailed information. Staff at Harwich were puzzled by their first sight of two DTDs, which had arrived with two detainees transferred from Tinsley House IRC near Gatwick. This was unusual as Harwich staff regularly transferred those recently detained to IRCs but rarely received detainees from an IRC. They did not know why this had happened, since neither detainee was being removed from Harwich port. Although the purpose of the new document was to collect more information, staff had not received any instruction about what they should do with it and were unsure whether they should write on it.

1.8 At Dover, the number of passengers arriving at the port and detained for further interview had reduced because of juxtaposed controls with Calais. Some clandestine passengers were picked up, after emerging from lorries within or close to the port, but many were detained during in-country enforcement operations. A number of the detainees present during the inspection had been transferred from other IRCs around the country and were to be transferred again. Consequently, most of the people detained at Dover arrived and left in escort vehicles of Group 4 Securicor, the IND's main escort contractor.

1.9 Staff complained that detainees often arrived with little information, even though they had been previously detained elsewhere. This was a matter of considerable concern given that the centre held men, women and occasionally families with children within a confined space. Staff welcomed the new, expanded detainee transferable document (DTD), which they had seen arriving with some detainees. However, they had been given no training or guidance on whether they should be opening or contributing to the documents.

1.10 Some people held at Dover had a considerable detention history. One, detained at a Scottish airport on 29 November, had been held successively at ten places in the past three months: a police station, Dungavel IRC in Scotland, Harmondsworth near Heathrow, Dover IRC, Harmondsworth, Manchester Airport short-term holding facility, Dungavel, Manchester Dallas Court short-term holding facility, Harmondsworth. He had arrived at the POD the previous day.

The risk factor section of his IS91 authority to detain was blank and so shed no light on why he kept being moved. A second detainee, a young Zimbabwean, who also arrived at the POD the previous day had been detained under Immigration Act powers for two months in six different places.

1.11 Detention in short-term holding facilities should be limited to five days (extendable to seven days to effect removal). We noticed three individuals who appeared to have been held at Dover for five days or more. One name appeared on seven consecutive days, although his time of arrival on the first day was not recorded. The record for a second detainee indicated 135 hours over a seven day period. It did not appear that the five day limit was exceeded to effect imminent removal since he reappeared a few days later to spend a further few days (88 hours) at the POD. Another was present on four days, left for a couple of days, then reappeared for another two days.

Further recommendations

1.12 Individual custody records should be opened when a person is detained and should accurately report all times and places of detention and any incidents. Police custody records should be attached to the IS91 authority to detain.

1.13 The IS91 form should include information about risk or special needs known to detaining authorities, including medication.

1.14 Detainees should not be held in short-term holding facilities in unsuitable conditions for excessive periods. If any detainee spends more than the five day limit laid down by the Immigration and Nationality Directorate in a single or in successive short-term holding facilities, reasons and the authorising officer should be recorded in the facility log and on the individual's IS91 authority to detain and notified to the detainee.

1.15 The holding facility should keep written logs recording when detainees arrive and depart, with individual details, for a minimum of three months.

1.16 All custodial personnel should be given guidance about how to complete detainee transferable documents.

1.17 Detainees should have access to professional healthcare during all periods of detention.

Achieved at Manchester; not achieved at Harwich and Dover. Manchester Airport was unusual among short-term holding facilities in that a well-qualified nurse attended daily, seven days a week. A general practitioner was on call all the time. The healthcare room had charts and questionnaires in common languages and healthcare staff used a telephone interpreter if required, although this involved using the reception telephone which was not confidential.

At Harwich, the manager had approached possible healthcare providers but so far without success. If health problems were raised, options were limited to escorting the detainee to the nearby primary health clinic or, out of hours, to Colchester hospital accident and emergency department. A number of security staff were first aid trained and the first aid box was well stocked and checked within the port regime.

Although people could spend a few days in the Dover facility, there was no health check. Staff said that if any health problem came to their attention they referred it to immigration staff who would consult the port medical inspector. Otherwise an ambulance might be called. Medical

problems might remain undetected as interpreters were not used and it was left to detainees to demonstrate any problems they had. IND documentation, often just the IS91 authority to detain, rarely offered much information about risk factors. The documents of a number of the occupants included sealed envelopes marked 'medical – in confidence'. DCOs could not open the envelopes to check the content, even though the detainee could be in their care, without any healthcare provision, for some time.

Further recommendation

1.18 Detainees should have access to a healthcare check within 24 hours of arrival.

1.19 Detainees should have daily access to exercise in the fresh air.

Not achieved at Manchester; partially achieved at Harwich; achieved at Dover. At Manchester, there was no exercise area and no access to fresh air anywhere in the centre.

At Harwich, detainees could be escorted into a large yard between the building and the seafront for some fresh air provided no ships were docked in that area and the gates at each end were locked (which they were likely to be if no ship was berthed for loading or unloading). Although the detainees present had been detained for a few days, their custody records did not indicate any access to exercise in the open air. This might have been because the freezing temperature made this unappealing.

Weather and staffing permitting, there was some opportunity for detainees at Dover to get out into the fresh air in the caged vehicle yard, which was sandwiched between cliff face and traffic lane. It was not particularly appealing, being located right beside the freight lane, and allowed little privacy or exercise. During the inspection, detainees welcomed the chance to get outside despite the freezing temperature.
We repeat the recommendation at Manchester and Harwich

1.20 All holding facilities should have a comprehensive child protection policy agreed with the local safeguarding children board. Staff in contact with children should receive appropriate training and all staff should undergo enhanced Criminal Records Bureau checks.

Not achieved at Manchester and Harwich; partially achieved at Dover. Manchester did not accept families with children. Families not given leave to enter at the airport would be asked to wait in the secondary examination area next to the immigration offices until they could be sent back on another flight, given temporary admission or transferred to suitable accommodation. Unaccompanied minors were referred to local social services but age dispute cases could be held in the centre until actual age could be determined. We were told about a female detainee, apparently aged 14, who had been held in the centre for several hours before her approximate age was agreed. Given the possibility that juveniles would be held for short periods in the centre, it was appropriate to have child protection policies and procedures in place and for staff to be trained in child protection procedures and to undergo enhanced Criminal Records Bureau checks.

No families with children had been held at Harwich in the previous three months; however staff said that in some circumstances children could be held for short periods. There was still no child protection policy in place and staff working in the unit had not yet received enhanced Criminal Records Bureau checks. One female member of staff had undergone childcare training. Unaccompanied children were not held in the facility. Children needing support were referred to social services by the immigration staff team. Staff were unaware if a child

protection coordinator had been appointed since the last inspection.

Dover had a child protection policy in place, agreed with the local social services team, and further discussions were planned. The policy had not yet been agreed with the local safeguarding children board. Since the 2005 inspection, the two senior detention officers had both received training in child protection and they shared the role of child protection coordinator for the facility. The officers had received a full police national computer check and a local Dover harbour police intelligence check but they had not undergone enhanced Criminal Records Bureau checks. Family groups were usually allocated to a single large room but we were told that fathers sometimes chose to sleep in separate accommodation. Staff were aware that groups might not always be related as claimed and these cases were referred to the immigration team for further investigation.
We repeat the recommendation

1.21 Medical examinations should always take place after every incident of use of force and any detainee injuries should be recorded. The Immigration and Nationality Directorate (IND) should monitor trends and where necessary commission investigations.

Partially achieved at Manchester; not achieved at Harwich or Dover. At Manchester, four control and restraint (C&R) incidents had been reported since February 2005 and were well documented. In two of the incidents, a custody officer had contacted an interpreter via a mobile telephone from outside an escort van. In both cases, the officer had tried to defuse a situation in which a non-English speaking detainee had become frightened as a result of a lack of information about the reason for escort into the airport from another facility. In the event, C&R had to be used in both cases but only as a last resort. Both detainees subjected to C&R were examined soon after the incident by the part-time nurse or airport paramedics. The nurse attended the Manchester holding room daily and noted any injuries that came to her attention. However, she was not able to record use of force injuries if detainees did not present them, if their visit did not coincide with her attendance or if they happened when they left for transfer or removal. The blanket policy of handcuffing detainees in the terminal building was not documented. We saw no evidence that IND was proactively monitoring trends.

The other centres had no medical cover. At Dover, staff told us that detainees who had been subjected to control and restraint were still not routinely seen by a healthcare practitioner. The manager told us that arrangements were underway to have a trained nurse on call 24 hours a day. When that contract was in place, the nurse would attend each time force was used.
We repeat the recommendation

1.22 Written reasons for detention should be provided in a language the detainee can understand.

Not achieved. The detainees we saw at Manchester had been given reasons for detention, in summary form, on the IS91R checklist. This was in English only.

At Harwich, two of the three detainees said they had been briefly interviewed with the help of an interpreter when detained. All three said they had not been given information about any appeal or bail rights. Documents given to them when detained, including the IS91R summary reasons for detention, were in English only. As they had been detained unexpectedly, they did not have with them documentation concerning their immigration history, without which it would have been difficult to instruct any solicitor if they found one.

At Dover, detainees had usually been informed about their status and given decision documents, with summary reasons for detention, at the time they were detained. Although

immigration officers usually used interpreters on those occasions, most documents, including reasons for detention, were in English only. We saw these documents left lying about the association room and some detainees seemed to have little idea of their content.
We repeat the recommendation

1.23 All centres should have in place safer custody procedures, including an anti-bullying policy and regular staff training in self-harm and suicide.

Not achieved at Manchester; partially achieved at Harwich; achieved at Dover. At Manchester, there was no anti-bullying policy. Staff told us that they were not aware of any bullying incidents. A daily occurrence sheet was maintained and we were told that any incidents would be recorded on it. There was good and regular observation of all areas of the centre by staff and closed-circuit television coverage of the day and dining rooms and the corridor. Those at risk of suicide and self-harm were managed through the F2052SH (at risk monitoring) procedure but no central log of these cases was maintained. There were no F2052SH documents open during the inspection as these forms went with detainees. At night, one supervisor and three custody officers, including a woman, were on duty. All staff had received suicide and self-harm awareness training during their custody officer training but they had not received any refresher training.

At Harwich, no bullying incidents had been observed since the inspection in 2004, although staff showed awareness of the potential for bullying. There was still no policy on the management of bullying. There was a reasonable suicide and self-harm policy but staff were still not trained in the management of suicide and self-harm. Detainees were routinely checked every hour during the day and night and these checks were recorded on the custody sheets. There had been one minor incident of self-harm in the previous six months. We were told that the details were entered on the detainee's custody record, which had accompanied him when he was transferred. At least one regular custody officer was on duty during the day until 11pm when a single member of the general Abbey Security team took over. During the day, the manager or an Abbey supervisor was sometimes in the unit but we were told that the custody officer was sometimes left on his or her own, which was not good practice. The three detainees present all stated in our written questionnaire that they did not feel unsafe because of the conditions in the Harwich holding room. One who spoke good English said he felt very depressed and confused about his detention and unresolved immigration status. His custody record showed that he had initially refused to eat and staff had succeeded in persuading him after a couple of days. The on-site chief immigration officer had also been kept informed.

At Dover, there was a comprehensive policy on the management of bullying in the centre. Custody staff were attentive to detainees' needs and regularly checked on those held. Managers had arranged for assistance if necessary from the Dover Harbour Board anti-bullying team, which was an internal organisation set up to advise the Port Authority on bullying in the workplace. All staff were trained in the management of suicide and self-harm and there was a suicide and self-harm policy in place. People at risk were regularly checked at varying intervals no longer than 15 minutes apart. Records of the checks were maintained in a register in the staff office and recorded on a continuation sheet kept with the IS91. All detainees were checked at 30 minute intervals during the night. Two staff were on duty at night at the time of the inspection but a revised shift pattern due for implementation would enable the night staffing to be raised to three officers. Three detainees we spoke to said they did not feel unsafe in the centre, although they had been worried when they first arrived.
We repeat the recommendation at Manchester and Harwich

Further recommendation

1.24 Copies of all suicide and self-harm documentation should be kept in the holding facility for 12 months.

1.25 All centres should have documented and approved fire and health and safety policies and procedures.

Not achieved at Manchester, partially achieved at Harwich, achieved at Dover. At Manchester, there was no health and safety policy document in the centre and no risk assessments had been completed. There were no displayed instructions for staff on fire safety or fire fighting, nor were there any notices on fire safety for detainees but we were told that information notices in the main languages were being developed. Staff checked detainee accommodation every day but findings were not recorded. Deficiencies were passed on to the airport maintenance team who were responsible for repairs.

At Harwich, there was no health and safety policy and there were no area risk assessments in the facility. Fire evacuation instructions were available only to staff. The fire alarms were tested every week and there were fire exercises each month. Fire equipment was maintained by a contractor and all the equipment had been recently checked.

At Dover, a health and safety policy document had been produced and was kept in the staff office. There were some risk assessments available but we were told that a revised set was due to be produced by the operations department of the Harbour Board. Several safe systems of work assessments had been completed. Checks of all facilities were conducted daily by staff and recorded. Deficiencies were attended to by the port maintenance team. There were fire evacuation notices on display but these were in English only. The fire prevention equipment was adequate and appropriately maintained by the port fire service.
We repeat the recommendation for Manchester and Harwich

1.26 Detainees should either be provided with adequate telephone facilities, including a free telephone call on arrival, or be able to use mobile phones to contact families and advisers to sort out practical problems.

Partially achieved at Manchester; achieved at Harwich; not achieved at Dover. Staff at Manchester helped detainees change money for coins or cards for the telephones. Staff made a free call on behalf of those with no money and asked the recipient to call the detainee back. There was an assumption that the recipient would be able and willing to do so. An instruction had been recently circulated allowing detainees to keep their mobile telephones so long as they did not have an integrated camera. However, we met detainees who had not been able to speak to the person they needed to speak to and who had no money, or had no money left, to make calls. One detainee with no money had spent most of the last 11 days in different short-term holding facilities. He needed to keep ringing people to tell them he had been moved but did not necessarily get a free call at each centre. Even if people could call in, there was no guarantee that their call would coincide with when the detainee needed to give them further news, such as of another move. Telephone numbers on the notice board included those of the Refugee Legal Centre, the Immigration Advisory Service and the Greater Manchester Immigration Aid Unit (GMIAU), a small voluntary advice centre. GMIAU gave a free telephone number but the recorded message on this said calls could be dealt with on only two mornings a week.

At Harwich, detainees were allowed to keep their own mobile, non-camera telephones. Staff kept a range of mobile telephone chargers and offered free telephone calls to those with no

money. The payphone available for detainees' use was in reception and it could be passed through the door to allow a detainee to sit down and have some privacy during a call. Privacy was possible only when the number of detainees present was small. Custody records we saw confirmed that detainees were routinely offered a free telephone call on arrival, usually to enable them to pass on the public telephone number so that people could call them.

At Dover, there were two payphones in the association room which required a minimum 30p payment and took British Telecom cards and credit cards, as well as sterling coins and euros. A third telephone received incoming calls. Detainees could get change from staff and the local shopkeeper, who visited daily with items for sale and changed euros into sterling. Staff were prepared to telephone or fax someone on behalf of detainees with no money and ask them to ring back. Detainees could not keep their mobile telephones despite the IND policy allowing this.

We repeat the recommendation at Manchester and Dover

1.27 Holding rooms should contain newspapers, books, notices and other reading material in different languages, including basic information on the facility and sources of legal assistance.

Partially achieved. At Manchester, staff had gathered a small selection of books and newspapers, sometimes in different languages, from the airport terminal. Almost all material was in English. Notices in reception and in the corridor provided some information about the facility and useful contact details.

At Harwich, the stock of books, magazines and board games had improved since the last visit. There was some reading material in different languages, including religious texts, in the holding room bookcase. Custody staff bought newspapers on request and donated their own. No notices about the centre rules were on display but staff told us that they explained the rules to detainees on arrival. We were also shown a set of rules in draft form. Detainees we spoke to said that they felt safe in the centre and that the staff were helpful. Staff were willing to buy items from the terminal such as cigarettes, newspapers and sweets on behalf of detainees who had enough money to pay for them. It was recognised that these relieved detainees' boredom and stress; however, all three detainees present said there was not enough to do.

At Dover, there were a few newspapers, magazines and books, and some board games. Detainees we spoke to complained about the boredom they experienced during the hours or days spent in the small association rooms, locked out of bedrooms, with little to do but watch television. There were child-friendly and clean books, crayons and toys available in a non-smoking association room. Notices on the wall included rules in several languages and a list of religious contacts. Some policy documents were found among a pile of newspapers and magazines. A couple of detainees commented that these were not always available for them to see.

We repeat the recommendation

1.28 Arrangements should be put in place to allow detainees to recover or arrange for the disposal of their property and detainees should be informed of this.

Not achieved. At none of the centres was there any formal help to address the welfare problems of detainees suddenly detained and facing removal; though in many cases they had been detained after some time in the UK. All allowed visitors, who could deliver property; but there were no volunteer visitor schemes for those without family and friends.

At Manchester, the visitors' book showed regular access. One detainee who arrived during the

inspection had been detained at a reporting centre with no money and only the clothing she wore. She said that she had lived for some years in the country, agreed to go voluntarily and had been reporting weekly to a centre as required. She was detained on one of these occasions but had not been allowed to collect her belongings.

The small number of people detained at Harwich and the cooperative attitude of staff meant that some help was offered to alleviate problems. The visitors' log showed a dozen visitors had been in the centre in the fortnight before the inspection.

At Dover, according to the visitors' book, there were two or three visitors on most days but the majority of detainees had no visitors.
We repeat the recommendation

1.29 There should be a complaints procedure and detainees should be informed about it.

Achieved at Manchester; not achieved at Harwich or Dover. A complaints procedure had been established at Manchester just before the inspection. It had not been used so its effectiveness and the timeliness of responses could not be validated.

There were no formal complaints procedures at Harwich or Dover.
We repeat the recommendation for Harwich and Dover[AO8]

1.30 An assessment should be made of the impact of policies on the different ethnic, religious and cultural groups in all centres.

Not achieved. No impact assessments had been made in any facility.
We repeat the recommendation

Additional information

1.31 There were no formal systems in any facility for detainees to make racist incident complaints and staff were unaware of any racist incident reporting policy, nor were there notices advising detainees how to make such a complaint. We were told that any complaint would be properly dealt with but none had been made. No central record of complaints was kept but we were told that any complaint would be recorded on the individual's IS91.

Further recommendations

1.32 Detainees should be aware of how to make a racist incident complaint and assisted to do so.

1.33 There should be a race relations and diversity policy in every holding room.

1.34 There should be a disability policy and a designated disabilities officer for every holding room.

Not achieved. There was no evidence of a disability policy and staff did not know of a disabilities officer in any facility.
We repeat the recommendation

1.35 A list of ministers of religion should be available in all centres.

Not achieved at Manchester or Harwich; achieved at Dover. At Manchester, various religious texts and a prayer mat were available and one of the dormitories was used for prayers. The airport had a chaplain who, along with ministers of other faiths, visited from time to time but there was no list of available ministers for detainees to consult.

No list of ministers was available at Harwich.

At Dover, there were several religious texts and a prayer mat available for detainees and, when not in use, one of the bedrooms was available for prayers. There was a list of available religious ministers on display and there were arrangements for ministers of religion to visit if requested by detainees.
We repeat the recommendation for Manchester and Harwich

Section 2: Manchester Airport

2.1 As at the last inspection, this facility, contracted to Group 4 Securicor, was used to hold passengers detained by airport immigration staff for further questioning or those who had been refused permission to enter the country and were awaiting removal on another flight. In fact, airport detainees are a minority. Its main function is as a staging post for detainees being transferred from one place of detention to another.

2.2 It has beds for up to 16 detainees in four rooms, male and female. Ten detainees, including one woman, were present on the morning we arrived, although numbers fluctuated as some left and others arrived. According to records for the previous two-and-a-half months, 14 detainees a day was the average, 13% being women. The average period spent at the facility, for those leaving in the first 16 days of August, was just over 33 hours.

2.3 The number of staff had increased since the last inspection to cover the DCOs' frequent absences when accompanying detainees arriving and leaving or attending interviews in a separate area. Even at night, a supervisor and a minimum of three DCOs, including a woman, were on duty. At least one was always stationed in the kitchen or association area of the secure detention corridor. Several DCOs were present during the inspection.

2.4 As before, the accommodation was clean and tidy. Comfortable new chairs lined the association room. The interactions we observed between staff and detainees were respectful. Detainees were usually addressed by their first names. Staff wore name badges and appeared aware of detainees' needs throughout the inspection. The shift supervisor introduced himself to new arrivals and offered support to people during their stay in the centre.

Progress against recommendations

2.5 Detainees should be risk assessed during the admission process.

Partially achieved. Custody officers carried out their own risk assessment of detainees during the admission process but the information available to them on the IS91 (authority to detain) was limited. The risk factors section was generally blank. Officers told us that they believed IND staff responsible for organising movement of detainees had an incentive to leave it blank because some detention centres, including Manchester Airport, were reluctant to accept cases where risks of special needs were highlighted. IND was trying to improve the information that accompanied detainees with a new, more detailed case file (the detained transferable document) that arrived with detainees from some centres.
We repeat the recommendation

2.6 The kitchen and equipment should be reviewed in the light of the number passing through the holding centre. A suitably equipped and ventilated facility should be provided.

Partially achieved. The kitchen still had only two microwaves and two small ovens, which meant that meals often had to be heated in batches. The number of people who stayed overnight at the facility was often supplemented by others left there for a period of hours to await transfer. They also required meals. The long period cooking in batches raised the temperature in the windowless, small kitchen to uncomfortable levels, even though improvements had been made to the ventilation.

Further recommendation

2.7 Additional cooking and temperature control equipment should be provided

2.8 There should be laminated notices, in common languages, informing detainees of rules and other necessary information.

Achieved. Notices in reception and in the corridor provided some information about the facility and other useful points of contact. These included the rules of the centre, in English. We were told that a full set of rules and instructions was being developed and would soon be available. A small stock of essential items, including cigarettes, was available for destitute detainees but detainees did not know to ask for them. Some of the detainees we met had no m[illegible] and, although staff made a free call for them when they arrived, they did not know they could ask for another free call.

Further recommendation

2.9 A notice should inform detainees that some essential items and a free telephone call are available for those without means.

2.10 A suitable healthcare room with a sink, telephone and emergency call button should be available.

Not achieved. The healthcare room was still poorly equipped and it was used to store property, which then had to be moved out to allow the nurse access. Plans to improve the facility had been drawn up.
We repeat the recommendation

2.11 Men and women detainees should have separate sleeping areas.

Not achieved. This recommendation had been rejected on grounds of lack of space. Women were allocated separately to one of the four bedrooms. Doors were not locked and all rooms were in a communal corridor along which women had to pass to reach sanitary facilities, dining and association rooms and the telephone. This remained unsatisfactory.
We repeat the recommendation

2.12 Detainees should be able to wash and dry clothing.

Not achieved. Staff said they tolerated small items being washed in the shower and left to dry in the rooms. There were no suitable washing, drying and ironing facilities, even though detainees spent a few days there and had often arrived with only the clothes they had on.
We repeat the recommendation

2.13 A stock of spare clothing should be available for detainees who have no change of clothing, or no suitable clothing.

Achieved. Bedding and towels were clean and included some new stock. A stock of basic clothing for detainees in need (track suits, T-shirts, underwear, socks and sandals) had recently been delivered, although availability was not yet advertised.

2.14 A secure property store should be available.

Not achieved.
We repeat the recommendation

2.15 Detainees should be provided with writing paper as required.

Partially achieved. We saw no paper and pens for detainees' use and no notices informing them they could request these. However, notices in reception and beside the telephone explained the complaints procedure and indicated that detainees could ask for paper and a pen.

2.16 General information about legal rights, including that issued by the Office of the Immigration Services Commissioner (OISC) should be freely available to detainees.

Achieved. Some leaflets of the Office of the Immigration Services Commissioner (OISC) were available in reception, though they were not the most recent and were not prominently displayed. As detainees spent little time in reception anyway, it was likely they would benefit more from up-to-date information placed in their accommodation.

2.17 Interpreters and a telephone interpreting service should be available to the holding centre staff.

Not achieved. Immigration officers used an interpreter if necessary at the time of detention but in general DCOs communicated by sign language if detainees did not speak English.
We repeat the recommendation

2.18 A legal visits room, suitable for confidential interviews, should be available.

Partially achieved. Legal visits could be conducted in the interview area used by immigration staff. However, as the area was not secure, a custody officer had always to be close by, which compromised confidentiality.
We repeat the recommendation

2.19 A central log of those managed through the F2053SH (self-harm monitoring) procedure should be maintained.

Not achieved. See general recommendation 1.24

2.20 Fire evacuation routes should be cleared.

Achieved.

2.21 Instructions should be available for staff on fire safety or fire fighting.

Not achieved.

2.22 Fire safety notices should be on display in the main languages.

Not achieved. The fire fighting extinguishers had been regularly checked by the airport fire service and the evacuation routes were clear of obstruction. Staff told us that they had not received any fire training and were not made aware of airport evacuation plans. We were told

that staff had on occasion found out by accident that the terminal had been evacuated. See general recommendation 1.25

Further recommendation

2.23 All staff should receive fire training as a priority and a protocol should be agreed with the airport authority to include the holding centre in evacuation contingency planning.

2.24 There should be a racist incidents policy and reporting procedure.

Not achieved. See general recommendation 1.33

2.25 The centre rules should be rewritten in the main languages of detainees and displayed in the residential areas.

Partially achieved. See paragraph 1.27 above

2.26 Handcuffing outside the centre should only take place following individual risk assessment.

Not achieved. This recommendation was rejected, by reference to airport security (though this has not been the case at other airports). As the vehicle access door was not beside the holding room, detainee custody officers (DCOs) had to accompany detainees some distance, part of which was within view of the public as well as other airport staff. In spite of criticisms made in the last report, detainees were still routinely handcuffed going to and fro. Staff said this was a requirement of airport security but they had nothing in writing to explain the policy, or who authorised it, and no records of use of handcuffs were kept. The application of mechanical restraints should be at the discretion of those who are trained in control and restraint. The practice was not generalised at other airport holding facilities. The single woman detainee, who had arrived that day, was tearful when she described this humiliating experience. She said she had felt like an arrested criminal even though she had been compliant in reporting to the immigration office as requested and when she was detained.
We repeat the recommendation

2.27 A complaints book should be accessible to detainees.

Achieved. Notices about a complaints procedure had been posted just before the inspection and included the information that detainees could ask for paper to write a complaint. A complaints book in the dining or association area would have been more accessible and easier to check.

2.28 Detainees should be able to watch television in a smoke-free environment.

Not achieved. There were televisions in the dining room and the day room but this was also where staff and detainees smoked. We were shown plans of alterations to the layout of the centre that would allow a smoke-free room. Staff told us that smoking would be banned across the airport by early 2006.
We repeat the recommendation

Section 3: Harwich International Port

3.1 The facility was open 24 hours a day, with a capacity of six, and an overflow room with six additional beds. Occasionally, it was used to hold people detained as passengers arriving at the port, whom port immigration staff wished to question further or refuse permission to enter. At the time of the inspection, though, all the occupants had been picked up by immigration enforcement officers within the region and detained with a view to removing them from the country. They had been there between two and three days and it was their second or third place of detention.

3.2 Over the previous three months, the average duration of detention at Harwich was 34 hours. Three people had been detained for just over five days. Women made up 22% of the total. No families with children were detained and we noted only one individual whose age was in dispute and who could have been a minor.

3.3 We were told by Abbey Security management that, since the 2004 inspection, the Immigration and Nationality Directorate (IND) had decided to review Harwich's use as a residential short-term holding facility. The conclusions of that review were not expected before 2006. We were also told that the possibility of refurbishment or closure had delayed the implementation of our recommendations from the last inspection. However, during this inspection we found that many of the minor and low-cost recommendations had not been addressed either. The vital staff training we recommended had not taken place, including DCO accreditation, control and restraint, and self-harm and suicide management. There were still no formal child protection, health and safety or complaints policies and procedures.

3.4 The dormitories were reasonably clean but had begun to look shabby. Deficiencies were recorded and reported to the Harwich port maintenance team. Despite the poor and cramped layout of the old building, staff managed to keep all areas reasonably clean and tidy. Some natural light entered the holding rooms from small windows and was supplemented by artificial lighting but partitions and fittings contributed to a dingy and claustrophobic atmosphere.

3.5 Staff were observed interacting positively with the three detainees in the facility. They were polite and helpful and tried to minimise the stress of detention. If necessary they could call on immigration staff to assist with explanation, using an interpreter in some cases. The reception process did not include any written explanation of rules, the use of a professional telephone translation service or a health check.

Progress against recommendations

3.6 Custody staff should be trained and accredited as detainee custody officers.

Not achieved. The facility was run by Abbey Security Ltd, whose staff performed a number of functions within the port and were trained and licensed in accordance with Security Industry Authority requirements. They were not trained or accredited detainee custody officers (DCOs). As detainees can spend some days at the centre, this remained a serious concern. The recommendation was still under consideration by Abbey Security.
We repeat the recommendation

3.7 The 'overflow' room should be made fit for purpose with access to sanitation and a means of summoning staff assistance.

Not achieved. The 'overflow' room had been taken out of regular use, but was occasionally used, for example if several clandestine travellers were discovered in a lorry on a ferry. It was the biggest room, containing three pairs of bunk beds. It had no sanitary facilities, no call bell, was overcrowded when full and could be observed only minimally through the door spy hole. When locked up, detainees in the two main dormitory rooms could gain staff attention using buzzers, but anyone located in the overflow room would have to knock.
We repeat the recommendation

3.8 Staff observation of detainee areas should be improved.

Not achieved. The facility was small and cramped. Though reasonably clean, the fabric had deteriorated badly since the 2004 inspection and no remedial work had been carried out. In 2004, we recommended that all accommodation should be fit for use and this was now under discussion in the context of review of the contract with IND. The least suitable 'overflow' holding room had been taken out of regular use but the remaining two main dormitories were still only just fit for purpose. The two rooms in use contained a total of six beds: one had one pair of bunk beds and the other had two. Both had their own integral toilet, sink and shower cubicle. The separate toilet/shower rooms still had extensive ligature points.

A call bell in the room was activated at night when doors were locked. The room doors were unlikely to be locked during the day unless there was a female detainee and one room needed to be isolated from the other. This allowed free access into a small association area that separated the bedrooms from the locked door to reception. The association area contained two tables, a few chairs, a wall-mounted television and a bookcase. It could be observed through a window by reception staff, who would also unlock detainees so they could go to the smoking room or use the telephone.

Women detainees were housed in a separate dormitory. We were told that staffing shortages meant that there was not always a female custody officer on duty when women detainees were held. At night there was sometimes only one custody officer permanently stationed in the holding area.
We repeat the recommendation

Further recommendation

3.9 A female custody officer should be on duty when women or children are detained.

3.10 A central log should record details of all visitors and visiting officials.

Partially achieved. The visits of immigration staff were not always recorded in the holding room log, although they were recorded in the immigration office log. During the visit, the chief immigration officer agreed to remind staff to record their visits in the holding room.
We repeat the recommendation

3.11 There should be a formal arrangement to ensure that detainees have access to emergency healthcare and a healthcare check within 24 hours of arrival.

Not achieved. See general recommendation 1.18

3.12 OISC (Office of the Immigration Services Commissioner) leaflets should be available in communal areas and detainees should be shown where they are.

Achieved.

3.13 The Refugee Legal Centre and Immigration Advisory Service advice line telephone numbers should be displayed.

Achieved. Advice line numbers of the Immigration Advisory Service and the Refugee Legal Centre were posted next to the telephone in reception. There were also leaflets of the Office of the Immigration Services Commissioner (OISC), in a range of languages, suggesting how to find competent advice and how to complain about poor advice.

3.14 The ligature points in dormitories should be minimised.

Not achieved. Ligature points identified at the 2004 inspection had not been removed.
We repeat the recommendation

3.15 A children's play area and a baby changing facility should be provided.

Partially achieved. Though we were told that there were no plans to hold children at Harwich, the facility's future was still under review and staff foresaw circumstances in which children might be held for short periods. Detained families with children were likely to be placed in the unsuitable overflow dormitory. We were told that the door was left open when this happened. Meals were eaten in the overflow dormitory. Other than some toys and games, there were no provisions for children and there was limited opportunity for access to the fresh air. A baby change room was available in the shopping concourse outside the detention area and carers needing access had to be escorted by custody staff. There was no specific play area or nappy changing area available in the facility itself.
We repeat the recommendation

3.16 Children and parents should be given access to the open air as part of the daily regime.

Partially achieved. See general recommendation 1.19

3.17 Staff working in the holding area should receive diversity training.

Not achieved. Staff had not received any diversity training since the last inspection.
We repeat the recommendation

3.18 All staff working in the holding centre should receive accredited control and restraint training as soon as possible.

Not achieved. As in 2004, none of the staff working in the facility had formal training in the use of control and restraint. A central log had been opened in the preceding month for recording the use of control and restraint but we were told that force had not been used in the facility since the last inspection.
We repeat the recommendation

3.19 Proper documentation should be maintained on the use of restraint on detainees.

Partially achieved. Handcuffs had been used and recorded three times since the log book

had been opened. There were no detailed individual incident record sheets.
We repeat the recommendation

3.20 Women should have access to sanitary products without having to ask a member of staff.

Achieved.

3.21 Disposable nappies should be freely available.

Achieved. As children were rarely in the holding room, baby food and nappies were not stocked but were purchased as required and provided free. Women's sanitary items were kept in stock but were not left in the room allocated to female detainees as it was usually occupied by men. The room had its own toilet and shower.

Section 4: Port of Dover

4.1 Dover Harbour Board managed the residential short-term holding centre, known as the Port of Dover (POD). There had been a number of changes since the last inspection. The Dover harbour police were no longer involved in the running of the facility. The port security manager was responsible for the management of the centre and had begun to implement a change programme. All the custody staff were accredited detainee custody officers (DCOs) with relevant training plans.

4.2 The facility comprised a reception area, three association rooms, dormitories, male and female sanitary facilities, interview rooms, staff offices and a small caged yard. There were more than 40 beds in the dormitories but not all were used and, in any event, such a large number of people could not be accommodated given the modest size of the day rooms. The rooms were clean and in good decorative order but bare as they contained little other than bunk beds. The opaque windows could be opened a little for ventilation. Detainees were in the bedrooms only at night. They were locked in around 10pm and released around 7am or 8am.They could ring the room call button to attract attention and the detainees we spoke to said these were answered promptly.

4.3 The POD was open 24 hours, seven days a week, and held people detained in the port area and detainees picked up during in-country enforcement operations, or being transferred around the detention estate. During the inspection, two women and ten men were detained, some of whom were temporarily lodged at the POD en route from one removal centre to nearby Dover immigration removal centre (IRC), which was not open round the clock. Detention of minors was rare.

4.4 People were not supposed to be detained at the short-term holding facility beyond five days, or seven if removal was imminent. According to the notice board, three of those present had been there four days, at which stage custody staff had chased the responsible officers to transfer them. However, entries on the board were erased as people left and staff kept no detailed register of use of the holding room over a period of time. Population information sent to us after the inspection was unclear. Information relating to January 2006 indicated that the average daily occupancy rate was 25, with up to 39 being held during one day. Women made up 3% of the population. Dates of birth were not given in the information provided but two children accompanied by a woman were recorded during the month. They were held for eight hours. The average stay was 58 hours.

4.5 Staff proactively engaged with detainees during the inspection. Detainees were addressed by their first name or title and surname if preferred. All staff wore name badges. Staff were very positive about their work and about the changes that had occurred affecting overall management of the centre within the security department of the port. The usual minimum staffing level was three officers, male and female, although only two might be on duty overnight. Three detainees who completed questionnaires said the staff treated them well and with respect.

Progress against recommendations

4.6 The men's shower room should be refurbished or deep cleaned.

Not achieved. Showers, towels, clean bedding and basic hygiene items were freely available.

Separate toilets and showers were clean, except for the male showers which were due to be deep cleaned.
We repeat the recommendation

Additional information

4.7 A single young woman, who spoke no English, occupied the women's association room. She had been detained two days previously and had spent the first night in a police station before transfer to the POD. She was wearing the same clothes, including the coat, she had been detained in. Staff said that they sometimes brought in a few items of spare clothing to help people out but there was no clothing store or laundry facility. Small items could be rinsed and left to dry in the shared shower rooms, provided detainees were prepared to risk losing them. Staff said that many detainees came from police stations rather than as Dover passengers with luggage, as used to be the case prior to juxtaposed immigration controls. This meant they could accumulate a stretch of days in poorly-resourced short-term holding facilities, without change of clothes, before transfer to a better equipped removal centre, by which time removal might be imminent.

4.8 The main association area, where detainees spent the day, comprised two adjoining average-sized rooms, smoking and non-smoking, with an open doorway between the two. A replacement door was planned to reduce smoke circulation. Although cleaned daily and decorated regularly, the rooms were drab and looked over-used as a result of the smoking. The television was in the smoking area. The other room was furnished with three form tables with surrounding plastic seats, a few soft seats, a free hot and cold drinks machine, two payphones and a third handset for incoming calls. During the previous month, the occupancy level had reached more than 30 men held at the same time. It was difficult to see how 30 could occupy the modest association area with any degree of comfort.

4.9 The third association room was reserved for women who did not wish to sit in the mixed association rooms, or for a family with children. It had its own television, table, chairs and a box of toys. The doorway was monitored by closed-circuit television (CCTV) in the corridor.

Further recommendation

4.10 A clothing store and laundry facilities should be provided for detainees.

4.11 A telephone interpreting service should be used by staff when necessary.

Not achieved. Although immigration officers used interpreters during interview, custody staff did not normally use them. With the help of a telephone interpreting service, we talked to a young woman, detained for a couple of days, who spoke no English. She said that, although staff were kind to her, they had asked her some questions and she had no idea what they were asking. She was still wondering and worrying about this the following day.
We repeat the recommendation

4.12 There should be a formal arrangement to ensure that detainees have access to a healthcare check within 24 hours of arrival.

Not achieved. See general recommendation 1.18

4.13 OISC leaflets should be accessible to detainees in communal areas.

Achieved.

4.14 The Refugee Legal Centre and Immigration Advisory Service telephone line numbers should be displayed.

Achieved. Some general information produced in different languages by the Office of the Immigration Services Commissioner was available. A notice gave telephone numbers of the Refugee Legal Centre and the Immigration Advisory Service but it was inconspicuous and we had to point it out to one detainee who asked us where he could get legal advice, even though he could speak and read English. Another detainee said that the only legal advisor he had seen was briefly at the police station where he was first detained. The solicitor had simply told him he could go home and appeared to be a criminal duty solicitor rather than an immigration solicitor.

4.15 Detainees should be able to contact legal representatives by telephone, fax or email in private and without charge.

Partially achieved. Two detainees confirmed that staff allowed them a free telephone call because they had no money. However, staff could not assist detainees to ring round to find legal representatives. The payphones were in the association room and could not be used in private. If a detainee had a representative, staff were prepared to fax documents but no email was available. Legal visits took place in one of the private interview rooms.
We repeat the recommendation

4.16 Ligature points in bedrooms and showers should be minimised.

Achieved. Our inspection of 2005 had noted ligature points in the bedrooms and showers. Since then, extensive remedial work had been carried out in all the high risk areas. A specialist company had been used to buy in a resilient and virtually tamper-proof mastic material that had been used to fill in all the gaps between electric conduits and ceilings. All high risk areas identified in the 2005 inspection had been addressed.

4.17 All detainees claiming to be children should be referred to social services for assessment.

Partially achieved. Dover occasionally held children with families but not children travelling alone. The limited records available did not record dates of birth so we were unable to check. The immigration team referred those claiming to be minors to Kent social services when they were in doubt but not those whom they believed to be adults.
We repeat the recommendation

4.18 There should be a formal system for detainees to make racist incident complaints and this should be publicised in the centre in the main languages encountered.

Partially achieved. See general recommendation 1.32

4.19 Proper documentation on the use of restraint on detainees should be maintained in the centre.

Partially achieved. Custody staff had all been trained in the use of control and restraint by the port police and there had been one use of force reported during the six months before this

inspection. The records of the incident were not comprehensive but the staff descriptions were detailed and indicated good use of de-escalation techniques. We were told of plans to introduce a revised control and restraint documentation system adapted from that used by the Prison Service.

We repeat the recommendation

4.20 The Immigration and Nationality Directorate should oversee the use of restraint in the centre and authorise and monitor the use of removal from association.

Achieved. There was a system for notifying detention services at IND of the use of force. Bedroom number one was called the 'holding room' by staff. It could be used to lock up or segregate disruptive detainees until they could be removed to secure conditions. The room was used on the authority of the senior staff member on duty in conjunction with a senior IND manager.

4.21 Writing materials should be available in the association room.

Achieved. Writing paper and pens/pencils were available by the telephone in the association room.

Section 5: Recommendations

General recommendations

To the Minister for Citizenship, Immigration and Nationality

5.1 The National Council of Independent Monitoring Boards should be enabled to implement swiftly the mechanism for regular, independent monitoring of short-term holding facilities. (1.2) To all establishments.

To the Immigration and Nationality Directorate

5.2 There should be regular, documented supervision of each holding room by on-site immigration managers, reporting to senior managers at the Immigration and Nationality Directorate (IND). (1.3) To all establishments.

5.3 Detainees should have access to a healthcare check within 24 hours of arrival. (1.18) To all establishments.

5.4 Detainees should have daily access to exercise in the fresh air. (1.19) To Manchester and Harwich.

5.5 All holding facilities should have a comprehensive child protection policy agreed with the local safeguarding children board. Staff in contact with children should receive appropriate training and all staff should undergo enhanced Criminal Records Bureau checks. (1.20) To all establishments.

5.6 Medical examinations should always take place after every incident of use of force and any detainee injuries should be recorded. The Immigration and Nationality Directorate (IND) should monitor trends and where necessary commission investigations. (1.21) To all establishments.

5.7 Written reasons for detention should be provided in a language the detainee can understand. (1.22) To all establishments.

To facility contractors

5.8 Individual custody records should be opened when a person is detained and should accurately report all times and places of detention and any incidents. Police custody records should be attached to the IS91 authority to detain. (1.12) To all establishments.

5.9 The IS91 form should include information about risk or special needs known to detaining authorities, including medication. (1.13) To all establishments.

5.10 Detainees should not be held in short-term holding facilities in unsuitable conditions for excessive periods. If any detainee spends more than the five day limit laid down by the Immigration and Nationality Directorate in a single or in successive short-term holding facilities, reasons and the authorising officer should be recorded in the facility log and on the individual's IS91 authority to detain and notified to the detainee. (1.14) To all establishments.

5.11 The holding facility should keep written logs recording when detainees arrive and depart, with individual details, for a minimum of three months. (1.15) To all establishments.

5.12 All custodial personnel should be given guidance about how to complete detainee transferable documents. (1.16) To all establishments.

5.13 All centres should have in place safer custody procedures, including an anti-bullying policy and regular staff training in self harm and suicide. (1.23) To Manchester and Harwich.

5.14 Copies of all suicide and self-harm documentation should be kept in the holding facility for 12 months. (1.24) To all establishments.

5.15 All centres should have documented and approved fire and health and safety policies and procedures. (1.25) To Manchester and Harwich.

5.16 Detainees should either be provided with adequate telephone facilities, including a free telephone call on arrival, or be able to use mobile phones, to contact families and advisers to sort out practical problems. (1.26) To Manchester and Dover.

5.17 Holding rooms should contain newspapers, books, notices and other reading material in different languages, including basic information on the facility and sources of legal assistance. (1.27) To all establishments.

5.18 Arrangements should be put in place to allow detainees to recover or arrange for the disposal of their property and detainees should be informed of this. (1.28) To all establishments.

5.19 There should be a complaints procedure and detainees should be informed about it. (1.29) To Harwich and Dover.

5.20 An assessment should be made of the impact of policies on the different ethnic, religious and cultural groups in all centres. (1.30) To all establishments.

5.21 Detainees should be aware of how to make a racist incident complaint and assisted to do so. (1.32) To all establishments.

5.22 There should be a race relations and diversity policy in every holding room. (1.33) To all establishments.

5.23 There should be a disability policy and a designated disabilities officer for every holding room. (1.34) To all establishments.

5.24 A list of ministers of religion should be available in all centres. (1.35) To Manchester and Harwich.

Other recommendations

Manchester Airport

5.25 Detainees should be risk assessed during the admission process (2.5)

5.26 Additional cooking and temperature control equipment should be provided. (2.7)

5.27 A notice should inform detainees that some essential items and a free telephone call are available for those without means. (2.9)

5.28 A suitable healthcare room with a sink, telephone and emergency call button should be available. (2.10)

5.29 Men and women detainees should have entirely separate sleeping areas. (2.11)

5.30 Detainees should be able to wash and dry clothing. (2.12)

5.31 A secure property store should be available. (2.14)

5.32 Interpreters and a telephone interpreting service should be available to the holding centre staff. (2.17)

5.33 A legal visits room, suitable for confidential interviews, should be available. (2.18)

5.34 All staff should receive fire training as a priority and a protocol should be agreed with the airport authority to include the holding centre in evacuation contingency planning. (2.23)

5.35 Handcuffing outside the centre should only take place following individual risk assessment. (2.26)

5.36 Detainees should be able to watch television in a smoke-free environment. (2.28)

Harwich International Port

5.37 Custody staff should be trained and accredited as detainee custody officers. (3.6)

5.38 The 'overflow' room should be made fit for purpose with access to sanitation and a means of summoning staff assistance. (3.7)

5.39 Staff observation of detainee areas should be improved. (3.8)

5.40 A female custody officer should be on duty when women or children are detained. (3.9)

5.41 A central log should record details of all visitors and visiting officials. (3.10)

5.42 The ligature points in dormitories should be minimised. (3.14)

5.43 A children's play area and a baby changing facility should be provided. (3.15)

5.44 Staff working in the holding centre should receive diversity training. (3.17)

5.45 All staff working in the centre should receive accredited control and restraint training as soon as possible. (3.18)

5.46 Proper documentation should be maintained on the use of restraint on detainees. (3.19)

Port of Dover

5.47 The men's shower room should be refurbished or deep cleaned. (4.6)

5.48 A clothing store and laundry facilities should be provided for detainees. (4.10)

5.49 A telephone interpreting service should be used by staff when necessary. (4.11)

5.50 Detainees should be able to contact legal representatives by telephone, fax or email in private and without charge. (4.15)

5.51 All detainees claiming to be children should be referred to social services for assessment. (4.17)

5.52 Proper documentation on the use of restraint on detainees should be maintained in the centre. (4.19)