imb Independent Monitoring Boards

National Annual Report 2023

Adult prisons, young offender institutions and immigration detention

May 2024

npm national preventive mechanism

Contents

Introduction from the National Chair

Inside every prison, young offender institution, immigration removal centre (IRC) and short-term holding facility (STHF), there is an Independent Monitoring Board (IMB), appointed by ministers to monitor and report on the treatment and conditions for those detained. During 2023, over 37,700 visits were carried out by 132 IMBs at these places of detention.

For the first time, this national annual report brings together IMBs' key findings and themes across these settings throughout the year. While children and adults are detained in prisons, YOIs or immigration detention on entirely different bases (the former hold those who have been sentenced or are awaiting sentencing by the courts; the latter is an administrative part of immigration control), IMBs have found cross-cutting issues impacting all those deprived of their liberty. Although IMBs found some good practice, often at a local level, this report focuses on our national concerns.

The context

Throughout 2023, both prisons and immigration were at the forefront of political conversation, pressure and uncertainty. The lack of continuity at the highest political level continued, with changes to both Justice and Home secretaries, the Prisons Minister, and immigration matters split, with the introduction of a new Illegal Migration Minister.

The Prison Service, still recovering from the Covid-19 pandemic, faced a new crisis of an increasing population (by over 5,200 people during 2023 alone) and not enough prison spaces.[1] These capacity and crowding pressures had many of the same adverse effects on safe, humane, and rehabilitative regimes. An alleged escape from HMP Wandsworth in September 2023 evidenced a serious security risk and raised questions about the state of our prisons in the public arena.

Similarly, the number of people in immigration detention was over 50% higher at the end of 2023 compared to 2022. The Illegal Migration Act 2023 also became law, meaning that if current arrival trends continue, the number of people detained is likely to double.[2] In 2023, both the UK Court of Appeal and Supreme Court ruled that the government's scheme to remove people to Rwanda was unlawful due to potential human rights breaches. However, the government was able to pass legislation in April 2024 which will bypass this, and intend to start sending asylum seekers to Rwanda in the summer of 2024. The statutory inquiry into the abuse of detained people at Brook House IRC in 2017 also reported.[3]

The findings

Prison population pressures and efforts to maximise capacity caused tremendous strain on all detention settings that IMBs monitor. In adult prisons, people were shifted around the estate wherever there was room, which was not always in keeping with the support they needed at that point in their sentence, or the local area they would be released to. Some prisoners who were more violent, disruptive or involved in ongoing crime were held in lower category prisons, or moved into more typically

settled parts of the estate, causing significant disruption, frequently needing to be moved back as a result. Over 18-year-olds were held in YOIs to free up adult prison places, but this contributed to a lack of stability in the youth estate. No suitable activity was provided for these young adults, who were bored and directionless as a result. More time-served foreign national offenders were held in immigration detention, causing similar disruption.

Despite some modest improvements in 2023, many adults and children across the prison and YOI estate remained locked up for too long with nothing meaningful to do. Purposeful activity remained significantly low overall, and access to education, training, work and progression opportunities was inconsistent. Many IMBs saw the toll that being locked in a cell for lengthy periods of time, without a reliable or full regime, took on detained people's mental health and wellbeing, and their confidence to progress and ultimately resettle back into society and turn their lives around.

Widespread staff shortages hindered every area of detained people's lives and compounded the lack of regime. Although operational staffing levels improved nationally during 2023, at a local level, prisons and YOIs were still understaffed in practice, as new officers spent significant periods in training away from frontline duties, and large numbers were redeployed to other sites on detached duty. Many adults and children lacked meaningful relationships with staff, and the key work scheme, where officers provide one-to-one support to adult prisoners, was almost non-existent. The lack of probation staff disadvantaged prisoners who were being released and the high numbers of those being released homeless was entirely unacceptable. In the immigration estate, Border Force staffing shortages contributed to detained people being held in inappropriate places for too long, such as police station cells and controlled waiting areas in airports.

Healthcare and education staff vacancies also impacted on prisoners' outcomes. Lack of healthcare staff, especially mental health staff, meant services struggled to meet high levels of need. Teacher shortages in YOIs meant children received insufficient levels of education.

The physical state of disrepair across the prison estate, and some YOIs and STHFs, meant some detained people were living or held in unacceptable environments. Adult prisoners were kept in conditions described as inhumane, sometimes without access to basic sanitation, which had serious implications for their hygiene and dignity. Some children lived in poor conditions due to delayed maintenance and repairs.

IMBs had widespread concerns about the safety of those detained across prisons, YOIs and immigration detention. High numbers of detained people were at risk of suicide and self-harm in prisons and immigration detention, and improvements were needed to safeguard them. There was an increase in serious incidents, violence and disorder in the youth estate, which was not always managed well; the use of separation (being isolated from others) also increased.

IMBs also had concerns about several groups of detained people, including children, who were particularly vulnerable and experienced clear shortfalls in their care and support.

Adult women and girls in prison had complex mental health needs and high levels of self-harm. IMBs remain concerned about women being sent to prison solely for their mental health or because they were at risk of suicide, and the suitability of placing girls in a prison environment – both of which should end. There were still lengthy delays in transfers from prison to secure hospitals across the prison estate.

In immigration detention, processes to identify and safeguard people deemed vulnerable (including those who have a serious mental health condition or have experienced trafficking or torture) were ineffective, as were mechanisms to prevent their detention in the first place. Too often during 2023, those known to be at risk of harm according to Home Office policy were nonetheless detained or kept detained for too long.

Many IMBs monitoring in adult prisons were concerned about the support for those serving imprisonment for public protection (IPP) sentences, and the spike in apparently self-inflicted deaths, after the government rejected the recommendation for a resentencing exercise in early 2023. IPP prisoners continue to face poor mental health, increasing feelings of hopelessness and frustration, and many obstacles to progression.

Although this is my first report as National Chair, many of these key concerns are markedly similar to those raised by my predecessor. Dame Anne Owers was in place for over five and a half years, carrying out her role with a diligence and determination equalled only by that of the local IMB members. Over recent years, IMBs' concerns have often gone unaddressed, with Boards having to pose the same questions to ministers again and again. While much of this lies with the government, and is an issue all scrutiny bodies face, IMBs also must ask: How do we have more impact? In 2023, we have started to work towards making even more out of IMBs' real-time intelligence and insight. We have improved the content of our published annual reports, introduced an internal quarterly reporting process to hear IMBs' key concerns more frequently to better influence change, and published national thematic monitoring reports, which bring together IMBs' local findings to paint a national picture.

One way that IMBs can be more effective in terms of impact, trust and confidence is by having a truly diverse membership. This report includes members' ethnicity data for the first time, which shows that 92% of those that provided this information (and over 30% didn't) are white (see Annex 2).[4] This is not good enough. While we have already started to take action to improve the diversity of IMBs – and our initial focus is on improving ethnic diversity – this is long-term work to which we are fully committed. I have made it a strategic objective for the next three years but our collective and shared commitment to this must transcend any timescale.

Elisabeth Davies **May 2024**
IMB National Chair

About IMBs and this report

Independent Monitoring Boards (IMBs) monitor and report on the conditions and treatment of those detained in every prison and young offender institution (YOI) in England and Wales, as well as every immigration detention facility across the UK and overseas removals. IMB members are unpaid public appointees.

IMBs are part of the UK's National Preventive Mechanism (NPM).

Our remit

Our remit is primarily set out in the Prison Act 1952 and the Immigration and Asylum Act 1999. Our functions and powers are further defined in the Prison Rules, Young Offender Institution Rules, Detention Centre Rules and Short-term Holding Facility Rules.

Our monitoring approach

Our approach is set out in the National Monitoring Framework agreed by ministers.[5]

Monitoring focuses on the outcomes for prisoners and detained people. IMBs assess outcomes in the following areas:

- Safety
- Fair and humane treatment
- Health and wellbeing
- Education and training (YOI IMBs only)
- Progression and release (including preparation for return or release in immigration detention facilities)

This report

This report is based on IMB findings from 1 January to 31 December 2023.[6]

IMB activity in 2023

132 Boards, made up of **1,176** members, carried out **37,715** visits between 1 January to 31 December 2023.[7]

Reporting

In 2023, we published **128** annual reports:

Adult prisons
- 101 reports on male prisons
- 11 reports on female prisons

YOIs
- 4 YOI reports

Immigration detention
- 5 IRC reports
- 6 STHF reports
- 1 charter flight report

We published **three** national thematic monitoring reports and **one** national annual report:

- The impact of IPP sentences on prisoners' wellbeing
- Mental health concerns in women's prisons
- Safety and regime in the youth estate[8]
- Immigration Detention Estate National Annual Report 2022

Consultations

Throughout the year, we responded to a range of consultations run by human rights bodies, the Ministry of Justice, HM Prison and Probation Service, and the Home Office. This included: segregation, drug treatment, the safety of children and young people, women in prison and the immigration detention estate, welfare and family provision in immigration detention, and detained people's technology.

Parliament

IMBs also gave evidence to parliamentary select committees:

Written evidence
- Joint Committee on Human Rights, Human rights of asylum seekers in the UK inquiry (January 2023)
- Home Affairs Committee, Human trafficking inquiry (June 2023)
- Welsh Affairs Committee, Prisons in Wales inquiry (October 2023)
- Justice Committee, The future prison population and estate capacity inquiry (October 2023)

Oral evidence
- All Party Parliamentary Group (APPG) for Penal Affairs, The role of Independent Monitoring Boards (February 2023)
- Justice Committee, The prison operational workforce inquiry (March 2023)
- Justice Committee, The future prison population and estate capacity inquiry (November 2023)

IMB findings

1. Adult prisons

Key findings

- Population pressures and overcrowding caused tremendous strain on every area of prison life, which was compounded by widespread staff shortages.
- IMBs had widespread and serious safety concerns. Improvements were reported as needed to safeguard prisoners at risk of suicide and self-harm, reduce and manage violence and disorder and to prevent the ingress of illicit items.
- Poor physical conditions meant some prisoners were living in unacceptable conditions, sometimes without access to basic sanitation, which had serious consequences for hygiene and dignity. Some IMBs described living conditions as inhumane.
- Mental health services strained to meet the high level of mental health need, particularly in prisons holding women. IMBs continued to be concerned about lengthy delays in transfers from prison to secure hospitals.
- Time out of cell and purposeful activity remained significantly low despite modest improvements in some prisons over the course of the year. Staff shortages meant regimes were unexpectedly cancelled or curtailed.
- Prisoners could not always access progression opportunities such as behaviour programmes and transfers. IPP prisoners faced significant obstacles to progression.
- Resettlement work was inadequate, mostly due to probation staff shortages, and disadvantaged prisoners on release. Lack of accommodation was a particular concern, as too many prisoners were released homeless.

Population changes

As a result of estate-wide population pressures, Boards across the adult prison estate observed changes in the prisoners received. The Boards of local prisons noted that increased numbers of out-of-area prisoners were received, which in turn reduced the places available for local prisoners. This had a damaging effect on resettlement provision, which was more challenging for out-of-area prisoners. In some prisons, the influx of out-of-area prisoners resulted in an increase in organised crime group (OCG) members, whom staff were not used to working with.

The Prison Service's efforts to maximise space accelerated the move through the system for significant numbers of prisoners. Some Boards of category C training prisons, such as Stocken, reported that that the prison seemed to be receiving prisoners much earlier in their sentence than previously. Transfers to a higher security category (C to B, or D to C) could be difficult to achieve. At the same time, transfers to open prisons occurred more quickly. Boards such as Wealstun, that had previously been concerned about the time taken for prisoners to transfer to open prisons, reported that these concerns had been alleviated.

Significant disruption took place in the open estate as a result of the changing population. The pressure to move prisoners through the system as quickly as possible, and in particular the Temporary Presumptive Recategorisation Scheme (under which risk-assessed category C prisoners near the end of their sentence could be sent to an open prison), meant open prisons were holding a far less settled population. Boards reported considerable friction between new arrivals and existing populations, though this rarely resulted in fights or assaults, and new arrivals were frequently found to be unsuitable for open conditions and returned to closed prisons, often on a one-for-one basis.

1.1. Safety

Reception and induction processes were strained

For the many prisons that received high numbers of prisoners during the year, managing reception and induction could be challenging. Late arrivals were noted by many Boards, which could cause significant problems if healthcare staff had left for the day, or if there was no food readily available. Late arrivals were a particular concern of Boards in the women's estate, in part because women sometimes shared escort vehicles with men and in these instances were often the last to be dropped off, leading to women spending long periods in vans. Several Boards of women's prisons reported women arriving very late, sometimes not until the early hours of the morning.

Boards also observed prisoners being quickly moved out of induction units to make room for new arrivals, or else remaining on induction/first night units for considerably longer than intended until space was found for them on the wings.

Improvements needed to safeguard prisoners at risk of suicide and self-harm

Self-harm continued to be a major issue across the estate, particularly in reception prisons and the women's estate. Self-harm figures within each prison were often impacted by those who repeatedly harmed themselves.

While many IMBs described prison officers as compassionate and dedicated to supporting prisoners who were at risk of self-harming, some were not confident that officers were adequately equipped to safeguard these vulnerable prisoners. In particular, some Boards raised concerns about the documentation of the Assessment, Care in Custody and Teamwork (ACCT) process, which supports prisoners at risk of self-harm, not always being completed satisfactorily. At Dartmoor, the Board raised concerns about the quality of some of the ACCT reviews; as a result, the prison accepted that the quality of the ACCT process required improvement, particularly in relation to the lack of detail in the care plans.

Where ACCT documentation was of concern to Boards, it was usually attributed to: overstretched staff as a result of an excessive prisoner-staff ratio; the inexperience of some staff, which could lead to sparsely completed documents; or the difficulty of adapting to the updated ACCT guidance, which many staff found more burdensome to follow than the previous version.[9]

Self-harm was an especially acute concern throughout the women's estate, where the high level of mental health need frequently impacted on operation across whole prisons, as staff struggled to keep women safe. IMBs in the women's estate commented on the increased level of serious mental health issues among the cohort and questioned where this dramatic increase in complex need had originated.

Self-inflicted deaths (SIDs) were also a prominent concern throughout 2023. A number of Boards (Leeds, Liverpool, Lowdham Grange, Styal, Wandsworth, and Wymott) reported clusters of SIDs occurring over a short timeframe, with prisons requiring additional support from HMPPS. These prisons all experienced broader safety concerns – high levels of illicit items were noted by all Boards, and violence, staffing issues and strained care and separation units (CSUs) were also commonly reported.

Following the government's rejection of the Justice Select Committee's resentencing recommendation for prisoners serving Imprisonment for Public Protection (IPP) sentences in February 2023, there was a spike in self-inflicted deaths of IPP prisoners. Three apparently self-inflicted deaths of IPP prisoners were reported at Bristol, Coldingley, and Swaleside within four weeks of the announcement.

Violence and disorder linked to overcrowding

Though not universal, many Boards described increasingly volatile environments in the prisons they monitored, mostly due to overcrowded conditions and changes in the demographic of prisoners received. Overcrowded environments could lead to difficulties in keeping prisoners away from those they had conflict with; this was a particular problem in prisons with high OCG populations, such as Pentonville. Boards of category C training prisons, such as Buckley Hall, noted that the prisoners received tended to be younger and more disruptive than previously, which had a destabilising effect on a previously calm environment.

Cell-sharing arrangements were a key cause of concern for many Boards. Several noted an increase in fights and adjudications. Cell-sharing risk assessments were not always carried out appropriately, due to the pressure to move prisoners off induction wings in some establishments, or simply to double-up as many cells as possible. Dartmoor IMB heard from a vulnerable prisoner that they had been required to share with an aggressive prisoner, and Hewell IMB reported that 114 high-risk prisoners could not be accommodated in single cells at the end of its reporting year.

There were also reports of vulnerable prisoners being held on main location or in induction units long-term, and of mainstream prisoners being held on vulnerable prisoner units, leading to fears over the safety of vulnerable prisoners.

In women's prisons, the high rates of self-harm had been linked to the continuing high level of staff assaults, many of which occurred when staff had to physically intervene to prevent women from harming themselves.

Use of force varied

The use of force and its oversight and management varied considerably across prisons holding men and women.

Some IMBs reported increasing uses, such as at Durham and Coldingley – Coldingley IMB reported a significantly upward trend of almost 60% to the year ending July 2023. Increases often appeared to be linked to low staffing levels, frequent drug use and availability, and population changes.

Many IMBs reported improved oversight, with most prisons analysing trends and holding weekly meetings to discuss incidents. Risley IMB noted particularly good oversight of incidents involving vulnerable prisoners and incidents at Styal were scrutinised from a trauma informed perspective.

However, staff's use of body worn video cameras (BWVCs) was poor overall. Brixton, Low Newton and Rochester IMBs reported that staff did not turn on their BWVCs quickly enough when an incident began, with Brixton and Low Newton IMBs noting concerns that staff seemed reluctant to do so. Hewell IMB was also concerned that BWVCs were not being used enough.

Throughout 2023, IMBs raised concerns about unexplained trends between uses of force and prisoners' ethnicity and religion. Both Birmingham and Brixton IMBs reported concerns over use of force data, which showed a disproportionate use on black prisoners, and also, at Birmingham, mixed race prisoners. Coldingley IMB questioned HMPPS about the over-representation of Muslim prisoners in use of force incidents.

The prevalence of illicit items was an issue across all prisons

Illicit items were a key concern of many Boards, spanning all security categories. Drugs were the most prominent issue by a wide margin. A common theme was an apparent increase in the use of the synthetic cannabinoid Spice, and a resulting increase in erratic behaviour (sometimes including violence) and medical emergencies. In open prisons, substance misuse was the main driver behind returns to closed conditions.

1.2 Fair and humane treatment

Poor living conditions too often amounted to 'inhumane treatment'

Poor physical conditions continued to be a common concern across the estate, with serious and wide-ranging impacts on the quality of prisoners' lives. The postponement of maintenance deemed non-essential by HMPPS exacerbated pre-existing issues with the fabric of many prisons. As a result, some Boards judged that prisoners were being held in conditions that amounted to inhumane treatment.

An example of this is the lack of in-cell sanitation still seen at Coldingley, Isle of Wight, Grendon, Long Lartin and Bristol. This results in some prisoners resorting to buckets and 'slopping out', with serious consequences for hygiene and dignity. At

Coldingley, where a considerable number of cells lacked in-cell sanitation and the communal toilets were often unusable, the Board described the resultant conditions as ‘appalling’. At Long Lartin, the Board maintained that the lack of in-cell sanitation and the frequent failures of the Night-San system resulted in ‘inhumane treatment’, noting that prisoners only had bottled water to wash their hands.

Heating and ventilation were particularly common problems, with Boards reporting that prisoners were either facing extreme cold (often without adequate blankets, as at Nottingham), or heat (which Styal noted was especially challenging for menopausal women).

The physical environment was especially unfit for elderly or disabled prisoners, who were commonly accommodated in healthcare units, and in some cases in CSUs, due to a lack of appropriate accommodation elsewhere. As a result, these prisoners missed out on basic daily tasks (such as showering and making phone calls), purposeful activity and socialising. Dartmoor and Lancaster Farms IMBs reported instances of prisoners in shared cells sleeping on the floor as they could not climb onto the top bunk. Wheelchair users were poorly provided for; Long Lartin continued to receive these prisoners despite having no suitable cells, and at Stafford the poor conditions of the walkways gave rise to significant safety risks.

The conditions in Victorian prisons were particularly dire, exacerbated by the fact that many of these prisons have a reception function. The increased churn experienced by reception prisons made it more difficult to maintain cells to an acceptable standard. The age of these prisons made it difficult to keep buildings functional and decent – for example, Winchester IMB reported crumbling walls and roofs all over the prison, leading to leaks, flooding, and slip hazards.

However, accommodation issues were not restricted to Victorian prisons. Many Boards monitoring in more modern prisons also had serious concerns. At Woodhill, built in 1992, the showers were of an unacceptable standard and the concrete flooring in many cells was breaking up, making it impossible to clean. At Five Wells, built in 2022, the Board reported significant design faults that had yet to be corrected; these included poor airflow on landings, leading to uncomfortably hot temperatures in summer months, and low mobility cells which could not be occupied for safety reasons.

In some prisons, maintenance was delayed even when it gave rise to security concerns. At Pentonville, a window-replacement scheme deemed extremely important for escape prevention had to be halted because the prison was too crowded for the cells to be taken out of use. At Winchester, there were several occasions throughout the year where prisoners were able to damage and attempt to dig through cell walls, on one occasion through the wall to the landing, using simple implements such as plastic cutlery.

Food quality, quantity and choice was poor and impacted by rising costs

Prisoners frequently complained to IMBs about the lack of quality, quantity and choice of food. Prisoners often supplemented inadequate portion sizes with food meant for later meals or canteen food, although many IMBs reported that the rise in

canteen prices had not been matched with increases to prisoners' wages or their spending limit. Some prisoners who required special diets for health or religious reasons did not receive them. The timing of meals, particularly hot meals, was also a key concern, as prisoners sometimes either received meals at inappropriate times, or more than one of their daily meals at the same time.

Many prison kitchens had maintenance issues, with broken appliances limiting menus and repairs often being delayed. Some prisons also experienced issues with food suppliers or new contractors.

The segregation of prisoners with severe mental health needs continued

Care and separation units (CSUs) continued to be generally fraught environments, exacerbated by overcrowding and population pressures which caused additional crowding and churn in CSUs across the estate.

Several Boards, such as Winchester, reported that the CSUs were routinely full, with prisoners segregated in cellular confinement on the wings instead. At Buckley Hall, cellular confinement punishments were sometimes suspended due to a lack of space in the CSU, thus impacting on the prison's ability to maintain clear discipline.

The lack of space available on 'normal location' made it difficult to separate prisoners in conflict with one another (due to debt, for example) on different wings. As a result, prisoners were increasingly held in CSUs for their 'own protection' instead.

CSUs were too often filled with prisoners with severe mental health needs who were unable to be cared for on main location. These prisoners could spend extremely long periods in segregation – frequently over 100 days, and often longer – because prison and healthcare staff were unable to arrange for them to be moved to a more suitable location. A national shortage of secure hospitals caused delayed assessments for, and transfers to, these resources and HMPPS lacked the specialist units and in-patient facilities to care for these prisoners appropriately.[10]

Generally, IMBs found CSU staff to be dedicated, hard-working and compassionate. Although some Boards found them to be highly skilled in managing extremely challenging prisoners, there was consensus that these staff did not receive enough specific training or resources.

Staff shortages negatively affected relationships with prisoners

Staffing changes and shortages continued to have an adverse impact on staff-prisoner relationships at many prisons. Experienced officers were often stretched too thin to continue building strong relationships with prisoners, and new officers were often in training. Officers were also redeployed to other prisons on detached duty, where there was a lack of rapport with prisoners.

Where staffing was more robust and consistent, there were clear benefits to the stability of the prison.

Key work was almost non-existent in some prisons

Key work remained poor across the estate. This was consistently associated with staff shortages. Although there were signs of improvement, particularly in late 2023, all Boards reported that key work was not running as intended, and several Boards described it as almost non-existent. This was particularly concerning to Boards monitoring prisons with high levels of self-harm, such as Hewell, who saw this as a missed opportunity to support prisoners and reduce self-harm rates.

Lost and missing property remained a critical issue across the prison estate

Throughout 2023, IMBs nationally remained seriously concerned about property being lost or missing. The most problematic element was property on transfer. Property was especially likely to go missing if a prisoner left the sending prison with a higher volume of property than they were permitted to travel with, resulting in the property having to be forwarded on after their departure. Not only was property frequently lost, but the inefficiency of the paper tracking system also led to a lack of transparency and accountability.

The loss of property negatively impacted prisoners, who could lose important legal papers and highly sentimental items on transfer. Despite the significance to prisoners' wellbeing, Boards found that officers took an excessively long time to resolve complaints about property.

Local property rules were inconsistent – certain items were forbidden at some prisons and permitted at others. This included extremely valuable items, such as video game consoles. This caused considerable distress and frustration to prisoners, who felt it was unfair when they lost access to these items on transfer.

More focus was needed on equality and diversity work

Many IMBs reported a lack of equalities staff with dedicated resources. Often equalities posts were either left vacant, had insignificant budgets, or had high staff turnover, with many being redeployed to cover staff shortages elsewhere. Where this happened, the result was little activity to promote equal and fair treatment for groups of prisoners who share protected characteristics.

Shortcomings in the management of discrimination complaints (known as DIRFs) were found across men and women's prisons. IMBs reported on staff's slow response times to DIRFs, the inconsistent quality of investigations which were often carried out by staff without the relevant training, and prisoners' lack of confidence in the process. Overall, IMBs found that the DIRF process was better when the prison had external scrutiny, although Boards also reported that this had stopped in a small number of prisons. Allegations of unfair treatment or discrimination that were reported by prisoners, but not through DIRFs, were not always dealt with sensitively by staff.

The collection and analysis of prisoners' diversity data was inconsistent. In a few establishments, data on prisoners' protected characteristics was not systematically

recorded or reviewed, but in others staff thoroughly analysed diversity data and attempted to address any unexpected trends.

1.3 Health and wellbeing

Staffing shortages negatively impacted on prisoners' health

Healthcare staffing was a common concern of Boards, who frequently found staff to be overstretched. Many prisons found it difficult to recruit healthcare staff. Changes in healthcare contractors caused further disruption at other prisons. Some healthcare providers relied on agency staff to cover staff shortages which caused disruption, as these staff were less familiar with the workings of individual prisons.

Additionally, the demand for officer escorts to healthcare appointments placed a strain on understaffed prisons, particularly when escorts were required for external hospital appointments, or when officers were required to provide supervision while a prisoner received in-patient care at a community hospital (a 'bed-watch'). This demand was particularly acute at prisons with a high proportion of older prisoners, such as Haverigg, where the strain could be felt even when staffing levels were generally adequate.

A common concern of Boards was the difficulties prisons faced in managing medication. This was mostly linked to officer shortages (which could hamper the monitoring of queues at pharmacy hatches and make it difficult for staff to escort prisoners to collect their medicine in a timely manner), shortages of pharmaceutical staff, and poor communication between prison and healthcare staff. Styal IMB reported particularly serious problems with women receiving the right medication at the right time, which adversely affected the daily lives of these women, including their access to education and work.

Mental health services were strained

Levels of mental health need were high, particularly for women in prison. Mental health services were often understaffed and strained to meet demand. Inadequate mental health provision was a key concern across many prisons.

Women's high level of mental health need

In May 2023, the IMB published a report on mental health concerns in women's prisons. Women were being sent to prison solely on mental health grounds as a 'place of safety' under the Mental Health Act, or for their 'own protection' under the Bail Act. Additional findings included:

- Dramatic increases in the rate of self-harm in the women's estate.
- The shortage of places in inpatient and specialist facilities in women's prisons compared to the high level of need.
- Women with severe mental health needs being held in segregation, and the extreme length of time taken for women to be transferred to secure hospitals where they could be cared for appropriately.
- The strain that caring for the complex needs of many unwell women placed on the general operation of prisons, particularly where there were already staffing shortages.

Delays in transfer to secure hospitals continued to be a national issue

Prisoners with severe mental health needs who require care in a secure hospital should be transferred within 28 days.[11] Many IMBs monitoring in prisons across England have continually reported serious concerns that this timeline was not being met and found delays at referral, assessment, and transfer stage. Prisoners in serious need of dedicated mental health care, for whom prison was not an appropriate setting, faced extremely long waits for transfers.

Some prisoners still spent too long in their cells with unpredictable regimes

Despite a general improvement across the estate compared to the previous year, time out of cell remained too low at the majority of prisons, especially at evenings and on weekends. Several Boards, particularly in local prisons, highlighted that prisoners not engaged in purposeful activity could spend 22 hours or more behind cell doors as a matter of course.

Regimes were unexpectedly cancelled or curtailed. Severely restricted regimes were particularly common for vulnerable prisoners and those self-isolating or segregated on wings.

The lack of regime and time out of cell was mostly due to staff shortages, competing priorities, or managing violence and safety issues. IMBs noted regime cancellations were because of staff training, high levels of staff sickness, or officers being redeployed from their core duties in response to emerging issues (for example, to provide hospital escorts or to assist with particularly complex prisoners).

Woodhill IMB reported that prisoners spent more time in cell due to high levels of violence and Pentonville IMB noted that the pressure of managing 'keep-aparts' (keeping prisoners in conflict with each other apart through different regimes) disrupted the whole prison's regime.

The unpredictability of the regime took a heavy toll on prisoners – some Boards linked the frustration caused by regime cancellations with disruptive behaviour, as at Wormwood Scrubs, or a heightened risk of self-harm, as at Doncaster.

1.4 Progression and resettlement

Purposeful activity remained significantly low

As with time out of cell, although the provision of vocational training and education improved over the year, it was too often hindered by staffing issues. Education and training staff shortages were common and these areas were difficult to recruit to. Officer shortages could also impact on provision, with wing lockdowns or insufficient numbers of officers available to escort prisoners from their cells leading to cancellations and missed sessions.

To improve the activities offered, prisons commonly ran work and education on a part-time basis. IMBs generally found this preferable to the significant proportion of prisoners going without any purposeful activity. However, Boards reported concerns that data regarding part-time education/work masked the reality of how many prisoners had nothing to do: for example, at Dartmoor the majority of prisoners had accessed purposeful activity, but only 41% were engaged in activity at any one point during the working day.

Prisoners could not always access progression opportunities

Boards reported widespread obstacles to progression. Many Boards highlighted the difficulties prisoners faced in obtaining progressive transfers, with High Down IMB describing the ‘frustration and hopelessness’ these prisoners felt.

Prisoners frequently struggled to access the offending behaviour programmes they needed to complete in order to progress, and were unable to transfer to prisons which offered these programmes, potentially prolonging their time spent in custody.

While some Boards reported that population pressures had sped up progression through the estate for some, and particularly for those prisoners who were transferred to the open estate under TPRS, this ‘rushing through’ brought its own challenges. A key concern of category D Boards was that TPRS prisoners were transferred so close to the end of their sentences, they were not eligible for many rehabilitative opportunities offered by open prisons, and staff were often left scrambling to draw together a release plan in time. Thorn Cross IMB commented that finding meaningful rehabilitative work for these prisoners was virtually impossible.

Compounding these problems was the shortage of staff in many offender management units (OMUs). This gave rise to issues such as backlogs of offender assessment system assessments (OASys) and delays in signing off releases on temporary licence (ROTL), which allow prisoners to leave the prison to access outside work or family contact in preparation for successful release.

Obstacles to progression for prisoners serving Imprisonment for Public Protection (IPP) sentences

In May 2023, the IMB published a briefing on the impact of IPP sentences on prisoners' wellbeing. The findings highlighted that IPP prisoners faced particularly significant obstacles to progression and release, including:

- Difficulties accessing courses required in their sentence plans – a large proportion of IPP prisoners were held in prisons which didn't offer the courses they needed.
- Challenges obtaining transfers to open conditions; even prisoners who had completed all the courses on their sentence plan could find it impossible to progress.
- Shortfalls in preparation for parole hearings, which exacerbated the difficulty IPP prisoners had in demonstrating reduced risk due to the factors listed above.
- Limited preparation for life in the community upon release, with some IMBs expressing concern that failures in 'through the gate' and resettlement services may have led to recalls.

Resettlement work was inadequate and disadvantaged prisoners on release

Probation staff shortages severely hampered resettlement efforts in most of the closed estate. Some prisoners found it extremely difficult to get any meaningful contact with their external probation officers (community offender managers), leaving them uncertain and anxious in the run up to their release.

Prisoners released directly from local or training prisons faced particular disadvantages, as these prisons were not adequately funded or equipped for resettlement work. Boards expressed concern that prisoners continued to be released from these prisons rather than being transferred to prisons with a resettlement focus beforehand.

Prisoners being released homeless, which was especially common for remand prisoners, was a serious concern for many Boards. Pentonville, Hewell and Winchester all reported rates of men released without accommodation of 40-50%. Hewell IMB reported that prison staff felt it necessary to equip men who were being released homeless with warm clothing. The women's estate faced similar challenges, mostly due to shortages of probation staff and the difficulties around liaison between a complex network of agencies. At Bronzefield, a survey carried out by the IMB in February/March 2023 showed that only 28% of women were released to sustainable accommodation, and 31% were released homeless.

2. Young offender institutions (YOIs)

Urgent action needed to improve conditions in YOIs across England

In June 2023, the IMB National Chair wrote to the then Prisons Minister on behalf of IMBs monitoring in YOIs across England. The letter highlighted IMBs' serious concerns regarding the poor regime and unsafe conditions, endemic in all YOIs.

IMBs were particularly concerned that:

- Many children and young people experienced very little time out of their room and those separated could spend over 23 hours a day in their rooms. Children and young people also experienced a limited and unpredictable regime, and a lack of education and other purposeful activity.
- Efforts to manage levels of violence, poor behaviour, assaults and weapon carrying resulted in a large number of 'keep-aparts' and increased use of separation.
- In some establishments there were shortfalls in care and support for an increasing cohort of children and young people with complex needs.
- Staff faced workplace-related stress, sickness and low morale, which exacerbated existing staffing shortages and compounded the lack of regime.

In contrast, at Parc young person's unit (YPU), a smaller unit based in Wales, the IMB reported good time out of room, low levels of violence, good availability of enrichment activities, and positive staff-child relationships despite low staffing levels.

In the latter half of the year, the concerns of IMBs monitoring at YOIs in England remained largely unchanged. Although modest improvements were noted, most Boards continued to observe acute shortfalls in safety and regime, particularly in time out of room.

Population changes

All YOI IMBs were concerned about the number of over 18-year-olds in the establishments they monitored, who were held in the youth estate to alleviate pressure in the adult prison estate. Over 18s made up a significant portion of the population in each YOI – generally over 30%. Despite this, Boards reported a lack of specific education, training, or activity for this group. Over-18s complained of boredom and a lack of direction as a result. YOI IMBs in England raised concerns over the high number of over-18s which, in their view, contributed to a lack of stability in establishments and risked the safety of younger boys.

2.1. Safety

Levels of violence and weapon carrying were too high

Violence and weapons were still central concerns of English Boards, particularly at Cookham Wood, Werrington and Wetherby. Cookham Wood and Feltham IMBs both commented that a small number of boys were responsible for most of the violence. Children commonly carried weapons because they felt unsafe, and at Werrington increased numbers of boys were self-isolating due to concerns for their safety.

Cookham Wood IMB specifically linked the level of violence to frustration at the inconsistency of the regime. The Board criticised the prison's overreliance on keep-aparts, which were counterproductive to encouraging positive relationships between boys and led to boys feeling unsafe and expecting violence. At any time during the 2022-23 reporting year, there were around 600 keep-apart directions at Cookham Wood, for an average total population of only around 80 boys. Some boys could have as many as 25 keep-apart directions each.

Although Feltham IMB welcomed the reduction in assaults from the late summer onwards, it remained concerned about the frequency of serious incidents involving larger groups of boys.

Vulnerable girls had high levels of self-harm

Self-harm was an especially prominent issue at Wetherby, in part because this was the only YOI in which girls were held. Girls self-harmed repeatedly, with staff often resorting to using force in an attempt to keep them safe. The Board once again raised concern that Wetherby was not a suitable place to meet the extremely complex needs of these girls who posed considerable challenges due to their volatile behaviour.

2.2. Fair and humane treatment

Delayed maintenance meant some children lived in poor conditions

Accommodation was a mixed picture. Although it was generally less problematic than in the adult estate, YOIs experienced similar issues regarding delayed maintenance.

For most of 2023, Wetherby noted poor conditions in the wing for new arrivals and boys on restricted status, with mouldy showers and rooms in poor repair. At Cookham Wood, ongoing delays to maintenance works meant one wing was shut down for months and the resettlement unit could only accommodate half the number of boys it was designed for. At Feltham, the roofing project scheduled for July 2023 had not been carried out and there were significant problems with leaks.

Staff-child relationships varied across YOIs

Boards continued to emphasise the importance positive relationships between staff and children had on children's wellbeing and rehabilitation. At Parc YPU, where

relationships were consistently good and a child-centred approach was prioritised, the Board reported a far more stable and productive environment than found at other YOIs. Wetherby and Feltham IMBs also reported more positively. Feltham IMB drew particular attention to the correlation with staffing levels, as relationships between staff and boys worsened when staff were overstretched and improved with increased staffing numbers.

However, Werrington IMB described a general lack of rapport and of meaningful relationships between staff and boys, and Cookham Wood IMB noted that despite staff's desire to form strong relationships with the boys in their care, staffing shortages and demanding workloads made this extremely difficult. Both Werrington and Cookham Wood IMBs reported witnessing staff talking to boys through locked doors; at Cookham Wood, this was due to a lack of sufficient staffing levels to unlock doors.

Custody Support Plans (CuSP) were not common at any YOI in England, with roll-out being restricted to the most vulnerable. Boards felt this wasted opportunities to forge stronger and more trusting relationships between staff and children. Comparatively, the Board at Parc YPU noted that CuSP sessions were prioritised, which likely contributed to the positive staff-child relationships.

2.3 Health and wellbeing

Physical and mental healthcare services were positive but access was challenging

Physical healthcare and mental healthcare services were generally reported on positively by Boards, and were seen as equivalent to or better than what could be expected for children in the community. However, YOI IMBs in England raised concerns over staff not always being able to access boys for substance misuse and mental health interventions. This was most commonly due to shortage of escorting officers or lack of suitable rooms, which was frustrating and demoralising for the boys.

Shortfalls in enhanced care for children with complex mental health needs

All Boards acknowledged the disproportionately high level of mental health need and trauma in YOIs compared with children in the community. At some YOIs the number of children with mental health needs continued to increase.

Many children required additional support which was not always provided. Feltham IMB had concerns about the use of the enhanced support unit as a national resource, which received children from other establishments with inadequate prior consultation, and no apparent consideration of how children on the unit would interact with others. The unit closed in 2023 due to damage caused by children. Other additional support units at Wetherby and Werrington lacked a clear purpose: Wetherby IMB found that the Keppel unit (which provides enhanced support for children with specific vulnerabilities) had experienced 'unprecedented' pressure. The other units providing enhanced support also struggled to reintegrate children back into a normal regime. At Werrington the purpose of the Wade unit was unclear. At

Cookham Wood, the Phoenix daycare unit for boys with complex needs had positive results but was frequently closed at short notice due to staffing shortages.

Children spent too long in their rooms with a poor regime

Time out of room remained a serious concern for Boards. While it remained good at Parc, and Feltham had significant improvements towards the end of 2023 alongside the increase in staff, other Boards continued to report poor performance.

Cookham Wood IMB reported that overall, despite a brief improvement during 2023, the regime had worsened since the previous reporting year and was now 'inhumane' for many boys. While Wetherby and Werrington reported improvements, children and young people still received far too little time out of room, particularly on the weekends.

IMBs monitoring at YOIs across England commented on the high number of separated children and young people, including those who were choosing to self-separate due to fears for their safety. Cookham Wood IMB highlighted serious concerns about the low time out of room for separated boys, who regularly received less than two hours a day.

2.4 Education and training

Education was insufficient mostly due to teacher shortages

Education was insufficient across the YOI estate and children continued to receive fewer hours and less choice than those in the community. Wetherby IMB reported that provision was still poor because of both classes being cancelled and regimes being restricted. At Cookham Wood, the recruitment of teachers remained problematic, and a shortage of officers resulted in the inability to escort children to and from education or monitor the safety of education corridors. This resulted in poor quantity and quality of education. Education delivery at Parc was challenging for much of the year following the change of provider and teacher shortages, though it improved by the end of 2023.

Vocational training was generally much better received, being popular with children and young people when available, though both Wetherby and Cookham Wood IMBs found the number of places was far less than the demand required.

2.5 Progression towards transfer or release

Remanded children faced long waits for trial and inconsistent support

YOI IMBs reported on the high proportion of children being held on remand (approximately half of the YOI population) and the extended periods of time these children spent in custody. For example, one young person who was almost 19 spent 15 months on remand at Cookham Wood. Feltham IMB highlighted the particular challenges these young people faced after turning 18, as they were no longer supported by their Youth Offending Team but could not receive support from the

Probation Service as they had not yet been sentenced. This gap in provision was not remedied until early 2024.

Shortfalls in release planning led to last-minute accommodation arrangements

Cookham Wood, Feltham and Wetherby IMBs all noted that some children did not have their accommodation finalised until very shortly before their release, causing considerable uncertainty and distress. At Cookham Wood and Wetherby, boys who could not live with their parents upon release could wait up until the day before their release to receive a confirmed address. This meant any other support (such as college or work placements) became impossible to arrange.

3. Immigration detention

Key findings

- The number of people entering the immigration detention estate increased throughout the year, contributed to by an increase in time-served foreign national offenders.
- Detained people were held for long periods without any realistic prospect of removal.
- Too many people remained detained, some for many months, after their release or bail had been authorised.
- Detained people were held in inappropriate places – such as controlled waiting areas, escort vehicles and police stations – for too long, partially due to Border Force staffing shortages and the distances of airports used for removal flights.
- It was commonplace for people detained in STHFs to be held beyond the statutory 24-hour time limit and this has increased since 2022.
- Vulnerable people were being placed at risk of harm by being detained. Overall, the processes intended to prevent vulnerable people from entering detention, and safeguard them in detention, were ineffective.
- While immigration detention was generally safe, serious incidents, disorder, violence and security breaches were at a high level; the use of separation increased; and the number of people at risk of suicide or self-harm in detention increased.
- People's basic needs – such as food, mattresses and medication in detention and prompt access to toilets on charter flights – were not always met.
- The health and wellbeing of detained people was adversely affected by their lack of timely access to hospital appointments and prescription medication.
- Interpreters and translation services, essential for detained people to understand the immigration process, were not consistently used or offered in IRCs, STHFs, or on charter flights.
- Lack of communication and engagement from the Home Office on how their immigration cases were progressing created frustration and distress among detained people.

Population changes

The number of people in immigration detention was 54% higher on 31 December 2023 than the same date in 2022.[12] In July, the total population at Yarl's Wood was 85% of the operational capacity of the centre, and at Brook House it was 75%. A significant contributing factor to this was the increase in the proportion of time-served foreign national offenders (TSFNOs) released from prisons into IRCs as part of 'Operation Safeguard'.[13]

As populations increased, already strained staff and services were further limited in facilitating regimes, keeping facilities open, delivering healthcare support and delivering case progression.

With no statutory time limit on immigration detention, Boards also observed an overall increase in the time that people spent detained in IRCs compared to 2022.[14] By summer 2023, the average length of detention was 20 weeks at Gatwick and the longest stay was 13 months (57 weeks). During the same period at Yarl's Wood, the average length of detention was 51 days. Heathrow IMB regularly observed detentions of over three months and reported that the indefinite nature of detention was a consistent cause of frustration and anxiety for detained people.

Length and places of detention

People detained in STHFs were often held beyond the statutory time limit

The statutory time limit for detention in an STHF is 24 hours, although this may be extended with authorisation of the Secretary of State.[15] However, throughout 2023, IMBs found that people detained in STHFs were frequently held for longer than 24 hours.

North West and Midlands STHF IMB found that there was an increase in the number of people detained for periods that exceeded 24 hours at Manchester and Birmingham Airports. This included two minors held for over 50 hours at Manchester Airport while accommodation was sought. Similarly, South and East STHF IMB found that the number of people detained for up to and over 48 hours in airport holding rooms had increased.

IMBs consistently found that lengthy delays due to processing procedures and issues with Clearsprings (the Government provider responsible for organising transfers between detention facilities and asylum accommodation) led asylum seekers to be held in holding rooms for extended periods awaiting collection and transfer. IMBs questioned the Home Office on casework processes and contractual expectations for Clearsprings, given that these consistent delays led to the 24-hour time limit being exceeded.

People remained detained in IRCs even after their release had been authorised

Throughout 2023, too many people remained detained across the IRC estate after their release or bail had been authorised, some for many months. This was mostly due to considerable delays in securing or approving accommodation.

Both Yarl's Wood and Heathrow IMBs found that release was regularly delayed because the necessary address checks were not being carried out by the Probation Service, or there was a lack of suitable accommodation. One man was detained at Brook House IRC for an additional seven months after he was granted bail, as six bail addresses he provided were rejected with no explanation why. At one IRC, a woman with complex needs remained detained for seven months after her release was authorised while awaiting social services support.

This was also the case for detained people who the Home Office agreed were vulnerable. At one IRC, a man had been detained for a further 16 weeks after being categorised as an ‘adult at risk’, due to not securing approved accommodation. This was despite a Rule 35 report (in which an IRC doctor reported concerns about his vulnerability to the Home Office) having been submitted, and the Home Office having recognised that continued detention would injuriously affect his health 32 weeks prior.

These delays, and the consequent additional time spent in detention unnecessarily, had a negative impact on the wellbeing of detained people. Gatwick IMB found these delays resulted in significant distress and self-harm attempts. At Brook House, a frustrated man climbed onto the wing netting for five hours in protest. The Home Office was unable to provide data to the IMB on the number of people that were affected by these issues. Staff at one IRC told the local IMB that the number of people detained while awaiting bail accommodation had reached ‘a critical point’.

Detained people were held in inappropriate places for too long

Throughout the year, IMBs found that too many detained people were held in inappropriate settings for too long, such as controlled waiting areas, escort vehicles and police stations.

IMBs monitoring at STHFs found that due to a variety of reasons including insufficient numbers of Border Force staff, many people, including minors, were held in controlled waiting areas (CWAs) for longer than two hours. CWAs are typically open seated areas next to passport control.[16] Those held in CWAs were unable to access the extra facilities available in holding rooms, and the lack of privacy from being held in a public area impacted on detained people’s dignity.

IMBs monitoring across the immigration detention estate found that detained people, including vulnerable individuals, were sometimes transferred from STHFs to police stations for overnight stays. IMBs noted that police stations should only be used to detain people under immigration powers as a last resort and for the shortest possible time. The North East Midlands, Yorkshire and Humber IMB found that an individual was detained at a police station for almost three days prior to their removal, rather than being transferred to a residential STHF. Data provided to the IMB indicated that there had been seven such uses of police stations between February and September 2023.

Ahead of charter flights, people were frequently subjected to long periods of vehicle confinement. This was partly because of the distances some people were required to travel to airports, always during the night. Charter Flight Monitoring Team (CFMT) members found that it was commonplace for journeys to take over five hours; some faced an additional three-hour wait on arrival at the airport. CFMT made suggestions to the Home Office on how to reduce the total number of hours people spent confined in parked vehicles inside their IRCs.

3.1. Safety

Vulnerable people were at risk of being harmed by immigration detention

There is a clear presumption in Home Office guidance that detention is not appropriate if a person is considered to be vulnerable, as this places them 'at risk' of being harmed by detention. An adult may be at risk if they are suffering from a serious physical or mental health condition, have experienced a traumatic event (such as trafficking, torture, or sexual violence), are aged 70 or over, or have transitioned, or are transitioning, from one gender to another.[17]

As such, those who are particularly vulnerable should only be detained if immigration control considerations outweigh the presumption of release from detention.

The Home Office 'Adults at Risk' policy explains that due to the intended short nature of detentions at port holding rooms, their use is likely to remain appropriate but that this should be reviewed in line with the individual's risk. However, according to IMB findings vulnerable people were too often detained in residential STHFs, and the number of vulnerable people detained in IRCs increased. Throughout 2023, IMBs consistently raised concerns about this issue to the Home Office.

Mechanisms to prevent the detention of vulnerable people were failing

This also led to concerns about the effectiveness of mechanisms intended to prevent vulnerable people from being detained, such as the role of the Detention Gatekeeper.[18]

IMBs monitoring at IRCs have reported concerns regarding the Detention Gatekeeper's failure to prevent the detention of especially vulnerable people. In April, Boards collectively questioned the Home Office over the quality of screening being completed by the Detention Gatekeeper. IMBs monitoring at three different IRCs were particularly concerned about:

- A man who had poor mental health and had been previously sectioned under the Mental Health Act but was approved for detention by the Detention Gatekeeper. He was held for months in the separation unit while awaiting transfer to a psychiatric unit, having been considered not well enough to return to the regular units. The Board raised concerns after observing that he hadn't washed, appeared to have lost weight and seemed disorientated.
- A trans woman remained in detention for 22 days even though a Home Office assessment at the outset of her detention had confirmed that she was at risk of harm. She was eventually transferred to hospital. The Board questioned the decision by the Detention Gatekeeper to allow her detention her in the first place.
- A man was eventually sectioned under the Mental Health Act following months of deteriorating health while detained. Having been approved by the Detention Gatekeeper, Home Office staff then confirmed that he was not fit for detention.

IRCs did not have the appropriate healthcare facilities to care for these vulnerable people. Although Boards found that staff attempted to manage those with complex needs, they generally lacked the training or resources to do so.

Processes to safeguard vulnerable people once detained were also ineffective

The Detention Centre Rule 35 process is designed to act as a safeguard for people in detention who are particularly vulnerable due to their health, risk of suicidal intention, or have been a victim of torture.

IMBs found that the Rule 35 process was largely ineffective, as vulnerable people weren't being identified quickly enough, and waited too long for an assessment once they had been identified. In mid-2023, two IMBs reported that there was a two- to three-week wait for an assessment. By the end of the year, three IMBs found that wait times had increased to a month. Gatwick IMB, monitoring at Brook House and Tinsley House IRCs, reported that the healthcare contractor had not taken appropriate action to improve wait times.

After a Rule 35 assessment has been completed, the assessing doctor provides a report of findings to the Home Office. The Home Office is required to respond within two days, confirming the outcome of the review of the individual's detention (including whether the individual will be released or have their detention maintained).[19] Despite this clear timeframe, IMBs found that responses were regularly delayed with, on occasion, people waiting two months for confirmation as to whether they were considered too vulnerable to be detained.

Processes to identify vulnerability in STHFs were inadequate

IMBs monitoring at some Residential Short-term Holding Facilities (RSTHFs), where people can be detained for up to seven days, were concerned by the lack of privacy during reception interviews where vulnerability and risk factors were identified. For example, Swinderby RSTHF IMB have been continually concerned about reception interviews being conducted in an open reception area that is only partially screened from other arrivals. The person being interviewed is standing and the interviewing staff member is behind a hatch. The Board was concerned that given the sensitive nature of many of the questions, this could affect a person's willingness to reveal information and therefore the success of risk, safety and exploitation factors being identified. The Board noted that although new arrivals may be offered a private room, they will likely not be made aware of or understand the nature of the interview and the benefit of privacy. As such, they called for all such interviews to be held in private as standard.

Removal processes for vulnerable people were concerning

The removal of people identified as particularly vulnerable was monitored by the CFMT. Known vulnerability is not a barrier to removal and care plans should be created for people considered to be at risk.

The CFMT was concerned about the removal of one individual who was collected directly from a secure psychiatric unit. The CFMT requested information regarding

how their removal directions were served, the timing of the collection, the escorts' level of engagement with the individual during the road journey to the airport, and how long they had to wait before boarding the plane. The removal occurred during the summer months and the CFMT continue to seek reassurance over concerns raised regarding the capacity of this particularly vulnerable person to understand what was happening to them.

Suicide and self-harm in detention increased

IMBs monitored the support provided to detained people who were identified as at risk of suicide and self-harm. This included those being managed through an assessment, care in detention and teamwork (ACDT) plan, designed to reduce the distress of those in detention and mitigate against the risk of self-harm or suicide.

Gatwick IMB found that the overall level of self-harm incidents increased throughout the year. The Board also found that the percentage of the population that was placed on an ACDT increased during the first quarter of the year. By October, the Board reported that acts of self-harm had become more frequent, at approximately twice the level of incidents than in July. Yarl's Wood IMB also found that many detained people were threatening self-harm and suicide attempts, including ligatures, and were only prevented from harming themselves through staff intervention.

Throughout 2023, IMBs were concerned by the number of 'serious incidents' involving attempts to self-harm.[20] An IMB at an IRC holding men reported an incident at height in which a man threatened to seriously harm himself with a blade. Heathrow IMB reported on the apparently self-inflicted death (SID) of a man detained in Colnbrook IRC; two days later a number of men attempted to self-harm with ligatures and some of them tried to get onto the netting. There were further incidents throughout the summer, which included men jumping onto the netting with broken glass, threatening to swallow razor blades and batteries and a man who, once inside, set his barricaded room on fire. In November, there was an apparent SID at Brook House IRC.

Deaths in immigration detention have been rare in previous years. IRC IMBs were deeply troubled by the occurrence of two apparent SIDs in one year across the estate.

The use of separation increased

The Detention Centre Rules outline that a detained person may be removed from association for a maximum period of 14 days, if necessary for security or safety (Rule 40).[21] Confinement in CSUs cannot be used as a punishment but can be ordered if a detained person's behaviour is unmanageable or violent (Rule 42).[22]

IMBs monitoring at IRCs found that there were a higher number of CSU confinements during 2023. At Brook House IRC, there was only one three-day period between June and October during which no detained people were separated under Rule 40. Heathrow IMB found that the CSU was often full and by October, a unit in Colnbrook had to be used for overflow.

IMBs questioned the justification for separation in some circumstances. For example, Brook House IMB was concerned that removal from association was used in cases where detained men refused to share rooms, as the increasing population necessitated doubling-up. At Yarl's Wood, the IMB found that many vulnerable people spent periods confined in the CSU. One IMB found that separation was used well beyond the 14-day maximum period, to manage the care of one very vulnerable person for 39 days while they waited to be transferred to hospital.[23]

Serious incidents, disorder, violence and security breaches increased

While levels of violence were generally low across IRCs, during 2023, disorder, violence, or safety and security breaches occurred at every male IRC in England.

At Yarl's Wood, there were four serious incidents between April-July 2023, which included detained men climbing on the roof and fencing, and thirteen men escaping. In October, the IMB reported that a non-serious incident occurred after what the IMB understands began as a peaceful protest in response to the cancellation at short notice of a Detention Engagement Team (DET) surgery, organised to provide legal and casework advice. The Board felt that this could have been entirely prevented if staff had communicated better with detained people. Heathrow and Gatwick IMBs also reported that delays in case progression contributed to some serious incidents and protests in the same period.

Heathrow IMB reported that in the immediate aftermath of an apparent SID, there was an increase in the already significant levels of stress and anxiety, culminating in a period of concerted indiscipline. The IMB National Chair wrote to the Home Office to relay the Board's observations and concerns about the treatment and safety of detained people during this period. The Board questioned the decision not to provide medication as usual unless critical. On one unit, it was decided that no food or water would be made available until all detained people were locked in their rooms. This was only provided after approximately seven hours, and affected all those on the unit, including those who had been compliant throughout.

Heathrow IMB reported that there was a marked rise in assaults on both detained people and staff, with some cases requiring hospitalisation. Detained people at Harmondsworth and Colnbrook IRCs were consequently subjected to lockdown on residential units which, in turn, increased frustration levels. The Board reported that assault victims were too frightened to identify perpetrators. Concerns regarding the safety of people detained at Harmondsworth and Colnbrook led the IMB to write to the Director of Detention Services in October 2023. The Board cited that inadequate staffing levels were contributing to an increasingly unsafe picture at Heathrow.

Use of force varied

Levels of use of force and how these incidents were recorded varied across IRCs. For instance, Yarl's Wood IMB found that during the second quarter of the year, incidents averaged five a month. By comparison, Gatwick IMB reported that there had been 81 use of force incidents during the same period at Brook House, averaging 27 cases a month. Considering that both centres have similar operational capacities, albeit differing populations, the variation in number raised concerns

regarding the consistency in which force was applied against detained people, and whether incidents were being properly recorded.

Gatwick IMB questioned the rise in violence and use of force at Brook House. In response, Home Office staff suggested that this may have been due to an increase in the number of Albanian men detained at the centre. Concerned by this response, the Board analysed use of force data. There was no evidence that Albanian men were more likely to have force used on them, nor were they more likely to be violent. The Board questioned staff's perception of this group and management's understanding of the rise.

Throughout 2023, the CFMT questioned the justification of the use of waist restraint belts (WRBs) during charter flights. CFMT members found that records about the use of WRBs were unreliable in terms of both the duration of use and the positioning of the belt. The CFMT also questioned the general position of escorts to continue using WRBs until after seat belt signs were off and, on one occasion, were concerned that a WRB had been used for over eight hours.

3.2. Fair and humane treatment

Detained people's basic needs were not always met at holding rooms or on charter flights

IMBs expect detained people to have their basic needs met in a way that respects their dignity. IMBs had concerns about the lack of heated food and satisfactory arrangements for sleeping at holding rooms, and prompt toilet access on charter flights.

In January, STHF Boards reported that mattresses had been removed from most holding rooms, having been deemed fire hazards, and had not been replaced. STHFs had still not received enough replacements to meet demand by the end of 2023. This meant that significant numbers of people held overnight were left to sleep on the floor, or on hard plastic chairs.

In July, STHF Boards across the estate reported that to meet longstanding Local Authority requirements, Border Force had withdrawn hot food in the facilities they managed (approximately half of the STHFs across the UK). For the remainder of 2023, people detained in Border Force managed STHFs could only be provided with hot drinks and cold snacks. IMBs considered these arrangements to be severely restrictive for anyone being detained for more than a few hours and remained unresolved by the end of 2023.

In two-thirds of the flights observed by the CFMT, removals were conducted using single-aisle aircrafts which were congested. On some occasions, IMB members monitoring removals observed people having to wait an hour after requesting to be escorted to the toilet, due to difficulties associated with moving around single-aisle planes.

3.3. Health and wellbeing

Detained people's health was adversely affected by their lack of timely access to hospital appointments and prescription medication

At times, the health and wellbeing of detained people in IRCs was negatively impacted by staff shortages, as escort staff for necessary hospital visits for detained people could not be facilitated. On one occasion, the GP reported to Heathrow IRC IMB that they had to 'beg' the centre's contract provider to prioritise facilitating hospital visits. The Board raised its concerns over the impact low staffing levels was having on the health of detained people with senior Home Office officials in October 2023.

At one IRC, a man in severe pain was taken to hospital following an injury. After being discharged with an instruction to return for a scan the next day, he missed two appointments due to the lack of available staff for escorts. He was not taken to hospital until the third day by which time the diagnosis was so severe that he needed to have an organ removed. While an earlier appointment would not have prevented this, the man had to spend two days in severe pain and discomfort.

In non-residential STHFs, Home Office policy requires that all medication, including prescribed medication, must be removed from those detained. Detention Custody Officers (DCOs) are not authorised to dispense medication even when a detained person requires a regular dose at a specified time. Most STHFs have no specific provision for healthcare. At those facilities without healthcare provision, if a detained person requires their medication, staff must first obtain medical input and advice via NHS phone services, paramedics or other emergency service facilities. IMBs have found that this process has resulted in detained people being unable to take their prescribed medication, leaving them at risk of medical deterioration.

IMBs first raised concerns about detained people's lack of access to prescription medication as far back as 2017, but it remains unresolved. Boards continued to raise concerns with the Home Office in 2023. IMBs noted that there had been no risk assessment to determine the risks posed by the current arrangement, which could have potentially fatal consequences.

In October, the IMB National Chair wrote to the Chief Pharmaceutical Officer for England, to note the denial of prescription medication as a patient safety issue related to prescribed medication.

3.4. Preparation for return or release

Issues with case progression created frustration and distress

Insufficient communication and engagement from Home Office staff in regard to how detained people's immigration cases were progressing led to frustration and distress. Throughout 2023, detained people in IRCs frequently expressed this frustration to IMBs. Gatwick IMB reported that this frustration led to acts of self-harm in some cases and resulted in a period of unrest at Brook House.

Brook House IMB called for the resumption of on-wing ‘surgeries’ with Home Office DETs to improve detained people’s understanding of their case progression. However, surgeries remained suspended for much of 2023 due to staff shortages. The Board reported that DET staff seemed fearful of working on residential units and surgeries did not resume until late November, running twice a week for the final six weeks of the year.

The IMB at Heathrow also reported on insufficient DET staff. In July, only a third of DET positions were filled and by October officers were refusing to enter the centre unless they were in pairs, due to safety concerns. The Board reported that this significantly delayed the provision of information to detained people, with one man refusing food for over a month apparently due to poor Home Office conduct relating to his case.

Poor mobile phone reception at Brook House, Derwentside and Yarl’s Wood also meant detained people did not have reliable access to their solicitors, which had become more essential as face-to-face legal consultations were less frequent.

Inconsistent use of interpreters and translation services

IMBs found that interpreters and translation services were not consistently used or offered in IRCs, STHFs or on charter flights.

For example, the IMB monitoring London STHFs found that interpreter services were unavailable for substantial portions of the year and used inconsistently during induction interviews. The lack of interpreters across STHFs meant that detained people may not have understood key questions asked of them intended to identify risk factors and vulnerability.

Similarly, too often on charter flights there were not enough interpreters present during the collection of individuals from detention centres. The CFMT was concerned that individuals for whom English was not their first language may not have understood what was happening, or been able to ask questions or raise concerns about the removal process. Comprehension was not tested.

Information sharing was lacking and records were incomplete

In January, Gatwick IMB found that Home Office records, including information on convictions and results of appeal hearings, were incomplete and out-dated.

The IMB monitoring the detention of asylum seekers detained on the Kent coast observed a lack of information provided, with many people left confused about what would happen to them next.

The CFMT reported that information on the Facilitated Returns Scheme (FRS), a grant scheme for people who have served a custodial sentence and comply with voluntary removal, was not routinely cascaded to escorts.[24] The IMB found that removed people were often left anxious about the FRS, asking escorts questions they were unable to answer. The FRS was the subject of a significant proportion of

complaints made and the CFMT felt that more could have been done to provide information regarding the FRS process to those being removed.

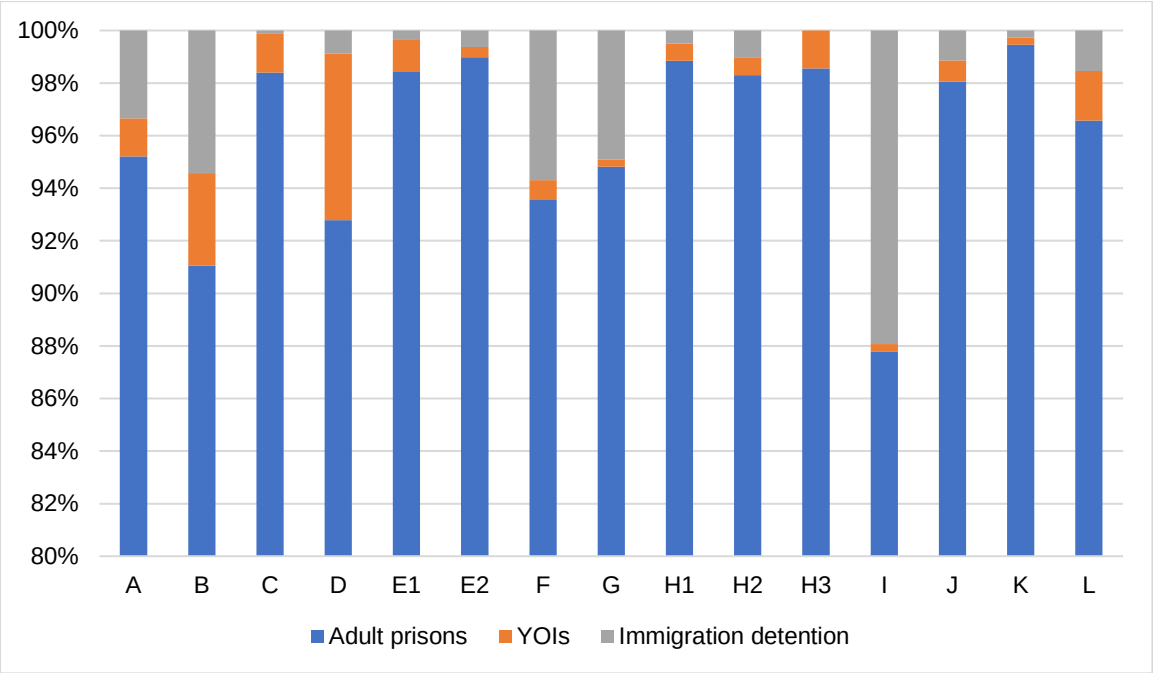
Annexes

Annex 1: Applications

Over 35,600 applications were made to IMBs across prisons, YOIs and the immigration detention estate (IDE) during 2023:[25]

- **33,888** applications were made to IMBs via written form or in-person.
- **1,728** applications were made via the 0800 applications line, which was discontinued from 1 August.[26]

Graph 1: Percentage split of applications made across detention settings by category type[27]



The highest number of applications made in adult prisons were regarding property (H1, H2 and H3) and health (G), in YOIs this was purposeful activity (D) and across immigration detention, this was case management (I).

Key

Code	Subject (IRCs)	Subject (Prisons and YOIs)
A	Accommodation including laundry, showers	Accommodation, including laundry, clothing, ablutions
B	Use of force, removal from association	Discipline, including adjudications, incentives scheme, sanctions
C	Equality	Equality
D	Purposeful activity including education, paid work, training, library, other activities	Purposeful activity, including education, work, training, time out of cell
E1	Letters, faxes, visits, phones, internet access	Letters, visits, telephones, public protection, restrictions
E2	Finance including detained people's centre accounts	Finance, including pay, private monies, spends
F	Food and kitchens	Food and kitchens
G	Health including physical, mental, social care	Health, including physical, mental, social care
H1	Property within centre	Property within the establishment
H2	Property during transfer or in another establishment or location	Property during transfer or in another facility
H3	N/A	Canteen, facility list, catalogues
I	Issues relating to detained people's immigration case, including access to legal advice	Sentence management, including HDC, ROTL, parole, release dates, re-categorisation
J	Staff/detained people conduct, including bullying	Staff/prisoner concerns, including bullying
K	Escorts	Transfers
L	Other	Miscellaneous

Annex 2: Membership

1,176 members were in post across **132** Boards as of 1 January 2024. During 2023, one new IMB was set up at HMP Fosse Way.

Table 1: Members in post by region

Regions	Members in post
East Midlands	107
Eastern	111
Kent, Surrey and Sussex	81
London	153
North East	60
North West	129
South Central	86
South West	105
Wales	41
West Midlands	99
Yorkshire and Humber	91
IDE	113
Total	***1,176***

Table 2: Members in post by detention setting[28]

Setting	Members in post
Prisons	**1,054**
Male prisons	936
Female prisons	118
YOIs	**40**
IDE	**118**
IRCs	40
STHFs	73
Charter flights	5

Table 3: Ethnicity data of participating members

Improving member's ethnic diversity has been identified as a key priority for the IMB's commitment to equality, diversity and inclusion. The data below relates to 67% of total members in post, 33% of members in post did not respond or preferred not to say.

Ethnicity	Percent (%)
Asian	4%
Black	2%
Mixed	1%
Other ethnic group	2%
White	92%
Total	***100%***

Endnotes

[1] Ministry of Justice, Prison population statistics, Population bulletin: weekly 5 January 2024, published 5 January 2024. The prison population as of week commencing 1 January 2024 was 87,448. The population 12 months prior was 82,212. This is an increase of 5,236.
[2] Home Office, How many people are detained or returned? statistics, published 29 February 2024. The number of people who entered detention in 2023 was 15,864. There were 36,704 irregular arrivals detected in 2023. Under the Illegal Migration Act 2023 (IMA), any irregular arrival could be subject to detention. This means that the number of arrivals detained under the IMA (irregular arrivals) could be over double the number detained last year.
[3] The Brook House Inquiry Report, published 19 September 2023. We published an initial response to the report (19 September 2023) and a formal response (19 March 2024).
[4] See recommendation 26 for IMBs to publish collated diversity data in the National Annual Report, Independent Monitoring Boards and Criminal Justice Alliance, Towards Race Equality, Executive Summary, published 8 April 2022.
[5] Independent Monitoring Boards, National Monitoring Framework, published February 2021.
[6] Some figures included in this report are local management information and may not align with official statistics published by the Ministry of Justice or Home Office.
[7] Estimated national figure based on IMB's reported visits data.
[8] This thematic report was in a letter from the IMB National Chair to the Prisons Minister. See Urgent action needed to improve poor conditions endemic in young offender institutions, published 1 August 2023.
[9] Ministry of Justice and HM Prison and Probation Service, Annex to PSI 64/2011, implemented 5 July 2021.
[10] Independent Monitoring Boards, Segregation of men with mental health needs. A thematic monitoring report, published 25 January 2024.
[11] NHS England, The transfer and remission of adult prisoners under the Mental Health Act 1983. Good practice guidance 2021, published 10 June 2021.
[12] See immigration detention summary tables, Home Office, How many people are detained or returned? statistics, published 29 February 2024.
[13] Operation Safeguard allows prisoners to be held in police cells to create temporary headroom. As part of the scheme, foreign national prisoners are also being held in immigration detention.
[14] See Figure 3, Home Office, How many people are detained or returned? statistics, published 29 February 2024.
[15] The Short-term Holding Facility Rules 2018, Part II, Rule 6(1) and (2).
[16] The STHF Rules 2018 do not apply for individuals held in controlled waiting areas (CWAs). In CWAs, people are initially held under an IS81 form which gives immigration officers authority to detain whilst further enquiries are being made.
[17] See page 5, Home Office, Adults at Risk in Immigration Detention, Version 9, published 20 April 2023.
[18] Home Office, Management of adults at risk in immigration detention, updated 13 December 2022.
[19] Home Office, Detention services order 09/2016, Detention centre rule 35 and Short-term Holding Facility rule 32, Version 7, published 5 March 2019.
[20] Serious incidents are categorised as any event which may impact the safety and security of staff, detained people and may result in reputational damage to the Home Office. See definition, Home Office Guidance, Reporting and communicating incidents in the immigration detention estate, updated 15 March 2022.
[21] Detention Centre Rules (2001), Part III, Rule 40.
[22] Detention Centre Rules (2001), Part III, Rule 42.
[23] Detention Centre Rules (2001), Part III, Rule 40 (4).
[24] UK Visas and Immigration, Facilitated Return Scheme: caseworker guidance, published 19 June 2023.
[25] This data is taken from annual reports published in 2023.
[26] The 0800 freephone line for prisoners to contact IMBs was introduced in 2020 to support IMBs' remote monitoring during the Covid-19 pandemic.
[27] This graph includes applications from in-person, written and 0800 applications. Some applications may have been allocated more than one category type. For example, one application may cover both property and accommodation and will be shown twice in these graphs.
[28] Some Boards monitor two establishments in different settings and some members are in post on two Boards (referred to as dual boarders) and will be counted twice in this table.