imb Independent Monitoring Boards

National Annual Report 2024

Adult prisons, young offender institutions and immigration detention

June 2025

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 2024, over 35,500 visits were carried out by 132 IMBs at these places of detention.

2024 was a year of uncertainty and flux. The change of government midway through the year brought with it many seismic policy changes, including the scrapping of plans to rent prison cells overseas, the cancellation of the Rwanda Asylum plan, the introduction of new early release schemes and the more recent decision to end the detention of girls in young offender institutions (YOIs).

IMBs have seen some much-needed improvements in terms of staffing levels and regime, which have the potential to dramatically change the lives of detained people for the better. However, each step forward risks being reversed – IMBs, particularly in the adult prison estate, reported that cancellations to purposeful activity and time out of room were all too common. While the unpredictability of cancellations may be marginally preferable to the predictable highly-restricted regimes of previous years, this undermines prisoners' trust in the ability of staff to deliver what they promise, and thus the stability of prisons overall. The combination of high populations and the extreme demands on staff – who, in some prisons, had to respond to drug-related medical emergencies or mental health crises on a daily basis – meant that staff sometimes struggled to deliver the very basics of regime to prisoners. Early release schemes caused anxiety in the prison population and raised questions about whether these prisoners were given what they needed to rejoin the community. Now it is clear that no long-term population reductions have been achieved, and prisons will have to weather yet more schemes to address the population crisis; IMBs will be watching this closely.

Alongside the many changes experienced in the prison and immigration estate, there were far too many areas where Boards were forced to report the same issues as in previous years. The physical condition of much of the prison estate, and parts of the immigration detention estate, remained appalling, with detained people facing unacceptable living conditions and shortages of vital supplies. Violence and drug use increased across many prisons, and population pressures caused this to spill into immigration detention facilities as well: under Operation Safeguard higher numbers of former prisoners were held in immigration removal centres, with a resulting surge in drug use and violence. Inexperienced prison staff lacked the confidence and knowledge to enforce order and support prisoners. The introduction of defensive measures such as PAVA will not address these root causes of violence and disorder, and IMBs are troubled by the government's recent decision to introduce PAVA into the youth estate despite the alarming disproportionalities seen in officers' use of force.

Finally, resettlement support still fell far below acceptable levels at many prisons. Unless prisoners have safe, stable accommodation, links to community support and a reasonable prospect of employment and reintegration, the revolving door effect will

continue to frustrate the government's efforts to reduce and stabilise the prison population.

The detention of those for whom these environments are entirely unsuitable continued, with harrowing results. IMBs across all estates saw people with severe mental illness and other complex needs held in separation units for hundreds of days awaiting transfers to suitable mental health facilities. Deprived of the specialised care they need, the welfare of these vulnerable people can decline drastically in these conditions. Immigration detention IMBs reported on the serious distress faced by people who were detained in IRCs for excessively long periods of time, often because delays prevented them from accessing bail accommodation or voluntarily returning to their countries of origin.

The persistency of these problems brings with it the dangers of complacency. IMBs continue to see indications of unacceptable situations being accepted by staff. Prisoners told IMB members that there was no point in complaining about horrendous physical conditions, such as flooding, vermin and sewage faults, because nothing would be done about it. Complaint processes, especially those targeting discrimination, were often mistrusted. Similarly, in the immigration detention estate, IMBs were told by detained people that they were afraid to complain about the conditions of centres in case it affected their immigration cases. Disturbingly, immigration detention IMBs found that some staff had become used to, and perhaps desensitised to, seeing people in acute distress. In YOIs, IMBs saw signs that expectations for time out of room had deteriorated so far that staff viewed the minimum hours out of room figure as a 'target' to strive towards rather than what it was: a minimum that even if delivered, still compromised children's chances of rehabilitation.

The importance of resolving these entrenched issues only increases with the length of time they are in play and the number of people whose lives are affected – they cannot be normalised. IMBs will continue to use their unique insight to highlight these failings with the urgency they deserve.

Elisabeth Davies **June 2025**
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.[1]

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 2024.[2]

IMB impact in 2024

132 Boards, made up of **1,186** members, carried out **35,865** visits between 1 January to 31 December 2024.[3]

IMBs can make a difference upon detained individuals, on the establishments they monitor and on the wider prison and immigration detention system. Examples of local impact are included throughout the body of this report and details of the wider system impact of IMBs are included below.

Reporting

In 2024, we published **127** annual reports:

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

YOIs
- 5 YOI reports

Immigration detention
- 4 IRC reports
- 8 STHF reports
- 1 charter flight report

More up-to-date Board findings are collated on a regular basis and utilised for regional, functional and national impact through responses to consultations, evidence provided to Parliamentary committees and through national thematic monitoring reports. The IMB published the following national reports in 2024:

- Segregation of men with mental health needs
- The 2023 national annual report for IMBs in the prison and immigration detention estate
- Chaos in the crisis – the damaging loss of prisoners' personal property
- Breaking point: the impact of a crumbling prison estate on prisoners

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, NHS England and the Home Office. This included: deaths in custody, the public protection policy framework, girls in custody, the children and young people strategy, NHS England health and justice, release of detained individuals from detention, removal from association in detention and immigration detainees in prison policy framework.

IMB findings

1. Adult prisons

Key findings

- The prison capacity crisis continued to adversely affect the conditions prisoners lived in and their opportunities for progression, with prisoners held in crowded and often unsuitable environments.
- Rising self-harm levels were of serious concern to Boards, and support for those harming themselves was not always adequate.
- Force was used disproportionately and was poorly scrutinised.
- Drug use was endemic across the prison estate, and the health concerns, debt and violence arising threatened the stability of many prisons.
- The crumbling fabric of the prison estate and delayed maintenance and refurbishment led to unacceptable living conditions.
- Staff inexperience and absence continued to adversely affect day-to-day operations.
- Opportunities to improve staff-prisoner relationships through the key work scheme were missed.
- Prisoners from minoritised ethnicities and religions were treated unfairly and the discrimination reporting process was widely mistrusted, often with good reason.
- Lost and missing property had serious consequences for prisoners, with one prisoner's prosthetic leg going missing for over a year.
- Prisoners with complex needs, such as severe mental illness or dementia, often did not receive appropriate care and support, with some shocking results.
- Time out of cell continued to be limited and unpredictable, often as a result of staff shortages.
- Probation and resettlement support continued to be limited in the closed estate, in some cases contributing to the 'revolving door effect' of prisoners being recalled shortly after release.

Population challenges

Population pressures remained a key concern for Boards, affecting every aspect of prison life. Boards continued to highlight the challenging, and sometimes miserable, conditions that arose when single cells were 'doubled up'. Some Boards reported double cells being converted to triples, or triples to quads. Prisoners in these cells were often left without the very basics necessary to preserve their dignity or quality of life, such as toilet privacy curtains (as at Bronzefield), or standard furniture like tables and chairs (as at North Sea Camp).

The capacity crisis had a negative impact on prison safety, as staff struggled to cope with sheer numbers, and prisoners could not always be safely located. These pressures eroded decency levels, as cells, units and facilities could not be taken out

of use for necessary maintenance, and resulted in too many prisoners spending time behind cell doors when there were not enough places for purposeful activity.

Efforts to reduce the population had mixed effects. Some Boards reported that the places created by early release schemes, including the recent SDS40 legislation, were quickly filled up again, and others had concerns over poor release preparation, which often resulted in recall.[4] However, Boards also reported on opportunities created by temporary drops in the population, such as at Thorn Cross where this enabled some long-overdue maintenance to take place.

The key issue at the end of 2024 was that the spaces created by SDS40 were concentrated in the open estate and category C training prisons. This meant that reception and high security prisons continued to struggle, whereas many Boards monitoring open prisons were wary about the impact of the drop in prisoners and the potentially destabilising effect of large numbers of new arrivals in the future.

1.1 Safety

Self-harm levels rose and the support offered was often inadequate

Self-harm continued to be an area of acute concern for Boards, with monitoring observations reflecting rising levels across the prison estate. 'Cluster sites' of self-inflicted deaths continued to emerge, including at Wymott, the women's prison Styal, and Leeds. Significantly, Leeds was designated a cluster site in 2023 and remained one for the entirety of 2024, meaning the prison has been unable to address the issue despite increased scrutiny. The long-term high security estate (LTHSE) was also overrepresented in this area, with Belmarsh, Garth and Frankland all being designated cluster sites.

Boards raised enduring concerns about the ACCT (Assessment, Care in Custody and Teamwork) process, used to manage those identified as at risk of suicide or self-harm, which some felt was unfit for purpose. Several Boards noted that ACCT observations, reviews or notes were carried out inadequately. For example, 78% of ACCT documents examined by the Board at Durham contained omissions, such as missing daily supervisor or night staff checks.

Self-harm was a particularly pressing issue in the women's estate. Many Boards reported that the number of extremely unwell women who repeatedly attempted to harm themselves meant that an enormous amount of staff resource was needed to keep them safe, and officer intervention led to frequent assaults on staff. Relatively small numbers of women with highly complex needs could have a disproportionate effect on the operation of a whole prison, with Boards highlighting the strain caused: at Eastwood Park, staff's time was dominated by firefighting due to the high number of women with complex needs, leaving little time for routine or rehabilitative activities. Likewise, IMBs such as Downview observed that when there were fewer women of this type the breathing space created was palpable, leading to better performance across the prison.

Levels of violence were an acute concern

Violence and disruptive behaviour remained excessively high across much of the prison estate. This was often attributed to debt, which was inextricably linked to the drugs crisis outlined below. Population pressures also made it difficult to defuse volatile environments, as it was difficult to separate prisoners in conflict. Some prisons, such as Pentonville, spent a great deal of staff resource on separating prisoners and arranging appropriate transfers to minimise conflict. Other prisons were shaken by an influx of out-of-area prisoners, often with gang affiliations, which the prison was unused to dealing with; at Stoke Heath, for example, an increase in out-of-area prisoners was linked to increased use of force. The lack of cells meant that vulnerable prisoners were not always placed on vulnerable prisoner units, leaving them feeling unsafe, with many self-isolating as a result.

At Oakwood, however, the ‘Enough’ campaign was introduced in November 2023, providing an enhanced regime and other incentives to wings that remained violence-free for extended periods of time. This had marked success: in March 2024, three wings had remained without violent incidents for at least 56 days, and another three had done so for at least 28 days.

Force was used disproportionately and was poorly scrutinised

Use of force was an area of concern for some Boards, though generally these concerns related to record-keeping and monitoring rather than implementation; several Boards reported that officers were still reluctant to wear body-worn cameras or to turn them on prior to incidents. At some prisons, officers often failed to complete post-incident paperwork in a timely manner, and at others prisoner debriefs were not always carried out. Worryingly, some Boards continued to report that inexperienced staff struggled to de-escalate incidents; Boards such as Hewell and Chelmsford were concerned that staff inexperience was behind an increase in the use of force. At Altcourse, where violence and use of force levels were low compared to similar prisons, the Board attributed this to the high proportion of experienced staff. Altcourse staff also told Board members that they felt that PAVA and batons were unnecessary there, as experienced and confident staff were unlikely to need them.

Young adults were prominently overrepresented in use of force incidents, as were neurodivergent prisoners. At Brixton, 74% of prisoners who had force used on them were registered as having some kind of disability. The majority of prisons carefully reviewed use of force trends for disproportionality, though not always effectively – at Aylesbury, while use of force incidents were broken down by protected characteristics, they were not compared with a demographic breakdown of the prison population.

At some prisons racial disproportionalities were obvious and concerning – at Elmley, black prisoners were significantly more likely to have force applied compared to white prisoners. Birmingham likewise saw clear racial disparities in the use of force, which persisted despite the diversity of prison staff and the introduction of cultural awareness training.

Drug use was endemic, undermining the stability of the entire prison estate

Drugs and illicit items were IMBs' most common safety concern, and Boards' concerns about drugs in particular rose throughout 2024. Many Boards described a seemingly unstoppable flow of drugs into prisons, despite efforts to stem supply; at Bristol, prisoners were found under the influence on a daily basis. At some prisons the impact of drugs was inescapable: debt drove up violence and bullying, while prisoners frequently experienced medical emergencies, which added further disruption as staff resource was directed towards assisting them and providing hospital escorts.

Drones continued to pose a significant threat, especially in the long-term high security estate and in the north-west of England. Boards such as Long Lartin and The Mount reported that shortfalls in security measures, such as outdated windows, permitted drugs to be smuggled in more easily. At Wymott, officers told the Board that suspicion testing was not being carried out due to staff shortages. Security shortfalls were also found elsewhere in the estate; at Coldingley, for example, several landings lacked CCTV and were not regularly patrolled by staff. At some prisons small improvements to security measures made a marked difference to the prevalence of drugs – at Ford, for example, the number of drug finds halved between the first and third quarters of the year, which the Board attributed to the success of simple initiatives, such as better gate security between the two halves of the prison and increased searching.

It is important to note, however, that there is no single solution: many Boards' reports demonstrated the adaptability of drug suppliers, with other routes opening as soon as one was closed; at Pentonville, following widespread cell searches on the largest wing and the arrest of an officer, throwovers significantly increased as prisoners tried to find new routes for contraband. This is testament to the importance of efforts to reduce demand and supporting prisoners to stop using drugs. The success of these efforts is analysed in the healthcare section.

1.2 Fair and humane treatment

The crumbling fabric of the prison estate and delayed maintenance led to unacceptable living conditions

Accommodation and facilities remained extremely poor across all regions and functions. [5]

The impact of a crumbling prison estate on prisoners

In November 2024 the IMB published a national thematic report on Boards' findings in this area, which found that:

- The crumbling fabric of the prison estate and delayed maintenance and repairs had serious safety implications. These included an increased likelihood of drugs and weapons being smuggled into prisons, and significant fire safety issues, such

as faulty alarm systems at Cookham Wood, poor evacuation capability at Stafford and outdated anti-barricade doors at Wayland.

- Heating and ventilation issues, flooding and vermin led to living environments that were uncomfortable, indecent, and at times inhumane. There were accounts of prisoners being bitten by spiders at Bullingdon, and by a rat at Hollesley Bay.
- At Pentonville, the Board consistently raised concerns about a rat infestation in the kitchen over a 10-month period. No effective action was taken by the prison or the maintenance provider, despite serious hygiene concerns such as rat droppings under numerous pieces of kitchen equipment, and chewed and spat out ceiling insulation in light fittings above open broilers of food and food workstations. The IMB escalated this issue to the relevant HMPPS Area Executive Director and Prison Group Director, and subsequently to Islington Council's Environmental Health Service and the then Prisons Minister. The kitchen was closed two days later.
- Vital laundry and kitchen equipment was frequently out of action, and prisoners sometimes went without hot food or clean clothes and bedding as a result.
- There was little accountability when maintenance providers' performance fell short, and Governors felt they did not have enough autonomy to tackle the problems at hand.
- Even in instances where there was a clear commitment from the Prison Service to upgrade the physical estate, it took far too long – sometimes years – for these improvements to be completed. Boards reported widespread cost ineffectiveness, including the frequent use of stop-gap measures and failed refurbishments and repairs.

During the publication process further concerns were raised about how serious maintenance concerns are addressed. It appeared that potentially serious health and safety concerns had not been investigated with necessary rigour, and that communication between prisons and service providers was not always sufficient to ensure safety lessons were learned in the wake of dangerous incidents, such as fires.

Segregation units were chaotic and usually full

Boards continued to report busy, strained care and separation units (CSUs) where staff were under huge pressure to manage the challenging nature of the populations. It was often difficult to move prisoners back to normal location, particularly where prisons had large numbers of non-associates (so safe locations could be difficult to find), or when prisoners had particularly complex needs. Estate and function-wide population pressures reduced the options for managing CSU populations. At Full Sutton, the Board noted that because of the high populations in the LTHSE, and in CSUs within LTHSE prisons, there was an inability to transfer prisoners to other establishments except on a one-for-one swap. Access to the most basic regime requirements could be limited on these units.

While Boards again observed that staff tried hard to care for segregated prisoners appropriately, it remained the case that these staff lacked the specialist training to do this – and that many prisoners, especially those with severe mental illness, were held in CSUs when it was not the appropriate location for them, simply for lack of

anywhere more suitable in the prison. This is further explored in the healthcare section.

Staff inexperience and absence continued to adversely affect day-to-day operations

Relationships between staff and prisoners varied considerably within and between prisons. It was rare (though unfortunately not unheard of) for Boards to report deliberate disrespect or bullying from staff towards prisoners. However, Boards continued to report widely on the impact of staff inexperience. Newer staff often lacked the 'jail craft' necessary to confidently set boundaries and challenge misbehaviour, or to form positive relationships with prisoners. In addition, while on-paper staffing levels were less of a concern than in previous years, high levels of staff absence due to sickness, leave or training put considerable strain on the day-to-day operations of many prisons. At some prisons, such as Downview, this also led to staff being redeployed between functions, which sabotaged efforts to build up experience and skills in specialised areas.

Opportunities to improve staff-prisoner relationships through the key work scheme were missed

When executed as intended, key work had the potential to improve staff-prisoner relationships and resolve many of the daily issues faced by prisoners. This in turn reduced the pressure on the complaints' process (in itself a very contentious area, with prisoners often complaining about delayed or inadequate complaint responses). However, it was rare for prisons to successfully deliver high-quality, consistent key work, and Boards widely reported that key work delivery was falling well below targets, with a considerable variation in the quality of sessions. Some prisoners told IMB members that they did not even know who their key worker was. Ashfield's key work programme, however, was reported to be exceptionally successful, which likely contributed to the excellent staff-prisoner relationships seen at the prison.

Prisoners from minoritised ethnicities and religions were treated unfairly

Black and Muslim prisoners continued to be overrepresented in use of force incidents and adjudications at some prisons. While many Boards reported that these disproportionalities were investigated in use of force review meetings, this seemed to have little effect in driving down disproportionate use. Some Boards reported other indications of disproportionality – at Coldingley, for example, prisoners from minoritised ethnicities were more likely to be housed in less desirable wings such as those without in-cell sanitation, whereas white prisoners were more likely to be held in more modern, refurbished accommodation.

The DIRF (discrimination incident reporting form – the method to report any incidents of discrimination, harassment or victimisation) process, was still widely mistrusted, with prisoners fearing reprisals if they complained. Some Boards noted failures in the process which can only have exacerbated prisoners' worries that they would not be

treated fairly. Shortfalls were reported even in prisons which had clear disproportionalities. At Birmingham, despite racial minorities being overrepresented in adjudications and use of force, DIRFs were not always available on the wings and staff did not always know where to locate them. At Elmley, despite racial disproportionalities in the use of force, DIRFs received no external scrutiny.

Boards such as Lindholme, Winchester and Swaleside highlighted the importance of having dedicated equality and diversity staff; when these responsibilities were instead distributed among other staff roles, it was easy for equality and diversity work to fall by the wayside.

Lost and missing property had serious consequences for prisoners

Lost or missing property remained one of the Boards' most pressing concerns, and an area given little importance by the Prison Service.[6]

How property loss impacts prisoners

An IMB thematic report published in September 2024 explored the devastating effect the loss of personal property can have on prisoners' wellbeing, and underscored the urgent need for investment in effective solutions, including a national digital tracking system. The report found that:

- Two years from its implementation, there is little to no evidence that the Prisoners' Property Policy Framework has improved or resolved the main problem areas identified.
- Prison Service staff often treated missing property as an administrative or process issue, with little recognition of the real impact it can have on the lives of prisoners.
- Delays to property being sent, increased prisoner movements and late arrivals, shortages of reception and searching staff, and ineffective complaints and compensation processes all contributed to prisoners' extremely poor experiences with the care and management of their property.
- A crucial failing was the antiquated use of paper property cards and paperwork rather than a digital system, which meant there was no effective audit trail or quick way to track property.
- Prisoners described to IMB members how the loss of important and sometimes irreplaceable items, such as family photos, children's drawings, legal papers and identity documents, damaged their mental and physical health and made it even more difficult to successfully restart their lives outside of prison. In one particularly shocking example, a prisoner's prosthetic leg went missing for over a year.

1.3 Health and wellbeing

Healthcare provision – both for physical and mental health - varied significantly across the prison estate. While some Boards reported good or even excellent healthcare provision, others had serious concerns. Some trends emerged between functions: healthcare was generally described as good in the open estate, whereas it was one of the most pressing concerns of IMBs monitoring the women's estate.

Healthcare concerns at HMP Styal

Styal IMB had significant concerns about the performance of the healthcare provider Spectrum Community Health CIC during the 2023-2024 reporting year, especially regarding failures to consistently provide safe and timely administration of medicines. It was common for prescription dispensing to be delayed, forcing prisoners to take their medication late or skip a dose altogether. Sometimes medications were not delivered at all, and the Board noted errors, where the wrong drugs were dispensed, incorrect dosages provided, medications were stopped without reason or prisoners were discharged without their required medication – all of which posed a risk of real harm to those with serious health conditions.

These issues caused significant anxiety for the women, some of whom told Board members that they were too stressed or not fit to attend purposeful activity when their medication was late.

There were also concerns about long waiting lists for GP and dentist appointments, appointments being cancelled due to lack of staff escorts and haphazard scheduling, which caused some women to decline appointments to avoid missing purposeful activity.

In response, the Board carried out thematic monitoring on healthcare and medications over a long period of time, sending their report to the Governor and Head of Healthcare, as well as a follow up letter. As the issue went unresolved, the Board then wrote to the CEO of Spectrum who promptly responded and arranged a meeting with the Board. Since this time the Board has seen a marked improvement in healthcare delivery, and continues to monitor closely to ensure this is sustained.

Staffing shortages led to patchy provision

As in 2023, healthcare staffing was problematic at many prisons, often with an overreliance on agency workers who were less familiar with the prison. Boards raised particular concerns about insufficient healthcare coverage in the evenings and at weekends. At some prisons this led to late arrivals not receiving their healthcare screening until the following day, which could lead to crucial vulnerabilities not being identified in a timely manner. At Usk and Prescoed, where healthcare staff often had

to stay late in order to manage late arrivals, some prisoners arrived seriously unwell and requiring review with a GP.

Prisoners with severe mental illness were often failed

Mental health was a pressing concern for many Boards, with reports continuing to highlight the extremely high level of mental health needs within the prison estate. Mental health teams appeared to be the most commonly affected by staff shortages, which could lead to long waits for prisoners in need of mental health care.[7]

Segregation of men with mental health needs

In January 2024, the IMB published a thematic report on the segregation of men with mental health needs which found that:

- Prisoners with mental health needs were often held for prolonged and long-term periods in CSUs (over 800 days in one instance) and the 28-day target to transfer severely unwell men from prison to secure hospital was often not met. IMBs found that this was mostly due to:
  - Men struggling to cope or refusing to reintegrate back onto the residential wings.
  - Lack of capacity in prison healthcare units or prisons with specialist functions.
  - Delays in referral, assessment, and transfer to a secure hospital.
  - There being no alternative, often because of a lack of diagnosis or men not having met the threshold for admission to a secure hospital. Although most IMBs understood why CSUs were deemed the most appropriate place for these men to be held out of the limited options available in prisons, there were still widespread concerns that CSUs were the only alternative for these extremely unwell men.
- Prisoners with mental health needs were often moved between different CSUs, healthcare units, or returned to wings for short periods, making it harder to track the cumulative time some prisoners spent segregated.
- For men who were already struggling with their mental health, their wellbeing and behaviour often deteriorated further while being segregated for prolonged periods.

While the scope of this report was limited to the men's estate, the issues outlined are mirrored in the findings of IMBs monitoring the women's estate.

Throughout 2024, Boards continued to raise increasing concerns about the imprisonment of people with severe mental illnesses for whom prison is not an appropriate or humane environment. Very unwell prisoners continued to wait hundreds of days for a transfer due to a shortage of beds, or had their referrals declined despite having been declared unsuitable for detention in a prison environment. The impact of these delays continued to be shocking: at one category C prison, a prisoner was segregated for approximately six months before being

transferred to a secure hospital, held in a cell almost entirely stripped of items due to his risk of self-harm and without access to social care support. Over that period his health deteriorated rapidly, he lost a considerable amount of weight, and his daily life was severely limited; he was supported by the ACCT process, but as he was often nonverbal the ACCT reviews were often perfunctory. Staff members demonstrated anxiety and sometimes distress over his condition, and some prisoners told the IMB they feared he would die before release from misery and inappropriate treatment. At another Category C training prison, a prisoner with a personality disorder spent approximately eight months in the constant watch cell due to repeated attempts to self-harm. This location was both distressing for the prisoner and a heavy drain on staff resource.

Boards were increasingly concerned about the treatment of older prisoners, particularly those with dementia or other significant social care needs

It was common for Boards to report that the prisons they monitored were entirely unsuited to providing for those with significant social care needs, which could have appalling consequences. For example, Dartmoor IMB described prisoners with dementia spending 23.5 hours a day in their cells, being unable to access their 'buddies' (prisoners assigned to help with some aspects of their care) due to regime restrictions and going 21 hours without being reminded to eat or drink. Another Board raised concerns about a very elderly prisoner who could no longer reach his in-cell toilet and as a result regularly soiled himself, with staff unable to find a dignified solution.

With the forecasted ageing of the prison population, this will only become a more pressing issue. An HMPPS ageing prisoners' strategy has failed to materialise, despite being promised for several years. It is vital that a realistic strategy be developed and funded as soon as possible in order to find acceptable solutions before such shortfalls in care become even more widespread.

Time out of cell continued to be limited and unpredictable

While IMBs across the estate reported concerted efforts to improve time out of cell, results were limited at most prisons. Unpredictability was a key issue – cancellations to activities were common, with prisoners feeling frustrated and demoralised as a result.

This was most commonly attributed to insufficient staffing, including at prisons which had good on-paper staffing levels but where staff absence was high. However, prisons with high levels of violence or disorder, or those that had to manage particularly disparate populations, also struggled to provide a good regime due to the pressures associated with managing different cohorts and 'keep-aparts' (prisoners who cannot associate with each other for safety reasons).

The frustrations resulting from regime restrictions often undermined the stability of prisons, with prisoners engaging in protesting behaviour or lashing out at staff or other prisoners. At Eastwood Park, for example, the lack of a Care and Separation Unit meant that segregated women were placed on main location, and other women

on the same units had to be locked up while segregated women received their time out of cell. The high number of women with complex mental health needs further limited time out of cell for the general population, as staff resource was directed towards assisting women in crisis rather than facilitating normal regime. Some women vented their frustrations by assaulting officers, exacerbating the strain on staff who were already struggling to provide a safe and stable regime.

Substance misuse support failed to tackle the problem

Many IMBs identified a lack of sufficient substance misuse services, with staff shortages often hindering this area of operation. Some prisons experienced staffing deficits of up to 50% in drug and alcohol services and several Boards found that the healthcare providers contracted to deliver drug and alcohol rehabilitation services were under-staffed and overstretched. Many prisons also lacked the facilities to support these prisoners; at Feltham, for example, there was a shortage of available rooms to carry out substance misuse interventions. The Board at HMP Leicester stated that the drug recovery unit was not operating effectively at the start of the year because the provision of psychosocial interventions had not yet started, despite being promised in the healthcare contract.

Some independent substance free living units (ISFLUs) were observed offering good incentives and support to prisoners, as described by the IMB at Rochester which reported on good engagement from prisoners and a relaxed atmosphere on the unit. The function of these units in other prisons, however, was often diluted by ineligible prisoners being placed on them for lack of space elsewhere. In some prisons, the high level of drug availability and use compromised the function of the ISFLU. At Long Lartin, until June 2024, the intended function of the unit was compromised by staff shortages and the presence of overspill prisoners, and drugs were readily available. At Coldingley, about two-thirds of recorded ‘under the influence’ incidents occurred on the ISFLU.

Drug testing arrangements were called into question by some Boards: for example, Coldingley IMB noted that the tests used on ISFLUs were unable to detect psychoactive substances, despite these being the most common drugs of concern on the unit there. At other prisons, such as Sudbury, concerns about the accuracy of swab tests led to considerable upset among prisoners. There were also indications towards the end of the reporting year that some prisons were beginning to deprioritise mandatory drug testing, either due to lack of staff resource or because of a decision to direct limited resources towards supporting prisoners rather than testing or disciplining them. The results of this will be monitored throughout 2025.

1.2 Progression and resettlement

Levels and types of purposeful activity on offer in the closed estate were poor

While training and education offerings were generally good in the open estate, they often fell below expectations in the closed estate. Outcomes were particularly poor in reception prisons, and several IMBs raised concerns over the number of remand prisoners who were not motivated to engage in purposeful activity and therefore

spent the majority of their days in their cells. This was not always a matter of choice: the IMB at Bullingdon noted that many remand prisoners complained about how difficult it was to access purposeful activity. At Pentonville, where over 60% of prisoners were on remand, prisoners not in work or education usually spent 22 hours a day in their cells.

Workshops were one of the areas most frequently taken out of use as a result of fabric issues, with the most common problems being leaks and cold temperatures; at Littlehey, conditions were so poor at times that workshop instructors refused to work. Such closures not only reduced the number of available activity places but also impacted on predictability, as prisoners could have their work session cancelled at the last minute due to poor weather.

Many Boards monitoring have commented that the training and education offer was mismatched to the needs of the population. Specific concerns vary widely – at some prisons there were insufficient lower-level maths and English classes for the needs of the population (as at Rochester, due to tutor shortages), whereas other Boards expressed concern about the prioritisation of these classes over more popular options like art, especially at prisons with high remand populations such as Bedford, as remand prisoners did not have to attend education and the withdrawal of more popular options meant that some declined to partake. Several Boards noted that there were insufficient places on the more popular vocational courses, such as the forklift training course at Wayland, which are also the courses that are highly likely to lead to employment on release.

While the open estate reported far more positively on purposeful activity (and on all other aspects of progression and resettlement), population changes also had an impact here: prisoners continued to be moved to open prisons as soon as possible to free up spaces in the closed estate, which had a destabilising effect. As many of these prisoners were transferred close to their release dates, they were less motivated to engage in work or education, which could be demotivating and disruptive for the rest of the population. In addition, the large number of empty beds as a result of early release schemes meant that fewer prisoners were able to take up work opportunities outside the prison, as a fixed number of prisoners were required to work inside the prison to keep daily operations running. This reduced the number of prisoners who could experience the benefits of ROTL (release on temporary licence) work placements, such as partial reintegration into community life and greater opportunities for employment on release.

Population pressures and staff shortages hindered prisoners' progression

As in 2023, population pressures made it difficult to locate prisoners where they could best be enabled to progress towards release. Prisoners continued to struggle to access the offending behaviour programmes they needed to complete, potentially prolonging their time spent in custody unnecessarily. This was particularly common for prisoners convicted of sexual offences who required specific courses to progress, as highlighted by Swaleside and Woodhill IMBs. Many prisoners found it hard to move through the estate and demonstrate reduced risk; for example, at Garth (a

category B prison in the LTHSE), approximately 20% of the population were category C prisoners who were unable to obtain progressive transfers due to population pressures.

Understaffed offender management units continued to impact on prisoners' progression, and the difficulty of obtaining contact with probation staff caused prisoners frustration and distress. Those ineligible for early release experienced knock-on effects from schemes such as SDS40, which necessitated probation resource being directed at those soon to be released at the expense of the wider population.

Patchy resettlement work contributed to the 'revolving door effect'

Boards in the closed estate continued to report serious shortfalls in preparation for release. In particular, IMBs underscored the high number of prisoners released homeless, many of whom were subsequently recalled to prison. This was most common for remand prisoners, those released from prisons without a dedicated resettlement function, and those serving short sentences or short recalls. As women were more likely to be serving short sentences or short-term recalls, this was a particular problem in the women's estate; for example, at Bronzefield 13% of women were homeless on release. Some IMBs described a resultant 'revolving door effect', with prisoners repeatedly released and recalled in quick succession. For example, at Winchester over 21% of 2024 releases were released homeless. Monthly data showed that a strikingly high percentage of these releases resulted in the man being recalled to prison within six weeks, ranging from 42-78% over the course of the year.

2. Young offender institutions (YOIs)

Key findings

- There was a concerning rise in levels of self-harm in English YOIs.
- Violence and weapons undermined YOIs' capacity to rehabilitate children, diverting resource away from every other area of operation.
- Room shortages affected the delivery of one-to-one interventions and mental health appointments.
- Children in England continued to spend far too long in their rooms with very limited activity or socialisation – this was especially true for those being separated from others. There were some disputes over the accuracy of data records in this area.
- The quality and quantity of education on offer was generally poor, often disrupted by 'keep-apart' arrangements, fights and staff shortages.

Population changes

This year saw significant changes in the structure of the secure youth estate, the results of which are yet to be fully realised. The full removal of Cookham Wood from the youth estate in May 2024 saw many children who had been detained there moved to other YOIs across the country, with predictable disruption as a result. The influx of new arrivals put additional strain on the receiving YOIs; at Feltham young people were anxious about the new arrivals (primarily because of community-based disputes) and self-harm levels rose. The closure also left Feltham as the only YOI serving the south of England. This increased the pressure on Feltham as its court catchment area expanded, and placed an increased number of boys far away from their homes, families and support systems.

The Oasis Secure School took its first placement in August 2024 after much anticipation. The results of this for YOIs are yet to be tangible; YOI IMBs are monitoring the situation with great interest.

Finally, the Youth Justice Minister commissioned a three-month review considering placement options for young girls in the children's secure estate. As a result, in February 2025 it was announced that girls would no longer be held in YOIs. This was a welcome development; Wetherby IMB has consistently highlighted that Wetherby is unsuited to hold girls, and that the detainment of girls there had unacceptable consequences for all children in the establishment.

2.1 Safety

Levels of self-harm were an acute concern in English YOIs

Wetherby saw continuing high levels of self-harm – this was mainly attributable to the girls held there, who had extremely complex needs and were often prolific self-harmers. At Feltham, self-harm rose from relatively low levels in the early months of

2024 to high levels in the summer months (3.5 incidents per 100 children in February to 23.8 in May; almost seven times higher). While this was partly attributed to the rising population and anxiety surrounding Cookham Wood arrivals, it also appeared connected to a decline in effective staffing levels. At Werrington, while self-harm incidents continued to decline, the Board was concerned about the number of incidents involving a small number of children (136 relating to 25 children), and by the significant increase in incidents requiring hospital treatment. The glass observation panels in cell doors were frequently smashed, and there were several incidents of children subsequently swallowing broken glass or reporting to have done so.

Feltham and Werrington IMBs reported increased ACCT levels, which the Werrington Board considered concerning. IMBs observed that ACCTs were opened readily and that the process was followed. However, Wetherby IMB questioned the suitability of the ACCT process for children, who are likely to find it difficult to talk about their mental health to a large group of adults they do not know well. At Werrington, the Board continued to struggle to monitor ACCT reviews because reviews were not scheduled sufficiently in advance.

Violence and weapon-carrying impacted all areas of detained children's life

Violence remained a serious challenge in all YOIs. While IMBs stressed that the majority of violence was committed by a small number of children, all children and every area of life was affected. The number of children who could not associate with each other ('keep-aparts') impacted on the time out of room children received, as well as their access to purposeful activity. Serious incidents had the same effect, as children could spend hours locked in their rooms without food or activities until the incident was resolved.

Werrington IMB reported significant increases in assaults on staff, assaults on other young people and fights; there was also a considerable spike in the number of staff requiring hospital treatment following assaults. The Board additionally reported a 39% increase in the number of children self-separating – children told the Board that this was because they were frightened of other children and wanted to avoid getting into trouble. At Feltham, violence and keep-apart levels improved in the first few months of the year but began to climb again from May onwards, coinciding with the closure of Cookham Wood and the rise in population. At Wetherby, significantly more children told the IMB that they were afraid of other children in the establishment, a previously rare occurrence.

2.2 Fair and humane treatment

Maintenance delays were common and room shortages affected the delivery of interventions

The condition of accommodation and facilities was generally better than in the adult estate, but there were still areas of concern. Some of these mirrored problems found in adult prisons, such as shower and drainage issues at Feltham and frequent complaints about uncomfortably cold or hot temperatures at Wetherby, where the

age of buildings meant it was a continuous struggle to provide an effective heating system. At Werrington, while improvements made over previous years were praised (such as the installation of more in-cell showers), the infrastructure was poor and the buildings were generally forbidding and institutionalising. The outlook at Parc was more positive, with a good standard of accommodation and renovations in progress.

A common problem faced by all YOIs was the shortage of rooms available, which particularly affected the delivery of one-to-one interventions. Often this was as a result of destruction of property by children, which could leave rooms out of order for weeks or months, sometimes taking dedicated facilities or units out of use. At Feltham, the enhanced support unit was seriously damaged in October 2023 and remained out of action until late 2024. Similarly, the welfare and development enhancement (WADE) reintegration unit at Werrington was closed for several weeks after a young person caused serious damage. At Wetherby, the library was out of use for a period of time following a serious incident.

Many children spent long periods separated from others, receiving very little education or exercise

IMBs monitoring English YOIs continued to report on the high numbers of children with complex needs held on separation units, although Parc reported reductions in both the number of children separated and the average length of separation; separated children were also incentivised to live as one community at Parc. The efforts of staff to support these young people, under very challenging conditions, were generally praised. However, both Wetherby and Feltham IMBs were concerned about some young people who spent extremely long periods separated, some of whom were likely to remain in the separation centre until release; this usually related to young people separated for their own protection.

In this context, the limited regime and education offered on these units was of deep concern. Both Wetherby and Feltham IMBs reported on the limited and inconsistent delivery of education on the units. At Wetherby young people only received 30 minutes a day in the fresh air and did not have any access to the gym during the week. The Board described the limited regime as not only inhumane but degrading, although they noted some improvements towards the end of the reporting year.

Relationships between staff and children varied significantly

Relationships between staff and children varied both between and within YOIs, and it was clear that this depended on staff confidence and opportunities for meaningful interaction. At Feltham, it was noted that the efforts of the standards coaching team, which was brought into the YOI in October 2023, had resulted in a noticeable improvement in staff confidence. Relationships between staff and young people were consequently observed to be very good by the end of the reporting year and staff attrition rates had fallen. At Parc, where staff-child relationships have been described as positive for the past several years, the supportive and caring culture was maintained despite periods of transition to new leaders.

In contrast, at Werrington the Board rarely saw protracted conversations or warm communication between young people and officers, noting “It continues to be difficult to see how meaningful communication through conversations could be achieved through locked doors.” At Wetherby, staffing levels had improved towards the end of the reporting period and an uptick in absences had been successfully addressed. The Board described most staff-child interactions as good, although there were some concerns about the inexperience and youth of many officers. Custody support plans (CuSPs, the equivalent of key work in the adult estate) showed promise but were inconsistent and underutilised in all establishments; at Wetherby, some young people told Board members that they did not know what a CuSP was or who their CuSP officer was.

Efforts to address equality and diversity issues were mixed

Parc saw increased support for and prioritisation of the diversity and inclusion function, and Wetherby and Feltham reported some good initiatives to improve attitudes surrounding race and sexuality. However, this was said to have mixed success at Wetherby: while staff became more confident in challenging inappropriate behaviour and there were efforts to improve the DIRF process, DIRF levels remained high and the Board concluded that racism was still an issue. At Werrington the number of DIRFs submitted increased, and the Board believed that the children had been let down by a lack of governance in equality and diversity for part of the reporting year.

2.3 Health and wellbeing

Mental health care and social care sometimes fell short

General health care was reported on positively, especially in comparison to the adult estate. However, Boards had continuing concerns about the care that could be provided for young people struggling with mental illness, and about the obstacles to carrying out successful mental health and social care interventions.

Wetherby IMB reported that Children and Adolescent Mental Health Services (CAMHS) struggled to find appropriate rooms in which to hold appointments, which sometimes led to children’s appointments being cancelled. Feltham similarly noted that the lack of available rooms could impede interventions, and Werrington was concerned that the mental health team often could not meet with boys face to face.

Wetherby and Feltham both reported some improvements in social care staffing throughout the year and noted that social care provision was generally satisfactory. Werrington, however, was concerned about significant social care staffing shortages throughout the year, particularly in the context of the decision (now reversed) to hold 18 and 19-year-olds in the youth estate.[8] Both Wetherby and Feltham flagged that there were often unacceptable delays in receiving the necessary financial support for looked-after children from local authorities.

Children's time out of room was far too limited at English YOIs

The time children spent out of their rooms continued to be far too low and inconsistent, and was a priority concern for all English YOI IMBs. It was particularly poor at weekends and for separated children. At Feltham, some boys could spend up to 23 hours a day locked up when staffing levels were low, such as on August weekends, and at Wetherby, separated children could spend up to 22 hours a day in their rooms. Werrington reported that time out of room had further decreased from the previous reporting year. Both Werrington and Wetherby highlighted the frustration that young people experienced as a result of unpredictable regimes and poor communication about cancellations and changes. However, at Parc, where time out of room was already better than in English YOIs, time out of room saw an improvement on the previous year.

Wetherby and Feltham also raised concerns about the way in which time out of room data was recorded. At Wetherby, records did not always seem to reflect what Boards observed on the wings. At Feltham, time out of room data was not readily available and there was no evidence that instances of boys receiving less than two hours' time out of room were being flagged.

2.4 Education and training

The quality and quantity of education on offer was generally poor

Education for children continued to be a troubled area, with sessions frequently cancelled (often at short notice) due to staff shortages or serious incidents, and sometimes disrupted by poor behaviour. At Feltham, 1,991 hours of education were cancelled during the reporting period; at Wetherby this figure was 12,500. Wetherby's education service was assessed as 'Requires Improvement' by Ofsted in December 2023 and the provider was subsequently issued with a notice to improve in 2024. Werrington's education received an inadequate Ofsted rating in August 2023, but was found to have made reasonable improvement in the follow-up visit in May 2024. Both Feltham and Werrington described the quality of the education, when it was delivered, as varying widely from excellent to poor. At Parc there was a decline in the quality of education in the first half of the year, but this had been successfully course-corrected by the year's end. The new curriculum was designed to help children develop the basic social skills needed in the workplace.

Werrington IMB additionally raised significant failings in the support of an academically promising child who wished to pursue A-level studies. He was so demotivated by repeated broken promises over several months that he told IMB members he felt there was 'no point' in making any more attempts to progress. The Board shared their concerns about this case and other issues around education provision with the Governor and the Director of the Youth Custody Service who were receptive to the need for change. The education provider has subsequently been issued with an Improvement Order. The Board is confident that should a child at Werrington want to study to A-level standard now, appropriate support would be made available.

Vocational training was generally well received where it was available, with Feltham describing the skills workshops as ‘pockets of excellence’. However, there were too few places to meet the needs of young people; at Feltham these workshops could only accommodate 4-6 at a time, and at Wetherby several workshop courses were unable to run due to recruitment issues reducing the number of places available. Werrington noted the lack of variety available and reported that young people were not always able to select their preferred pathway.

2.5 Progression towards transfer or release

Resettlement

Preparations for transfer or release were generally carried out well by both the YOI and, where applicable, the receiving establishment. However, Wetherby and Feltham both had concerns about the care that could be provided for those on remand or those serving very long sentences. Werrington, on the other hand, observed some improvement in the work carried out with those serving longer sentences.

3. Immigration detention

Key findings

- The population in IRCs increased, detention centres were ill-equipped to respond to the changing demographic and safety was adversely affected as a result.
- Male immigration detention centres became increasingly unsafe, and substance misuse increased significantly across the estate.
- A concerning number of people resorted to self-harm, suicide attempts were commonplace, and distress was widespread.
- Vulnerable people were exposed to unnecessary harm.
- There was an increase in the use of force and the principles of usage were not always followed.
- Processes for identifying vulnerable people were applied inconsistently.
- There was inadequate provision of basic necessities in STHFs, including food and bedding.
- People were detained in settings that failed to provide humane standards of accommodation.
- There were serious concerns about practices during the removal of significantly vulnerable people.
- A concerning proportion of people detained in IRCs experienced acute and complex mental health issues and centres were not equipped to provide the care they required.
- People detained at the majority of STHFs continued to be denied access to their prescription medication, placing their health at significant risk.
- People were detained for exceptionally long periods, with no real prospect of removal and communication on the progress of cases was poor.
- People were routinely held in STHFs beyond the statutory 24-hour time limit.

Population changes

The population of detention centres increased and there were significant changes to the demographic of those being held.

The increased and changing population in immigration detention was, in part, a consequence of the capacity crisis affecting the prison estate. The Home Office continued to provide support to HMPPS to alleviate the prison capacity crisis through measures known as Operation Safeguard. Under Operation Safeguard, the number of people transferred from prisons to immigration detention significantly increased. To facilitate the reduction in the number of foreign national offenders (FNOs) in prisons, the Home Office amended the risk assessment criteria for immigration detention. This resulted in a higher volume of transfers of time-served FNOs, including those who had been convicted of violent offences, sexual offences and those who had been assessed as posing a significant risk of harm to children.

IMBs at most IRCs reported concerns over detention centres being ill-equipped to handle these changes. Boards observed an increase in violence and altercations between detained people, with staff unable to maintain a safe environment, free from disorder (as at Harmondsworth and Colnbrook). As a result of the increased occupancy of IRCs, detained people were increasingly room sharing at some centres, and rooms previously occupied by one person had bunk beds installed. The Home Office's management of this process appeared to prioritise operational constraints over adequate consideration of and planning for people's needs. Prior to this expansion, IMBs had raised concerns over the adequacy of essential provisions, including healthcare capacity and safeguarding processes, to meet the needs of the population, which the Home Office failed to resolve.

3.1 Safety

Male immigration detention centres became increasingly unsafe, and substance misuse increased significantly across the estate

Violence was a frequent occurrence in some male detention centres. At Harmondsworth and Colnbrook IRCs in particular, the Board found that assaults between detained men and assaults on staff, as well as the use of improvised weapons, affected the safety of the centres. Safety was further compromised by the failure to ensure detained men were protected in emergency situations. For example, on one occasion, staff failed to evacuate two men who were later found locked inside their rooms which raised significant concerns about emergency procedures.

Illicit drugs, which have rarely been found in immigration detention in the past, became commonplace. This may have contributed to disorder, with some violent incidents thought to have been drug related. Substance misuse, including psychoactive and synthetic substances, had a knock-on effect on healthcare, with ambulances required in some instances. At Brook House IRC dealers were thought to have used vulnerable men as guinea pigs to test these substances, with one man requiring medical care on several occasions as a result.

Serious incidents were a frequent source of disruption throughout the year. On many occasions unresolved frustrations escalated into organised protests, such as men refusing to return to their rooms or climbing onto the netting, sometimes for many hours. There were some instances where property was damaged, force was used, and input from the National Tactical Response Group was required. The source of this frustration, IMBs were told, included the slow progression of immigration cases, the lack of communication from the Home Office, the length of detention for those who wanted to leave the country voluntarily, healthcare issues, and safety concerns. On one occasion detained people protested over the treatment of a man who had died in detention.

A concerning number of people resorted to self-harm, suicide attempts were commonplace, and distress was widespread

An increasing number of people in detention resorted to self-harm, some prolifically. IMBs were also very concerned about the rise in numbers attempting suicide while detained, evidencing high levels of distress across the IRC estate.

As well as observing these acute symptoms of distress, IMBs at detention centres reported on a high proportion of the people they spoke to struggling with poor mental health and feelings of depression since arrival. IMBs felt that seeing detained people in distress became normalised for staff, perhaps as a result of the pervasiveness of poor mental health among the population. Boards questioned whether enough was done to understand, address and prevent issues that exacerbate poor mental health and feelings of distress in detention, and which may have contributed to self-harm rates.

Care plans were used to manage those identified as at risk of suicide or self-harm. However, the number of people requiring constant supervision increased at some centres, necessitating significant resource. Some mental healthcare departments were worryingly understaffed and overloaded by the level of need at points, and some detained people went without the psychological support they required; talk-therapy or counselling services were not available to many of those it may have benefitted. As a result, the needs of many of those experiencing significant distress could not be met and the mental health of some individuals deteriorated to the point where, unable to cope, they caused serious and life-altering harm to themselves.

Vulnerable people were exposed to unnecessary harm

Gatwick and Heathrow IMBs wrote to Home Office officials in May 2024, escalating their concerns over the serious failings they had observed in the Home Office's statutory duty to protect vulnerable people from harm

IMBs found that detention centres were ill-equipped to manage population changes, and that a rise in the number of vulnerable people detained revealed systematic failings in the safeguards intended to protect them. As part of the admissions process in IRCs, it is a statutory requirement that all consenting arrivals must receive a healthcare screening within 24 hours. These Rule 34 examinations act as an essential safeguard for healthcare staff to identify vulnerabilities at the earliest opportunity. Furthermore, Rule 35 requires that healthcare practitioners report without delay (following this initial examination or at any point during an individual's detention), the case of any person whose health is likely to be injuriously affected by detention, those who are suspected of having suicidal intentions, or those who may have been a victim of torture.

IMBs, however, observed failures in these processes when a higher proportion of vulnerable people were detained. In Spring 2024, there were widespread failures in compliance with wait times for both Rule 34 and Rule 35 assessments. IMBs found that new arrivals in detention were left waiting as long as 14 days for Rule 34 appointments at some centres. As a result, early opportunities to assess individual needs, and provide appropriate care, were missed. At the same time, wait times for a Rule 35 assessment were 19 days in these centres. This resulted in a combined wait time of 33 days for some new arrivals during this period.

As an administrative process, detention should only be used as a last resort and existing safeguards should work to identify vulnerable people, review the appropriateness of their detention, prevent them from harm and provide them with appropriate care and support. However, systematic failures in these safeguards were identified across the detention estate.

If the IRC doctor considers that one or more of the criteria of risk in Rule 35 apply, they must complete and submit a report without delay to the Home Office. The appropriateness of continued detention is then reviewed, considering the doctor's assessment. Home Office guidance is clear that there is a presumption that detention is not appropriate if a person is "at risk". However, the Home Office balances this presumption alongside the weight of immigration control considerations in each individual case.[9]

Many people, however, remained in detention for months after a doctor had assessed that they would be at risk of harm from detention, despite the Home Office having decided that the risk of harm outweighed immigration control considerations and that they should be released. This was often due to the lack of effective pathways to appropriate support for them.

One IMB monitoring at a male IRC raised serious concerns about the continued detention of a vulnerable person, confirmed to be at harm

Mr A arrived in detention, having been transferred to the IRC in an ambulance. He had numerous medical and mental health conditions, including cerebral palsy, epilepsy, mobility issues and learning difficulties. Communication was difficult for Mr A, even with native speakers of his first language.

A Rule 35 assessment was completed soon after his arrival in detention. The doctor concluded that the detention of Mr A was "grossly detrimental to his wellbeing" and reported to the Home Office that it was "unsafe to look after him at the detention centre". Unable to live amongst the general population, Mr A remained in the healthcare facility throughout his period of detention, which was located on the second floor. The IMB observed the efforts of staff, who did their best to support him, but as he was unable to move about the facility without assistance, he spent the majority of his time confined to one room.

The IMB were extremely concerned about Mr A's wellbeing. The Board questioned the appropriateness of his detention at the establishment and whether he was receiving the care he required at monthly meetings with centre management. His physical health was impacted during his time in detention with at least one admission to hospital. Mr A's mental health was also adversely affected; the Board observed him in distress at his situation and he made it clear that he wanted to return to his country of origin.

In the end he was detained on the inpatient's unit in the IRC for a period of 10 months between 2023 and 2024, despite having received a Rule 35 assessment in his first month there, identifying that he was at risk of harm from detention.

Across the estate, ineffective processes were observed during reception interviews, the first opportunity for identifying vulnerable people and recording safeguarding needs. Detained people were seen being asked about any history of exploitation, sexual abuse or modern slavery in non-private spaces.

At STHFs across the country, processes for recording those who had been identified as vulnerable were inconsistently applied. IMBs reported that vulnerable adults were not always identified as such in detention records and safeguarding issues were poorly recorded. Procedures for identifying vulnerable people were mismanaged and it was not always clear where responsibilities lay between Border Force and contractors managing STHFs, resulting in a lack of accountability.

In one example, the IMB monitoring STHFs in the south and west was concerned about the treatment of a family of five with children, the youngest being three years old, claiming asylum. They were held in a Controlled Waiting Area (CWA) for nine hours through the night. Permission to allow access to the facilities in the STHF, which would have provided the family with more amenities and the opportunity for respite was authorised at some point during the night but staff failed to see the notification.

At shift changeover, concerns about the family not having been properly processed were logged and important records, that would have documented their vulnerabilities, were missing, which has child safeguarding implications. The IMB was extremely concerned about the failures surrounding the treatment of this family.

There was an increase in the use of force and the principles surrounding usage were not always followed

Use of force against detained people increased during 2024. At some detention centres force was used in response to altercations and Boards were told that the increased levels were, in part, due to changes in the demographics of the IRC population under Operation Safeguard. Force was also frequently used to facilitate removals, and on some occasions was applied for prolonged periods, including on vulnerable people. The CFMT (charter flight monitoring team) found that the decision-making process and records relating to use of force were not always clear.

IMBs monitoring at IRCs and STHFs had significant concerns about the frequency with which force was applied. For example, Boards across the estate described observing a ‘blanket approach’ to handcuffing, which should only be used as a last resort and on a risk assessed basis. Gatwick IMB found that close to 100% of people taken to hospital appointments were handcuffed, and the Board was told by the centre that this was deemed necessary due to the implications of Operation Safeguard and the case of one absconder. This explanation raises serious questions about the risk assessment process and whether a widespread approach to the use of force with detained people was adopted largely on the basis of a single case. As a result, some people were reluctant to go to hospital given the stigma surrounding being handcuffed, evidencing that this practice could limit access to healthcare for those requiring medical attention.

IMBs monitoring STHFs observed the sweeping use of handcuffs by escort teams responsible for transporting people around the detention estate; the handcuffing of people on transfer was standard practice. The Board monitoring the STHF at Sheffield Vulcan House repeatedly raised concerns about the safety of the vehicle loading bay. Detained people were escorted to vans through an area used to store hazardous items, which someone could use to harm themselves or use as a weapon. To mitigate against this, detained people were handcuffed as standard instead of resolving the problem and ensuring the area was safe.

As well as the principles that force should only be used on a risk assessed basis and as a measure of last resort, detained people should never be threatened with force as a means of getting them to comply with the operational preferences of the Home Office. Women, however, were threatened with the use of handcuffs if they did not agree to a transfer from Yarl's Wood, in Bedfordshire, to Derwentside, near Durham. As Derwentside IRC is hundreds of miles away from Yarl's Wood, this would make visits from family members or legal advisers for most women highly unlikely. Yarl's Wood IMB had previously been assured that force would not be used if transfers were for administrative or operational reasons. Women were nevertheless told by one member of staff that non-compliance with the move would result in handcuffing, which IMBs considered entirely unacceptable.

The use of care and separation units increased

IMBs were concerned about the number of people that were removed from association, the length of time that some were placed in care and separation units (CSUs) and, in some instances, the justification for its use. Boards at male IRCs found that the use of CSUs was high throughout the year.

Individuals were often placed in CSUs for periods that well exceeded the time expectations set out in legislation (no more than 24 hours, although this can be extended to a maximum of 14 days by the Secretary of State in exceptional circumstances).[10] IMBs found that some of those separated had their 14-day authorisations renewed and spent many weeks in CSUs as a result.

People with complex mental health issues were also held in CSUs for prolonged periods due to the lack of alternative, appropriate means to care for them, and as they were often unable to cope amongst the general population. Heathrow IMB raised concerns about the separation of a vulnerable man, held in the CSU for over a month due to his mental state, during which time the Board observed an apparent deterioration in his mental health. A man with mental health problems was confined to the CSUs at Yarl's Wood IRC and Brook House IRC for a combined period of nine weeks before he was eventually transferred to the prison estate, where the IMB was told he could be more appropriately cared for. It was concerning to IMBs that detention centres failed to provide a suitable environment for those with complex needs, housing them for long periods in CSUs which, in many cases, resulted in further deterioration.

The Detention Centre Rules allow for a detained person to be placed in separation under Rule 40 when it "appears necessary in the interests of security or safety". However, as the population of centres increased, those that refused to share a room

were consistently placed in separation. At Harmondsworth IRC, there were periods when five Rule 40 applications were being made per day for this reason. Another common justification for the use of Rule 40 was in preparation for the deportation removal process. IMBs were frequently told by detention staff that it was necessary to 'position' people, isolating them from the general population days in advance of their removal flight, as an assessment had been made that they may try to disrupt the collection process. IMBs consistently questioned the common practice application of the use of separation, which IMBs maintain ignores the principle of separation as a measure of last resort.

3.2 Fair and humane treatment

Processes to manage the expansion of the detention estate failed to adequately prioritise and plan for the needs of the detained population

At the start of the year the Home Office announced that Derwentside, a women's IRC, would be reroled as a detention centre for men to accommodate the expansion of the estate. The IMB reported concerns over management's focus moving away from the provisions for the women detained there as preparations for the rerole were prioritised, despite the change not materialising.

In May, IRCs started to receive those who were detained having been designated for possible relocation to Rwanda. Despite Gatwick IMB having raised concerns as early as January about the levels of preparation to support this cohort, when they arrived in detention healthcare was unable to provide statutory examinations within 24 hours of arrival. The Home Office's lack of preparation and understanding of what this group would need was demonstrated in part by the fact that the main information leaflet about relocation to Rwanda was initially only available in English.

People were held in places without access to adequate facilities or privacy from public view

Throughout the year, a shortage in Border Force staff, amongst other reasons, resulted in many people, including young children, being detained for hours in CWAs instead of holding rooms. Typically, CWAs comprise nothing more than a few chairs positioned adjacent to passport control and are used to seat those waiting for Border Force to complete immigration controls.

Care & Custody, a contractor managing some STHFs, refused to admit children to holding rooms without an adult present. As a result, unaccompanied children were left exposed to public view for many hours in CWAs, unable to access the facilities available in holding rooms. While IMBs were advised that Border Force officers aimed to be mindful of any unaccompanied minors in this position, Boards found this insufficient reassurance that children were being provided with adequate support.

At Frontier House, an STHF used to process people identified in lorries or freight lanes at the Kent coast ports, there was only space to induct one person at a time. Others were left waiting in vans outside the facility, which staff agreed with the IMB was unacceptable.

There was inadequate provision of basic necessities in STHFs, including food and bedding

People were detained overnight in facilities that were ill-equipped. It was common for people to be left without bedding and many sat through the night on hard plastic chairs or slept on the floor. The mattresses that were available were so thin that people tended to need to use two together.

Unable to meet Local Authority requirements, hot food was withdrawn from all Border Force managed STHFs in July 2023. Failing to resolve the issue, many Border Force controlled holding rooms remained unable to provide hot food or drinks throughout 2024. IMBs were particularly concerned about the lack of hot food for those held at ports, where people may have arrived after long and arduous journeys. Where hot food was available it didn't always meet the needs of those detained, for example IMBs found that some settings didn't offer Halal options.

People were detained in settings that failed to provide humane standards of accommodation

People detained at both IRCs and STHFs were impacted by recurring and persistent maintenance issues which often went unresolved for many months, and in some instances resulted in wholly unacceptable living conditions. Maintenance delays at STHFs were exacerbated at ports and airports where the number of agencies involved created lengthy decision-making processes.

Some people held in STHFs were exposed to unacceptable temperatures. On one occasion, a family of four held at Birmingham Airport had to be moved out of the family holding room after it was discovered that the temperature of the room was just 10.9 degrees Celsius. At Heathrow IRC, a fault in the ventilation system created extremely high temperatures on a residential wing and fans were not provided to keep people cool.

At Tinsley House IRC, persistent drainage issues resulted in blocked toilets and foul smells in the residential area. The IMB noted that major investment was required to permanently resolve these issues. On just one visit to Tinsley House, a member received 20 applications from detained people about living conditions and cleanliness at the centre, including having to go without toilet paper and soap, the lack of shower curtains and regularly overflowing bins. Men detained there told the IMB that they were too frightened to make formal complaints to staff about conditions, in fear of action being taken against them in their immigration cases. The Board therefore raised these issues on behalf of detained people and while some action was taken, the centre remained grubby, smelly and messy.

Translation and interpreter services failed to meet the needs of detained people

Detained people were disadvantaged by the lack of sufficient translation and interpreter services, and some individuals were unable to communicate with or receive information from staff. For example, the effectiveness of some reception

interviews in which vulnerabilities are meant to be identified and risks assessed, were significantly undermined.

At STHFs in many ports and airports, the lack of signal meant that staff were unable to communicate with anyone detained who did not speak English. Furthermore, some translation tablet devices failed to translate to all languages, so those that spoke languages such as Bengali had no way of speaking to staff. This lack of understanding over what was happening on arrival to the UK, for example that they were being detained, is likely to have been extremely distressing for those affected. There were also persistent problems with the availability and operation of translation tablets at some IRCs, and interviews necessary for the progression of immigration cases were sometimes cancelled due to a lack of interpreters.

IRCs frequently made unreliable assessments ahead of the removal process based on an individual's ability to understand English; too often it was assumed that a person could understand all that was being said to them if they could speak a few basic words of English. Additionally, professional interpreters were consistently unavailable during removal operations. IMB members observed the negative impact this had on the many people identified as requiring language support, who it was clear did not understand what they were being told during the removal process.

People were confined in vehicles for unacceptable lengths of time

The operational planning around removal processes was often poor, and airports located hundreds of miles from the majority of IRCs in the south of England were frequently used. It was common for those being collected from IRCs to spend hours on a coach in the detention centre car park before setting off. As well as lengthy journeys, there were also instances of vans arriving too early spending hours parked outside airports before being able to enter. As a result, it was common for people to spend up to 12 hours confined in a coach before being removed from the country.

Boards monitoring at IRCs found that people were often being transferred or arriving at detention centres through the night. At some points, as many as 50% of all women at Derwentside were transferred during the night due to staff shortages. IMBs found that night-time arrivals following long journeys were disorientating and stressful for women, and best practice for risk assessing individuals and identifying vulnerabilities or needs were less likely to be followed.

There were serious concerns about practices during the removal of significantly vulnerable people

While monitoring charter flight removal operations, IMB members raised serious concerns about the practice of removing those detained in secure mental health facilities directly from these hospitals. In all cases that the CFMT were made aware of, these individuals had been detained in hospital having been sectioned under the Mental Health Act. Here, they were served legal paperwork not by immigration officials, but by hospital staff, and in all cases individuals waived their legal rights in the process.

Healthcare staff, however, have no understanding of complex immigration processes and are therefore not able to effectively explain the process to their patients or ensure they have understood it. It is of concern that these legal documents were being served without proper procedure or oversight.

The IMB National Chair has written to the Director of Returns for Home Office Immigration Enforcement outlining IMBs' findings and seeking assurances on how these concerns will be addressed to ensure that the process of removing vulnerable individuals is transparent, lawful and follows due process. In response, we have been advised that current operational practice, guidance and legislation around the service of immigration documents to those detained in hospital will be reviewed by 31 May 2025, the outcome of which the IMB eagerly awaits.

3.3 Health and wellbeing

A concerning proportion of people detained in IRCs experienced acute and complex mental health issues and centres were not equipped to provide the care they required

It was commonplace for IMBs to observe the detention of individuals with complex and acute mental health needs. Some people were so unwell that they were sectioned under the Mental Health Act. Care and support were delivered by staff who, despite their best efforts, were not equipped to manage such high needs. IMBs questioned the absence of trauma informed practice for supporting those with complex needs and recommended that all detention staff receive mental health first aid training.

The ability to provide appropriate care was further limited by poor communication from other agencies, such as HMPPS. Throughout the year, people with complex mental health issues were transferred from prison and police stations, arriving at IRCs without handover documentation or medication.

Once in immigration detention, some spent many months awaiting transfer to hospital, as the number of bed spaces allocated for individuals from detention centres was not reflective of the level of need, or in line with the rising occupancy of centres. This meant that those in need of inpatient care over and above allocated levels remained detained without the required treatment.

Gatwick IMB reported that the quality of mental health care was inadequate, nurses appeared overloaded and under-supported, and the three most senior healthcare positions did not have anyone permanent in them.

People detained at the majority of STHFs continued to be denied access to their prescription medication, placing their health at significant risk

In non-residential STHFs, Home Office policy requires that all medication, including prescribed medication, must be removed from every person detained. Detention custody officers (DCOs) are not authorised to dispense medication even when a person requires a regular dose at a specified time. Most STHFs have no specific provision for healthcare and at these facilities, if a person requires medication, staff

must first obtain medical advice via NHS phone services or other emergency service facilities. IMBs have found that this process often results 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 and have continuously urged the Home Office to extend healthcare services to enable vital healthcare provision. The Home Office has finally reported that it will be awarding a bid for medication provision in 2026; in the meantime, however, those detained in the majority of STHFs will continue to be denied access to their prescribed medication, placing their health at unnecessary risk.

3.4 Preparation for return or release

Case progression was slow and communication poor

A higher proportion of those detained in IRCs in 2024 had been transferred from the prison estate. For too many people, it was not until they arrived that any work commenced to progress their immigration case. The time that they had spent in prison was not used effectively by the Home Office to make arrangements for their removal, such as identifying passports or other necessary documents, which would have expedited the process and prevented long, costly periods of immigration detention. IMBs observed first-hand the distress this caused time-served foreign national offenders (TSFNOs) who described feeling that they had been punished with a double sentence.

Many were willing to leave the country voluntarily but, due to delays, instead remained in detention for extended periods. Those affected expressed frustration at the length of time it took to progress their cases. Some told IMBs that they would be willing to book their own flight, but Home Office policy prevented them from doing so. TSFNOs who signed voluntary return forms whilst in prison also had to wait months before eventually returning home.

Slow case progression was coupled with poor communication. Without information on the status of their immigration case, those detained often became increasingly anxious. In 2024, the Detention Duty Advice Scheme and legal aid solicitors were given the option to hold appointments remotely; feedback to IMBs suggests this has disadvantaged those in detention who are trying to navigate often complex paperwork written in English. In addition, many people reported having limited communication with their engagement officer and probation services. Those that did manage to obtain an update often told IMBs that they struggled to understand the information they received.

People were detained for exceptionally long periods, with no real prospect of removal

With no statutory time-limit on immigration detention, IMBs observed the impact indefinite and prolonged detention had on people. Many were detained in IRCs for over a year and, in the year ending September 2024, the highest number of people

were detained for over six months since 2018. To be lawful, however, immigration detention must only be exercised when there is a realistic prospect of removal within a reasonable timeframe. IMBs questioned whether these timeframes could be considered reasonable.

Many people continued to be detained for months after they had been granted bail due to delays in securing or approving accommodation. For example, Gatwick IMB reported on two men waiting at least three months after being granted bail before being allowed to leave detention, receiving little in the way of updates in the meantime. The impact on the wellbeing of those affected was concerning, with a number of people reporting distress caused by delays in their immigration case as their reason for self-harming.

People were routinely held in STHFs beyond the statutory 24-hour time limit

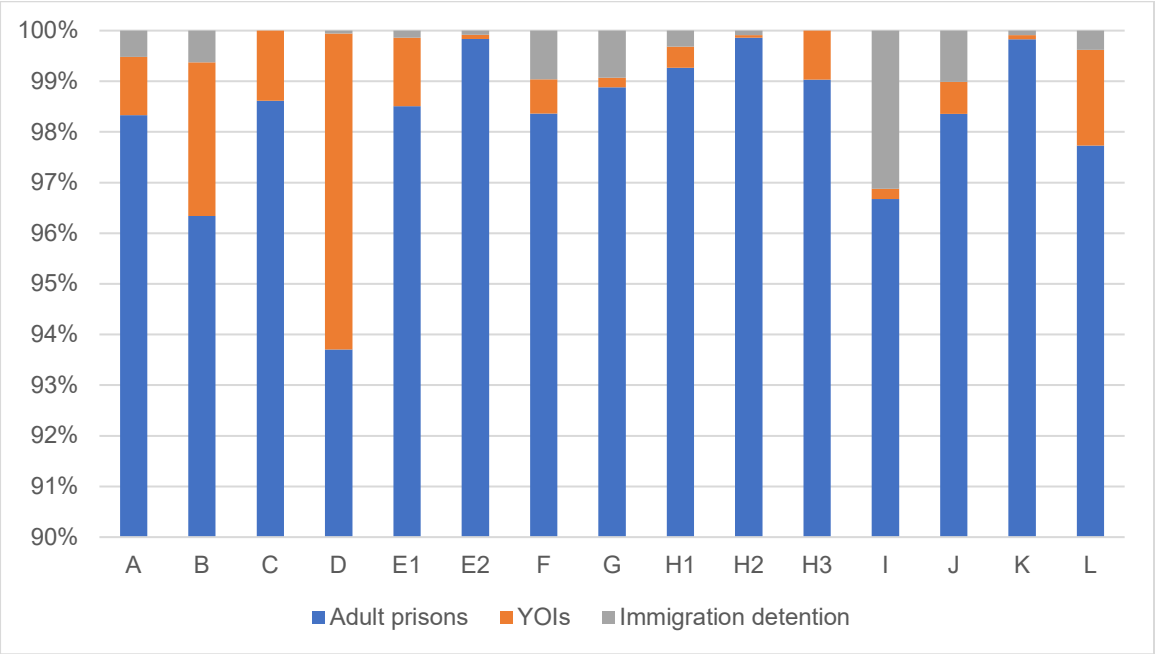
The statutory time limit for detention in holding rooms is 24 hours, only to be exceeded in exceptional circumstances with authorisation from the Secretary of State. People, however, were still detained beyond 24 hours. IMBs across the estate were concerned about the length of detention in small, windowless rooms without access to any fresh air or natural light.

Annexes

Annex 1: Applications

Over 30,400 applications were made to IMBs across prisons, YOIs and the immigration detention estate (IDE) during 2024:[11]

Graph 1: Percentage split of applications made across detention settings by category type[12]



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

1,186 members were in post across **132** Boards as of 1 January 2025.

Table 1: Members in post by region

Regions	Members in post
East Midlands	102
Eastern	114
Kent, Surrey and Sussex	92
London	160
North East	60
North West	119
South Central	88
South West	101
Wales	40
West Midlands	97
Yorkshire and Humber	96
IDE	117
Total	***1,186***

Table 2: Members in post by detention setting[13]

Setting	Members in post
Prisons	**1,039**
Male prisons	923
Female prisons	116
YOIs	**39**
IDE	**123**
IRCs	48
STHFs	69
Charter flights	6

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 73% of total members in post, 27% of members in post did not respond or preferred not to say.

Ethnicity	Percent (%)
Asian	4%
Black	3%
Mixed	1%
Other ethnic group	1%
White	91%
Total	***100%***

Endnotes

[1] Independent Monitoring Boards, National Monitoring Framework, published February 2021.
[2] 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.
[3] Estimated national figure based on IMBs reported visits data.
[4] SDS40 allows eligible prisoners serving a standard determinate sentence (with a 50% conditional release point) to be released at the 40% point of their sentence. Some prisoners, such as those convicted of sexual offences, are excluded from the scheme. SDS40 has been in operation since 10 September 2024.
[5] Breaking point: the impact of a crumbling prison estate on prisoners, IMB, 27 November 2024.
[6] Chaos in the crisis – the damaging loss of prisoners' personal property, IMB, 25 September 2024.
[7] Segregation of men with mental health needs, IMB, 25 January 2024.
[8] Between November 2022 and October 2024 the government changed the youth estate transitions policy to raise the age young people transferred from the children's secure estate to the adult secure estate from 18 to 19, in response to capacity pressures in the adult prison estate.
[9] Detention Services Order 08/2016 Management of adults at risk in immigration detention, August 2022.
[10] Detention Centre Rules (2001), Part III, Rule 40.
[11] This data is taken from annual reports published in 2024.
[12] This graph includes in-person and written 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.
[13] 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.