Independent Monitoring Boards

Annual Report of the short-term holding facilities in Scotland and Northern Ireland

For reporting year
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national preventive mechanism

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1. Statutory role of the IMB

The Scotland and Northern Ireland Short-term Holding Facilities Independent Monitoring Board is appointed by the Home Secretary to monitor and report on the welfare of people in a Short-term Holding Facility (STHF) through observation of their treatment and of the premises in which they are held.

The Board conducts its work in line with the Short-term Holding Facility Rules 2008, which place the day-to-day operations of STHFs on a statutory footing. Part 7 of the Rules sets out the responsibilities of the Independent Monitoring Board (referred to in the Rules as the Visiting Committee). The Board has unrestricted access to every detained person and all immigration detention facilities and to most records. IMB members have access, at all times, to all parts of the facility and can speak to detained people outside of the hearing of officers. They must consider any complaint or request which a detained person wishes to make to them and make enquiries into the case of any detained person whose mental or physical health is likely to be injuriously affected by any conditions of detention. The IMB must inform the STHF manager about any matter which they consider requires their attention, and report to the Secretary of State about any matter about which they consider the Home Office needs to be aware.

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

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

2. Description of the facilities

We monitored **Larne House,** a Residential Short-term Holding Facility based at Larne Police Service of Northern Ireland (PSNI) station. There adults can be held for up to seven days before removal from the UK or transfer to an immigration removal centre (IRC) in Great Britain.[1] It has five single bedrooms, two double bedrooms, and a four-bed room. Facilities include a dining room, recreation room, and outdoor access. The Home Office contracts Mitie Care and Custody to manage the facility.

We also monitored two **reporting centre holding rooms.** One is at Festival Court in Glasgow and another at Drumkeen House in Belfast. The Home Office contracts management of both rooms to Mitie Care and Custody. These holding rooms can detain adults and children for up to 24 hours, after which people are either transferred to another facility or released.

Some ports of entry have **non residential holding short-term holding rooms.** These can detain adults and children for up to 24 hours, which can be extended, under authorisation, in exceptional circumstances. This applies to those arriving to the UK, returning for further Border Force interviews, or brought from other detention centres for removal from the UK. We monitored the following:

- At **Aberdeen Airport** a holding room is in the main terminal. Border Force runs this facility.
- At **Edinburgh Airport** a holding room is in a modular building outside the terminal. The Home Office contracts management to Mitie Care and Custody.
- At **Glasgow Airport** a holding room is in the main terminal. The Home Office contracts management to Mitie Care and Custody.

Ports of entry also feature controlled waiting areas (CWAs), which Border Force administratively designates as distinct from holding rooms. As such, CWAs are not regarded as short-term holding facilities. This means that CWAs are not subject to statutory rules that limit detention periods or establish baseline standards for care and treatment. Despite this, individuals can be deprived of their liberty in these areas for extended periods. For example, one person was held for 10 hours at Belfast International Airport.

The Home Office does not permit us to access CWAs, even if a holding room at the same port is monitored. As a result, people held solely in CWAs remain invisible to the IMB. The only exception to this was at Prestwick Airport, where we monitored the CWA while the holding room was closed for repairs. However, in November 2024, the director of Border Force national headquarters abruptly terminated the monitoring agreement, offering no rationale for how this decision was consistent with OPCAT or how it would improve care standards, transparency, or accountability.

1 Extensions to the maximum periods of detention noted in this section may be authorised.

Prestwick now joins other ports of entry in the UK as places where a person can be deprived of their liberty without any independent oversight from a UK NPM body.[2] This is an intolerable position.

2 Controlled waiting areas are not mentioned in the MoU with HM Inspectorate of Prisons.

3. Key points

3.1 Background to the report

3.1.1 Short-term holding facilities (STHFs) detain individuals who may not have the right to enter or remain in the UK. But this does not necessarily mean all people in detention at STHFs have broken any laws. For example, many at airport holding rooms are eventually released. Detention may cause uncertainty and distress, especially for children, people with mental or physical illness, and survivors of modern slavery.

3.2 Main findings

3.2.1 We have observed both good and poor practice, with significant variations in standards. For example:

Safety:

- Men and women were still detained together at Larne House, despite the Home Office's 2021 commitment to end this practice.
- The use of force is supposed to take place only when necessary and lawful, yet a blanket handcuff policy was implemented by the Care and Custody provider and applied unnecessarily.
- There are several areas where a strategic focus on continually improving safe delivery of detention is not evident, such as induction and provision for children and families.

Fair and humane treatment:

- During the Board's observations, staff usually treated people in detention in a way that was dignified and took account of their needs; however; this was not always the case.
- Issues persist in accommodation standards, including cleanliness and fitness for purpose as the housekeeping standards can vary on a day to day basis.
- In our view, several other aspects are concerning, such as the unusually low number of formal complaints, which contrasts with concerns raised in our visits.

Health and wellbeing:

- At holding rooms, healthcare provision varies by location rather than clinical need for the individual.
- Prescription medications were still removed from persons detained at airport and reporting centre holding rooms. The IMB is of the opinion that this practice poses serious risks to people's health – as mentioned in previous annual reports.

Preparation for removal, transfer, or release:

- People were detained for longer than necessary in unsuitable conditions. For example, some people have been held more than 26 hours with no access to natural light, fresh air or washing facilities.

- We only, currently, have the opportunity to monitor escorting provision, apart from when people are escorted from an airport holding room through the terminal to an aircraft.

3.2.3 Good governance and accountability should be strengthened. For example, transparency has been insufficient. Internal audits are shared only sporadically with us, marked as being protectively marked without clear reasoning, and lacking transparency in methodology. These audits failed to address key issues like culture and whistleblowing. On occasions, other information necessary to carry out our monitoring was either withheld or unavailable. Our view is that defensiveness continues to be a concern, with responses to our enquiries focusing on defending past actions or citing policies, rather than recognising areas for improvement. We also observed unwarranted variations in services, like healthcare in holding rooms, and a lack of collaboration with relevant bodies or adoption of best practices. On occasions the Home Office fails to meet its own targets, including those for length of detention, including 'out of our sight' detention in controlled waiting areas, and poor practices we reported on last year persist, highlighting inefficiency. The Home Office engagement with us in this reporting period has not led to any noticeable improvements.

3.3 Recommendations

3.3.1

TO THE MINISTER

1. Men and women are still detained together at the residential facility at Larne House. Particularly given that men convicted of sexual offences have been detained at Larne House, what will the Minister do to stop this?

2. Ministers should end unwarranted variation and bring immigration detention facilities up to the minimum standards they require of the police. For example, police custody rules prohibit under-18s from mixing with unrelated adults, yet in facilities such as Edinburgh children may have to pass through rooms with unrelated adults to reach the toilet. How does the Minister propose to address this issue?

3. Ministers should also mandate that immigration detention procedures at least meet the same standards expected of the police. A particular area in need of improvement is healthcare:

- **Policies and practices:** A senior clinician should oversee healthcare policies and practices, approving any departure from standards applied in police custody. This would ensure that practices such as the failure to require routine clinical assessment of pregnant women detained at ports, and the lack of provision for people to take their own prescribed medicines in holding rooms – both clear disparities with police custody – are subject to clinical oversight. To date, we are not aware of any clinician having formally approved these practices. How will the Minister bring immigration detention healthcare policies and practices in line with standards applied in police custody?

- **Provision at holding rooms:** As in police custody suites, all monitored facilities should provide access to a healthcare professional, with provision based on clinical need rather than reliance on emergency services. There is no justification for inconsistent standards, such as dedicated healthcare at some airports but no provision at the facilities we monitor. In such circumstances it is unclear to us how Border Force and Immigration Enforcement can be sure that people with health conditions, or those who are pregnant, are fit to be detained and interviewed. How will the Minister guarantee every individual held in immigration receives consistent access to a healthcare professional, based on clinical need?

4. Just as it would be unacceptable for a police force to decide that some police stations were exempt from monitoring, it is not acceptable for the Home Office, as the detaining authority, to distinguish between holding rooms and controlled waiting areas with the effect that the latter are excluded from independent monitoring. This also leaves people detained in CWAs, sometimes for many hours, without the protection of statutory rules, including the time limits that apply to holding rooms. Will the Minister provide a timeframe by which all aspects of immigration detention are subject to independent monitoring, in line with OPCAT?

5. Standards of accommodation vary significantly across airports. For instance, Edinburgh has no showers, despite people being detained there for over 26 hours during this reporting period, whereas Aberdeen has two. We understand one barrier to achieving consistently high standards is that primary legislation restricts the measures the Home Office can require airport operators to implement to improve accommodation. How will the Minister ensure operators implement acceptable standards of accommodation in every airport?

TO BORDER FORCE / HOME OFFICE IMMIGRATION ENFORCEMENT

1. There is an unwarranted variation in practice when Mitie Care and Custody staff use body-worn video but other staff do not. Similarly, interviews are not consistently audio-recorded, despite this having been

standard practice in the police for many years. How will you ensure all appropriate staff make consistent use of body-worn video and audio-record interviews?

2. What mechanisms are in place to detect and address unusually low levels of complaints or staff whistleblowing at the facilities we monitor?

3. How did you investigate the apparent serious governance failures that led Mitie Care and Custody, in May 2024, to issue an instruction mandating the blanket use of handcuffs – a directive it later rescinded?

4. Please clarify when the standards for the care of vulnerable people were last reviewed, how they reflect current evidence, and how they can be effectively enforced. At present, several requirements are expressed in vague or subjective terms, for example, the standard that detainee custody officers should have a ‘meaningful’ conversation with vulnerable people after a fixed period- how do you define ‘meaningful’ and ensure this standard is consistently applied?

5. What have you identified as the causes of avoidable delays in progressing cases and what are the specific actions being taken to address each cause, given that such delays unnecessarily prolong detention and create inefficiency?

TO THE FACILITY MANAGER / DETENTION CONTRACTOR (MITIE)

1. Access to phones in holding rooms is often poor. Information provision can also be weak. For example, some people we spoke to did not recall being informed of their right to legal advice. What steps are being taken to standardise provision in line with best practice, and to properly enforce non-compliance?

3.4 Progress since the last report

3.4.1 In the annex we report on each recommendation made in our last report.

Evidence sections 4–7

4. Safety

4.1 Reception

4.1.1 Inductions are conversations carried out upon arrival at a STHF to assess people's needs and provide key information. Many people we spoke to at airport holding rooms lacked awareness of information that should have been covered in the induction. This suggests that inductions do not make full use of available resources and techniques to ensure that people in detention genuinely understand the information provided. An illustration of poor practice is the culture of managers assuming that an induction is successful based on the signature of a person in detention on a form, which is not only in English, but also presented in an inaccessible format. We recommend asking people in detention what was understood, rather than if it was being understood.

4.1.2 The physical reception environment is not always child-friendly to reduce distress for minors. This contradicts Mitie Care and Custody's policy on safeguarding child welfare, which advocates 'softening the environment' to ease a 'clinical and oppressive atmosphere.' In the Board's view, the Home Office should go beyond merely softening these environments and proactively eliminate any oppressive elements in the facilities they manage, such as ensuring that the hygiene facilities within the toilet provision is upgraded to the accepted standard of basic amenities, i.e. more appropriate washing facilities.

4.2 Suicide, self-harm, deaths in custody

4.2.1 No deaths in custody, self-harm or close monitoring incidents have taken place in this reporting period at any of the facilities we monitor. There continue to be concerning indicators of poor practice in suicide and self-harm prevention. For instance, there have been instances observed by the Board where CCTV was not functioning in support of direct human observations and at an Edinburgh interview room, the panic alarm button was broken off.

4.3 Violence and violence reduction

4.3.1 No violent incidents were observed or notified to the Board at any of the facilities we monitor. We are, therefore, unable to assess whether violence reduction work reflects best practice.

Case study: The safe management of facilities, flagged in our last report in the context of violence reduction, remains a concern. This year, we have seen safety hazards that should never exist in a genuinely safe system – such as materials obstructing a potential evacuation route at Edinburgh.

4.4 Vulnerable adults, safeguarding

4.4.1 We noted the following numbers of adults had an identified vulnerability:

Short-term holding facility	Number of vulnerable adults detained
Larne House	10
Glasgow Airport	27
Edinburgh Airport	60
Aberdeen Airport	1
Prestwick Airport	0
Festival Court	13
Drumkeen House	32

4.4.2 For several reasons we cannot provide any assurances about care for vulnerable adults. First, we visited a small number of such people. Second, Care and Custody staff should complete a vulnerable adult warning form (VAWF) and follow the associated procedure to ensure vulnerable people in detention receive appropriate support. However, we cannot assess from our visits whether VAWFs were always opened when needed or whether follow-up action was appropriate. This is partly because we do not always get to see VAWFs. For example, we have been told they were shredded before we could see them. Other sources of information, such as feedback forms, are not available.

Case study: A form we reviewed at Edinburgh noted a person had a substance use problem, but no additional records on vulnerability existed. So, we cannot independently verify if the person in detention received any extra support he needed.

4.4.3

Case study: During a visit to Larne House, we learned that two people reported suicidal thoughts, though these later subsided. Staff did not start vulnerable adult care plans; instead, they opted for a level of 'increased awareness.' When we asked how this was communicated across all staff, we were informed it was mentioned during handovers. We cannot verify if this took place because there was no VAWF.

The Inspectorate of Prisons said in their 2024 report on Mitie Care and Custody short term holding facilities[3] that VAWFs are not always opened when needed; can be poorly focused; and show follow-up checks with no or cursory interactions. It is regrettable that in this context, it appears that neither the Home Office nor Mitie Care and Custody had worked with local health and social care services to evaluate or improve care for vulnerable people.

Consideration: Modern slavery survivors are among the most vulnerable, requiring trauma-informed care including a calm, supportive environment. Yet, the holding rooms fall short. People face potentially re-traumatising questions, such as being asked about past sexual violence during inductions conducted in cramped, airless spaces – very far from a trauma-informed approach.

4.4.5 In 2021, the Home Office agreed to create a separate space at Larne House for women with single-occupancy rooms and a dedicated association space, promising it within 18 months. This aspiration remains unfulfilled. During the reporting year, men flagged as a risk to women were detained at Larne House.

4.5 Children and families

4.5.1 Children and families can be detained at the airport and reporting centre holding rooms. This has included unaccompanied children at Edinburgh and Glasgow airports. We did not visit when an unaccompanied child was present. Families we spoke to had mixed experiences in detention. Some reported boredom, others upset, especially during Border Force activities, like fingerprinting. Children and families were not always given the privacy they deserve, as the area designated for them was not always separated from areas for other adults. We did not see any feedback forms completed by families.

3 HM Inspectorate of Prisons, (April 2024). *Mitie STHFs*. [online] Available at: https://hmiprisons.justiceinspectorates.gov.uk/hmipris_reports/mitie-care-and-custody-short-term-holding-facilities/

4.6 Use of force

4.6.1 The Home Office promised to tell the Board of any use of force in facilities, except for compliant handcuffing in holding rooms. No such cases were reported, and we did not observe use of force during this reporting year. However, we are concerned by the introduction of policies requiring potentially disproportionate use of force. In May 2024, Mitie Care and Custody mandated handcuffing for all adults in detention in insecure areas. This replaced an approach where staff made a judgment about whether handcuffing was necessary in each case. Staff working at the facilities we monitor expressed concerns to us about this change in policy. In conversations with on site operatives it was reported to us that being handcuffed caused some people distress. Despite this, Mitie Care and Custody defended the policy, claiming it was working well. This response raises questions about its willingness to listen to staff concerns, which is essential in a safety-focused culture.

5. Fair and humane treatment

5.1 Accommodation, clothing, food

5.1.1 In respect of accommodation, we observed the following problems:

- **Facilities are usually clean but there can be significant failings.** For example, we repeatedly identified unclean spaces at Edinburgh Airport.

- **Facilities can be in such poor condition that they cannot be used.** At Prestwick the holding room was closed (and never reopened) and people in detention instead sat in the controlled waiting area.

- **Accommodation can fail to uphold basic dignity.** At Drumkeen House, for example, a stall-type toilet cubicle is within the main holding room. In such a confined space, this denies people privacy and dignity. Capacity at Edinburgh was increased to 25 by adding more seats, but at this capacity, people would be forced to sit in degrading positions, right next to toilets.

- **Only two facilities, Larne House and Festival Court, have access to natural light and the open air.** Airport and reporting centre holding rooms lack any natural light or ventilation. This inevitably contributes to increased stress.

- **Showers are available at only one holding room, in Aberdeen.** This is inadequate, for example for those detained overnight or after a long flight.

Case study: Border Force at Edinburgh said that while they aim for an individualised approach, they 'prioritise moving people to Dungavel IRC as the facilities allow them to shower before return flights.' This means people make a 100-mile round trip for the sake of shower facilities.

- **Privacy at an airport holding room or reporting centre holding room may be very limited, adding to stress.** For example, only at Glasgow Airport can men and women be detained separately, if the family room was in use. At Edinburgh, normal volume sounds are clearly audible in adjacent rooms.

- **Light and noise can add to people's stress.** For example, at Edinburgh, people are held only in intensely bright light.

- **Arrangements in place at airport holding rooms and reporting centre holding rooms are unsatisfactory for sleeping.** While pop-up

beds are used elsewhere[4], people at the facilities we monitor can use plastic-covered mats to lie on, which are deemed inadequate[5] for overnight stays.

- **Information about activities and rights in accommodation is often outdated, complex, and hard to access.** People are overloaded with irrelevant and outdated information in posters and folders, making it difficult for them to navigate in an already stressful context.

5.1.2 There are also frequent delays in repairs; effective leadership to ensure speedy and effective delivery of repairs has not been demonstrated.

Case study: At Edinburgh, damaged holding room chairs posing a choking hazard for children were identified in February but not repaired until August. Several children were detained in the intervening period. The Home Office ignored our suggestion to follow good practice recommended by HM Inspectorate of Prisons, leading to replacement seating being installed that is not only less comfortable but often unclean.

5.1.3 We have observed major shortcomings in access to clean linen for sleeping, with degrading impacts on people in detention.

Case study: At Edinburgh, we repeatedly observed unclean linen being provided for detainees. Despite contractors being required to conduct daily facility checks to identify and resolve such issues, records show that such checks are not taking place on a daily basis.

5.1.4 At Edinburgh in early 2024 the Board observed that people were not always given water, even when they asked. Snacks are available in all facilities, whereas hot meals were available only in some.

5.2 Staff/detainee relationships

5.2.1 There were times when we were very impressed by the kind and caring attitude of staff. On other occasions, there were failures in even the most basic transactional interactions.

Case study: When we visited Larne House the atmosphere was very calm and constructive. We observed strong interactions between staff and people in detention. When we spoke to people in detention, they said that relations with staff were good.

4 HM Inspectorate of Prisons, (2023). *STHFs managed by Border Force.* [online] Available at: https://hmiprisons.justiceinspectorates.gov.uk/hmipris_reports/short-term-holding-facilities-managed-by-border-force/

5 This judgment was made by HM Inspectorate of Prisons, Ibid. 3

5.2.2

Case study: We visited facilities where basic needs had gone unmet. For example, a person in detention at Edinburgh was not given drinking water, despite asking for it, until we raised it with staff. On another occasion, a family's food needs were not met until we raised it with staff.

Case study: In Edinburgh, a Border Force officer detained an individual with a mental health issue who refused to provide even a first name when asked. This, along with other aspects of the interaction, caused the person to become distressed. The officer's abrupt and uncaring response was unacceptable. The conduct of Border Force staff reflects the standards and values the organisation and its leaders uphold.

5.2.3 Recommendation 27 of the Brook House Inquiry report[6] calls for action plans to promote a safe and healthy culture in Immigration Removal Centres. The IMB would see this as continuous improvement and would recommend that this is implemented at the facilities we monitor.

5.3 Equality and diversity

5.3.1 In our last annual report, we stressed the need for the Home Office to improve collaboration with partners to ensure better care for people with complex needs, following a serious incident at Glasgow airport. We have not received any updates on the outcomes of these efforts, so we cannot be sure that measures are in place to prevent a similar incident in the future. Moreover:

- **Facilities are not physically accessible.** For example, sleeping arrangements at airport and reporting centre holding rooms are inadequate for wheelchair users. Transferring to floor mats is impossible.
- **Provision for people with sensory and non-visible impairments is poor.** For example, materials such as leaflets are not always available in accessible formats. There was limited provision in airport holding rooms and reporting centre holding rooms for a private space free from noises, smells and bright lights to support people with non-visible disabilities.

5.4 Children and families

5.4.1 Some age-appropriate provisions, like toys, are available for children, but significant gaps remain. Written materials are not always offered in a wide range of languages, and sensory or fidget toys, crucial for children with non-visible

6 Brook House Inquiry (2023). *Report HC 1789*. [online] Available at: https://brookhouseinquiry.org.uk/

disabilities, are not universally provided. More generally, accommodation does not always support the best interests of children and families. For example, at Edinburgh the nappy changing bench is within a room with no natural ventilation and children in the family room have no visual privacy from unrelated adults. The Home Office has not, as we understand it, benchmarked provision against comparator facilities such as secure care in this reporting period. Nor has it sought the input of relevant bodies, such as local children's services.

5.5 Faith and religious affairs

5.5.1 A chaplaincy service exists at Glasgow airport, but the Home Office has chosen not to extend it to the holding room. With the exception of Aberdeen airport, none of the airport or reporting centre holding rooms had dedicated prayer spaces. While religious artefacts and texts were available, they were not always stored respectfully. For example, on several occasions at Edinburgh religious materials were piled up disrespectfully and at Glasgow airport a Bible had been all but torn from its cover.

5.6 Complaints

5.6.1 Only one formal complaint was recorded (at Larne House) in this reporting period. This is a strikingly low figure when many issues are raised by people we speak to during our visits. We observed several barriers to complaints, for example lack of writing instruments, outdated guidance, and complaint boxes placed in inaccessible location or in staff's line of sight, discouraging use. Feedback forms are also rarely completed. All this is especially troubling when recommendation 28 of the Brook House inquiry called for the Home Office to take decisive measures to remove all barriers to complaints.

5.7 Property

5.7.1 We observed that the property of people in detention is handled sensitively at the facility and tagged to ensure its traceability.

6. Health and wellbeing

6.1 Healthcare: general

6.1.1 Healthcare is available at Larne House and people in detention we spoke to praised it. However, it is unclear if any external regulation is provided of the care.[7] This is unacceptable; no healthcare provision should exist without external regulation to give assurance that care provided is safe and effective. In all the other facilities we monitor healthcare is limited to basic first aid. Any additional needs are addressed by calling an ambulance or NHS out of hours. This has the potential to have negative effects on people in detention, including people being in pain for longer than they otherwise would be.

Case study: A VAWF was opened in Edinburgh for a woman who, while detained, suffered severe period pain, pacing the holding room at night. Staff could only suggest lying on a mat. At a police station or at London airport holding rooms, she would have had access to on-site healthcare professionals who could, for example, have prescribed over the counter painkillers. We find this location-based disparity in healthcare provision, rather than one based on clinical need to be unacceptable.

6.2 Physical healthcare

6.2.1 Medication continues to be removed from people in detention at the airport holding rooms and reporting centre holding rooms, as a matter of policy. Staff at the facilities we monitor have therefore faced absurd situations. For example, to comply with the policy, a person in detention at Glasgow airport was formally released from detention for a few moments to take medication, only to be immediately detained again.

6.3 Mental healthcare

6.3.1 As far as we understand, there have been no links established with local mental health services. No listening service exists at any of the facilities. It would be helpful for people in detention to be proactively informed of all the mental health support available, but this does not routinely happen. At the reporting centre holding rooms, we observed that there is a lack of signposting to all available support services, such as Breathing Space in Scotland. Any existing signposting is provided in English only.

6.4 Soft skills

6.4.1 At all facilities, distraction interventions are provided to help pass the time in detention and reduce stress, which is crucial, given the environment's potential impact on anxiety. These interventions include access to a

7 The service is not registered with the Regulation and Quality Improvement Authority, according to its website. More broadly, and in another concerning illustration of a poor safety culture, we are unaware of any collaboration between the Home Office and the relevant healthcare services in Scotland and Northern Ireland to assess or improve practice.

television, books, newspapers in various languages, plus other activities and toys. However, they do not include specific mental health resources to support people in managing anxiety and stress.

7. Preparation for removal, transfer or release

7.1 Case management

7.1.1 580 people were detained at Larne House, of which 2% were detained for five days or more. The following numbers of people were detained elsewhere:

Holding room	Number of people detained	Percentage detained for 7 hours or more
Aberdeen airport	38	2
Edinburgh airport	1063	24
Glasgow airport	445	12
Prestwick airport	17	47
Festival Court	89	1
Drumkeen House	330	0

7.1.2 People detained in airport holding rooms are deprived of access to the fresh air and natural light. They are often detained in intensely bright artificial light for very long periods.

Case study: One person was detained in such conditions for 26 hours and 50 minutes. Another couple was detained for 27 hours and 25 minutes. Another person was held for 26 hours.

7.1.3 We are not permitted to observe all aspects of a person in detention's interactions with Border Force or Immigration Enforcement. However, from what we observed, we noticed shortcomings. For instance, people are often kept waiting for long periods without updates on their cases. Timings are not routinely given for activities like interviews, meaning things will happen suddenly and without notice to people in detention. Our view is that all this indicates that alleviating stress for people in detention is not a priority.

Case study: At Edinburgh, a family including a young child said they didn’t know what was happening or how long they would wait after the interview. They told us that this lack of information escalated the level of their anxiety and stress.

7.1.4 Other shortcomings include:

- **Very serious failings in recordkeeping.** For example, on a large number of occasions IS91 authority for detention forms were incorrectly completed. In some cases, safety-critical sections were left incomplete.

- **Needlessly complicated written communications.** For example, form IS91R, given to every person in detention, uses complex language and does not clearly explain the process. It is the IMB's view that this could add to unnecessary stress.

- **Unacceptably long waits in controlled waiting areas at airports.** Border Force often fails to meet its own standard of a two-hour maximum wait. It is our understanding that people can be detained in the controlled waiting areas for extended periods before being transferred to the holding rooms.

Case study: In an 18-day period at Edinburgh, over one third of those detained in the holding room, including a 9-year-old and a 4-year-old, had been in the controlled waiting area for more than two hours. Explanations we were given for the delays were, in our view, potential indicators of Border Force's inefficiency, for example IT failures.

- **A lack of curiosity about why there is an unusually low take-up of legal or consular[8] advice.** We have not seen any person in detention at an airport or reporting centre holding room get legal or consular advice. This unusually low take-up of advice remains unexamined and unaddressed, especially when there could be indications of unacceptable barriers. At the very least, details of any advice provision should be documented.

Case study: A person at Edinburgh with whom we spoke said he was not aware of his right to access a lawyer. He did not have access to the IS91R either. None of this is acceptable practice; it raises questions about the fairness of the interview that had, by the time we had visited, taken place. He said it would have been helpful to get advice before his interview.

7.2 Family contact

7.2.1 At Larne House people in detention have a right to receive visitors in person and access the internet, including to make video calls with family. This provision was working when we visited. At all other facilities, mobile phones with cameras or internet access are confiscated upon admission

8 The UK is required to notify consular authorities of detention. See FCDO (2013). *Consular mandatory notifications*. [online] Available at: https://www.gov.uk/government/publications/table-of-consular-conventions-and-mandatory-notification-obligations.

to detention. While people are generally allowed supervised phone calls, including access to non-camera phones (unless exceptional circumstances apply), awareness of this entitlement is far too variable. For example, we observed far too many instances where non-camera phones could have been provided but were not. This is a very serious breach of basic procedure.

Case study: At Edinburgh, a person with a mental health condition was detained, and his family, who witnessed the detention, was separated from him. The person in detention had no access to a phone until after we visited. Despite his believing Border Force would inform his family, no updates were provided, leaving them in the dark until the call. This highlights a troubling lack of communication and sensitivity from Border Force.

7.3 Removal

7.3.1 We have not had the opportunity to monitor people being escorted from an airport holding room through the terminal to an aircraft on enough occasions to draw definitive conclusions. However, we are concerned that certain systemic features, such as the descriptions on staff uniforms, may hinder the discretion of the process.

7.3.2 Removal processes are, in our opinion, often shockingly inefficient and time-consuming. For example, a person detained after travelling from the Republic of Ireland to Northern Ireland may be transferred to London before being sent back to Dublin. People have also been unnecessarily moved in the middle of the night to airport holding rooms before being removed.

Case study: One person in detention was moved in a van between 00:45 and 02:30 for a flight departing at 10:43. It is hard to understand how this could ever be justified as an appropriate use of power. Aside from eliminating the chance for uninterrupted sleep during such a stressful time for that person, this process seems an extremely inefficient use of public resources.

7.4 Transfer or release

7.4.1 Delays in transfers from detention, whether to asylum accommodation or Immigration Removal Centres, often result in prolonged stays. In our view, not only can this increase stress for people but also highlights sometimes inexcusable inefficiency in our borders and migration system.

Case study: At Glasgow, an asylum seeker was released from detention but was not provided with asylum support for four days. During this time, the individual slept in the landside part of the airport terminal. This occurred despite the intensive efforts of Border Force staff at the airport to resolve the situation.

The work of the IMB

It is important to note that this report reflects observations made during our visits, and behaviour may differ when we are not present.

The frequency of our visits is set and determined by the SHTF and the Home Office as it pays our travel and subsistence expenses.

Board statistics

Recommended complement of Board members	12
Number of Board members at the start of the reporting period	10
Number of Board members at the end of the reporting period	11
Total number of visits to establishments	217
Total number of visits to Larne House RSTHF	16
Total number of visits to Aberdeen Airport	25
Total number of visits to Edinburgh Airport	48
Total number of visits to Glasgow Airport	43
Total number of visits to Prestwick Airport	21
Total number of visits to Festival Court	43
Total number of visits to Drumkeen House	21

Annex: Recommendations from last year's report

Recommendation	Response	Progress
To the Minister		
Ensure people can take prescription medication	Accepted	Not implemented. See section 6.2.1.
Upgrade facilities to meet disability access audit	Partially accepted: the statutory framework the Home Office sets means it has insufficient power to require this at ports.	Not implemented. See section 5.2.1.
Review appropriateness of lengthy stays in inadequate facilities	Not accepted	
Introduce a continuous care improvement programme for facilities	Partially accepted: Existing transformation work sufficiently addresses the underlying objective of the recommendation.	This report demonstrates existing work is ineffective in preventing unwarranted variation in care and unacceptable practice.
Order a check on quality of provision for vulnerable adults and children	Partially accepted: Existing internal assurance work sufficiently addresses the underlying objective of the recommendation.	Existing assurance work failed to stop the poor practice outlined in section 4.4 and 4.5.
Order a check on quality and speed of repairs and improvement works	Partially accepted: Existing internal assurance work sufficiently addresses the underlying objective of the recommendation.	Existing assurance work failed to stop the poor practice outlined in section 5.1.2.
Require routine proactive publication of performance metrics	Partially accepted	Not implemented. This information is still not made public.
Stop late night moves involving families	Partially accepted	See section 7.2 for examples of continued late-night moves.
To Border Force/Immigration		

Recommendation	Response	Progress
Enforcement		
Standardise translation and interpretation	Accepted	Implemented.
To Border Force/Immigration Enforcement and the Facility Manager/Detention Contractor		
Address shortcomings in facility environments	Partially accepted	Not implemented. See section 5.1.
Reopen the holding room at Prestwick	Not accepted	
Stop detaining men and women together at Larne House	Accepted	Not implemented. See section 4.4.6.

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Any enquiries regarding this publication should be sent to us at imb@justice.gov.uk.