Independent Monitoring Boards

National Annual Report 2025

Adult prisons, young offender institutions and immigration detention

June 2026

national preventive mechanism

Contents

Introduction from the National Chair

Having previously served for many years on an Independent Monitoring Board (IMB), monitoring in immigration removal centres, I am delighted to present my first report as interim National Chair. When I joined the IMB in 2006, my primary motivation was a desire to shine a light on places that are largely hidden from public view and to amplify the voices of society's most marginalised. From my experience as an IMB member, my time on the IMB National Board, and the conversations I have had since taking up the National Chair role, I know that IMB members share these values and remain steadfastly committed to them. IMBs occupy a unique position, with regular access to prisons, young offender institutions (YOIs), immigration removal centres and short-term holding facilities, enabling them to monitor the lived realities of detention. In doing so, they provide the public and ministers with essential insight into whether people in detention are being treated fairly, justly and humanely, and whether conditions meet the standards of decency expected in a civilised society.

Too often, these standards are not met. 2025 was marked by both enduring challenges and repeated upheavals. Procedures supposed to safeguard some of society's most vulnerable people, instead frequently failed them. Seriously unwell individuals continued to be harmed by lengthy and indefinite detention. Behind closed doors, force was used disproportionately.

As in previous years, Boards monitoring prisons described a crumbling estate and relentless population pressures. In many YOIs, boys spent most of their days locked in their rooms. Although the Youth Custody Service showed robust awareness of what works, there was little evidence of that being translated into practice. In the immigration detention estate, progress on significant concerns raised over the years by Boards was, in many regards, negligible.

Alongside these persistent issues, new challenges emerged. In the prison estate, early release schemes, uncertainty following the sentencing review and planned changes to recall made it difficult for prison staff, prisoners and IMB members alike to anticipate what the coming months or years would hold. In the immigration detention estate, 'Operation Hillmore,' a pilot 'one in one out' scheme under which individuals crossing the channel were removed to France, loomed large in the second half of the year. Boards raised serious concerns about the significant number of people detained under this operation who were found to be children – which must be taken in the context of wider safeguarding failures that Boards have repeatedly highlighted. The absence of effective safeguards results in routinely illogical situations. Extremely vulnerable people are detained, then assessed as unfit for detention, but cannot be released because of the lack of hospital beds or support in the community. Meanwhile, their health continues to deteriorate.

Uncertainty about the future was a regular, and often agonising, part of detained people's day-to-day existence. People in immigration detention often received minimal information and faced unacceptable barriers to accessing legal advice and translation services. Children in YOIs were not informed about their release or transfer arrangements until the very last minute. Too often, prisoners struggled to get information crucial to their wellbeing, such as the timing of their medical appointments or the whereabouts of their property. They received little or no communication about their case progression and were left in the dark about the impact of early release schemes.

Poor communication and uncertainty were challenges sometimes shared by IMBs themselves, and on occasions this was further complicated by a lack of transparency. In YOIs, IMBs often found it difficult to obtain data on time out of room and education, and saw out-of-use areas being temporarily opened during visits from senior leaders. In prisons, IMBs reported enormous efforts to repair estates prior to inspection visits, and uncovered significant issues with data reporting, including an alarming under-reporting of PAVA use in one prison. On some issues, such as the reduction in education provision, the IMB, like others in the wider justice sector, found it difficult to obtain clear answers about what practical changes were being made and how. In the immigration detention estate, access to information to which IMBs are entitled was at times lacking or curtailed, subject to undue delays and questioning, or denied altogether. Boards persistently sought to overcome these ever-increasing difficulties to discharge their statutory duties effectively and monitor the treatment of detained people.

In periods of rapid change and financial pressures, the gulf between plans and practice is often only visible to those on the ground. This is the space in which IMBs operate. IMBs continue to act as the eyes and ears of the public, and their vital insight provides officials with the opportunity to close the gap between plan and practice and to enact meaningful, sustainable improvement. The IMB's commitment to shining light on the outcomes for detained people remains resolute. In the light of the Ministry of Justice's (MoJ) recent announcement of its intention to merge the IMB with the Lay Observers and HM Inspectorate of Prisons, we will actively engage with the MoJ as it develops the model to ensure the vital elements of IMBs are preserved.

Jane Leech MBE **June 2026**

Interim IMB National Chair

About IMBs and this report

IMBs monitor and report on the conditions and treatment of those detained in every prison and 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 removal centres [IRCs] and preparation for removal, transfer or release in short-term holding facilities [STHFs])

This report

This report is based on IMB findings from 1 January to 31 December 2025.[2]

IMB impact in 2025

133 Boards, made up of **1,030** members, carried out **37,870** visits between 1 January to 31 December 2025.[3]

IMBs can make a difference for detained individuals, the establishments they monitor and on the wider prison and immigration detention systems. 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 2025, we published **127** annual reports:[4]

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

YOIs
- 5 YOI reports

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

More up-to-date Board findings are collated on a regular basis and have regional, functional and national impact through regular stakeholder engagement, responses to consultations, evidence provided to Parliamentary Committees and through national thematic monitoring reports. The IMB published the following national reports in 2025:

- The 2024 national annual report for IMBs in the prison and immigration detention estate
- An open letter to the Prisons Minister on the use of force in prisons and YOIs
- A thematic report, *By force of habit: How the use of force in immigration detention has lost sight of necessity and dignity*
- An open letter to the Prisons Minister on cuts to real-term education budgets.

Consultations

Throughout the year, we responded to a range of consultations run by human rights bodies, Parliamentary Committees, the Ministry of Justice, HM Prison and Probation Service (HMPPS) and the Home Office, which included, but were not limited to:

- The Justice and Home Affairs Committee inquiry into prison culture, governance, leadership and staffing[5]
- The Justice Select Committee inquiry into tackling drugs in prisons[6]
- The Independent Sentencing Review[7]
- The Justice Select Committee inquiry into rehabilitation and resettlement[8]
- The Welsh Affairs Committee inquiry into prisons, probation and rehabilitation in Wales[9]
- The Autism Act 2009 Committee inquiry[10]
- Module Eight of the UK Covid-19 public inquiry[11]
- The Public Bill Committee on the Mental Health Bill[12]

IMB findings

1. Adult prisons

Key findings

- System-wide population pressures stalled prisoners' progression, destabilised prisons and exacerbated safety issues.
- Prisoners faced long journeys and sometimes did not arrive until the early hours of the morning, leading to serious healthcare concerns. Women continued to experience verbal abuse and degrading hygiene issues on journeys.
- Illicit drugs remained the most pervasive threat to safety and stability across the estate, fuelling violence, self-harm, debt, medical emergencies and deaths.
- Prisoners who self-harmed, self-isolated or had severe mental illness often went without the support they needed, and frequently waited months or even years to be transferred to suitable facilities.
- Poor accommodation and failures in maintenance work left many prisoners living in inhumane conditions: flooding, extreme temperatures, and vermin ate away at the quality of life in many prisons, and fire safety continued to be an acute concern.
- Staff-prisoner relationships were patchy across the estate, and staff inexperience at many prisons worked against establishing a positive rehabilitative culture.
- Prisoners with disabilities went without vital social care support, mobility aids and suitable accommodation, and disproportional outcomes for prisoners from minoritised ethnic backgrounds went unaddressed.
- Prisoners' health care could be compromised by healthcare staff vacancies, which left remaining staff scrambling to cover the gaps in provision, and poor medication management.
- Mental health support failed to meet the extremely high levels of need, and prisoners faced excessively long waits for secure mental health facilities when they could not be cared for appropriately within the prison estate.
- Time out of cell remained far too low at most prisons, especially in the long-term high security estate and reception prisons. Some prisoners continued to face up to 23 hours a day locked in their cells.
- Swingeing cuts to education provision led to cancelled courses, staffing cuts and widespread anxiety. Vocational training opportunities were further compromised by maintenance and equipment issues.
- Prisoners struggled to contact offender management and probation staff and were often left in the dark about their sentence progression, especially when early release schemes and high recalls placed strain on staff.
- Prisoners continued to be released homeless or with very little preparation, perpetuating the revolving door effect.

1.1 Safety

Population pressures continued to compromise safety and rehabilitative efforts

Estate-wide population pressures impacted the function of the entire estate. At times Boards reported increased churn, with prisoners appearing to be rushed through the system, advancing to less secure categories before they were ready to do so. Others saw gridlock, with prisoners unable to progress despite gaining a lower security categorisation. Often both effects were observable within the same prison. The lack of breathing space within the system made allocation a complex, sometimes unpredictable process – for example, some Boards monitoring category C prisons reported that category D prisoners could not obtain a move to an open prison, whereas some Boards monitoring category D prisons reported such large numbers of empty beds that the prison could not function as it should.

As in 2024, the common thread was a persistent shortage of spaces in local and reception/resettlement prisons, with more breathing room in category C training prisons and significant vacant space in the open estate. The challenge of appropriate allocation had profound implications for prisoners' wellbeing. At Erlestoke for example, a prisoner who had been approved to transfer to a prison closer to his dying father had his transfer delayed by three months. Another prisoner was transferred to Swaleside, from where he had previously been airlifted to hospital after being stabbed by another prisoner, despite the prison's best efforts to prevent the transfer. At Ford a prisoner was transferred in despite having medical needs which the prison could not accommodate; he was therefore immediately returned, in a seven-hour round trip.

Cell-sharing continued to be common and the practice of placing two prisoners in a cell originally designed for one continued to be widespread. Whilst at relatively safe prisons, such as Usk, cell-sharing could be managed appropriately, at others it could make safety arrangements very difficult. At Doncaster, for example, over half of prisoner-on-prisoner incidents of violence occurred between those sharing a cell.

More broadly, population pressures made it difficult to manage prisoners safely, especially in prisons with high numbers of gang-affiliated prisoners who needed to be kept apart. Several Boards reported that high populations made it difficult to separate prisoners who were from rival gangs or otherwise in conflict; at Brinsford, the lack of space to move prisoners around made it difficult to implement Challenge, Support and Intervention Plans (CSIPs) successfully, which manage prisoners who are engaged in, or at risk of engaging in, violent or bullying behaviour.

Churn was most prominent in reception prisons and in the women's estate, the latter as a result of sustained high levels of recall. Boards monitoring the women's estate described the difficulty of maintaining a constructive rehabilitative atmosphere when women often stayed for such short periods that they could not engage with

substance misuse, mental health or resettlement support, further increasing their likelihood of future recall.

Churn was also a challenge in the open estate, which continued to receive prisoners with very little time left to serve. Some of these prisoners were also unprepared for the open estate and were quickly returned to closed conditions because of substance misuse or other disruptive behaviour. Some open prisons, such as Leyhill, were able to minimise disruption by keeping the population as high as possible, avoiding large numbers of new arrivals. Often this was achieved by the prison proactively collecting transfers-in using its own vehicles rather than relying on the Prisoner Escort and Custody Service (PECS).

Late arrivals and poor travel conditions caused prisoners great distress and led to healthcare concerns

Journeys to prison, whether from court or other prisons, were often lengthy and exhausting. Many Boards raised concerns about prisoners arriving late at night or in the early hours of the morning. This often meant they arrived after healthcare staff had left for the evening, which could give rise to serious healthcare concerns. At Thorn Cross, one serious healthcare incident requiring community hospital attendance related to a late arrival.

Low Newton had particularly acute concerns about the wellbeing of women who arrived having spent many hours travelling in the same van as men. The Board reported multiple occasions where women had been subjected to verbal abuse by men during transport. There was also a lack of access to adequate toilet facilities, giving rise to alarming dignity and hygiene concerns - women often arrived in extreme discomfort, and in one particularly alarming instance a woman soiled herself because she had not been provided with adequate toileting equipment. The Board escalated these concerns to the Deputy Head of PECS in November 2025. The response to this letter focused primarily on transport suppliers' adherence to contractual performance indicators. Such an approach carries a real risk of eclipsing the reality of women's experiences, which have the potential to affect their wellbeing long after their journeys have concluded.

Drugs threatened the stability of the entire prison estate

Illicit items continued to be the single most common safety concern raised by Boards, and the pervasive availability of drugs undermined every other aspect of safety and stability within the estate. Boards linked widespread drug use to increases in violence, self-harm and self-isolation, as well as to the persistent issue of debt. Code blues placed considerable strain on healthcare staff and operational staff, and were a daily occurrence in some prisons; at High Down, 13 took place in a single day. Drug-related deaths were, sadly, reported by many Boards.

The closed male estate was the hardest hit in terms of medical emergencies and debt, but the women's and open estates also experienced significant challenges.

Within the open estate, prisoners under the influence threatened to destabilise the generally peaceful, rehabilitation-focused regime. In the women's estate, medication trading was the most common drugs issue, though several Boards, including New Hall, also noted with concern the quantity of drugs entering from outside the prison.

Boards generally described prisons as proactive and dedicated in their efforts to stem the flow of drugs, despite low success rates. There were, however, some observations of complacency in scanning and gate security, and some Boards noted that it was too easy for prisoners to predict when searches or drug tests would take place. In one case, a member of staff at Manchester even informed prisoners about a cell search in advance. Drones were a significant concern in several prisons, yet some Boards, such as Long Lartin, noted that even when drone drops decreased, there was no corresponding reduction in the level of drugs within the establishment. This highlights the considerable agility of supply chains, with new routes emerging rapidly.

When reductions in drugs levels were achieved, this was often accompanied by an increase in debt-related violence, self-isolation and anxiety-related self-harm, as drug dealers sought to collect their debts during this period. This presented an additional challenge to the prison's stability as it attempted to maintain the progress made.

Prisoners who self-harmed and self-isolated sometimes went without the vital support they needed

Self-harm continued to be a key concern at many prisons, particularly prolific self-harm, which placed enormous strain on establishments as staff struggled to keep prisoners safe. As in previous years, this was most acute in the women's estate, where the challenge of managing women with very complex needs often threatened to destabilise the entire regime. The smaller size of the women's estate also made it more vulnerable to disruption, as the arrival of just a few women with highly complex needs could cause considerable upheaval. At Send, for example, a relatively small number of highly disruptive prisoners had a significant impact on the general operation of the prison.

Self-inflicted deaths were a key concern in the men's estate, and cluster sites continued to be difficult to address – as in 2024, Leeds remained a cluster site, with self-inflicted deaths occurring at an alarming frequency.[13] Cluster sites were particularly frequent in the long-term high security estate (LTHSE), with Belmarsh, Long Lartin, Garth and Frankland all designated as such over the course of the year.

Boards raised concerns about the ability of operational staff to care appropriately for these prisoners. In too many prisons, Assessment, Care in Custody and Teamwork (ACCT) processes, used to manage those identified as at risk of suicide or self-harm, were not followed correctly. Boards described missing, incomplete and even falsified entries, deviations from the proper process, and prisoners being managed

inappropriately. At Belmarsh, for example, the Board expressed concern that prisoners' ACCT records were not following them from their houseblocks to other parts of the prison, as the guidelines stipulate, and that ACCT observations were not always recorded in an appropriate or timely manner – a CCTV spot check conducted during one week in May 2025 suggested that only 50% of ACCT observations were carried out thoroughly and on time.

Often these failures were attributed to staff inexperience, or occasionally a lack of familiarity with the ACCT process, such as in the open estate where ACCTs are far less common. Nonetheless, ACCTs were generally managed well in the open estate, likely due to the calmer environment and reduced pressure on staff.

Boards had similar concerns about shortfalls in the care of self-isolating prisoners, who isolated due to safety fears or a desire to 'stay out of trouble'. In many prisons, such as Belmarsh, staff did not always have adequate knowledge of which prisoners were self-isolating, running the risk that this already vulnerable group could slip through the cracks. Self-isolating prisoners often faced an extremely restricted regime, sometimes without access to fresh air, showers or exercise.

Use of force was too high in many prisons, and often poorly scrutinised

In October 2025, the then IMB National Chair Elisabeth Davies wrote to the Prisons Minister Lord Timpson to express her concerns about expansions to the Prison Service's use of force measures, including the roll-out of tasers to the men's estate and the introduction of PAVA to the children's estate.[14] Her letter highlighted that:

- The number of officers supplied with tasers had increased by 2,400%, following a two-month trial with no taser discharges and therefore no lessons learned. This appeared to contradict the Ministry of Justice's statement, when the trial of tasers was first announced in July 2025, that it would run until enough data had been collected to make an informed decision about any further roll-out.
- Many Boards had significant concerns about the ability of staff to exercise force appropriately, citing inexperience and insufficient training. This often led to officers resorting to force rather than using effective de-escalation techniques.
- There is no convincing evidence that PAVA is effective as a deterrent or de-escalation technique. PAVA has been deployed 68% of the times it has been drawn since its initial introduction in 2022. Once its usage has become common in a prison it tends to remain so, becoming entrenched as the 'new normal'.

- In the 10 prisons with the highest rates of PAVA use, IMBs also reported staff shortages, restricted regimes, and little or no key work – all factors that damage staff-prisoner relationships and make violence and challenging behaviour more likely.
- The Prison Service's own analysis acknowledges the significant disproportionality in force used against minoritised ethnic groups, especially when PAVA is used. Boards also have significant concerns about the use of force against prisoners with severe mental illness, many of whom should be placed in suitable secure mental health facilities, and against prisoners with disabilities, about which there is not yet strong enough central data to enable trend analysis.

In the course of publishing this letter, an alarming data recording failure was uncovered during the pre-publication HMPPS fact-check process. At one prison, inaccurate data entry by officers had led to approximately 40% of the PAVA use in May 2025 being recorded incorrectly. Whilst senior leaders at the prison were aware of the discrepancy, it was not until the IMB made contact that the central HMPPS use of force team was made aware and the prison agreed to introduce additional measures to ensure correct data recording.[15]

1.2 Fair and humane treatment

Prisoners endured unacceptable conditions, including flooding, infestation and fire risk

The physical state of many prison buildings remained poor, and in some prisons conditions were shocking. Boards continued to describe dilapidated cells, flooding, extremes of temperature, infestations, and frequent large-scale equipment failures. In some prisons, the problems were so widespread that the sites seemed generally unfit for purpose. At Manchester, for example, the Board described collapsed drains, sinkholes and a loss of water supply to half the prison for a week in November 2025, whilst the maintenance provider had over 1,000 outstanding tasks.

Excessively hot and cold temperatures were a common concern of Boards, particularly during the warmer months when cells in many prisons became oppressively hot. For prisoners who were elderly, frail, experiencing perimenopause or otherwise vulnerable, these conditions could be unbearable. The Board at Foston Hall was informed that the prison could not afford to purchase fans to help keep prisoners cool in periods of excessively hot weather and noted a spike in self-harm coinciding with a period of hot weather.

Flooding and leaks frequently created safety risks. In some prisons the results were dramatic: in Isle of Wight, where there were several incidents of leaks and flooding on some houseblocks, there was an incident where water cascaded down the steps

of the segregation unit and flooded the ground floor. Workshops and visiting areas were frequently taken out of use, or operated at reduced capacity, because of leaks.

Pests and vermin continued to plague many prisons. A severe rat infestation at Feltham led to serious hygiene issues. At Bullingdon, there were three reports of spider bites between September and November 2025; two prisoners required hospital treatment and one was warned he could lose his leg.

Boards had particularly acute concerns about fire safety, including the adequacy of evacuation arrangements for prisoners with mobility issues and the lack of working fire alarms in parts of some prisons. At Garth, one prisoner tragically died in a cell fire after the alarm apparently failed to sound.[16] False fire alarms were also common at several prisons. Although fire safety remedial work continued to be prioritised, Boards noted that this could be extremely disruptive. At Eastwood Park, for example, the prison's only open wing had to be closed due to fire safety concerns, significantly compromising the regime offered to women who had achieved open status.

Showers and kitchens were described in particularly negative terms by Boards. In December 2025, Buckley Hall IMB wrote to the Minister to draw attention to unacceptable delays in facilities maintenance and repairs, citing periods where 80 men shared four showers and 150 men shared one washing machine. In some prisons kitchens had to be taken out of use entirely, with wide-ranging implications for daily life. At Long Lartin, the main kitchen has been out of use since mid-2024, and by early 2026 no reopening date was available despite in excess of £1 million having been spent on repairs and temporary kitchen arrangements. The temporary kitchen was inadequate for the delivery of hot food to wings, and the Board described it as unsafe and wholly unsuitable for providing food to nearly 600 prisoners over a prolonged period. Having highlighted these issues in its 2024-25 annual report, the Board wrote to the Minister in October 2025 to reiterate its acute concerns that the provision of daily hot meals may become impossible, ultimately putting the prison's continued operation at risk.

Segregation units were pushed to their limits

Segregation units continued to face extreme pressure, with many Boards reporting units that were consistently full or overflowing onto the wings. Although this was most common in the long-term high security estate, local prisons and women's prisons also often struggled to manage the volume of segregated prisoners. Whilst the dedication of officers on these units was repeatedly praised, there were some instances where they were unable to provide decent accommodation for prisoners with extremely complex needs and challenging behaviour.

Boards also continued to raise serious concerns about the high numbers of prisoners with severe mental health issues held in care and separation units (CSUs) because they could not be safely managed elsewhere. In some cases this occurred even when healthcare staff had declared a prisoner unfit for segregation, because of the

absence of any safe alternative. In August 2025, 30 of the 58 new arrivals in Hewell's segregation unit were deemed unfit for segregation, but they stayed in the unit nonetheless, because there was no safe alternative accommodation for them.

Whilst there was almost always a member of healthcare staff present at segregation review boards, in accordance with the relevant Prison Service Order, IMBs reported better outcomes when a mental health professional was present. This was not always achieved, and practice appeared to vary greatly depending on the healthcare provider. Hewell IMB described the introduction of a dedicated segregation nurse as 'transformational', noting that it provided vital continuity between reviews.

Staff-prisoner relationships were eroded by staff inexperience, limited capacity and inconsistent practice

Many Boards' monitoring observations highlighted shortcomings in staff-prisoner relationships, whereas others testified to the power of these relationships in fostering stability and a positive rehabilitative atmosphere. In many prisons, such as Swinfen Hall, staff lacked the experience and confidence to engage constructively with prisoners. In others, officer inexperience led directly to safety and discipline concerns. Some Boards reported inadequate supervision of prisoners congregating, most commonly in medication queues, and raised concerns about unsafe practices, such as officers walking in front of prisoners in a LTHSE. Boards also described incidents of prisoners breaking prison rules (for example, vaping outside permitted areas) in full view of officers without being challenged. There were indications that this was being addressed in some prisons: for instance, at Channings Wood, where the Board had raised concerns about staff inexperience, the introduction of the Enable workforce transformation programme was welcomed as a positive development, with staff engaging enthusiastically.

Serious concerns regarding the early operation of HMP Millsike

In December 2025, Millsike IMB wrote to the Minister to escalate significant, wide-scale concerns about the prison's operation, combined with an apparent acceptance within the Prison Service that new prisons would remain unstable for up to four years after opening. Staff experience and competence, insufficient staffing levels, and the limited support offered to new staff, were common threads running through most of the Board's concerns. IMB monitoring uncovered:

- High levels of staff inexperience: the prison's predominantly new workforce lacked the confidence, skills and custodial experience needed to manage prisoners safely and consistently, and staff were expected to perform demanding roles before having adequate time to consolidate training, contributing to operational errors and unsafe practice.

- Poor delivery of core roles due to capacity constraints: key work was far too low, prisoners felt unsafe, and IMB members witnessed unacceptable behaviour and language from staff members towards prisoners.
- Regime restrictions: insufficient staffing levels resulted in an inability to deliver even a restricted regime reliably, with prisoners spending prolonged periods of time locked in cells and frequently missing appointments.
- Unsafe management of prisoners at risk: gaps in staff competence and capacity undermined the ACCT process, including missed observations, lost documentation and ineffective constant supervisions.
- Compromised access to healthcare and medication: unlock failures and escort shortages caused missed healthcare appointments and serious medication delays, despite clinical provision being available.
- Issues with training, work and visits: insufficient staff reduced prisoners' access to workshops, vocational training and family visits, undermining rehabilitative efforts and maintenance of family contact.

Limited staffing capacity hindered the development of positive staff-prisoner relationships, with officers at many prisons feeling so overstretched that they lacked time for meaningful interaction. This issue was most common in prisons with widespread violence, drug use or prolific self-harm, creating a vicious cycle: staff were unable to build the trusting, respectful relationships with prisoners that would enable them better to identify and address safety risks before they escalated. Detached duty staff were often deployed when safety concerns became acute, but this brought challenges of its own, as these officers were unfamiliar with the prison and tensions sometimes arose between them and those permanently based there.

In contrast, where staff-prisoner relationships were strong (most commonly in the open and women's estates), this was described as the bedrock of stability. For example, Drake Hall IMB noted that positive relationships between officers and prisoners were key to the prison's functioning, particularly given its house-style accommodation and the high number of women with complex needs and mental health challenges.

Inconsistent leadership also posed challenges at some prisons. In February 2025, Rochester IMB wrote to the Minister to register concerns relating to the churn of senior leadership at the prison. The prison had had three Governors within the space of a few months, which exacerbated broader challenges to the prison's stability: an Urgent Notification had been issued the previous summer, and staff resignations and

absence levels were high. The Board noted that as a result of this instability, prisoner applications to the IMB were almost double pre-Covid levels.

Key work remained patchy across the estate, and many prisoners told Board members they did not know who their key worker was. Although prison management generally recognised its importance, and many Boards saw concerted efforts to improve delivery, these were not always sustained. At Channings Wood, for instance, 1,000 key work sessions were delivered in March 2025, but this dropped to just 73 in August after staff were redeployed to other prisons on detached duty. There were reservations among staff and IMB members alike regarding the suitability of the scheme for prisoners on very long sentences, given its focus on progression; this was one reason given for the low rates of fulfilment in the LTHSE.

Staff inexperience was a factor, though not the only one, in routine failures that significantly affected prisoners' daily lives and damaged the culture of a prison. Many Boards, such as Swinfen Hall and Foston Hall, reported that simple requests were frequently not fulfilled by staff, causing considerable anxiety and frustration among prisoners. One such area was property management, which remained a key IMB concern; the loss of valuable or irreplaceable sentimental items on transfer remained common, and Boards frequently observed property being handled ineffectively by reception staff and cell clearances being poorly managed, leading to delays in property distribution and belongings being lost or stolen.

Launchpad in-cell technology, which enabled prisoners to carry out simple administrative tasks independently, was very well-received where it had been introduced. Boards highlighted its potential to reduce conflict and improve prisoner wellbeing if rolled out more widely across the estate.

Disabled, older and minoritised ethnic prisoners faced significant disadvantages

Boards raised ongoing concerns about prisoners with disabilities, who were still being housed in cells unsuitable for their needs and in environments where they could not easily move around independently. At Brixton, for example, a prisoner with a broken arm and a prosthetic leg was placed on an upper landing despite the lift being out of order. Some prisoners faced long delays in receiving social care equipment, such as wheelchairs or cell adaptations. At Wymott, waits for individual wheelchairs were unacceptably long, and prisoners who acted as social care 'buddies' told the Board that there were not enough general-use wheelchairs to transport prisoners to their activities.

The situation for prisoners suffering from dementia became increasingly acute last year. Boards described prisoners who had little understanding of their surroundings, left to wander around in a state of confusion and heavily reliant on social care buddies. As highlighted at Exeter, these buddies could not always reach the prisoners they were assigned to when there was a shortage of available staff.

Dedicated social care placements were far too limited, and even in prisons with specialist units, such as The Verne, it was apparent that end-of-life care arrangements required improvement. Prisons with high numbers of older prisoners, such as Ashfield and Haverigg, experienced significant strain because of the high health needs of their populations, including frequent hospital escorts taking staff away from other duties. These concerns will only escalate unless a comprehensive HMPPS older prisoners' strategy, already long overdue, is implemented as a matter of urgency.

More positively, several Boards reported on efforts to improve support for neurodivergent prisoners. At Hewell the introduction of a new neurodiversity hub was a promising development, and staff at Brixton received training on the use of force and de-escalation with neurodivergent prisoners, a welcome introduction given the overrepresentation of this cohort in use of force incidents.

However, disproportionalities relating to ethnicity seemed entrenched at some prisons. At Isis, for example, disproportionate use of force against black prisoners persisted, and the Board was particularly concerned about the overrepresentation of young black men affected by PAVA. Worrying signs of complacency were also seen, especially in prisons already struggling with widespread safety issues. At Wakefield, for instance, specific training on race issues had not been delivered despite the fact that half of the prison's discrimination incident reporting forms related to race.

1.3 Health and wellbeing

Staffing gaps undermined the delivery of safe, reliable health care

Shortages of healthcare staff were reported by many Boards across the estate, placing strain on healthcare provision. Posts often remained vacant not only because of recruitment difficulties, but also through protracted delays in security vetting. At some prisons, vacancies in senior healthcare positions caused significant disruption and disquiet.

Co-ordination between healthcare staff and operational staff often fell short, leading to missed appointments when officers failed to escort prisoners, or when prisoners were not properly informed that appointments had been scheduled. Some Boards reported that responsibility for such oversights was frequently passed back and forth between prison and healthcare staff, and suggested that a more collegiate, whole-team approach would be more effective in ensuring good outcomes for prisoners. Bronzefield IMB noted that a cultural shift in this direction, following the appointment of a new prison Director, had begun to drive improvements in health care delivery.

Poor medication management impacted prisoners' daily lives

Medication management remained problematic in too many prisons, especially in the women's estate but also in many men's prisons. Boards described poorly supervised queues and delays in medication dispensing, which could interfere with prisoners'

attendance at daily activities. At Durham, for example, medication queues were often left unsupervised; the healthcare provider warned that this increased the risk of medication trading and bullying. At Chelmsford, one prisoner went four days without essential heart medication, and medication was administered according to staff availability, meaning that some prisoners prescribed sleep medication had to take it as early as 4pm.

The daily dispensing of medication sometimes disrupted the wider prison regime, resulting in prisoners spending more time locked in their cells and missing out on purposeful activity. Several Boards reported the roll-out of secure locker units to improve the distribution of medicine (including in-possession medication in some prisons), which was welcomed; however, many of these units experienced technical and operational issues which prevented their use for long periods after installation. At Bronzefield these issues continued for several months.

Mental health support failed to meet the high levels of need

Mental health continued to be the most common healthcare concern raised by Boards, and the area of healthcare most frequently described as understaffed. At Cardiff, the Board raised concerns that the healthcare provider did not deliver the number of psychiatric support sessions recommended in the healthcare needs assessment. At Foston Hall, a survey undertaken by the Board revealed that 57% of responding prisoners felt their mental health needs were not being met.

Prisoners continued to face excessively long delays for transfer to secure mental health facilities, and were often held in CSUs or in-patient healthcare units in the meantime. For example, in August 2025, Wakefield IMB wrote to the Chief Operating Officer for prisons to escalate their concerns about a prisoner who had continuously resided in either the CSU or healthcare since June 2023, with minimal engagement with the regime or interaction with other prisoners. Members' monitoring observations and assessment of the prisoner's case notes led the Board to conclude that he was at risk of mental health crisis because his complex needs could not be met at Wakefield.

The scale of this issue cannot be overstated: the vast majority of Boards monitoring the closed estate repeatedly highlighted delays in transfer to mental health facilities. This placed significant strain on prisons, as CSU staff and healthcare staff alike struggled to provide appropriate care and to minimise the knock-on impact of prisoners' challenging behaviour on others within the units. Whilst the recent removal of prisons as a 'place of safety' under the Mental Health Act may eventually ease some of this pressure, particularly in the women's estate, it is clear that more secure mental health beds are urgently needed, along with a more efficient and transparent allocation process.

Boards also have particular concerns about the provision of care for prisoners with diagnosed personality disorders or other complex needs, who are often denied placements in secure mental health facilities with no suitable alternative offered.

Gaps in substance misuse support hindered prisoners' recovery at many prisons

The support offered to prisoners with drug and alcohol dependency issues varied widely across the estate. Some prisons, particularly open prisons where prisoners were able to attend support group meetings in the community, offered excellent provision. At others, staff vacancies and extremely high levels of need made it difficult for substance misuse teams to fulfil their function.

Incentivised substance-free living units were generally reported on positively, with Boards praising the supportive environments they provided and describing the help available as far superior to that offered on other units housing prisoners with substance misuse issues. However, these units were still vulnerable to drug ingress, which could quickly undermine their purpose if not addressed promptly. Competing demands on staff time also occasionally caused units to fall off-track. Both Coldingley and Rochester IMBs reported successful relaunches of units which had previously been failing to meet their objectives.

Prisoners spent excessive periods locked in their cells

Time out of cell was an acute concern for many Boards, especially in reception prisons and the LTHSE. There were many prisons across all categories and functions that made concerted efforts to increase time out of cell during 2025, which led to considerable unevenness even between prisons of similar types. Staff shortages, including those caused by hospital escorts and staff sickness, were by far the most common reason for regime curtailments. At Swinfen Hall, for example, this sometimes led to prisoners spending 23 hours a day behind locked doors. As noted above, medication dispensing issues also frequently contributed to prisoners spending excessive periods in their cells.

Increasingly, inaccurate roll counts became a significant factor in 2025, with Boards such as Wayland describing these errors as 'biting into the regime'. In some prisons, concerns about violence led to regime restrictions, which in turn could exacerbate safety risks: at Swaleside, for instance, regime restrictions were accompanied by a significant rise in self-harm. Boards often noted that such restrictions caused men immense frustration and distress, leading to 'explosions' of violence or disruptive behaviour once they were finally unlocked, risking a vicious cycle of instability.

Time out of cell was not spread evenly, and some groups of prisoners received far less than others. Self-isolating and vulnerable prisoners were of particular concern, regularly spending the vast majority of the day locked in their cells. Prisoners not engaged in purposeful activity also experienced highly restricted regimes in some prisons. At Isle of Wight, these issues overlapped with significant decency concerns:

prisoners past the age of retirement spent their days in cells that, in many cases, lacked in-cell sanitation. As the night-sanitation system did not operate during the day and officers often did not respond promptly to cell bells, these prisoners frequently resorted to using buckets.

1.4 Progression and resettlement

Population pressures continued to impede progression

Population pressures across the estate continued to prevent many prisoners from being placed in the appropriate category or type of prison, creating a serious obstacle to progression. Prisoners were still being transferred between establishments for population management reasons, often leaving courses and interventions unfinished. Some remained in prisons that did not offer the programmes mandated in their sentence plans, hindering their chances of progression.

It is hoped that the introduction of the Building Choices programme, intended to replace most offending behaviour programmes, will help reduce this issue. However, there was a long period during the year when the old programmes had ceased to be provided but Building Choices had not yet begun, leaving many prisoners in limbo. At Rochester, prisoners were transferred in specifically to undertake the programme from March 2025, but delivery did not begin until January 2026. At Coldingley, which also received prisoners requiring Building Choices, delivery had still not begun by May 2026.

Boards continued to describe the demotivation and, at times, despair experienced by prisoners who felt they had little realistic prospect of progression or release, such as those on long sentences in the LTHSE and Imprisonment for Public Protection (IPP) prisoners designated as high-risk. Whilst some Boards reported on the prison's positive engagement with IPP prisoners, for example through constructive IPP forums at Moorland and Lindholme, the same Boards raised concerns that many IPP prisoners had very little optimism about their future prospects. The IMB at Swinfen Hall, a national resource for young adult prisoners, wrote to the Executive Director for Rehabilitation in 2025 to raise its concerns about the lack of rehabilitative opportunities for long- and life-sentenced young adults. This was particularly worrying in light of the dramatic increase in the number and proportion of Swinfen Hall prisoners serving a life sentence (from 38 in April 2020 to 132 in April 2025).

Prisoners on remand, short sentences or short-term recall also remained challenging for prisons to support. Remand prisoners faced considerable uncertainty, and those who began education or training were often released or transferred midway through a course. Short-stay prisoners of all categories often spent too little time in custody to benefit from education or interventions. Boards were particularly concerned about this in the open estate, where prisoners frequently arrived too close to release to benefit from the enhanced opportunities on offer, including release on temporary

licence. However, some prisons began adapting by creating short courses for remand and short-stay prisoners, which was welcomed by Boards.

Open prisons continued to grapple with challenges arising from the Temporary Presumptive Recategorisation Scheme (TPRS), which allows certain prisoners with up to 36 months left to serve, but often far less, to transfer into open conditions. As a result, many prisons, particularly Kirkham, experienced high rates of churn, which had a destabilising effect, especially when men arrived extremely close to release.

Women's open prisons faced a different challenge: Askham Grange and East Sutton Park often operated with many empty spaces, as women who had achieved open status were often reluctant to transfer out of the closed estate. This was largely because of their remote locations, which would make it difficult for women to maintain close family contact, and some were also reluctant to exchange single cells for shared rooms. This meant that the greatly enhanced training and resettlement opportunities available in the women's open estate could not be fully utilised.

Cuts to education provision slashed prisoners' access to meaningful learning and purposeful activity

By the close of 2025, cuts to education provision had become the most widespread urgent concern among IMBs, affecting almost the entire estate except for private and Welsh prisons. The then National Chair, Elisabeth Davies, wrote to Minister Timpson to highlight the findings of an IMB survey, which revealed that:

- Almost all Boards were concerned about cuts to education budgets. Of the Boards that could obtain a percentage figure from the establishment, 12% reported cuts of between 56-65%; 15% reported cuts of 46-55%; 34% reported cuts of 36-45%; 20% reported cuts of 26-35%; 12% reported cuts of 16-25%; and 7% reported cuts of 5-15%.[17]
- There had been dramatic curtailments to courses, particularly vocational courses, across all categories of prison, with no clear link to function, attendance or performance. Many of these courses were popular among prisoners and had strong links to future employment prospects.
- At many prisons, several teaching positions had been cut, and class sizes were being expanded, resulting in a greater mix of abilities within a single class.
- The management of the situation fell short in many prisons, with poor communication to both teaching staff and prisoners.

While the response to this letter emphasised that there has not been a reduction in the overall education budget, the practical reductions in what is being provided to prisoners are evident and wide-ranging.

These developments continue to unfold, and at many prisons the real-term implications of these cuts is yet to be realised. However, many Boards were already seeing distressed and demotivated prisoners, and more time spent in cells rather than engaged in purposeful activity. These reports have continued into 2026, and as of spring 2026 it remains a priority concern for the IMB. The effect of the reduced provision on future employment prospects and reoffending rates will likely take years to become clear, although Boards are in no doubt as to the gravity of these consequences.

The IMB understands the financial pressures the Prison Service faces and the need to demonstrate value for money, especially when some prisons regularly have vacant spaces on courses. However, Boards have also continually reported on the major barriers to attendance at purposeful activity. One of these is regime issues, including lockdowns, a shortage of officers available to escort prisoners, and clashing scheduling of healthcare appointments. Prisoners being transferred or released mid-course is another common reason for vacant spaces and, like regime issues, are outside the control of prisoners. Another crucial factor is motivation; prisoners routinely tell Boards that they do not feel motivated by 'time-filling,' menial activities which do not result in meaningful qualifications. This will only become more of a challenge when popular pathways are removed and prisoners lose faith in their ability to build a skillset to equip them for life in the community.

Maintenance and equipment issues further compromised vocational training opportunities

Vocational training and work were too often brought to a halt by fabric issues. Workshops were among the areas most frequently taken out of use for maintenance, with heating failures, leaking roofs and pest infestations halting operations. Problems with equipment were also common, with repairs taking far too long to complete. In some prisons, such as Bure, these issues, or shortages of vital supplies, resulted in workshop activity ceasing altogether. This was particularly damaging in a context where genuinely purposeful activity was already in short supply.

Overstretched offender management units failed to offer adequate support and information to prisoners

Prisoners frequently told Boards that they were unable to get in touch with their prison offender manager and felt in the dark about arrangements for their sentence progression, such as the date of their next parole hearing. Difficulties contacting community offender managers were also common. Often these issues were linked to probation staffing shortages, but Boards repeatedly highlighted the additional pressure placed on offender management units (OMUs) by the TPRS and the early release 'SDS40' scheme.[18] These schemes generated considerable anxiety among eligible prisoners, who frequently did not know what to expect.

As in 2024, the overloaded nature of OMUs too often meant that staff focused only on prisoners approaching release or imminent transfer, leaving others with little or no contact. At Pentonville, wing-based OMU clinics, which were introduced in 2024 and valued by prisoners, had to be cancelled because the OMU lacked the staff resource to sustain them.

Failures in release planning left many prisoners unprepared and at risk of homelessness

Preparations for release remained alarmingly inadequate at many prisons. Boards reported that prisoners were released directly from training prisons, such as Whatton, which did not have the resources or remit for resettlement work, or were transferred to resettlement prisons only weeks before release (or sometimes just days, as at Chelmsford), leaving no time for meaningful preparation.

Wealstun IMB witnessed prisoners' frustration at the lack of contact from the OMU in the run-up to release, and stated that pre-release conversations about accommodation were not taking place when they should. Additionally, some prisoners did not know how to get to their probation appointments on release from Wealstun.

Shortages of community accommodation often result in prisoners only being informed of accommodation arrangements immediately prior to release which can be unsettling at an already anxiety-inducing time. Prisoners also continued to be released homeless, sometimes at alarming rates. At Hewell, for example, approximately a third of prisoners were released without accommodation on their first night in the 2024-25 reporting year. At Doncaster, a survey conducted by the Board revealed that the proportion of prisoners worried about being unprepared for release rose from 8% to 38% during their 2024-25 reporting period, which the Board linked to the early release scheme.

2. Young offender institutions (YOIs)

Key findings

- Fear of violence was widespread among children, and staff struggled to manage boys who were in conflict. Many children self-separated in an attempt to protect themselves.
- Separated boys often did not receive the support, interventions or education they needed, and spent even less time out of their rooms than the general adult population.
- The physical estate continued to work against rehabilitation, making it difficult for staff to develop positive relationships with children and foster a sense of community on wings.
- Staffing shortages and inexperience sometimes undermined the safety, stability and rehabilitative culture of YOIs.
- Mental health staff could not always access the boys who needed their support.
- Boys continued to spend far too much time locked in their rooms in most YOIs, causing widespread frustration and low mood among the boys and drastically limiting access to purposeful activity and rehabilitative opportunities.
- Education provision was frequently undermined by staffing issues, poor performance by providers and safety concerns, although there were areas of promising good practice, such as the expansion of vocational training.
- Boys were often failed by the local authorities responsible for providing them with funds and visits, and communication failures in the run-up to release or transfer to the adult estate left boys frustrated and in the dark.

2.1 Safety

Children continued to live in fear of assault

Many boys felt extreme fear and anxiety at the prospect of mixing with others, and self-isolated as a result. This was of serious concern to Boards: not only did these boys miss out on crucial socialising with their peers, they also spent almost all their time in their rooms and had limited educational opportunities. Education outreach was insufficient to meet their needs. Although mandatory visits from designated staff members were carried out appropriately, the observation panels in doors were often obscured, making it difficult to carry out ad hoc visual checks on these particularly vulnerable boys.

Assaults and serious incidents were a regular feature of life in the English YOIs, despite continued efforts to reduce violence. This threatened all progressive elements of the establishments: serious incidents triggered lockdowns and class cancellations, and staff sickness (whether caused by injuries sustained at work or more generally linked to high stress levels and low morale) further restricted the regime and opportunities for positive engagement with children. As in previous years,

this created a vicious cycle where children misbehaved because of their frustration at being locked in their rooms, leading to further fights, assaults and lockdowns. Feltham IMB identified a clear correlation between restricted regimes and protesting behaviours such as incidents at height. The high number of boys who had to be kept apart to minimise the risk of conflict, often relating to gang associations, posed a further challenge. The pressure of providing multiple separate regimes for groups of boys often compromised the regime and access to purposeful activity. Even at Parc young person's unit (YPU), which had far lower violence and keep-apart rates, education allocation was still hampered by separation requirements.

There were concerted efforts to address these issues. Violence reduction officers were introduced at Wetherby, and successful drives to reduce keep-aparts were seen at Werrington and Feltham, although at Feltham improvements were only sustained for a few months. Nonetheless, attempts to reduce keep-aparts and self-isolation were in tension with the reality of frequent child-on-child assaults. At Werrington, for example, staff reduced keep-aparts by keeping boys in the same regime groups, even when boys reported isolating due to fear of others, unless specific intelligence indicated a clear risk. However, the Board was aware of at least two instances in which a boy was persuaded to mix and was subsequently assaulted.

Although use of force remained high, Boards generally considered it to have been applied appropriately. Reductions in the use of force were seen at Feltham and Wetherby (although the Wetherby Board was disappointed by an increase in planned restraints), whilst Werrington saw an unexplained rise. Welcome reductions in pain-inducing techniques were reported across all English YOIs. PAVA was first deployed in October 2025 in Feltham, and has since been used several times in both Feltham and Werrington, despite the Youth Custody Service's assertion, prior to introduction, that it would be used rarely if at all. IMBs are monitoring this closely and have now been invited to attend post-24-hour and post-72-hour incident reviews.

Illicit items posed a further threat to stability

The fear of assault, combined with the complex needs and mental health issues common among the population, led many boys to carry weapons. Boards were particularly concerned about weapons made from sharp pieces of metal taken from laptop components. Although every establishment had a dedicated weapons strategy – for example, every child found with a weapon was interviewed by the violence reduction team at Wetherby, metal detection wands were introduced at Feltham, and more rigorous room searches were carried out at Werrington – this continued to be a serious issue. At Feltham, for instance, 50 weapons were found in August 2025 alone, despite a population of only around 100 boys.

Drugs were far less of a challenge than in the adult estate, but they were present in all three English YOIs, and both Feltham and Werrington IMBs reported an increase. Werrington IMB noted that drug finds were lower than expected, given the frequent

smell of cannabis on the wings. At Feltham, poor GCSE results were attributed in part to students' cannabis use.

2.2 Fair and humane treatment

The physical estate continued to hinder rehabilitation

The physical fabric of YOIs remained considerably better than that of the adult estate overall, although many areas were drab or run-down. Issues with facilities were far less common and it was rare for any area to be out of action long-term due to maintenance problems, despite the destructive behaviour of some boys necessitating frequent repairs. Wetherby, Feltham and Werrington IMBs all reported initiatives to brighten up the building interiors, such as repainting walls or adding murals. However, Feltham IMB highlighted significant concerns about excessively cold temperatures, with some boys resorting to sleeping in their coats.

Despite these improvements, the structure of the buildings remained fundamentally unsuitable for the population held there. The layout of the three English YOIs largely reflects that of the adult estate and is distinctly not child-friendly. Boards commented that the large wings were often intimidating for boys and hindered the formation of a community atmosphere. Wetherby IMB noted that the transition from the small, modern induction unit to the larger, traditional wings could be unsettling, and that some boys reported preferring smaller units, describing them as feeling 'more like a family'.

Wetherby and Werrington IMBs both noted that there were too few spaces for private conversations between staff and boys, and that the CSUs lacked adequate space for mental health interventions or education outreach. Although some new areas for one-to-one conversations had been introduced at Feltham and on the main wings at Werrington, these still fell short of the number needed. In addition, Feltham's social video call booths were underused, in part because conversations could be easily overheard.

Staff-child relationships were vital but unreliable

Relationships between staff and children varied significantly. At Feltham they were broadly positive, with Board members observing friendly, confident and appropriate engagement from staff. At Wetherby they were more variable; relationships were significantly better on smaller units, where staff could more easily develop a rapport with the children in their care. The Werrington Board raised concerns about the low level of interaction between staff and boys, noting that protracted, warm conversations appeared to be rare and that it was difficult to see how meaningful interactions could be achieved through a locked door. The most positive relationships at Werrington were seen in the CSU, despite the more complex needs of the children held there, again demonstrating the importance of higher staff-child ratios and smaller units in fostering positive relationships.

The IMBs at Feltham, Werrington and Wetherby continued to criticise the delivery of CuSP (Custody Support Plan) sessions, the equivalent of key work in the adult estate. These were inconsistent in both delivery and quality. At Feltham it was common for boys to refuse to attend sessions, and at Wetherby boys told IMB members that they did not know who their CuSP worker was and were unsure of the scheme's purpose. At Werrington, CuSP was replaced with biweekly welfare checks, which were received much more favourably.

Separated boys sometimes went without the support they needed

All IMBs monitoring English YOIs noted the limited regime and outreach provision for separated boys. Mandatory staff visits were generally carried out properly, although at Werrington there were times when no healthcare or Governor visits were recorded. Werrington IMB reported that boys generally spent very short periods on the separation unit, and Feltham IMB noted a reduction in the number of separated boys from 2025 onwards.

Separation, however, was a priority concern for Wetherby IMB. The Board highlighted that boys often spent extended periods of time on the unit – particularly those awaiting transfer or release – and that the same boys often returned time and time again. Mental health interventions and education were often not delivered, either due to a lack of suitable intervention spaces or a shortage of teaching staff. The Board also criticised the extremely small rooms, many of which were out of order and only just met the minimum permitted dimensions.

Both Werrington and Wetherby Boards faced barriers to monitoring Rule 49 separation reviews because of insufficient communication from the establishment.

2.3 Health and wellbeing

Healthcare provision was generally good, but mental health care was sometimes compromised

Physical health care was described as very good across English YOIs, although there were some minor concerns about dental waiting lists at Feltham and Wetherby. At Werrington, appointments were sometimes missed because of regime issues, which could result in boys waiting several weeks for a new appointment.

Mental health care was generally described by Boards as comprehensive and multi-disciplinary in approach, a welcome assessment given the high level of need among children in YOIs**.** The enhanced support units at Wetherby and Feltham, which provide care for children with especially complex needs, operated effectively and were staffed by dedicated, experienced officers. Boards reported that the ACCT process was generally carried out well; however, Wetherby IMB observed that mental health staff faced challenges attending ACCT and GOoD (good order or discipline) reviews, because of inconsistent communication and scheduling.

All IMBs monitoring English YOIs reported that when children with very complex needs (including complex physical needs) could not be cared for appropriately within the YOI, they faced excessive delays in being transferred to appropriate specialist facilities. Werrington IMB also observed instances where responses to referrals to specialist mental health services were slow.

At both Wetherby and Feltham, a shortage of suitable, dedicated spaces for mental health interventions frequently resulted in sessions being cancelled or interrupted, undermining the delivery of consistent and effective support. At Feltham, the IMB also highlighted the effect of staff shortages and restricted regimes on access to therapeutic work, with interventions often cancelled as a consequence. Records from the interventions team showed that 40% of planned meetings with boys did not take place in 2025. In one instance, repeated postponements meant that a programme intended to last one week took four months for a boy to complete.

Looked-after children were let down by local authorities

Feltham and Wetherby IMBs continued to report that looked-after children were not receiving the financial support they were entitled to from the local authority responsible for their care. At Wetherby the situation appeared to be worsening. As looked-after children make up a significant proportion of those held in YOIs, chasing this up was a time-consuming endeavour, especially when teams were understaffed. At Feltham, for example, the team dropped to just one social worker during the 2024-2025 reporting year, despite a population of approximately 90-100 boys.

Restrictions to time out of room continued to be inhumane

Time out of room remained far too low across English YOIs, particularly at weekends, though there was considerable variation. Both Werrington and Wetherby IMBs reported general improvements: at Wetherby most boys received approximately five hours out of their rooms per weekday, and at Werrington this ranged from five to seven hours. At Feltham, time out of room was very low at the beginning of the year but began to improve in the spring. The establishment saw a much better summer than in previous years in terms of regime, violence levels and purposeful activity, attributed largely to the Governor’s efforts to maintain staffing levels, which typically dip over peak holiday periods. Unfortunately, in autumn 2025 the situation deteriorated significantly, with severe staff shortages, restricted regimes and a surge in violent incidents; by November 2025 boys were receiving only two hours out of their rooms on most days. One boy told the Board that his week had felt ‘very dark’.

Parc YPU continued to perform better than other YOIs; whilst the 2024-25 reporting year was more challenging than the previous year in terms of keep-aparts – one of the two units was closed for refurbishment – the average time out of room during the reporting period was 7.5 hrs per day.

Even within the same establishment, boys could have markedly different experiences. Some, such as those on the enhanced 'platinum' unit at Feltham or members of the Q-Branch maintenance team at Wetherby, could spend most of their day out of their rooms, except during lockdowns. Conversely, all IMBs at English YOIs were concerned about the very limited time that separated boys spent outside of their rooms. At Parc YPU, however, staff were able to provide more time out of room to separated boys, who were encouraged to live together as a community.

2.4 Education and training

Education often fell short, but vocational training saw a welcome expansion

Education was an extremely mixed picture across the youth custody estate. At Feltham, whilst the Board praised some areas of excellence in teaching, classes were often disrupted by lateness (caused by regime issues or violent incidents), poor behaviour or attendance issues. Attendance was also hampered by court dates, other interventions or separation; young people themselves very rarely refused to attend.

Poor behaviour was also a challenge at Wetherby, but there it was often linked to the extremely poor provision delivered by the education provider, which is now under an Outstanding Issues Notice (a formal signal that problems identified during an Ofsted inspection remain unresolved and require urgent improvement). Whilst operational staff attempted to plug the gaps by offering alternative provision, the combination of a poorly designed curriculum, staff shortages and class cancellations resulted in unacceptably poor outcomes for the children.

The situation was somewhat more positive at Werrington. Although education was poor for much of the reporting period, towards the end of 2025 there was more cause for optimism. The Board welcomed changes such as a move to smaller class sizes, refurbishment of previously dingy classrooms, improved attendance and a concerted effort by teaching staff to promote good behaviour. However, concerns about class cancellations and punctuality remained, and the Board was frustrated by the difficulty of obtaining meaningful data with which to assess the quality of provision. Werrington also raised concerns about the limited opportunities for higher-level learners, such as boys wishing to study for A-Levels. GCSE exams, however, were facilitated at all English YOIs.

At Parc YPU the IMB described education provision as generally good, although not without challenges. Misbehaviour disrupted many lessons and, unlike at Feltham, boys themselves regularly refused to attend.

Vocational training was expanded at all English YOIs, with offerings such as horticulture, barbering and waste management. At Feltham, all boys now have access to a vocational pathway – an extremely positive development given many boys' preference for training over traditional academic education. Non-accredited opportunities to build boys' skills and confidence were also increasingly explored.

Both Wetherby and Werrington Boards praised the employment of some boys in repair and maintenance work: Wetherby IMB described Q-Branch, a minor repairs work party made up of boys, as an excellent initiative both in terms of maintaining the estate and promoting boys' morale and practical skills. In addition, all English YOIs introduced 'red-band' roles for boys on enhanced status who have demonstrated good behaviour and built trust with staff. These boys could be employed in wing-cleaning roles, as peer mentors or in departments such as reception.

2.5 Preparation for transfer and release

External challenges compromised preparation for release, leaving boys anxious and unprepared

Resettlement planning and preparation for transfers to the adult estate were of significant concern to the IMBs monitoring English YOIs. Local authorities routinely confirmed post-release accommodation far too close to release dates, causing uncertainty, anxiety and frustration for boys at an already extremely stressful time. These delays had knock-on effects on other aspects of resettlement preparation, such as GP registration, treatment referrals, education and work placements, none of which could be arranged until accommodation was confirmed. At Feltham, in the year to July 2025 more than half of boys released had their accommodation confirmed less than 10 days before release, and fewer than 20% had any confirmed education, training or employment plan.

Transfers to the adult estate were also described as problematic by Feltham and Wetherby IMBs, as many adult prisons were reluctant to accept boys considered high-risk or those with complex needs. This led to protracted delays and the same uncertainty, anxiety and frustration described above; Wetherby IMB noted that boys' behaviour sometimes deteriorated as a result. One boy at Wetherby had a transfer called off on the day of planned departure, after he had already packed up. Several months later, his transfer had been refused by two other adult establishments. He was eventually transferred a month after that, to a prison at the opposite end of the country from his family.

3. Immigration detention

Key findings

- Force was used against detained people in ways that were often arbitrary, with routine heavy-handedness and limited effective oversight. The standard use of handcuffs for hospital visits discouraged access to healthcare.
- Use of force and separation were routinely applied for operational convenience rather than on the basis of individual risk assessments. Instances of isolation and confinement increased.
- Vital safeguards, such as health screenings and age assessments, failed to prevent harm to vulnerable people.
- Many individuals experienced significant distress and disorientation; as a result, their health declined, and self-harm and suicide attempts were widespread.
- Access to healthcare, even in emergencies, could be severely delayed: one month to see a doctor for a broken finger and nearly three hours to secure a hospital transfer in the case of a suspected stroke.
- Many detention facilities remained unsafe, with ongoing security concerns.
- Reception conditions were frequently poor, despite some welcome improvements. At STHFs in particular, contractors failed to address substandard facilities adequately.
- Reception and induction processes varied considerably – the practice of conducting many transfers and removals at night resulted in sleep deprivation, uncertainty and distress. Unacceptably long periods spent on coaches remained routine.
- Communication issues significantly affected the treatment of detained individuals: legal advice was often difficult, and at times impossible to access; essential information was not consistently translated, and principles of confidentiality were not always upheld.
- People detained in STHFs continued to be prevented from accessing their prescribed medication, creating serious risks for both their health and the staff responsible for responding to the predictable emergencies that may ensue.
- Lengthy, indefinite and unnecessary detention contributed to many of the difficulties observed. Even when individuals were willing to return, or had been granted bail, administrative delays were common and often unexplained.

Population changes

In 2025, 22,996 people entered immigration detention, an increase of 11% compared with the previous year.[19] Enforced removals from detention to a person's country of origin or a third country also rose by 20%. Campsfield House IRC reopened in December 2025, following its closure in 2018, despite IMB concerns about the

expansion of the immigration detention estate – most people are released from detention, and less costly and harmful alternatives exist.

Since the *UK – France Agreement on the Prevention of Dangerous Journeys* ('the 'Hillmore Treaty') entered into force in August 2025, 305 people had been detained for the purpose of return to France by 3 February 2026.[20] A significant number of those detained under the Operation Hillmore pilot were subsequently identified as children and released. IMB analysis at Gatwick IRC conducted in February 2026 found that since the start of the pilot in August 2025, 12% of the cohort were subject to age disputes, of which over 20% were assessed to be children – a strikingly high rate that indicates serious safeguarding gaps. People detained under the treaty remained in detention for lengthy periods of time – an average of 54 days. The increased detention of newcomers processed under Operation Hillmore, for whom no prior records were available, presented a particular challenge for managing people's needs and vulnerabilities, especially in relation to interpretation and medical support.

3.1 Safety

IMB findings covered a wide range of safety issues across the immigration detention estate and indicated significant shortcomings. These included harmful practices and poorly functioning safeguards that failed to protect those most vulnerable from harm.

Detained people were routinely subject to use of force for operational convenience rather than as a last resort

The IMB's first national thematic report on the immigration detention estate, *By force of habit: How the use of force in immigration detention has lost sight of necessity and dignity,* published in November 2025, showed that fundamental principles such as proportionality, necessity and the requirement that force be used only as a last resort, were frequently overlooked in favour of operational convenience.[21] This was to the detriment of detained people, many of whom are highly vulnerable and unable to understand or too afraid to challenge the actions taken against them.

Routine handcuffing during transfers, including to hospitals, was commonplace. Boards raised concerns about the legality of this approach, finding little evidence of meaningful individual risk assessments or critical oversight. Explanations provided for blanket handcuffing were sometimes inconsistent with legal requirements governing the use of force. This included references to isolated absconding incidents or claims that the practice was 'consensual.' The presumption of risk was applied even in cases involving older, frail or unwell people, despite personnel acknowledging that such individuals posed no threat of violence, or absconding.

Boards noted that unnecessary or disproportionate use of force had wider effects, including creating reluctance to seek necessary medical attention. Some individuals told Boards they avoided healthcare appointments because of the

stigma attached to being handcuffed in public. The IMB at Brook House IRC was told that detained people had been informed that they would only be taken to hospital if they agreed to be handcuffed, which in the Board's view is a form of coercion.

The report also highlighted correspondence between the then IMB National Chair and the Home Office, in which the Home Office stated that a comprehensive review of handcuff usage would be completed, as well as a review of restraint use during escorting operations. The IMB still awaits the outcome of these reviews.

Whilst these issues are still routinely being highlighted by IMBs, some have also reported positive practice, including the appropriate use of de-escalation techniques. The South and East STHF Board also reported a change in practice later in the year, with restraints used during transfers only when justified by an individual risk assessment.

Access to oversight mechanisms in relation to use of force across the detention estate was variable, with some Boards unable to monitor use of force debriefs and encountering barriers to accessing CCTV footage. This was representative of the wider trend in which the IMB was not provided with, or was denied access to, information necessary for discharging its statutory scrutiny function. An example of this was the attempt to restrict access to certain detention forms, in the context of a Border Force pilot scheme, which was ultimately reversed following IMB challenge. Indeed, on multiple occasions, the IMB had to reiterate its right of access to all records it deemed relevant to discharging its statutory monitoring function.

Boards have also identified concerns relating to Operation Hillmore. The limited information available on newly arrived individuals – compared with people entering detention from the community – could increase the likelihood of risk being presumed, which has the potential to lead to the use of restraints or other force.

Isolation and confinement were used more, and for the wrong reasons

Separation is intended to be used only in the interests of safety and security, or in the management of violent individuals, and only as a last resort. As with the use of force, however, isolation was frequently applied for reasons of operational ease. Some IRC Boards observed that people were increasingly subject to removal from association and temporary confinement. These measures were often used to manage removals or when individuals were assessed as being at risk of disruptive behaviour. In one instance, a detained person at Heathrow IRC was removed from association and placed in a separation unit for eight nights prior to their removal.

Boards regularly observed people with complex mental health needs being held in separation units for prolonged periods: one detained person at Heathrow IRC had yet to be transferred to a local psychiatric unit after five weeks. This is often because of challenges in accessing appropriate mental health beds in the community.

Vulnerable people were let down by ineffective safeguarding procedures

The IMB continued to raise the alarm that key safeguards, designed to prevent further harm being caused to individuals whilst in detention, faced systemic challenges. Boards consistently reported concerns about the quality of screening that allowed extremely vulnerable people to enter detention, raising questions around the effectiveness of mechanisms such as the Detention Gatekeeper – a specialist team within the Home Office that reviews proposals to detain. These shortcomings resulted in routinely illogical situations, whereby people with extreme vulnerabilities were assessed as unfit for detention only after they had already been detained, yet were ineligible for release because of the lack of hospital beds or difficulties accessing support in the community. Ultimately, Boards noted that many individuals identified as highly vulnerable were later granted bail, having had their continued detention assessed as inappropriate.

Delayed safeguarding processes were also observed in relation to children. At Heathrow, on more than one occasion, children, whose detention should be avoided at all costs, remained detained for almost two weeks, due to delays in assessing their age. In another instance, it took nearly three weeks for social services to assess a young person whose age was disputed. STHF Boards were similarly concerned, with one flagging wait times of up to 17 hours for children's services to respond. Additional failures identified by Boards included detained people being left for hours, with no proof of welfare checks.

The IMB is deeply concerned about the implications of these systemic deficiencies in safeguarding in the context of the UK – France Agreement, particularly regarding failures to ensure prompt identification of children. In addition to observing an increase in the detention of children under this pilot scheme, IMBs have noted acute vulnerabilities among this cohort. They have arrived exhausted after long and risky journeys, many with histories of trauma, and some have been separated from their family members who arrived on the same vessel. The criteria for their inclusion in the pilot were unclear, with Boards receiving explanations that it is random by design, in order to undermine smuggler operations. Detained people were therefore highly confused, and the information provided to them was less accessible than is generally the case in detention. This group faced a lack of translated written material specific to their situation, despite greater language needs compared to others in detention who may have spent years in the UK. The timeframes for returning legal paperwork were tight – seven days were given for a response to the letter of intent informing an individual that they will be returned to France, which was not always long enough to speak with a lawyer. Many individuals included in the pilot have been recognised as highly vulnerable, from asylum seekers to victims of modern slavery, and so their release could be expected as a result of safeguarding procedures. Instead, they were held in detention for longer than average, unclear as to what would happen to them when returned to France. Their opportunity to make representations to a Chief Immigration Officer – a final safeguard in preventing unlawful deportations from the

UK – is more challenging on these removal flights which, unlike other charters monitored, are extremely short.

Vital medical safeguards were particularly ineffective, with serious human and financial costs

Individuals must undergo health assessments upon arrival in detention, under Rule 30 of the STHF Rules and Rule 34 of the Detention Centre Rules, unless they withhold their consent. However, IRC Boards reported that many detained people were not effectively informed of this process because of a lack of interpretation and rushed explanations. As a result, many did not benefit from this provision: at Gatwick IRC, only half of new arrivals agreed to a health assessment, and up to 40% of those scheduled did not attend the subsequent appointment, often unaware of its significance. This means missed opportunities to identify vulnerabilities, including serious health conditions, disabilities, and experiences of sexual abuse, trafficking and modern slavery.

Barriers to effective disclosure and medical attention included a lack of privacy during screenings, partly attributable to inadequate facilities. Boards also noted repeated breaches of medical confidentiality, such as staff discussing an individual's medical condition openly in front of others. These practices undermine trust, erode dignity, and reduce the effectiveness of safeguarding mechanisms. Medical professionals have themselves expressed concerns to the IMB: at one STHF, they feared their licence to practise could be placed at risk if a complaint were to be made about the lack of privacy for medical checks. Their concerns were particularly acute in the case of unaccompanied children.

Boards reported that individuals, particularly those with complex mental health needs, experienced deterioration in their health whilst held in detention settings that were ill-equipped to provide appropriate care. Healthcare staff at Gatwick IRC also confirmed to the Board that they see detention frequently exacerbating mental health conditions. Vital safeguards set up to prevent such deterioration did not always operate as intended. Many people were identified as adults at risk, for instance people with learning difficulties, those placed on ACDT plans, or those medically assessed as unfit for detention, yet remained detained for prolonged, indefinite periods, despite the numerous safeguarding mechanisms available, which were often uncoordinated.

Rule 35 of the Detention Centre Rules and Rule 32 of the STHF Rules serve to bring acutely vulnerable cases to the attention of the Home Office, via a GP's report, so the continued suitability of their detention can be reviewed. However, Boards found that these mechanisms, intended to ensure medical considerations are central in decisions to detain or release those whose health may be injuriously affected by continued detention, such as torture victims and those experiencing suicidal ideation, were often ineffective. Month-long waits for Rule 35 appointments were recorded, with backlogs exceeding 100 cases in some instances. As a result, people may have

been kept in detention longer than necessary, at significant human and financial cost. In response, additional GP sessions were organised at Gatwick IRC towards the end of the year to reduce the backlog.

Concerningly, IMBs also reported reticence among some healthcare staff to refer individuals for a Rule 35 assessment. Referrals were often only made in response to reports of torture, rather than for individuals with broader health or suicide risks. However, this improved slightly at Gatwick IRC towards the end of the year.

Release of those who had been assessed as at risk of serious harm if kept in detention, was rarely seen in practice. At one IRC, only 10% of cases where it was found that continued detention would injuriously affect a person's health, resulted in release, compared with earlier averages of 25-30%.

Boards maintain that greater coordination is needed across all safeguarding processes, and that Rule 34 and Rule 35 procedures should be used in conjunction with ACDT plans and Vulnerable Adult Care Plans to strengthen responses to vulnerability and prevent deterioration in detention.

Detention exacerbated distress among vulnerable individuals, fuelling widespread self-harm and suicide attempts

IRC Boards reported increasing or consistently high levels of serious self-harm and suicide attempts, raising questions as to whether the care available was sufficient, despite prompt responses from staff in many cases. Practical measures to prevent furnishings being used for ligatures were at times delayed or ineffective. However, trauma-informed approaches were commended in certain locations, such as Derwentside IRC.

Uncertainty regarding case progression and length of detention contributed to distress and mental health concerns, and Boards saw a growing number of incidents related to attempts to avoid removal, including climbing on the netting and episodes of self-harm.

Security incidents further undermined safety across many detention sites

Security incidents continued to occur, with some IRC Boards reporting an increase in assaults, altercations and incidents of indiscipline, including those linked to frustration at the length of detention. At Brook House IRC, a significant number of serious incidents on the netting were reported involving individuals reluctant to be placed on deportation flights or protesting about slow case progression.

At Dungavel IRC, women are required to be escorted around the mixed-gender site for their own protection. The Board considers it unjust that women's movements are restricted in this way, rather than men's. At Yarl's Wood IRC, the Board identified another safety issue in which an individual with a Personal Emergency Evacuation Plan (PEEP) had restricted access to a wheelchair, creating risks in the event of an emergency evacuation.

IRCs also experienced increasing issues with drug throw-overs, particularly at Brook House, whilst at Heathrow IRC the Board deemed the growing number of illicit items entering the centre, including drugs, 'alarming.' In contrast, the Board at Dungavel IRC noted that staff were effective in detecting and minimising substance misuse.

3.2 Fair and humane treatment

IMB findings on fair and humane treatment were mixed. Positive practices were highlighted in some locations, including the provision of religious support and the presence of multilingual staff. However, underlying challenges remained in the implementation of key procedural safeguards, particularly in relation to confidentiality and communication. Gaps in the provision of legal advice and interpretation were also identified by Boards.

On two occasions during the summer, staff at one STHF were observed wearing England flags affixed to their uniforms. The Board felt this risked perceptions of bias or even intimidation among detained people, especially in the light of recent anti-immigration protests in which flag displays were prominent. At a minimum, the Board concluded that this raised concerns about professional standards and workplace culture at the facility. In contrast, code of conduct violations were highlighted by the Board at Gatwick IRC as being addressed in an increasingly robust manner by the contractor, Serco.

Reception and induction processes were inconsistent and disrupted by lengthy nighttime transfers

Improvements to induction processes and reception facilities were observed at Derwentside and Harmondsworth IRCs, where private areas for processing new arrivals were introduced, and on the Kent Coast, where new arrivals were able to change into warm, dry clothes prior to triage. A multilingual 'Welcome to Derwentside' video was also made available at that IRC, which the IMB considered a commendable practice.

Nonetheless, shortcomings persisted, including in relation to privacy. The South and East STHF Board reported medical assessments being conducted in open areas, whilst plans to redesign parts of the Residential STHF at Swinderby to remedy the lack of privacy for confidential reception interviews did not deliver results during the reporting period. The effective identification of vulnerabilities may therefore have been compromised. Reception procedures were also deemed inconsistent: at some sites, Boards observed that people were not informed that they were not required to answer certain questions, such as those relating to religion or marital status.

The length and timing of transfers were also of significant concern. Journeys were often scheduled at night, at times with little regard for geographical planning. Women were repeatedly transferred in and out of Derwentside from other IRCs, or transported from Derwentside to another IRC to collect additional passengers before being driven back past Derwentside on the same journey. The Derwentside Board

documented cases of women being transported overnight on up to three consecutive nights. In June, the Board calculated that 46% of collections took place at night.

Transfers also often involved excessively long periods spent in, or waiting for, coaches or vans. Individuals were observed remaining seated for up to seven hours, and coaches regularly had malfunctioning heating or toilets. The cumulative effect of prolonged nighttime transfers and repeated movement between facilities was identified as having a negative impact on individuals' wellbeing, with women providing evidence to the Derwentside Board of how the resultant sleep deprivation had worsened their mental health.

Staff often failed to make use of translation and interpretation services, leaving detained people confused and uninformed

Concerns were raised about detained people's ability to access information in a language they understood during their time in the detention estate. Boards saw individuals with very little English for whom interpretation services were needed but not used. As a result, people often did not fully understand what was happening to them or what support was available. At Derwentside IRC, where translation tablets were available, the Board observed limited use of these for everyday conversation between staff and residents.

Particular concerns were identified in relation to removal charter flights monitored by the IMB. Language support needs were often underestimated, especially when individuals were collected in the middle of the night from IRCs and STHFs. These issues were compounded by an instruction, since withdrawn, that interpreters were not permitted to bring mobile phones into some collection centres. The IMB documented three cases where this resulted in people not receiving adequate information or assistance until arrival at the departure airport.

Use of online interpretation services was inconsistent across the estate, with barriers including poor connectivity, limited availability of interpreters during evenings and nighttime hours, and difficulties supporting less common languages, with Boards concluding that the 'Big Word' online interpretation service was not sufficiently resourced. This impacted those being removed under Operation Hillmore most significantly due to the wide range of languages spoken in this cohort and the resultant reliance on Big Word. On other charter flights, which typically gather a group of individuals being returned to their shared country of origin, only one or two languages will be in use: in-person interpreter staffing is therefore straightforward, and interpreters are often highly experienced in the routine procedures and paperwork used in these operations.

Despite the possibility of oral interpretation, the absence of written translations was also identified as a challenge, as individuals were served legal documents in English only. When Campsfield IRC first opened, information displayed around the centre was only available in English and, despite improvements, the provision of translated information remains inconsistent. At Yarl's Wood IRC, written complaints did not

always receive a response in plain English, limiting detained people's ability to use complaints mechanisms effectively. However, a policy of recruiting staff with the ability to speak additional languages has led to improvements in communication at this particular centre.

Access to legal advice was frequently impeded

In addition to limitations arising from insufficient interpretation services, communication with lawyers (and family members) was hindered in some locations by difficulties in accessing the internet, which is already subject to restrictions, poor signal, and other persistent issues with telephone systems. Detained people were often unaware that they could make more than one phone call or that loan phones were available.

STHF Boards raised concerns about incorrect contact numbers being listed for legal service providers. In London, the IMB observed that lawyers did not always answer or provide prompt assistance, or were unavailable out of hours. These barriers impeded access to legal advice and risked violating detained people's rights. The disconnect between entitlements on paper and in practice raised concerns that unrealistic expectations were being fuelled among already distressed individuals.

The Heathrow Board also reported cases in which detained people missed court proceedings because the Home Office did not provide transport from the IRC, or an escort, to enable their attendance.

Persistent facilities and maintenance failures, coupled with a lack of accountability among operators, resulted in substandard conditions

Facilities and maintenance issues were flagged across the detention estate, resulting in fire, chemical and other safety hazards, as well as loss of essential services, including electricity, heating and water, and gaps in hygiene and cleaning provision. In some locations, these issues remained unresolved for long periods, while remedial works were undertaken elsewhere. At Vulcan House STHF in Sheffield, longstanding concerns about the safety of the vehicle loading bay, where detained people are escorted to vans through an area used for storing hazardous items, have not resulted in any safety-remedying measures: instead, handcuffing is still being used as a standard risk-mitigation measure.

Upgrades continued throughout 2025, including the opening of a kitchen for residents at Derwentside IRC and the introduction of private areas for health assessments at Harmondsworth IRC. However, refurbishment works at Heathrow and Gatwick IRCs generated additional issues, including disruption to heating and ventilation. Persistent maintenance problems were flagged at Tinsley House and Heathrow IRCs in relation to waste drainage, and at Derwentside, plumbing issues kept eight rooms unusable more than three years after the centre opened. Where redesigns took place, these did not always address concerns previously raised by

the IMB; for instance, disability access issues identified and escalated to the Home Office by the Board at the new facility at Ruskin Square, were not resolved.

The range of stakeholders involved in operating air, land and seaports contributed to delays and uncertainty regarding the prospects for essential works at STHFs, despite clear deficiencies in the fabric of some sites, such as Felixstowe port, which the Board deemed unfit for purpose. STHF Boards reported unusable showers (or an absence of showers), issues with running water, drainage, ventilation, sanitation and heating breakdowns. The London STHF Board raised concerns about the limited capacity of family rooms, which would not be able to hold more than one family at a time, whilst at Western Jet Foil on the Kent Coast, the IMB reported a lack of mats for people sleeping overnight on wooden benches, some of whom were children awaiting age assessments. These concerns were echoed by the Board at Luton Airport, where limited holding room space resulted in individuals sleeping on the floor in crowded conditions. The insufficient provision of mattresses, which were often poor quality, in some holding rooms meant that many people were, in effect, sleeping directly on floors or hard plastic chairs when held overnight in STHFs after long journeys. At Birmingham Airport, temperatures sometimes dropped so low that the family room could not be used.

Food provision was also identified as inadequate at multiple STHFs, with no hot food or options for those with dietary restrictions in certain locations. Some STHFs did not provide a halal option for meat-based meals, or labelling was unclear. Improvements to food provision were, however, noted at Stansted, Ruskin Square and Gatwick STHFs.

At Heathrow and Yarl's Wood, instances of detained people's property going missing were also recorded. This resulted in allegations of theft at Heathrow, exacerbating frustrations within detention settings more generally.

3.3 Health and wellbeing

The IMB remains profoundly concerned about the harm caused by the detention of vulnerable individuals with complex and acute health needs. Detention, by its very nature, is detrimental to a person's physical and mental health, and for those who are already unwell, being held in a closed facility limits access to some basic services, support and assistance. In such cases, detention typically causes deterioration in health rather than recovery.

These fundamental healthcare concerns were underpinned by gaps in essential services and safeguards, including medical assessments and access to translation and interpretation. Detained people with limited or no English often had difficulty understanding their medical records, and records were not always readily accessible. At Heathrow IRC, for example, individuals' requests to receive their medical records, needed for continuity of care following removal, took up to six weeks to process.

However, one concerning practice was changed during the year: the Charter Flight Monitoring Team discovered instances of removal directions being served by hospital staff in secure mental health units, which the IMB found to be wholly inappropriate. Following escalation by the then IMB National Chair, the Home Office confirmed that this would no longer happen.

Positive practices were also identified later in the year, including the translation of NHS documents by the healthcare provider at Gatwick IRC, and deployment of medical staff on rescue vessels on the Kent coast. At Derwentside IRC, the Board noted effective health promotion and wellbeing initiatives, as well as robust case meetings that supported improved care for adults at risk.

Access to medication and medical care was delayed or denied, causing unacceptable levels of risk

In detention at STHFs, people continued to be denied access to their prescription medications, which are confiscated, creating serious risks for both their health and the staff responsible for responding to any resulting emergencies. No individual risk assessments were undertaken in relation to medication denials, including for people with life-critical prescriptions. This is an issue that Boards have highlighted for many years and has yet to be fully resolved across the STHF estate. Boards continued to highlight the absence of healthcare professionals in STHFs, as well as the long wait times for medical staff to arrive when required, particularly at a busy London airport.

In some cases, however, the IMB observed staff facilitating access to remote healthcare advice, which enabled individuals to take their medication. This was identified as a potentially useful interim practice for replication as a stop-gap measure in locations without current healthcare provision. At one airport STHF, staff were also observed allowing a detained person to take their diabetes medication when needed. The Board commended this common-sense approach, which nonetheless placed staff at variance with Home Office policy.

As populations increased in IRCs following Operation Hillmore, Boards also observed significant delays in access to healthcare. Examples included a one month wait to see a doctor for a broken finger and delays of nearly three hours in securing an emergency medical response for a suspected stroke.

People’s mental health deteriorated while facing indefinite detention

Uncertainty as to how long their detention will last remained a major source of anxiety among detained people. IMBs across the immigration detention estate observed an increase in the number of individuals requiring constant supervision as a result of significant distress. Boards raised concerns about the quality of support available to these highly vulnerable individuals and noted the impossibility of meeting people’s needs in prolonged, indefinite detention. In some cases, individuals’ mental health was observed to deteriorate to the point where, unable to cope, they caused serious and life-altering harm to themselves.

Despite their best efforts, detention staff generally had neither the training nor the resources to provide the level of care and support required. IMBs also observed that healthcare staff sometimes assessed individuals' mental health needs as manageable in detention until deterioration reached a level requiring sectioning under the Mental Health Act. Boards considered that this raised significant safeguarding concerns, as well as questions about the quality and scope of mental health support provided in detention: with limited access to psychiatric input, most interventions focused primarily on medication. Board recommendations to provide mental health first aid training to detention staff have not been implemented.

Activities failed to engage most detained people but were effective for those who participated

In general, participation in activities in detention centres remained low. Whilst activities were clearly very important to some individuals, Boards reported that most detained people did not engage with education, catering or handicraft programmes.

The exception to this was Derwentside IRC, where the Board highlighted efforts to promote wellbeing among detained women through leisure activities and access to outdoor spaces, including opportunities for some women to work as gardeners. Access to garden areas was also identified as beneficial at the newly reopened Campsfield IRC. In contrast, some STHF Boards flagged the lack of access to natural light or fresh air, including in cases where individuals were held for more than 24 hours.

3.4 Preparation for return or release

Across the immigration detention estate, Boards continued to raise concerns about the length of detention and the deleterious effects of its indefinite nature. Inefficiencies were common across case progression, bail decision-making, release processes and removals, exacerbated by a lack of accessible and timely information for detained people.

People were held in detention for excessive periods of time without clear justification

Extended detention was a concern in both STHFs and IRCs, with Boards reporting STHF stays that at times exceeded the 24-hour limit, and long waits for transfers or responses from social services. These situations most commonly occurred during periods of staff shortages, although most detentions remained under the 24-hour threshold. Detention in STHFs often followed lengthy periods spent in Controlled Waiting Areas, which typically amount to a few designated chairs or benches.

The quality and accuracy of detention records remained an issue in multiple STHFs, potentially hampering oversight efforts. Boards also reported broader challenges obtaining information throughout the year. However, the possible transition to electronic record keeping presents an opportunity to address some of these access issues, and the IMB awaits the outcome of a feasibility study currently underway.

Notwithstanding these concerns, improvements in record keeping were noted at Bristol Airport STHF.

In IRCs, Boards flagged excessive stays in detention, including one case exceeding 15 months. This raised concerns about whether the conditions required for detention to remain lawful, such as a legitimate purpose and realistic prospects of removal, continued to be met. Even those who wished to return voluntarily continued to experience long delays prior to removal, in part due to inefficiencies in administrative procedures.

Administrative inefficiencies prolonged detention unnecessarily and increased costs

Complaints to the IMB about slow and inefficient administrative processes continued throughout the year. For example, in the case of time-served foreign national offenders, who arrived in increasing numbers and often with complex needs, voluntary return forms completed whilst individuals were in prison were not transferred to IRCs. As a result, the process had to restart upon arrival, delaying removal and extending detention unnecessarily.

Other administrative oversights also had financial implications. In some cases, once return decisions were served, individuals were not asked to confirm their final destination. In one instance, this resulted in an individual being sent to a location 2,000 miles from their place of origin, requiring the escorting team to arrange emergency funds to cover onward travel within his country of return. The Board noted that uncertainty about onward travel was driving anxiety among detained people.

On a positive note, the Gatwick IRC Board reported improved on-site presence and communication by the Home Office Detention Engagement Team, which appeared to ease difficulties in contacting caseworkers. This was associated with fewer security incidents and a reduction in applications to the IMB relating to difficulties in obtaining casework updates. However, a pilot initiative intended to improve communication between on-site agencies and probation services, strengthen the case management of time-served foreign national offenders, and accelerate approval of bail addresses was deemed by the Board to have had little to no effect.

Information was scarce or inaccessible, leaving detained people disoriented

Boards reported that a lack of accessible information affected all aspects of detained people’s lives, causing anxiety and creating obstacles to legal and administrative procedures, leaving people in the dark as to the status of their detention or removal. These issues intersected with widespread challenges relating to translation and interpretation.

At Dungavel IRC, the Board noted that detained people were typically unaware that decisions about their cases were not made on site. At Leeds Bradford Airport, IMB monitoring identified that detention paperwork (the IS91R form) was consistently

served late, leaving many individuals detained for hours without being informed of the reasons for their detention.

The need for better signposting to information within IRCs, particularly in relation to reintegration support, was also highlighted by Boards. This was considered especially important given the variety of different reintegration providers. Access to clear and timely information is central to informed decision-making and may encourage voluntary return or compliance with enforced removals, potentially reducing the possibility of force being used during removal processes.

Boards noted that information provision was particularly lacking in the context of returns under Operation Hillmore. Given that this group, unlike those being returned to their countries of origin, are especially unfamiliar with the place to which they are being sent, there is a heightened need to deliver accessible information on what to expect upon arrival.

Although leaflets on reintegration assistance were available at some sites, Boards noted that these were often provided with little explanation. This may limit their effectiveness, especially where literacy barriers are present. No such equivalent was available to those being returned to France under Operation Hillmore.

Bail and release procedures were highly inefficient

Many people remained in detention for weeks or months after being granted bail, primarily due to delays in finding approved accommodation. Release decisions were sometimes made with little notice, creating additional challenges. Too many people were released with no fixed abode, including a case that particularly worried one Board involving a lone woman released from an STHF without any accommodation or apparent means of subsistence. This practice occurred despite lengthy periods in detention during which such arrangements might reasonably have been expected to be resolved.

In other instances, people's health deteriorated so significantly that release could not take place until suitable accommodation and care were arranged in the community, a process that could take months. At Gatwick IRC, the Board highlighted the case of one person held in detention for well over a year whilst local authorities and health agencies disputed responsibility for providing care.

The availability of mental health beds in the community remained insufficient compared with the number of seriously unwell people in IRCs who were sectioned under the *Mental Health Act* and required transfer out of detention. IMBs noted that bed allocations did not reflect the rising levels of need associated with increased detention centre occupancy. For example, only one such bed was allocated to the Heathrow IRCs. As a result, lengthy delays occurred before transfers could be arranged, including a wait of over a month at Yarl's Wood. Towards the end of the year, however, IMBs observed some improvement in achieving the 28-day transfer target for those requiring inpatient mental health care. At Derwentside IRC, the

Board flagged a case in which a hospital bed became available for a detained woman with acute and complex mental health needs, but the transfer warrant was not prepared in time and the bed was lost.

The high proportion of detained women released from Derwentside IRC for case management in the community also raised questions about the original purpose of detention. By the end of the year, alternatives to detention were ultimately applied in around 60% of cases.

Removals increased, with distress reported

Although the number of removal flights increased over the year, reaching the highest level of charter operations seen since 2019, monitors found that escorting staff generally performed their duties professionally, treating those in their custody with compassion and respect despite challenging circumstances.

However, monitors reported concerns about the presence of large numbers of centre staff, escorts and search teams, particularly at cramped collection points ahead of flights, which sometimes was observed to be overwhelming and distressing for those being removed.

Annex - Membership

1,030 members were in post across **133** Boards as of 1 January 2025.

Table one: members in post by region[22]

Regions	Members in post
East Midlands	104
Eastern	98
Kent, Surrey and Sussex	83
London	156
North East	51
North West	124
South Central	88
South West	85
Wales	40
West Midlands	81
Yorkshire and Humber	102
IDE	113
Total	***1125***

Table two: members in post by detention setting[23]

Setting	Members in post
Prisons	**995**
Male prisons	894
Female prisons	101
YOIs	**29**
IDE	**113**
IRCs	49
STHFs	64
Charter flights	7

Table three: ethnicity data of participating members

Improving members' ethnic diversity has been identified as a key priority for the IMB's commitment to equality, diversity and inclusion.

Ethnicity	Percent (%)
Asian	2.6
Black	2.0
Mixed	1.2
Other ethnic group	0.9
White	68.4
Prefer not to say	4.3
None recorded	20.6
Total	***100***

Endnotes

[1] Independent Monitoring Boards, https://imb.org.uk/document/imb-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] 127 reports were published between 1 January 2025 and 31 December 2025. The individual breakdown of reports per category may not tally with the wider total due to the combination of some reports e.g. IMB Parc produces a single report covering the adult male prison and the young person's unit.
[5] Written evidence provided by IMBs to the prison culture: governance, leadership and staffing inquiry, available at: https://committees.parliament.uk/writtenevidence/136084/pdf/.
[6] Written evidence provided by IMBs to the tackling drugs in prisons inquiry, available at: https://committees.parliament.uk/writtenevidence/136254/pdf/, oral evidence transcript available at: https://committees.parliament.uk/oralevidence/15420/pdf/.
[7] Written evidence provided by IMBs to the independent sentencing review, available at, https://cdn.websitebuilder.service.justice.gov.uk/uploads/sites/13/2025/07/IMB-response-to-the-independent-sentencing-review.pdf.
[8] Written evidence provided by IMBs to the rehabilitation and resettlement: ending the cycle of reoffending inquiry, available at: https://committees.parliament.uk/writtenevidence/135631/pdf/, oral evidence transcript available at: https://committees.parliament.uk/oralevidence/15906/pdf/.
[9] Written evidence provided by IMBs to the prisons in Wales inquiry, available at: https://committees.parliament.uk/writtenevidence/139579/pdf/https://committees.parliament.uk/writtenevidence/125476/pdf/, oral evidence transcript available at: https://committees.parliament.uk/oralevidence/15967/pdf/.
[10] Written evidence provided by IMBs to the Autism Act 2009 committee, available at: https://committees.parliament.uk/writtenevidence/142272/pdf/.
[11] Witness statement to module eight of the UK Covid-19 inquiry, available at: https://covid19.public-inquiry.uk/wp-content/uploads/2025/10/17111108/INQ000587900.pdf.
[12] Written evidence provided by IMBs to the Public Bill Committee: Mental Health Bill, available at: https://publications.parliament.uk/pa/cm5901/cmpublic/MentalHealth/memo/MHB41.htm.
[13] A cluster site is a prison in which two self-inflicted deaths occur within an eight-week period, or three self-inflicted deaths occur within a 12-month period.
[14] Independent Monitoring Boards, use of force in prisons and YOIs, available at: https://cdn.websitebuilder.service.justice.gov.uk/uploads/sites/13/2025/10/Use-of-force-in-prisons-and-YOIs-open-letter.pdf
[15] However, the IMB is pleased to note that a function to retroactively amend inaccurate use of force entries was introduced in January 2026, which should make similar issues easier to amend in the future.
[16] A coroner's investigation is ongoing at the time of publication.
[17] Independent Monitoring Boards, Concerns raised over cuts to real-term prison education budgets, 2025, available at: https://cdn.websitebuilder.service.justice.gov.uk/uploads/sites/13/2025/12/Cuts-to-real-term-education-budgets.pdf
[18] The SDS40 scheme, introduced to tackle the ongoing overcrowding crisis in prisons, meant certain prisoners serving standard determinate sentences became eligible to be released after serving 40% of their sentence instead of 50%.
[19] Accredited official statistics: How many people are detained under immigration powers in the UK?, Home Office, 2026, available at: https://www.gov.uk/government/statistics/immigration-system-statistics-year-ending-december-2025/how-many-people-are-detained-under-immigration-powers-in-the-uk.
[20] Research briefing: Unauthorised migration: UK-France border cooperation, Commons Library Research Briefing, 2026, available at: https://commonslibrary.parliament.uk/research-briefings/cbp-9681/.
[21] Independent Monitoring Boards, By force of habit: How the use of force in immigration detention has lost sight of necessity and dignity, 2025, available at: https://cdn.websitebuilder.service.justice.gov.uk/uploads/sites/13/2025/11/By-force-of-habit-How-the-use-of-force-in-immigration-detention-has-lost-sight-of-necessity-and-dignity.pdf
[22] Some members are in post on multiple Boards and will be counted multiple times in this table.

[23] Some Boards monitor multiple establishments in different settings and some members are in post on multiple Boards and will be counted multiple times in this table.

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