Independent Monitoring Boards

Annual Report of the Independent Monitoring Board at the North East Midlands, Yorkshire and Humberside Short-Term Holding Facilities

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national preventive mechanism

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Introductory sections

1. Statutory role of the IMB

The North East Midlands, Yorkshire & Humberside Independent Monitoring Board (IMB) is appointed by the Home Secretary to monitor and report on the welfare of people in short-term holding facilities (STHFs) through observation of their treatment and of the premises in which they are held.

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

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

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

2. Description of the holding rooms

The Board monitored three different types of STHF at eight different locations during the reporting period, each with its own requirements and challenges:

- Residential facilities
    - Swinderby Residential STHF (RSTHF)
- Port holding rooms
    - STHFs at the ports of Teesport, Hull, Killingholme and Immingham
    - An STHF at Leeds Bradford Airport
- Reporting centre holding rooms
    - STHFs at Home Office reporting centres at Leeds Waterside House and Sheffield Vulcan House

These facilities are spread over a wide geographic area, with a distance of 133 miles from Teesport in the north to Swinderby in the south and 86 miles from Leeds Bradford Airport in the west to Immingham in the east.

Residential facilities

Swinderby

Swinderby RSTHF is located adjacent to His Majesty's Prison (HMP) Morton Hall, Lincolnshire and is operated by Mitie Care & Custody on behalf of the Home Office.

Under the STHF Rules, detained individuals can be held in an RSTHF for a maximum of five nights, which can be extended to a maximum of seven nights if removal directions are in place within the seven days. Medical facilities available at Swinderby include a registered general nurse 24/7, general practitioner support, mental health practitioner access, and on-site pharmaceutical amenities.

The site has one accessible room for people with disabilities and does not accommodate women. In total, there are 37 single occupancy rooms plus two additional single occupancy rooms designed for situations in which an individual must be separated from the rest of the population.

The facility will not accept the following people: individuals with excessive and current violent behaviour; individuals requiring full-time medical care; individuals with terrorist links or national security cases; a person currently refusing food or fluid; men convicted of sexual offences (if others who may be at risk are detained); individuals undergoing alcohol withdrawal; women; children, and individuals with active tuberculosis (TB). Anyone with latent TB must be referred to the healthcare team prior to transfer.

Port and airport holding rooms

Hull

The STHF at Hull consists of four rooms, located at King George Dock, which are used as interview rooms and to detain people, if required. Local procedure is for each room to be used for a maximum of one detained person, unless they are a

couple or a family group. If there are more than four people detained, any additional individuals may be required to remain seated in the Controlled Waiting Area (CWA) in the arrivals hall. The CWA comprises fixed chairs against the wall within the arrivals hall.

Ports of entry feature CWAs, which are designated as distinct from holding rooms. As such, CWAs are not regarded as short-term holding facilities and are not subject to the statutory rules that limit detention periods or establish baseline standards for care and treatment.

The holding room seating consists of wooden beams attached to the floor set in a backed bench style around a central table. There are no dedicated toilet facilities for the sole use of those detained in the holding rooms but male, female and accessible toilets with baby changing facilities are located nearby. People held in detention are accompanied to these facilities.

A limited range and supply of snacks and refreshments is available, but additional provisions can be purchased locally, as required. Clothing, blankets, pillows and mattresses are also available as are religious books and prayer mats. Information is available in a wide range of languages and relevant information is displayed in the holding rooms, including information about the IMB.

Immingham

Immingham STHF is a repurposed facility and has been operational since December 2022. The facility has had a complete refurbishment. It has a large holding room with capacity for eight detained persons. The holding room has its own toilet and wash basin. There are two interview rooms, one being significantly larger than the other. The smaller one can also be used as a holding room (with a capacity for six people) should there be a need to separate people being held, or the capacity of the larger holding room has been reached.

The seating is made from wood and fixed to the floor. There is an adequate range and supply of food, snacks and refreshments available on site. Relevant information is displayed in the holding rooms, including information about the IMB, and is available in a wide range of languages. Clear-fronted lockers are used to store the property of people who are detained.

Killingholme

Killingholme STHF is a new purpose-built facility. It opened for Border Force use on 20 July 2022. It consists of two holding rooms, each having the capacity to hold seven detained persons. Both holding rooms have ensuite facilities consisting of a toilet, wash basin, shower and baby changing facilities. There is one interview room that has a spider conference phone installed to enable interviews with interpreters. The seating is made from hard plastic and fixed to the floor.

The office area contains a ‘search of person’ area and clear-fronted lockers to store the property of people detained. Wi-Fi is available within the building.

There is an adequate range and supply of food, snacks and refreshments available on site. Relevant information is displayed in the holding rooms, including information about the IMB, and is available in a wide range of languages.

Leeds Bradford Airport

During the reporting period, the Board monitored two different holding facilities at Leeds Bradford Airport, following the transfer of the STHF from the original terminal to the new terminal in June 2025.

Former holding facility (prior to 17 June 2025)

Prior to 17 June 2025, the STHF was located in the main terminal building. The STHF comprised two separate and basic interview rooms, each with a table and four chairs affixed to the floor. The seats were partly cushioned. The walls contained a panic strip alarm, but there were no locks on the doors, no CCTV and no dedicated viewing portals for detained persons to be safely monitored by staff. There was a toilet nearby that could be used. A mat could be laid down should anyone who is detained wish to lie down or rest. However, the rooms were very small, with only a small distance between the walls and the table. Only one room had a window/external light. Neither had sufficient space to exercise or a television should people face a longer detention time here.

A limited range and supply of snacks and refreshments were available, but additional provisions could be purchased locally, as required. There were some reading materials in languages other than English. Relevant information was displayed in the holding rooms, including information about the IMB, and was available in a wide range of languages.

New holding facility (as of 17 June 2025)

On 17 June 2025, the STHF transferred to the new terminal at Leeds Bradford Airport. The new STHF comprises two holding rooms: one of which is designed to accommodate children and families. Both holding rooms are of a similar design and specification. Each room is equipped with a television and has en suite facilities, consisting of a toilet, wash basin, and shower. Seating is fixed, with seats that are partly cushioned. Neither holding room has any access to external or natural light. The walls in both interview rooms contain a panic strip, CCTV coverage is installed, and both holding rooms are lockable.

The new terminal also includes a CWA comprising chairs within the main terminal. The area is visible to staff and to other people passing through the terminal. There are no dedicated facilities within the CWA, and anyone held there is accompanied to the public toilets when required. People may remain in the CWA for several hours.

During the reporting period, there were occasions when detained people remained in the CWA rather than being transferred to the STHF, including a period when both holding rooms were unavailable because of failures of the door locks. The Board’s concerns regarding the detention of people in CWAs, including the implications for safeguards, records and independent monitoring, are addressed in the substantive sections of this report.

The new terminal was designed to enable the provision of hot food; however, hot food was not available because the necessary food-handling arrangements had not been completed. Recreational provision within the holding rooms was also limited, with no reading materials or other activity materials available and the television was non-operational for a significant period following the move.

Teesport

There is a purpose-built STHF at Teesport with capacity for 16 individuals in two rooms, designated as an adult room and a family room. Each room has toilet and shower facilities. There is also a multi-faith room and toys and welfare supplies are on offer, as well as food and drinks.

Reporting centre holding rooms

Leeds Waterside House

Waterside House is a Home Office Immigration Enforcement (HOIE) reporting centre near Leeds city centre. It operates from 9am to 3pm, Monday to Thursday. Detentions predominantly arise from people who are reporting at the centre. As such, detentions are predictable in comparison with the port holding rooms and, wherever possible, the Board aims to coincide some of its monthly monitoring visits with times when people are scheduled to be detained in the holding room. The holding room hours are Monday to Friday, 8.30am to 5.30pm. Officers from the Immigration, Compliance and Enforcement Teams are based in Waterside House and conduct operations in the community which may also lead to the holding room being used for detentions. These are less predictable than planned detentions.

The officially stated capacity at Leeds Waterside House is nine people. Nine people might be reasonable for brief periods. But if detentions stretch into periods of many hours waiting for onward transport (which is fairly typical of detentions at the location), then the IMB would be concerned if more than four people were detained, based on a calculation derived from Health and Safety Executive (HSE) workplace space standards.

Sheffield Vulcan House

Vulcan House is the HOIE's reporting centre in Sheffield and is located to the north of the city centre in a multistorey building occupied by HOIE staff. The reporting centre is open from 8.30am to 3pm, Monday to Thursday. Detentions predominantly arise from people who are reporting at the centre. As such, detentions are predictable in comparison with the port holding rooms and, wherever possible, the Board aims to coincide its monthly monitoring visits with times when people are detained in the holding room. The holding room is normally open Monday to Friday. Officers from the Immigration, Compliance and Enforcement Teams are based in Vulcan House and conduct operations in the community which may lead to the holding room being used for detentions. These are less predictable than planned detentions.

The officially stated capacity at Sheffield Vulcan House is eight people. This is very concerning as, in the view of the Board, the room is not suitable (having regard to HSE workplace space standards) for holding more than four people at any one time, particularly if detentions stretch into periods of many hours waiting for onward transport (which is fairly typical of detentions at the location).

3. Key points

3.1 Structure of the report

The RSTHF at Swinderby is a different facility to the other locations we monitor in that it is the only residential facility in the region. Also, it has a capacity for up to 37 people so it is by far the largest facility in terms of people likely to be detained. The evidence chapter of this report reflects this distinction with two separate sections - one on Swinderby RSTHF and one on the port and reporting centre STHFs - and this executive summary follows the same format.

3.2 Context

STHFs are used to detain individuals who may not have the right to enter or remain in the UK, or while further immigration decisions are being made. However, this does not mean that all people detained in STHFs have committed any criminal offence. In particular, many people detained in airport holding rooms are subsequently released following further examination.

Detention in STHFs is often unexpected and can be experienced as highly distressing, particularly given the uncertainty surrounding its duration and outcome. The Board is mindful that the impact of detention may be more acute for children, people with mental or physical health conditions, and individuals who may have experienced trauma, including survivors of modern slavery.

The purpose of the Board's monitoring is therefore to assess outcomes for detained people, including whether they are treated safely, fairly and humanely and whether conditions of detention take appropriate account of vulnerability and welfare, having regard to the statutory rules and operational processes that shape those outcomes.

3.3 Main findings

We have observed both good and concerning practice, with significant variations in standards.

Although presenting our findings under discrete domains, the Board has identified a number of issues that have implications across more than one area. Each issue is therefore addressed in its primary domain for clarity, while the Board recognises that matters such as the use of force, confiscation of medication, and failures in communication and safeguarding may affect safety, fair and humane treatment, health and wellbeing, and the experience of removal, transfer or release.

The Board is additionally sharing its findings in relation to the cross-cutting issue of access to information.

Safety

Swinderby RSTHF

The Board has consistently raised serious concerns about the effectiveness of arrangements to identify risk and vulnerability at Swinderby RSTHF. In particular, the Board remains concerned that reception interview arrangements - a key safeguard for identifying risk, vulnerability and welfare needs at the point of detention - are inadequate. In the previous reporting year, the Board welcomed assurances that reception interviews would be moved to a private and confidential space; however, during this reporting period, these planned improvements have not been realised

and the arrangements remain unchanged. As a result, the Board is not assured that current processes reliably support the early identification of risk and vulnerability.

Concerns regarding the identification and support of vulnerable individuals, including those at risk of self-harm and suicide, also persist. The Board is not assured that existing systems consistently enable vulnerability to be identified promptly or that appropriate safeguarding measures are reliably implemented once risks are recognised. These safeguarding concerns are compounded by inconsistent use of interpretation, which undermines accurate risk identification at the point of detention.

Where vulnerability was identified, the Board observed that safeguards were not always applied in a timely or effective manner. The Board considers that shortcomings in identifying vulnerability, and in responding appropriately once vulnerability is known, risk compounding distress and undermining humane treatment in practice.

The Board also identified serious deficiencies in fire safety assurance. An evacuation observed during the reporting period highlighted significant weaknesses in staff familiarity with and application of fire evacuation procedures, consistent with concerns raised in the Board's 2023/24 Annual Report. While the contractor has stated that policies are under review and additional training planned, the Board is not assured that fire safety procedures are currently embedded or consistently understood in practice.

The Board also identified concerns regarding staff culture, including the exposure of detained people to inappropriate material, inconsistent professional boundaries, and concerns, raised by staff, about a working culture in which issues were not always escalated or challenged, which undermined confidence in safeguarding and professionalism.

A directly monitored collection ahead of a charter removal raised serious concerns about disproportionate use of force by way of mechanical restraint and weaknesses in governance and assurance.

Port, airport and reporting centre STHFs

The Board remains concerned about practices that pose direct risks to detained people's safety in port, airport and reporting centre settings. Health-related concerns, including the routine confiscation of prescribed and other medication at the point of detention, are addressed in detail in the Health and wellbeing section.

The Board also remains seriously concerned about the routine and indiscriminate use of force in port, airport and reporting centre settings. The Board has repeatedly identified force being applied and justified on the basis of generalised 'security' considerations relating to the location, rather than through a dynamic, individualised assessment of the risk presented by the detained person. This concern has arisen particularly in facilities managed by Mitie Care & Custody, where the Board has observed restraint being treated as a default component of transfer or movement, rather than an exceptional measure.

The Board is additionally concerned that similar approaches are applied at facilities managed by Border Force, such as Leeds Bradford Airport, where the Board understands that detained people are routinely transferred using force on the basis of general security rationale, rather than individual assessment. The use of blanket

approaches across different operational settings raises fundamental concerns regarding necessity, proportionality and the protection of detained people's dignity and wellbeing. However, unlike contractor-managed facilities, the Board is refused access to any use of force documentation, including the use of force policy, at sites managed by Border Force, despite the Board's statutory remit, which severely constrains its ability to meaningfully assess these practices.

During the reporting period, the Board became aware of a blanket handcuffing policy disseminated by Mitie Care & Custody, resulting in the inappropriate and unnecessary application of force. Following escalation by the Board, the Home Office stated that it had not been aware of, nor had it approved, this policy and that it only became aware of it through IMB escalation. While this position was subsequently challenged, the Board's monitoring indicates that the underlying practice has not materially changed in operation.

These issues indicate systemic weaknesses in the governance and assurance arrangements intended to ensure that force and restrictive measures are used only when necessary, proportionate and individually justified. The Board remains concerned that, without robust internal challenge, assurance and enforcement of these principles by the Home Office, detained people in port, airport and reporting centre settings remain at risk of inappropriate and disproportionate use of force and avoidable harm.

The Board is particularly concerned about the safeguarding of children across facilities managed by Border Force, and particularly at Leeds Bradford Airport, including the existence, awareness and practical application of safeguarding arrangements for children. During the reporting period, the Board identified a child who was detained in the CWA without appropriate, independent adult support. Border Force subsequently maintained, including following challenge by the Board, that the child had not been detained, but during the fact-check process for this report confirmed that detention had occurred.

Fair and humane treatment

Swinderby RSTHF

During the reporting period, the Board observed many instances where staff treated people in detention respectfully and with care, and feedback received directly from detained people was generally positive regarding day-to-day interactions with staff. However, this positive experience co-exists with systemic weaknesses that are not always visible to detained people themselves, but which nevertheless materially affect the fairness and humanity of detention.

In addition, the Board observed instances where the language, conduct and manner used by some staff, including contractors, did not reflect respect, professionalism or appropriate boundaries. These observations indicate broader weaknesses in how expectations around dignity, respect and humane treatment are reinforced and embedded in practice.

Systemic failures in communication and interpretation also undermine procedural fairness and humane treatment.

As noted in the preceding and following sections too, the Board identified repeated failures to respect dignity and confidentiality. These included inadequate

arrangements for private inductions, which are incompatible with fair and humane treatment and risked causing distress, stigma and loss of trust. Similarly, while searches are a necessary element of detention, the Board is concerned that they were not always carried out in a manner that consistently respected privacy, dignity and personal boundaries.

The Board remains concerned about the experience of detained people during charter removals, particularly in relation to communication and dignity.

The Board also identified concerns regarding detained people's ability to maintain contact with family, friends and legal representatives. Restrictions on access to mobile phones and social media, combined with ineffective access to legal advice in practice, risk increasing distress and undermining detained people's ability to understand their situation, seek support and exercise their rights.

Port, airport and reporting centre STHFs

As set out elsewhere in this report, the Board's ability to assess fair and humane treatment in facilities managed by Border Force has been materially constrained by limitations on access to detention-related records, which the Board considers necessary for the discharge of its statutory functions. Nonetheless, across port, airport and reporting centre STHFs, the Board has observed examples of staff treating detained people with dignity and respect, and feedback received directly from detained people has generally been positive in relation to interpersonal treatment. As with Swinderby RSTHF, however, this positive feedback co-exists with systemic weaknesses that materially affect the fairness and humanity of detention, but which may not always be immediately visible to those detained.

The Board also continues to have serious concerns about the physical suitability of certain facilities used for detention. Longstanding concerns regarding conditions at the Port of Hull remain unresolved. At Leeds Bradford Airport, while the Board acknowledges the move to a new terminal in June 2025, concerns persist about whether the new arrangements consistently deliver fair and humane treatment in practice. At Sheffield Vulcan House, the Board remains concerned about conditions within a windowless holding room, including periods of high temperatures and stagnant air, which the Board considers unsuitable for detention.

The Board also remains concerned about detention practices that involve holding individuals overnight in police stations or non-residential holding rooms, rather than transferring them to residential STHFs, which are better equipped to meet welfare needs. The Board considers such practices to undermine humane treatment, particularly where detention extends beyond short periods.

At Leeds Bradford Airport, the Board identified significant weaknesses affecting fair and humane treatment, including delays in conducting welfare checks and serving detention-related documentation, such as IS91Rs which set out the reasons for detention. Such delays undermine detained people's ability to understand why they are detained, exercise their rights, and engage meaningfully with decisions affecting their liberty. The Board also remains concerned about the absence of reading and recreational materials at this location, particularly where detention extends beyond very short periods.

The Board has grave concerns regarding detention governance and transparency across sites managed by Border Force, and particularly at Leeds Bradford Airport. During the reporting period, the Board's ability to assess fairness and humane treatment was materially constrained by Border Force's failure to provide access to relevant detention documentation, despite the Board's statutory rights. Across multiple visits, records were inconsistent, incomplete or did not reconcile. As a result, the Board cannot be confident that it has had full visibility of all detentions at the facility, including the number of people detained, or the length of detention. Accordingly, the Board's ability to discharge its obligations in respect of the conditions and treatment of detained persons is materially constrained.

The Board is seriously concerned about the use of the CWA for detained people across sites managed by Border Force, and particularly at Leeds Bradford Airport, where individuals may remain for prolonged periods rather than being transferred to the STHF. The concern relates to both the impact of the setting and duration on detained people's dignity, rights, welfare and treatment, and to the operational fluidity of the arrangements governing detention in the same physical space. This is particularly significant at ports where a designated STHF is present but not used.

The Board does not suggest that the presence of a detained person changes the formal designation of a CWA or automatically brings it within its statutory remit. The significance is that the same physical area may be used solely as a CWA at one time, while at another, where the designated STHF cannot be used, a detained person may remain in the CWA instead of being transferred to the STHF, with the detention entered on the STHF log and the relevant STHF documentation, rights, safeguards and associated independent monitoring applied. In practice, Border Force's decisions about how the detention is managed and recorded may therefore determine whether those arrangements are applied. The Board is concerned that this operational fluidity has direct consequences for detained people's dignity and welfare, the rights and safeguards afforded to them, the records generated, and the Board's ability to independently monitor and verify their detention and treatment.

More broadly, the Board remains concerned about the operation of immigration detention powers across sites managed by Border Force, and particularly at Leeds Bradford Airport, including inappropriate and disproportionate use of force during transfers, and uncertainty among Border Force staff about when detention begins, where detained people must be held, and what safeguards and records must accompany detention.

Finally, the Board has observed a culture of suspicion and resistance to independent oversight among some Border Force staff. During the reporting period, some IMB members experienced hostile and intimidating behaviour by Border Force staff that has not been substantively addressed. The Board raises this not principally in relation to the treatment of Board members, but because a culture resistant to scrutiny undermines transparency, accountability and, ultimately, fair and humane treatment in detention.

Collectively, these issues cause the Board serious concern about whether detention across sites managed by Border Force, and at Leeds Bradford Airport in particular, is being exercised lawfully, fairly and humanely, with proper regard to statutory safeguards and independent oversight.

Health and wellbeing

Swinderby RSTHF

People detained at Swinderby RSTHF have access to on-site healthcare provision, including 24/7 general nursing cover, GP support, access to mental health practitioners and pharmaceutical services. The facility also offers a range of indoor and outdoor recreational opportunities that contribute positively to wellbeing. Feedback from detained people was generally positive, with some suggesting that additional recreational facilities, including enhanced exercise provision, would further support wellbeing during detention.

During the reporting period, the Board became aware that the healthcare provider commissioned to deliver services at Swinderby RSTHF had given notice of withdrawal, necessitating a future transition to a new provider. Given the increased regulatory scrutiny surrounding this withdrawal, the Board maintained heightened vigilance in its monitoring of healthcare provision at the centre. Nonetheless, the Board did not identify systemic concerns regarding the quality or delivery of on-site healthcare services during the reporting period.

The Board observed appropriate practices by the Swinderby healthcare team to safeguard detained people and protect medical confidentiality, including the secure handling of confidential records. However, the Board remains seriously concerned about repeated breaches of medical confidentiality by non-healthcare staff, including Mitie Care & Custody personnel and other providers operating at the facility. A serious concern regarding widespread breaches of medical confidentiality was raised in the Board's previous annual report and escalated by the Chair. Despite continued escalation and assurances from the Home Office, no substantive response has been received as of March 2026. The Board considers this lack of resolution to be a matter of serious concern.

The Board also notes that failures to manage vulnerability in detention have implications for health and wellbeing. While these issues do not arise from the provision of healthcare services themselves, they have clear implications for health and wellbeing. The Board remains concerned that failures in the timely identification of vulnerability, and in the effective support and management of vulnerable individuals once identified, risk compounding distress and undermining detained people's health, welfare and overall wellbeing while in detention.

Port, airport and reporting centre STHFs

Unlike the residential facility at Swinderby, port, airport and reporting centre STHFs have no commissioned on site healthcare provision and rely on external NHS services where medical needs arise. Many people taken into detention at these locations have pre-existing medical conditions and arrive carrying prescribed or over-the-counter medication required for their health and wellbeing.

The Board has repeatedly raised serious concerns regarding the Home Office policy that requires the routine confiscation of medication at the point of detention, with detained people prohibited from taking their medication when required. In each of the last three annual reports, the Board has concluded that this practice is inhumane, dangerous and wrong, and the Board remains firmly of that view.

During the reporting period, the Board did not see evidence of individualised risk assessment, clinical oversight or consultation with a healthcare professional when medication was confiscated. The Board observed instances in which medication for serious pre-existing conditions was confiscated, including prescribed cardiac medication, without any documented assessment of risk or mitigation. The Board considers that the blanket application of this policy, without regard to individual medical need or the timing of doses, creates a foreseeable and unnecessary risk of harm.

Beyond medical risk, the Board considers that detained people should be able to take their own medication - particularly prescribed medication - as and when required. Routine confiscation of medication is not, in the Board's view, compatible with fair and humane treatment, respect for dignity, or protection of fundamental rights in detention. The Board remains deeply concerned that the continued operation of this policy in its current form undermines health and wellbeing and falls significantly short of the standards expected where individuals are deprived of their liberty.

Preparation for removal, transfer or release

Swinderby RSTHF

The Board is generally satisfied that people detained at Swinderby RSTHF are kept informed about planned transfers, releases or removals, and that staff seek to manage these processes in an orderly manner. However, the Board remains concerned that preparation for removal and transfer is not consistently delivered in a way that upholds dignity, understanding and wellbeing, particularly in the context of charter flight operations and night-time removals.

A recurring concern relates to communication at the point of removal. During the reporting period, the Board observed inconsistent access to interpretation services and insufficient checks that detained people meaningfully understood what was happening to them. The Board remains concerned that communication during removals is not consistently effective or rights-based, particularly where language needs are known. This is especially concerning given that removals often take place in the early hours of the morning, when individuals may be woken abruptly, disorientated and under significant stress.

Concerns regarding restraint use and governance during charter operations are addressed in the Safety section.

In addition, the Board observed that detained people may experience extended periods of waiting during removal operations, including remaining on transport for prolonged periods while processes are completed. The Board considers that such delays undermine dignity and exacerbate anxiety at an already distressing point in detention.

The Board is particularly concerned about the impact of these practices on vulnerable individuals. Where vulnerability has not been identified earlier in detention, it is least likely to be recognised or appropriately managed during removal or transfer. The Board is not assured that current arrangements consistently identify and support vulnerable individuals in a way that protects health, wellbeing and dignity at the point of removal.

Port, airport and reporting centre STHFs

In conversations with people detained in port, airport and reporting centre STHFs, the Board has generally found that individuals are informed of the immediate reason for their detention and whether they are awaiting transfer, release or removal. However, the Board is not satisfied that this is consistently the case at Leeds Bradford Airport, where individuals are not always clearly informed of why they are detained or what is likely to happen next.

At Leeds Bradford Airport, the Board has consistently identified delays in the completion and provision of detention-related documentation, in particular the IS91R, which sets out the reasons for detention. The Board considers that delays in issuing this information materially undermined detained people's ability to understand their detention, engage meaningfully with decision-making, and exercise their rights. Where reasons for detention were provided, the Board also found that these were issued only in English, despite known language needs. This further limited people's ability to understand the basis for their detention and had a direct and adverse impact on fairness and effective preparation for transfer, release or removal.

Across port, airport and reporting centre STHFs, the Board remains concerned about difficulties in the availability and coordination of onward transport, which frequently resulted in people being held for longer than necessary. In some cases, detention was extended for many hours while individuals waited for transfer or release, despite holding rooms being poorly suited to prolonged stays. The Board considers that extended waiting periods, combined with limited information about timescales, undermine dignity and increase anxiety at a critical point in detention.

The Board also continues to identify instances where individuals are transferred overnight to police stations rather than to an RSTHF or are released late at night following extended detention. The Board considers that these practices risk exposing detained people to settings not designed for immigration detention, disrupt rest and wellbeing, and undermine humane preparation for onward movement. They may also prevent detained people from accessing the facilities, safeguards and arrangements ordinarily available within an immigration detention setting, including, for example, access to a telephone. Once individuals are transferred to police custody, they fall outside this Board's statutory remit, although police custody is subject to separate oversight arrangements.

In reporting centre holding rooms, the Board observed that detention often follows planned reporting events but may nonetheless involve prolonged periods of uncertainty while decisions are made or transport is arranged. The Board considers that limited welfare provision and lack of clear timescales during these periods adversely affect detained people's wellbeing and sense of procedural fairness.

Across port, airport and reporting centre STHFs, the Board remains concerned that preparation for transfer, release or removal does not consistently take sufficient account of vulnerability. Where vulnerabilities are not identified at the outset of detention, they are unlikely to be recognised or appropriately managed during extended waiting periods, late-night transfers, or release. The Board is not assured that current arrangements consistently safeguard vulnerable individuals at these points.

Overall, the Board concludes that, while preparation for removal, transfer or release in port, airport and reporting centre STHFs may be procedurally managed, these procedures are not consistently experienced by detained people as clear, timely or humane. The Board considers that greater attention is required to communication, documentation, welfare provision and the management of delay to ensure that departures from these facilities are handled with appropriate dignity, care and regard to wellbeing.

Were there any barriers to the Board fulfilling its monitoring duties?
In its 2024-25 Annual Report, the Board raised serious concerns about restrictions on access to records and information at port and airport STHFs, namely those managed by Border Force, and particularly at Leeds Bradford Airport, and formally requested the legal basis for those restrictions. Border Force has provided explanations regarding the records it considers available to the Board and its interpretation of the Board's remit; however, no substantive response, including the legal basis of the restrictions identified by the Board, was received, and the concerns remain unresolved.

As set out in Annex 1 to the Board's 2024-25 Annual Report, the concern is not simply one of access to particular records. It concerns the principle that, subject to any lawful restriction, the Board must be able to form its own view as to what records and information it reasonably requires in order to discharge its independent monitoring functions. The Board does not consider it appropriate for the body being monitored to be, in effect, the sole arbiter of what information is relevant to or necessary for that scrutiny. This is particularly so where the Memorandum of Understanding with Border Force expressly provides for access to records and documents in accordance with Rule 52(3), including other records which may reasonably be required by the Board in the exercise of its duties. The Memorandum of Understanding further provides that refusals on security classification or data protection grounds are expected to be rare. Where access is refused on security grounds, a full written explanation is to be provided; where refusal is on data protection grounds, the relevant legislative provision and its application to the request must be provided in writing. The Board has not received any such written explanation or legislative basis in relation to the restrictions it has raised. As the Board stated in its 2024/25 report, it considered that position to be 'wrong in law and wrong in principle'. The Board remains of that view.

The Board does not seek unrestricted access to all records and recognises that some categories of information, including confidential healthcare records, fall outside its statutory remit. Its concern relates to records, documentation and policies which it reasonably requires in order to discharge its statutory functions in relation to the treatment of detained people and the conditions of their detention, including detention documentation, use of force records and relevant policies, and chronological records relating to detention, irrespective of the format in which they are held.

The practical effect of the present restrictions is that the Board is increasingly reliant on Border Force to mediate the information available to it, limiting its ability independently to verify information and obtain a complete picture of detention practice. The importance of that independent verification is illustrated by the case involving a child referred to at page 37: despite the evidence identified by the Board, Border Force maintained, including following challenge, that the child had not been

detained, but subsequently confirmed during the fact-check process that detention had occurred. More broadly, restrictions on documentary access impede effective triangulation and, as previously reported, could enable serious failings to be concealed by rogue actors seeking to keep matters beyond IMB scrutiny. This concern is further compounded by Border Force's arrangements for the detention of people in CWAs, as addressed in the substantive Fair and humane treatment section. The Board considers the present approach difficult to reconcile with the access arrangements contemplated by the STHF Rules and the Memorandum of Understanding, and with the purpose, spirit and independence of effective monitoring.

During the current reporting period, the Board's ability to monitor facilities managed by Border Force has deteriorated further. The Board has been informed that it may no longer access key detention documentation (including detention forms, use of force records, and relevant policies), and at some port locations has been told that no documentation may be viewed, and information will be conveyed only verbally. The Board considers this incompatible with independent monitoring and its statutory rights of access.

This deterioration is most pronounced at Leeds Bradford Airport, where progressive restrictions have coincided with persistent concerns about inaccurate and incomplete record-keeping. During the reporting period, the Board has been excluded from entering certain operational areas, denied access to records (including withdrawal of previously permitted access), and prevented from independently verifying information. On two occasions, the Board was not permitted to enter the STHF and were directed to conduct their monitoring in the publicly accessible CWA.

The Board also considers that aspects of the working culture encountered at sites managed by Border Force and particularly at Leeds Bradford Airport have, in themselves, become a barrier to effective monitoring. As reported elsewhere in this report, the Board has observed indications of resistance and suspicion towards the IMB's statutory role among some Border Force staff. During the reporting period, some IMB members experienced instances of hostile and intimidating behaviour when attempting to carry out their duties, which have not been substantively addressed. While these behaviours were not universal, their impact has nonetheless been significant, contributing to a chilling effect on monitoring activity and resulting in some members feeling constrained in their ability to monitor effectively. In the Board's view, even limited resistance to independent oversight undermines transparency and accountability and is incompatible with good detention practice. Collectively, restrictions on access, documentation deficiencies and the monitoring environment have reached a point where effective independent monitoring at sites managed by Border Force, and particularly at Leeds Bradford Airport, is extremely difficult.

Delays by the Home Office in responding to IMB concerns

The Board reported in 2024-25 that delays by the Home Office and contractors in responding to IMB concerns undermined oversight and accountability. The Board considers that the position has not improved and, in several respects, worsened during the current reporting period.

Since January 2024, the Board has repeatedly sought the legal basis for restrictions on its access to records at port and airport facilities. Border Force has provided explanations regarding the records it considers available to the Board and its interpretation of the Board's remit; however, no substantive response including the legal basis for the restrictions identified by the Board has been provided. The issue is therefore not simply the adequacy of the explanations provided, but whether the restrictions themselves are consistent with the Board's rights of access and the requirements of effective independent monitoring. The concerns remain unresolved and, as set out above, access has deteriorated further during the reporting period.

Most notably, for a period exceeding eight months during the reporting year, the Board received no responses to monitoring visit reports relating to Border Force managed sites, despite those reports raising serious concerns including safeguarding failures, inaccurate detention records, delays in detention paperwork and restrictions on IMB access. The Board considers the absence of response over such a prolonged period to be unacceptable and indicative of a significant failure of accountability.

More generally, where responses were received, they were often delayed by weeks or months, limiting the Board's ability to clarify matters, verify assurances or ensure risks had been addressed. The Board has also found that a large proportion of responses are defensive in tone and limited in substance, focusing on disputing observations rather than addressing underlying and systemic issues.

The Board also records that a formal complaint and a serious concern escalation (both originating in 2024-25) remained unresolved for much of the reporting period despite sustained escalation throughout the year. Further, a substantive response to the Board's 2024-25 Annual Report and recommendations was received only on 25 March 2026, representing significant delay.

3.4 Recommendations

TO THE MINISTER

1. End the confiscation of prescribed medication

Immediately review and end the policy and practice of routinely confiscating prescribed medication from people detained in STHFs. The Board considers this practice to be dangerous, inhumane and fundamentally unfair, and notes that it has continued despite repeated concerns raised over successive reporting periods.

Pending the introduction of a revised policy, interim arrangements must be implemented without delay, including standardised, individualised risk assessments supported by appropriate clinical input where any restriction on medication is proposed. Continuing the current practice presents a significant and foreseeable risk to detained people's health and wellbeing.

The Board further notes that in August 2024 it was informed that procurement of dedicated healthcare services for port and airport detention settings was being progressed; however, as of March 2026, this has not been realised.

2. Strengthen accountability and make effective use of IMB findings and escalation mechanisms

Review the Home Office's handling of IMB correspondence, serious concern alerts and annual report recommendations, and ensure that accountability mechanisms are utilised effectively to guarantee timely, substantive and transparent responses to escalated concerns.

This should include clear and effective arrangements enabling the IMB to progress concerns where responses are not received within an appropriate timeframe, notwithstanding assurances, or where responses fail to address the concerns adequately, appropriately, or substantively.

3. Ensure IMB access to all necessary records

Ensure that the Board is given access to all records necessary to discharge its statutory duties under the Short-Term Holding Facility Rules, irrespective of whether those records are held electronically or in paper form. Where access is refused, ensure that the Board is provided with the legal basis for the restriction.

While the Board acknowledges that Border Force has introduced a revised set of documents said to contain 'all detention-related records', evidence in this report demonstrates that throughout the reporting period the Board has been denied access to records central to effective monitoring, including detention paperwork (IS81/IS91), use of force documentation, and chronological case records.

The Board remains concerned that records made available are frequently inconsistent, incomplete or inaccurate, and that requiring the Board to rely on verbal information it cannot verify materially weakens independent oversight. Subject to any lawful restriction, the Board must be able to form its own view as to which records are reasonably required for the exercise of its statutory functions, rather than being restricted to what is deemed appropriate by operational managers.

The practical importance of independent verification is illustrated by the case involving the child referred to in this report, at page 37. Despite evidence identified by the Board and subsequent challenge, Border Force maintained that the child had not been detained, before confirming during the fact-check process that detention had occurred. This demonstrates the risk inherent in requiring the Board to rely on information provided or mediated by the body it is responsible for monitoring.

Failing to provide full documentary access undermines the independence of monitoring, impedes effective triangulation of issues and, as previously reported, could enable concealment of serious failings by rogue actors wishing to keep matters beyond IMB scrutiny.

4. Ensure prompt transfers from CWAs into STHFs

Ensure that detained people are transferred from a CWA to an STHF as soon as possible, with particular priority given to children, especially those who are unaccompanied.

TO THE UK BORDER FORCE / HOME OFFICE IMMIGRATION ENFORCEMENT

Governance and safeguarding

1. Publish and implement clear CWA transfer arrangements

In consultation with the Board, publish and implement clear written instructions governing the transfer of detained people from CWAs to STHFs, including: the requirement that transfer takes place as soon as possible and that no fixed target is treated as permitting a period of routine delay; the recording, justification and review of any delay; particular priority and appropriate safeguarding arrangements for children, especially those who are unaccompanied; and the circumstances in which detained people may remain in the CWA at ports where a designated STHF is present but the detained person is not transferred to it, and the arrangements that must apply in those circumstances.

2. Strengthen safeguarding arrangements for children

Ensure all staff are trained and knowledgeable on safeguarding duties where children are detained, including the criteria for detention, independent adult requirements, notification obligations and escalation routes. Any uncertainty about whether a child is detained must be resolved in favour of applying safeguarding protections.

3. Strengthen Rule 32 governance and use

Review the application of Rule 32 reporting across the detention estate to ensure concerns relating to health or welfare are escalated, recorded and acted upon consistently and transparently.

Detention duration, welfare and data integrity

4. Improve transport planning to reduce unnecessary detention

Improve coordination of onward transport so that individuals are not detained for extended periods solely due to transport availability, including eliminating transfers to police stations.

5. Ensure timely and documented meaningful welfare checks

Ensure meaningful welfare checks are conducted at appropriate intervals during detention, particularly where detention is prolonged, are accurately recorded, and respond to emerging physical or mental health concerns.

6. Ensure full and accurate detention recording

All periods of detention, regardless of location, must be accurately recorded, included in detention data and made available for independent scrutiny.

Accountability, monitoring and responses

7. Ensure the timely and accurate submission of stakeholder returns

Submit accurate stakeholder returns monthly, in full and on time, to support effective monitoring, analysis and thematic oversight.

8. Meet agreed response times for IMB concerns

Ensure monitoring visit reports, serious concern alerts and complaints are responded to in line with the Memorandum of Understanding, make effective use of findings submitted via escalation routes and introduce and clarify clear escalation routes where responses are delayed.

9. Agree a lawful position on IMB access to records

Work with the Board to procure an independent legal opinion clarifying the records, information and data to which the IMB is entitled, in order to fulfil the statutory obligation to provide the IMB with access, so that we can fulfil our statutory duties. Where access is refused to records or information which the Board considers reasonably required to discharge those duties, provide the Board with the legal basis for the restriction.

Health, force and communication

10. End routine confiscation of prescribed medication

Pending Ministerial review, cease blanket confiscation of prescribed medication. Any restriction must be based on an individualised, documented risk assessment with appropriate healthcare input and mitigation.

11. Review use of force across the detention estate

Conduct a review of use of force practices, in particular where use of handcuffs has been shown to be a default approach, and share the findings with the IMB.

12. Ensure access to necessary detention records

Ensure that the IMB is provided with access to records it reasonably considers necessary to discharge its statutory duties. In particular, address the refusal to provide use of force documentation relating to force used at locations managed by Border Force, and establish clear arrangements for the timely provision of such records. Effective routes should also be established for the Board to challenge or escalate decisions to withhold access, with any dispute considered and resolved promptly.

13. Communication

Improve access to communication, including mobile phones and digital contact. Ensure that arrangements for detained people to maintain contact with family, friends and support networks are fair, humane and reflect current modes of communication. This should include reviewing restrictions on mobile phone use and access to commonly used messaging or social media platforms, particularly where detention extends beyond very short periods.

The Board considers that reliance on limited or outdated communication options can increase isolation, distress and anxiety, and may restrict detained people’s ability to seek reassurance, practical support and advice at a critical point in detention. It may also inhibit their ability to make practical arrangements for removal and onward return, including maintaining contact with family and support networks who may assist with reintegration.

14. Ensure appropriate interpreter provision

Ensure sufficient professional interpreter provision is consistently available, particularly during charter flight operations, inductions and welfare checks.

15. Address medical confidentiality breaches

Review the handling of medical information, including content placed on movement orders, and take appropriate action to safeguard confidentiality.

TO THE FACILITY MANAGER / DETENTION CONTRACTOR

1. Ensure all interviews, inductions and safeguarding discussions are conducted in private, confidential settings.

2. Provide the IMB with a clear timeline and consultation process for the Safer Detention Review at Swinderby RSTHF, including engagement on content, findings and implementation.

3. Develop and implement an action plan on use of force, ensuring restraint is only used when necessary, proportionate and based on dynamic individual risk assessment, and dismantling any residual blanket or default practices.

4. Develop and implement an action plan to address systemic interpreter provision failures, including during inductions, welfare checks and safeguarding activity.

5. Review fire safety arrangements in light of the Board's concerns about risks that have arisen during the reporting period.

TO NHS ENGLAND

1. Work with the Home Office to clarify healthcare pathways for people detained in port, airport and reporting centre STHFs, including access to clinical advice and prescribed medication during detention.

2. Support the development of proportionate, medically led arrangements for meeting healthcare needs, so that detention is not used as a means of managing access to treatment, medication or NHS services.

3.4 Progress since the last report

Issue raised	Response given	Progress
Revision of the policy on medication in STHFs	Accepted	Not implemented. See section 4.2.2
Response times to IMB concerns	Partially accepted	Not implemented. See section 3.3
Modernising IMB access to records and data in an electronic age	Not accepted	
The implementation of Rule 32 provisions in STHFs	Accepted	Not implemented. See section 4.1.1
Medical confidentiality	Accepted	Not implemented. See section 4.1.3
Ensuring the IMB has appropriate access to STHF records	Not accepted	

Use of handcuffing at Sheffield Vulcan House	Not accepted	
Unacceptable summer temperatures and stagnant air at Sheffield Vulcan House RSTHF	Not accepted	
Disability access at Border Force STHF locations	Not accepted	
Ensuring all reception interviews are conducted in a private, confidential setting	Not accepted	
Safer detention	Accepted	Not implemented
Medical emergency response times at Swinderby	Not accepted	
Use of body-worn cameras at Swinderby RSTHF	Accepted	Implemented
Medical emergency response	Not accepted	

Evidence sections

4.1 Swinderby RSTHF

4.1.1 Safety

Overview and continuity from previous reporting periods

During the reporting period, the Board continued to monitor safety at Swinderby RSTHF. The centre generally operates as a calm environment, and the Board observed positive interactions between staff and detained people and a stable physical regime. No detained person reported feeling unsafe during Board visits.

However, the Board remains clear that the absence of routine disorder does not, of itself, provide assurance that safety risks are being reliably identified and managed. As in previous reporting periods, the Board's concern continues to centre on the effectiveness and consistency of safeguarding arrangements, particularly given the vulnerability profile of the detained population and the frequency of multi-day detention.

In its 2024/25 Annual Report, the Board identified significant concerns regarding 'safer detention' arrangements at Swinderby, following a thematic monitoring of support to vulnerable people in detention, including the Assessment, Care in Detention and Teamwork (ACDT) process. These concerns included weaknesses in the identification of risk, inconsistencies in care planning, and the absence of escalation through higher-level safeguards such as Rule 32 and Adults at Risk Level 2 reporting. The Board concluded that the persistent absence of such indicators was not credible and should be treated as a safety and assurance concern.

During the current reporting period, the Board has not seen evidence that these underlying concerns have been fully resolved. While formal safeguarding frameworks remain in place, patterns in monitoring and reporting continue to suggest a risk of under-identification or under-escalation of vulnerability rather than a sustained reduction in underlying need. On this basis, the Board remains concerned that safeguarding mechanisms at Swinderby are not yet operating with sufficient consistency or robustness to provide full assurance on safety.

Fire safety and evacuation procedures

The Board remains concerned about fire safety arrangements at Swinderby RSTHF, particularly staff familiarity with evacuation procedures and the consistency with which they are applied in practice. In an RSTHF, detained people are entirely dependent on staff knowledge and leadership during emergency situations.

Case study: fire evacuation
During a monitoring visit on 20 September 2025, a fire alarm activation resulted in the evacuation of two buildings rather than the single building in which the alarm was sounding. When the Board sought clarification, staff were unable to locate the relevant evacuation procedures, were unclear where they were held, and could not explain the decision-making framework governing evacuation at the site.

Concerns regarding the clarity and embedding of fire evacuation procedures at Swinderby were raised in the Board's 2023/24 Annual Report. The recurrence of similar issues during the current reporting period indicates that previous learning has not been fully embedded in practice. The Board therefore remains concerned that fire safety procedures are not consistently understood or applied, and sufficient assurance that emergency arrangements would operate effectively under pressure has not been provided.

Detention profile and risk factors

The Board considers the volume and duration of detention at Swinderby RSTHF to be a key safety-relevant factor. While the physical environment is generally stable, the frequency of multi-day detention means that risks may emerge or escalate over time rather than being identifiable at reception alone.

Stakeholder returns for seven months of the reporting period indicate that Swinderby continues to accommodate a high throughput of detained individuals, with a consistent pattern of detention lasting three days or more and a smaller but significant number of individuals approaching the upper limits permitted in an RSTHF.

The Board considers this relevant to assessments of safety because extended detention increases the likelihood of distress, deterioration in mental wellbeing and the emergence of safeguarding concerns, particularly among individuals with pre-existing vulnerabilities. In such circumstances, effective safeguarding arrangements must remain actively engaged throughout detention rather than relying solely on initial screening processes.

The Board's assessment is consistent with HM Inspectorate of Prisons' inspection in July 2025, which described Swinderby as calm and generally well managed, but noted that some detained people were held for excessive periods of time and that night-time transfers occurred too frequently.[1] The Board considers that such prolonged or disruptive detention can have a detrimental impact on physical and mental wellbeing, particularly for vulnerable individuals.

Based on stakeholder reporting and monitoring visit evidence, the Board consistently encounters detained individuals with indicators of trauma, histories of torture or modern slavery, physical and mental health needs, and, in some cases, histories of self-harm. The Board therefore considers the interaction between detention duration and vulnerability to be particularly significant at Swinderby.

Accordingly, the Board assesses safety at Swinderby on the basis that sustained periods of detention, even within a generally calm environment, increase the potential for harm if safeguarding mechanisms are not applied consistently and proactively throughout detention.

[1] HM Inspectorate of Prisons (2025). *Report on an unannounced inspection of the residential short-term holding facilities at Larne House, Manchester and Swinderby*, available at: https://hmiprisons.justiceinspectorates.gov.uk/hmipris_reports/residential-short-term-holding-facilities-at-larne-house-manchester-and-swinderby/

Reception interviews, identification of risk and early safeguarding

The Board continues to regard reception interviews at Swinderby RSTHF as a critical first-line safety safeguard. They are the primary point at which vulnerability should be identified, risks assessed and safeguarding frameworks initiated. The effectiveness of safeguarding at later stages of detention therefore depends heavily on the quality, privacy and accessibility of these initial interviews.

In its 2024/25 Annual Report, the Board raised concerns about reception interview arrangements at Swinderby, particularly in relation to the lack of privacy, inconsistent use of interpretation and the limited support for meaningful disclosure of vulnerability. The Board considered these weaknesses likely to undermine subsequent safeguarding processes. During the current reporting period, the Board has not seen evidence that these concerns have been fully resolved.

While reception processes were generally conducted promptly and professionally, interviews were not consistently carried out in private and the purpose and scope of safeguarding questions were not always clearly explained. In the Board's view, such conditions are not conducive to disclosure, especially for individuals who may be traumatised, fearful of authority or uncertain about the consequences of sharing sensitive information.

The Board also remains concerned about the inconsistent use of interpretation during reception and induction. Although professional interpreters were used in some cases, they were not always provided where language barriers were evident, increasing the risk that vulnerability would not be identified or appropriately escalated. The Board observed repeated instances during the reporting period where other detained people were used to translate, and saw no evidence that the facility consistently applied Home Office requirements in respect of the assessment of English fluency.

Case study: failure to use interpretation and conduct private induction
During a monitoring visit in early September 2025, the Board observed a reception and induction process involving individuals who made clear that they could not understand or speak English. No professional interpreter was provided or offered. Instead, another detained person was asked to translate. The process was conducted in a shared space, requiring discussion of sensitive health and safeguarding matters in the presence of others. The Board considered this combination of non-private conditions and lack of professional interpretation to represent a serious safeguarding failure.

The Board does not consider it appropriate in any circumstances to rely on another detained person to interpret during reception, induction or safeguarding discussions. These practices are inconsistent with Home Office requirements on interpretation and translation.

The Board notes that these findings are consistent with HM Inspectorate of Prisons' inspection in July 2025, which identified that reception interviews were frequently conducted in non-private settings and that professional interpretation was

under-used during induction and welfare checks at both Swinderby and Manchester.[2]

Taken together, the Board concludes that reception interviews at Swinderby are not yet operating as a consistently effective first-line safeguard. In the absence of private, well-supported and fully interpreted reception processes, the Board is not assured that vulnerability is being reliably identified at the earliest point of detention.

Identification of vulnerability and safeguarding indicators

The Board assesses safeguarding at Swinderby RSTHF by considering how consistently vulnerability is identified, escalated and recorded through formal mechanisms including Adults at Risk (AAR), Assessment Care in Detention and Teamwork (ACDT), Vulnerable Adult Care Plans (VACPs) and Rule 32 reporting. [3]

In its 2024/25 Annual Report, the Board raised concern that recorded indicators of higher-level vulnerability were implausibly low, including the absence of any Adults at Risk Level 2 cases across the year. The Board remains of the view that such patterns should be treated as an assurance concern, not as evidence that vulnerability is absent.

Stakeholder returns for seven months of 2025 provide the following safeguarding indicators:

Table 1: safeguarding indicators at Swinderby RSTHF

Indicator	Total across 7 months
Total detentions	922
Detentions lasting ≥ 3 days	172 (18.7%)
Detentions lasting ≥ 5 days	16 (1.7%)
Vulnerable adult care plans	34 (3.7%)
ACDTs opened	8 (0.9%)
Rule 32 reports	0
AAR level 2 or 3 cases	0

Across the seven months reported, nearly one in five detentions lasted three days or more. Centre management also reported frequent vulnerability indicators, including VACPs for modern slavery and torture disclosures and ACDTs linked to threats of self-harm or attempted suicide. However, the same records contain no Rule 32 reports nor AAR level 2 or 3 cases.

[2] *Ibid*.

[3] The AAR policy supports adults at risk to be well supported in detention, including putting them onto a VACP which is a care plan for vulnerable adults. ACDTs are used when detained people are at an increased risk of self-harm or suicidal ideation. Rule 32 reports are a mechanism for healthcare practitioners to alert the Home Office of safeguarding or medical concerns.

The Board does not consider this position to be reassuring. The Board continues to encounter detained people with indicators of trauma, histories of torture or modern slavery, physical and mental health needs and, in some cases, histories relevant to self-harm risk. The Board therefore remains concerned that vulnerability may not be consistently escalated or fully reflected in safeguarding records.

The Board has also received updated information from healthcare, subsequently confirmed by the Home Office, indicating that Rule 32 reports and Adult at Risk reports were submitted during the reporting period, and that outcomes are as follows:

Table 2: safeguarding indicators and Rule 32 submissions and outcomes

Indicator	Total across 7 months
Total Rule 32 reports	16
AAR not engaged	5
AAR level 1	1
AAR level 2	10
Detention decision maintained	15
Released	1

The Board notes that, on the Home Office's account, the single release was not driven by the Rule 32 report alone, but occurred in the context of an existing barrier to removal that had already triggered consideration of release.

While this updated information confirms that Rule 32 processes have been used during the reporting year, it does not appear that the process is operating effectively as a safeguard in practice. In particular, the very limited number of releases, combined with the absence of a clear link between identified vulnerability and changes to detention decisions, raises questions about the practical impact of Rule 32 reporting.

It also introduces a further issue of transparency and consistency: monthly information-sharing with the Board recorded zero Rule 32 and zero AAR level 2/3 cases, despite repeatedly documented vulnerability indicators. The Board also notes the discrepancies between the information submitted by the contractor and by healthcare, with adult at risk cases identified only following healthcare's submission. The Board therefore remains concerned that escalation and recording are not operating in a way that is consistently visible, reconcilable, or capable of providing assurance.

This concern is strengthened by the Home Office's report to the Board that the Rule 32 process changed during the reporting period such that the Home Office compliance team and local RSTHF staff are no longer informed when a Rule 32 report is submitted, limiting the Home Office's ability to track what action was taken. The Board also notes that the healthcare team at Swinderby reported a delay

between submission of a Rule 32 report on 31/03/2025 and receipt of a response on 16/04/2025, which raises concerns about timeliness where risk may be acute.

The Board further notes that Home Office and contractor documentation analysed during the year include a consistent and significant number of detained people making disclosures that would ordinarily be expected to trigger consideration of whether Adults at Risk assessments should be initiated; however, the same returns record no AAR level 2 or 3 cases. The Home Office has advised the Board that submissions are made to the case owner in respect of vulnerabilities that should trigger AAR processes; however, the Board has no evidence to determine whether such submissions resulted in AAR categorisation, or whether the measures associated with AAR were applied in practice.

This concern is consistent with HM Inspectorate of Prisons' inspection in July 2025, which found that the Rule 32 process, intended to protect individuals whose health or wellbeing may be at risk in detention, was under-used.[4]

The Board concludes that its safeguarding concern at Swinderby does not arise from the absence of formal frameworks, but from the consistency, timeliness and transparency with which they are applied, escalated and evidenced in practice. The Board therefore remains not fully assured that safeguarding mechanisms are operating proactively and consistently, particularly where detention extends beyond very short periods and vulnerability may emerge or escalate over time.

Use of force and restraint

Recorded use of force within the residential setting at Swinderby RSTHF remains low. However, the Board considers that local figures provide only a partial picture, as restraint during charter flight removals is exercised by specialist escorting teams and is not routinely reflected in on-site use of force data.

During the reporting period, the Board raised concerns regarding the proportionality and justification for the use of handcuffs and waist restraint belts during a collection from the centre ahead of a charter flight removal that it monitored. Although the detained individual was compliant at the point of removal, restraint was applied by the escorting team.

Case study: use of force during charter operation collection
The Board observed a fully compliant detained individual having a waist restraint belt applied during a collection ahead of a charter flight removal. This was initially assessed as fully compliant by both the contractor and the Home Office. Following escalation by the Board, the Home Office undertook a further review and concluded that the use of force was not compliant, determining that the application of restraint was unnecessary, not justified and not proportionate, and that the original assessment involved an oversight. A response from the contracted provider regarding the rationale for the initial 'fully compliant' assessment remains outstanding, raising concerns about the ability to prevent harmful errors, such as the inappropriate use of force in the future.

[4] *Ibid*.

The Board considers this case significant because it highlights weaknesses in decisions to use force, and in the review and scrutiny of uses of force. While the Board welcomed the reviewed position that force had not been necessary and there was an oversight in this case, the fact remains that disproportionate use of force was only identified through IMB scrutiny.

The Board notes that concerns relating to the proportionality of restraints during collections for charter operations have been raised in previous annual reporting. The recurrence of such issues reinforces the Board's concern that individualised, dynamic risk assessment is not yet consistently embedded in practice during removals.

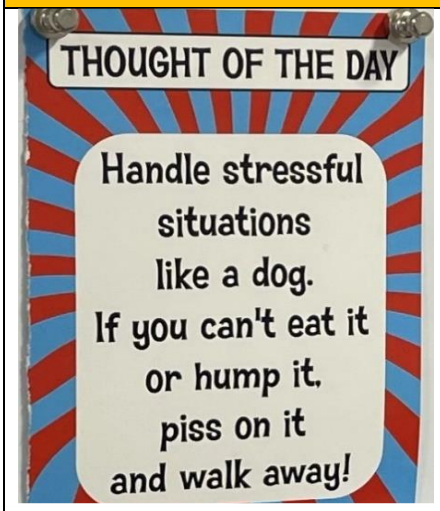
Removal is often a point of heightened distress and vulnerability. Where vulnerability has not been fully identified or recorded earlier in detention, decisions taken at the point of removal may not be informed by a complete understanding of risk. The Board therefore remains concerned regarding weaknesses in the governance and oversight of restraint decisions, and that detained people may be exposed to unnecessary or disproportionate use of force, during collections for charter removals in particular.

Staff culture and safeguarding environment

The Board considers staff culture to be a fundamental component of safety in detention. A calm environment and the absence of recorded incidents do not, in themselves, provide assurance that safeguarding responsibilities are consistently understood, challenged and appropriately exercised. Everyday practices, professional judgement and supervisory response all play a critical role in how vulnerability is identified and addressed.

The Board observed an instance in which a manager requested that a VACP be opened retrospectively, which staff indicated they were unfamiliar with, raising concerns about the integrity of safeguarding processes and the reliability of recorded evidence. The Board also observed instances during the reporting period where inappropriate language was used by staff in the presence of detained people, which the Board considers incompatible with a respectful detention environment. Further, the Board also observed instances of unprofessional conduct between members of staff in environments visible to detained people, raising concerns about professional boundaries and workplace culture.

Case study: inappropriate staff signage visible to detained people



During the reporting period, the Board observed inappropriate signage displayed in an office used by the duty manager at Swinderby RSTHF, which was visible to detained people when the office door was open during routine operations. The content of the signage was considered wholly inappropriate in a detention setting.

While the matter was raised and the signage removed, the Board was concerned that the response focused primarily on removal rather than reflection and learning. In the Board's view, the initial failure to recognise the inappropriateness of the material, combined with the absence of an evident reflective response, raised concerns about safeguarding awareness and professional judgement at a senior operational level.

Case study: staff affixing national flags to uniform

During the reporting period, the Board observed repeated instances of staff wearing national flags affixed to their uniform while on duty within the facility. These displays were not associated with any specific event, celebration or organised activity, and the Board was not provided with any operational explanation for the practice.

The Board recognises that individuals may wish to express pride in their national identity; however, in an immigration detention setting, staff conduct should actively promote a sense of safety, dignity and neutrality for all those detained. Given the wider contemporary context surrounding the use of the national flag, the diverse backgrounds of detained people, and the heightened sensitivities surrounding national identity in the context of immigration detention, such symbols may be perceived as exclusionary or intimidating rather than neutral.

The Board considers that the display of national flags by uniformed staff in this environment risks undermining confidence in the neutrality and professionalism of detention operations and raises concerns about professional judgement and safeguarding awareness. The Board notes that this issue was raised with both the Home Office and the detention contractor, whose responses focused on whether the applicable policy permitted such adaptations and who, on that basis,

did not consider the practice to be inappropriate. The Board does not share that assessment.

In addition, during the reporting period the Board was made aware of concerns raised by staff regarding aspects of the working culture at Swinderby RSTHF, including a lack of confidence that concerns could always be raised safely or acted upon. The Board considers that a culture in which staff feel unable to escalate issues presents a direct safeguarding risk. Such conditions may impede early identification of vulnerability or abuse, delay appropriate intervention, and reduce opportunities for organisational learning.

Overall, the Board is not assured that safeguarding awareness, supervisory accountability and professional standards are consistently embedded in day-to-day practice, including in visible staff conduct within the detention environment.

4.1.2 Fair and humane treatment

During the reporting period, the Board observed many instances in which staff treated people in detention respectfully and with care, and feedback received directly from detained people was generally positive in relation to day-to-day interactions with staff.

However, the Board's assessment of fair and humane treatment extends beyond interpersonal behaviour alone. The Board remains concerned that a number of systemic issues - including weaknesses in communication, safeguards, and aspects of charter flight collections - continue to undermine the fair, humane and dignified treatment of detained people.

The evidence below focuses on how these issues are experienced in practice by detained people, particularly in relation to communication, dignity, access to support, and the conduct of key detention processes.

Interpreter provision and effective communication

The Board remains concerned about systemic weaknesses in interpreter provision and effective communication with detained people at Swinderby RSTHF, particularly during collections prior to removal.

Effective communication is essential to fair and humane treatment. Where detained people cannot understand what is happening to them, why decisions are being taken, or what is expected of them, detention risks being experienced as arbitrary and distressing, regardless of staff intent.

Case study: interpreter provision during removals
Board monitoring during the reporting period identified significant shortfalls in interpreter provision during removals. Between January and May 2025, fewer than 28% of charter collections requiring interpreter support had a professional interpreter physically present, despite advance knowledge of detained individuals' language needs. Where interpreter support was provided, it often relied on a single interpreter who could not support simultaneous processing of multiple detained

people. There was also an instance where an interpreter was ‘forgotten’ by the escorting provider.

The Board considers these failures to have had a material impact on detained people’s ability to understand proceedings at a critical point in detention. The lack of effective interpretation increased the risk of misunderstanding, distress and escalation, and undermined the fairness and humanity of removal processes. As reported elsewhere, the Board also observed a systemic reliance on peer-to-peer translation during the reporting period and saw no evidence that detained people’s English comprehension was meaningfully assessed in line with Home Office policy.

Collections for enforced returns

The Board remains concerned about the way collections for removals are operationalised and the impact this has on detained people. While removals are inherently complex, the Board considers that current practice places disproportionate emphasis on operational expediency, at the expense of communication and dignity. As such, the Board has concerns about whether detained people’s rights are upheld during these operations.

During the reporting period, the Board observed prolonged waiting times and extended periods of confinement during charter operations. The Board considers that such delays significantly exacerbate distress, particularly where detained people are already anxious about imminent removal.

Case study: delays during charter flight collections
During monitoring of a charter operation, the Board observed detained people being boarded onto a coach at 22:45, with the vehicle not departing until 01:26. As a result, detained individuals remained confined on the coach for over two and a half hours late at night, during hot weather conditions, with limited information provided.

Searches and preservation of dignity

The Board remains concerned about the way searches are conducted at Swinderby RSTHF and the impact this has on detained people’s dignity. While searches are a necessary element of detention, the Board observed repeated instances where they were carried out with doors open or without sufficient privacy. The Board also observed instances where detained men were searched by female staff without being asked whether they consented to this, as required by Home Office policy.

The Board considers that searches conducted in such conditions are degrading and intrusive and undermine respect for personal dignity and boundaries. Humane treatment requires not only that searches are lawful, but that they are carried out in a manner that is private, respectful and proportionate.

Contact with people outside detention

Detained people at Swinderby RSTHF are provided with a non-smart mobile phone. The Board nevertheless remains concerned about restrictions on access to

smartphones, messaging services, social media and other commonly used forms of communication. While the provision of a mobile phone enables voice contact, it does not provide access to the wider range of communication methods through which people now commonly maintain relationships, exchange information and make practical arrangements.

These limitations are particularly relevant at Swinderby RSTHF because people may be removed directly from the facility. Individuals facing removal may need, sometimes at relatively short notice, to communicate with family and friends overseas, arrange accommodation or onward travel, access information or documents, obtain practical or financial support, and make other arrangements to support their return and reintegration. Family and other support networks may themselves be abroad and may rely substantially on internet-based communication.

The Board considers that restrictions of this kind can affect wellbeing and meaningful contact with people outside detention, particularly at a time of uncertainty, distress or anxiety. They may also limit a detained person's ability to prepare practically for removal and onward return. In that context, reliance on a non-smart mobile phone alone does not, in the Board's view, adequately reflect the way in which people commonly communicate or the practical needs which may arise before removal.

The Board also notes that HM Inspectorate of Prisons has also raised similar concerns about access to contemporary forms of communication, including social media, reinforcing the systemic nature of this issue within the detention environment.

Access to legal advice

The Board remains concerned about detained people's ability to access legal advice while at Swinderby RSTHF. During the reporting period, the Board made direct attempts to contact organisations listed as potential sources of advice.

Case study: access to legal advice
The Board reviewed the legal advice information provided to detained people at Swinderby and attempted to contact each organisation listed. The results were concerning. Several organisations did not answer calls or return messages. Multiple Citizens Advice services could only be accessed via lengthy English-only telephone menus, required postcodes before calls could proceed, and confirmed that they were unable to provide immigration, asylum or detention advice beyond a very high-level overview. Some organisations listed did not provide immigration advice at all, while others confirmed that detained people were out of scope of their services.

The Board concluded that, in practice, the information provided did not enable effective or meaningful access to legal advice. Although staff advised that a new Home Office poster had been issued containing a QR code intended to improve access, detained people do not have access to smartphones and are issued with basic handsets upon detention. The Board therefore did not consider this to be a viable or appropriate solution.

This concern is consistent with HM Inspectorate of Prisons' inspection in July 2025, which found that the lack of access to free legal advice, detention engagement staff or systematic welfare provision meant that large numbers of detained people

removed from Swinderby had less specialist support than those removed from an immigration removal centre.

In the Board's view, the failure to provide accurate, accessible and relevant legal advice information materially undermines detained people's ability to understand their situation and exercise their rights. The Board considers this incompatible with fair and humane treatment.

4.1.3 Health and wellbeing

During the reporting period, the Board did not receive concerns from detained people regarding the adequacy or responsiveness of healthcare provision at Swinderby RSTHF. Monitoring visits indicated that healthcare staff were knowledgeable, engaged and appropriately focused on maintaining detained people's physical and mental wellbeing, and the Board did not identify instances in which clinical care itself was compromised.

The Board's assessment also took account of earlier publicly reported regulatory concerns regarding the delivery of healthcare services across the wider service portfolio of the healthcare provider operating at Swinderby. In light of those concerns, the Board has remained particularly vigilant in its monitoring of healthcare provision at the facility. On the basis of its monitoring during the current reporting period, including engagement with detained people and discussions with healthcare practitioners, the Board is satisfied that healthcare services have been delivered appropriately and that clinical safeguards are in place and operating as intended.

However, as in previous years, the Board identified repeated breaches of medical confidentiality during the reporting period. The Board observed multiple instances in which confidential medical information was disclosed or displayed by non-healthcare staff in settings visible to others, including detained people. This included where private medication information was routinely displayed on movement orders and other operational materials.

The Board considers these breaches incompatible with detained people's rights to dignity and privacy and a risk to trust in healthcare engagement. Trust is fundamental to effective healthcare in detention, particularly in relation to mental health, safeguarding and the disclosure of vulnerability. The fact that medical confidentiality concerns were raised in the Board's 2024/25 Annual Report, and that breaches have occurred again during the current reporting period, remains a matter of serious concern.

The Board notes that Swinderby offers a range of indoor and outdoor recreational opportunities which contribute positively to detained people's wellbeing, and feedback from detained people has been broadly positive. Detained people have, however, consistently suggested that additional facilities - particularly access to gym or structured exercise equipment - would further support physical and mental wellbeing. While this feedback has been acknowledged by the contractor, the Board has not yet seen any improvements.

4.1.4 Removal, transfer or release

The Board's assessment of preparation for removal, transfer or release at Swinderby RSTHF focuses on whether these processes are managed in a manner that

safeguards dignity and wellbeing, particularly at points of heightened stress for detained people.

As in the 2024/25 reporting period, the Board remains concerned about the continued use of night-time transfers and removals. While the Board does not hold authoritative or complete data for the current reporting period to quantify trends, monitoring evidence confirms that night-time moves continue to occur. The Board considers such transfers to be inherently destabilising and potentially distressing, particularly for vulnerable individuals, and remains concerned about their impact on wellbeing and humane treatment.

The Board also remains concerned about the timing and conduct of charter flight collection operations, which frequently take place during late night or early morning hours. These operations often require detained people to be woken abruptly, prepared for transfer under time pressure, and moved through a complex sequence of events at a point of heightened anxiety and uncertainty.

Detained people are required to wait for extended periods during removal operations, including remaining on transport for many hours late at night before onward movement occurs. The Board considers that such delays exacerbate anxiety and undermine dignity at a critical stage of detention.

From the perspective of preparation for removal, the Board considers that current practice places disproportionate emphasis on operational expediency rather than on ensuring that detained people are adequately informed, supported and treated with dignity. While removals are generally managed in operational terms, the Board remains concerned that they are not consistently experienced by detained people as humane, well-communicated or supportive of wellbeing, particularly where removals take place at night.

4.2 Port, airport and reporting centre STHFs

This section of the report covers the STHFs at the ports of Hull, Killingholme, Immingham and Teesport; at Leeds Bradford Airport; and at the Home Office reporting centres at Leeds Waterside House and Sheffield Vulcan House. The latter two facilities are staffed and managed by Mitie Care & Custody under contract to the Home Office. The port and airport holding rooms are staffed and managed by Border Force. Descriptions of each facility are given in section two of this report.

4.2.1 Safety

Use of force and restraint practices

The Board remains concerned about the use of force, including restraints, across port, airport and reporting centre STHFs, particularly where restraint has been applied indiscriminately rather than on the basis of individualised risk assessment.

During the reporting period, the Board became aware of a policy note issued by Mitie Care & Custody instructing staff to apply handcuffs to all detained people during transfers, amounting to a blanket approach to restraint. The Board considers such an approach incompatible with Home Office guidance, which requires restraint to be necessary, proportionate and based on individual risk.

The impact of this approach is most acute at Sheffield Vulcan House, where the Board has previously raised serious concerns about the safety of the physical environment. As set out in the 2024/25 Annual Report, the failure to provide a safe and secure environment has resulted in restraints being routinely applied to detained people as a compensatory measure. The Board escalated this practice formally. The Home Office subsequently advised that the blanket approach to handcuffing had not been approved, attended the site, and challenged the practice directly.

While the Board understands that further guidance was issued following this intervention, the Board has not seen evidence that practice has changed, and an indiscriminate approach to restraint continues to be applied at this location.

The Board is also aware of a similar approach at facilities managed by Border Force, such as Leeds Bradford Airport, where transfers are less frequent but restraints are nonetheless applied routinely rather than on the basis of individualised assessment. The Board remains concerned that such practices normalise the use of force and expose detained people to force unnecessarily.

Detention and safeguarding of unaccompanied children

The Board has serious concerns regarding the detention and safeguarding of unaccompanied children, particularly at Leeds Bradford Airport. While such detentions are rare, the Board considers that the seriousness of safeguarding obligations towards these children requires a high level of staff awareness, preparedness and procedural clarity whenever they occur.

Case study: detention of an unaccompanied child at Leeds Bradford Airport
During monitoring, the Board identified that an unaccompanied child was detained. Documentation confirmed that an independent adult was required; however, none was provided. Despite the Board having reviewed evidence of formal detention, Border Force subsequently asserted that the child had not been detained and also

suggested that they had been held in a CWA and had not been transferred to the designated STHF, with the implication that the matter fell outside of the Board's remit. During the fact-check process for this report, Border Force has now confirmed the child was detained. The Board's safeguarding concerns regarding the circumstances of the detention remain unresolved.

The Board remains concerned about this case and, more broadly, about children who, following detention, remain in CWAs without the independent adult support identified as necessary. Border Force's change in position during the fact-check process for this report, from maintaining that the child had not been detained to confirming that detention had occurred, also illustrates, as reported elsewhere in this report, the practical importance of the Board being able independently to verify information, and the risk to effective monitoring where it is unable to do so. Related concerns have been reported elsewhere in the immigration detention estate regarding children in CWAs without a designated independent, responsible adult.[5] The Board does not seek to extend its statutory remit to CWAs. Its concern is with the broader implications of continuing to detain people in CWAs at ports where an STHF is present, including the consequences for detained people's rights and safeguards, the records generated and independent monitoring. These matters are considered in the Fair and humane treatment section below.

Emergency response and safer-detention failures

The Board also identified serious concerns regarding emergency response and safer-detention practice at Leeds Waterside House.

Case study: prolonged exposure to acute self-harm due to delayed intervention
During the reporting period, a detained person obtained a weapon and repeatedly threatened suicide, holding the weapon to his neck on multiple occasions from approximately 15:00 until 21:00. This was compounded by significantly limited engagement with the detained person by Mitie Care & Custody staff, who did not remove the weapon for around six hours. Police were eventually called, and force was used before the weapon was removed from the individual's possession.

The Board is concerned by the length of time during which the detained person remained at serious risk of harm, the delayed intervention, and the eventual reliance on police involvement and force. The Board has not been provided with evidence of learning, review or improvement arising from this incident, despite the seriousness of the failure and its implications for safer-detention practice.

The Board considers that this incident raises significant concerns about emergency response, risk escalation, and the effectiveness of safer detention arrangements at reporting centre locations.

[5] Independent Monitoring Board at London Short-Term Holding Facilities (2026). *Annual report, 1 February 2025 to 31 January 2026,* available at: https://cdn.websitebuilder.service.justice.gov.uk/uploads/sites/13/2026/06/London-STHF-IMB-2025-26-annual-report.pdf

4.2.2 Fair and humane treatment

The Board's assessment of fair and humane treatment across port, airport and reporting centre STHFs extends beyond interpersonal interactions with staff. While the Board has observed examples of respectful treatment, the fairness and humanity of detention in these settings is shaped primarily by the suitability of the physical environment, the conditions under which people are held, the availability of information and support, and the length and context of detention. These factors are particularly significant where detention is prolonged, occurs late at night, or involves children and other vulnerable individuals.

The evidence below therefore focuses on how these features are experienced in practice by detained people, including the impact of detention conditions, access to support, communication and documentation, and the way in which key detention processes are implemented.

Suitability of facilities

The Board remains concerned about the ongoing poor suitability of facilities at Leeds Bradford Airport, particularly in the period prior to 17 June 2025, and at the Port of Hull, for use as immigration detention environments. Monitoring indicated that these facilities were not designed to support prolonged detention and did not consistently provide an environment conducive to dignity, comfort or humane treatment. The Board also remains concerned about conditions at Sheffield Vulcan House, including high temperatures, and about the limited provision for sleep or the ability to lie down and rest in port and airport holding rooms, particularly where detention extends overnight. While the Board acknowledges improvements made at Leeds Bradford Airport following the opening of the new terminal in June 2025, concerns remain regarding the appropriateness of port and airport environments for extended detention.

Accessibility and provision for people with disabilities

In the previous reporting year, the Board raised serious concerns regarding accessibility and provision for people with disabilities across port, airport and reporting centre STHFs. Independent disability access reviews commissioned by the Home Office identified a range of shortcomings, including facilities described as 'broadly' or 'partially' non-compliant with current accessibility standards, affecting both adapted premises and newer facilities.

In response, Border Force did not accept the Board's recommendation for further independent audit and stated that there was no legal requirement to implement the report's recommendations, citing existing sign-off and assurance arrangements. The Board remains concerned that detained people with disabilities may be unable to access or use these environments safely, with dignity, and without disadvantage during detention.

During the current reporting year, detention facilities at Leeds Bradford Airport moved to a new terminal. While this development is noted and welcomed, the Board has not seen evidence that the new holding rooms are fully accessible or compliant with disability access requirements. The Board remains concerned that aspects of the physical environment, including the absence of natural light, may continue to

adversely affect detained people with disabilities, including neurodivergent individuals.

Duration of detention and impact on detained people

Across port, airport and reporting centre STHFs, the Board remains concerned about the length of time individuals are held, often due to delays in onward transport, release arrangements, or decision-making. Detention in these settings can regularly extend beyond what holding rooms are designed to accommodate, with people held for many hours and, in some cases, into the late night or overnight period.

The Board is particularly concerned about the impact of prolonged detention in port and airport environments, where facilities are poorly suited to extended stays. Long periods of detention can undermine humane treatment where space is limited, welfare provision is basic, and individuals receive little information about timescales. On occasion, prolonged detention has included children, heightening concerns about comfort, access to appropriate facilities, and cumulative impact on wellbeing.

The Board also continues to identify cases where individuals experience extended detention while awaiting transport, only to be transferred late at night to police stations or released during unsocial hours. These practices risk exposing detained people to environments not designed for immigration detention, disrupting rest and wellbeing.

In reporting centre holding rooms, detention often follows planned reporting events but may involve prolonged uncertainty while decisions are made or transport arranged. Limited welfare provision and a lack of clear information about expected timescales adversely affect wellbeing and undermine detained people’s sense of procedural fairness.

Provision of food and basic welfare

The Board is concerned that, despite the new terminal at Leeds Bradford Airport being designed to support the provision of hot food, staff were unable to serve hot meals for a prolonged period after its opening. While hot food was present on site, staff were unable to provide it because required food-handling certifications had not been completed and a temperature probe had not been procured. The Board was informed that a temperature probe was only confirmed as having been procured on 17 September 2025, and that until at least 22 September 2025, staff remained unable to serve hot food. The Board considers that, while snacks were available, the inability to provide hot food - sometimes during prolonged detention and, in some cases, following long or arduous journeys - undermined detained people’s dignity and basic welfare.

The Board also continues to note a lack of recreational and distraction materials within holding rooms at Leeds Bradford Airport, both before and after 17 June 2025. The absence of reading materials, activities or age-appropriate resources exacerbates the impact of lengthy detention, particularly for children, and contributes to an environment that is neither humane nor supportive.

Use of the CWA across Border Force managed sites

The Board recognises that CWAs, while operating solely as CWAs, are outside its statutory monitoring remit. The Board does not monitor CWAs and is not seeking to extend its remit to them. Its concern relates to the use of CWAs across Border Force managed sites, and particularly at Leeds Bradford Airport, where people who have been detained may remain in a CWA rather than entering the STHF framework. The Board's concern is the resulting impact on those individuals and on its ability to discharge its existing monitoring responsibilities.

Published Home Office guidance states that, as part of established ports procedure, individuals detained pending further examination following service of an IS81 must be placed in an STHF 'as soon as possible'. During the reporting period, records, reports and other information available to the Board indicated repeated instances of detained individuals remaining in CWAs for significant periods, including because of operational pressures, staffing constraints and competing priorities.

Border Force initially told the Board that guidance provided for no more than one hour between the issuance of an IS81 and an IS91 and the detained person's subsequent transfer to an STHF, although available resources, pressures at the primary control point and other competing priorities could prevent this. It also acknowledged that, although the preference was to place a detained person in an STHF at the earliest opportunity, there were occasions across Border Force where this was not possible and detained people remained in the CWA for the duration of their detention.

Subsequently, in response to the Board's concerns, Border Force stated that it now operated a two hour target for transferring detained people from a CWA to an STHF. The Board has been unable to establish when or on what basis this position was adopted, whether it represented a formal departure from the earlier one hour position communicated to the Board, or how the two timings were intended to operate alongside one another.

When asked to identify the basis for the two hour target, Border Force initially attributed it to guidance from the Operational Assurance Directorate. It subsequently corrected that account and confirmed that the Operational Assurance Directorate had not provided such guidance. At the time of writing, the Board has not been provided with any policy, instruction or otherwise written material establishing the two hour target.

The published Home Office material reviewed by the Board instead states that a transfer to an STHF must take place 'as soon as possible'. The Board has therefore been unable to reconcile the earlier one hour position, the subsequently reported two hour target and the published requirement. In any event, monitoring indicates that detained people were regularly held in CWAs for longer than the reported two hour target.

The distinction between transfer as soon as possible and treating one or two hours as a routine period has a practical impact on detained people. Any avoidable delay prolongs the period during which a person may remain detained in an open or otherwise non-private waiting environment, without access to the designated STHF facilities, admission processes, welfare arrangements, safeguards and other records ordinarily associated with an STHF. A person may also be released without ever

entering the formal STHF arrangements. These concerns are heightened where the detained person is a child, particularly if they remain in the CWA without independent or responsible adult support.

The Board has also consistently encountered records or reports of detained people being held in the CWAs at ports where a designated STHF is present. Border Force has confirmed that, in some circumstances, detained people may continue to be held in the CWA rather than being transferred to the STHF where operationally required. The Board is seriously concerned both about individuals who may be held in these areas for lengthy periods and about whether decisions not to transfer, and the arrangements applied to those detentions, are consistently clear, justified and recorded.

Case study: detentions in a CWA where STHF arrangements applied
In August 2025, the Board was informed that detained individuals remained in the CWA at Leeds Bradford Airport for the duration of their detention rather than being transferred to the STHF. The Board was also informed that these detentions were entered onto the STHF log and that the relevant STHF arrangements applied. However, the information available to the Board indicated that they were not provided with all the facilities, safeguards and arrangements ordinarily associated with an STHF. For example, detained people had to request an escort to use publicly accessible toilets and did not have ready access to food, drink or recreational facilities. The Board continued to identify similar instances during the reporting period.

The Board does not suggest that the presence of a detained person changes the formal designation of a CWA or automatically brings the area within the Board's remit. The significance is that the same physical area may be used solely as a CWA at one time, while at another, where the designated STHF cannot be used, a detained person may remain in the CWA instead of being transferred to the STHF, with the detention entered on the STHF log and the relevant STHF documentation, rights, safeguards and independent monitoring arrangements applied.

Information available to the Board therefore suggests that operational practices may determine whether and when a detained person enters the formal STHF arrangements. This affects their access to the facilities, rights and safeguards associated with an STHF, the records generated, and whether their detention and treatment are visible through the ordinary mechanisms of independent monitoring.

Where a detained person remains in the CWA without those STHF arrangements being applied, the Board cannot exercise its statutory access and monitoring rights that attach to an STHF. It may consequently be unable to observe the person's treatment, speak with them privately or review the records that would ordinarily have been available following admission to an STHF. The Board may also be unable to satisfy itself fully about the length and circumstances of the detention, the welfare arrangements provided, or whether and when the relevant STHF arrangements were applied to the detention.

In the Board's view, the period for which detained people remain in CWAs should be kept to the minimum necessary, and they should be transferred to an STHF as soon

as possible in accordance with published guidance. The Board's concern is not the use of CWAs generally. It is the impact on detained people, and on the visibility of their detention and treatment, where operational decisions or staffing constraints result in them remaining outside the usual STHF arrangements and independent monitoring framework.

Communication and contact

At Sheffield Vulcan House, the Board identified concerns regarding detained people's ability to communicate with family members and others outside the facility. Monitoring visits indicated that mobile phone use was not practically possible due to poor reception within the facility. While detained people had access to a landline telephone, access was staff-controlled, requiring detained people to request its use, and the landline was unable to make international calls. As a result, detained people's ability to maintain contact with family members or support networks, both inside and outside the UK, was significantly restricted. The Board considers that these combined limitations increased isolation, heightened anxiety and undermined humane treatment during detention.

Use of police stations for immigration detention

The Board also continues to have concerns about the detention of individuals in police stations. Detention in police custody environments raises concerns about dignity, proportionality, and access to immigration-specific safeguards. They may also prevent detained people from accessing the facilities, safeguards and arrangements ordinarily available within an immigration detention setting, including, for example, access to a telephone. Once individuals are transferred to police custody, they fall outside this Board's statutory remit, although police custody is subject to separate oversight arrangements. While recognising that police stations may be used in limited circumstances, the Board considers them inherently unsuitable for immigration detention beyond the shortest possible period.

4.2.3 Health and wellbeing

The Board remains seriously concerned about the approach to health and wellbeing in port, airport and reporting centre short-term holding facilities, particularly in relation to the confiscation of prescribed medication, the absence of adequate risk assessment, and inconsistent welfare monitoring during detention. These issues echo concerns set out in the Board's 2024-25 Annual Report and, in the Board's view, remain unresolved.

Confiscation of medication

The Board continues to consider it wrong, dangerous, inhumane and fundamentally unfair to confiscate people's medication, particularly prescribed medication, and deny them access to it during detention. As previously reported in 2024-25, the Board remains concerned that prescribed medication is routinely taken from detained people, despite the absence of any individualised, documented risk assessment or appropriate mitigation to manage clinical risk. The Board's position is unchanged: denying access to prescribed medication places detained people's health at risk, undermines wellbeing, and is inconsistent with humane treatment.

While the Board considers the confiscation of prescribed medication to be inappropriate in itself, it is particularly concerned that where this practice occurs, it is

done without evidence of formal risk assessment, medical oversight, or proportionate mitigation. The absence of such safeguards exposes detained individuals to avoidable harm and fails to take proper account of individual health needs.

A consistent theme is that responsibility for managing these risks is far too often transferred to the detained person, their family, or non-clinical staff. In the Board's view, there should instead be a clear, standardised and clinically informed system for ensuring continuity of prescribed medication, assessing the risks of any interruption, obtaining necessary medical information, protecting confidentiality and escalating medical needs and vulnerability without delay.

In response to the Board's concerns, Border Force has stated that detained people should be able to identify and raise relevant medical risks themselves. The Board does not consider this an adequate safeguard. Some detained people may previously have lived in countries or circumstances where access to primary care, diagnostic services or prescribed medication was limited, fragmented or dependent upon ability to pay. They may enter detention with untreated or incompletely diagnosed conditions, limited supplies of medication or little information about their diagnosis and treatment. Language barriers, trauma, mental ill health, or limited health literacy may further affect their ability to explain their needs.

A lack of documentation, an inability to name a condition or medication, or a failure to identify a risk should not be treated as evidence that no significant medical need exists. Detention in a facility without healthcare provision may therefore compound existing inequalities in access to care. These circumstances underline the importance of proactive clinical assessment and appropriate safeguards, rather than relying on detained people to recognise and communicate their needs without support.

The Board's monitoring also indicates an overlap between cases involving indicators of modern slavery, torture, sexual violence or other trauma and those involving prescribed medication or pre-existing physical and mental health conditions. These individuals may experience the consequences of interrupted medication or inadequate healthcare particularly acutely. There is also a risk of compounding effect: trauma or ill health may make it more difficult for a detained person to communicate their medical needs, while a failure to respond to those needs may itself increase distress. This further reinforces the need for proactive, clinically informed assessment rather than reliance on self-reporting.

The Board is especially concerned that this practice persists in port and airport settings, where detention may be prolonged and access to on-site healthcare support is limited. The Board notes that the Home Office previously informed the Board that dedicated health services were being procured to support detained people in these settings; however, no such provision was operational during the reporting period.

Case study: confiscation of prescribed medication at Leeds Bradford Airport
During monitoring at Leeds Bradford Airport, Board members observed prescribed cardiac medication being confiscated from a detained individual. There was no evidence of a documented risk assessment, medical oversight, or mitigation plan to manage the potential risks arising from the denial of essential medication.

The Board also identified further instances involving the confiscation of prescribed medication for a detained person with circulatory problems, medication from another detained person with hepatitis, and an inhaler from a third detained person. These cases reinforce the Board's broader concern that medication may be removed with insufficient consideration of the individual's medical condition, the risks of interrupting treatment or the need for appropriate clinical oversight.

The Board considers these cases illustrative of the broader systemic concern regarding the handling of prescribed medication during detention.

This concern is further reinforced by the following case, which demonstrates the inappropriate use of detention to manage health needs.

Case study: detention linked solely to medical needs

At Leeds Bradford Airport, the Board identified a case where an individual with serious and significant medical conditions was detained on two separate occasions solely because they required access to prescribed medication. All of the individual's medication was confiscated, although they were permitted to retain blood pressure monitoring equipment.

Following the initial detention, concerns about the individual's health resulted in the fire services being contacted because there is no medical cover at the facility. The fire service advised that an ambulance should be called; however, the ambulance did not arrive.

Rather than allowing the individual to retain and take their medication, they were released and then re-detained at a later point to facilitate access to prescribed medication. The documentation reviewed contained no evidence of a clinical assessment, documented risk assessment or plan for safely managing the individual's medical conditions and medication while detained.

The Board is deeply concerned that detention was used in place of a proportionate, health-led response. This resulted in additional deprivation of liberty, disruption and distress, alongside the potential adverse health effects arising from the confiscation and interruption of prescribed medication.

Welfare checks and monitoring

The Board is also concerned about consistent delays in welfare checks at Leeds Bradford Airport. Monitoring and case reviews indicated that welfare checks were not always carried out at appropriate intervals, particularly during prolonged detention. Delays or omissions in welfare monitoring increase the risk of deteriorating physical or mental health needs going unrecognised, especially in environments where access to healthcare is already limited. The Board is not assured that current arrangements consistently protect detained people's health and wellbeing during detention.

4.2.4 Removal, transfer or release

The Board remains concerned about delays in transfer following detention, particularly at Leeds Waterside House and Sheffield. These are planned detentions, yet delays are consistently linked to difficulties in securing onward transport. As a result, detained people frequently remain in facilities for longer than anticipated, affecting timely preparation for onward transfer or release.

At Leeds Bradford Airport, similar difficulties in securing onward transport have resulted in individuals remaining detained for longer than anticipated. As at other sites, outcomes for detained people are frequently shaped by transport availability rather than by assessed need or proportionate planning. On some occasions, delays in onward transport have resulted in Border Force officers transporting detained individuals themselves, typically to police stations for overnight stays. This further highlights the fragility of current transfer arrangements and the poor suitability of some holding environments for extended detention, complicating humane and orderly preparation for onward movement.

In addition to delays in transfer, the Board has identified persistent delays in the completion and service of detention paperwork at Leeds Bradford Airport, particularly IS91R forms, which set out the reasons for detention. These delays undermine detained people's ability to fully understand why they are being deprived of their liberty, challenge their detention, and engage meaningfully with decisions relating to their detention, removal, transfer or release. Where reasons for detention were provided, these were only provided in English, despite known language needs, further limiting detained people's ability to understand and respond to decisions affecting them.

Case study: delays in service of paperwork setting out detention reasons
During monitoring, the Board consistently identified delays of over two hours in the service of paperwork setting out the reasons for detention at Leeds Bradford Airport. As a result, individuals were detained for extended periods without being fully and meaningfully informed of the reasons for their detention and without being provided with the formal legal documents authorising that detention.

As reported in the Board's 2024-25 Annual Report, concerns regarding the accuracy and reliability of documentation and record-keeping at Leeds Bradford Airport persist. These concerns remain unresolved during the current reporting period.

Case study: inaccurate, conflicting documentation at Leeds Bradford Airport
Across 23 monitoring visits to Leeds Bradford Airport within the reporting period, the Board identified concerns relating to the accuracy of documentation on at least 19 occasions, representing approximately 83% of visits. The inaccuracies identified included errors and omissions relating to health and wellbeing, the consistent under-recording of the length of detention, and conflicting or inconsistent information across different records, which prevented effective scrutiny and made it difficult to establish a reliable account of detention events.

These concerns are further exacerbated by the use of the CWA at Leeds Bradford Airport. Where an individual is detained in the CWA before subsequently being admitted to an STHF, the period spent in both settings forms part of the overall length of detention. The Board is concerned that this cumulative period can result in lengthy detention and, where the earlier period in the CWA is not accurately reflected in the records, may obscure the true duration of detention. This contributes to prolonged uncertainty for detained individuals and adversely affects humane preparation for onward movement.

These issues are compounded by the Home Office's restrictive interpretation of the Board's statutory access to records, particularly in relation to facilities managed by Border Force. As described elsewhere in this report, increasing limitations on access to documentation and policies underpinning detention practices impair the Board's oversight and prevent independent scrutiny of the lawfulness, fairness and duration of detention.

The work of the IMB

Independent monitoring is an unpaid public role. The Board adopts a risk-based approach to monitoring, focusing limited monitoring resources on locations and times the Board judges to be most beneficial. The RSTHF at Swinderby is typically visited weekly, Leeds Bradford Airport twice monthly, and other port and reporting centre holding facilities monthly or in line with assessed need.

Detention in non-residential settings is often sporadic and unpredictable. The Board seeks wherever possible to speak directly with people in detention to understand their experiences and identify concerns. During the reporting period, the Board conducted 107 monitoring visits across the facilities within its remit.

The Board also undertakes training and development activity to support effective monitoring, and is grateful to detained people who have shared their experiences, and to staff who facilitate access, while noting concerns about access to records at facilities managed by Border Force raised elsewhere in this report.

Board statistics

Recommended complement of Board members	8
Number of Board members at the start of the reporting period	5
Number of Board members at the end of the reporting period	6
Total number of visits to establishment(s)*	107
Total number of visits to Swinderby RSTHF	39
Total number of visits to the Port of Hull STHF	11
Total number of visits to the Port of Immingham STHF and the Port of Killingholme STHF	10
Total number of visits to Leeds Bradford Airport STHF	23
Total number of visits to Leeds Waterside House STHF	11
Total number of visits to Sheffield Vulcan House STHF	10
Total number of visits to Teesport STHF	3

*The total number of visits includes remote monitoring at one port location, where detention numbers are sufficiently low that monitoring is undertaken remotely rather than through regular in-person visits.



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