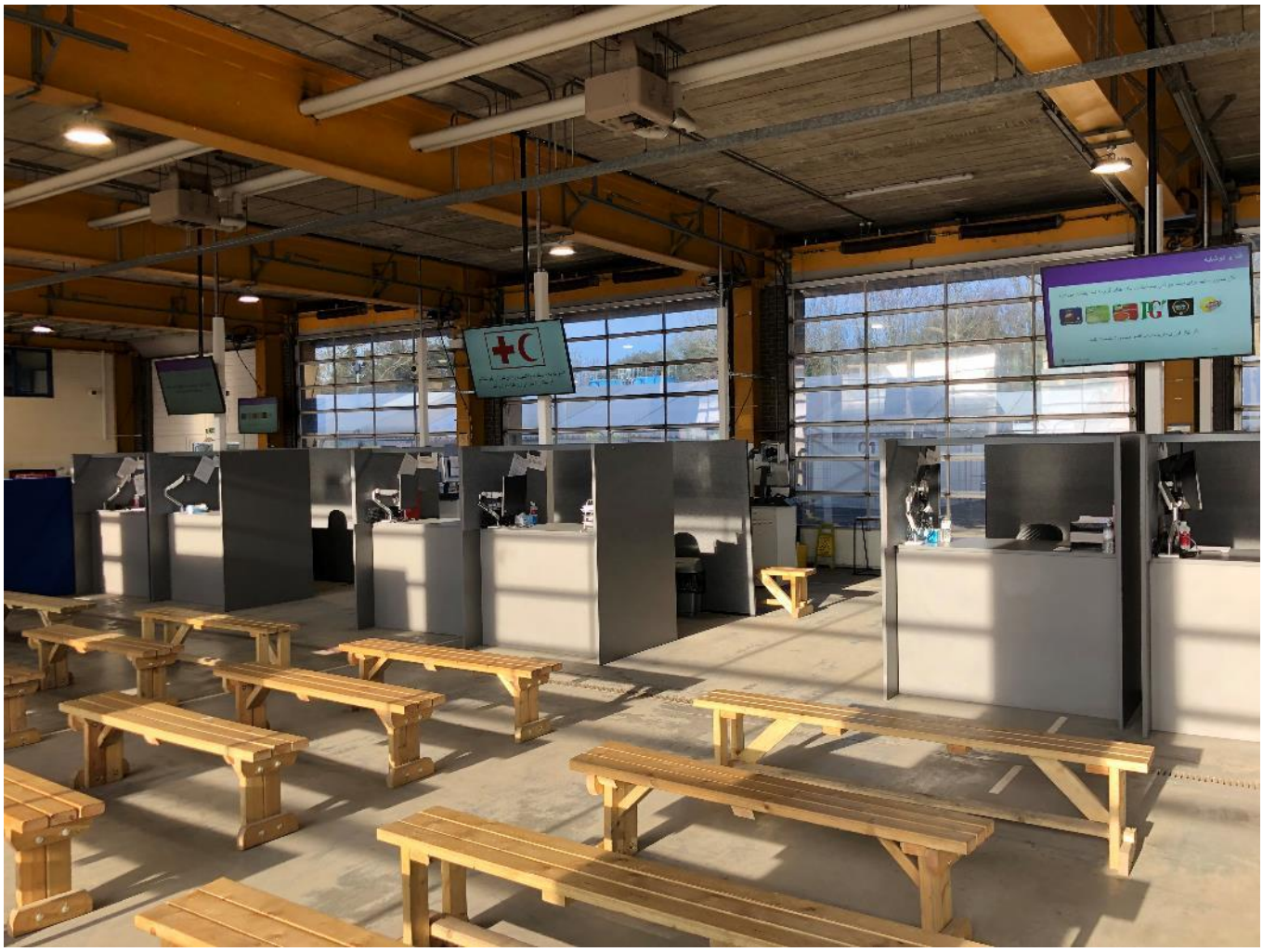
Report on an unannounced inspection
of short-term holding facilities at

Western Jet Foil, Manston and Kent Intake Unit

by HM Chief Inspector of Prisons

30 January – 17 February 2023



Contents

Introduction 3

Summary of key findings 5

About Western Jet Foil, Manston and the Kent Intake Unit short-term holding facilities 7

Section 1 Leadership 8

Section 2 Safety 10

Section 3 Respect 20

Section 4 Preparation for removal and release 34

Section 5 Progress on recommendations from the last report 36

Appendix I About our inspections and reports 40

Introduction

HM Inspectorate of Prisons last inspected the Kent short-term holding facilities for migrant arrivals who had crossed the channel in summer 2022. We noted improvements to the facilities at Western Jet Foil (WJF) in Dover, with more streamlined processes and better treatment of detainees. At Manston, we observed that some aspects of the site were reasonably good, with detainees held for short periods of time in new marquees that included decent facilities, particularly for families. We did, however, highlight some emerging risks, particularly the amount of time that detainees were beginning to spend at the site. Later in the year, those risks materialised. Good weather in the channel meant the number of arrivals increased, leading to detainees spending much too long at a site which was only set up to look after migrants for a matter of hours. The Home Office was not providing sufficient hotel places to which detainees could move. The result was that Manston rapidly became overcrowded and difficult to manage.

When our report was published in October, I announced that given the reports we had received about the site, inspectors would be returning in the near future. This report details our visit to Manston, WJF and the Kent Intake Unit in February this year and again highlights our concerns both about both the site's capacity and the leadership at Manston.

During this inspection, the number of new arrivals from across the channel was relatively low, with just a few hundred passing through the site. In general, Manston was performing reasonably well, with most migrants moved on within 24 hours of arrival, although some were still not passing through quickly enough. In this report, we particularly highlight the improvement in medical services at Manston which had been transformed since our last visit. At WJF, there had been further improvements in facilities, and they were now suitable for the numbers seen on this inspection. There were showers in operation and a good stock of clean clothes for those who had got wet during the crossing. Kent Intake Unit had moved to a more suitable site with improvements in accommodation.

Our major concern continued to be the leadership of Manston. With Border Force, Interforce, MTC, Mitie Care and Custody and GSA Security Solutions all providing services on site, there were insufficient governance arrangements to make sure that work was coordinated and that there was continuity of direct, on-site leadership of the facility as a whole. Staff members could not say who was in charge and this increased the risk of a lack of coordination between the different agencies and functions. The following three examples illustrate the difficulties that were caused by a lack of clear leadership.

First, there was no real oversight of safeguarding processes, nor evidence that the most vulnerable were being consistently identified or provided with the right support. For example, although the Home Office was able to provide data on the total number of referrals made to the National Referral Mechanism (NRM) for all small boat arrivals, it was unable to break this down into the number of referrals made by adult, child or location. Only 91 vulnerable adult warning forms had been opened by Mitie staff, just 0.5% of the total number of migrants

passing through. While not all migrants who arrived at the centre were placed under the care of Mitie Care and Custody at busy times, we saw no evidence of any equivalent plans to support vulnerable detainees having been used by other agencies responsible for supervising them. This was compounded by a failure to make sufficient use of interpreting services, so those at risk could easily have been missed.

Second, there was no proper oversight of the use of force or violent incidents at the centre: inadequate data was available on when incidents had occurred, when force had been used, and whether it was justified by the circumstances.

Third, we found that many Mitie staff were distant in their interactions with migrants, sitting behind a desk talking to each other, rather than engaging with the people in their care. Detainees often struggled to obtain information or resolve difficulties, and we were not confident that welfare issues were being properly identified or handled.

If there was a chain of command in which leaders were clear about their responsibilities and accountable for outcomes, examples such as these could have been identified and dealt with.

While Manston was able to function reasonably when it was fairly empty during our inspection, I was not assured that if numbers increase, as they are expected to in the summer, the site will be able to cope much better than it did during the autumn. This could lead to vulnerable children and families remaining on the site for too long, the risk of infectious disease spreading and an increased possibility of disorder. It must be an absolute priority for the Home Office to make sure that there are enough on-site staff and onward accommodation, so that migrants pass through Manston without delay.

Charlie Taylor
HM Chief Inspector of Prisons
February 2023

Summary of key findings

What needs to improve at this short-term holding facility

During this inspection we identified 11 concerns, of which four should be treated as priorities. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to the Home Office.

Priority concerns

1. **The recorded length of detention in all facilities was too long.** In October 2022 the average was more than six days, and in recent months many children had been held beyond the 24-hour limit.

2. **Governance of adult and child safeguarding was poor.**

3. **There were no accurate data on the use of force or separation from the general population, or of incidents of violence and non-compliance.** There was also no evidence of adequate governance or scrutiny of incidents.

4. **Professional interpretation was not always used consistently.** This applied to Home Office processing and to staff interactions with detainees.

Key concerns

5. **The facilities at Manston were adequate for short stays of 24 hours or less but were not suitable for longer periods of detention.** During busy periods detainees had often been held for considerably longer in marquees in unacceptable conditions.

6. **Care planning for vulnerable detainees, children and those with disabilities was poor and did not demonstrate individual planning, risk assessment or meaningful welfare checks.**

7. **There was limited evidence of engagement by staff with detainees to monitor their welfare or resolve concerns.**

8. **Processes for managing medical isolation at the Kent Intake Unit were inadequate and the facilities for medical isolation at Western Jet Foil were poor and not fit for purpose.**

9. **There were weaknesses in the maintenance of medical confidentiality.** Inappropriate levels of information about detainees' medical records were discussed among custody officers.

10. **Detainees had limited access to any form of communication with the outside world at all sites, including contacting their families after their journeys.**

11. **Detainees were not made aware before leaving of where they were going and what would happen next.**

Progress on concerns/recommendations

We last inspected Western Jet Foil and Manston in 2022 and highlighted 14 concerns. We last inspected the Kent Intake Unit (KIU) in 2021 and made 15 recommendations. With regard to our 2021 report on the KIU, the Home Office and Mitie fully accepted eight of the recommendations and partially (or subject to resources) accepted five. They rejected two of the recommendations.

At this inspection we found that six of our concerns and recommendations had been achieved, six had been partially achieved, 16 had not been achieved and one was no longer relevant. Most progress had been made in the area of respect, where all our recommendations had been achieved or partially achieved. However, there was much less progress in preparation for removal and release, where no recommendations had been achieved. Just under 40% cent of our recommendations in safety had been achieved. For a full summary of the progress against the recommendations, please see Section 5.

Notable positive practice

We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Inspectors found no examples of notable positive practice during this inspection.

About Western Jet Foil, Manston and the Kent Intake Unit short-term holding facilities

Role of the facilities

These facilities primarily hold migrants who had arrived from France on small boats after undertaking sea crossings of the Channel. Western Jet Foil functions as an initial point of entry where people undergo initial health checks and are given an opportunity to change out of wet clothes. Manston is a short-term holding facility where immigration documents are issued and some detainees start the asylum screening process. The Kent Intake Unit is mainly used for unaccompanied children who arrive at the coast to be supervised, identified, interviewed and issued with immigration documents.

Leadership structure

'Primacy' of leadership had recently passed from the Ministry of Defence to the Home Office, which had set up the Small Boats Operational Command (SBOC) within Border Force. At Manston managers had recently been appointed to new posts of Site Director and Operations Director, both of whom reported to a Senior Director responsible for SBOC. This had followed transfer, within the Home Office, in late 2022 of the Clandestine Channel Threat Command from Immigration Enforcement to Border Force.

Location

Western Jet Foil and the Kent Intake Unit are in Dover, Kent. Manston is close to the village of Manston, Kent.

Lead agencies and contractors

Western Jet Foil: Home Office and Interforce
Kent Intake Unit: Home Office and Mitie Care & Custody
Manston: Home Office, Mitie Care & Custody, Interforce and MTC

Date of last inspection

July 2022 for Western Jet Foil and Manston.
November 2021 for the Kent Intake Unit.

Section 1 Leadership

1.1 The concentration of many operational responsibilities within Border Force, through the establishment of the Small Boats Operational Command, led to some greater clarity and coordination in day-to-day running as well as long-term planning. Several operational leaders were using their experience over the last two years to keep the complex processes going smoothly, through responding flexibly to the changing circumstances. However, management structures for the short-term holding facilities remained complex and many staff and managers at all levels found it difficult to answer the most basic question: 'Who is in charge?'.

1.2 At Manston, the holders of new Site Director and Operations Director posts had started to explore the possibilities of integrated leadership, but the number of different departments, teams and contractors at work on the site still led to some uncertainty and inconsistency. The new post holders and their teams were defined in terms of 'landlord' and 'conducting' (coordination). This still left a gap in overall authority and accountability.

1.3 A lack of full-time leadership on site and clear lines of accountability contributed to the fact that systems for overseeing safeguarding, use of force and the collection of data remained unsatisfactory. One consequence of this was that serious incidents or risks were not always recorded or reported.

1.4 At the time of our inspection, the centres operated relatively efficiently, with the number of detainees rarely exceeding 100 a day. It was not clear that Manston would be able to operate safely if numbers increased as predicted over the summer with the risk that the difficulties faced in October and November 2022 could be repeated.

1.5 There were some 'surge' provisions for bringing in extra staff and staffing levels had improved since our previous inspection. Recruitment and retention in a challenging labour market were difficult, but Border Force had set ambitious recruitment targets and Mitie Care & Custody Services had increased staffing considerably. There was still a long way to go towards full staffing at the time of our inspection. Much would depend not only on the volume of arrivals, but crucially on the prompt allocation to sufficient suitable accommodation of those ready to leave Manston.

1.6 The medical director and managing director for Medevent had provided a clear vision for health services. Much of the improvement stemmed from bringing in doctors with relevant experience and an impressive commitment to delivering the services needed in such distinctive conditions.

1.7 At Manston particularly, there was inadequate practical leadership from operational managers and team leaders on the ground. It was clear

that some staff lacked direction and support to engage positively and professionally with detainees.

1.8 The collection of data on detention and safeguarding need remained poor and much of the data were unreliable. We saw little evidence of leaders using data to identify trends and take appropriate action.

Section 2 Safety

Detainees are held in safety and with due regard to the insecurity of their position.

Arrival and early days in detention

Expected outcomes: Detainees travelling to and arriving at the facility are treated with respect and care. Risks are identified and acted on. Induction is comprehensive.

2.1 Detainees arrived at Dover after journeys that were often dangerous, lengthy and traumatic. Many had not slept for long periods and were wearing wet clothes.

Western Jet Foil

2.2 The arrival process at Western Jet Foil (WJF) remained organised and efficient. Detainees disembarked in groups of 10 and children, families and women were appropriately prioritised at all stages of the arrivals process. Detainees were first taken into a marquee, where they received a basic health screening by a paramedic (see paragraph 2.14). They were then directed to changing areas where there was a large supply of clothing for adults and children and they could change into dry clothes and footwear in private. Facilities for feeding and changing babies were also available.

2.3 After a non-contact search with a hand-held metal detector, detainees were moved into a large portacabin where they were arrested by Border Force staff, who used printed information in a range of commonly spoken languages to explain this. We saw one detainee who could not read this information eventually receive interpreting support through a hand-held device. Detainees were then searched again, including a rub-down search and a search of their property. This search included the women and children and was conducted in front of other waiting detainees. Detainees' property, including their personal phones, was bagged and stored securely (see paragraph 4.1).

2.4 Staff were respectful throughout the arrival process, but interpreting was not routinely used (see paragraph 2.14) and it was clear that some detainees did not fully understand what was happening and what was required of them.

2.5 After arrest and searches, families, women and children were seated in a separate waiting area from adult men. All detainees received a hot meal and drinks while awaiting onward transfer, but they were given little information about where they would be taken next, apart from some generic information given in several languages on display screens.

Kent Intake Unit

2.6 Unaccompanied children were transferred in small groups to the Kent Intake Unit (KIU), where they received an induction interview by Mitie Care & Custody staff. The induction was sometimes not detailed or documented enough when numbers were high. After induction, children were put in a holding room, often with unrelated adults (see paragraph 2.40) where they had access to toiletries, food and drink. They had been unable to shower until the week of our inspection when the facilities were repaired and brought into service.

Manston

2.7 Most other detainees were transferred to Manston. Families and women travelled on coaches with unrelated males, but they alighted first and were seated separately while waiting to be formally processed by Border Force staff. Interpreters were now present on site and in most cases helped with the initial interactions with Border Force staff, which was an improvement since our previous inspection. However, they were not used consistently to help detainees through this stage of the process (see paragraph 2.14).

2.8 After formal processing, detainees were moved to the Mitie induction marquee, where they were given a full search by Mitie staff. These searches were conducted sensitively and in private.

Manston search area

2.9 Mitie staff used a standard induction checklist, which included questions about trafficking and modern slavery. However, these interviews were often cursory and telephone and hand-held interpreting

devices were not used enough. The interviews were conducted in adjacent open booths, which afforded little privacy.

2.10 After induction, detainees were moved into designated marquees, one for women and families and one for single adult males. Detainees had access to showers, toiletries, food and drink in the marquees.

Safeguarding adults

Expected outcomes: The facility promotes the welfare of all detainees and protects them from all kinds of harm and neglect. The facility provides a safe environment which reduces the risk of self-harm and suicide. Detainees are protected from bullying and victimisation, and force is only used as a last resort and for legitimate reasons.

2.11 The introduction of the new Small Boats Operational Command had started to improve the recording and follow up of identified vulnerabilities. Agencies working on site now submitted concerns to Border Force and the Home Office safeguarding hub, and a team of Border Force safeguarding officers were responsible for collating safeguarding issues and vulnerability, referring cases and making sure that online immigration records were updated. A monthly multi-agency safeguarding meeting was now held for staff from all agencies to discuss concerns and best practice.

2.12 This new procedure had led to improved organisation in recent weeks, but it was in its early stages and records indicated that there had not previously been any governance or oversight of safeguarding issues. The Home Office could not provide comprehensive data from the site on the number of vulnerable detainees, and could only supply information covering the two months leading to the inspection. The information provided showed that only about 3% of detainees who had passed through Manston had been referred to the Home Office central safeguarding unit. We were told that these referrals often took several months to action, which was concerning, and there was not always evidence of concerns being appropriately followed up after referral.

2.13 The safeguarding policies for all three sites were generic and not tailored to the specific context of the facilities or to the particular indicators of vulnerability that might be displayed by people who had recently undertaken potentially dangerous journeys. Staff from all agencies had undergone basic safeguarding training and, while some Border Force officers working at WJF and Manston had undertaken more advanced training on safeguarding and mental health, no staff at the KIU had done so.

2.14 On arrival at WJF all detainees saw a paramedic, who could identify medical conditions or injuries which required attention or made it inappropriate for the detainee to be sent to Manston. Detainees were constantly supervised by staff at WJF, who could identify any observable signs of vulnerability. However, interpreting was not used

and detainees were not given the opportunity to discuss more complex issues or to disclose vulnerability themselves.

2.15 Women and children were held in separate areas from single men at WJF and could use separate bathroom and changing facilities. Female staff were available to search women and children.

2.16 When they arrived at Manston, detainees had several opportunities to disclose vulnerability, but without the routine use of interpreting (see paragraph 2.4). We observed detainees being asked questions about health and trafficking that they clearly did not understand. The first opportunity to disclose vulnerability privately was at the asylum screening interview and records showed that staff carrying out these interviews had made 540 safeguarding referrals to the Home Office during the previous six months. However, records also indicated that only about half the detainees had been screened before leaving Manston. When screening did take place, it could be many hours after arrival. Overall, there was a risk that some vulnerable detainees would not be identified at Manston.

2.17 Asylum interviews were no longer abridged as they had been during the COVID-19 pandemic, which was positive. Professional interpreting was routinely used, providing a better opportunity for detainees to disclose vulnerability. We observed interviews at Manston that were reasonably good, but some screening interviews had been very brief during the previous six months. Screening interviews only took place during the day at Manston, but at the KIU we saw evidence of adults being woken at night to be screened, which was inappropriate.

2.18 At the KIU, there was no local Home Office adult safeguarding lead, nor any multidisciplinary meetings to share experience, review data and drive improvements in safeguarding.

2.19 Mitie Care and Custody (Mitie) had opened 91 vulnerable adult warning forms (VAWFs) at Manston during the previous six months which represented just 0.5% of the number of detainees held. Most of the sample that we reviewed referred to physical disabilities or illnesses. It was not clear that every detainee who had disclosed a physical or mental illness, was pregnant or who claimed to be a victim of torture or trafficking had been placed on a VAWF. These documents did not document risks, needs or care planning at any length and did not demonstrate engagement with detainees. Observations were not always completed.

2.20 The Home Office was unable to provide information at any site about detainees who had been designated adults at risk under its own policy, although individuals with disabilities, mental health conditions and experiences of significant trauma had been held. At the KIU, women who had disclosed being raped and one woman who said she was fleeing the threat of honour killing in her home country had not been assessed as at risk. In addition, the Home Office was unable to provide accurate data from any site on the number of adult safeguarding referrals made to social services.

2.21 The Home Office was unable to break down referrals to the National Referral Mechanism (NRM, see Glossary) by location, and so could not tell us how many referrals had been made from WJF, Manston or the KIU. We were told that Mitie had not raised any concerns about modern slavery with the Home Office during the last six months, even though all detainees had been asked about indicators such as trafficking.

2.22 Some vulnerable detainees continued to be held for much too long. At Manston, we were not given adequate information about vulnerability to assess how long the most vulnerable detainees had been held for. However, at the KIU, one woman who disclosed she was a victim of torture and rape had waited more than 7.5 hours for a screening interview and was held for a total of 23 hours 35 minutes.

2.23 The on-site team of social workers based at the KIU provided good additional support but were underused in cases involving vulnerable adults.

Personal safety

2.24 All sites were well ordered and generally calm during our inspection. Staff provided an appropriate level of supervision, but at the KIU staff could not view all areas of the holding rooms from their office and CCTV coverage was very poor. Detainees expressed no concerns about their safety, but many were exhausted and expressed uncertainty about what was happening and when they could leave.

2.25 Staff at all sites told us that violence and non-compliance were infrequent and that self-harm was rare, but that tension had increased during the busier period in late 2022, particularly at Manston. However, there were serious deficiencies in record-keeping and oversight of safety and we could not be confident that incidents involving violence, the use of force or self-harm were properly recorded and scrutinised. This was a particular problem at Manston.

Use of force

2.26 Home Office records indicated 29 incidents of use of force at WJF during the previous six months but did not describe the extent of or justification for use of force or how often handcuffs and restraint techniques were used. Staff told us that some non-compliant detainees had been placed into cellular vans on several occasions. Records were available of two such uses of vans, but more than two were noted in the local incident log.

2.27 We were particularly concerned that there was still no central record or oversight of the use of force at Manston. Data initially provided by the Home Office showed six incidents in the last six months, but information from Mitie and subsequent Home Office records that we examined suggested that this was incorrect. We judged all the data to be inadequate. Local records listed a considerable number of incidents, some of which had involved restraint techniques, handcuffs and, in at

least one case, leg restraints. We could not determine the accurate number of times that force had been used, still less make a judgement on the justification or proportionality of force.

2.28 At the KIU, force had been used twice in the last six months. Records from this site were better but indicated that lessons could have been learned from these incidents.

2.29 Across all three sites we saw no evidence of scrutiny or governance of the use of force or of lessons learned from poor practice. We were concerned that poor record keeping and oversight could undermine a fair investigation process.

Violence

2.30 The Home Office could similarly not supply accurate data on the number of violent incidents at Manston. They provided details of just three incidents, but local records indicated many more, including fights, assaults, escapes, protests and general unrest. We did not receive any information about incidents of violence or non-compliance from WJF or the KIU. We saw no evidence of investigations or reviews of incidents and were not confident that lessons had been learned to manage future incidents.

2.31 Three container-type units were available to hold non-compliant detainees separately from the general population at Manston. We were not convinced that they were suitable for use for more than a short time, but we were told that the containers had not been used.

2.32 Non-compliant detainees had previously been held in cellular vehicles, but we could not determine the number of occasions, the reasons for separating detainees or how long they were held. Local records showed that the vans had been used on at least 34 occasions to allow detainees to ‘calm down’ during the past six months, but these records were not quality assured and we were not confident that this figure was accurate. There was no evidence of any oversight of single separation and we were unable to assess whether its use was justified or whether detainees were appropriately monitored. One detainee had self-harmed while in a cellular van and it was unclear how regularly detainees were monitored while locked in the van.

Self-harm

2.33 Record-keeping on self-harm was also poor. We received no data on incidents of self-harm at WJF or the KIU, although staff at WJF said that some incidents had occurred. The Home Office provided details of one suicide attempt at Manston and seven instances of detainees attempting to self-harm or expressing suicidal thoughts. Local records included a number of other examples, including at least two serious incidents in which detainees attempted suicide. There were no details of the support provided to detainees nor evidence of referrals to sources of further support after release. Mitie staff used suicide and self-harm warning forms when detainees indicated that they might

attempt to self-harm: just nine forms had been opened during the previous six months.

Safeguarding children

Expected outcomes: The facility promotes the welfare of children and protects them from all kinds of harm and neglect.

2.34 There was little formal governance of child safeguarding and no monitoring of safeguarding data to identify and act on emerging trends and patterns (see paragraph 2.12).

2.35 Most age assessments were carried out at WJF and this process had improved. Social workers contributed to most assessments and detainees were no longer assessed as adults on the basis of a visual check only. Unaccompanied children were held separately from adult men before being transferred to the KIU. Most children in family groups were transferred to Manston.

2.36 Children were detained for far too long at all sites. All children were held for several hours longer than Home Office records indicated because the logs did not include the time they spent at WJF (see paragraph 2.49).

2.37 From analysis of detention logs, during the previous six months, 1,257 children had been held at Manston, including 26 who were unaccompanied. The average recorded time of detention for children travelling in family groups was two days 11 hours although 232 children had been held for more than 96 hours and the longest time of detention for a child was more than 19 days. Unaccompanied children were held for an average of 21 hours 44 minutes.

2.38 Families with children were prioritised at Manston, but processing remained slow at busy times and we observed some families with very young children waiting for several hours to be progressed into the family marquee. The family marquee was in good condition and provided baby food, children's toys and changing facilities. However, at the time of our inspection there was no private area for women to breastfeed.

2.39 Over the same period, from our analysis of detention logs, 2,457 children had been held in the KIU, of whom 2,410 were unaccompanied. The average recorded length of detention for unaccompanied children was 20 hours 22 minutes. Detention records indicated that 337 children had been held in breach of the statutory 24-hour time limit on the detention of unaccompanied children. The longest recorded period of detention for an unaccompanied child was three days 55 minutes. Unaccompanied children were released to the care of the on-site Refugee Council team and sometimes spent a further 20 hours waiting to be taken to release accommodation.

2.40 Adult detainees from 'lorry drops' were also detained in the KIU; on the figures given to us, 324 men in the six months before our inspection, although official records were said to show 242. At the building in use until December, they had been in the same holding room as children, and at the new building, we saw adult men held in the same room as children on two days during our inspection.

2.41 On-site social workers in the KIU now provided additional support to vulnerable children, for example by participating in welfare interviews. This was welcome but the team was underused. No social workers were based in Manston, although social workers from the KIU team had travelled there to see a small number of children.

2.42 All unaccompanied children were given a full interview (the 'welfare interview') to identify immediate welfare and trafficking concerns. These interviews did not usually take place until several hours after the children had arrived in the UK and sometimes at night. Children were not interviewed by specialist officers trained in safeguarding and modern slavery, and many were questioned with no responsible adult present. Records indicated that some interviews were cursory, but interviews attended by social workers showed much better exploration of vulnerability and safeguarding need.

2.43 There were no accurate data on the number of child safeguarding referrals. Home Office data for the KIU suggested just 30 during the previous six months, representing 1% of children held. The social work team had 36 referrals recorded and it was unclear if some of these were included in Home Office figures. We did not consider that these figures were likely to reflect the risks inherent in journeys by unaccompanied children. The Home Office could not provide us with data on NRM referrals for children and could not readily identify children who had been referred under the NRM. This left the Home Office poorly placed to monitor the identification of need and outcomes for at-risk children following their release. Mitie had made no NRM referrals in any of the facilities during the previous six months.

2.44 Care planning in both sites was poor and on the evidence available, only a minority of children in Manston had a plan. Plans were not tailored to individual risks and need and there was no enhanced care planning for very young children or those who had experienced more severe trauma. On a few occasions, we observed Mitie and immigration staff engaging well with vulnerable children in the KIU. However, in both sites there was too little staff engagement with children overall, welfare checks were cursory and care was undermined by poor use of professional interpreting.

2.45 Some particularly vulnerable children were held for long periods. One case concerned a 17-year-old girl and her 10-month-old baby, who the girl said had been conceived after she was raped. They arrived in the KIU at 11.30am and were held until 10am the following day, when accommodation was made available.

2.46 Good support was provided to children in the KIU who had been released to the care of the on-site Refugee Council team.

2.47 We were concerned about the handling of an incident in the KIU when a member of staff saw a colleague on CCTV appearing to use force on a child. Records of the incident appeared to raise questions about awareness of safeguarding responsibilities.

2.48 We were told that Mitie staff in the KIU had been DBS checked (Disclosure and Barring Service), but some immigration are not. Record keeping at Manston was poor, but it was evident that many staff there had not been DBS checked.

Legal rights

Expected outcomes: Detainees are fully aware of and understand their detention, following their arrival at the facility and on release. Detainees are supported by the facility staff to freely exercise their legal rights.

2.49 Detainees could be held for several hours in WJF. Data on the length of detention supplied by Border Force did not include the time detainees were held in WJF, nor the time they were then held in Manston or the KIU before completion of their detention paperwork. All detainees were held for longer than records indicated.

2.50 The lack of interpreting during the processing stages at WJF left many detainees unaware of what was happening to them (see paragraph 2.4).

2.51 Records in both facilities indicated that the period of detention was too long. During the previous six months, 17,562 detainees had been held in Manston, including 1,257 children. These detainees were held for an average of 40 hours 43 minutes compared with 14 hours 56 minutes when we last inspected. There was limited hotel accommodation for family groups, and women and children were held for an average of 59 hours.

2.52 It was clear that the lack of onward accommodation had led to unacceptably long periods of detention in October and November 2022. The average length of detention in Manston had increased from 16 hours 28 minutes in August to six days 18 hours in October 2022 with 6,498 detainees held for more than 24 hours and 1,756 detainees for more than four days. The longest detention period was more than 26 days. The average length of detention had reduced to 13 hours 16 minutes by January 2023.

2.53 During the previous six months, working from the raw data supplied to us, 2,841 detainees had been held in the KIU, including 2,410 unaccompanied children. The average recorded length of detention was 20 hours. The statutory 24-hour time limit on the detention of unaccompanied children had been breached for 337 children and a 17-year-old boy who had spent just over three days in the KIU had been

held for the longest time. After they had been formally released, children could spend up to 20 hours more waiting to be taken to accommodation. A shortage of accommodation in October 2022 had resulted in about 20 boys spending two weeks with the on-site Refugee Council team.

2.54 Professional interpreting was consistently used at all sites in initial Home Office interviews. Formal detention paperwork was not translated at any site, leaving many detainees with little understanding of what was going to happen to them. There was good use of interpreting at screening and welfare interviews. We observed interviews that were handled reasonably well at Manston, but some records of interviews at both sites appeared cursory. About half the detainees left Manston with no screening.

2.55 Access to legal representation was poor. There was no duty legal advice service at Manston or the KIU. Notices in the holding rooms at both sites provided contact details of solicitors and advice agencies but they were of little value. Some telephone numbers were incorrect and some representatives told us they did not offer advice on immigration law. None of the representatives listed on the notices provided free legal advice and representation.

Section 3 Respect

Detainees are treated with respect for their human dignity and the circumstances of their detention.

Accommodation and facilities

Expected outcomes: Detainees are held in a safe, clean and decent environment. They are offered varied meals according to their individual requirements. The facility encourages activities to promote mental well-being.

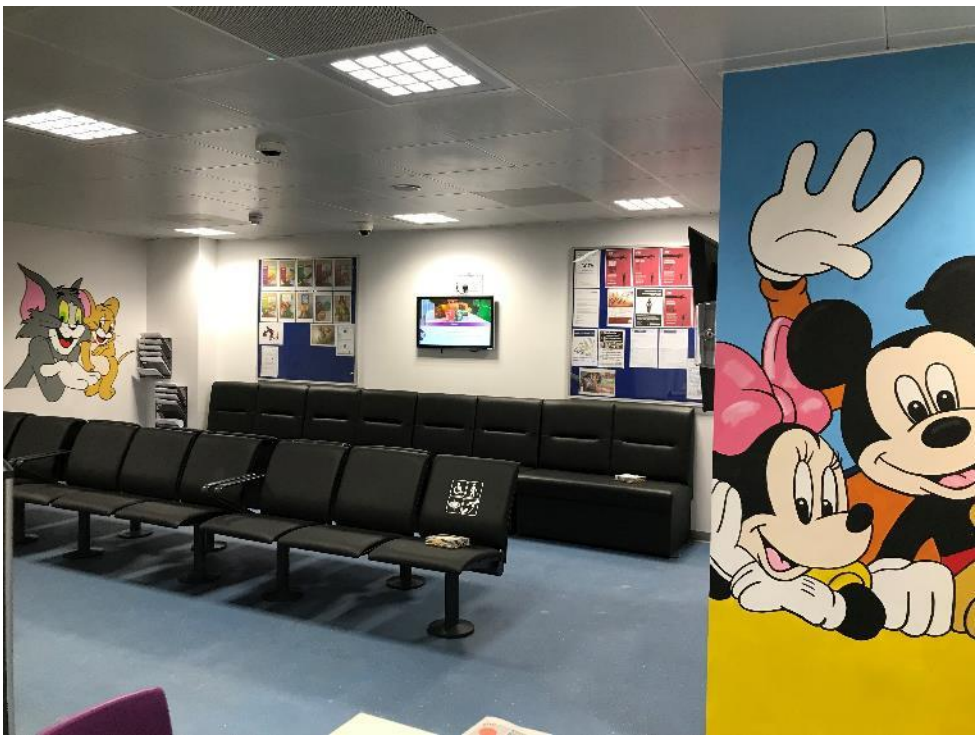
Western Jet Foil

3.1 At the time of our inspection, the waiting areas had enough wooden benches, but this would not be the case at busier times. Women and families were seated separately from men at all times. The arrival marquee and the main building were clean, adequately heated and ventilated and provided a reasonable environment for the time that detainees were held. The areas used for interviews and searches lacked privacy. There were clean toilet facilities in both areas, but those in the main building did not have lids or seats. Female sanitary products were not available in all areas: women had to ask staff for them, which was not appropriate. There were baby-changing facilities but no private spaces for women to breastfeed their children.

3.2 Detainees were given fresh clothes and could change in private cubicles. Their property was appropriately recorded and secured but, in the absence of interpreting, detainees did not always understand what would happen to their possessions. Television screens provided rolling information in several languages, but there were no other activities to pass the time. There were no facilities for prayer or worship. The food was adequate - an on-site caterer provided hot meals three times a day and drinks and snacks were freely available.

Kent Intake Unit

3.3 At Kent Intake Unit (KIU) detainees were held in two rooms, one holding up to 85 detainees and a family room for 34. The unit was newly built and rooms were in good condition, warm and brightly lit, although there were no windows. The rooms contained soft chairs and fixed tables with seating, televisions and information screens. Pillows, blankets and thin mattresses were available, but the arrangements for cleaning bedding after use were inadequate.



Smaller (family) holding room at KIU

3.4 The rooms were reasonably clean but became less so during the day as there was no cleaner on duty and no cleaning schedule. The toilets were unacceptably dirty and the toilet for people with disabilities lacked safety rails. The three showers had been out of use since the building opened at the beginning of December 2022, but were repaired during our inspection. There was a good stock of clothing for detainees and their property was stored safely.

3.5 The range of toys for young children was too limited and there was little reading material. Some activities such as Jenga and dominoes were readily available and well used by detainees. Newspapers and a range of magazines were also available but were unlikely to have been of interest to young detainees. A small outdoor area with picnic benches was not in use at the time of our inspection. There was a small prayer room off the main holding room.

Outdoor area at KIU (left) and religious material in the prayer room

3.6 The food was reasonably good and detainees could choose from a range of microwave meals, including options for special dietary requirements. A range of snacks and drinks was available at all times.

Provisions table, main room, KIU

Manston

3.7 Facilities in the arrivals hall at Manston were basic. Detainees waited for their interview on wooden benches. A small, curtained area was available for baby changing and breast feeding in private. Toilet facilities were in mobile units outside the hall. They were in reasonable condition, but sanitary products were not freely available in the women's toilets. Detainees' property was collected and stored safely.

Holding space after arriving, Manston

Baby change and breast-feeding area, Manston

3.8 Two accommodation marquees were in use at the time of our inspection, one for women and families and one for men. They were clean and well heated and afforded an adequate environment for stays of up to 24 hours, although there were no beds for detainees held overnight. There was soft floor covering and seating and mattresses and bedding were readily available.

Children and families unit, Manston

Adult unit, Manston

3.9 Showers and toilets were in good condition, but there were only six toilets and two showers in each marquee, which would not have been enough if the accommodation had been full. There were good stocks of towels and clean clothes, toiletries and female sanitary products.

3.10 Managers had considerably improved the food provided to detainees. Kitchens in the marquees were clean and well equipped. New storage ovens had been installed to keep meals fresh, so that detainees could be offered a hot meal whenever they arrived. The range of meal options included Halal, vegan and special meals for detainees with food allergies. Detainees were offered breakfast and lunch packs and could help themselves to fruit, drinks and snacks throughout the day.

Food supplies, Manston

3.11 The family marquee was decorated in bright cheerful colours, with plenty of toys to occupy children. However, in other areas there were not enough activity materials to occupy adults. They could watch television but in most areas there was nothing to read. Detainees did not have enough access to fresh air. They were not allowed to leave the marquees during their detention, except when being escorted to interviews in other buildings. Both marquees included a small prayer room furnished with religious books and prayer mats.

Marquee prayer room, Manston

Respectful treatment

Expected outcomes: Detainees are treated with respect by all staff. Effective complaints procedures are in place for detainees. There is understanding of detainees' diverse cultural backgrounds. Detainees' health care needs are met.

3.12 Detainees told us that they were happy with the treatment they had received and we observed positive interactions by staff in each of the sites. However, for most of the time we saw a lack of engagement by staff, particularly at Manston where they congregated behind a desk and rarely spoke to detainees. Staff at the KIU spent most of their time in the observation room rather than the holding room, and leaders who were present did not challenge staff or encourage them to take part in activities.

3.13 The use of professional interpreting remained limited at all three sites, with the exception of the screening interviews. Staff were observed speaking loudly or using hand gestures to communicate with detainees and they did not make the best use of hand-held devices where they were available. We observed a woman at Manston who did not understand her induction, including the search process, with no interpreting in use. At the KIU, we saw detainees who were being

bailed, being asked to sign documentation that had not been translated for them.

3.14 During the initial processing stages at Manston, Interforce staff continued to address detainees by numbers instead of their names. Professional interpreters were now available during this processing stage but were not always used when required (see paragraph 2.4). Interforce and MTC staff no longer managed the marquees during busy periods, as there were now more Mitie staff.

Complaints

3.15 Complaint boxes and forms at Manston were still only available once detainees were in the custody of Mitie. Both boxes were left unlocked and the complaints procedure was not confidential. Responses from Mitie that we reviewed were generally polite and efforts were made to send them to detainees once they had left the site. However, responses took more than a month and were not in the complainant's language. Home Office responses to complaints were not available for us to review and there did not seem to be a coordinated system.

3.16 At KIU, detainees were told about the complaints process during their induction. Forms were available in different languages and in a child-friendly format. The submission box was left unlocked in the family room. We were informed that no complaints had been made in the last six months.

Equality, diversity and inclusion

3.17 The initial screening and induction at Manston did not cover all protected characteristics (see Glossary). The marquees remained unsuitable to accommodate detainees with disabilities and the temporary toilet was in a poor state. Vulnerable adult warning forms (VAWFs) (see paragraph 2.19) were not opened for all detainees with protected characteristics who required additional support and care planning was poor.

Portaloo used as disabled toilet, Manston

3.18 The KIU had not made all the necessary adjustments to make the new building suitable for those with disabilities. Handrails had recently been removed in the accessible toilets and one toilet was being used for storage. Induction forms identified detainees' protected characteristics, but this information was missing from some care plans.

3.19 The needs of women and children were considered at all three sites. We saw young children being searched at Western Jet Foil (WJF) by female staff who treated them kindly and with consideration. Pregnant women had been held at all three sites, but VAWFs and care plans had not been opened for all of them. Health care provision had improved for women who were pregnant (see paragraph 3.26).

3.20 Sanitary products were not readily available in all areas at WJF and Manston. A new, very basic area was now in use for baby changing and breastfeeding in the fire station at Manston, but the room that had been used for breast feeding in the Mitie marquee was now being used for storage. Only a small number of detainees who had been at the KIU were female, but they were provided for and there were enough female staff.

3.21 Prayer rooms and religious materials were available at Manston and KIU. Detainees in the family room at the KIU had to be escorted to use

the facility in the main holding room. No prayer room or quiet space was available at WJF, nor any religious materials.

Baby changing tables in family marquee, Manston

Health care

3.22 Health services had improved considerably with the introduction of senior emergency medicine doctors who provided on-site treatment from 8am to 8pm at Manston and at WJF and an on-call service out of hours, working alongside skilled paramedics.

3.23 Two companies were contracted to deliver health services. Medevent Medical Services provided paramedic services at WJF and Manston and had introduced the senior emergency medicine doctors to the service in October 2022. IPRS Aeromed delivered paramedic services at the KIU and Manston and there was a paramedic on board when any of the five Border Force patrol vessels was in use.

3.24 The paramedic on the Border Force patrol vessel passed on any relevant health information. Everyone arriving at WJF received a basic health assessment, early detection of immediate health needs and emergency care. The screening that we observed was completed in a professional and friendly manner by a skilled team of paramedics and the doctor. Rolling information on a screen identified key health issues in several languages and key phrases. This was a helpful initiative, but use of interpreting remained limited.

3.25 The senior emergency medicine doctor on site was able to provide urgent medical care and expertise. Patients were interviewed in a private area in the marquee and a screened area was used for physical examination. Two medical rooms in the building could also be used for

private interview or examination. The rooms had a shower with a privacy curtain for use by detainees who had sustained fuel burns. Medical concerns needing continuing attention were dealt with or alerted to the doctors at the Manston Medical Centre if that was where the individual was being sent. If hospital care was needed, the doctor liaised directly with the appropriate specialist and arranged a transfer. Those going to the KIU were collected by staff from that unit, together with their records containing medical information which was not in a sealed envelope. The staff looked through the records to identify which detainees needed to see a paramedic. This did not adhere to medical confidentiality.

3.26 The burden on local health services had considerably reduced when the doctors had been introduced and effective clinical pathways were developing, including good links with maternity services. All pregnant women were now seen by a doctor and received appropriate care. There was an arrangement with the local ambulance service for the Medevent paramedics to undertake urgent transfers to hospital and 999 calls from WJF and Manston were redirected to Medevent, which had fully-equipped emergency ambulances at both sites.

3.27 Detainees with potentially infectious diseases identified by the team at WJF were transferred either to the Manston isolation unit, the KIU or a suitable isolation hotel, depending on clinical need. If diphtheria was suspected, swabs were taken and sent for testing to the local microbiology laboratory where effective links had been established. Following the outbreak of diphtheria at Manston in 2022, the NHS had offered diphtheria vaccinations and prophylactic antibiotics to all detainees. The UK Health Security Agency had produced information leaflets and consent forms in 16 languages to promote the importance of the treatment. The Aeromed paramedic team had recently taken over responsibility for this. There was a diphtheria vaccination clinic with appropriate emergency equipment and all detainees at Manston were offered diphtheria vaccinations and antibiotics – an estimated 50–54% had accepted the offer of a diphtheria vaccination. The heat-sensitive vaccines were stored in a secure room in a locked fridge with regular temperature checks. Locked cupboards for the vaccinations were on order and due for imminent delivery. Medevent paramedics also offered the vaccination to staff.

3.28 The isolation facilities at WJF were too small with no windows and were not fit for purpose. At Manston individual well-ventilated rooms and shower facilities were of a much better quality and at the KIU we were informed that there was an isolation room which was used as a storeroom instead. The three showers had been out of use since the unit opened in December 2022 (see paragraph 3.4), There was a shower in another part of the building which could be used, but with difficulty. Custody staff whom we spoke to were unclear about how to act if a detainee needed to be isolated for medical reasons. There had been confusion over whether a particular detainee had scabies: a shower had not been facilitated until several hours later and the detainee had not been isolated, which was a concern. The pillows did

not have a cover that could be cleaned between use, which did not meet infection prevention and control standards.

3.29 There was 24-hour paramedic cover by Aeromed at the KIU but no access to doctors if concerns were identified on site, in which case local NHS emergency services were used. The paramedic only saw detainees if a medical need had been identified at WJF or if any concerns were identified on site. Most detainees came from WJF to KIU, but a few did not and they did not receive an initial health screening. This presented a potential risk of health concerns not being detected and needed to be addressed.

3.30 At Manston, Medevent were based in a purpose-built clinical facility, with a team of paramedics present 24 hours a day, two doctors on site from 8am to 8pm and a doctor on-call out of hours. The medical centre was clean with facilities for a range of treatments and examinations. Equipment was regularly checked and in good order. The management of medicines, including controlled drugs, had improved since the last inspection, with safe storage and documentation in place. The service agreed to address a few minor problems, including a lack of temperature checks in rooms where medicines were held and a need to secure the new drugs trolley to the wall.

3.31 Detainees could continue with their prescribed medicines, subject to verification of previous prescribing and existing needs. Any medication needed could be prescribed, which improved the care and reduced the burden on local services.

3.32 A clinical pathway was being developed with the psychiatry service at a local hospital emergency department for detainees presenting with acute mental health issues.

3.33 Any detainee presenting with substance use withdrawal symptoms was clinically assessed by a doctor and taken to hospital for observation and treatment if required. This happened rarely. There was access to limited symptomatic relief at Manston and the team were reviewing this treatment pathway.

3.34 The medical director provided a very informative newsletter for all staff, with clinical updates and service developments which staff found very helpful. At the time of the inspection, information was sent to the hospital and to community services on paper and work had started to introduce digital medical records, which would be beneficial.

3.35 There were some weaknesses in maintaining medical confidentiality. Detailed medical information was not routinely placed in an envelope and was easily visible to escort staff. We heard some detainee custody officers openly talking about medically confidential information in an open space with no clear purpose for doing so other than general conversation, which was inappropriate.

3.36 When Mitie Care & Custody took over responsibility for the detainee, Aeromed staff provided paramedic support at Manston. Paramedics

were available 24 hours a day and could refer to the Medevent doctors on site when needed, which was positive.

3.37 Aeromed staff were now based in a more spacious room, although staff told us that it acted as a clinical space and a staff room, which was not ideal. The area had two individual bays for seeing patients. The main drugs cabinet was locked but we found medicines stored in an unlocked fridge, which the service rectified.

Section 4 Preparation for removal and release

Detainees are able to maintain contact with the outside world and be prepared for their release, transfer or removal.

Communications

Expected outcomes: Detainees are able to maintain contact with the outside world using a full range of communications media.

4.1 Detainees' mobile phones were taken from them on arrival at Western Jet Foil (WJF) and stored with their property. The reasons were not explained to them. They had no further access to them until they were released from the holding facilities. Staff told us that detainees could ask to take down phone numbers from their mobiles, but in practice this generally was not offered and did not happen; detainees told us they were not informed about how they could get hold of the numbers they needed.

4.2 Access to phones remained inadequate across the three sites. Detainees had no access to phones in the initial screening area at Manston. A stock of mobile phones had been purchased for detainees when they moved into Mitie custody, but they were not made available for use. Only one phone was available for detainees to use in each marquee, located on the staff desk, but staff put time limits on the calls and there was no privacy.

4.3 There was no access to payphones in any of the facilities. In the new Kent Intake Unit (KIU), detainees could use the landline in the interview rooms to contact family, friends or legal representatives. A small stock of mobile phones was available to detainees, but the signal was poor. Detainees were told about the use of phones during their induction at the KIU, but incorrect information was provided in the induction leaflets at Manston.

4.4 Following their formal release, detainees were transferred from KIU staff to the care of the Refugee Council, awaiting onward transport. They were provided with mobile phone chargers before they left, which was positive, and something that was not available at the other sites. Detainees at all three sites still had no access to the internet during their stay.

Leaving the facility

Expected outcomes: Detainees are prepared for their release, transfer or removal. They are able to retain or recover their property. Families with children and others with specific needs are not detained without items essential for their welfare.

4.5 Most detainees arrested and searched at WJF were moved to departure areas to await transfer to Manston or KIU. However, between July and December 2022, 164 people were bailed from this location and transported direct to hotels when this was considered to be better on health grounds.

4.6 Unaccompanied children at KIU were bailed to the care of the Refugee Council, which had facilities in the building to hold up to 10 children temporarily on release while asylum accommodation with foster carers or in hotels was sourced, supported by social services. The committed Refugee Council staff offered the children drinks, food and a welfare bag, which contained clothes and toiletries. When the child's transfer was delayed, which happened frequently, there was a limited number of beds and mattresses for use. Many children were transported to asylum accommodation by taxi.

4.7 At Manston, different agencies were responsible for transporting screened and unscreened detainees bailed to asylum accommodation, although both groups were mainly transferred to hotel accommodation by coach. The Home Office was not able to provide accurate data on the number of detainees who left Manston unscreened or the type of accommodation to which they moved. Any detainee who was not bailed was moved to immigration detention, either a short-term holding facility or an immigration removal centre, and Mitie Care & Custody was responsible for managing this transportation. Coaches and vans that we checked were clean and in a suitable condition for transporting detainees.

4.8 At both KIU and Manston, the bail documents that we looked at were in English only and were not given directly to detainees. Instead, they were issued to the Refugee Council or to escort staff, who accompanied detainees on vehicles to their onward destination. We were advised that staff at the detainees' final location issued the documents and explained the bail process.

4.9 At Manston, detainees were given no notice of their removal until vehicles were on site and there was little evidence that their welfare needs were considered before departure. During the departures that we observed, detainees were not told where they were going or what would happen next and, when some asked for information, they were told that more would be explained once they had departed.

Section 5 Progress on recommendations from the last report

The following is a list of all the recommendations made in the last report, organised under the four tests of a healthy establishment.

Safety

Detainees are held in safety and with due regard to the insecurity of their position.

Recommendations

The Home Office should undertake full screening and welfare interviews for adults and children when detainees have had a chance to rest in suitable accommodation. Decision-makers should recognise the challenging circumstances in which detainees currently receive their screening interview when assessing any subsequent disclosure of vulnerability.
Partially achieved

Women and children should not be held with unrelated men.
Achieved

The Home Office should ensure that its practice at Dover complies with its duty to safeguard and promote the welfare of children arriving in the UK
N**ot achieved**

Detainees should not be held overnight in non-residential holding facilities without access to fresh air and exercise and beds for sleeping.
Partially achieved

Chief immigration officers should follow national guidance on conducting age assessments by interacting with detainees and should use professional interpreters when doing so.
Achieved

Mitie should make sure that staff have regular engagement with children and conduct individual assessments of their needs and any risks.
Not achieved

The Home Office should explore how safeguarding support for all children and potentially vulnerable adults could be achieved by making better use of the skills and experience of the on-site social workers.
Partially achieved

The Home Office and Mitie should work alongside other relevant agencies to make sure there is prompt action to safeguard any children who arrive at the facilities with a significant health issue, a high risk of harm or urgent needs.
Not achieved

Exhausted detainees were regularly held for more than 24 hours in non-residential accommodation.
Not achieved

Professional interpretation was used inconsistently, with the exception of the screening interview.
Not achieved

Detainees' vulnerability was not always recorded to inform subsequent assessments. Detainees with disabilities and trafficking victims were held at Manston, but no detainees had been designated as adults at risk.
Not achieved

Some children were detained for too long. The documented average length of detention for unaccompanied children was 27 hours and the longest was 48 hours.
Not achieved

The governance of security clearances and training of staff at Western Jet Foil and Manston sites was weak. There was no single co-ordinated database of the security clearance or disclosure and barring service (DBS) status of all staff working on the sites and it was not possible to determine if all staff had had clearance or appropriate training to work with children and vulnerable adults.
Achieved

Data collection was inconsistent and fragmented. The total length of detention from arrival at WJF to departure from Manston was not recorded and data on the number of referrals made to the National Referral Mechanism were not consistent or complete.
Not achieved

The lack of single leadership oversight and consistent coordination of agencies at Western Jet Foil and Manston presented risks to the vulnerability and welfare of detainees.
Partially achieved

Detainees were searched too many times and not always with sufficient sensitivity by Home Office staff.
Not achieved

Mitie Care and Custody induction interviews were held in noisy booths where staff and detainees struggled to hear and understand each other, and interpretation was not always used where needed.
Not achieved

Records did not adequately show whether the use of force and restraints were proportionate.
Not achieved

Respect

Detainees are treated with respect for their human dignity and the circumstances of their detention.

Recommendations

Effective and coordinated action by all agencies involved should ensure that there are safe, decent and hygienic reception conditions for arrivals at Tug Haven, KIU and Frontier House. In particular, contingency planning should ensure there is an effective response to fluctuating numbers and rapid mobilisations of resources whenever necessary.
Partially achieved

Agencies responsible for contracting health care services at Tug Haven, Frontier House and KIU should commission a health needs assessment and establish an integrated care pathway for detainees. The pathway should contain milestones for assessment and treatment, and an agreement should be reached with East Kent Hospitals NHS Trust about when emergency hospital services are to be engaged.
Partially achieved

There should be a care pathway for detainees who are pregnant, including routinely taking them to hospital for assessment.
Achieved

The health care provision at Frontier House should meet infection prevention and control standards, and have adequate provision to meet detainees' health care needs.
No longer relevant

Governance of health care processes was weak. Medevent's management of controlled drugs was particularly poor and breached standards for the safe storage of medicines. The care pathway lacked coordination or clinical leadership and there were no policies, protocols or governance of clinical standards.
Achieved

Detainees at the screening building were not allowed to use toilets in private.
Achieved

Preparation for removal and release

Detainees are able to maintain contact with the outside world and be prepared for their release, transfer or removal.

Recommendations

Detainees should have access to the internet, including email, video calling and social networks, unless an individual risk assessment indicates otherwise.
Not achieved

Immigration staff should ensure that detainees understand their bail conditions and what will happen to them when they leave the detention facility. All documentation should be provided in a language and format understood by the person being bailed.
Not achieved

Home Office and Mitie staff should make sure that any unmet welfare needs are identified ahead of detainees leaving the facilities, and that information is passed on to their accommodation providers and relevant referrals made where necessary.
Not achieved

Detainees did not have adequate access to phones. A stock of mobile phones at Manston were not routinely offered and some detainees' request for a phone was refused with no explanation.
Not achieved

Detainees were given very little information about the next steps when leaving Manston.
Not achieved

Appendix I About our inspections and reports

HM Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, court custody and military detention.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of detainees, based on the tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For short-term holding facilities the tests are:

Safety
Detainees are held in safety and with due regard to the insecurity of their position.

Respect
Detainees are treated with respect for their human dignity and the circumstances of their detention.

Preparation for removal and release
Detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their country of origin and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.

(Note: One of our standard tests is 'purposeful activity'. Since they provide for short stays, there is a limit to what activities can or need to be provided. We will therefore report any notable issues concerning activities in the accommodation and facilities section.)

Inspectors keep fully in mind that although these are custodial facilities, detainees are not held because they have been charged with a criminal offence and have not been detained through normal judicial processes.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for detainees. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are

summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Inspectors use key sources of evidence: observation; discussions with detainees; discussions with staff and relevant third parties; documentation; and, where appropriate, surveys. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

This report

This report outlines the priority and key concerns and notable positive practice identified during the inspection. There then follow sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees* (Version 4, 2018) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/immigration-detention-expectations/). Section 5 lists the recommendations from the previous full inspection and our assessment of whether they have been achieved.

Inspection team

This inspection was carried out by:

Martin Kettle	Team leader
Deri Hughes-Roberts	Inspector
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Chelsey Pattison	Inspector
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Matthew Tedstone	CQC inspector
Joe Simmonds	Researcher
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Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Adults at risk policy This Home Office policy sets out what is to be taken into account when determining whether a person would be particularly vulnerable to harm if they remained in detention.

National Referral Mechanism (NRM) A framework for identifying and referring potential victims of modern slavery and making sure they receive the appropriate support. It is the responsibility of immigration staff in the STHFs to refer detainees held there for consideration under the NRM.

Protected characteristics
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

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