Report on an unannounced inspection of the detention of migrants arriving in Dover in small boats

Detention facilities: Tug Haven, Kent Intake Unit, Frontier House, Yarl's Wood and Lunar House

by HM Chief Inspector of Prisons

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Glossary of terms

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/

National Referral Mechanism
The National Referral Mechanism was put in place in the UK in April 2009 to identify, protect and support victims of trafficking.

Personal protective equipment
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

Rule 32 of short-term holding facilities rules
This rule requires that health care professionals notify the Home Office if they are concerned that a detainee's health is likely to be injuriously affected by continued detention or the conditions in detention; if they consider the detainee may have been the victim of torture; or if the detainee may have suicidal intentions.

Social/physical distancing
The practice of staying two metres apart from other individuals, recommended by Public Health England as a measure to reduce the transmission of COVID-19.

Introduction

This report covers inspections of the short-term immigration detention facilities at Tug Haven and Kent Intake Unit in Dover, Frontier House in Folkestone, Lunar House in Croydon and Yarl's Wood in Bedford. These facilities primarily held migrants who had arrived from France on small boats after undertaking sea crossings from Calais. During our interviews, many detainees described journeys that had started several years previously and usually included some time spent in difficult conditions in Calais. They mainly came from Iran, Iraq, Sudan, Syria and Eritrea.

In the three months from June to August 2020, about 2,500 people arrived at Tug Haven before being bailed or dispersed to other detention facilities. Small boat crossings have been increasing since late 2018, when the then Home Secretary declared a 'major incident'. Several hundred people had already started arriving on single days in 2019. While the number of arrivals had been far higher in 2020 than in previous years, the reception arrangements at Tug Haven were not fit for even small numbers. This was readily acknowledged by local Home Office staff who were themselves working in challenging conditions. We were told that Home Office managers had long been seeking an improvement in conditions, but with little success.

The facilities at Tug Haven were unsuitable. The area resembled a building site. Detainees almost always arrived wet and cold, but then often had to spend hours in the open air or in cramped containers, before moving to another detention environment. Basic supplies, including dry clothing, ran out during the inspection and some detainees were placed on escort vehicles in wet clothes. Despite the poor conditions, the detainees we interviewed were almost all very positive about the way individual staff at Tug Haven treated them.

Kent Intake Unit (KIU) and Frontier House provided acceptable accommodation for short periods but were not suitable for very lengthy detentions. Some detainees were held for more than two days in rooms with no sleeping facilities, showers or access to the open air. KIU in particular was crowded and poorly ventilated. Social distancing (see Glossary of terms) was not possible and there were some basic omissions, such as not providing hand-washing facilities or even sanitiser in the women's toilets. Home Office detention reviews often did not take place and record-keeping was poor. There were weaknesses in child safeguarding procedures and in one case a child was mistakenly taken to a detention centre for adults. There was no overall health needs assessment to help respond to detainees' changing needs at Tug Haven, KIU or Frontier House, and detainees did not always receive a health screening.

Mitie staff routinely used interpretation at KIU and Frontier House for initial interviews. Detainees also told us that they felt safe and that staff from all agencies at these facilities treated them with respect. The Home Office safeguarding hub provided detainees being released with useful information, primarily about health services. Detainees had inadequate phone access through which to contact family or friends on arrival. Little information was provided about onward detainees' destinations and many of those we subsequently met at Yarl's Wood said they were still not sure where precisely in the UK they were.

Yarl's Wood has, for some years, run a residential short-term holding facility (STHF), but its main function was as a women's immigration removal centre. In August 2020, it transitioned to holding only men and was now run entirely under STHF rules. The centre had adapted well to its recent change in function. Detainees were received into a high standard of accommodation and reported that staff treated them well. The facility's safeguarding processes for vulnerable detainees, including potential children and those at risk of self-harm, were good. Health services were good. The chaplaincy continued to provide useful support to detainees. Detainees had good access to well-maintained outside yards and could participate in some education and use gym equipment. They could also use the internet, but not social media, which limited their ability to contact family and friends.

Detention staff, especially those in reception, did not make adequate use of interpretation. Vehicles arriving from Dover were poorly coordinated, causing long and avoidable delays for detainees entering the centre. Not all detainees received an induction and many continued to be inadequately informed about what would happen next. Phones were provided but detainees were not always properly informed about how to activate them.

Lunar House was subject to a short inspection after it became apparent that a significant number of detainees were taken there from Dover. No detainees were held there during the visit. The facility's conditions for detainees held for a short time were good, but the average detention period was lengthy at about 11 hours. Detainees arrived from Tug Haven and received an induction, but not in private. There had been no recent incidents involving self-harm or the use of force and facility staff had a reasonable awareness of safeguarding procedures. Children were rarely held and only generally for short periods. The vast majority of asylum screening interviews were undertaken in person, which was positive. There were telephones in the holding rooms and detainees could obtain a phone and a SIM card.

There were undoubted challenges involved in detaining large numbers of migrants arriving on small boats at Dover and the situation was fast-moving. Shortly after the inspection, we were informed that Tinsley House immigration removal centre was also now receiving detainees from Dover and was being run under STHF rules. We were also told that Napier Barracks in Folkestone was being used to house asylum seekers, but that it was not, the Home Office assured us, a place of detention. We met detainees who had been extremely traumatised after their long journeys, and their positive feedback on the decency shown to them by many individual staff cannot be underestimated. However, the detention facilities in Dover were very poorly equipped to meet their purpose and important processes had broken down.

While some of the concerns identified in this report can be addressed by local managers, an effective response requires coordinated and strategic action involving different Home Office agencies and the port authorities. The poor conditions at Tug Haven in particular were not the result of a large number of people arriving. It was simply that there was inadequate provision. Contingency planning, by this stage of a long-running situation, should be able to deliver a flexible and adequate response. So far it has not done so, and it is hard to understand this failure to prepare properly for what must have been a predictable increase in migrant numbers. It needs to be understood that just because numbers are unprecedented, that does not mean they are unpredictable, or cannot be planned for. We look forward to seeing a properly coordinated plan that shows how conditions will be improved in future to meet fluctuating demand.

About this inspection and report

Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, immigration detention facilities and police custody.

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 HM Inspectorate of Prisons reports carry a summary of the conditions and treatment of detainees, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. The tests have been modified to fit the inspection of short-term holding facilities, both residential and non-residential. The tests for short-term holding facilities are:

> **Safety** – that detainees are held in safety and with due regard to the insecurity of their position
>
> **Respect** – that detainees are treated with respect for their human dignity and the circumstances of their detention. (Note: Non-residential STHFs are unsuitable for long stays and detainees should not be held in them for more than a few hours. This limits what activities can or need to be provided. We will therefore report any notable issues concerning activities in the accommodation and facilities section.)
>
> **Preparation for removal and release** – that 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.
>
> Inspectors kept fully in mind that although these were custodial facilities, detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes.

Note on the structure of the report

There were two sites of detention at Dover: Tug Haven, where migrants first arrived, and Kent Intake Unit (KIU), which we have previously described as the Dover Seaport STHF. We refer to the KIU in this report for reasons of clarity, as it was now the established term used to describe these facilities. A third 'overflow' detention facility was located at Frontier House in nearby Folkestone. Where comments apply to Tug Haven, this is always stated. Other comments apply to both KIU and Frontier House unless one is specified. These detention sites are reported on in the first section of the report.

Most detainees were subsequently transferred to the Yarl's Wood residential STHF in Bedfordshire. The second section of this report covers this facility.

Once detention logs were received from the Home Office, it became clear that a significant number of detainees were also transferred from Dover to the non-residential Lunar House facility in Croydon. We therefore undertook an additional short visit to Lunar House to inspect conditions and speak to staff. No detainees were present during the visit and the facility was not

comprehensively inspected. A summary of the main findings on Lunar House is provided in the third section of this report.

Section 1. Tug Haven, Kent Intake Unit and Frontier House

Task of the establishments
To hold newly arrived migrants (men, women and families)

Location
Tug Haven and Kent Intake Unit are located in Dover, and Frontier House is in Folkestone

Name of contractor
Mitie Care and Custody

Last inspection of Kent Intake Unit (referred to as Dover Seaport in the last report) and Frontier House
15–16 August 2016
Tug Haven has not previously been inspected.

Escort provider
Mitie Care and Custody

Summary

1.1 At our inspection in 2016, we made 13 recommendations in relation to the Kent Intake Unit (KIU) and Frontier House. Tug Haven has not previously been inspected. At this inspection, we found that one recommendation was achieved, four were partially achieved and eight were not achieved.

1.2 Reception arrangements at Tug Haven were very poor. Detainees almost always arrived wet and cold and then usually spent hours in the open air or in containers units, before moving to another detention environment. Basic supplies, including clean and dry clothing, ran out during the inspection. Despite the poor conditions, interviewed detainees were positive about the way they were welcomed and treated by individual staff at Tug Haven.

1.3 In the previous three months, 1,856 people had passed through KIU and 264 through Frontier House. Detainees were received respectfully by detention staff at both facilities. Initial interviews by detention staff were routinely conducted using telephone interpreting but were not always private or sufficiently thorough.

1.4 Abridged asylum screening interviews regularly took place in the early hours of the morning, which reduced the likelihood that detainees would disclose safeguarding needs. Men, women and children were often held in the same holding rooms, but staff supervision was usually good. Levels of violence, antisocial behaviour and self-harm were low, as was the number of incidents involving force. Detainees were positive about their experience of safety at all facilities.

1.5 Unaccompanied minors waited long periods for social workers to arrive. On average, unaccompanied children were held at KIU for just over 17 hours, which was longer than the average for adults. The UKVI's (UK Visas and Immigration) electronic record keeping in all children's cases we looked at was poor. During the inspection, a detainee who was clearly a child was not identified for assessment before being transferred to Yarl's Wood. The Refugee Council had resumed its service for children, having suspended it during the lockdown, and provided good support to those placed in their care.

1.6 Detainees were held for long periods. The average length of detention was 15 hours and 45 minutes at KIU and 17 hours at Frontier House. During the inspection, some detainees were held in excess of 50 hours without access to the open air or sleeping facilities. Detention reviews often did not take place. Almost all of those interviewed told us that no one had explained what would happen to them next. Nearly all interviewed detainees said they had not seen any information about legal advice.

1.7 Tug Haven resembled a building site and was not fit for purpose. It was impossible to socially distance in the cramped containers. Some gazebos had been erected, but they did not protect detainees from the cold. Some refurbishment of KIU and Frontier House had taken place, but neither facility was adequate for the numbers held. Staff from all agencies treated detainees with courtesy at all sites.

1.8 No overall health needs assessment had been completed. Newly arriving detainees were triaged at Tug Haven for urgent medical conditions and symptoms of COVID-19. A designated van was available where migrants would be seated if they displayed any symptoms of COVID-19. Otherwise, detainees had to be treated in the open air, regardless of the weather.

1.9 The Home Office's national safeguarding hub at KIU directed detainees who were being released on bail to suitable support, mainly in relation to health. Detainees still had no access

to email, video calling or social networks to maintain contact with friends and family. Mobile phones were always confiscated at Tug Haven and detainees were rarely given the opportunity to call someone to advise them of their whereabouts. Detainees were often released on immigration bail without having had the conditions of their release fully explained through an interpreter.

Key concerns and recommendations

1.10 **Concern:** The reception facilities at Tug Haven were very poor and those at KIU were unsuitable for the large number of detainees who frequently had lengthy stays. There was no ready access to showers or lockable toilets with seats and lids. Many detainees at Tug Haven were not sufficiently protected from the cold, basic supplies including clothing were running out and detainees were often crowded into spaces where social distancing was not possible. Managers agreed that the environment was not acceptable but not enough progress had been made towards improving the situation, which was especially poor in view of the risks posed by COVID-19.

Recommendation: 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 mobilisation of resources whenever necessary.

1.11 **Concern:** Detainees arriving at Tug Haven routinely had their mobile phones removed from them, and they could not gain access to the contact details for family or friends that were stored on their phones.

Recommendation: Detainees arriving in the UK should be able to make initial contact with their family and friends by telephone free of charge.

1.12 **Concern:** Detainees' vulnerability was not always identified. Screening interviews were undertaken in the early hours of the morning, making it less likely that vulnerabilities would be identified. No vulnerable adult warning forms had been opened at Frontier House between June and August 2020. An elderly woman was held there for 40 hours. Mitie had not reported any modern slavery concerns and we did not receive information on how many UKVI referrals were made under the National Referral Mechanism.

Recommendation: The Home Office should promptly assess and meet the needs of vulnerable detainees. Care plans should be in place for all detainees at risk.

1.13 **Concern:** Unaccompanied children were often held overnight with adults and often for too long. Welfare interviews with unaccompanied children arriving in the daytime regularly took place in the early hours of the next morning, which undermined the purpose of the interviews. Some children had not been identified at Dover and were placed on a coach to adult detention facilities.

Recommendation: 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.

1.14 **Concern:** Detainees, including children, were held for far too long and often overnight in facilities with no access to the open air and little or no natural light. Detention reviews frequently did not take place.

Recommendation: Detainees should only be held overnight in non-residential holding facilities without access to fresh air and exercise in exceptional circumstances and reviews of their detention should be timely and thorough.

1.15 **Concern:** Health services had developed in response to changing and growing needs, but no overall health needs assessment had been completed to establish what services, equipment and clinical supplies were required.

Recommendation: 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.

Safety

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.

1.16 In the three months from June to August 2020, about 2500 people were received at Tug Haven. Most arrived wet and cold having travelled on small boats from France and were either picked up at sea or after landing on beaches around Kent. They were all arrested by Immigration Enforcement under the Immigration Act before undergoing a temperature check, a search and being photographed and fingerprinted so basic identity checks could take place. All of this took place outside.

1.17 Most detainees had a blanket on arrival or were provided with one reasonably quickly. Most were usually given dry replacement clothing and footwear, but stocks ran out during the inspection (see key concern and recommendation 1.10 and paragraph 1.49). Detainees were generally provided with a hot drink and a biscuit. Paramedics were on site to deal with any identified medical issues (see paragraph 1.58).

1.18 Most interactions between staff and detainees at Tug Haven were formal but courteous. When they were later interviewed, detainees told us that staff had received them respectfully. There was no formal assessment of detainees' risks or identification of their vulnerabilities at Tug Haven. Detainees, who were not spoken to, waited for immigration enforcement staff to complete the IS91 form (which authorises detention) and for a decision to be made about their onward destination. They were not given the reasons for their detention (see paragraph 1.39). There was no record of detention times at Tug Haven, but we saw detainees remain in a facility that was exposed to the elements and that was unsuitable for up to three hours (see paragraph 1.42).

1.19 During the inspection, Tug Haven had received over 200 arrivals in one day and, shortly before, over 400. The throughput had increased significantly since the end of 2018 and with this came the logistical challenge of accommodating detainees. There were efforts to keep family groups together and, along with women and unaccompanied children, they were generally allocated to the KIU detention facility. When Tug Haven was busy, as it regularly was, adult male detainees were often allocated to various other detention facilities. Most frequently, they travelled to Yarl's Wood or Lunar House by coach, escorted by immigration staff.

1.20 During the busiest day of our inspection, a number of detainees were moved to a waiting room in the Atrium waiting area at KIU, where they were held by Border Force staff. We were told this was not uncommon. A decision was taken later in the evening to open Frontier House, the designated overflow facility in Folkestone run by Mitie, and 22 detainees were moved there from about 1am. Detainees did not therefore receive an initial interview until the middle of the night, often hours after their arrival from Tug Haven (see also paragraph 1.24).

1.21 Detainees were transported in a range of vehicles. Those we looked at were clean and well maintained and most had safety belts for detainees. Those arriving at KIU from Tug Haven were generally disembarked promptly from vehicles and without the use of handcuffs. They were moved to the search room in groups of up to 14. There they were quickly offered food and drinks while awaiting an initial interview. The room was warm and reasonably

welcoming. There was information in 20 languages for those who could read. Information was also shown on a rolling basis on the television. Those who arrived at Frontier House were also disembarked swiftly without the use of handcuffs, but they were moved directly to the holding room where staff frequently failed to point out the information available.

1.22 In the three months to the end of August 2020, 1856 individuals were detained at KIU and 264 at Frontier House. Detainees were searched respectfully. Mitie staff routinely used telephone interpreting facilities to go through an initial questionnaire with newly arrived detainees. An abridged version designed for busier times was frequently used, but it was not always clear why; we also saw it used when there were few detainees to interview. Initial interviews did not always take place promptly and at KIU they were not conducted confidentially. There was a focus on detainees' immediate welfare, but not on identifying individual safeguarding concerns, and vulnerable adult warning forms were not always raised when necessary (see paragraph 1.26). Detainees were not always offered the opportunity to make a telephone call to advise someone of their whereabouts (see key concern and recommendation 1.11 and paragraphs 1.41 and 1.67).

Recommendation

1.23 Initial interviews should take place promptly, be held in private and focus on identifying safeguarding concerns as well as detainees' immediate welfare needs.

Safeguarding adults and personal safety

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.

1.24 UKVI staff were trained in safeguarding and had a good knowledge of the National Referral Mechanism (NRM, see Glossary of terms). Asylum screening interviews were conducted face to face, but detainees arriving in the day time were regularly interviewed in the early hours of the following morning while they were still exhausted following arduous journeys. This meant they would have been less likely to disclose sensitive information, hampering the identification of safeguarding needs. Most detainees were no longer asked standard questions on their asylum claim, when they might have disclosed such needs, and interviews were short (see key concern and recommendation 1.12). Screening records showed that some medical concerns were being identified (see paragraph 1.66). In the three months to the end of August, 43 detainees were determined to be adults at risk (20 at Level 1, 21 at Level 2 and two at Level 3). Given the number of detainees who had passed through the facilities at Dover, this number was low. The Home Office was unable to produce data on the number of adult safeguarding referrals made to social services, or the number of NRM referrals in the three months to 31 August 2020.

1.25 Many detainees were held overnight and some particularly vulnerable detainees were held for far too long. For example, at Frontier House, an 80-year-old woman, travelling without her family, was held for over 40 hours. (See key concern and recommendation 1.12.)

1.26 There was inconsistent use of vulnerable adult warning forms for detainees considered to be particularly vulnerable. Mitie staff opened 123 vulnerable adult warning forms at KIU between June and August 2020, mostly for health-related concerns, but none at Frontier House, although we saw some vulnerable people there for whom this would have been

appropriate. Mitie staff had not raised any modern slavery concerns with the Home Office in the three months to 31 August 2020 (see key concern and recommendation 1.12). Mitie staff we spoke with had received some awareness training on aspects of vulnerability and were aware of a variety of issues that could impact on the safety and well-being of detainees.

1.27 In the three months to the end of August 2020, there had been 142 incident reports completed at KIU and six at Frontier House. They mostly concerned medical issues but some related to mental health problems, pregnancy or, in a few cases, safeguarding concerns, such as sexual assault.

1.28 Self-harm was rare. Where risks were identified, staff would complete a suicide and self-harm or vulnerable adult/child warning form. This generally led to an increase in the level of observation that the person affected received. Mitie staff all carried personal anti-ligature knives.

1.29 Violence and antisocial behaviour were infrequent and detainees we spoke to at all facilities told us they felt safe. Limited space meant that men, women and children were frequently held together. Staff's supervision of the holding rooms was good and they were responsive to potential problems – for example, staff responded quickly to raised voices at the queue for the shower at KIU and de-escalated a potentially volatile situation well.

1.30 Force was rarely used and Home Office and contractor staff focused on de-escalation and communicating with detainees to avoid it. All Mitie detainee custody officers (DCOs) were trained in the Home Office Manual for escorting safely (a training package developed specifically to cover the restraint of non-compliant immigration detainees). DCOs applied handcuffs rarely and we did not see them used during our inspection. All DCOs we spoke to were aware of the need to complete individual use of force statements if they used force against detainees.

Safeguarding children

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

1.31 The treatment of children was a matter of concern. Most children were held in KIU. According to holding room logs, in the three months to 31 August 2020, 73 unaccompanied and 250 accompanied children had been held there.

1.32 All unaccompanied children received a face-to-face Home Office welfare interview. However, if they arrived in the day time, they were regularly interviewed about their welfare in the early hours of the following morning, suggesting the Home Office might have lost sight of the purpose of the interviews. For example, a 15-year old boy had arrived in the UK at 4.10pm, but had a welfare interview at 4.55am the next morning. Interview records we looked at were perfunctory and demonstrated little meaningful exploration of the children's welfare. (See key concern and recommendation 1.13.)

1.33 Children were held for far too long and often overnight. This was partly because Kent County Council's social services department no longer had the capacity to care for unaccompanied minors, who therefore waited a long time for social workers to arrive from other counties. (See key concern and recommendation 1.13.)

1.34 According to holding room records, unaccompanied children were held at KIU for, on average, just over 17 hours, which was longer than the average for adults. Twenty-nine per

cent of unaccompanied children at KIU were held for over 24 hours. In one case, a 15-year old boy was held for over 66 hours. Electronic records gave no indication of detention in this case having been reviewed, when social services were called or why he was held for so long. (See key concern and recommendation 1.13.)

1.35 Some very young children in family groups were also held for far too long. One such group, held in Frontier House for 45 hours, included a baby and other children aged 5, 7, 9 and 10.

1.36 During the inspection, a detainee who was clearly a child was not identified as such or given a chief immigration officer (CIO) assessment. He was transferred to Yarl's Wood as an adult where he was quickly noticed by staff and taken into local authority care. In the three months before the inspection, three other detainees who were transferred as adults, without having had a CIO assessment, were subsequently also taken into local authority care. (See key concern and recommendation 1.13.). In the three months to the end of August 2020, 109 detainees who said they were children were assessed by CIOs to be adults. No data was kept on the number assessed to be children. The Home Office was also unable to provide data on the number of age assessments carried out by local authority children's services, or their outcomes. Mitie routinely opened children's care plans. They were largely in tick-box format, and we saw little documentation of care.

1.37 The Refugee Council had resumed its service for children, having suspended it during the lockdown. Staff provided good support. Children were released into their care following the welfare interview and were then held in a more child-appropriate environment in rooms close to the KIU holding rooms. Since the suspension of Kent County Council's social service provision, children were no longer always interviewed by a social worker before being taken to dispersal accommodation. Some older children were sent unaccompanied to accommodation in a taxi. According to UKVI electronic records, a 12-year-old boy was dispersed to hotel accommodation in London with his 18-year-old brother, with no indication that any contact had been made with local authority social services departments (see key concern and recommendation 1.13).

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.

1.38 Detainees were held for very long periods. The average length of detention was 15 hours 45 minutes in KIU, and 17 hours in Frontier House. During the inspection, some detainees were held in excess of 50 hours without access to the open air or sleeping facilities. (See key concern and recommendation 1.14.) The Home Office was unable to provide data on the number of child safeguarding referrals made to social services.

1.39 IS91 forms were completed at Tug Haven, but they were often inaccurate, or not completed in full. Almost all detainees we interviewed told us that no one had explained what would happen to them next. We did not observe written reasons for detention (IS91R) forms being handed to people when they were first detained or explained to them in a language they understood.

1.40 In many cases we looked at, electronic records, used to share information between various Home Office departments, were very poor. Seventeen per cent of detainees in KIU and 23% in Frontier House were held for over 24 hours. We saw little evidence in electronic records that detention exceeding 24 hours had been reviewed. UKVI staff told us that detention

reviews often did not take place owing to work pressure. (See key concern and recommendation 1.14.)

1.41 Details for various legal representatives were displayed in the holding rooms. However, the information was in English and few detainees used it or understood its relevance. Nearly all of those we interviewed said they were not aware of receiving information about legal advice. We did not observe any detainee being offered a free phone call (see key concern and recommendation 1.11 and paragraph 1.67).

Respect

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.

1.42 The facility at Tug Haven resembled a building site (see Appendix III: Photographs). After disembarking from a boat in the harbour, detainees entered a fenced compound with a loose rubble base on which to walk. The metal fence had only recently been erected and had made a small improvement to the environment. The compound held three small metal containers with a maximum seating capacity for 24 detainees without social distancing. Additionally, several gazebos had been purchased and erected in open areas of the compound. They offered detainees some limited shelter from the elements, but did not protect them from the cold. There was insufficient seating and many detainees had to sit or lie on the ground. Each of the containers had a chemical toilet attached. They quickly became dirty and smelly. There were no showers. Blankets and replacement clothing were handed out to detainees when they were available, but they ran out during the inspection, leaving some detainees cold and/or wet until they reached their next destination. There was nowhere private for detainees to change, other than the toilets. (See key concern and recommendation 1.10 and paragraph 1.49.)

1.43 Bottled water and snacks were available, and a limited number of hot drinks could be provided, as a single household kettle was used to make them. During the inspection, the facility ran out of cups and sugar, which meant no hot drinks could be offered. There were no activities to occupy detainees held in the facility. A new cabin with the capacity for 52 detainees, with single sex toilets, had been delivered but was not yet operational or approved for use.

1.44 The holding rooms at KIU and Frontier House had seen some refurbishment since our previous inspection, but they remained cramped and inadequate for the large number of detainees who frequently stayed there a long time (see section on legal rights). Both facilities consisted of one large room with rows of fixed metal seating and some tables with attached seats. The room at KIU had some natural light and a smaller designated family room was available. There were no proper sleeping facilities and detainees slept on the floor on thin mattresses, mats and beanbags, which were not cleaned between uses. Blankets were provided but pillows were only available at KIU. Water fountains in the rooms had been taken out of use as a result of the COVID-19 pandemic, but bottled water was available on request. Social distancing in the holding rooms was often not possible because of the number of detainees held. The rooms were often dirty and staff told us that it was difficult to ensure the facilities were cleaned as a result of the number held.

1.45 Detainees were given wash-kits, but there was no shower at Frontier House and only one shared shower at KIU. It was mostly kept locked and staff told us this was so they could supervise its use. Many detainees were held for lengthy periods without being able to have a shower. There were designated separate men's and women's toilets, but we saw them being used by all detainees. They were often dirty and continued to have no seats or lids and could not be locked. Sanitary products in the women's toilet at KIU were stored in an unhygienic condition and the sink was not in use (see key concern and recommendation 1.10). Hand sanitiser and wipes were only made available after we pointed out that the women needed to be able to clean their hands.

1.46 Detainees were not provided with enough activities to occupy them when held for lengthy periods. At Frontier House, they were issued with new packs of playing cards when we asked about the lack of activities. A television and DVDs were in both holding rooms and in the family room, and toys for children were available. Detainees' property was not always stored safely at KIU, and at Frontier House, it was stored in a corridor that was not secure.

1.47 Detainees were issued with and asked to wear face masks during any interactions they had with staff but they routinely removed them when in the holding rooms with their peers. They were not routinely offered hand sanitiser.

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.

1.48 We observed staff from all agencies treating detainees with respect and courtesy. DCOs were aware of the stresses of detention and expressed their frustrations to us about the often long delays in the onward transfer of detainees. Detainees whom we interviewed were almost all very positive about the respectful and caring attitudes of the staff they met on their arrival.

1.49 Replacement clothing packs were usually available at all sites but Tug Haven ran out of both clothing and footwear on one day of the inspection. Efforts were made to procure additional supplies from local shops, but this was not sufficient and some detainees remained in wet clothing until they reached other locations. (See key concern and recommendation 1.10 and paragraph 1.42.)

1.50 Professional telephone interpreting services were not used at Tug Haven but had been used routinely to conduct initial interviews at KIU and Frontier House – they had been used on 1745 and 242 occasions respectively in the three months to 31 August 2020. Staff were confident using interpretation, but initial interviews at KIU lacked privacy as they regularly took place in the presence of other detainees. Interpretation services were rarely used after the initial interview.

1.51 Complaints and feedback forms in English and a range of other languages were available at KIU and Frontier House. The forms were not advertised or prominently displayed at Frontier House as they were held in A4 folders. At KIU there was a notice on the wall promoting the complaints forms, but the complaints box was not labelled so detainees would not have been aware of its purpose. Written records showed that the complaints box was not emptied every day. The Home Office was unable to tell us the number of complaints it had received during the time period covered by the inspection.

1.52 DCOs said they completed disability care plans when required, but the holding rooms were inadequate for those with disabilities. At KIU, for example, there was no ramp to allow wheelchair access from the van dock and the toilets were not suitable. A wheelchair was available at KIU and Tug Haven should a detainee have needed one (see paragraph 1.55).

1.53 Catering arrangements remained reasonable. Snacks were provided in the holding rooms and replenished throughout the day. At KIU, fresh fruit was also available. Microwave meals to meet a range of dietary needs were offered shortly after detainees arrived at the facility and at reasonable periods throughout the day, but we observed the timescales varied as an increasing number of detainees arrived.

1.54 DCOs had a basic understanding of equality and diversity issues and told us their annual refresher training further covered this topic. There were no separate quiet spaces or faith rooms, but detainees could practise their religion. A limited number of religious books and prayer mats was available in the holding room at KIU but not at Frontier House, where they were stored in the office. Detainees could not go outside for exercise or fresh air.

Health care

Expected outcomes:
Detainees' health care needs are met.

1.55 The health needs of detainees had changed compared with the previous year. Those with more serious disabilities were now increasingly arriving in boats. There was no health needs assessment to help inform the service or indicate which pathways of care were required (see key concern and recommendation 1.15).

1.56 At KIU, Aeromed was contracted to provide health services, and Medevent provided health services at Tug Haven. Contracts and governance arrangements were managed separately, and while health services had been developing in response to detainees' needs, they functioned in isolation. We were informed that patients sent from KIU to East Kent Hospitals NHS Trust were occasionally refused care, which suggested that there was no shared understanding or agreed local pathway of care. (See key concern and recommendation 1.15.)

1.57 Aeromed and Medevent ensured staff, all paramedics, were competent, supervised and registered with the Health Care Professionals Council.

1.58 Paramedics were on site at Tug Haven on demand 24 hours a day. At KIU paramedics attended from 10am until 4pm seven days a week, which was not sufficient as the demands on the service at KIU had changed, with many detainees arriving after 4pm. While funding had been agreed to expand the health service at KIU, it was not yet in place. KIU paramedics were occasionally deployed to Frontier House when demand was high, which could have deprived KIU of their services. (See key concern and recommendation 1.15).

1.59 All detainees arriving at Tug Haven were triaged for urgent medical needs and for symptoms of COVID-19. A designated van was available where migrants would be seated if they displayed any symptoms of COVID-19. At KIU, custody staff referred detainees to paramedics, which meant not all detainees received an in-depth health screening. Some detainees were held at KIU for long periods of time without their health needs being identified, which put their well-being and that of others at risk. (See key concerns and recommendations 1.10 and 1.15).

1.60 Detainees were held in the holding rooms in close proximity to one another, increasing the likelihood of airborne communicable diseases, such as TB or the COVID-19 virus, being transmitted to others. There was nowhere suitable to isolate COVID-19 symptomatic patients. At KIU and Frontier House facilities were better, but options for isolating suspected cases were extremely limited and, when the units were full, it was almost impossible to safely isolate those who were symptomatic.

1.61 The working environment at Tug Haven was unsuitable, as it contained multiple trip hazards that could lead to accidents and injuries to detainees and staff members. The very young and infirm were at an increased risk of falling due to rubble strewn around. The site was not equipped to respond to the needs of people with disabilities because the ground was uneven,

and there were no grab rails or ramps to enable access to toilets for wheelchair users or those needing assistance with walking. (See key concern and recommendation 1.15.)

1.62 Paramedics at Tug Haven brought with them comprehensive medical equipment and could treat any emergency. However, there was no dedicated medical room. Treatments were conducted in the open air and sometimes in bad weather, where other people were standing nearby. Some treatments such as wound closure could not be administered safely because of the general lack of cleanliness.

1.63 Unlike in 2016, custody staff had been trained in first aid and the use of an automated external defibrillator (AED). An AED was deployed at KIU and staff knew where to find it. An order was placed for another AED for Frontier House during the inspection. Oxygen was available for detainees in need of potentially life-saving treatment at Tug Haven, but not at KIU or Frontier House.

1.64 Medicines for use in emergencies or to relieve suffering were available from the paramedics. Medicines management was good. Detainees could continue with their prescribed medicines, subject to a verification of previous prescribing and current needs.

1.65 Opiate substitution therapy (OST) was not available at the facilities. Detainees on OST prior to their arrival, and who were kept at KIU for longer than 24 hours, risked suffering withdrawal effects. Limited medicinal relief for withdrawal symptoms was available. Nicotine replacement gum was also available for detainees requiring it at KIU, where smoking was not permitted.

1.66 Mental health services were not available. However, Aeromed worked closely with the Home Office safeguarding lead staff member, who encouraged staff to organise an early transfer or release for detainees with any health problems, and helped them to locate services in the community via the national safeguarding hub. During the inspection, GP referrals were made for two men who were receiving OST.

Preparation for removal and release

Communications

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

1.67 Detainees arriving at Tug Haven with mobile phones had them removed immediately without being able to gain access to contact details for family or friends that were stored on their phones. Payphones that accepted incoming calls were available in the holding rooms, but the one at Frontier House did not allow outgoing calls. Detainees could only use the payphone in KIU if they had change. Neither of the payphones had a privacy hood. Detainees without a phone were not routinely offered a free telephone call to a friend or family member (see key concern and recommendation 1.11).

1.68 Detainees held in these facilities continued to have no access to email, internet, video calling or social networks.

Recommendation

1.69 Detainees should have access to the internet, including email, video calling and social networks, unless an individual risk assessment indicates otherwise.

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.

1.70 During the inspection, all detainees left via the KIU. Detainees who had been moved to Frontier House were brought back to KIU for their interview with immigration officials and for subsequent release. Outcomes for detainees varied depending on whether or not they were claiming asylum. The majority, who claimed asylum, were granted immigration bail. A small minority were transferred to long-term detention when they were thought to pose a high risk of harm or if they were to be considered for possible removal from the UK under the Dublin arrangements (which provides for the transfer of an asylum seeker to a European Union member state). The few who did not claim asylum were also transferred to long-term detention so they could be returned to their country of origin. During the inspection, we did not see any detainees moved from KIU to another longer-term detention facility, but were informed that most went to Yarl's Wood short-term holding facility (STHF). They were not routinely provided with any information about what to expect at their onward destination. We were told that women were nearly always bailed from KIU.

1.71 Immigration staff at KIU explained the conditions of bail to detainees who were granted immigration bail. However, they did not always use interpretation services and, even when they did, some detainees said they did not understand what was required of them and others told us they did not know what was happening to them. Documentation was provided only in English and contained complicated legal terminology, which some told us was confusing. Limited generic support information was provided, but again only in English.

1.72 The Atrium at KIU was described as a 'non-detained' area, where those granted immigration bail could wait for transport to their onward destination. The Atrium was reasonably comfortable, with sofas, free access to showers, drinking water, food and toilets. Detainees were free to leave the Atrium if they wished.

1.73 Where necessary, immigration staff were responsible for providing a suitable address for those on bail and for arranging transportation to get them there. A range of short-term accommodation was used to house people, and local taxis and mini-buses transported them to their initial accommodation. However, transfers often happened only when a number of people were ready to move and consequently some experienced lengthy delays. Records we reviewed from August and September 2020 suggested a small number of waits of over 12 hours, while delays of over six hours were not uncommon.

1.74 A Home Office safeguarding lead staff member was available to provide detainees with information about relevant support agencies in the community (see paragraph 1.66).

Recommendation

1.75 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.

Section 2. Yarl's Wood

Task of the establishment
To detain newly arrived male migrants.

Location
Bedfordshire

Name of contractor
Serco

Last inspection
5–7 and 12–16 June 2017

Escort provider
Private hire firms

Summary

2.1 At Yarl's Wood, about 1,500 detainees had been received in the three months to the end of August 2020. Efforts to coordinate the arrival of coaches from Dover had been unsuccessful and this led to unnecessary waits before detainees could enter the centre and further delays in reception. Initial interviews were usually not conducted with professional interpretation and many detainees did not receive an induction into the centre.

2.2 Almost all asylum screening interviews were conducted by telephone and did not allow for a visual assessment. We received no information on National Referral Mechanism (NRM) (see Glossary of terms) referrals made in the three months to 31 August 2020. Serco care plans for vulnerable adults were good when they were in place. There was little self-harm in the centre. Assessment, care in detention and teamwork (ACDT) case management plans for detainees at risk of suicide or self-harm were comprehensive and demonstrated some good care. In the previous three months there had been no incidents involving violence, bullying or the use of force. Very few detainees had been placed in separation. Almost all of the detainees we spoke with stated that they felt safe at the centre.

2.3 Arrangements for safeguarding detainees who said they were children were sound. Children's care plans were good. Detainees we interviewed had little understanding of what was happening next or even where they were. Detainees were not inducted by Home Office staff, and there were no surgeries where they could ask about their status. Welfare staff provided detainees with contact details of solicitors, but detainees told us they did not understand what they were and did not know how to make use of them.

2.4 Residential units were clean and in good condition. Most detainees were in single rooms, which were spacious and generally well furnished. An adapted regime was in place to enable better social distancing. Detainees were never locked behind their doors and had keys to their rooms. All units offered some activities and distractions, and detainees could use well-presented outside areas.

2.5 Almost all of the detainees we spoke with praised the way they were treated at Yarl's Wood. There were no recorded complaints in the previous three months. Centre staff did not make adequate use of professional interpretation. The chaplaincy maintained a daily presence.

2.6 The health team had responded well to the centre's change of function and provided a good service. Detainees with COVID-19 symptoms were promptly identified, isolated and tested. No detainees had tested positive for COVID-19 in the previous three months. Despite some delays, the health team continued to complete face-to-face health screenings. Rule 32 assessments (see Glossary of terms) were booked, but health care staff were not routinely informing the Home Office when detainees had left the centre before their allotted appointment. Detainees had swift access to mental health and substance misuse assessments. Emergency dental treatment was available. All detainees were seen by a nurse before leaving the facility.

2.7 All detainees were provided with a mobile phone with £1 in credit. They could buy more credit from the centre shop. Detainees had access to the internet, email and Skype, but not social media platforms commonly used to contact family and friends.

2.8 Detainees usually spent up to five days at the centre before being granted temporary admission and escorted to approved accommodation. Detainees we spoke with did not know where they would be going even at the point of their release. In some cases, the

discharge process was delayed by a lack of communication between escort contractors, the Home Office and centre staff.

Key concerns and recommendations

2.9 **Concern:** Centre staff did not make adequate use of professional interpretation services. This undermined effective information sharing between staff and detainees and left many detainees uncertain and anxious.

Recommendation: Detention staff should use professional interpretation whenever necessary to ensure communication with detainees is effective.

2.10 **Concern:** The induction process was not always completed promptly, if at all. The induction's usefulness had been undermined by the provision of outdated information and a lack of professional interpretation and written material in languages other than English.

Recommendation: The centre should ensure that all detainees have a prompt and effective induction in a language they understand.

2.11 **Concern:** Asylum screening interviews were usually conducted by telephone and did not allow for a visual assessment that could help to identify vulnerabilities. The Home Office could not provide information on National Referral Mechanism referrals made in the previous three months and very few detainees had been assessed to have been adults at risk.

Recommendation: The Home Office should ensure that detainees' vulnerability is thoroughly assessed at the earliest stage and that their identified needs are met.

2.12 **Concern:** There was no Home Office induction for detainees and there were no surgeries where detainees could ask about their status. Many detainees we interviewed had little understanding of what was happening to them, even after they had received a screening interview.

Recommendation: Onsite immigration staff should offer detention surgeries to detainees.

Good practice

We define good practice as: impressive practice that not only meets or exceeds our expectations, but could be followed by other similar establishments to achieve positive outcomes for detainees.

2.13 Care plans for vulnerable detainees (including potential children) and adults with health care problems were robust and better than we usually see in short-term holding facilities (STHFs), as were ACDT plans. We saw vulnerable detainees being provided with good support (see paragraph 2.32).

Safety

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.

2.14 The centre was busy and detainees arrived from Dover port facilities at all hours, seven days a week. The number of new arrivals fluctuated and was usually heavily dependent on the weather. About 1,500 detainees had been received in the previous three months, with over 700 in August 2020 alone. During our inspection, we observed one day with over 100 new arrivals.

2.15 Measures were in place to manage the risks of COVID-19. They included making hand sanitiser freely available, providing personal protective equipment (PPE) (see Glossary of terms) for staff and masks for detainees. All detainees also had their temperatures taken on their coach prior to disembarkation. However, several coaches carrying detainees could arrive at the same time. Efforts to coordinate their arrival had not been successful and staff at Yarl's Wood were not always told they were on their way. This led to detainees having to wait on coaches for lengthy periods before they could get off. We were told waits of over two hours were not unusual.

2.16 While reception procedures were generally prompt, we observed excessive delays when detainees arrived at the same time, often because it took time to complete health care screening interviews. Detainees arriving at night remained in reception for anything up to 15 hours, and we saw some sleeping on holding room floors and seats, despite space being available in other parts of the centre. Social distancing measures were not observed in these cases, and we saw more than the maximum of six detainees in each holding room.

2.17 Most detainees we spoke with were positive about how reception staff treated them; our own observations found they treated detainees with respect. Food and drink were offered and staff tried to put detainees at ease. However, some arrival processes failed to take account of detainees' possible stress and anxiety, and their needs were not sufficiently addressed. For example, initial interviews were not held in private and usually took place without professional interpretation. Instead, staff often used hand gestures, attempted to mime questions or used other detainees to interpret, which was poor practice, particularly when dealing with sensitive issues such as self-harm. (See key concern and recommendation 2.9.) Such interviews were unlikely to have elicited key information and identify risks. A nurse saw all new arrivals in a separate dedicated health care room.

2.18 As part of the reception process, detainees' photos and fingerprints were taken and their property, including cash, removed and stored. Detainees were generally not permitted to keep their own phone if they had one but could receive a replacement (see paragraph 2.58). Before going to their residential unit, detainees were provided with clean bedding, clothes and toiletries.

2.19 All received additional welfare checks during their first 24 hours. There was a reduced induction process that residential staff and the welfare team ran. However, not all detainees participated promptly in the process, if at all. The facility's data indicated that only about 50% of arrivals within the previous two months had received any induction from residential staff and a similar percentage had taken part in welfare inductions. Detainees were given an information booklet in reception but some of the information was out of date and inaccurate

as it was designed for the previous long-term female population. Many detainees we spoke to remained uncertain of their surroundings and the provision available. (See key concern and recommendation 2.10.)

Recommendation

2.20 Reception processes should be swift and safe. In particular, vehicles leaving Dover should be staggered and facility staff informed of their estimated time of arrival.

Safeguarding adults and personal safety

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.

2.21 In most cases, Home Office staff only had very limited face-to-face contact with detainees prior to their transfer to Yarl's Wood and opportunities to identify their vulnerabilities at that stage were limited. Serco reception staff did not usually use interpretation services, which undermined their ability to identify safeguarding issues (see key concern and recommendation 2.9 and paragraph 2.17).

2.22 Detainees had an asylum screening interview after they arrived at Yarl's Wood. The interview process had been abridged and, although detainees were asked questions about their health, they were not asked about their asylum claim, which meant they had fewer opportunities to disclose any safeguarding needs. Almost all screening interviews were conducted by telephone, which added to the problem because no visual assessment was possible and Home Office staff could not identify issues, such as trafficking indicators arising from detainees' appearance or demeanour. No NRM referrals had been made in the three months to 31 August 2020. During the same time period, only 45 detainees were identified as adults at risk, about 3% of the population held (23 at Level 1; 17 at level 2; and 5 at Level 3). (See key concern and recommendation 2.11.)

2.23 Serco staff generally had a limited awareness of safeguarding, trafficking processes and the adults at risk policy. They said that if they had concerns about a detainee, they would raise them with onsite immigration enforcement staff, who were the designated first responders for Yarl's Wood.

2.24 Serco staff opened vulnerable adult care plans for detainees considered to be at risk in detention. Plans were good when they were in place, but only 36 had been opened in the three months to 31 August 2020, most because of physical or COVID-19-related concerns. This represented about 2% of the population held during that period, which was unlikely to have reflected the needs of the population. In the three months to 31 August 2020, Serco only had records of nine adults at risk compared to 45 held by the Home Office (see paragraph 2.22), indicating inadequate communication of this information between agencies. Health care staff booked Rule 32 appointments, but several did not take place because the detainee was released before their appointment (see paragraph 2.51). The Home Office was not informed of Rule 32 appointments, and in these cases, would not have known that the detainee had raised concerns, for example, about possibly having been subject to torture. Local Home Office records suggested that four reports had been forwarded in the three months to 31 August 2020.

2.25 Self-harm was rare. ACDT plans were established for detainees who had been identified as being at risk of self-harm. The plans were comprehensive and demonstrated some good care. They were of a much better standard than 'warning forms' used in other STHFs. We saw evidence of staff communicating their concerns about detainee self-harm to the Home Office.

2.26 Despite the high rate of change in the detainee population, the atmosphere in the centre was calm. Detainees remained in their own unit most of the time. In the previous three months, there had been no incidents of violence, bullying or use of force reported. On two occasions during the previous three months, detainees were held separately from others for safety reasons. We examined the files and found that this measure had been appropriate and the individuals had been held for a suitably short period with adequate supervision. The centre continued to hold a monthly safer detention meeting, to monitor violence, self-harm and use of force. Almost all the detainees we spoke with said they felt safe at the centre.

2.27 Rules setting out expected standards of behaviour were included in the induction process, although during our visit some detainees had not had their induction two days after arriving. (See key concern and recommendation 2.10 and paragraph 2.18.)

2.28 Staff were available in the units to provide supervision and guidance, and the number of staff on duty at night had been increased to offer greater reassurance.

Safeguarding children

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

2.29 Chief immigration officer (CIO) assessments of detainees who had been assessed as adults in Dover were very poorly documented and did not demonstrate that their cases had been considered properly. Serco said they would only challenge the assessment if the detainee was very clearly a child, but could not remember having done so. (See also key concern and recommendation 1.12 and paragraph 1.36).

2.30 As a residential holding facility, no children should have been held in Yarl's Wood. However, in the three months to 31 August 2020, two unaccompanied minors were transferred from Tug Haven to Yarl's Wood without previously having been identified as such, and we saw two more cases during the inspection in September. One, who told staff he was 15, was very clearly a child. In both cases, there were no electronic records of the care the detainees had received prior to their arrival in Yarl's Wood. (See key concern and recommendation 1.12 and paragraph 1.36.) After they arrived at Yarl's Wood, staff called the local authority social services department and the boys were taken into care. In the three months to the end of August, three detainees who said they were children were assessed by CIOs to be adults.

2.31 Arrangements to safeguard detainees who said they were children at Yarl's Wood were sound, and children's care plans were good. Staff from the social services department attended the centre promptly.

Good practice

2.32 Care plans for vulnerable detainees (including potential children) and adults with health care problems were robust and better than we usually see in STHFs, as were ACDT plans. We saw vulnerable detainees being provided with good support.

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.

2.33 On average, detainees were held for just over 76 hours. The IS91 forms received by the centre were often inaccurate or not completed in full.

2.34 Staff in the detention engagement team had been redeployed to other activities. Immigration staff did not organise an induction for detainees and there were no surgeries where they could ask about their status. Many detainees we interviewed had still not received a screening interview after having been held for over a day. They had little understanding of what was happening to them or even where they were. Telephone screening interviews focused on gathering information and not on advising detainees on the asylum process. Many detainees who had had a screening interview still had a limited understanding of their position and what would happen next. (See key concern and recommendation 2.12.)

2.35 There were notices in the library advising detainees about obtaining legal assistance. There was no duty legal advice surgery. Welfare staff provided detainees with contact details of solicitors, but detainees told us they did not understand what they were or did not know how to make use of them given language barriers. None of the detainees we interviewed knew how to access legal support.

Recommendation

2.36 Detainees should receive comprehensive information on how to access legal support.

Respect

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.

2.37 The centre was clean and in good condition, despite the high turnover of detainees. Rooms did not feel oppressive and were sufficiently spacious, well ventilated and well furnished. Detainees could store valuable items securely. Although rooms were prepared for two people, the reduced detainee population enabled all detainees to have a room to themselves. All units had laundry rooms so that detainees could wash their own clothes.

2.38 Catering arrangements were adequate. Hot meals were always served and cultural and dietary needs could be catered for. All units had their own dining rooms, although to ease any concerns regarding social distancing, detainees could also take their meals to their rooms. Staff monitored non-attendance at meal times and followed up detainees to encourage them to eat. The shop provided snacks and other items that detainees could purchase to supplement the meals provided.

2.39 An adapted regime was in place to enable better social distancing at the centre. It still enabled most detainees to move around the centre, although reasonable restrictions were in place to manage the risks of COVID-19. Detainees spent most of their time in their own units as a result. However, they were never locked behind their doors and all had keys to their own rooms.

2.40 All detainees had access to activities and distractions to occupy themselves. Some of them were in individual units while others were centrally located. They included gym facilities, computer access, library provision (including books in languages other than English), games rooms and games consoles. Detainees could also borrow DVDs from the library to watch in their rooms. All units had their own well-maintained outside exercise areas, which had some exercise equipment, benches and seating.

2.41 A teacher was on site and tried to delivery some activities that were relevant to the short-term population.

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.

2.42 During our visit we saw many positive interactions between staff and detainees, and almost all the detainees we spoke with were positive about their treatment at Yarl's Wood. However, there was almost no use of professional interpretation services once detainees had been through the reception process. (See key concern and recommendation 2.9.)

2.43 There had been no recorded complaints from detainees held at Yarl's Wood under STHF rules in the previous three months. Information about how to make a complaint was

included in the induction process, but some detainees did not receive an induction before leaving the centre (see paragraph 2.19). Complaints forms were available in the laundry room in each unit, in a range of languages, although they were not replenished frequently enough to respond to the rapidly changing population and in one unit we found no copies in Farsi, even though this was the single most spoken language at the time.

2.44 The centre identified detainees with protected characteristics during the reception process, although a decision had been taken to refrain from asking about detainees' sexual orientation for reasons that were not clear. The centre continued to hold a monthly equality action team meeting. Almost all staff at the centre had recently completed training on equality and diversity.

2.45 Detainees with a disability or who needed assistance with everyday tasks had supported living plans. Those we examined generally demonstrated appropriate care and support. During our visit, none of the detainees had been assessed as needing a personal emergency evacuation plan.

2.46 The chaplaincy operated an open-door policy to support detainees to practise their faith and there was either a Muslim or Christian chaplain on site every day. Measures to keep detainees safe from COVID-19 while practising their faith included holding Friday prayers in the spacious sports hall and providing disposable prayer mats that could be used in the unit prayer rooms or in detainees' rooms.

Health care

Expected outcomes:
Detainees' health care needs are met.

2.47 The conscientious health team had responded well to Yarl's Wood new temporary role as an STHF for men. The team provided a good health service within a short timeframe of up to five days for this transient population.

2.48 Northamptonshire Healthcare NHS Foundation Trust (NHFT) provided health services. The health team, centre staff, Public Health England (PHE), NHS England and the Home Office worked effectively together to manage the risks related to COVID-19. A nurse checked detainees' temperatures on the coaches that had arrived from Dover. Any detainee displaying COVID-19 symptoms used a separate entrance to the centre. A protective unit was in place, where symptomatic detainees were isolated and tested promptly. No detainee had tested positive for COVID-19 since the centre had become an STHF. Some reception practices undermined this positive work (see paragraph 2.16).

2.49 There was a good supply of PPE and health staff had been fit-tested for FFP3 masks (medical grade respirator masks). Emergency equipment had been updated in line with current guidance.

2.50 Staffing levels had been maintained, despite some vacancies due to COVID-19. However, at times the increase in the number of detainees arriving at and leaving the centre had put intense pressure on the health team. Despite some delays, the team continued to carry out face-to-face health screenings for everyone, identifying potential risks and effectively following up on detainees' health needs. Health staff made good use of telephone interpretation services during initial screenings and follow-up appointments.

2.51 All detainees were offered a GP appointment within 24 hours of their arrival and anyone with an immediate health need or a long-term condition was prioritised. During their short

stay, a few detainees had needed to attend hospital, which was arranged. Detainees requiring a Rule 32 assessment were identified and assessments booked but due to their brief length of stay, several were not undertaken with the detainee leaving the centre before their appointment took place. These identified needs were not routinely being conveyed to the Home Office, which could have affected any future asylum claims.

2.52 Medicines were well managed and overseen by a pharmacist, who visited the centre regularly and supported the two pharmacy technicians based at Yarl's Wood. Several processes had been established to ensure medicines were available promptly and administered safely. This included increasing emergency stock medication, such as antibiotics, inhalers and creams. An in-possession medicine risk assessment was completed on arrival and if the detainee had any medication with them, it was checked and reconciled.

2.53 Detainees requiring a referral to the mental health team were identified at reception or during their brief stay. The two mental health nurses responded swiftly to urgent needs and attendance at ACDT reviews was prioritised. Detainees had access to a psychiatrist, and a psychologist and assistant psychologist had just joined the team. Nobody had required a transfer to a mental health facility under the Mental Health Act.

2.54 A GP with specialist skills and the substance misuse nurse on the team saw detainees with substance misuse issues. The need for opiate substitution therapy was low, but appropriate assessments and monitoring were undertaken.

2.55 Emergency dental treatment, including antibiotics and pain relief, was available from a dentist and dental nurse from Time for Teeth Limited, one day a week. The dentist was multilingual, but there was no access to telephone interpretation within the suite to aid communication with detainees whose language he did not speak. The small dental suite met infection control standards and dental equipment was well maintained and serviced regularly.

2.56 A nurse saw all detainees before they left the facility. They checked their temperature and provided a discharge summary of any health interventions and up to 14 days' prescribed medication if necessary.

Recommendation

2.57 Health care staff should inform the Home Office of all detainees identified as requiring Rule 32 assessments, including those whose assessments are not undertaken because they have left the centre before their appointment takes place.

Preparation for removal and release

Communications

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

2.58 Detainees were able to retain their own mobile phones if they did not have cameras or internet access. However, in practice this rarely occurred as most phones were confiscated either at Dover by Home Office officials (see paragraph 1.67), or placed in detainees' stored property by centre staff on arrival at Yarl's Wood.

2.59 Mobile phones were loaned to detainees on arrival but we spoke to many who either did not have phone numbers for their family and friends or did not understand how to use the phones provided. All detainees received £1 in phone credit and a £5 grant, which they could use to buy more credit at the centre shop.

2.60 The demand for social and legal visits had declined significantly, but visits could be facilitated if required. A group of volunteers, Yarl's Wood Befrienders, no longer visited the centre, but they were exploring options to return and support detainees.

2.61 Detainees had access to the internet and email through a central information technology (IT) suite and smaller IT rooms in some units. Skype was available through the library, but was seldom used. Social media platforms commonly used for contacting family and friends were not accessible, which was an inappropriate restriction.

Recommendation

2.62 Detainees should be permitted to access social networking sites.

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.

2.63 Detainees usually spent up to five days at the centre before being granted temporary admission into the country and being escorted to Home Office-approved accommodation. The number of detainees leaving the centre had increased and over 800 left in August 2020.

2.64 Owing to the large number of detainees leaving the centre on any given day, the decision had been taken to use the large social visits room as a central discharge point. This was a sensible measure, which allowed for social distancing, and provided a better departure location than reception holding rooms. Detainees had their personal property and money returned to them on their release and received a medical discharge letter and any prescribed medication.

2.65 However, the process was undermined by unnecessary delays and, in some cases, a lack of communication between escort contractor, the Home Office and centre staff. For example, we observed 40 detainees being brought to the discharge area and then not being released

for onward escort for over three hours. This caused detainees to become restless and agitated.

2.66 Detainees we spoke with did not know where they were being discharged to and release paperwork we viewed simply stated a geographical area, such as the 'north east' with the precise location yet to be confirmed. This was unhelpful and meant centre staff could not provide detainees with any information about their onward destinations and detainees were unable to inform their family and friends in advance of where they were going.

2.67 Coaches we viewed, were generally suitable, except toilets were locked and not in use. This was apparently standard practice, but centre managers were not aware of it, nor was it raised with detainees before they boarded the vehicles so that they could make use of the centre's facilities prior to departure. Coach drivers insisted that all detainees sat at the rear of the vehicle, which did not allow for social distancing.

Recommendations

2.68 The Home Office, escort contractor and centre staff should communicate effectively with one another to ensure that the discharge process for detainees is prompt.

2.69 Detainees should receive information about their onward destination in a language they understand before their release so they can inform family and friends.

2.70 Detainees should have access to adequate toilet facilities during their journey from the centre.

Section 3. Lunar House

Task of the establishment
To hold immigration detainees following arrest or reporting and before transfer to residential detention.

Location
Croydon

Name of contractor
Mitie Care and Custody

Last inspection
3 May 2016

Escort provider
Mitie Care and Custody

Summary

3.1 In the three months to the end of August 2020, 427 detainees had arrived at Lunar House from Tug Haven. All detainees received an induction and we were told interpretation was used, but welfare interviews were not carried out in private.

3.2 Families, pregnant women and anyone identified as vulnerable were held in an appropriate family room. Facility staff had a reasonable awareness of safeguarding procedures. Care plans were opened for all children entering the facility. There had been no instances of self-harm or use of force in the previous three months.

3.3 The average length of detention in the previous three months was just under 11 hours and the longest was over 29 hours. Children were rarely held and if they were, they generally only stayed for short periods of under an hour. However, the only unaccompanied child held in the previous three months was detained for over 22 hours while awaiting the arrival of a social worker.

3.4 Most asylum screening interviews were undertaken in person, using a telephone interpreter. Detainees were informed about bail and the asylum process during the screening interview. A limited amount of information about how to access a solicitor was on display in the holding room in a variety of languages.

3.5 The holding rooms were bright, clean and well ventilated. There was a plentiful supply of blankets and pillows, but the facility did not provide a suitable sleeping environment. Detainees could not go outside. Staff were aware of potential health concerns, but there was no medic on site.

3.6 There were telephones in the holding rooms and detainees could be given a phone and a SIM card. Home Office staff used interpreters to release detainees on bail and explain where they were going. They received literature on the asylum process in English.

Safety

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.

3.7 In the three months to August 2020, 427 detainees had arrived at Lunar House from Tug Haven. Ninety-four per cent of them were male, most of whom were travelling individually, but a small number of single women and families had also arrived.

3.8 Staff at Lunar House told us that detainees were brought directly inside from the coaches on arrival. However, if several coaches arrived simultaneously, some detainees would be asked to wait on board to stagger arrivals at the facility. Centre staff told us that detainees arrived in dry clothing, and that they had not experienced any instances of detainees with significant injuries or well-being concerns arriving at Lunar House.

3.9 IS91 forms were completed at Tug Haven and shared with staff at Lunar House. We were told that IS91 forms were often incomplete. Detainees' names regularly failed to be recorded, and personal details were often missing or recorded incorrectly. Centre staff told us this could cause confusion when trying to identify detainees and keep accurate records. Staff at Lunar House were unable to say if detainees were routinely handed an IS91R form, outlining the reasons for their detention. Lunar House staff also told us that they would have expected staff in Dover to have told detainees why they were being detained and where they were to be taken, and would not routinely explain this to detainees (see paragraph 1.39).

3.10 Detainees received an induction from staff, which provided basic information about the centre and included a brief welfare check. Staff told us that a telephone interpretation service would usually be used for this. The induction area that we were shown was in a busy corridor outside the holding room, and was not private. After arriving, detainees were routinely offered the use of a phone, food and drink and amenities, such as blankets and pillows.

Safeguarding adults and personal safety

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.

3.11 Families, pregnant women and anyone identified as vulnerable were routinely placed into the smaller family room. The room was large enough for several families. Centre staff said they avoided placing vulnerable men into the room when it was occupied by women and families. A female member of staff was routinely on shift.

3.12 A member of centre staff was always behind the observation panel when detainees were in the centre. Staff at Lunar House had a reasonable understanding of basic safeguarding procedures, and a good knowledge of how to escalate concerns if they wanted to report

any. Hourly checks took place on all adults held in the facility. However, managers reported that staff had not been trained in mental health first aid and told us that identifying less visible safeguarding concerns relating to mental health or well-being was a challenge.

3.13 In the three months to the end of August 2020, no vulnerable adult warning forms had been completed at Lunar House and no safeguarding referrals to the Home Office had been made.

3.14 During the same period, staff at Lunar House had recorded no incidents involving self-harm or the use of force.

Safeguarding children

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

3.15 Children were rarely held at the facility. Ten accompanied children had arrived at Lunar House in the three months to the end of August 2020. Home Office data showed that one unaccompanied minor was held at the facility for over 22 hours before being admitted into the country. We were told this was because of a delay in the arrival of a social worker.

3.16 Children and their families were held separately from single male detainees, and their cases were prioritised. Children were generally held for short periods of less than one hour, and in the three months to the end of August 2020, no accompanied children had been held at Lunar House for longer than 12 hours.

3.17 Children detained at the facility were given welfare checks four times an hour. Every child was also placed on an individual care plan, which noted their needs and any safeguarding concerns. Managers told us that this had initially proven challenging, as Lunar House was not routinely used to detain children, but that staff had gained confidence in dealing with minors. During our visit, we were shown a template for children's care plans, but were unable to review any completed plans.

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.

3.18 Centre staff told us that they attempted to process and bail detainees on the day they had arrived. However, those who arrived late at night would often remain at Lunar House overnight and were processed early the next morning. In the three months to the end of August 2020, the average length of detention was 10 hours and 52 minutes. The longest single period of detention was 29 hours and 23 minutes. Half of detainees had been held for over 12 hours, but only one person had been held for over 24 hours.

3.19 Lunar House operated with a reduced staff on weekends, so managers often requested that no detainees be sent there on Friday afternoons, if they were not sure they could process their cases promptly on Saturday morning.

3.20 An abridged asylum screening interview was used at Lunar House. Most detainees were interviewed in person during which telephone interpretation was routinely used. We were

told that detainees were informed about the terms of their bail and the next stage of the asylum process in the screening interview, but we could not observe any interviews to confirm this.

3.21 A limited amount of information about how to access a solicitor and legal aid was displayed in the holding room in a variety of languages.

Respect

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.

3.22 The holding rooms at Lunar House were bright, clean and well ventilated. The newer overflow holding room was clean and newly decorated. Drinks, snacks and microwave meals were available. Televisions and some magazines – mostly in English – were provided. A small number of children's toys was available.

3.23 The main holding room could hold 32 people, and the overflow room another 30. Detainees arriving from Dover were considered to be part of the same COVID-19 'bubble', which meant social distancing was not regarded as being necessary. Staff we saw at the facility were not consistently socially distancing, although there were no detainees present during our visit.

3.24 There was a plentiful supply of blankets, pillows and towels. However, the main holding rooms did not have sofas or beds. The family room had sofas which were more suitable for sleeping on. The new overflow room had not yet been installed with a TV or a place where detainees could easily obtain snacks (although snacks were readily available from staff), and children were therefore not held in this room. Detainees could not go outside for fresh air.

3.25 There were no showers, but the toilets were clean and the women's toilets had freely available sanitary products.

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.

3.26 Complaints and feedback forms were displayed in the holding room and were available in several languages. Staff and managers told us that they had not received any complaints from detainees in the three months to the end of August 2020.

3.27 Detainees could freely access religious materials such as prayer mats. However, there was no separate area for religious practices to take place.

3.28 No medic was on site at Lunar House and detainees did not receive health screenings, as they did not generally remain at the facility for more than 24 hours. However, staff told us they were mindful of the journeys that detainees had made, and had been 'more cautious' about health, having taken a small number of detainees to hospital for problems, such as abdominal pain. None of these had been serious incidents, staff said

Preparation for removal and release

Communications

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

3.29 Each holding room had a telephone, which detainees could freely access, and detainees were provided with a phone and a SIM card if their own mobile phone had been removed from them. We were not shown any computers or means of accessing the internet in the holding rooms.

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.

3.30 Home Office staff used interpreters to release detainees on bail and explain where they were going. They received literature on the asylum process, but it was in English.

3.31 Most detainees bailed from Lunar House were sent to short-term accommodation in London, where they would stay for a few days before being dispersed elsewhere in the UK.

Section 4. Summary of recommendations

Tug Haven, Kent Intake Unit and Frontier House

Recommendations to the Home Office

Safeguarding children

4.1 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. (1.13)

Leaving the facility

4.2 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. (1.75)

Recommendations to the Home Office and facility contractor

Arrival and early days in detention

4.3 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 mobilisation of resources whenever necessary. (1.10)

4.4 Detainees arriving in the UK should be able to make initial contact with their family and friends by telephone free of charge. (1.11)

Safeguarding adults and personal safety

4.5 The Home Office should promptly assess and meet the needs of vulnerable detainees. Care plans should be in place for all detainees at risk. (1.12)

Legal rights

4.6 Detainees should only be held overnight in non-residential holding facilities without access to fresh air and exercise in exceptional circumstances and reviews of their detention should be timely and thorough. (1.14)

Health care

4.7 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. (1.15)

Communications

4.8 Detainees should have access to the internet, including email, video calling and social networks, unless an individual risk assessment indicates otherwise. (1.69)

Recommendations to the facility contractor

Arrival and early days in detention

4.9 Initial interviews should take place promptly, be held in private and focus on identifying safeguarding concerns as well as detainees' immediate welfare needs. (1.23)

Yarl's Wood

Recommendations to the Home Office

Safeguarding adults and personal safety

4.10 The Home Office should ensure that detainees' vulnerability is thoroughly assessed at the earliest stage and that their identified needs are met. (2.11)

Legal rights

4.11 Onsite immigration staff should offer detention surgeries to detainees. (2.12)

Communications

4.12 Detainees should be permitted to access social networking sites. (2.62)

Recommendations to the Home Office and escort contractor

Leaving the facility

4.13 Detainees should have access to adequate toilet facilities during their journey from the centre. (2.70)

Recommendations to the Home Office, escort contractor and facility contractor

Leaving the facility

4.14 The Home Office, escort contractor and centre staff should communicate effectively with one another to ensure that the discharge process for detainees is prompt. (2.68)

Recommendations to the Home Office and facility contractor

Arrival and early days in detention

4.15 Reception processes should be swift and safe. In particular, vehicles leaving Dover should be staggered and facility staff informed of their estimated time of arrival. (2.20)

Leaving the centre

4.16 Detainees should receive information about their onward destination in a language they understand before their release so they can inform family and friends. (2.69)

Recommendations to the facility contractor

Arrival and early days in detention

4.17 Detention staff should use professional interpretation whenever necessary to ensure communication with detainees is effective. (2.9)

4.18 The centre should ensure that all detainees have a prompt and effective induction in a language they understand. (2.10)

Legal rights

4.19 Detainees should receive comprehensive information on how to access legal support. (2.36)

Health care

4.20 Health care staff should inform the Home Office of all detainees identified as requiring Rule 32 assessments, including those whose assessments are not undertaken because they have left the centre before their appointment takes place. (2.57)

Section 5. Appendices

Appendix I: Inspection team

Hindpal Singh Bhui	Team leader
Martin Kettle	Inspector
Rebecca Mavin	Inspector
David Owens	Inspector
Kellie Reeve	Inspector
Deri Hughes-Roberts	Inspector
Kam Sarai	Inspector
Fiona Shearlaw	Inspector
Nadia Syed	Inspector
Maureen Jamieson	Health inspector
Paul Tarbuck	Health inspector

Appendix II: 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. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Note, only recommendations made at the last Kent Intake Unit inspection in 2016 have been reviewed. No previous recommendations for Yarl's Wood were reviewed as the centre was now temporarily operating under short-term holding facility (STHF) rules.

Safety

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

Recommendations

Induction interviews should be conducted in private, focus on the welfare of detainees and incorporate all elements of the induction checklist. (1.6)
Partially achieved

Detainees should be offered a free telephone call on arrival. (1.7)
Not achieved

Staff should be trained in safeguarding adults at risk, including the Home Office's adults at risk policy, and should use care plans for all adult detainees at risk. (1.14)
Partially achieved

Suitable separate facilities should be provided for receiving children, including those with families, and vulnerable adults. Unaccompanied children should never be held with unrelated adults. (1.23)
Not achieved

All detainees claiming to be children should undergo a Merton-compliant age assessment by social services. (1.24)
Not achieved

Detainees should be given written reasons for detention (IS91R) promptly in a language they can understand, and should have ready access to a telephone and a fax machine to contact or send documentation to legal representatives. (1.32)
Not achieved

All detainees, including children, should be held in the facility for the minimum period possible. (1.33)
Not achieved

Respect

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

Recommendations

The holding rooms should be suitable for the designated number of detainees, who should have ready access to showers, lockable toilets and hot drinks. (1.38)
Not achieved

The holding rooms should have appropriate foreign language reading material, and those held for longer periods should have access to fresh air. (1.39)
Not achieved

DCOs should receive regular training that helps them to understand the needs of refugees and asylum-seekers. (1.44)
Achieved

Detainees should receive health care screening on arrival. (1.45)
Partially achieved

Custody staff should be trained how to use the automated external defibrillator and know where it is kept. (1.46)
Partially achieved

Preparation for removal and release

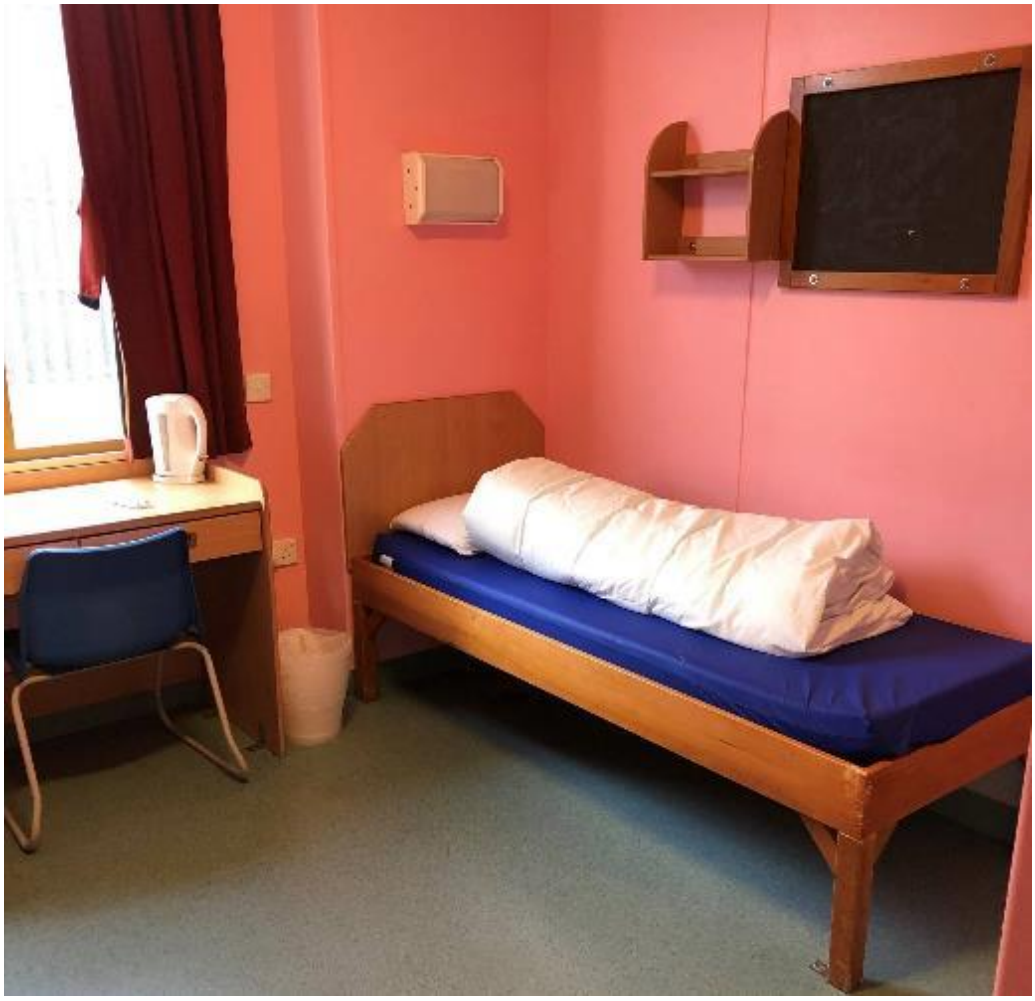
Detainees are able to maintain contact with the outside world and be prepared for their release, transfer or removal.

Recommendation

Detainees should have supervised access to the internet, email and Skype facilities. (1.50)
Not achieved

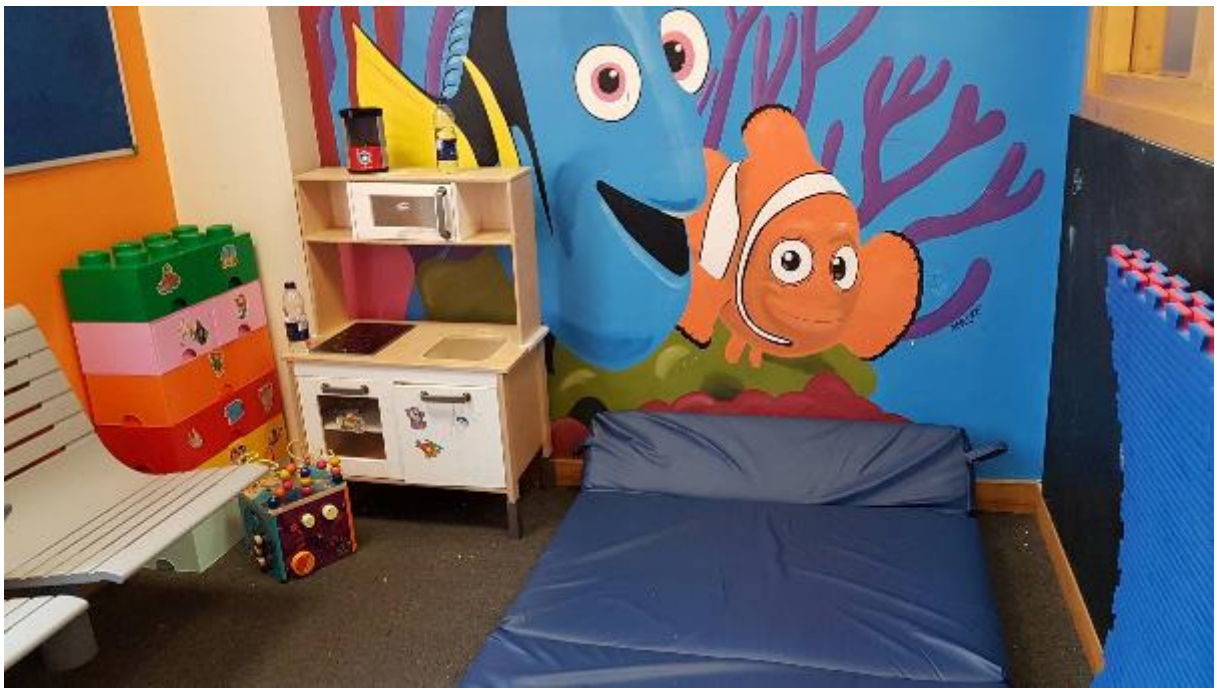
Appendix III: Photographs

Frontier House – holding room with camping mattresses on the floor

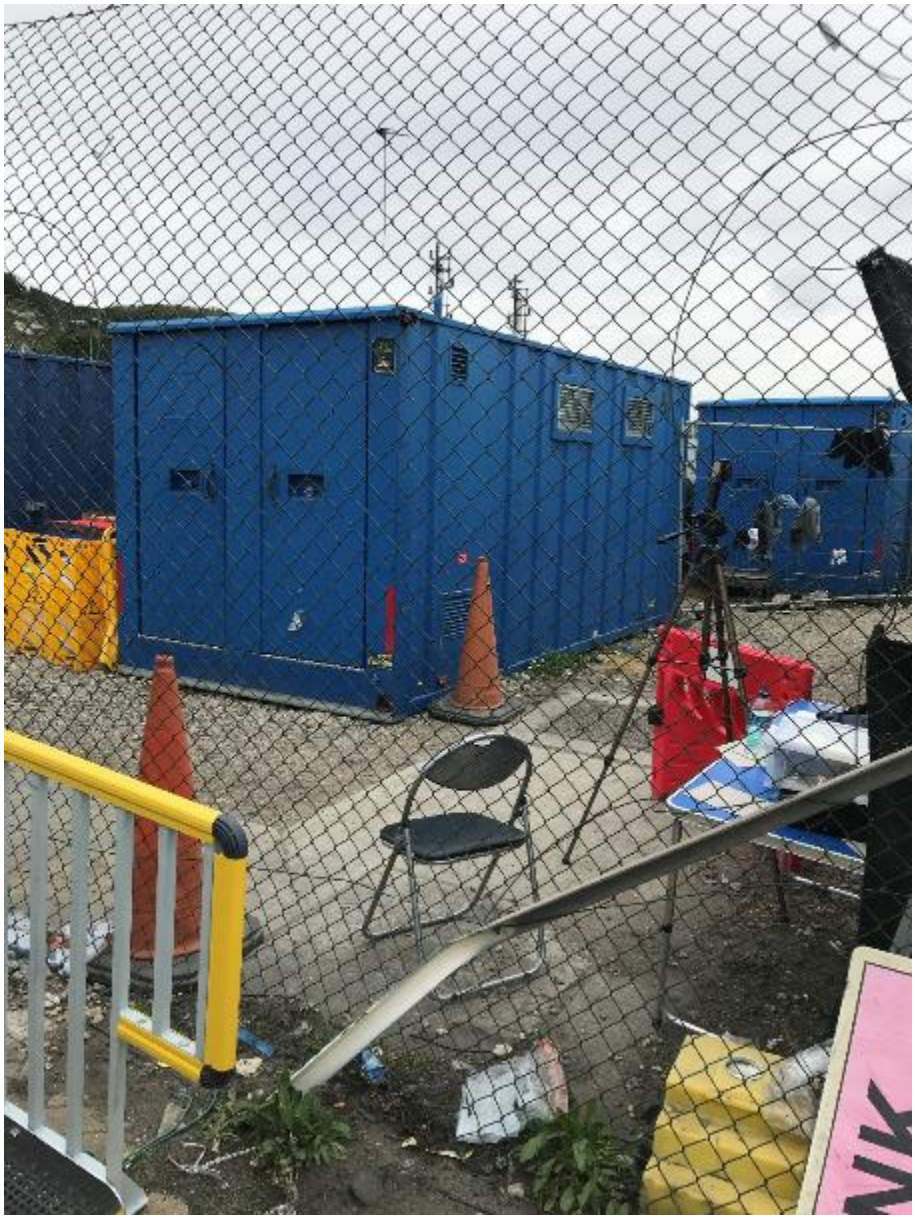


Yarl's Wood – bedroom

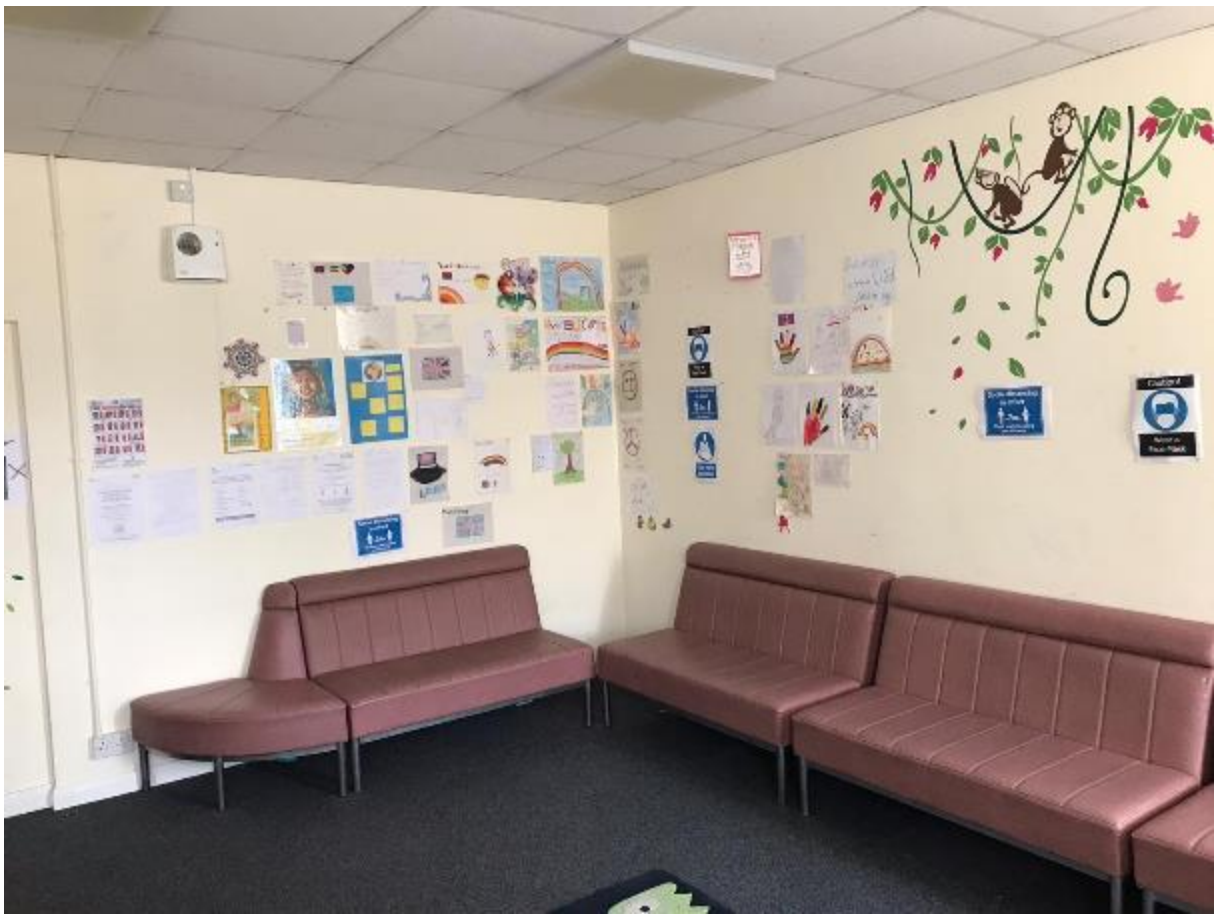
Yarl's Wood – social visits area set up as a departure lounge



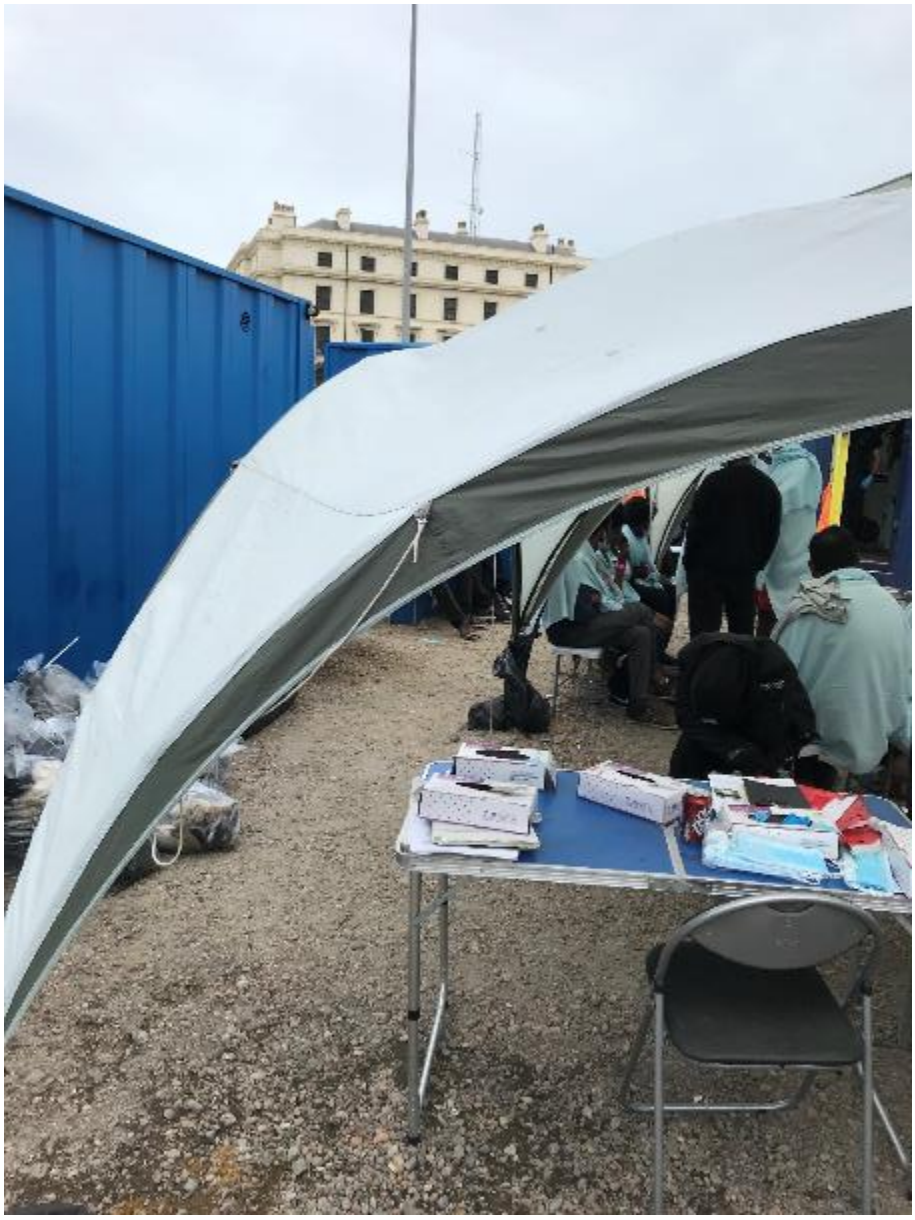
Kent Intake Unit – family room



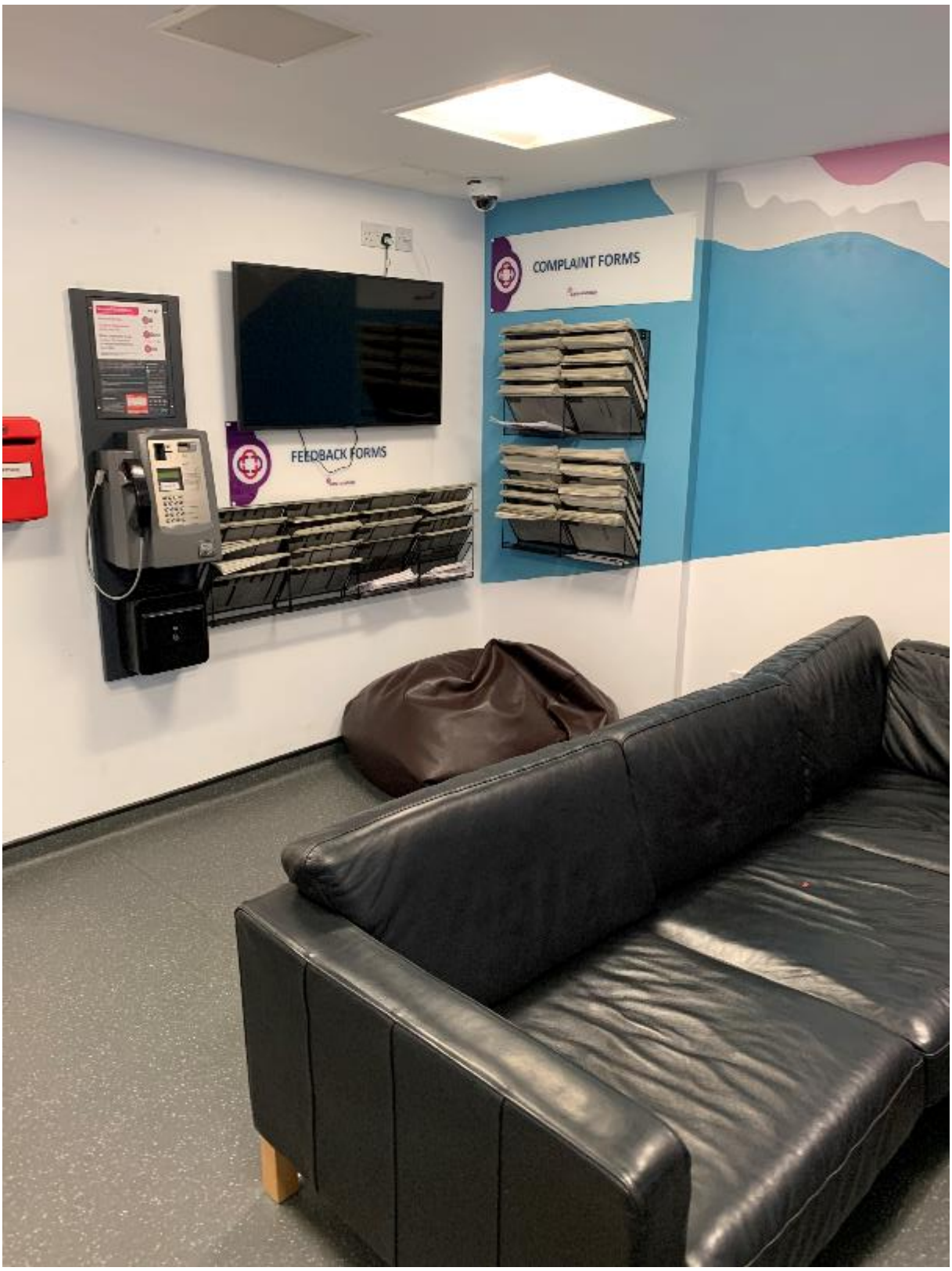
Tug Haven - container unit



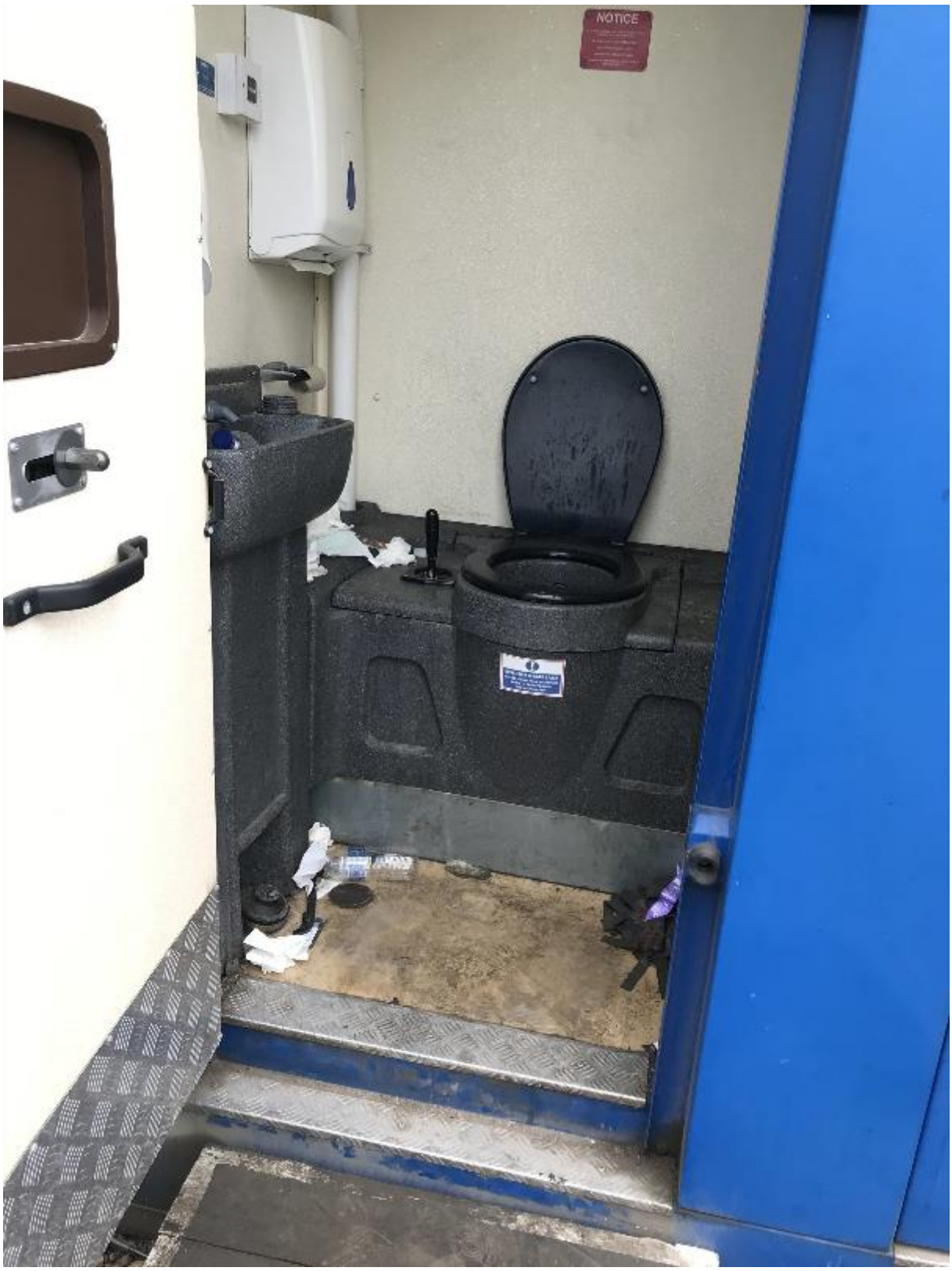
Kent Intake Unit – Refugee Council room for unaccompanied children



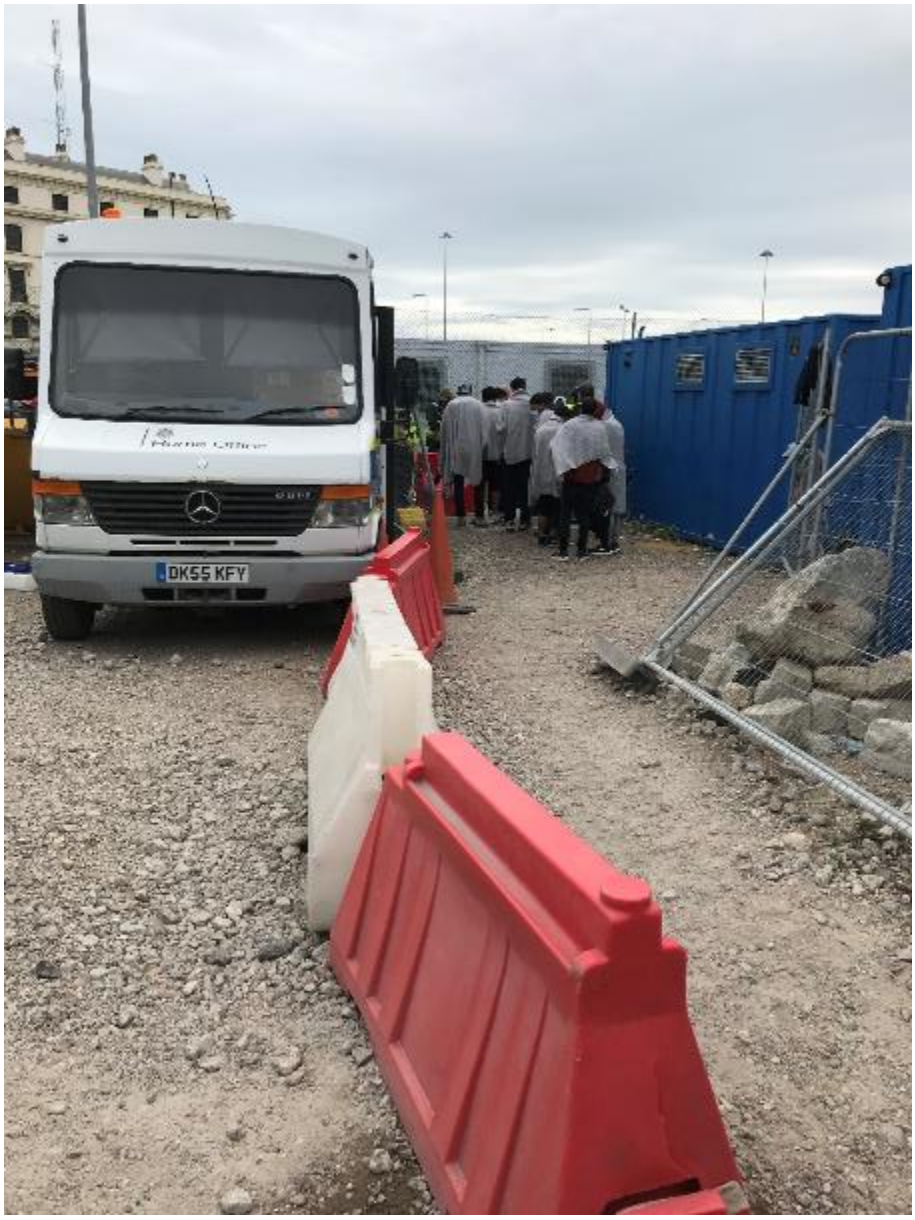
Tug Haven - gazebo



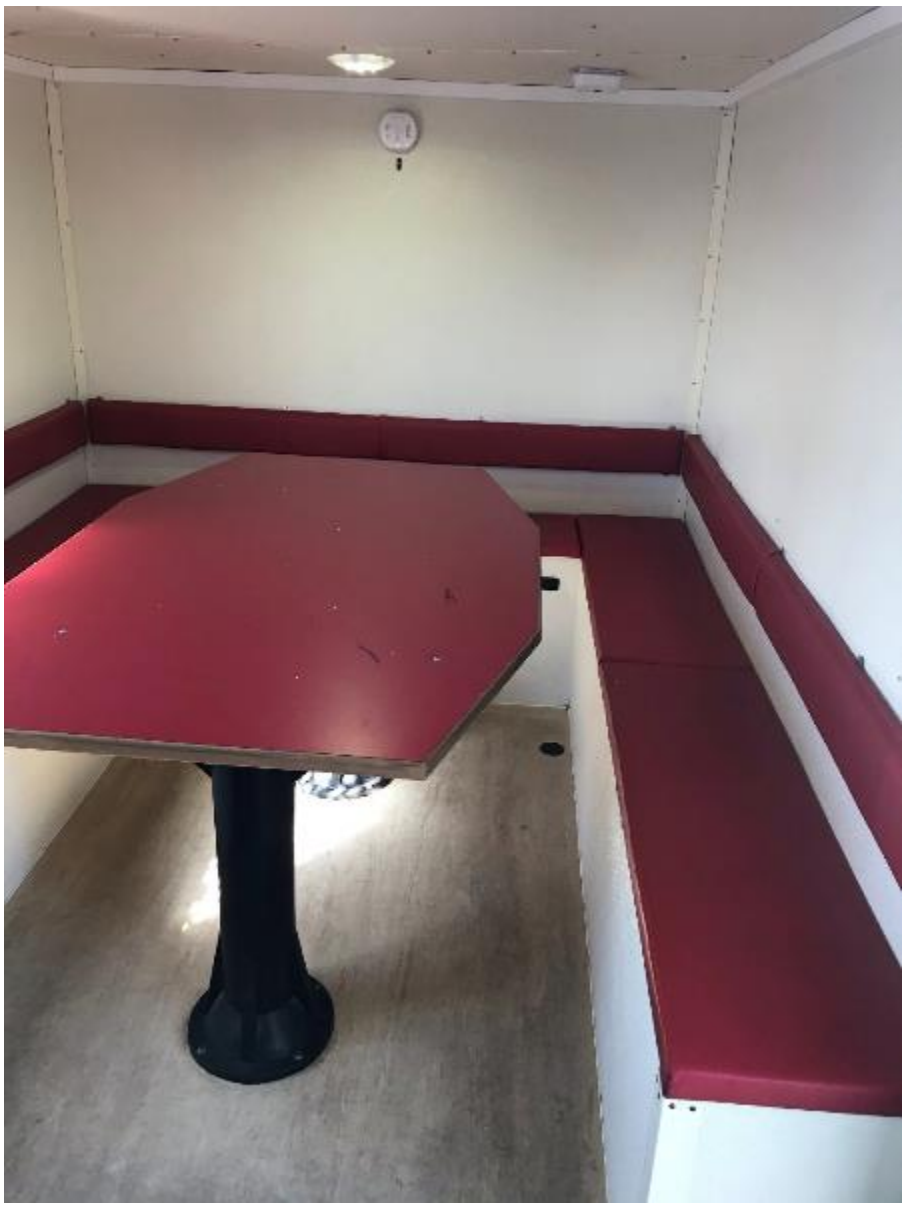
Lunar House – holding room



Tug Haven – toilet



Tug Haven – detainees walking through site



Tug Haven – inside of container unit