Report on a scrutiny visit to

# Harmondsworth immigration removal centre

by HM Chief Inspector of Prisons

**15–16 and 23–24 March 2021**

# Contents

# Introduction

Harmondsworth immigration removal centre (IRC) is Europe's largest detention facility and can hold up to 676 adult male detainees. Close to Heathrow Airport in west London, it is run for the Home Office by Care and Custody, a division of the Mitie Group. During this scrutiny visit, the centre held under 100 detainees. The numbers had declined markedly from March 2020 as a result of the COVID-19 pandemic, partly because, if there is no reasonable prospect of removal, immigration detention ceases to be lawful. Since February 2021, two units in the centre had also been used on an occasional basis as a short-term holding facility to accommodate people arriving across the English Channel in small boats.

Reduced detainee numbers, the ability to accommodate them in single cells, effective cohorting procedures and good partnership working between centre managers and health care and Home Office staff, had all helped to limit the incidence of COVID-19 in the centre. There had been only eight confirmed detainee cases since the start of the pandemic and subsequent measures to prevent further transmission of the virus had been effective.

The centre had taken advantage of the relatively high staff-to-detainee ratio to improve resourcing of key areas, such as safer detention and equality and diversity. There was little violence and governance of force was good. There was a high level of vulnerability in the population and a substantial amount of self-harm. Most detainees subject to assessment, care in detention and teamwork (ACDT) procedures for those at risk of suicide or self-harm in IRCs were reasonably positive about the care staff provided, although we identified some shortcomings in individual case management.

It was a concern that some detainees had been held for very lengthy periods, often, we were told, as a result of systemic problems with the provision of suitable release accommodation. Eight people had been in detention for over a year and 26 for more than six months. Yet the majority (58%) were simply released after a potentially damaging period of detention. Many detainees had complex needs and a very high percentage – about 45% – were assessed by the Home Office as being at the two higher levels of risk under the adults at risk in detention policy (see Glossary of terms). More detainees than we have seen before were assessed at level 3, the highest risk level.

Health care provision was good and the mental health team met the needs of detainees particularly well. There was significantly more translated information than at the last full inspection in 2017, especially about health matters.

Detainees could access a good and improved range of activities each day despite some proportionate restrictions intended to support COVID-19 safety. Those who attended activities told us they provided some relief from the stress of detention, although take-up was low and promotion was not good enough.

More could have been done to improve detainees' treatment and conditions, especially in relation to the physical environment. The centre was prison-like and detainees were still locked in their cells for significant periods. Living areas were rundown and the general environment was bleak and dispiriting. Toilets in many cells were in a particularly poor condition and managers told us they lacked investment for the required refurbishment. Many detainees complained about the food and we agreed that it was of generally low quality.

Overall, the centre had adapted well to the challenges of the pandemic and we found that centre staff cared for detainees reasonably well. However, Harmondsworth needed significant refurbishment to bring it up to an acceptable standard. The lengthy detention of people with substantial vulnerabilities who had, in some cases, been declared unfit for detention, was also a serious concern.

**Charlie Taylor**
HM Chief Inspector of Prisons
April 2021

# About Harmondsworth immigration removal centre

**Task of the establishment**
To detain people subject to immigration control.

**Certified normal accommodation and operational capacity (see Glossary of terms)**
Detainees held at the time of this visit: 93
Baseline certified normal capacity: 676
In-use certified normal capacity: 676
Operational capacity: 635

**Name of contractor**
Mitie Care and Custody

**Key providers**
Escort provider: Mitie Care and Custody
Health service commissioner and providers: Central and North West London NHS Foundation Trust
Learning and skills providers: Mitie Care and Custody

**Location**
Colnbrook By-Pass, Harmondsworth, West Drayton, UB7 0HB

**Brief history**
Harmondsworth opened as a purpose-built immigration removal centre (IRC) in 2000. In 2006, following a major disturbance, two of the four original residential units were put out of commission. In August 2010, four residential units and a six-bed separation unit were built to category B prison standards. In 2013, a further 46 beds were added to the Dove residential unit. In September 2014, Harmondsworth and the neighbouring Colnbrook IRC were placed under the same management and the two centres became known collectively as the Heathrow IRC. However, they remain discrete sites and, in light of their size and complexity, they are inspected separately. In 2015, additional beds in the Dove unit increased the centre's capacity to 676. Since 2021, the Cedar and Dove units have been used as a short-term holding facility for those who had crossed the English Channel on small boats.

**Short description of residential units**
Harmondsworth has seven residential units, Ash, Beech, Cedar, Dove, Elm, Fir and Gorse. Elm is a six-bed separation unit and Ash is the induction unit. There is also an inpatient facility.

**Centre manager and date in post**
Paul Rennie, April 2018

**Leadership changes since last inspection**
Paul Morrison, September 2014–March 2018

**Independent Monitoring Board chair**
Karina Kielbinska

**Date of last inspection**
Short scrutiny visit: 12 May 2020
Full inspection: 1–20 October 2017

# Summary of key findings

## Key concerns and recommendations

S1 Key concerns and recommendations identify the issues of most importance to improving outcomes for detainees and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

S2 During this visit we identified some areas of key concern, and have made a small number of recommendations for the establishment to address.

S3 **Key concern:** Detainees were locked in their cells for an hour over lunch and during the night from 9.15pm. Such restrictions on free movement were inappropriate for a detainee population.

**Recommendation: Detainees should be able to live in an open environment and security restrictions should be proportionate to the risks posed. Detainees should not be locked in cells.**
(To the Home Office and centre manager)

S4 **Key concern:** Levels of vulnerability were high and a number of detainees assessed to be at risk of harm in detention had been held for too long. There were systemic problems in the provision of release accommodation for detainees who were considered unfit for detention and/or could not be removed.

**Recommendation: Detainees should be released promptly when there is no prospect of their removal within a reasonable period. The Home Office should resolve systemic problems with the provision of release addresses. There should be a time limit on the length of detention.**
(To the Home Office)

S5 **Key concern:** Living conditions in the units were below an acceptable standard. Persistent problems with pests, filthy cell toilets and broken and dilapidated communal showers were particularly problematic.

**Recommendation: Action should be taken to address longstanding problems with the living conditions in the centre. This should include developing a plan for eradicating pests and investing in the refurbishment of units, as well as further deep cleaning.**
(To the Home Office and centre manager)

S6 **Key concern:** The take-up of activity places was low. Not enough was done to make detainees aware of the benefits of participation or to encourage them to attend. Their learning and language needs were not assessed.

**Recommendation: Detainees should receive clear and detailed information about the activities available and the benefits of taking part in a format and language they understand. Their learning and English language needs should be assessed and considered when making referrals to education classes.**
(To the centre manager)

# Notable positive practice

S7 We define notable positive practice as innovative practice or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

S8 Inspectors found six examples of notable positive practice during this visit.

S9 **The centre had purchased several headsets, which gave detainees a virtual tour of the centre and provided some basic information. They were used to provide detainees with additional knowledge as part of the induction process.** (See paragraphs 1.1 and 2.5.)

S10 **The reinstatement of detainee consultation, particularly of those with protected characteristics, during the pandemic was positive, and minutes indicated that the process was constructive.** (See paragraphs 3.13 and 3.15.)

S11 **There was much more translated health information for detainees since the last full inspection. It included: a comprehensive induction pack with information about COVID-19 and advice on how to keep safe; helpful guidance on how to deal with stress and sleeping issues; mental health self-help guidance booklets; and useful information displayed in the health centre.** (See paragraph 3.26.)

S12 **The mental health team's reports to the Home Office regarding detainees' vulnerability (IS91RA Part C reports) were clear and thorough, and helped the Home Office to make informed decisions about their fitness for detention.** (See paragraph 3.35.)

S13 **Managers had devised and implemented efficient cohorting arrangements so that most activities could continue reasonably safely despite the COVID-19 restrictions.** (See paragraph 4.2.)

S14 **The centre had increased the number of creative activities on offer. They now included floristry, sugar craft cake decoration and balloon decoration, as well as model making, sewing and art. While the uptake was not as high as it should (or might) have been, detainees we spoke to found these activities absorbing and said they offered them relief from the worry and tension arising from their situation.** (See paragraph 4.5.)

# Section 1. Leadership and management

In this section, we report mainly on whether leaders and managers are responding effectively to the challenges of the pandemic, the proportionality of restrictions on activity and movement, whether recovery plans are in place and understood by staff and prisoners, the support provided to prisoners and staff, and the effectiveness of cohorting arrangements.

**1.1** Centre managers had successfully managed the risk of virus transmission in partnership with the Home Office and health agencies. There had been only a handful of positive cases since the start of the pandemic. Cohorting arrangements had proven effective and conditions in the reverse cohorting unit were at least as good as those in the main centre.

**1.2** Managers had focused well on informing detainees of the measures taken to protect them from COVID-19 and the reasons for the restrictions in place. Centre and health care managers had provided a good range of translated information and newly arrived detainees now received an innovative virtual reality induction delivered in several languages (see paragraph S9).

**1.3** Senior managers communicated effectively with staff. In our staff survey, 95% of staff who responded said they were kept informed of what was expected of them and 90% said they felt able to perform their duties to a satisfactory extent, despite COVID-19. Most staff (79%) also felt that reasonable steps had been taken to keep them safe.

**1.4** The establishment's recovery plan was largely aligned with the easing of community restrictions and was disseminated among staff during the inspection. Most of the staff who were aware of it, thought it was achievable. Given the stability of the centre and the success in limiting virus transmission, the recovery plan could, in some respects, have been more ambitious – for example, it was not obvious why some team sports were not permitted within the well-established detainee bubbles.

**1.5** Centre managers had taken advantage of the relatively high staff-to-detainee ratio, for example by rolling out restorative practice training and increasing staffing of the safer detention team (see paragraph 2.23). They had also made sure that key safety areas were governed well, such as the use of force (see paragraph 2.12) and protected detainees' access to an improved range of activities. Another notable area of progress was the strategic management of equality and diversity, which had been strengthened during the pandemic with useful monitoring and a range of consultation groups (see paragraphs 3.14 and 3.15).

**1.6** However, there was scope for more to be done with the resources available. For example, while consultation had improved and was valued, it was still limited to only one unit a month at best. Despite greater staff availability, detainees were still locked up in the middle of the day and overnight. (See key concern and recommendation S3.) Promotion and take-up of education facilities were limited. (See key concern and recommendation S6.) There had also been too little attention paid to improving living conditions in the centre. (See key concern and recommendation S5.)

**1.7** Since February 2021, the older units in Harmondsworth (Cedar and Dove) had been used as a short-term holding facility, accommodating people who had crossed the English Channel on small boats. Three groups of detainees had arrived before the inspection and one during it. While the Home Office and escort providers' coordination of the first arrival was poor, managers had quickly addressed the problem and subsequent arrivals, including the one that we observed, were managed efficiently (see paragraph 2.7).

# Section 2. Safety

In this section, we report mainly on arrival and early days in detention; Security, freedom of movement and personal safety, use of force and single separation; safeguarding; and legal rights.

## Arrival and early days in detention

**2.1** With the exception of detainees held in the short-term holding facility (see paragraph 1.7), new arrivals were received into the reception at the adjacent Colnbrook immigration removal centre (IRC). Detainees spent up to 21 days in a reverse cohort unit (see Glossary of terms) before being moved to one of the residential units at Harmondsworth. The reception was open for 24 hours, seven days a week, and there had been an average of 101 arrivals per month in the previous six months. As at previous inspections, detainees continued to arrive during the night.

**2.2** On arrival, a member of health care staff took detainees' temperature before they got off the bus. They were then taken into the reception and given a rub-down search and offered a lateral flow COVID-19 test. They were then given a mobile phone, a SIM card and additional clothing if required. Interviews with detainees did not take place in private, reducing the likelihood of them disclosing important information.

**2.3** Three-quarters of the detainees we interviewed said they were treated well or quite well in reception. The reception area was clean and spacious. It had one large holding room, which had been risk-assessed for six detainees. The holding room contained some useful information for detainees in a variety of languages. Hot drinks were available and staff offered detainees food. The centre's welfare officer met new arrivals shortly after their arrival to offer them assistance with their immediate needs (see also paragraph 5.3).

**2.4** Staff were aware of the professional interpreting service, but in our detainee interviews 25% said it had not been offered to them on their arrival (see paragraph 3.17).

**2.5** In a recent innovation, the centre had purchased virtual reality headsets, which provided newly arriving detainees with a tour of the centre and some basic information in six commonly spoken languages (see paragraph S9). Staff undertook first night welfare checks.

**2.6** Detainees received an induction booklet, which was available in a variety of languages. Those to whom we spoke who had been in the reverse cohort units were positive about their treatment and access to facilities.

**2.7** Two units at Harmondsworth had been designated as a short-term holding facility (STHF) for those arriving in small boats after they had crossed the English Channel. Prior to our visit it had been used for this purpose three times and we observed another group arriving. The first move from the port to Harmondsworth had been poorly organised – detainees were transported in several vehicles at the same time, many without completed paperwork, delaying their entry into the centre, and some had arrived in wet clothes. However, the process had improved since then. During the arrival we observed, detainees on the first coach had the correct paperwork, were all in dry clothing and were in the STHF within a couple of hours, although some then had to wait for some time to be allocated to their rooms. Centre staff were attentive and caring in reception and in the STHF.

## Security, freedom of movement and personal safety, use of force and single separation

**2.8** The centre's design and some of its procedures remained too prison-like. Detainees were locked in their cells for an hour at lunchtime and again at night from 9.15pm until 8.00am during the week and 8.30am at the weekend. This was an inappropriate restriction for a detainee population.

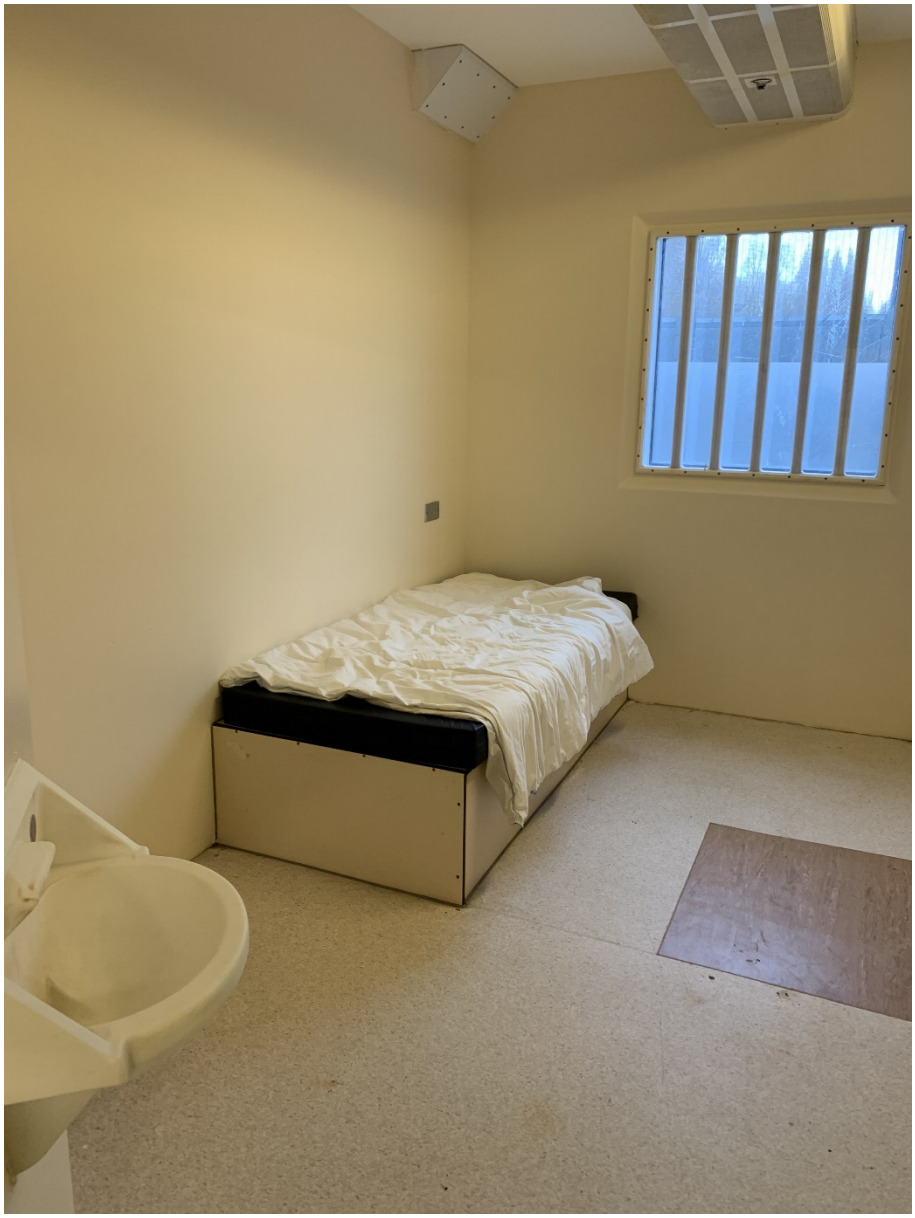
**2.9** In the previous six months, 236 security information reports (SIRs) had been submitted. The SIRs we examined were processed quickly and intelligence was communicated across the centre. Security committee meetings had continued to take place during the pandemic and centre staff were aware of the key threats and concerns.

**2.10** There was evidence that our previous concerns about detainees being excessively handcuffed during hospital escorts were being addressed. In our sample of cases, handcuffing was justified on the basis of clearly documented individual risk assessments. However, the paperwork did not demonstrate that the increased risk of COVID-19 transmission had been considered. Managers told us that personal protective equipment (see Glossary of terms) was routinely used but it had not been recorded in the cases we reviewed.

**2.11** The centre held many detainees who had mental health needs and some presented challenging behaviour. Despite this, safety was generally good and the atmosphere was largely calm. Of the detainees we interviewed, a quarter reported feeling unsafe and 33% said they would not report it if they were being bullied or victimised. Violence was uncommon; there had been seven assaults on detainees by other detainees and one assault on staff in the six months to the end of February 2021. Most incidents were minor. Investigations into the small number of more serious assaults were good, but there was insufficient evidence of enquiry in some of the low-level incidents we reviewed.

**2.12** In the previous six months, force had been used 30 times. Documentation on the use of force indicated it was proportionate and used as a last resort in response to violent or non-compliant behaviour. Governance of the use of force had continued during the pandemic and was good. A monthly use of force committee meeting reviewed incidents and identified trends. Managers investigated poor practice and lessons were learned. Allegations of inappropriate use of force were taken seriously and investigated thoroughly. Disciplinary action against staff had been taken in some instances.

**2.13** Separation under detention centre rule 40 (in the interests of safety and security) had been used 37 times in the six months to the end of February 2021. Rule 42 (separation for violent and refractory detainees) had been used twice in the same period. The average length of separation was high at about 37 hours. However, this figure was skewed considerably by a small number of particularly violent and unpredictable detainees, who were justifiably separated for reasons of safety and security. Some records we examined did not give adequate reasons for separation or show that it was used for the shortest possible time.



Separation unit cell

**2.14** Some detainees had their mobile phone removed once they were in the separation unit. This was not based on an individual risk assessment and we were told individual managers applied different policies.

## Safeguarding

**2.15** The detainees who remained at the centre had a particularly high level of need. Half of the detainees we interviewed said they had mental health problems and 80% said they had felt depressed while at Harmondsworth. Health professionals considered some detainees to be unfit for detention (see paragraph 3.35).

**2.16** About 45% of the population had been assessed at the two higher levels of vulnerability under the Home Office's adults at risk policy. On 10 March 2021, 25 detainees were assessed to be at level 2 because of professional evidence showing they were particularly vulnerable to harm in detention, for example due to a history of torture, trafficking or mental illness. Sixteen detainees were assessed as being at level 3 of the policy because there

was professional evidence demonstrating that ongoing detention was likely to cause the detainee harm. The number of level 3 detainees was far higher than the levels we saw during inspections before the pandemic. (At Morton Hall, there were five such detainees and at Brook House, none.) On average, detainees had been held for 75 days after their level 3 assessment and four individuals had been held for more than four months after their assessment at that level. (See key concern and recommendation S4.)

**2.17** We looked at the cases of eight detainees assessed at level 3. Among them, two had a diagnosis of schizophrenia, one had severe depression, one had lymphoma and there were several whose vulnerability was associated with past trauma as a result of torture or modern slavery. One of the detainees in our sample had been diagnosed with a learning disability and lacked mental capacity (see paragraph 2.19). A second detainee, whose case we did not examine, also had a learning disability.

**2.18** The detainee held the longest following his level 3 assessment was diagnosed with schizophrenia. By the time of the inspection, he had been detained for five months after his level 3 assessment. The Home Office maintained its decision to detain him despite repeated release recommendations since June 2020 from the case progression panel (see Glossary of terms). By the end of September 2020, Home Office officials dealing with the case decided he should be released. Despite this decision, and repeated subsequent grants of bail, he remained in detention because the Home Office was unable to secure appropriate release accommodation. He stopped taking his medication in October 2020 and since then had experienced persistent paranoid delusions. (See key concern and recommendation S4.)

**2.19** Another level 3 detainee had been diagnosed with mental illness and a learning disability. He had been granted bail subject to the provision of accommodation in November 2020. The bail grant had been renewed repeatedly since then. He remained in detention because the Home Office was again unable to provide release accommodation. Health care staff in Harmondsworth did not consider that he had the mental capacity to consent to a COVID-19 vaccination. (See key concern and recommendation S4.)

**2.20** Detainee custody officers had a limited awareness of the adults at risk policy and some had a poor understanding of the vulnerability of detainees assessed to be at risk. The centre opened vulnerable adult care plans (a care planning process similar to assessment, care in detention and teamwork case management for those at risk of suicide or self-harm in IRCs) for detainees considered to be most at risk. The plans we reviewed lacked focus and their purpose was poorly understood by some staff. Care maps were often perfunctory and case reviews were often not multidisciplinary when they should have been.

**2.21** We saw several cases where the Home Office had not informed the centre that it had raised a detainee's risk to level 3, in one case for three months. These delays undermined the ability of centre staff to monitor and care for vulnerable detainees. The Home Office recognised the problem and had put in place measures to address it before our inspection.

**2.22** Staff in the mental health team monitored and reported well on detainees at level 3 of the adults at risk policy. They also provided these detainees with good support (see paragraph 3.35). These factors mitigated to a considerable degree the weaknesses in care planning in residential units.

**2.23** The most vulnerable detainees were monitored at the weekly vulnerable detainees meeting. Home Office case owners routinely dialled into the meeting, which was well attended by health care and onsite Home Office staff. A member of the safer detention team also attended. The meeting shared information effectively on detainee risks, although it could not address systemic problems such as the delay in the provision of release accommodation.

**2.24** In the six months to 15 March, 124 rule 35 reports (see Glossary of terms) had been submitted on detainees because of concerns about torture, seven because of health concerns and two relating to suicide risks. About a third (35%) of reports led to the detainee being released. Health care professionals completed reports promptly, although parts of the assessment were conducted over the telephone (see paragraph 3.29). In the three months to the end of February 2021, local records indicated that 59% of Home Office rule 35 responses were late.

**2.25** We reviewed 10 rule 35 reports in detail, nine of which concerned torture. Assessments in these reports lacked detail and some key detainee experiences, such as mistreatment by traffickers, were not explored sufficiently. They included a brief statement of the consistency of scarring with the mistreatment and an assessment of the impact of ongoing detention on the detainee. However, there was a lack of individual reasoning behind these assessments. One report prepared by a psychiatrist concerned detention adversely affecting the detainee's health and was good. We also saw several good IS91RA Part C risk assessment reports (used to notify the Home Office of any change in circumstances that might affect the risks to detainees), which the mental health team had submitted to the Home Office (see paragraph 3.35).

**2.26** The Home Office accepted evidence of torture in eight of nine relevant cases. In one case, officials did not accept that a detainee's mistreatment met its definition of torture. The detainee said he had been beaten, burnt with cigarettes and cut with knives on several occasions. The Home Office considered this did not meet its definition because there was no clear indication that the detainee was in a position of powerlessness, or that he was under the control of the perpetrators of his mistreatment.

**2.27** Detention was maintained in eight cases because it was considered that immigration factors, including detainees' offending behaviour, outweighed their vulnerability. In one case, the detainee had been released on bail before the Home Office had considered the rule 35 report.

**2.28** At least five detainees held under STHF rules in Harmondsworth told officials when they arrived in Dover they were children. All had subsequently been detained as adults in Harmondsworth following an abridged, rather than full, Merton-compliant assessment (the standard social services-conducted age assessment). Two people were assessed to be 20, two 22 and one 23. All were subsequently dispersed to asylum accommodation as adults.

**2.29** We were shown social worker assessments for three cases, all completed late in the evening following arduous cross-Channel journeys. In the case of one of the detainees assessed to be 20, the assessors merely concluded that he had 'the appearance of a young man who appears to have completed his developmental stage'. The assessors also relied on inconsistencies in his interview, which was completed at 12.42am. Home Office records showed that this detainee was first encountered crossing the Channel at 5.10am the previous morning.

# Legal rights

**2.30** The average length of detention had been reduced since our short scrutiny visit in May 2020 from 92 days to 73, but was high compared with levels seen during inspections before the pandemic. Twenty-six detainees had been held for more than six months, of whom eight had been held for more than 12 months.

**2.31** In our casework sample, some detainees had been held despite there being little prospect of their removal as a result of travel bans or re-documentation delays caused by the pandemic. In the six months before the inspection, 58% of detainees leaving the centre were released

into the community and only 24% were removed. The length of detention of detainees assessed at level 3 of the adults at risk policy was a significant concern. (See key concern and recommendation S4 and paragraphs 2.16-2.19.)

**2.32** In some cases, detention was maintained despite repeated release recommendations from case progression panels because of a lack of suitable accommodation. In other cases, there were long delays waiting for the probation service to approve release accommodation. (See key concern and recommendation S4 and paragraphs 2.18 and 2.19.)

**2.33** At the beginning of the inspection, 13 individuals had been granted bail but remained in detention pending a suitable release address. Three had been waiting for accommodation for more than six months. Two detainees with learning disabilities, one of whom had been assessed to lack mental capacity had been waiting for bail accommodation for over six months. (See key concern and recommendation S4 and paragraphs 2.16-2.19.)

**2.34** Face-to-face free legal advice surgeries were still suspended, but telephone appointments were available. Some detainees reported problems with the telephone advice rota and the centre did not monitor whether detainees had received the advice. Forty-three per cent of detainees interviewed said it was difficult to get free legal advice.

**2.35** Detainees who were financially eligible could receive ongoing legal representation to help with bail applications and protection claims. Solicitors could book Skype legal 'visits' but take-up of this provision was low and only 26 such visits were booked in the three months to the end of February 2021.

**2.36** It was a concern that some vulnerable detainees did not have a lawyer. In one case, the Home Office decided that the detainee was a victim of modern slavery, but nevertheless decided to remove him. He has been detained for over a year because no flights were available during the pandemic.

**2.37** Many detainees complained about the lack of any progress in their cases and 72% of detainees interviewed said Home Office immigration staff were not keeping them informed about the progress of their case. Home Office Detention Engagement Team staff were no longer providing detainee surgeries, but were still maintaining contact with detainees in person and by telephone.

# Section 3. Respect

In this section, we report mainly on staff-detainee relationships; living conditions; detainee consultation, applications and redress and residential services; equality, diversity and faith; and health services.

## Staff-detainee relationships

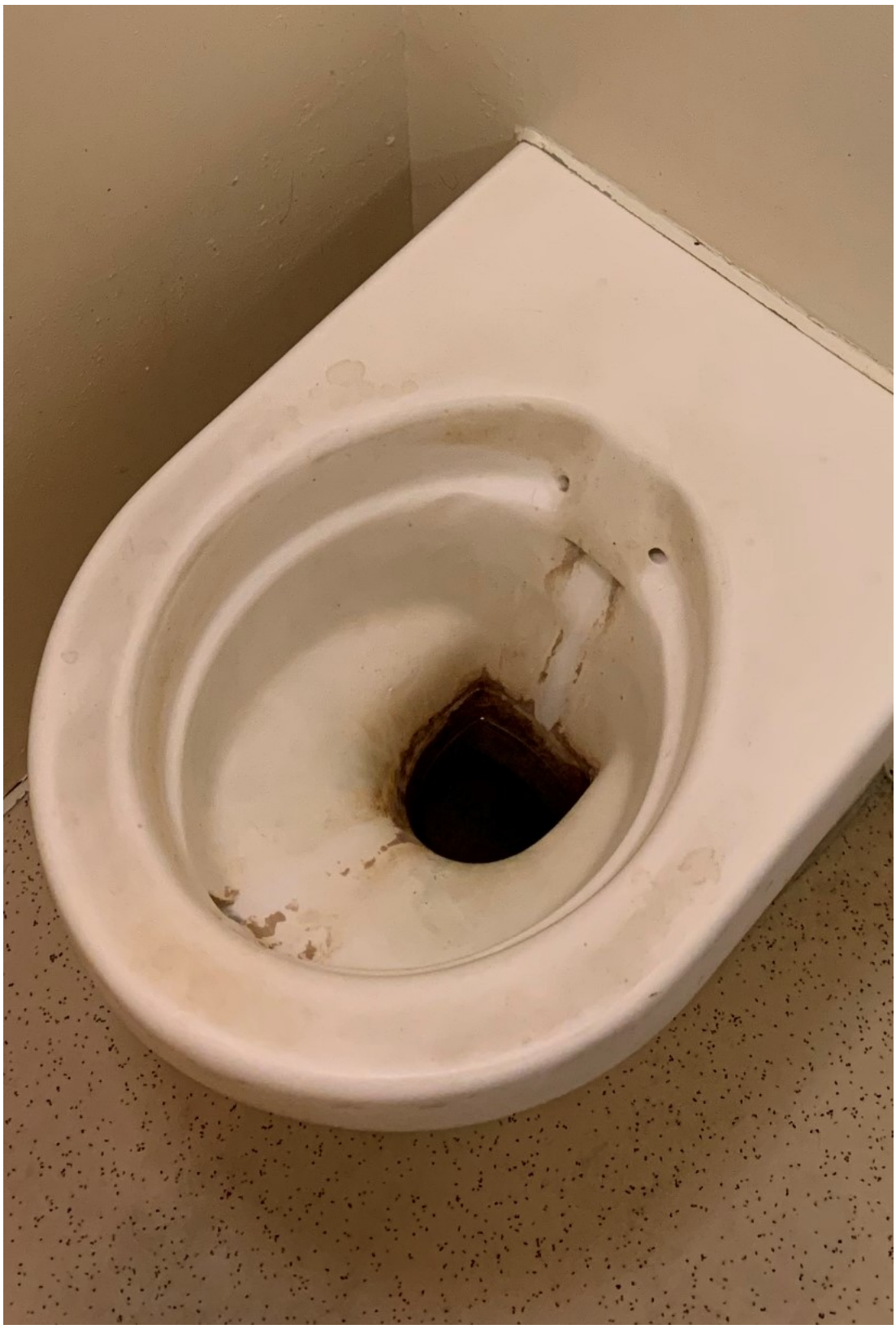
**3.1** Sixty-nine per cent of detainees we interviewed told us that staff at the centre treated them with respect and 78% said that they had a member of staff they could turn to if they had a problem. Most interactions between detainees and staff that we witnessed were polite but functional, and we often found staff in offices rather than interacting with detainees. However, we also saw some staff having lengthy conversations with detainees or eating alongside them.

**3.2** Some detainees told us they had to ask for help with basic issues repeatedly before they were resolved. We also saw some instances of staff failing to challenge poor behaviour, such as smoking in the units or playing excessively loud music.

**3.3** Staff were allocated specific cells in the units and acted as care officers for the residents of those cells. Managers told us they would expect to see care officers submitting records showing interactions with each detainee at least every two weeks. The records we reviewed showed evidence of regular care officer entries, but most were superficial, containing observational comments or information about administrative tasks, and there was little evidence of meaningful interactions or welfare checks. Only 55% of detainees interviewed said that a member of staff had asked them how they were getting on in the week before our visit.

## Daily life: living conditions

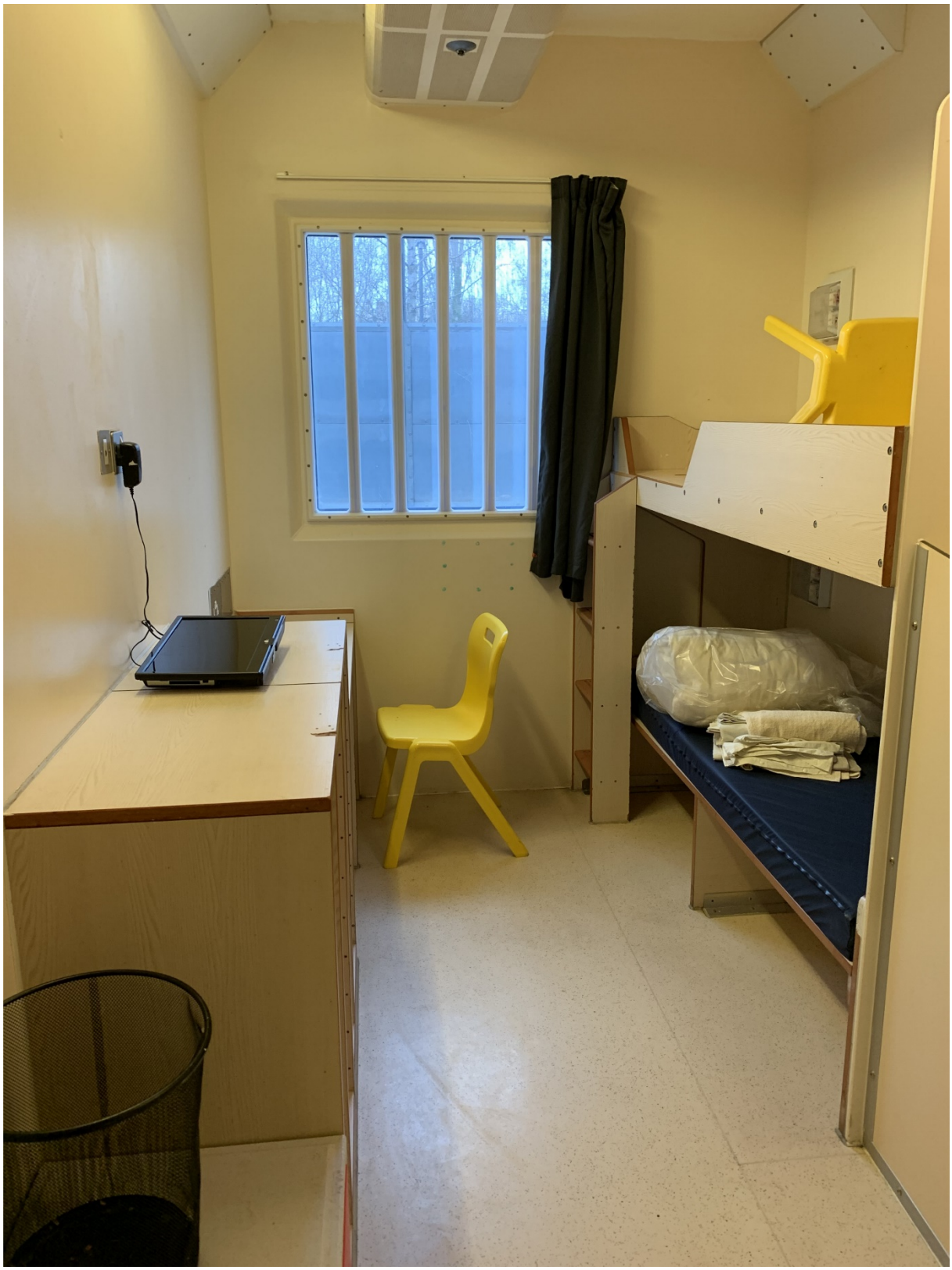
**3.4** Some of the conditions in the centre were below acceptable standards. Most cell toilets we saw were filthy and needed to be replaced as managers said they were too damaged to clean. Communal showers on the wings were dilapidated and regularly broken. Detainees also told us about unpredictable heating system and poor ventilation; cell windows were sealed and detainees could not control the flow of fresh air. There was also a persistent problem with mice. Pest control teams visited the centre several times a week, but the problem had remained unresolved for many years. (See key concern and recommendation S5.)



Toilet

**3.5** Communal areas were cleaned every day by paid detainees and were superficially clean despite being rundown. During the pandemic, paid detainees also regularly sanitised high-contact points, such as stair railings and door handles. Mitie cleaning staff performed weekly cleaning audits and deep-cleaned areas on an ad-hoc basis, but this had not adequately raised the overall standards. (See key concern and recommendation S5.)

**3.6** During the pandemic, all detainees had their own cells and were offered keys. Records showed that emergency call bells generally received a prompt response. Cell cleaning materials were widely available and most of the occupied cells we saw were kept in a clean and orderly condition.



Detainee cell

**3.7** The centre had a good supply of clothing and shoes, in a variety of sizes. Supplies of bedding were also adequate. Each wing had a laundry, which was open throughout the day and supervised by paid detainees.

**3.8** The detainee shop was open during the pandemic. Detainees could not attend in person but could order up to 10 items as often as twice a day. The shop contained a good variety of items, including food and drinks, cosmetics and hygiene products, cigarettes and vapes, and mobile phone credit. Prices were comparable with the community. Orders from Argos had temporarily stopped in line with lockdown restrictions, but detainees could still order clothing from a catalogue service.

**3.9** Notices displayed in the units were predominantly in English, although complaint forms and some information about library services were available in commonly used languages.

**3.10** The Cedar and Dove units, used as the short-term holding facility (STHF), were better than the main centre. The communal showers and toilets were in a much more acceptable condition than those in other parts of the centre.

## Daily life: detainee consultation, applications and redress and residential services

**3.11** Detainees commonly complained about the standard and variety of the food. They told us that there was not enough fresh produce and that the food was unhealthy. The food we saw and tasted was neither fresh nor appetising. Records from detainee consultation showed that the quality of food was frequently raised, but there had not been any improvements in the standard or range of meals. The popular cultural kitchen was still closed.

**3.12** The centre had received 36 complaints in the three months leading up to the inspection. Investigations were thorough and timely and responses to complaints were polite, dealt well with the issues and provided an apology when necessary. Managers quality assured each response and a monthly report enabled managers to track trends. In the year before our visit, there had been one complaint about serious misconduct submitted to the Professional Standards Unit. The investigation and report relating to the incident were very thorough.

**3.13** Detainee consultation meetings had recently been resumed and took place monthly in each unit. They covered a range of issues, which were recorded and received a response within a week. Most responses we reviewed handled the issues that had been raised constructively. However, given the centre's small population, consultation could have taken place more regularly. (See paragraph S10.)

## Equality, diversity and faith

**3.14** The strategic management of equality and diversity had improved since the last full inspection. The equality manager produced useful monthly reports monitoring a range of issues, including the extent to which detainees with different protected characteristics participated in activities or were subject to the use of force or removal from association. An adequate action plan was in place to strengthen equality and diversity in the centre over the coming year.

**3.15** Consultation meetings with young people under 21, specific nationality groups, LGBT detainees and disabled detainees had taken place in the three months before our visit, although attendance could be low. Staff ran separate groups in each unit to support social

distancing and had collated responses. Minutes showed that detainees raised issues freely and centre staff responded to most issues constructively. (See paragraph S10.)

**3.16** Detainees could submit complaints about discrimination through the local complaints system. They were forwarded to suitable members of staff for review. However, no discrimination-based complaints had been received in the three months before our visit.

**3.17** Health care staff used professional interpretation regularly, but there was insufficient use in other parts of the centre. Managers told us this was because the centre had many multilingual staff who could communicate with detainees in their own language. However, we noted that professional interpretation was not used for some sensitive discussions, including during assessment, care in detention and teamwork (ACDT) case management reviews for those at risk of suicide or self-harm in immigration removal centres, or in some cases where there were no staff who spoke the detainee's language (see also paragraph 2.4).

**3.18** The chaplaincy continued to provide good support. The team met members of different faiths in small groups in the units while communal worship was suspended. Some small group activities, such as Bible study and Arabic lessons, had continued during the restrictions and religious services were being broadcast on the centre's radio and television. The chaplaincy also provided pastoral and welfare support to detainees and had visited each wing every day during the pandemic.

## Health services

**3.19** Effective contingency plans were in place to manage COVID-19. Partnership working between the centre, the Home Office, health care providers, NHS England and Public Health England was good. Only eight detainees had tested positive for COVID-19 since the beginning of the pandemic and the risk of wider transmission through the detainee population was managed effectively.

**3.20** A business continuity plan and service restoration plans had been followed to make sure health care continued to be delivered. There was a good supply of personal protective equipment (PPE). All staff had been fit-tested for filtering facepiece (FFP3) masks (see Glossary of terms) and emergency equipment had been updated in line with current guidance.

**3.21** Longstanding health staff vacancies, exacerbated by the pandemic, had been challenging but were mitigated by the use of regular agency and bank staff, ongoing staff recruitment and the substantial reduction in detainee numbers at the centre.

**3.22** Clinical management of the service was robust and regular local delivery board meetings had continued throughout the pandemic to provide strategic oversight. Effective daily nurse triage made sure detainees were seen by the nurse or GP when necessary. Other services, such as the podiatrist and optician, were offering routine clinics with short waiting times.

**3.23** Reception health screening continued and clear arrangements were in place for reverse cohorting at Colnbrook (see paragraph 2.1). COVID-19 lateral flow tests were taken on arrival, again on the fifth day of detention and again when the detainee was transferred to Harmondsworth following their quarantine period at Colnbrook. If a detainee tested positive, they were isolated in the protective isolation unit and a COVID-19 PCR test was taken.

**3.24** All detainees were offered a GP appointment within 24 hours of arrival and anyone with an immediate health need or a long-term condition was prioritised. Since the beginning of the

pandemic some consultations were completed over the phone, but detainees were seen if clinically indicated.

**3.25** The health team had effectively accommodated the increased volume of work, arising as a result of two units' temporary use as an STHF for people who had crossed the Channel in small boats (see paragraph 2.7), and health screenings and lateral flow tests were undertaken in the Harmondsworth reception area.

**3.26** The team had created a comprehensive induction pack, which included information about COVID-19 and keeping safe, and helpful guidance on how to deal with stress and sleep issues. This and a wealth of information displayed in the health centre was available in several languages. The amount of translated health information had increased substantially since the last inspection. The health care team used telephone interpretation services for assessments when needed, which was documented in detainees' medical records. (See paragraph S11.)

**3.27** Health care staff had identified 24 detainees who fulfilled the shielding criteria (see Glossary of terms), but all had declined to shield. They received advice and health care staff saw or contacted them every day.

**3.28** The roll out of the national COVID-19 vaccination programme had been set up well and detainees had been informed of the benefits of having the vaccination. However, uptake was low and only 13 eligible detainees had received their first dose. Long-term conditions were managed well, with evidence-based care plans, and an additional drop-in clinic at weekends was a positive initiative, which was advertised in multiple languages.

**3.29** Detainees had prompt access to rule 35 assessments. However, some were initially completed over the phone. Face-to-face appointments were then arranged for those who needed a physical examination. This could have compromised the effectiveness of the assessment and potentially caused the detainee distress by requiring them to repeat traumatic details. Some medical staff had undertaken specific training on the production of rule 35 reports, but the standard of reports was variable (see paragraph 2.25).

**3.30** The enhanced care unit consisted of a 20-bed inpatient unit, which included two en-suite isolation rooms. Occupancy rates were very low and only two patients were there during our visit. It was clean and well-maintained. The unit had 24-hour nurse and officer cover and multidisciplinary oversight, and detainees were located there for clinical reasons. Care plans were in place and the care we observed was good.

**3.31** Staff were aware of the care needs of detainees on food and fluid refusal and appropriate observations and assessments were conducted.

**3.32** External hospital appointments continued to be arranged throughout the pandemic and routine appointments were offered.

**3.33** Medicines management, overseen by a pharmacist, was good. The single point of administration was within the health care department, where paracetamol could be purchased. In-possession medication had increased following a robust risk assessment and we observed supervised medication being administered competently.

**3.34** The dental provider ran four sessions a week at either Harmondsworth or Colnbrook, depending on which had the highest waiting list. The dental service could now offer most necessary dental care on site as a result of factors such as enhanced PPE, the availability of mechanical room ventilators and strict adherence to cross infection controls. During our visit the longest wait was about three weeks and slots were available for urgent needs at each session. The dentist provided a similar service to the community and detainees had

good access to emergency treatment, which had been available throughout the pandemic. Antibiotics and pain relief were available.

**3.35** The integrated multidisciplinary mental health and substance misuse team provided good support to detainees on their caseload through telephone and face-to-face consultations. The team now provided weekend cover and could see detainees seven days a week. They attended ACDT reviews and the centre's weekly vulnerable detainees meeting. The mental health team informed the Home Office about detainees' vulnerability by completing good quality IS91RA Part C reports, which clearly described the reasons why they considered detainees to be unfit for detention. (See paragraphs S12 and 2.16-2.19.)

**3.36** The number of referrals had declined as the population within the centre had decreased and the current caseload was about 15. Referrals came through reception, self-referrals and from officers. In February, the team received approximately 60 referrals, which received a prompt response. A range of interventions were offered to detainees with mild to moderate mental health issues and those with more complex needs. A good variety of self-help material was available in several languages. No patients had been transferred to mental health facilities under the Mental Health Act during the previous year.

**3.37** Detainees requiring substance misuse treatment and alcohol detoxification were identified at reception and observation for those who required monitoring over the first five days was in place. The small number of detainees on opiate substitution therapy had regular joint clinical and psychosocial reviews.

**3.38** Psychosocial services were provided by Phoenix Futures. Groups had been suspended during the pandemic, but recovery workers continued to support approximately nine detainees. They provided work booklets and harm minimisation and relapse prevention support in a range of languages.

**3.39** A nurse saw all detainees before their release or removal. They provided a medical summary, advice on COVID-19 and 28 days' medication. Training and support in the use of naloxone (a drug to manage a substance misuse overdose) was not yet available.

# Section 4. Activities

In this section we report mainly on time out of cell and access to activities.

**4.1** Detainees were locked up for an hour at lunchtime and from 9.45pm to 8am. At other times, they could move freely around their units, and access the outdoor courtyard areas. (See key concern and recommendation S3 and paragraph 1.5.)

Courtyard

**4.2** Managers had changed the regime to enable all detainees to participate in activities despite the COVID-19 restrictions. Detainees stayed in their residential unit bubbles and each unit attended activities separately. Units were each allocated a 1.5-hour session in the education corridor every weekday, where they could attend classes, the library, or the internet computer room. Detainees could also attend one or two evening sessions each week and use the internet room and library at weekends. (See paragraph S13.) However, some popular activities, such as the cultural kitchen and barber shop, remained suspended.

**4.3** About half of detainees had paid work, mainly as cleaners and food servery workers. On average 52 were employed in the month before our visit. The recruitment process was informal, but new workers received a brief induction and a work contract. Their work experience was not recorded and they could not gain vocational qualifications.

**4.4** The range of education opportunities had improved. Classes in English for speakers of other languages were delivered to small groups or individuals, according to demand. The centre provided vocational courses, such as those in food hygiene and customer service, through

classroom-based and distance learning courses. Teachers monitored the progress of learners who attended regularly to help them achieve. One hundred and forty-one externally accredited awards were achieved in 2020, which was a positive result given the difficult circumstances.

**4.5** A good range of creative classes promoted detainees' well-being, as well as teaching them new skills. Managers had increased the range of creative activities since the previous full inspection and they now included music and art, as well as craft skills, such as floristry and sugar craft (usually for cake decoration). The music room was well equipped and we saw some creative music production. Tutors were enthusiastic and supportive, and detainees enjoyed these courses, which they said offered them relief from the stress and tension of their situation. They produced good quality work, in several cases achieving platinum awards from Koestler Arts, which promotes the arts in criminal justice settings. (See paragraph S14.)

**4.6** Managers had introduced classroom observation to monitor the quality of teaching. Observers' feedback to teachers was supportive but did not always indicate clearly how the class could be improved.

**4.7** Despite these improvements, the take-up of activity places was very low. There were no waiting lists for activities. The centre's data showed that, on average, detainees attended activities for less than five hours per month. Most classes we saw had fewer than three learners and in several cases no detainees attended. The induction session on activities was weak. Welfare staff advised new detainees to visit the education department, but they were not shown around the facility because of COVID-19 restrictions. The virtual tour (see paragraph S9) mitigated the issue to a limited extent, but was not an adequate replacement. Detainees' English language and learning needs were not routinely assessed during induction. Not enough was done to promote activities or encourage participation. (See key concern and recommendation S6.)

**4.8** Access to the gym was good: detainees could attend two sessions a day. However, attendance was low – typically there were between three and five detainees per session during our visit. COVID-19 restrictions meant that the group induction was no longer offered and the sports hall was only used for badminton. Physical education staff ran exercise programmes and offered fitness coaching, but there were few participants.

**4.9** The library service was efficient. There was an adequate stock of legal texts and a print facility for detainees' use. Detainee custody officers managing the library had received some relevant training. They reviewed the library's stock every month and ordered new books on request. The book stock included a wide range of languages, but many publications were old. Most detainees borrowed DVDs rather than books. There was a good range of international newspapers. The library did not provide reader development activities.

**4.10** Activities in the units included pool tournaments, competitions and social activities, such as bingo. Unit staff organised regular competitions, including quizzes, and provided a stock of board games for residents to use.

# Section 5. Preparation for removal and release

In this section, we report mainly on contact with welfare; visits and family contact and communications; and leaving the centre.

## Welfare

**5.1** The welfare office remained closed, but welfare staff were visible in the centre and visited each wing regularly, including the separation unit. Data suggested that detainees had a high level of contact with welfare staff during their stay.

**5.2** Welfare officers had not been trained for their role, but were experienced and reasonably knowledgeable. Some detainees complained about the help they provided, but their dissatisfaction largely related to matters that were outside welfare officers' control, such as the lack of information about their immigration case or ineffective solicitors.

**5.3** Onsite access to non-governmental organisation (NGO) support groups, such as those run by Hibiscus, Detention Action and Bail for Immigration Detainees, was still suspended, but the agencies provided advice remotely by telephone. Detainees were seen on arrival by welfare officers and given contact details of NGOs, but their services were not otherwise well promoted (see also paragraph 2.3).

## Visits and family contact and communications

**5.4** Social visits had resumed in the summer of 2020 with appropriate safeguards in place. They were suspended again in November 2020 in line with national restrictions but were due to resume in April 2021.

**5.5** Nearly all detainees interviewed (94%) said they had never used video calling facilities to speak to friends and family. Many told us there was insufficient privacy for such calls in the IT room, where other detainees would be present. Centre statistics confirmed that take-up of Skype video calling was low, with not even one call a day in the three months to the end of February.

**5.6** Detainees could contact friends and family on the mobile phones provided by the centre. They had been given extra phone credit to compensate for the suspension of social visits.

**5.7** Detainees had reasonable access to internet facilities and we found no inappropriately blocked websites.

## Leaving the centre

**5.8** In the six months before our visit, 698 people had left the centre: 167 (24%) were removed from the UK; 407 (58%) were released on immigration bail; and 124 (18%) were transferred to a prison or another immigration removal centre (see paragraph 2.31). The welfare team appropriately focused on preparing detainees for removal or release from the day of their arrival.

**5.9** Multi-agency meetings were routinely held in cases where removals were considered high risk or potentially complex. They involved representatives from a variety of departments, including the Home Office and health care department when necessary.

**5.10** We saw good quality printed information for detainees who were being released, including details about sources of support and their entitlements, as well as COVID-19 restrictions in the community. Hibiscus Initiatives (see Glossary of terms) also provided detainees who were being removed with good information that outlined the removal process and offered details on common countries of removal.

**5.11** The welfare team provided luggage, winter coats and hats to detainees who were being released or removed to colder climates.

**5.12** The discharge of people from the short-term holding facility had often been very late in the day, causing people unnecessary stress. They then had to undertake sometimes lengthy journeys to new accommodation.

# Section 6. Appendices

## Appendix I: Background and methodology

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

All visits 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 21 bodies making up the NPM in the UK.

During a standard, full inspection HMI Prisons reports against Expectations, the independent criteria against which we inspect outcomes for those detained. Inspection teams of up to 12 people are usually in establishments across two weeks, speaking to detainees and staff, observing life in detention and examining a large amount of documentation and evidence. The COVID-19 pandemic means that it is not currently possible to carry out inspections in the same way, both for health and safety reasons and because it would not be reasonable to expect places of detention to facilitate a full inspection, or to be assessed against our full set of *Expectations*, at this time.

HMI Prisons has therefore developed a COVID-19 methodology to enable it to carry out its ongoing, statutory duty to report on treatment and conditions in detention during the current challenging circumstances presented by COVID-19. The methodology has been developed together with health and safety guidance and in line with the principle of 'do no harm'. The methodology consists of three strands: analysis of laws, policies and practice introduced in places of detention in response to COVID-19 and their impact on treatment and conditions; seeking, collating and analysing information about treatment and conditions in places of detention to assess risks and identify potential problems in individual establishments or developing across establishment types; and undertaking scrutiny visits to establishments based on risk.

HMI Prisons first developed a 'short scrutiny visit' (SSV) model in April 2020 which involved two to three inspectors spending a single day in establishments. It was designed to minimise the burdens of inspection at a time of unprecedented operational challenge, and focused on a small number of issues which were essential to the safety, care and basic rights of those detained in the current circumstances. For more on our short scrutiny visits, see our website: http://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/short-scrutiny-visits/.

As restrictions in the community eased, and establishments became more stable, we expanded the breadth and depth of scrutiny through longer 'scrutiny visits' (SVs) focusing on individual establishments, as detailed here. The SV approach used in this report is designed for a detention system that is on the journey to recovery from the challenges of the COVID-19 pandemic, but recognises that it is not yet the right time to reintroduce full inspections. SVs provide transparency about the recovery from COVID-19 in places of detention and ensure that lessons can be learned quickly.

SVs critically assess the pace at which individual immigration removal centres re-establish constructive rehabilitative regimes. They examine the necessity and proportionality of measures taken in response to COVID-19, and the impact they are having on the treatment of and conditions

for detainees during the recovery phase. SVs look at key areas based on a selection of our existing Expectations, which were chosen following a further human rights scoping exercise and consultation.

Each SV report includes an introduction, which provides an overall narrative judgement about the progress towards recovery. The report includes a small number of key concerns and recommendations, and notable positive practice is reported when found. SV reports include an assessment of progress made against recommendations at a previous SV, but there is no assessment of progress against recommendations made at a previous full inspection. Our main findings are set out under each of our four healthy establishment assessments.

SVs are carried out over two weeks, but entail only three days on site. For more information about the methodology for our scrutiny visits, including which *Expectations* will be considered, see our website: http://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/

## Scrutiny visit team

This scrutiny visit was carried out by:

| | |
|---|---|
| Charlie Taylor | Chief inspector |
| Hindpal Singh Bhui | Team leader |
| Deri Hughes-Roberts | Inspector |
| Rebecca Mavin | Inspector |
| Tamara Pattinson | Inspector |
| Kam Sarai | Inspector |
| Fiona Shearlaw | Inspector |
| Maureen Jamieson | Health care inspector |
| Steve Oliver-Watts | Associate activities inspector |
| Helen Ranns | Researcher |
| Joe Simmonds | Researcher |

# Appendix II: Further resources

Some further resources that should be read alongside this report have been published with it on the HMI Prisons website. For this report, these are:

## Detainee survey methodology and results

A representative survey of detainees is carried out at the start of the scrutiny visit, the results of which contribute to our evidence base for the visit. A document with information about the methodology, the survey and the results, and comparisons between the results for different groups are published alongside the report on our website.

## Staff survey methodology and results

A survey of staff is carried out at the start of every scrutiny visit, the results of which contribute to the evidence base for the visit. A document with information about the methodology, the survey and the results are published alongside the report on our website.

# Appendix III: 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/

**Adults at risk policy**
This Home Office policy sets out what is to be taken into account when determining whether a person would be particularly vulnerable to harm if they remained in detention. It is intended to reduce the number of vulnerable people detained and the length of their detention.

**Case progression panel**
Internal Home Office review panels established to scrutinise decisions to detain individuals. They are intended to minimise the likelihood of inappropriate or unduly prolonged detention.

**Certified normal accommodation (CNA) and operational capacity**
Baseline CNA is the sum total of all certified accommodation in an establishment except rooms in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged rooms, rooms affected by building works, and rooms taken out of use due to staff shortages. Operational capacity is the total number of detainees that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

**FFP3 masks**
Filtering face piece (FFP) masks come in three respirator ratings: FFP1, FFP2 and FFP3. FFP3 offers the wearer the highest level of protection and is recommended for use during outbreaks of SARS, avian flu and coronavirus.

**Hibiscus Initiatives**
A charity that works mainly with immigration detainees and women prisoners, and targets support to those who may be marginalised by language and cultural barriers. The charity also helps people transition from prison or immigration detention into the community in the UK or other countries. See: https://hibiscusinitiatives.org.uk/project/prison-services/

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

**Reverse cohort unit (RCU)**
Unit where newly arrived detainees are held in quarantine for 14 days.

**Rule 35**
Rule 35 of the detention centre rules requires a medical practitioner to report to the Home Office on the case of any detainee whose health is likely to be injuriously affected by continued detention, who may have suicidal intentions, or who may have been the victim of torture.

**Shielding**
Those who have health conditions that make them vulnerable to infection are held for at least 12 weeks in a shielding unit.

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This publication is available for download at: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England