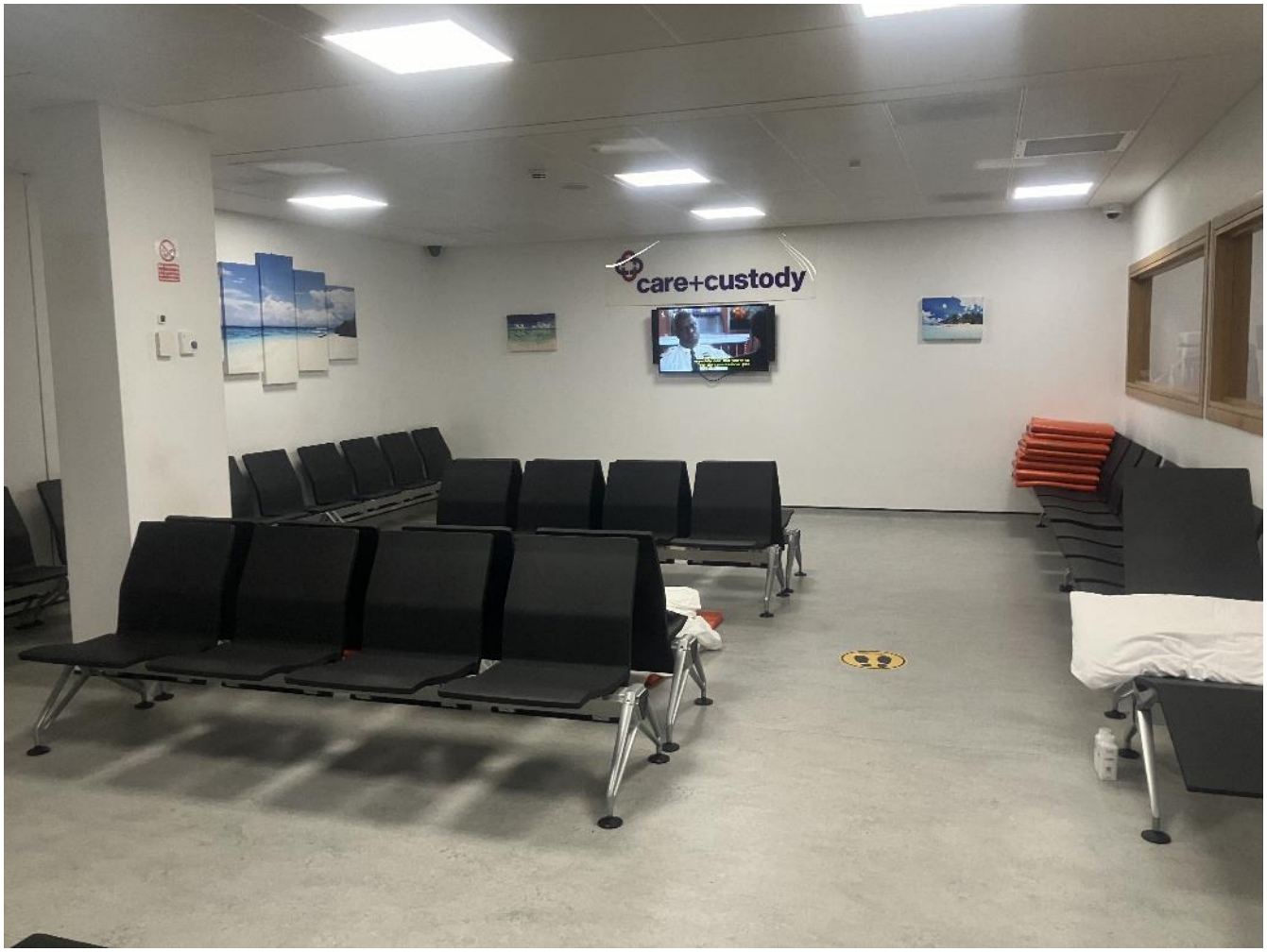
Report on an inspection of non-residential

Airport and seaport short-term holding facilities managed by Mitie Care and Custody

by HM Chief Inspector of Prisons

15–26 January 2024



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Introduction

In the airside part of most UK airports, there are small immigration detention facilities holding people who have either just arrived from incoming flights or been brought from other places of detention to be removed from the country. The busiest of them tend to be managed for the Home Office by Care and Custody, part of the Mitie group. HMI Prisons has previously inspected these facilities individually but, in line with the national inspection model we first used in 2020, we visited 15 facilities around the country, including one seaport, Holyhead, because it is also managed by the same company.

Most short-term holding facilities (STHFs) are intended to cater for short stays of only a few hours and are not designed or equipped to hold people for extended periods. It was concerning therefore that in the previous six months, over a quarter of detainees, including far too many children, were held for more than 12 hours and nearly 600 people for more than 24 hours.

The facilities were generally suitable for holding detainees for short periods, but there were wide variations among them. The busiest detention facility was now at Luton, which received more detainees than even the Heathrow sites, partly because of the high number of flights going to and from Eastern Europe. Luton was simply unable to cope with the demands placed on it and we were particularly concerned to find that children were placed in crowded holding rooms with unrelated adults. By contrast, the new facilities at Manchester provided a well-designed and reasonably comfortable environment.

Care and Custody staff were, with a few unfortunate exceptions, trying to support people who were often extremely anxious about their situation. Care and Custody leaders had also improved some aspects of care, especially through a new induction process, although, in general, implementation of good policies was too variable. Similarly, startling inconsistencies in safeguarding data provided by Border Force suggested either that the data were unreliable, or that safeguarding responsibilities were not carried out well at all STHFs.

Overall, we found reasonable procedures and leadership across the sites, but too many inconsistencies in care and some safeguarding weaknesses that need to be addressed. The most urgent challenge for the Home Office is to find a solution for the unacceptable conditions at Luton.

Charlie Taylor
HM Chief Inspector of Prisons
February 2024

Summary of key findings

What needs to improve at this short-term holding facility

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

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

Priority concerns

1. **People were held for far too long in facilities that were not designed or equipped for long stays. In the previous six months, nearly 600 people, including six children, were held for over 24 hours.**

2. **The small holding rooms at Luton and Stansted airports were grubby and crowded. Luton was unable to provide decent conditions for the number of detainees it held.**

3. **There were weaknesses in some aspects of child safeguarding, including a lack of enhanced DBS checks for all Border Force staff who had contact with children and some questionable decisions regarding vulnerable children.**

4. **Detainees were not allowed access to their prescribed medication and, at many sites, there was limited access to paramedics.**

5. **Detainees' access to telephone contact was limited and few were offered use of the mobile phones held in every Care and Custody office.**

Key concerns

6. **Searches and induction interviews were often not conducted with sufficient privacy.**

7. **Telephone interpretation was not used enough after induction and, despite being available, hand-held translation devices were rarely used.**

8. **Border Force did not systematically collect, verify and analyse data on adult and child safeguarding, or on the length of detention.**

9. **Detainees did not have sufficient access to legal advice.**

10. **Complaints submitted in a foreign language were not systematically processed, translated and answered, and there were extremely long delays in Border Force responses.**

11. **Escorting of detainees to flights through public areas was not always sufficiently discreet.**

Notable positive practice

We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for detainees, and/or particularly original or creative approaches to problem solving.

Inspectors found three examples of notable positive practice during this inspection, which other facilities may be able to learn from or replicate. Unless otherwise specified, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other establishments. They show some of the ways our expectations might be met but are by no means the only way.

Examples of notable positive practice		
a)	The new holding facility at Manchester airport was well designed and properly equipped with soft chairs, bean bags, mattresses and a fridge. The facility also had a separate multi-faith room.	See paragraph 3.1
b)	Children held in the family room of Gatwick North terminal had access to various brand-new picture books in many languages.	See paragraph 3.6
c)	At Stansted and Heathrow Terminal 3, searching of vulnerable women who spoke little or no English was carried out with a telephone interpreter explaining each step of the search in real time. This allowed the women to understand the process fully and provided reassurance.	See paragraph 3.12

About Mitie Care and Custody short-term holding facilities at airports

Role of the facility

The Home Office Immigration Enforcement arm contracts Care and Custody, which is part of the Mitie Group, to manage short-term holding facilities at the busiest UK airports. Local Border Force managers oversee the holding rooms.

Locations and total number of detentions, June to November 2023

Luton	2,898 detainees
Heathrow Terminal 3	2,303 detainees
Heathrow Terminal 4	2,181 detainees
Heathrow Terminal 2	2,017 detainees
Gatwick South	1,637 detainees
Stansted	1,210 detainees
Cayley House	1,125 detainees
Heathrow Terminal 5	1,115 detainees
Gatwick North	928 detainees
Manchester	797 detainees
Edinburgh	486 detainees
Birmingham	403 detainees
Glasgow	180 detainees
Holyhead seaport	179 detainees
London City	46 detainees
Total	**17,445**

(Excluding individuals detained more than once, the total number of detainees was 15,985.)

Most common nationalities of detainees

Romanian
Indian
Brazilian
Bulgarian
Colombian

Section 1 Leadership

1.1 Border Force and Care and Custody leaders met regularly and had good working relationships. This had encouraged collaborative working at all levels and we saw positive examples of local operational problems being managed through goodwill on both sides.

1.2 Leaders had not resolved the serious and worsening problem of lengthy detention in rooms that were not designed for residential stays. In particular, the Luton airport facility was unfit for purpose and leaders had not established a clear timeline for provision of more suitable accommodation, despite discussions with airport authorities over several years.

1.3 The newly built holding rooms at Manchester were a good example of what could be achieved with forward thinking and successful joint working. It was also positive that leaders had advanced plans to refurbish and expand the Heathrow facilities by the end of 2024. In the meantime, progress on relatively simple matters, such as installing toilet seats, was far too slow at several sites, largely because Home Office staff had been unable to secure the consent of airport authorities.

1.4 While a good amount of data were now gathered to support strategic and operational management, the data returns were not verified and were of questionable accuracy. Data were also not analysed sufficiently well or used to make changes.

1.5 The identification of vulnerable individuals varied greatly across the facilities, suggesting that leaders had not done enough to ensure consistent understanding and application of safeguarding policies.

1.6 However, leaders ensured regular monitoring of children in most facilities and Care and Custody leaders had improved the focus on safeguarding through, for example, a regular national safeguarding meeting and a well-designed induction that included questions about vulnerabilities.

1.7 Care and Custody leaders did not do enough to make sure that good policies, such as offering suitable mobile phones to detainees, were consistently applied.

1.8 The availability of Aeromed paramedics in the larger airports was a positive development, but leaders continued to implement a policy that refused detainees nearly all access to their medication, which was disproportionate.

Section 2 Safety

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

Arrival and early days in detention

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

2.1 Most detainees in the holding facilities had arrived on commercial flights or, at Holyhead, by ferry. Some were also brought from other places of detention to await a removal flight. They either walked to the holding room or were transported in vehicles that were in generally good condition (see paragraph 2.27).

2.2 Care and Custody staff searched people in a sensitive and friendly manner. Adults received a rub-down search followed by a search using a hand-held metal detector or 'wand'. Children were only subjected to a search using the wand, which avoided unnecessary physical contact, but was still potentially disturbing for a child. These searches were often not conducted in private and some took place in front of other detainees.

2.3 Induction interviews were generally completed thoroughly and we saw some excellent examples of staff speaking to detainees sensitively and clearly about what they could expect while held in the holding room, for example at Gatwick South and Heathrow Terminal 3. However, in most facilities interviews were not conducted in a private or quiet area and, while useful questions about risk and vulnerability were included in the induction checklist, they were not always asked by staff.

2.4 Care and Custody staff were reasonably attentive to detainees in their care in nearly all facilities. However, detainee custody officers (DCOs) sometimes failed to respond to reasonable requests at times when they were not particularly busy. For example, at Gatwick South, we observed a detainee politely and patiently asking for a phone call to his family over the course of several hours. He only received it when inspectors relayed one of his many requests to the DCOs in the staff office. More assertive operational management was required in such cases to ensure a consistent level of care.

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.

2.5 Border Force teams in all ports included well-trained safeguarding and modern slavery (SAMS) specialist officers. We were told that, on the rare occasions when they were not available, staff could contact regional safeguarding teams for advice. The SAMS trained officers had good knowledge of modern slavery, forced marriage and female genital mutilation. However, while about 120 detainees had been subject to the Home Office policy on adults at risk in immigration detention in the previous six months, none of the staff we spoke to was sufficiently familiar with important features of the policy, such as the various risk levels.

2.6 Border Force did not systematically verify and analyse safeguarding data to help determine the effectiveness of Border Force teams in identifying concerns at different ports. There were anomalies in the safeguarding data provided by Border Force, which suggested it was not reliable. For example, despite being the busiest port, the team at Luton had identified just three potential victims of modern slavery while there were 29 referrals at Terminal 4 at Heathrow. Overall, in the previous six months, Border Force teams had identified 136 potential victims of modern slavery, while detaining almost 16,000 people.

2.7 We saw some good examples of SAMS lead officers promoting the importance of safeguarding with staff, particularly in Heathrow Terminal 3, although safeguarding needs were not always sufficiently explored. (see case study 1) and identified need was not always acted on (see case study 2).

Case study 1

A woman was found at border control to be carrying a substantial quantity of cigarettes. She gave different accounts about how she came to have them; in one informed Border Force that her boyfriend had packed her cases and she was unaware of their contents. During induction, she told Care and Custody she was seven weeks pregnant and became upset. She stated she did not want to telephone her boyfriend and that she had no next of kin. There was some evidence that Care and Custody had informed Border Force that the woman was pregnant, but not that she had declined a phone call to her boyfriend. There was no record in the Border Force electronic case management system of the woman's pregnancy. The interview record with the woman suggested that no consideration had been given to the possibility that she had been coerced into carrying the cigarettes such that a National Referral Mechanism referral might have

been appropriate. She was removed to her country on the same day that she arrived.

2.8 Care and Custody staff opened a vulnerable adult warning form (VAWF) for detainees considered to be vulnerable. VAWFs, which provided a means of making sure that vulnerable detainees received appropriate support, were not always opened when needed and were poorly focused on the individual needs of each detainee. Recorded checks suggested no or cursory interactions.

2.9 Care and Custody staff had a basic understanding of trafficking and other vulnerability issues. They said they would report any concerns to Border Force, but they did not maintain a record of safeguarding referrals at any site.

2.10 Self-harm was rare and staff carried anti-ligature knives. In one case, we observed staff spending considerable time talking to a particularly distressed and vulnerable young man at Terminal 3 and making sure that he had quick access to a phone call.

2.11 DCOs had rarely witnessed tensions or bullying between detainees. Use of force was infrequent, with only 14 instances during the previous year. Most paperwork was completed well enough to show justification for force being used, although some reports lacked sufficient detail.

2.12 We reviewed footage of two incidents in Heathrow, both of which showed that force had been justified and that there had been good initial efforts at de-escalation. However, in both cases staff took too long to gain safe control of the detainees and ongoing efforts to de-escalate were too limited. Some poor restraint techniques were used, for example in the application of handcuffs and head control, and staff were slow to call for medical support.

2.13 All DCOs had received annually refreshed training in restraint techniques for use with adults, but no staff had been trained in the safe use of force on children.

2.14 Supervision of the holding rooms was adequate overall. However, at Luton staff were often too busy to supervise detainees appropriately and at Stansted some detainees were left unsupervised in interview rooms for extended periods.

2.15 Escort staff seldom used restraints or guiding holds when taking detainees through secure areas to the holding room or to departure gates. However, in one case the use of handcuffs during a hospital escort was questionable given the co-operative approach from the detainee who was in a secure area for part of his journey. Children were never handcuffed.

Safeguarding children

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

2.16 Eight per cent of detainees (1,281) during the previous six months were accompanied children and 1% (149) were unaccompanied children. Both groups had been detained for an average time of about 6.5 hours, which was too long. No unaccompanied children were held for more than 24 hours, but 20 had been in holding facilities in excess of 12 hours. Six children travelling with an adult had been held for more than 24 hours. In the cases that we reviewed, delays in Children's Services agreeing to accept and collect children were a significant factor in the length of their detention (see case study 2). However, no facility kept data on the timeliness of social services referrals and responses. We were not satisfied that child safeguarding referrals were always made when necessary (see case study 2).

2.17 In two cases that we reviewed, we saw some good initial action taken to safeguard children, including prompt referrals to Children's Services. However, in one case, a vulnerable child was released to unsafe accommodation while safeguarding enquiries were continuing (see case study 3). In the other case, a 15-year-old child and her 20-month-old baby were not bailed to social services care, but instead detained for 49 hours while arrangements were made for their removal. There was good collaboration between the UK and Romanian authorities: reception arrangements were in place in Romania, and the girl and her baby were accompanied on the journey by social services.

Case study 2

A woman was detained with her children, aged 9 and 6. In her interview with Border Force, she disclosed that she was a victim of domestic violence at the hands of her husband who remained in her country of origin. She also disclosed that he had physically abused her two children. A note in Border Force records states that she should be signposted to domestic violence support, but this was not acted on. Despite evidence that the children might have suffered significant trauma, Border Force did not ask their mother to provide any further details of the abuse and no referral was made to Children's Services to establish the welfare of the children and the possible continuing impact of trauma.

2.18 A significant variation in child safeguarding referrals was made by each port. For example, for no obvious reason, in the six-month period to the end of November 2023, child safeguarding referrals varied from 4% in Luton to 14% in Birmingham and 43% at Terminal 5 Heathrow. It was not possible to establish if these disparities were the result of divergent safeguarding practices or poor data collection (see paragraph 2.6). However, it was clear that child safeguarding referrals were not always made when necessary (see case study 2).

2.19 While all Border Force staff had undergone security vetting, only SAMS trained officers had Disclosure and Barring Service (DBS) checks to the enhanced level. The latter were not always available to interview children in some ports and children could therefore be interviewed by someone who had not been DBS checked at a level appropriate to working with children and vulnerable adults.

2.20 In Gatwick and Heathrow terminals an independent responsible adult could sometimes be supplied by a specialist social worker-led NGO, Travel Care. Otherwise, at all facilities, responsible adults were usually drawn from airline staff or sometimes chaplains. There was no requirement for these staff to be trained for the role. In Glasgow, we found that a 17-year-old boy experiencing mental trauma was interviewed alone because no responsible adult was available.

2.21 Children were usually searched using a hand-held metal detector, which avoided the need for physical contact. In Luton, it was a considerable concern that children were not always held separately from unrelated adults because of a lack of space. Care plans were usually opened for child detainees to help provide consistency of care, but their tick-box format did not promote individualised care. For reasons that were not clear, no plans were opened for most children held in Holyhead.

2.22 Border Force staff we spoke to were familiar with Home Office guidance on the age assessment of children. Age disputes seldom arose, with just seven in the last six months. The majority of these found the detainee to be a child.

Case study 3

A 15-year-old girl arrived at an airport with a 31-year-old man. She initially described him as her boyfriend, but subsequently said he was her cousin. She was known to social services as she had stayed at her cousin's address on a previous visit to the UK, when she had attended hospital due to a miscarriage. The police took no action on this occasion as they mistakenly believed her pregnancy was conceived in a country where the age of consent is 14. In fact, Border Force records, which were not checked at the time, confirmed that her pregnancy was conceived in the UK.

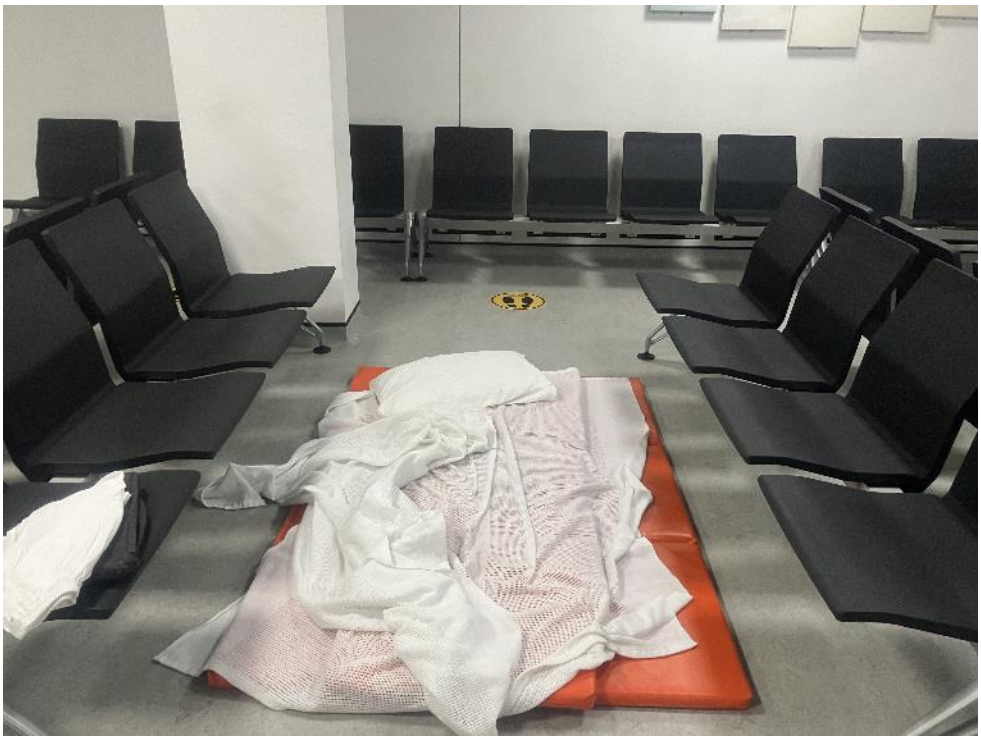
The girl's cousin was admitted to the UK and she was detained as an unaccompanied child. Prompt referrals were made to the NRM, Barnardo's and Children's Services. Social services would not accommodate her, as the matter had previously been investigated and her file closed. Rather than holding the girl until the next day, Border Force bailed her to her cousin's address while its concerns that she was at risk there were still being explored. No other action was taken to safeguard her.

The next day, following further representations, social services and the police visited the child at her cousin's property. Following interviews with the child and her cousin, she was taken into care and her cousin was arrested for trafficking for the purpose of sexual exploitation.

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.

2.23 People were held for far too long in facilities that were not designed for long stays: the average length of detention during the previous six months was nine hours 12 minutes and the longest recorded period of detention was 56 hours 51 minutes.



Mattress and bedding between chairs at Heathrow Terminal 3

2.24 During this period, 15,985 different people had been detained from 170 countries. Some detainees were held more than once and the total number of detention events including these was 17,357. More than a quarter of these, 27%, had been held for more than 12 hours, and 581 (3.6%) for over 24 hours.

2.25 The length of detention was affected by the time taken for an immigration decision, but also by three other factors relating to transfer to and from the short-term holding facility (STHF).

2.26 First, while detainees being removed were, as a rule, brought to the STHF about five hours before the planned departure time, some arrived much earlier than necessary to suit the convenience of the escorting contractor. In one case, a detainee was brought to Gatwick almost nine hours in advance of their flight.

2.27 Second, time in the STHF was often prolonged by waits for onward transport after a decision had been made on the next move, whether into immigration detention or on bail to asylum accommodation.

2.28 Third, considerable periods could be spent in a controlled waiting area (see Glossary) before moving into a holding room, often more than the target time of two hours. Waiting times were usually short at many airports, but they were particularly long in Luton where the overall number of detainees had doubled since our previous inspection.

2.29 It was positive that data were now being collected and recorded systematically across all the STHFs, giving a clearer picture than has been possible in previous inspections. The figures in this report are drawn from HMIP's analysis of the raw data supplied. There was no evidence that leaders in Border Force or Care and Custody were themselves analysing or using the data to detect patterns or trends, to identify specific challenges or plan for the future.

2.30 The authority to detain (IS91) was properly completed in all cases reviewed, although the written reasons for detention were provided in English only. Home Office staff said that they would explain the reasons through interpretation when necessary. Information on risk of harm, or an entry to confirm no known risk, was included in almost all IS91 forms.

2.31 Lists of local advice centres and law firms were displayed in all holding rooms, and many told us they renewed them fortnightly. However, staff in several STHFs had found that these lists were not useful, for example because there was no reply or no relevant service available on that number.

2.32 There was no system of free legal advice. Detainees could ask staff to fax material to their legal adviser, but not all sites facilitated email of documents. Care and Custody staff facilitated a call to a legal adviser on an office phone if no other means was available (see paragraph 4.1).

2.33 Independent Monitoring Board members visited the STHFs regularly, and there was good communication between them, Border Force and Care and Custody.

Section 3 Respect

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

Accommodation and facilities

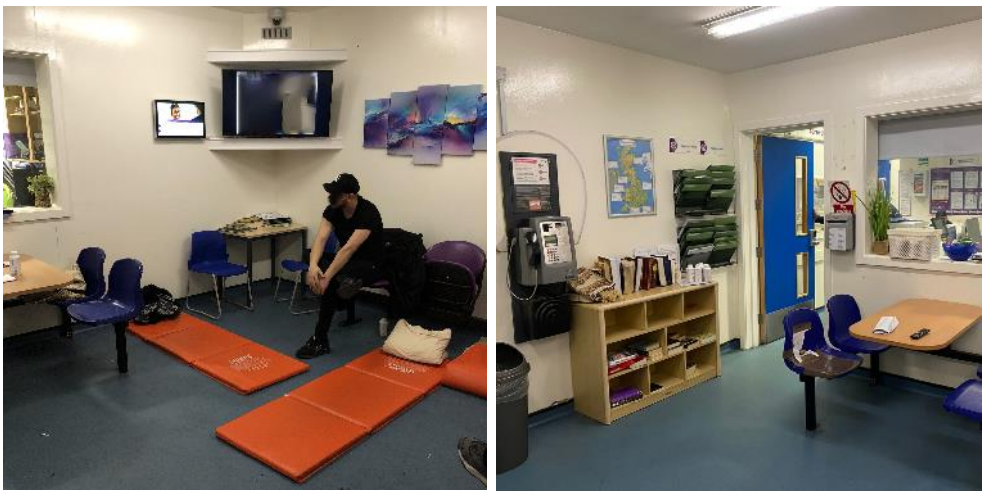
Expected outcomes: Detainees are held in a safe, clean and decent environment. They are offered varied meals according to their individual requirements. The facility encourages activities to promote mental well-being.

3.1 The majority of holding rooms were spacious, clean and well maintained, with plenty of seating and tables for the number of detainees. They contained televisions, magazines, newspapers and books, some in different languages. The new facilities at Manchester airport were particularly well designed and equipped. They provided a range of suitable seating, including soft chairs and bean bags, as well as reasonably thick fold-out mattresses. Fridges were available to keep drinks and food chilled and the facility had a separate multi-faith room.

Main holding room at Manchester

Manchester family room

3.2 However, the holding rooms at Luton and Stansted were small and grubby, with damaged seating and flooring. At Luton, we spoke to many detainees who were frustrated and upset at the poor conditions. They included two men who had been in detention overnight, one for nearly 24 hours, in a cramped environment where body odours intermingled with food smells, to create an unpleasant and oppressive environment. Nearly 3,000 people had passed through the main and family holding rooms at Luton in the previous six months.



Main holding room at Luton

3.3 Most facilities were well ventilated and had a comfortable temperature, but none had an outdoor area where detainees could get fresh air. Apart from Birmingham, no facilities had natural light and clocks, where present, were not 24-hour. Some detainees we met were confused and disorientated about whether it was day or night.

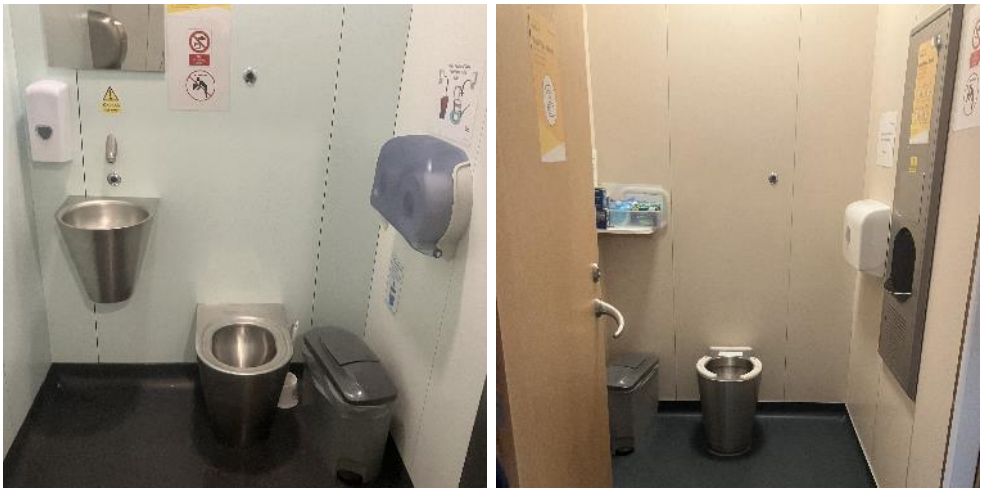
3.4 None of the facilities was suitable for overnight stays. Most had thin plastic covered mats, but not always enough to meet need. Thicker fold-out mattresses were only provided in a minority of sites. Pillows and blankets were available, but on occasion they were not offered by staff when required.

3.5 Most facilities had only one main holding room for single adults. We were told that, unless they presented as particularly vulnerable, single women would be placed with adult males even if the family room was empty. This was particularly problematic for women held for long periods who might, for example, want to use showers or to sleep.

3.6 Family holding rooms were generally in good condition and decorated with posters and bright murals for children. A selection of toys, games and age-appropriate books were available in the rooms. Although some were limited in their offer, the family room of Gatwick North terminal had various brand-new picture books in many languages, including French, Portuguese, Turkish, Albanian, Vietnamese, Urdu, Punjabi, Malayalam, Hindi, Spanish and Farsi.

3.7 There were problems with the design of many family areas. At Stansted, Gatwick North and Heathrow Terminals 2 and 5, the family rooms were too small to accommodate large families comfortably. At Edinburgh and Heathrow Terminal 5, families had to walk through the main holding area to access toilets while, at Terminal 5, Care and Custody staff had no direct line of sight into the family room and instead monitored the area through CCTV. The family holding room at Birmingham was cold and generally not in use because of persistent problems with temperature control.

3.8 Showers and toilets, including those for detainees with disabilities, were mainly clean and well maintained, although not in Gatwick South where the condition of one toilet floor was too poor for it to be kept clean. The metal toilets for use by adults and children at Edinburgh and several Heathrow terminals had no seats.



Toilets without seats at Heathrow Terminal 3

3.9 There were no showers for detainees at Luton, Stansted, Edinburgh and Glasgow, and we were told that the shower at Heathrow Terminal 2 was not in use because of a risk of Legionella bacteria. Detainees who needed a shower could be transferred to other short-term holding facilities in the airport. Basic toiletries, sanitary products, nappies and clothing were readily available at all facilities.

3.10 A range of basic ready meals was available and adequate for short stays, and staff said that they occasionally bought food for special diets from the airport. Snacks were easily accessible and in good supply, including croissants, cereal bars, fruit pots, crisps and sometimes fruit and pots of noodles. Baby food was also available. Cold drinks were freely available in the holding rooms, although hot drinks had to be provided by staff at Stansted, Edinburgh and Glasgow.

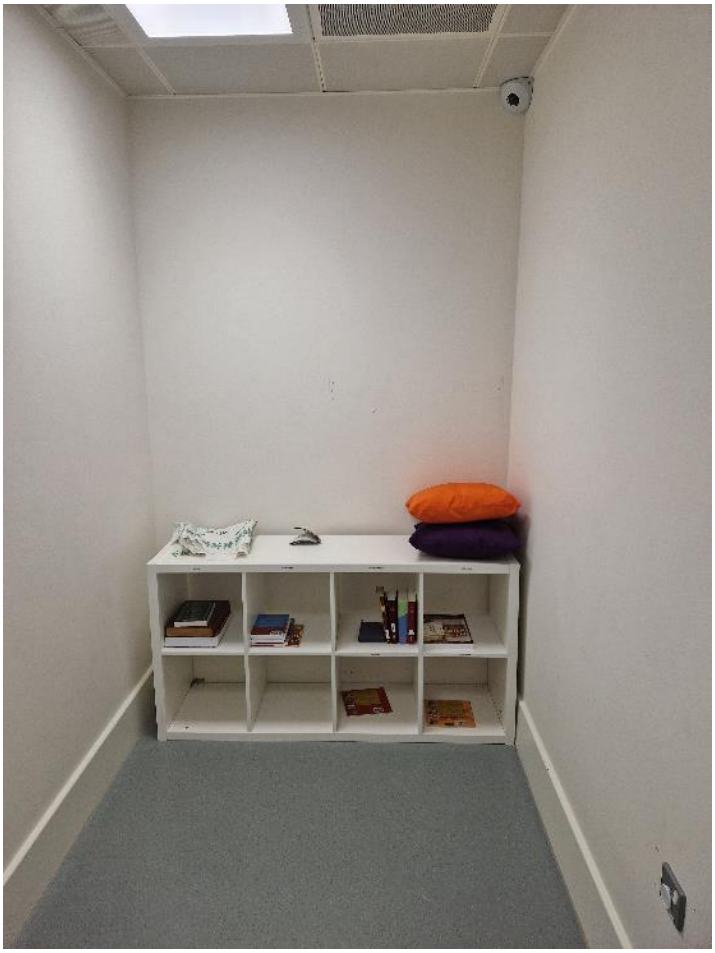
Respectful treatment

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.

3.11 Detainees we spoke to were largely positive about Care and Custody staff. We saw some good interactions where staff introduced themselves, used first names and were responsive to detainees' needs. However, there were some exceptions at the busiest sites, for example we observed an induction where a detainee's concern about not understanding what was being said was laughed at and dismissed.

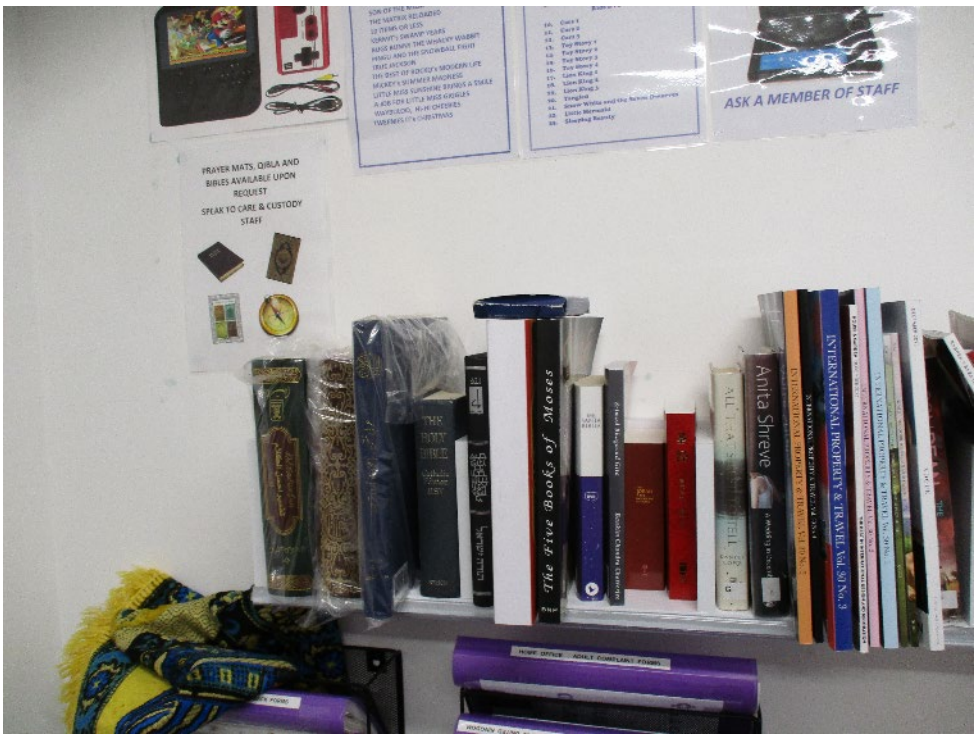
3.12 In general, staff used phone interpreting well for induction and we saw some excellent examples of this at Heathrow Terminal 3 and Stansted. At these sites, staff continued to use phone interpretation during searches and explained what they were going to do at each stage. There was little evidence that interpretation was used beyond induction and, although staff had access to hand-held devices with translation applications, they were rarely used.

3.13 Manchester and Gatwick North had dedicated multi-faith rooms and we observed the room in Manchester being used by a vulnerable detainee who had arrived upset. We observed a DCO in Manchester appropriately asking Border Force to wait until a detainee had finished his prayers before taking him for interview.



Multi-faith room at Manchester

3.14 Religious texts and artefacts were available in all holding rooms, but the range of translated options varied. For example, Gatwick had the Bible translated into eight languages and the Qur'an into six languages which was much more than other facilities. At Luton and Glasgow, prayer mats were not respectfully used or stored.



Religious texts and prayer mats at Glasgow

3.15 The holding rooms had generally good accessibility and adaptations for those with mobility difficulties. Most sites had female staff on duty for inductions and searches and, when they were not available, we were told that either female Border Force staff searched women detainees or they were searched using a hand-held metal detector only. Incident reports and vulnerable care forms were opened for pregnant women and led to increased observations.

3.16 Few complaints were submitted: in the previous 12 months, we were told that Care and Custody had received 14 complaints and Border Force five. Where contact details were provided, Care and Custody sent responses to detainees. Most responses that we reviewed were timely, clear and polite with a reasonable investigation, and gave an apology when needed. However, Border Force took much longer to respond, usually five to eight months, and we saw one outstanding response from a complaint made over a year previously.

3.17 All holding rooms had complaint forms in 21 languages and boxes which were regularly emptied by Border Force staff. However, Luton did not have forms in key languages and did not respond to inspectors who submitted a test complaint. Many staff also reported confusion and uncertainty about what to do with complaints written in another language, and we were not confident that all these complaints were properly processed. Consequently, the actual number of complaints received may have been higher than the official numbers reported. Very few sites provided pens or pencils alongside the complaint forms.

3.18 There was still no routine health screening on arrival or after 24 hours of being detained at any of the facilities. However, it was positive that some of the busiest airports (Luton, Heathrow, Gatwick and Stansted)

had introduced health care coverage from a 24-hour on-call paramedic service (Aeromed), which was an improvement since our previous inspections. The other airports continued to rely on more limited medical support from a shared airport paramedic who might be engaged in other duties, or they called the NHS 111 telephone advice service.

3.19 Detainees continued to be denied access to their prescribed medication even if Aeromed staff were available, which resulted in them being sent to hospital unnecessarily. For example, at Holyhead a detainee was taken to hospital in handcuffs so he could take his prescribed mental health medication. At Gatwick, Aeromed would not see a detainee with epilepsy and advised DCOs to call an ambulance if the person had a seizure.

3.20 Staff now offered nicotine lozenges for all new arrivals who were smokers.

Section 4 Preparation for removal and release

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

Communications

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

4.1 If a detainee's phone had a camera or internet access, it was removed and stored with their possessions. Most detainees had good access to an incoming-only phone in each holding room and could give family and friends this number on arrival. We also observed many detainees being offered a phone call following their induction, although at Luton and Gatwick South this had not happened in some cases. At Heathrow terminal 5, the holding room phone had been broken for several weeks.

4.2 All facilities had non-camera mobile phones, which they could give to detainees to use with their own SIM. However, staff practice in offering them varied widely and we saw very few being used by detainees. For example, despite the Heathrow Terminal 5 phone being out of order intermittently since July 2023, the log showed that mobile phones had been issued only seven times during a period when over a thousand detainees had been held. At Manchester and Stansted, detainees could not use the mobile phones because the signal was too poor.

4.3 Some of the facilities had wi-fi available but detainees were unable to use it at the time of the inspection. No detainees were allowed to video-call, send emails or access websites. The reason for a complete ban was unclear. Faxes were sometimes available, but we were told they were rarely used.

4.4 Visitors were not allowed at any of the holding rooms because of security restrictions imposed by the airports.

Leaving the facility

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

4.5 For those being released, useful translated information was available about sources of support in the community. Detainees being transferred to further detention were told why this was necessary and information about the centre to which they were being transferred was available at all sites.

4.6 We saw some detainees being escorted to flights to remove them back to the country from which they had travelled. The escorting arrangements were generally adequate.

4.7 Detainees' property was returned to them on release or removal or travelled with them to a further place of detention. Stocks of fresh clothing, including jackets and in some cases footwear, to cater for different climates were also available for issue if required (see paragraph 3.9).

Appendix I About our inspections and reports

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

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

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

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

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

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

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

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

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

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

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

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

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

This report

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

Inspection team

This inspection was carried out by:

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Alice Oddy	Inspector
Steve Oliver-Watts	Inspector
Chelsey Pattison	Inspector
Emma Roebuck	Inspector
Fiona Shearlaw	Inspector
Joe Simmonds	Senior research officer

Appendix II Glossary

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

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

Controlled waiting areas (CWAs) Small demarcated zones within the airside arrivals hall supervised by Home Office staff. CWAs do not have access to any of the facilities of a holding room and people are not permitted to leave them unaccompanied.

National Referral Mechanism (NRM) A framework for identifying and referring potential victims of modern slavery and making sure they receive the appropriate support.

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

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