Report on a national inspection of the short-term holding facilities in the UK managed by

Border Force

by HM Chief Inspector of Prisons

2–13 March 2020

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Glossary of terms

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

IS81 detention authority
The IS81 form gives immigration officers the authority to detain people while they undertake further inquiries.

IS91 detention authority
If, following further inquiries, a detainee is handed over to an escorting contractor, prison or police staff, an IS91 (detention authority) must be served, with an IS91R (reasons for detention). If the detainee remains in the custody of an immigration officer, they should be served with an IS91R.

Responsible adult
Independent people who check on the interests of a child being interviewed.

Fact page

Task of the facilities
To hold individuals and families who have been detained at the border by the UK Border Force.

Location
There are in-use holding facilities at five airports and eight seaports; see Appendix III.

Last inspection
There has been no previous national inspection, but four facilities have been inspected as single facilities: Harwich (2008), Portsmouth (2013), Cardiff (2014) and Bristol (2014).

Escort provider
Mitie Care and Custody

Introduction

This report describes the first national inspection of UK Border Force-run short-term holding facilities (STHFs). It is also the first time that HMI Prisons has undertaken an inspection of STHFs on a national basis rather than as individual facilities or geographical clusters. Inspectors visited 13 STHFs across the country, eight of which were at seaports and five at airports.

Individuals detained at airports generally arrived after short flights, usually from Europe. While some of those detained at seaports had arrived in cars or as foot passengers, most arrived after arduous and often dangerous journeys concealed in lorries and containers. These detainees were subsequently held in often very poor conditions. Local Border Force staff were themselves commonly embarrassed by the low standard of accommodation and lack of facilities.

Border Force was unable to provide us with comprehensive information on the numbers of detainees, length of detention and the types of detainees held. The available data suggested that detainees could be held for lengthy periods, occasionally over 24 hours, in facilities that were not fit for purpose.

The Home Office should inform HMI Prisons – and other members of the UK's National Preventive Mechanism – of any site of detention. In 2019, we became aware that some currently operational STHFs run by Border Force had not been notified to us. Border Force subsequently supplied a list of 11 holding facilities subject to the STHF rules, nine of which were previously unknown to us. This list was amended several times in the lead up to the inspection and during it. Inspectors eventually visited 13 STHFs in seaports and airports, and a further airport to assure ourselves that an old holding facility was not in use.

As will be clear by now, a major finding from this inspection is that there has to date been inadequate leadership and management of detention. The fact that Border Force senior managers could not even tell us with certainty which of their ports actually had detention facilities suggests an alarming lack of oversight and accountability. Despite receiving considerable notice, the list of facilities provided to us changed more than once in the lead up to the inspection, and during it. In many facilities, Border Force staff told inspectors that they felt like they had been 'forgotten' and that there was neither national guidance nor sharing of best practices.

There is an urgent need for Border Force managers to undertake a comprehensive national audit of detention, to assure themselves and the public that all sites of detention are identified, properly equipped for holding detainees and subject to consistent management. We have been informed that work is under way to make substantial improvements, and will examine what progress has been made in due course.

About this inspection and report

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

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

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

> **Safety** – that detainees are held in safety and with due regard to the insecurity of their position
>
> **Respect** – that detainees are treated with respect for their human dignity and the circumstances of their detention (*Note:* Non-residential STHFs are unsuitable for long stays and detainees should not be held in them for more than a few hours. This limits what activities can or need to be provided. We will therefore report any notable issues concerning activities in the accommodation and facilities section)
>
> **Preparation for removal and release** – that detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their country of origin and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.

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

Summary

S1 Detainees at seaports often arrived after arduous and dangerous journeys. We saw respectful treatment by Border Force staff, but there was no formal induction of detainees to identify their immediate needs. The correct legal authorisation for detention was not always completed. Searching practices varied significantly. At some ports, children were searched with a hand-held metal detector and only given a rub-down search if there was an indication suggesting a concealed item, while at others they were rub-down searched routinely. Children were not always searched by officers of the same gender.

S2 Border Force officers had a general understanding of trafficking indicators, and of the national referral mechanism (NRM) to identify, protect and support victims of trafficking and modern slavery (available online at: https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms). However, safeguarding and modern slavery (SAMS)-trained officers were not available on every shift. NRM referrals varied very widely between ports. Border Force officers did not systematically explain the dangers of clandestine entry to detainees being removed from the UK.

S3 Many ports had no means of recording the care provided to detainees. Where recording was undertaken, it was generally poor. Some vulnerable detainees had been held for far too long. In one case, a pregnant woman was detained for over 27 hours; the detention log evidenced little meaningful engagement with her.

S4 Officers at all facilities said they had never witnessed tension or bullying between detainees. There were no recorded incidents of self-harm in the previous year, nor was there any recorded use of force in the short-term holding facilities (STHFs). However, detainees were regularly handcuffed. Risk assessments were not completed at any facility before the planned use of handcuffs, and at two facilities, Poole and Portsmouth, children were regularly handcuffed regardless of risk. Children and adults were also transported in cellular vans without obvious need.

S5 There was inadequate oversight of detention practices for children. Border Force did not keep centralised records of children's detention and could not give us sufficient data to calculate the average length of detention for children. Some children were held for long periods waiting for social services or escort vehicles to arrive. In some cases, unaccompanied children were not permitted to leave ships on which they were found, were not interviewed with a responsible adult (see Glossary of terms) present, and did not have access to legal advice or a telephone call. During our inspection, two children were held on separate occasions at the Scanner building in Immingham. They were treated sensitively, although interpreting was not used when needed.

S6 There was no access to a detention duty legal advice service in any of the facilities and generally limited information about legal advice. There was no management oversight of the length of detention. Border Force did not keep centralised holding room logs. The limited data available suggested that detainees could be held for substantial periods, sometimes in very poor conditions. On average, detainees were held for over eight hours, longer than nearly all of the contracted-out short-term holding facilities inspected in 2019. The average length of detention in individual facilities ranged from one hour 55 minutes in Aberdeen to 14 hours 42 minutes in Harwich. Staff at some facilities did not realise that the STHF rules applied to them.

S7 Physical conditions at most seaports were poor and there was little evidence of any meaningful attempts to soften the environment. Most airport facilities were in a reasonable

state of repair but the holding rooms were generally stark and lacked natural light. Most facilities had only one holding room and could not separate men, women and children. Most detainees were required to share toilets, not all of which could be locked. Detainees travelling in lorries or on wheel axles arrived at ports cold, filthy and exhausted. Showers were available only in three airports and Harwich seaport. None of the rooms were suitable for overnight stays. Detainees could rarely have time in the fresh air.

S8 Basic toiletries, sanitary products and nappies for babies were generally available, although some facilities had none and others had only recently begun to provide them. Not all facilities offered hot drinks and there was a very limited range of food, with no fresh fruit. There were few or no distractions for detainees to occupy themselves, such as books, information leaflets or television.

S9 Where we saw them, staff interactions with detainees were mostly polite, courteous and respectful. Border Force staff generally demonstrated an awareness of the vulnerability and anxieties that detainees could be experiencing. In the previous 12 months, no written complaints had been submitted at any facility, but some had no means to make complaints.

S10 Provision for detainees to practise their religion varied significantly and was inadequate at many sites. Not all facilities were accessible or suitable for detainees with disabilities or mobility issues. There were not always sufficient Border Force female staff on duty to search and supervise female detainees. Where figures were available, they showed reasonable use of interpreters, but we found instances where they were not used quickly enough.

S11 There was no on-site health care provision at any facility but all Border Force staff had received basic first aid training, with some having emergency life-saving and higher first aid qualifications. The NHS 111 telephone advice line was used or ambulances were called when needed. Staff at some ports were not trained in the use of the available defibrillators. All ports had local multi-agency partnership arrangements enabling Border Force to trigger a priority emergency services response. We saw these arrangements used effectively at Hull and Immingham.

S12 Detainees' opportunities to engage with the outside world were very limited. Their ability to make telephone calls was at best restricted, and at worst prohibited. While some ports allowed detainees to use their own mobile phones, others allowed no telephone contact at all, restricting contact with families, friends or lawyers.

S13 For detainees transferring to immigration removal centres, Border Force staff reported regular delays of several hours before the arrival of the escort contractor, Mitie Care and Custody. Some detainees were taken to police stations to await the arrival of ongoing escorts. Staff provided little or no information to detainees about the sources of support available to them on release, in their destination country or the detention centre to which they were being transferred.

Key concerns and recommendations

S14 **Concern:** There was poor governance of Border Force-managed short-term holding facilities. Senior Border Force officials were unclear about which ports had holding facilities. The treatment of detainees varied considerably. Staff often felt they were 'forgotten', lacked guidance or did not sufficiently understand guidance that was provided. Staff had a poor understanding of the STHF rules. Poor data collection, record keeping and accountability left these problems largely unmanaged.

Recommendation: Border Force should undertake a comprehensive national audit and assure itself and the public that all sites of detention are identified, properly equipped and consistently managed, and that local staff are given adequate support and guidance.

S15 **Concern:** Border Force was unable to provide us with comprehensive information on the numbers of detainees, length of detention and the types of detainees held. The available data suggested that detainees could be held for lengthy periods, occasionally over 24 hours, in facilities that were not fit for purpose.

Recommendation: Accurate data should be kept on the number of people detained and the length of their detention. This information should be used, in part, to help reduce the lengths of stay in detention.

S16 **Concern:** Physical conditions at most seaports were poor and there was little evidence of any meaningful attempts to improve the environment. Few facilities provided detainees with access to shower facilities, suitable clean clothing and an adequate range of toiletries. Facilities did not meet requirements for those with mobility issues or disabilities. Most facilities could not separate unrelated men, women and children.

Recommendation: All facilities should provide accommodation that is clean, well equipped, suitable for men, women, unaccompanied children and families, and accessible to those with mobility difficulties or disabilities.

Section 1. Safety

Arrival and early days in detention

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

1.1 Most detainees had arrived at airport facilities on short-haul flights, although some could have been on longer connecting flights. At seaports, some detainees arrived as foot passengers or in cars, but most had been concealed in lorries and containers, including some in refrigerated units.

1.2 None of the holding facilities were permanently staffed. They opened only when someone was detained but could then operate 24 hours a day.

1.3 In airports, detainees were usually detained initially at the border control area under an IS81 detention authority. They then walked a short distance to the holding room if they were subsequently detained on a IS91. At seaports, people were detected in freight lanes or in some cases at border control. They usually had longer journeys to holding facilities in the port, often on escort vehicles, some of which were cellular. Most of the vehicles we saw were in reasonable condition, but the vans used at Killingholme and Immingham were dirty and one van at Tilbury had no safety belts.

1.4 At airports, detainees were searched with a hand-held metal detector and given a rub-down search in private. At the point of detection in seaports, detainees were subject to an initial 'protective search', which aimed to discover concealed weapons. Detainees were searched again when admitted to the holding facilities, and we were told this search was for telephones or documentation that might help to establish their identity.

1.5 There were differing practices in the searching of children at seaports (see key concern and recommendation S14). For example, at Felixstowe and Harwich, they were searched initially with a hand-held metal detector, and if there was an indication of a concealed item this was followed by a rub-down search. At Tilbury and Purfleet, they were given a rub-down search as routine. At some ports, children were not always searched by officers of the same gender (see paragraph 1.64).

1.6 Conditions for detainees were generally reasonable in airports but were poor in most seaports, where detainees often arrived cold, tired and filthy after arduous journeys (see paragraph 1.52 and key concern and recommendation S16).

1.7 There was no formal induction to ensure that detainees were introduced to the detention facility or that their immediate needs were met (see also recommendation 1.67). At some ports we were shown a useful induction checklist to help staff cover all important points, but this had only been issued recently and none of the facilities had yet used it. Some staff were sceptical about the value of the checks that were specified.

Case study 1 – Arrival of 10 Eritreans at Hull

On Tuesday 3 March 2020, a group of 10 Eritreans was discovered inside a container at King George Dock in Hull. The group comprised seven men, two women and a 17-year old boy who was not travelling with any family. The detainees said they had been inside the container for five days. Border Force's response to the arrivals was efficient. However, telephone interpreting was not used

sufficiently to identify the detainees' needs, and the correct legal detention authority (IS91) was not issued promptly.

The group arrived at the port at 9am, concealed in a container originating from Zeebrugge, Belgium. At about 12.30pm, a member of the group phoned 999 from inside the container. The police notified Border Force, who initiated a joint emergency service operation. The police and ambulance services attended the docks.

At 1.25pm the detainees were taken to a temporary incident room in a disused Border Force dock hall, as per the mass arrivals contingency plan. Border Force did not have a short-term holding facility at Hull. An ambulance crew assessed the detainees. We interviewed five detainees using telephone interpreters, and all said that medical staff attending the port had not used telephone interpreting to assess them. Three detainees, both women and a man, were transferred to a local hospital for treatment.

A Border Force officer interviewed the remaining detainees one by one and completed a 'clandestine mass arrivals log' to record their basic details, but did not use a telephone interpreter. Detainees were offered sandwiches and water. Border Force officers searched detainees and their baggage, took their photographs and fingerprints, and issued the written authority to be detained for further examination (IS81) and gave reasons for their detention (IS91R). A senior officer said that the form would be generated electronically once the team were back in the office. However, it could easily have been completed by hand. Detainees had their mobile phones and other possessions removed but were not offered a telephone call.

At 3.20pm, Border Force contacted Hull City Council's children and families department to alert them to the child's presence. A social worker attended the temporary incident room at 5.38pm.

With the help of staff from a local Home Office Immigration Compliance and Enforcement team, all the detainees were given a more in-depth welfare and screening interview from about 3.30pm onwards. These interviews were conducted in private rooms with the aid of telephone interpreting. The use of telephone interpreters allowed detainees to divulge more of their immediate needs, and indeed one detainee was assessed as in need of immediate medical care and transferred to hospital. Had telephone interpretation been used by ambulance staff or Border Force staff earlier, the detainee might have been transferred to hospital more promptly. Border Force officers were mostly polite and respectful.

At 5.47pm, Border Force conducted welfare and screening interviews with the child using telephone interpreting. The social worker also attended the interview. Following the interview, the child was bailed to the care of social services. At 6.55pm, the child left the temporary incident room with the social worker.

At 10.45pm, Border Force staff transferred the remaining five detainees to Morton Hall immigration removal centre, 57 miles away. The four detainees who went to hospital were discharged the same evening and initially transferred to police custody.

Recommendation

1.8 All detainees should be given a formal structured induction to ensure their initial needs in the holding facility are met.

Safeguarding adults and personal safety

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

1.9 Border Force teams at all facilities included officers who had completed a three-day enhanced safeguarding and modern slavery (SAMS) training course. SAMS-trained officers were not rostered on every shift. Border Force was subject to the national Home Office 'adults at risk in immigration detention' policy but officers we spoke to were unaware of basic features of the policy.

1.10 Border Force officers conducted brief welfare checks on clandestine entrants at seaports and those entering holding rooms at airports. Officers had a general understanding of trafficking indicators, and of the national referral mechanism (NRM) to identify, protect and support victims of trafficking and modern slavery (available online at: https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms). Senior Border Force managers told us that their STHFs had made 36 referrals to the NRM in the year to January 2020. However, we were not assured that these figures were accurate as nearly two-thirds of referrals, 22, had come from a single port, Harwich.

1.11 SAMS-trained officers in Aberdeen were particularly alert to the risks of modern slavery and exploitation of those working in the fishing industry. Officers at East Midlands Airport correctly notified the Home Office when a suspected victim of trafficking did not give consent to be referred to the NRM. Border Force in Scotland and the charity Justice and Care (www.justiceandcare.org/about-justice-and-care/), which helps victims of trafficking and modern slavery, were to pilot a 'victim navigator' scheme (www.justiceandcare.org/a-day-in-the-life-of-a-victim-navigator/) shortly after our inspection. The partnership intended to provide extra support to potential victims of trafficking and modern slavery, especially those who were suspicious of authority. It also aimed to improve engagement with victims, connect them with services and prevent exploitation.

1.12 Border Force told us that organised criminal networks smuggled and trafficked detainees through airports and seaports. The deaths in October 2019 of 39 Vietnamese people who had attempted to enter the UK through Purfleet had highlighted the dangers of clandestine entry. Some people were attempting to re-enter the UK clandestinely after being removed. Border Force officers at Purfleet and Tilbury told us that they were not explaining the dangers of clandestine entry to detainees being removed from the UK.

1.13 Posters promoting national safeguarding helplines were displayed in some facilities but detainees' ability to make telephone calls was at best restricted, and at worst prohibited (see paragraph 1.72 and recommendation 1.76).

1.14 There was no process for Border Force to open care plans for vulnerable detainees and no special monitoring arrangements for them. Many ports had no means of recording the care provided to detainees. Where recording was undertaken, it was generally poor and provided little evidence of care given to detainees, beyond the offer of food and drink.

1.15 Some vulnerable detainees had been held for far too long. In Harwich in the year to January 2020, a pregnant woman was detained for 27 hours 45 minutes. The detention log evidenced little meaningful engagement with her beyond the offer of food and drink. Another pregnant woman travelling in a family group had been detained at Harwich six months before our

inspection. Despite the poor records, it was clear that there were avoidable delays in her care. At 7.30am, her father told Border Force officers she was three months' pregnant, and that she had been confined in a van and had not eaten for two days. The NHS helpline was not called until 9.27am. Staff were advised to take her to the local accident and emergency department, which they did at 10.45am. Her pregnancy was confirmed at the hospital. She was returned to the holding room later that day and held for a further six and half hours before being released with her family just after midnight. Border Force was unable to provide us with enough data to enable us to calculate the average detention time for women.

1.16 Staff could maintain good supervision of detainees at all facilities (see paragraph 1.50). Officers at all facilities said they had never witnessed tension or bullying between detainees. Border Force officers at seaports confirmed that 'facilitators' (the driver of a vehicle in which a detainee was found) would be held separately from the people they were carrying.

1.17 Staff at most facilities could not recall detainees harming themselves, but officers in Tilbury cited one incident where a detainee transferring to the Kent Intake Unit (a short-term holding facility in Dover run by Mitie Care and Custody) had made a ligature. Most officers did not carry or even have access to anti-ligature knives. There were no processes to plan for the care of detainees considered to be at risk of self-harm. Risk information was recorded in brief on the document authorising detention (IS91). However, unlike in privately run facilities, staff did not use more extensive suicide and self-harm warning forms to inform ongoing care of detainees or convey risks to escort staff.

1.18 In the 12 months to January 2020, Border Force did not record any use of force incidents in any facilities. We were told that use of force during transport to the facility was noted in individual officers' notebooks and was recorded as a use of force on an online system. These data were not available to us at the time of the inspection and we could not therefore judge whether it was sufficient to provide adequate assurance. Border Force officers underwent five days of personal safety training during their initially training course, and took an annual two-day refresher course. Officers carried handcuffs, protective stab vests and retractable batons.

1.19 Handcuffing practices differed between facilities. At most seaports, handcuffs were routinely used when transferring detainees to detention facilities because of flight risks and concerns about safety in open port areas. However, we were told that some detainees were handcuffed to the rear as a matter of routine, which is more restrictive and unnecessary with compliant detainees. At airports, handcuffs were generally not used. However at Aberdeen, all detainees leaving the facility were handcuffed regardless of individual risk; some walked in handcuffs to the front of the airport in view of the public, where they were handed over to the escorts.

1.20 Contrary to the Home Office's own policy, a risk assessment was not completed at any facility before the planned use of handcuffs. In Poole and Portsmouth, children were regularly handcuffed (see paragraph 1.33).

Recommendations

1.21 Border Force managers should ensure that all cases referred to the National Referral Mechanism are recorded, and that referrals are analysed to inform trends and patterns of trafficking.

1.22 Border Force officers should explain the dangers of clandestine entry to detainees being removed from the UK.

1.23 Border Force officers should complete records that evidence the care offered to detainees.

1.24 Border Force officers should promptly assess and meet the needs of vulnerable detainees, such as pregnant women, who should be swiftly transferred or released.

1.25 Border Force officers should complete warning forms for detainees who may be at risk of suicide or self-harm. The warning forms should accompany detainees to their next place of detention.

1.26 Handcuffs should only be used where there are clearly identified risks, documented in use of force paperwork, to ensure accountability and proportionality.

Safeguarding children

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

1.27 Border Force did not keep centralised records of children's detention and could not give us sufficient data to calculate the average length of detention for children. This lack of centralised recording meant that Border Force senior managers did not have adequate oversight of detention practices. (See also key concern and recommendation S15.) Border Force officers, unlike detainee custody officers in Mitie-run facilities, did not complete child welfare plans.

1.28 Some children were held for long periods and social workers were sometimes slow to collect unaccompanied children from facilities. In Harwich, one 16-year-old boy arrived in the facility at 9.30pm but social services did not attend until 11.10am the next day. In another overnight case in Harwich, social services took 10 hours 30 minutes to attend a detainee claiming to be a minor. In Southend, staff told us there was a lack of clarity about which local authority was responsible for children and that there could be delays as their cases were passed from one authority to another.

1.29 We were told that Border Force called social services promptly when an unaccompanied child was found and saw some examples of this happening (see paragraph 1.36). However, there was no central monitoring of response times and we could not therefore verify that it was always happening.

1.30 In Tilbury, three unaccompanied children were not permitted to leave the two ships on which they were found. We were told they would have been taken off the ship had they claimed asylum. All three were removed from the UK without being interviewed with a responsible adult present, having access to legal advice or being permitted a telephone call. Border Force asked the Belgium police to meet the children on their return.

1.31 Border Force senior managers told us that in the year to 31 January 2020, 157 children had been referred to social services across all the STHFs. However, again we were not assured these figures were accurate. Almost half of these referrals were from Portsmouth alone, and many ports had not referred any children. At Portsmouth we found good relationships between Border Force and the local authority, with prompt referrals and responses.

1.32 At Poole and Portsmouth, Border Force regularly handcuffed children when transferring them to holding rooms regardless of individual risk, which was unacceptable.

1.33 Children could not always be held separately from unrelated adults as some facilities only had a single holding room (see paragraph 1.51). Border Force staff we spoke with were familiar with the correct test to apply when disputing the claimed age of a young person. Before the inspection, Border Force told us that staff or social workers had assessed as adults eight detainees who said they were children.

1.34 During our inspection, two children were held on separate occasions at the Scanner building in Immingham. In the case of one 13-year old boy, Border Force staff were focused on promoting his welfare. Although processing and transferring the child were protracted, this was largely due to concerns that the child could have had coronavirus. Social services were notified promptly of the child's arrival and attended the docks to collect him. There were delays in communicating with the child in English using telephone interpreting (see case study 2).

Case study 2 – Arrival of Afghan child at Immingham

On 4 March 2020 at 9.30am, port security at Immingham dock notified Border Force that a clandestine entrant had been found in a lorry. The lorry had arrived from Vlaardingen in the Netherlands that morning. The situation was handled professionally and sensitively by Border Force but was at times avoidably prolonged.

A team of Border Force officers arrived at 9.47am and were briefed by the driver of the vehicle. The officers opened the rear door of the lorry and helped the child out of it. He was given a brief rub-down search. Other officers proceeded to search the lorry fully to see if anyone else was on board.

A Border Force officer conducted a welfare check with the detainee in the trailer park but was unable to find a telephone interpreter to assist. The child indicated that he had travelled through Italy, which raised concerns that he could be carrying the coronavirus.

At 10am Border Force triggered 'Operation Newlyn', a joint emergency services response, and notified North East Lincolnshire Social Services, Special Branch, the police and medical services. Border Force did not transfer the child from the dock immediately. We were told this was because they did not have a cellular vehicle; the child had been searched and was not refractory, so it was unclear why a cellular vehicle was required. At 10.17am the boy was given crisps and water.

At 10.41am the vehicle arrived and the child was placed in the cellular area at the back of it. He was transported to the short-term holding facility at Scanner Building, arriving at 10.48am. He waited in the vehicle until 11.10am. On entering Scanner Building he was offered water. At this point, Border Force agreed that it would not be able to transfer the child from the facility until he had undergone a medical assessment. As an ambulance had not yet arrived after Operation Newlyn had been triggered, Border Force called 999.

It was not until 11.40am that Border Force spoke to the detainee with a telephone interpreter and the detainee confirmed that he had spent one day in Italy, six days previously. Only at 12.11pm was the detainee offered hot food, a pot of porridge.

At about 1pm, East Midlands Ambulance Service arrived. Border force officers briefed the crew on the detainee's situation. At 1.15pm, two social workers arrived and were also briefed.

At 2.10pm, the ambulance crew took the detainee to a temporary medical centre to be tested for coronavirus. The child was accompanied by a Border Force officer. The social workers followed the

ambulance in their own car. Following the test, the detainee was released into the care of social services. He tested negative for the virus.

Recommendations

1.35 Border Force should keep centralised records of children's detention, including the response times of children' social services, and monitor these to identify trends and patterns in the governance of child detention.

1.36 Unaccompanied minors being removed from the UK should receive a welfare interview with a responsible adult present, have access to legal advice and be given the opportunity to make a telephone call.

1.37 Child detainees should only be transported in cellular vans or handcuffed in very exceptional circumstances, and only following a risk assessment.

Legal rights

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

1.38 There was no management oversight of the length of detention. Border Force did not keep centralised holding room logs in any facility to enable detention times to be monitored easily. We were given some limited data for the facilities we inspected for the previous three months, from which we could make only approximate calculations (the data provided by Border Force was partial and inexact. The figures provided here are the best that could be derived from the poor-quality information that Border Force was able to provide. We have been informed that more systematic recording and collation of data on detention is under way) (see key concern and recommendation S15).

1.39 That data suggested that detainees could be held for substantial periods, sometimes in very poor conditions (see section on accommodation and facilities). On average, detainees were held for over eight hours. This was longer than at any of the nine contracted-out facilities we inspected in 2019 (except Heathrow Terminal 5).

1.40 The average length of detention in each facility ranged widely, from one hour 55 minutes in Aberdeen to 14 hours 42 minutes in Harwich. The longest single period of detention in the three-month period was for 21 hours 41 minutes in Portsmouth. In Harwich, we found a case of a pregnant woman held before this period for almost 28 hours (see paragraph 1.16).

1.41 Data provided by Border Force did not enable us to calculate the average length of detention for children or women. At most facilities, staff described various factors which could increase the length of detention, for example, lengthy delays in social services attending to take children into care (see paragraph 1.29). Some facilities told us there were also delays in escort vans arriving to transport detainees to immigration removal centres - in Harwich, we were told it could take up to 12 hours for an escort van to arrive. Poor record keeping meant that such delays could not be quantified. This left Border Force poorly placed to address the problem and reduce the length of detention.

1.42 Detainees were initially held under an IS81 detention authority. We were told that the IS91 authority for longer detention was generally issued within four hours.

1.43 Reasons for detention were issued with the IS91. They were not translated, but Border Force told us that they explained the reasons for detention using telephone interpreting. However, most facilities did not keep central records of the use of telephone interpreting, and we were not satisfied it was always used when necessary (see case study 2).

1.44 There was no access to a detention duty legal advice service in any of the facilities. In Aberdeen and Cardiff, there were notices advising detainees about legal advice. None of the other facilities had any such information. In practice, a detainee's ability to contact a lawyer depended on where there were. Some facilities had a blanket prohibition on any contact with the outside world (see paragraph 1.72). In most facilities, staff did not understand that detainees might have legal support needs. A Border Force manager at Tilbury suggested that detainees had no right to legal representation while they were held there.

1.45 In three cases in Tilbury, three unaccompanied children were removed from the UK without being interviewed in the presence of an appropriate adult (independent individuals who provide support to children and vulnerable adults in custody), access to legal advice, or permitted a telephone call (see paragraph 1.38).

1.46 The differences in practice for searching, handcuffing, contact with the outside world and access to legal representation suggested that staff had little understanding of the Short-term Holding Facilities Rules 2018. For example, staff in Tilbury and Purfleet were unclear about the status of the holding facilities there and did not consider that the rules applied to them (see key concern and recommendation S14).

Respect

Accommodation and facilities

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

1.47 Conditions at most seaports were poor. They all had fixed seating and there was little evidence of any meaningful attempts to improve the environment. Conditions at Killingholme and Felixstowe port were especially poor for even short stays, and the latter was particularly filthy (see photographs Appendix II). Most airport facilities were in a reasonable state of repair but the holding rooms were generally stark and lacked natural light.

1.48 Border Force staff told us they would supervise detainees at all times, allowing detainees to gain staff attention easily and quickly in an emergency. However, at Killingholme supervision was by CCTV only; at Cardiff, supervision was theoretically possible from the observation room, but as the room faced away from the holding facility, staff told us they used CCTV.

1.49 Most facilities had only one holding room and did not have the space to separate men, women and children. Border Force staff told us that special arrangements would be made if separation was required, such as the use of interview rooms. A designated family room was available at Portsmouth and Harwich ports, although both were grubby, and at Harwich the room was small and stuffy. (See key concern and recommendation S16.)

1.50 Most detainees were required to share toilets, not all of which could be locked. Shower facilities were in generally good condition and accessible, but only available in three airports and Harwich seaport. Detainees travelling in lorries or on wheel axles could arrive at ports cold, filthy and exhausted. Where there were no showers they could only wash in hand basins. All rooms had heating. (See key concern and recommendation S16.)

1.51 Basic toiletries, sanitary products and nappies for babies were generally available, although some facilities had none and others had only recently begun to provide them. Access to clean clothing varied, with some facilities not having any at all. This was poor given the condition of some arriving detainees. None of the rooms were suitable for overnight stays. Many detainees were held overnight and some could stay in the facilities up to 12 hours or longer (see paragraph 1.41). Not all facilities had blankets and pillows and sleeping arrangements were generally poor, with detainees sleeping on the floor in some facilities.

1.52 Detainees were offered water but not all facilities offered hot drinks. A very limited range of ready meals were available but no fresh fruit or other fresh food was provided. Food was not always freely available. In some facilities, Border Force officers would go to terminal shops to buy sandwiches, and in one facility staff said they would buy items with their own money because there was no petty cash. The food available at other facilities was limited, mainly consisting of pasta, noodle pots or frozen ready meals.

1.53 There were few distractions for detainees to occupy themselves, such as books, newspapers or information leaflets. Most facilities offered nothing at all and only some provided activities for children, such as toys, books and DVDs. Most facilities did not allow detainees access to fresh air. However, some staff said they would accommodate this where they could, and we did see a record of a detainee being taken outside.

Recommendations

1.54 Detainees should be offered a suitable range of food and drink that is readily available and meets their individual needs.

1.55 Detainees should have sufficient activities to occupy themselves, and access to the fresh air.

Respectful treatment

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

1.56 Detainees were held at only two of the sites that we visited. Staff interactions with detainees were mostly polite, courteous and respectful. In the case of one unaccompanied minor, staff were particularly mindful of the child's emotional well-being and sensitive to his vulnerabilities (see paragraph 1.29 and case study 2).

1.57 At other sites, most Border Force staff demonstrated an awareness of the vulnerability and anxieties that detainees would likely be experiencing. However, entries in the detention logs we reviewed were largely perfunctory and provided little evidence of the care provided (see paragraph 1.15 and recommendation 1.24).

1.58 In the previous 12 months, no written complaints had been submitted at any facility. At Harwich, forms were available in 20 different languages, but elsewhere they were usually in English only. Too often, detainees were unable to submit complaints confidentially, and in some facilities there were no complaint forms or boxes at all.

1.59 Local Border Force staff usually had no collated information on how many detainees had been held in the facilities. The most common countries of origin for detainees were unknown. All staff had a good awareness of the professional telephone interpreting service available to them, and we observed it being used competently on several occasions. However, it was not used consistently or early enough to undertake welfare checks and identify detainees' needs (see case studies). The service had been used 615 times in nine facilities during the previous 12 months. These figures did not include Harwich, Southend and Felixstowe, which could not provide any records.

1.60 Border Force staff confirmed that they completed online equality and diversity training annually, but training records were not always up to date. Provision for detainees to practise their religion varied significantly but was inadequate at many sites. Religious artefacts, usually prayer mats, a compass, Bible and Qur'an, were available in only about half the sites we inspected. In other sites, provision was poor or non-existent.

1.61 Detainees' protected characteristics were not identified systematically on arrival and so they were not always recognised and addressed. Not all facilities were accessible or suitable for detainees with disabilities and mobility issues. The facilities at Bristol and Aberdeen offered wheelchair-accessible showers and toilets, but most ports had few or no suitable adaptations to meet access requirements, such as handrails or emergency pull cords. (See key concern and recommendation S16.)

1.62 There were not always sufficient female Border Force staff on duty to search and supervise female detainees and children. At the small number of facilities where this was the case, such

as Cardiff, staff attempted to seek assistance from the airport security contractor. However, at Poole, we were told by staff that male staff could be used to undertake 'protective searches' (see paragraph 1.4) of female detainees was inappropriate.

1.63 All Border Force staff had received basic first aid training, with some having emergency life-saving and higher first aid qualifications. However, at some ports, staff were not trained in the use of the defibrillators. There was no on-site health care provision at any facility. Most detainees were not permitted to retain their own medication. Where access to medication, advice or treatment was required, staff usually contacted the NHS 111 telephone helpline or 999 for emergency services. Some facilities also had access to paramedics, and Felixstowe had its own ambulance service.

1.64 All ports had local multi-agency partnership arrangements enabling Border Force to trigger a priority emergency services response. We saw these arrangements used effectively at Hull and Immingham (see case studies).

Recommendations

1.65 Border Force staff should use professional telephone interpreting services throughout all stages of their engagement with detainees, especially during initial welfare checks.

1.66 Detainees, including those who do not speak English, should have effective access to a confidential complaints process.

1.67 Detainees should have access to relevant artefacts to practise their religion.

1.68 Female detainees should only be searched by female staff.

1.69 Facilities should identify detainees' protected characteristics on their arrival to ensure their needs can be quickly identified and addressed.

Preparation for removal and release

Communications

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

1.70 Detainees' ability to engage with the outside world was very limited. Policies about access to telephones limited the ability of many detainees to contact families, friends or legal support. The most severe approach applied at Immingham, Killingholme, Tilbury, Purfleet and Felixstowe ports, where detainees were not permitted any means of making contact with the outside world throughout their detention. This was an excessive restriction and not based on individual assessment of risk.

1.71 At Southend and Bristol airports, detainees could retain their smartphones, which was positive. Mobile phones were confiscated in all other facilities, although some provided access to an alternative non-internet-enabled mobile phone. Detainees at Aberdeen Airport could have supervised access to their own mobile telephones to obtain numbers and they were then given access to a staff telephone to make calls. Harwich was the only facility with a payphone. At Portsmouth, detainees were offered a free call on the staff telephone, but only to a UK number.

1.72 At Portsmouth and Bristol, Border Force staff could scan and email documents on behalf of detainees. At Aberdeen and Bristol airports, detainees could ask Border Force staff for use of a fax.

1.73 Detainees could usually not use email, social networks, the internet or video-calling. The only exception was at Southend and Bristol airports, where detainees were permitted to use any facilities available to them on their mobile phones.

Recommendation

1.74 All detainees should be able to make telephone calls to family, friends or lawyers.

Leaving the facility

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

1.75 Detainees could be released unconditionally or on bail; transferred to further detention in an immigration removal centre (IRC); detained in a police station; detained at another short-term holding facility (STHF) pending removal; or detained at another STHF because of the unsuitability of port detention facilities.

1.76 For those transferring to IRCs, Border Force staff reported regular delays of several hours before the arrival of the escort contractor, Mitie Care and Custody. Border Force staff in some facilities said they sometimes took detainees to police custody, from where they were

collected by Mitie Care and Custody or bailed. At Tilbury and Purfleet, Border Force staff said they took detainees to the Stansted Airport STHF because conditions there were better. In some cases, Border Force took detainees to IRCs themselves to avoid lengthy detention at port facilities.

1.77 At King George Dock in Hull, we observed detainees being kept up to date about what was happening to them in a language that they understood. The detention logs at the other sites had little evidence that detainees were kept up to date.

1.78 Staff provided little or no information to detainees about the support available to them on release, in their destination country or the detention centre to which they were being transferred.

1.79 In some facilities, such as Aberdeen, Portsmouth, Immingham and Killingholme, handcuffs were nearly always used on detainees for onward travel to another place of detention. At other sites, such as Cardiff and Bristol, handcuffs were not routinely used. Where Border Force was transferring detainees, we were told that information during the journey was not always recorded on a standard person escort record (PER) but instead on IS91s, or even in notebooks. At Aberdeen and Bristol, detainees leaving the facility were led by uniformed staff through public areas of the airport, and in handcuffs at Aberdeen (see paragraph 1.20).

Recommendation

1.80 Detainees leaving the STHFs should be advised about what is going to happen to them next, in a language they understand, and be informed about relevant support agencies they could approach for assistance.

Section 2. Summary of recommendations

Key concerns and recommendations — To Border Force

2.1 **Concern:** There was poor governance of Border Force-managed short-term holding facilities. Senior Border Force officials were unclear about which ports had holding facilities. The treatment of detainees varied considerably. Staff often felt they were 'forgotten', lacked guidance or did not sufficiently understand guidance that was provided. Staff had a poor understanding of the STHF rules. Poor data collection, record keeping and accountability left these problems largely unmanaged.

Recommendation: Border Force should undertake a comprehensive national audit and assure itself and the public that all sites of detention are identified, properly equipped and consistently managed, and that local staff are given adequate support and guidance. (S14)

2.2 **Concern:** Border Force was unable to provide us with comprehensive information on the numbers of detainees, length of detention and the types of detainees held. The available data suggested that detainees could be held for lengthy periods, occasionally over 24 hours, in facilities that were not fit for purpose.

Recommendation: Accurate data should be kept on the number of people detained and the length of their detention. This information should be used, in part, to help reduce the lengths of stay in detention. (S15)

2.3 **Concern:** Physical conditions at most seaports were poor and there was little evidence of any meaningful attempts to improve the environment. Few facilities provided detainees with access to shower facilities, suitable clean clothing and an adequate range of toiletries. Facilities did not meet requirements for those with mobility issues or disabilities. Most facilities could not separate unrelated men, women and children.

Recommendation: All facilities should provide accommodation that is clean, well equipped, suitable for men, women, unaccompanied children and families, and accessible to those with mobility difficulties or disabilities. (S16)

Recommendations — To Border Force

Arrival and early days in detention

2.4 All detainees should be given a formal structured induction to ensure their initial needs in the holding facility are met. (1.8)

Safeguarding adults and personal safety

2.5 Border Force managers should ensure that all cases referred to the National Referral Mechanism are recorded, and that referrals are analysed to inform trends and patterns of trafficking. (1.21)

2.6 Border Force officers should explain the dangers of clandestine entry to detainees being removed from the UK. (1.22)

2.7 Border Force officers should complete records that evidence the care offered to detainees. (1.23)

2.8 Border Force officers should promptly assess and meet the needs of vulnerable detainees, such as pregnant women, who should be swiftly transferred or released. (1.24)

2.9 Border Force officers should complete warning forms for detainees who may be at risk of suicide or self-harm. The warning forms should accompany detainees to their next place of detention. (1.25)

2.10 Handcuffs should only be used where there are clearly identified risks, documented in use of force paperwork, to ensure accountability and proportionality. (1.26)

Safeguarding children

2.11 Border Force should keep centralised records of children's detention, including the response times of children' social services, and monitor these to identify trends and patterns in the governance of child detention. (1.35)

2.12 Unaccompanied minors being removed from the UK should receive a welfare interview with a responsible adult present, have access to legal advice and be given the opportunity to make a telephone call. (1.36)

2.13 Child detainees should only be transported in cellular vans or handcuffed in very exceptional circumstances, and only following a risk assessment. (1.37)

Accommodation and facilities

2.14 Detainees should be offered a suitable range of food and drink that is readily available and meets their individual needs. (1.54)

2.15 Detainees should have sufficient activities to occupy themselves, and access to the fresh air. (1.55)

Respectful treatment

2.16 Border Force staff should use professional telephone interpreting services throughout all stages of their engagement with detainees, especially during initial welfare checks. (1.65)

2.17 Detainees, including those who do not speak English, should have effective access to a confidential complaints process. (1.66)

2.18 Detainees should have access to relevant artefacts to practise their religion. (1.67)

2.19 Female detainees should only be searched by female staff. (1.68)

2.20 Facilities should identify detainees' protected characteristics on their arrival to ensure their needs can be quickly identified and addressed. (1.69)

Communications

2.21 All detainees should be able to make telephone calls to family, friends or lawyers. (1.74)

Leaving the facility

2.22 Detainees leaving the STHFs should be advised about what is going to happen to them next, in a language they understand, and be informed about relevant support agencies they could approach for assistance. (1.80)

Section 3. Appendices

Appendix I: Inspection team

Hindpal Singh Bhui	Team leader
Colin Carroll	Inspector
David Foot	Inspector
Natalie Heeks	Inspector
Deri Hughes-Roberts	Inspector
Jade Richards	Inspector
Kam Sarai	Inspector
Paul Cocking	Observer, Independent Monitoring Board

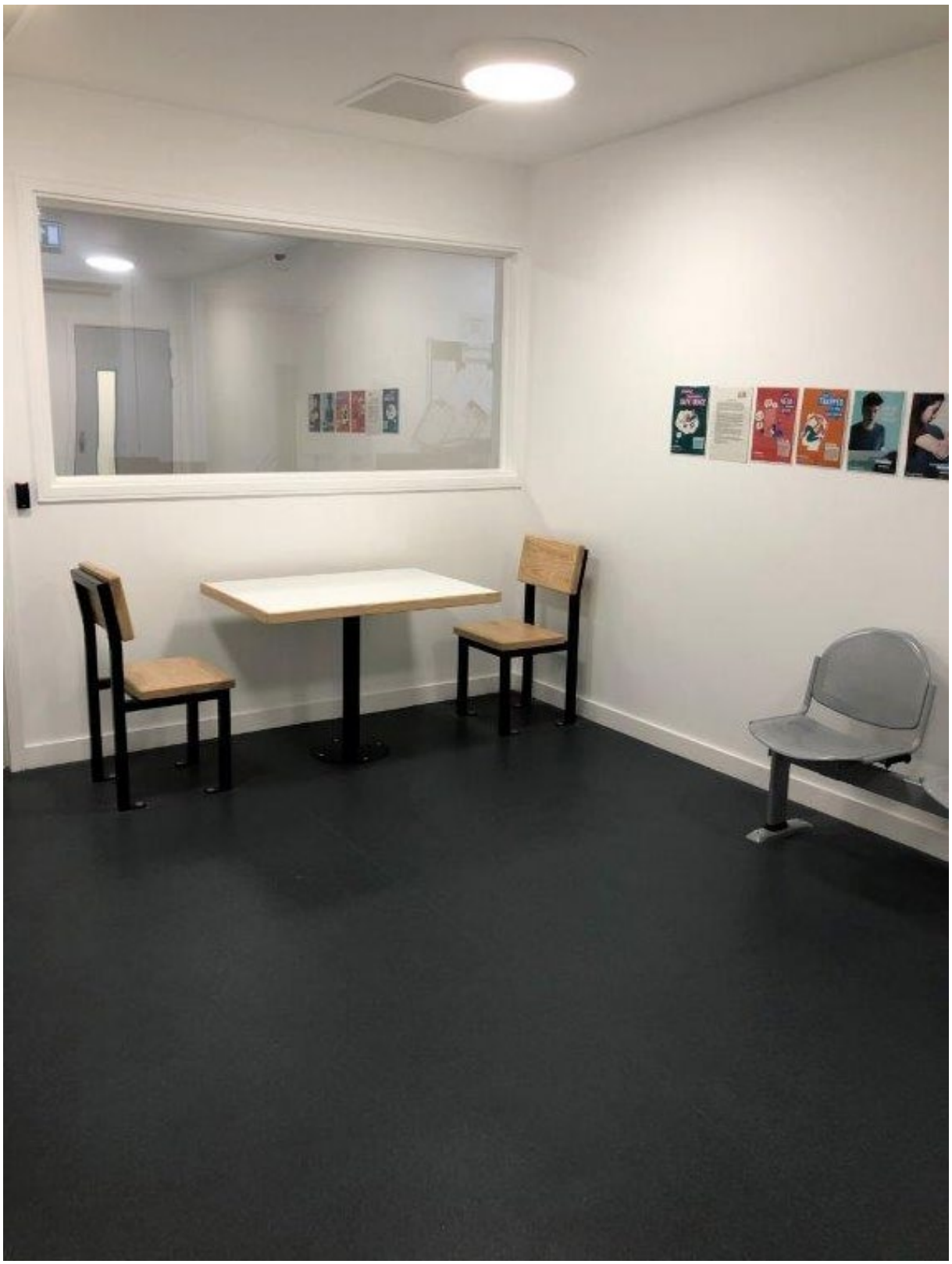
Appendix II: Photographs

Adult holding room at Aberdeen Airport

Adult holding room at Harwich International Port

Family holding room at Harwich International Port

Adult holding room at Portsmouth Docks



Bristol Airport holding room

Cardiff Airport holding room

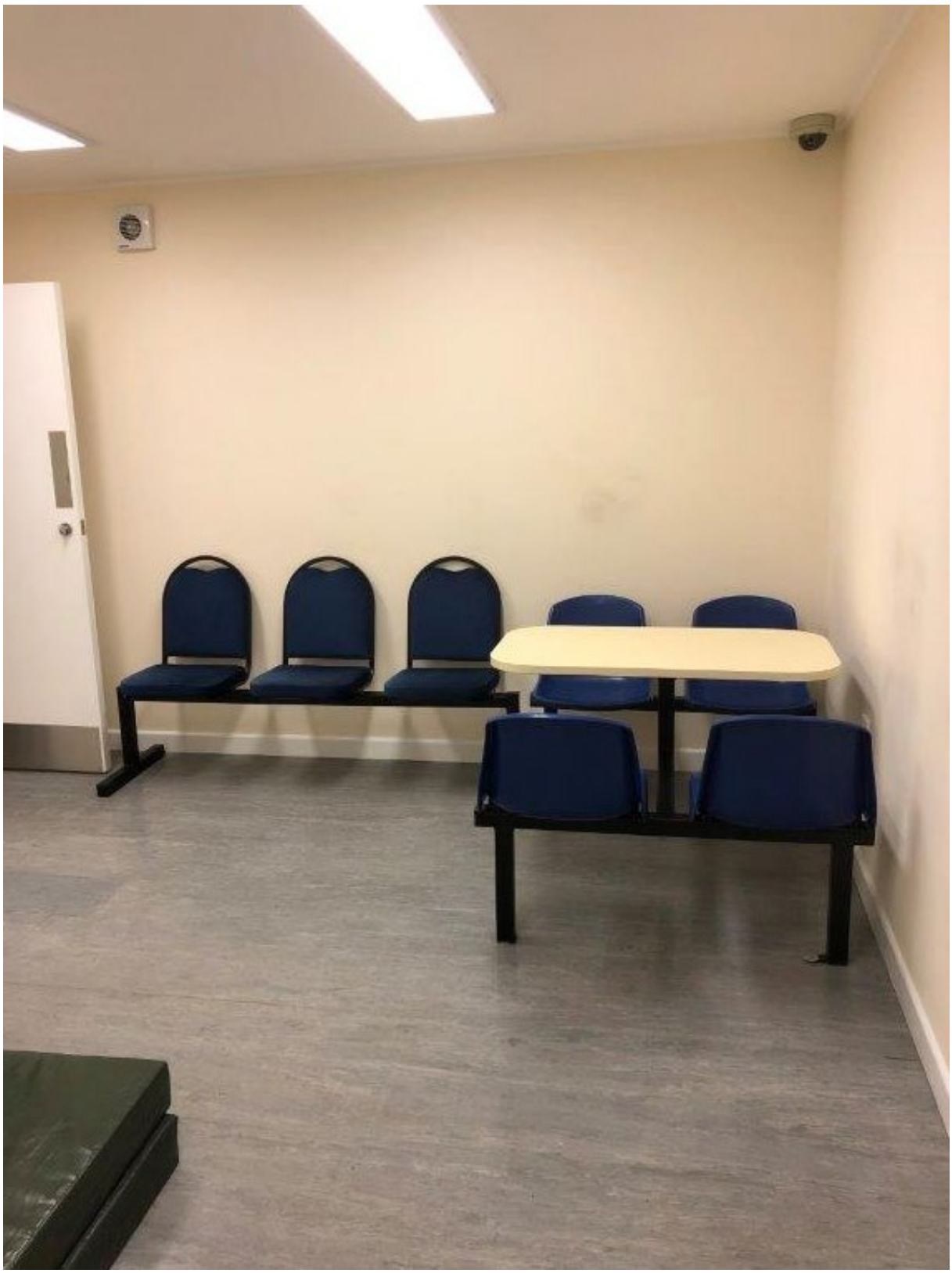
East Midlands Airport holding room

Holding room at Felixstowe (exterior)

Holding room at Felixstowe (interior)

Holding room at Killingholme Port

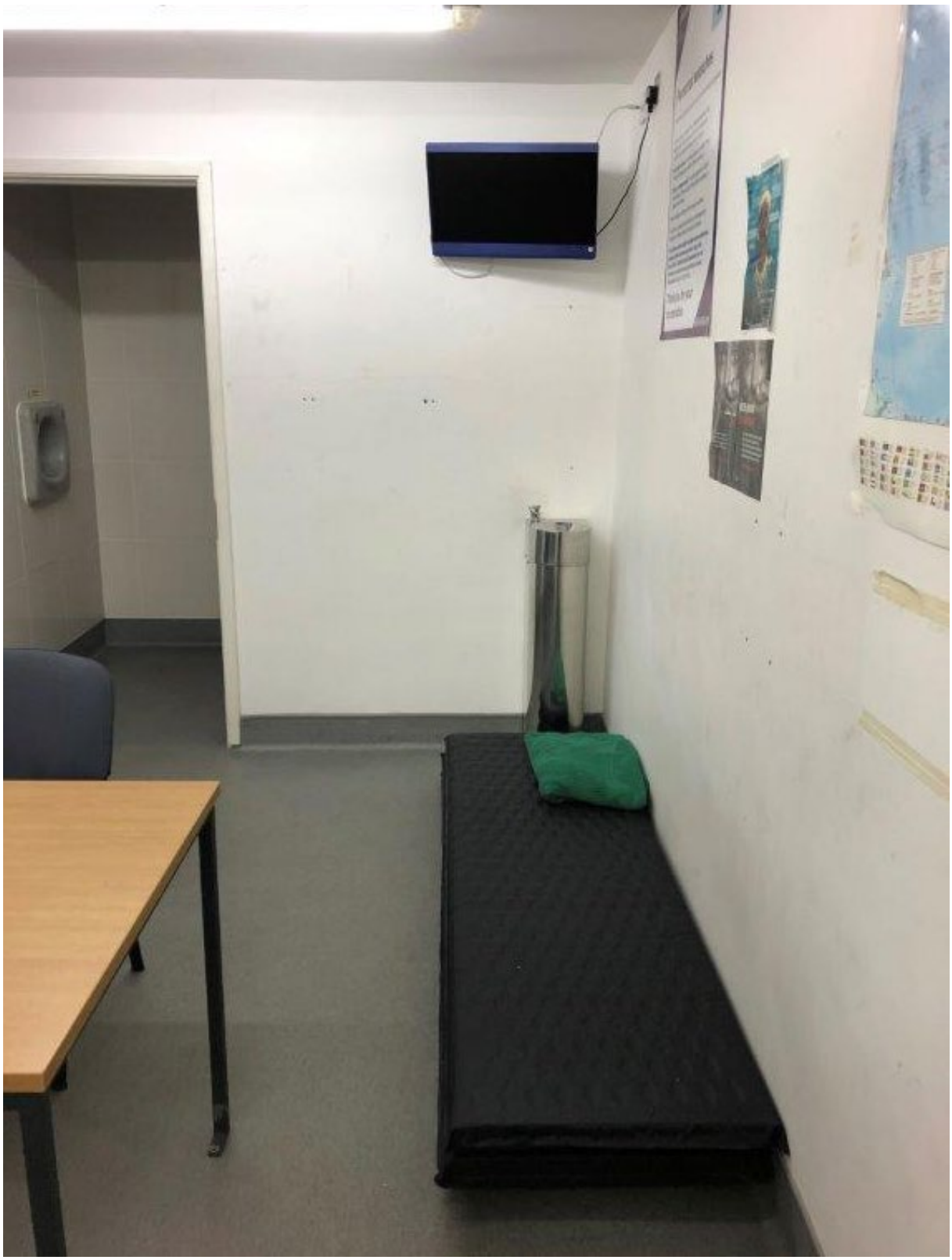
Overspill holding container at Killingholme Port



Holding room at Poole Ferry Terminal

Scanner building at Immingham Docks

Scanner holding room at Immingham Docks



Sleeping facilities in Portsmouth Docks holding room

Purfleet Docks holding room

Southend Airport holding room

Appendix III: Locations

Airports

Aberdeen Airport
Aberdeen Airport is in Dyce, just outside the city of Aberdeen, and opened in 1934. It had approximately three million passengers in 2019, to destinations across the UK and Europe.

Bristol Airport
Bristol Airport is in North Somerset and opened in 1957. Almost nine million passengers travelled through it in 2019, making it the eighth busiest airport in the UK. It serves the UK and Europe.

Cardiff International Airport
Cardiff International Airport is in the Vale of Glamorgan. It had 1.6 million passengers travelling through it in 2019. It is the busiest airport in Wales and owned by the Welsh government. It serves the UK and Europe.

East Midlands Airport
East Midlands Airport is close to Castle Donington in north west Leicestershire. The airport carries over four million passengers a year in the UK and Europe. After Heathrow, it is the UK's busiest air cargo hub.

Southend Airport
Southend Airport is in Southend-on-Sea, Essex. Two million passengers travelled through it in 2019. It serves the UK and Europe.

Seaports

Felixstowe
The freight-only port at Felixstowe in Suffolk has been in existence since 1875 and was the first UK port to receive container traffic. In 2018 it was the sixth busiest port in England, handling 28 million tonnes of freight. It is the busiest container port, taking around half of the UK's containerised freight.

Harwich International Port
Harwich International Port is a freight and passenger port on the south bank of the River Stour near Harwich, in Essex. It is opposite the port of Felixstowe. The ferry terminal services the Hook of Holland and several cruise liners during the summer months.

Immingham Docks
Immingham freight terminal near Grimsby in Lincolnshire is the busiest freight-only terminal in the UK, handling 55 million tonnes from across the world in 2019.

Killingholme Port
Killingholme is a freight terminal located on the south bank of the Humber estuary, near Grimsby in Lincolnshire. Ferries operate to the Hook of Holland, Rotterdam and Zeebrugge. The freight terminal is part of the larger Immingham facility and as such is part of the UK's busiest freight terminal.

Poole Ferry Terminal
Poole Ferry Terminal handles both passenger and freight ferries, with the addition of cruise liners during the holiday season. The terminal handled 800,000 tonnes of cargo in 2019. Passenger ferries serve destinations to France and the Channel Islands.

Portsmouth Docks
Portsmouth international ferry terminal is both a freight and passenger port with regular ferries to France, Spain, the Channel Islands and the Isle of Wight. Portsmouth handled 3.5 million tonnes of freight in 2018.

Purfleet Docks
Purfleet is a freight-only port on the bank of the River Thames near Purfleet in Essex. Along with Tilbury and several other ports, it makes up the Port of London, the second biggest in the UK handling 53 million tonnes of cargo in 2019.

Tilbury Docks
Tilbury is a freight-only port on the bank of the River Thames near Tilbury in Essex. It is 22 nautical miles east of London, making it part of the major port for the capital, and handles mainly container traffic. Tilbury, Purfleet and several other ports make up the Port of London, the second biggest in the UK handling 53 million tonnes of cargo in 2019.

Ports visited by inspectors which did not have in-use holding facilities

King George Dock, Port of Hull
King George Dock at the Port of Hull is a passenger and freight terminal located at Kingston upon Hull in East Yorkshire. It is home to regular ferry services to both Rotterdam and Zeebrugge and processes around 10 million tonnes of freight each year.

Glasgow Prestwick Airport
Glasgow Prestwick Airport is 32 miles from the city centre of Glasgow. About 640,000 passengers travelled through it in 2019. It serves a small number of European destinations.