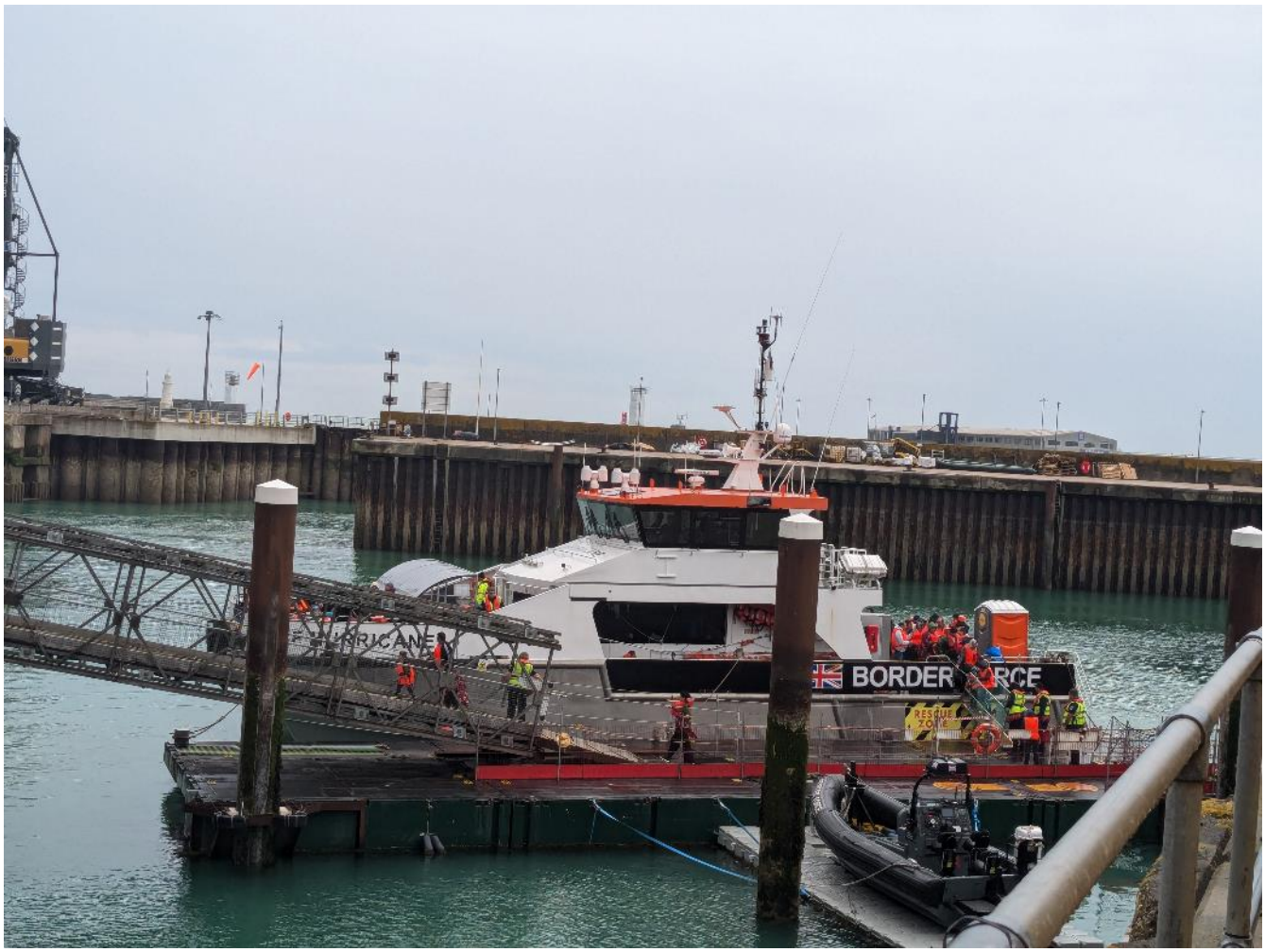
Report on an unannounced inspection
of the short-term holding facilities at

Western Jet Foil, Manston and Kent Intake Units

by HM Chief Inspector of Prisons

1–12 July 2024



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Introduction

This is the third consecutive year that we have inspected the large detention facilities at Manston and Western Jet Foil (WJF), which hold people arriving on small boats after dangerous journeys across the English Channel. We also inspected Kent Intake Unit Dover (KIU Dover), the facility used to detain unaccompanied children arriving on small boats, and Kent Intake Unit Folkestone (KIU Folkestone), which had recently been used mainly to hold people who had been found entering the country on vehicles.

In general, the story of these facilities over the previous three years has been one of complex challenges and uneven improvements. Our findings at this inspection reflect an acceleration of progress since our last visit, and we found a properly resourced and consequently more effective contingency operation that could manage high numbers of new arrivals with reasonable efficiency. Staff from different agencies were keen to tell inspectors of the way that they had managed nearly 900 arrivals on one recent day.

Safeguarding and general governance had also improved. While both adults and children were still being held for too long in many cases, the average length of detention had greatly reduced, and this in turn meant that there was now little evidence of the high levels of tension and distress that we have previously seen among people held for far too long in unsuitable conditions.

Staffing problems that we described at previous inspections had largely been resolved. In fact, a new challenge for the Home Office and its contractors was keeping staff occupied and motivated during frequent quiet times. We saw staff relating reasonably well to detainees, although interpretation was still not used consistently well. There was a good level of safety across the sites, but our staff survey suggested that there was still work for leaders to do to ensure consistently professional staff behaviour across Manston and WJF.

Although joint working had improved, inadequate coordination among the plethora of agencies at WJF and Manston was still creating problems and risks. For example, the varied requirements of different agencies were partly responsible for the fact that leaders had failed to achieve relatively simple objectives such as giving detainees access to fresh air or a bed during longer periods of detention. It was also disappointing that, despite good staff support at KIU Dover, the environment was so lacking in warmth for the children held there, many of them very young and vulnerable. Another concern was the flaws in the data kept by the Home Office. Figures on the numbers detained and length of detention were substantially corrected long after the inspection had finished, in one case showing that the longest period of detention was double the original figure. It should not take an inspection for the Home Office to review its data carefully and provide accurate information to its own staff and contractors.

Notwithstanding these concerns, this was an encouraging inspection which shows that the reception and care of detainees at the south coast is continuing to improve.

Charlie Taylor
HM Chief Inspector of Prisons
July 2024

Summary of key findings

What needs to improve at these short-term holding facilities

During this inspection we identified 10 key concerns, of which four should be treated as priorities. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

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

Priority concerns

1. **While the length of detention had reduced at all of the sites, it remained too long for many.** A child had been held for 51 hours at Manston and adults at KIU Folkestone had been detained for up to 33 hours.

2. **Border Force did not always explore safeguarding concerns sufficiently in interviews with adults and children, and child safeguarding referrals were not always made when necessary.**

3. **The large number of different service providers at Western Jet Foil and Manston created risks and problems, including the failure to ensure that detainees had fresh air or a bed during longer periods of detention.**

4. **Many detainees did not understand what was happening to them because of a lack of professional interpretation at key moments of their detention.**

Key concerns

5. **Induction and initial interviews to identify individual risks and needs were not always private and they were not age appropriate for children at KIU Dover.**

6. **The data provided by the Home Office on fundamental issues such as numbers of detainees, length of detention and safeguarding referrals, were poor and were still being corrected long after the inspection.**

7. **Residential accommodation was not used enough for those being detained for more than 24 hours.**

8. **Facilities for medical isolation at Western Jet Foil remained unfit for purpose.**

9. **Detainees were given no opportunity to write down contact numbers to make calls to family and friends before their phones were confiscated.**

10. **Child safety seats were not provided in the regularly used transport vehicles.**

Progress on concerns

We last inspected Western Jet Foil, Manston and KIU between 30 January and 17 February 2023 and highlighted 11 concerns. At this inspection we found that two of our concerns had been addressed, four had been partially addressed and five had not been addressed. For a full summary of the progress against the concerns, please see Section 5.

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 one example of notable positive practice during this inspection, which other facilities may be able to learn from or replicate. Unless otherwise specified, this example is not formally evaluated, is a snapshot in time and may not be suitable for other establishments. It shows a way our expectations might be met but is by no means the only way.

Example of notable positive practice		
a)	Staff trained in safeguarding walked through the reception marquee at Western Jet Foil, looking for signs of vulnerability, and had identified some concerns.	See paragraph 2.10

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

Role of the facility

These facilities primarily held migrants who had arrived from France on small boats after undertaking sea crossings of the Channel. Western Jet Foil functions as an initial point of entry where people undergo initial health checks and are given an opportunity to change out of wet clothes. Manston is a short-term holding facility where immigration documents are issued and most detainees have their asylum screening interview. The Kent Intake Unit in Dover is mainly used for unaccompanied children who arrive at the coast to be supervised, interviewed and issued with immigration documents. The Kent Intake Unit in Folkestone reopened earlier this year, holding mainly adult detainees from 'lorry drops'.

Leadership structure

Border Force Small Boats Operational Command (SBOC) had the main leadership responsibility for Western Jet Foil and shared responsibility for Manston with the Illegal Migration Intake Unit (IMIU). The latter had overall leadership responsibility for the Kent Intake Units. Border Force leaders met contractors regularly (see below).

Location

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

Lead agencies and contractors

Western Jet Foil: Home Office, Interforce, Medevent Medical Services
Kent Intake Units: Home Office, Mitie Care & Custody, IPRS Aeromed
Manston: Home Office, Mitie Care & Custody, Interforce, MTC, Medevent Medical Services, IPRS Aeromed, Complementary Medical Services (CMS)

Date of last inspection

30 January – 17 February 2023

Section 1 Leadership

1.1 Leaders had improved the detention infrastructure, staffing and procedures at both Western Jet Foil (WJF) and Manston. Increased staffing levels meant that all facilities could now cope more effectively with high numbers of migrants arriving at short notice. Together with increased availability of social services and hotel accommodation, this had helped to reduce substantially the length of detention, which had previously been a major cause of poor outcomes for detainees.

1.2 Monitoring and oversight of the detention facilities had improved. Sophisticated information systems helped to predict migrant arrivals and work was advancing to track detainee movements through WJF, Manston and Kent Intake Unit (KIU) Dover to allow for better use of resources. However, a concern that emerged after the inspection was that the data previously supplied by the Home Office were in many cases inaccurate, including on fundamental points such as the length of detention. For example, the longest period of detention in Manston was corrected from 51 hours to 106 hours.

1.3 Leadership of small boat arrivals had been strengthened by the appointment of separate senior Border Force leaders at WJF and Manston. Leaders from all agencies we spoke to told us that there was improved collaborative working between them and that there had been gradual progress towards more efficient working practices. However, problems of coordination and consistency continued to arise from the multiplicity of different service providers. For example, the varied requirements of different agencies were partly responsible for the fact that exhausted detainees continued to sleep on floor mats in Manston, while much more appropriate residential accommodation on the site usually lay empty. We also found examples of poor joint working between the three health care providers, which did not ensure that needs were understood and met effectively as detainees moved to different sites.

1.4 Border Force leaders had appropriately sought external regulation of the complex health care arrangements to provide them with greater assurance, despite being legally exempt from Care Quality Commission (CQC, see Glossary) oversight. Following the inspection, the CQC was actively considering how it might enable registration and regulation of these services.

1.5 We found a more welfare-oriented approach to detainees across agencies. This was supported by investment by Border Force and its contractors. For example, Mitie Care & Custody had provided a mobile electronic induction tablet that allowed more staff engagement with detainees. Border Force had also funded a two-hour training package for staff from all agencies, which aimed to promote the focus on communication and welfare, with some signs of success.

1.6 Leaders had improved the focus on safeguarding with regular meetings that included community agencies such as Kent County Council, better staff training and working practices and better use of social work expertise. However, important safeguarding-related data, such as the number of NRM (national referral mechanism) referrals, remained inaccurate and could not be used to improve services.

1.7 At KIU Dover, which held unaccompanied children, some of whom were very young and had obviously been frightened on arrival, leaders had not created a sufficiently child-friendly environment or procedures that were fully adapted for children.

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 Over 400 people arrived at Western Jet Foil (WJF) from small boats while inspectors were at the site. They had generally experienced exhausting and dangerous journeys and some had injuries such as fuel burns.

2.2 The arrivals process was organised and efficient, following the same pattern as we observed at the last inspection. On arrival at the WJF jetty at Dover, detainees were first taken into the reception marquee, which had been extended substantially to cope with higher numbers. They were quickly given blankets to help them warm up. A digital identification system using wrist tags with QR codes, originally fitted to each person when picked up in the Channel, was working well at this stage of the procedure and expedited the reception process. A team of paramedics saw each person for a brief initial consultation, to identify any clear injuries or medical conditions (see paragraph 3.27). Staff speaking the detainee's language were occasionally available to help, but the team generally used pictorial cue cards and tablets with translation software that was of variable effectiveness.

2.3 The newly arrived detainees were then directed to changing areas, where they could change in private into dry clothing and footwear. The number of cubicles and the space available had been increased. There was an ample supply of clothing in all sizes, including closed-toe plimsolls so that nobody needed to wear flipflops as we had previously seen. Portable toilets were outside the marquee and detainees could ask to be taken to them.

2.4 Sandwiches, hot drinks and water were said to be available in the reception marquee, but inspectors only saw bottled water being given on arrival and food offered after the person had been searched, which was sometimes two hours later, although this was not done consistently; for example, we met a child at the end of the reception process who said he was hungry and did not know when he would be offered food.

2.5 Everything needed for baby care was available, but there were no facilities for mothers to breastfeed in private at WJF.

2.6 Adults and families were taken into the main building at WJF. The conditions were reasonable (but see paragraph 3.1). All were searched which still did not happen in private but in the open area. A private interview was then conducted by a member of Border Force staff, and at this point professional telephone interpreting was used. After this, coachloads were taken to Manston. At Manston there were further booking-in and induction processes.

2.7 Unaccompanied children were collected in small groups from WJF by Care & Custody staff based at KIU Dover and taken there in a van, a short journey from WJF. On arrival they were given an induction interview by a member of Care & Custody staff to identify any specific risks or needs. The setting for this was not confidential or appropriate for children. New arrivals sat on rows of chairs in a large area. At the front was a row of open interview stations, where children were interviewed from behind Perspex screens. Personal questions were asked, using telephone interpreting, but often in a voice clearly audible to everyone else in the room. A search took place appropriately with a hand-held detector only, in a curtained cubicle.

Induction booth for unaccompanied children, KIU Dover

2.8 At all sites, staff were respectful throughout the arrival process, but professional interpreting was not used enough and it was clear that

some detainees did not fully understand what was happening, nor what was to happen to them next.

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.

2.9 The staff we spoke to at all sites had a good understanding of their safeguarding responsibilities. Most other Border Force staff had received a three-day safeguarding course tailored to the challenges of small boat arrivals and trained staff were available for guidance on all shifts.

2.10 Staff trained in safeguarding walked through the reception marquee at WJF, looking for signs of vulnerability, and had identified some concerns. Good adjustments were made for vulnerable adults at WJF. For example, a woman with learning difficulties who was very sensitive to noise was given ear defenders, prioritised for searching and taken to a quiet space to wait for transport.

2.11 Staff in all agencies described a more collaborative approach to meeting safeguarding needs and we saw a number of cases where Border Force, custodial staff and social workers worked well together to safeguard detainees.

2.12 Social workers were used more effectively than at our last inspection for cases involving adult safeguarding. However, we remained concerned that social workers were not funded to work at night when many detainees arrived (see paragraph 2.39).

2.13 Detainees had several opportunities to disclose vulnerability during the initial arrival and induction process, but insufficient privacy and routine use of unreliable translation software did not encourage disclosure of vulnerability. Detainee custody officers (DCOs) at Manston and both KIUs were also rightly concerned that they could not further support or assist people who had disclosed traumatic experiences during induction interviews. The questions were not appropriately adapted for children at KIU Dover (see paragraph 2.38).

2.14 The first opportunity for adult detainees to disclose concerns in private and with professional interpreting was at the asylum screening interview. Unlike children in KIU Dover, adult detainees were not woken up to be interviewed during the night. Women sometimes had histories of sexual violence but were not offered an interview with a female officer. We found one such case where a woman had disclosed sexual violence before her screening interview but was still interviewed by a man.

2.15 Border Force had been interviewing some detainees with their children present, potentially exposing them to sensitive or traumatic accounts or inhibiting parents from disclosure. Border Force had recently taken some steps to mitigate these concerns, for example giving children attending interviews DVDs and headphones, while they considered introducing appropriate longer-term arrangements, such as the provision of child care (see paragraph 2.41).

2.16 Most adult screening interview records that we looked at showed a reasonable level of inquiry, although some were cursory and did not explore vulnerability sufficiently. In our review of cases, safeguarding referrals were made when concerns had been identified for adults, but not always for children (see paragraph 2.42).

2.17 Most safeguarding referrals were made to a central Home Office safeguarding team. In some cases, it took too long for the safeguarding team to act on referrals. In one case, a detainee suffering from schizophrenia and depression reported to staff in Manston hearing voices telling him to kill himself. A prompt safeguarding referral was made but not acted on until 11 days later, when the safeguarding team sent an email to his housing provider to ask for an urgent GP referral.

2.18 Governance of adult and child safeguarding was improving, with better collaboration and emphasis on sharing and learning from experience in well-attended meetings. However, the collection and monitoring of safeguarding data remained weak.

2.19 The data we were given showed that in the previous six months, safeguarding referrals had been made for 7% of adults held in Manston, compared with just 3% before our last inspection. However, this increase still did not reflect the vulnerability of people arriving in small boats and staff themselves questioned the accuracy of these data. The data we were given initially suggested that no adult safeguarding referrals at all had been made at either KIU in the previous six months, although this was corrected after the inspection to show that 30 referrals had been made.

2.20 Border Force could not provide accurate data on NRM referrals made from each location. This left Border Force poorly placed to assess the effectiveness of different parts of the organisation in identifying modern slavery concerns.

2.21 Border Force was undertaking appropriate work to centralise whistleblowing policies of the various agencies working in the sites. There was evidence that a small but significant number of people were unclear on how to report concerns or reluctant to do so. In our survey, 88% of frontline operational staff said they knew how to raise concerns and 86% said they would raise concerns if they had any. There was some evidence of concerns being raised and responded to appropriately using existing processes.

2.22 We were told that the Home Office had plans to implement its policy on adults at risk in detention, which was welcome because it was holding

detainees who had experienced significant trauma, health needs and disabilities.

2.23 In Manston, many Border Force and some cleaning staff who had frontline roles had not been appropriately checked with the Disclosure and Barring Service (DBS).

Personal safety

2.24 All sites were well ordered and generally calm during our inspection. We observed good staff engagement with detainees in all sites. Detainees expressed no concerns about their safety at the time of the inspection, but many were exhausted and expressed uncertainty about what was happening, when they could leave and what would happen next.

2.25 Violence and non-compliance were very rare. There had been no finds of illicit items or any violent incidents at any site in the previous year. This contrasted particularly with our last inspection of Manston when there had been tensions arising from lengthy detention. We were told that there had been no assaults in the previous six months.

2.26 Records suggested that no detainee had self-harmed in the six months before the inspection. Custodial staff had opened 21 suicide and self-harm warning forms for detainees considered to be at risk. Our review of documents suggested that escort teams had not always been informed about relevant detainees transferred to their care.

2.27 There were some examples of serious staff misconduct in the last six months, although only one involved misconduct towards a detainee. In this case, a Care & Custody officer had been dismissed for behaviour which included aggressively pulling a sleeping child to his feet and making disparaging comments to him (see paragraph 3.13).

2.28 We were told that no detainee had been placed in single separation during the previous six months and records suggested that force was rarely used, with two incidents in WJF and three in Manston in the last six months. Except for the case that led to dismissal, the use of force appeared to be minimal, but use of force paperwork was poorly completed and did not provide enough detail. Nevertheless, there was better leadership oversight of the use of force and incidents, including CCTV footage, were now reviewed by senior managers who took appropriate action. Staff had not been trained in the use of force on children, although there were plans to address this.

2.29 Given the generally safe environment that had been created, some security measures were unnecessary. For example, despite a thorough search of detainees in WJF, they were searched again when they arrived in Manston, where they were also scanned with a hand-held electronic metal detector each time they entered an accommodation marquee. Detainees' fingerprints were also scanned on return to Manston accommodation marquees, including children and babies. We were told that the requirement for detainees to wear high-visibility vests

in Manston was to distinguish them from staff, but this did not justify toddlers being given vests.

Safeguarding children

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

2.30 During the previous six months, 1,147 unaccompanied children had been held, almost all in KIU Dover. On average unaccompanied children were detained for eight and a half hours in KIU Dover, compared with 20 hours at our last inspection. This was still a long time for an unaccompanied child to be detained, but no child had been held in KIU Dover for more than 24 hours. At the last inspection, such children had been held for more than 20 hours on average, and 337 for more than 24 hours. It remained a concern that no record was kept of the time children were held in WJF. We found two cases of unaccompanied children held cumulatively in breach of the statutory 24-hour time limit. In one case, a child was held for 42 hours and in the other for 37 hours. These cases appeared to be exceptional, but this was difficult to verify in the absence of adequate detention records.

2.31 We were pleased to find that arrangements with Kent County Council for the onward care of unaccompanied children were far more effective than at our last inspection, contributing considerably to the reduced length of detention.

2.32 There were also better arrangements for the timely placement of children who were with their families in onward accommodation. The average length of detention of accompanied children held in Manston was just over 13 hours, compared with more than two days at our last inspection. However, 11 children had still been held at Manston for over 24 hours, and the longest was held for about 38.5 hours (see paragraphs 2.36 and 2.44).

2.33 There was better governance of child safeguarding, but the collection and monitoring of data were still poor (see paragraph 2.18).

2.34 Children were held separately from single male detainees in WJF. From there, unaccompanied children were transferred to KIU Dover and those in families to Manston. Since March 2024, adults detained from vehicles were no longer held with children in KIU Dover, which was appropriate. A small number of children were also found in vehicles and held with adults in KIU Folkestone, but most were quickly moved to KIU Dover. In Manston, accompanied children were held separately from single male detainees.

2.35 Processes to identify children in WJF were not always effective. Social workers contributed to many of the age assessments, but not those taking place at night. During the inspection, a detainee who was clearly a child arrived at Manston, although it was positive that Border Force staff quickly identified him and arranged his transfer to KIU Dover.

Records suggested that nine unaccompanied children had mistakenly been sent as adults to Manston in the last six months. The Home Office safeguarding team told us there were cases where detainees sent from Manston to hotel accommodation as adults were subsequently assessed by local social services to be children. Border Force did not keep data to quantify the problem, and there was no review of such cases to learn lessons.

2.36 Staff at all sites engaged well with children, better than at previous inspections. However, at busy times at WJF and in the family marquee in Manston, staff struggled to supervise or care for children appropriately. At Manston, four young children were mistakenly left on their own in the family marquee when their parents were taken for a screening interview. The practical inability of detainees to contact their family was particularly detrimental to the welfare of children. For example, in one case a 10-year-old Afghan boy was formally detained at WJF and then taken to KIU Dover almost eight hours later. His welfare interview started at 10.38pm without an appropriate adult. At the start of the interview, he said 'I want to speak to my mum, please. I want a mobile.' The officer replied, 'Unfortunately, this is not something we can provide you with currently. This is something you can discuss when you are moved to accommodation after we have processed you.'

2.37 We saw some good examples of multi-agency work to safeguard children. In one case, concerns were appropriately identified in WJF about a seven-year-old boy who travelled with an unrelated family. Border Force, social work, Care & Custody and Refugee Council staff described good collaborative work to safeguard the boy, before he was taken to foster carers in Kent.

2.38 We had concerns about Care & Custody induction interviews for unaccompanied children arriving in KIU Dover. Children, some very young, were asked the same questions as adults in other sites, including whether they had been a victim of sexual violence, with no further follow up.

2.39 All unaccompanied children were given a full interview (the 'welfare interview') to identify immediate welfare and safeguarding concerns. These interviews sometimes did not take place until many hours after children had arrived in the UK and sometimes at night. For example, a 16-year-old boy who was detained in KIU Dover at 8.40am did not have a welfare interview until 1.19am the following morning. In contrast to the last inspection, specialist trained officers were now available during each shift to provide guidance to staff interviewing children. Many children continued to be interviewed without an appropriate adult, particularly at night when the social work team was unavailable (see paragraph 2.36). In one case, a 10-year-old boy was interviewed without an appropriate adult (see paragraph 2.36). In another case, we saw a record of a 15-year-old girl who believed she had been sold to traffickers being interviewed with no appropriate adult.

2.40 Records indicated that some interviews did not explore children's welfare in sufficient detail. In two cases, children said they had travelled

through Libya, but had not been asked what had happened there, despite the Home Office accepting the high risk of migrants being abused and subjected to modern slavery in that country.

2.41 Some children at Manston were present at the interview of their parents, potentially exposing them to sensitive or traumatic accounts or possibly inhibiting parents from disclosure. Border Force was taking steps to address this concern (see paragraph 2.15).

2.42 Staff awareness of safeguarding risks was much better than at previous inspections. In the previous six months, 152 children had been referred to the Home Office central safeguarding team from both KIUs, representing about 16% of cases, compared with just 1% at our last inspection. Nonetheless, we found some cases where safeguarding referrals were not made when necessary. In one, Border Force made an NRM referral, but no safeguarding referral, for a 16-year-old boy who had been held for ransom and physically abused in Libya for about three months. Similarly, no safeguarding referral was made for a 16-year-old girl who had been sold to pay family debts and trafficked to the UK.

2.43 Social workers from Kent County Council always attended KIU Dover to collect unaccompanied children, which was a positive development, and the Refugee Council provided good support.

Legal rights

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

2.44 During the previous six months (December 2023 to May 2024), 10,316 detainees had been held in Manston, including 664 children. Detainees were now held for an average of just over 19 hours at Manston, compared with over 40 hours at our last inspection. The longest period of detention was for about 106 hours compared with more than 26 days previously. Three hundred and five detainees had been held in KIU Folkestone for an average of almost 13 hours, with the longest period of detention being over 33 hours.

2.45 The improvement in provision of onward accommodation for detainees had contributed to this reduction, although there was still scope for further improvement. Detainees could be held for several hours in WJF and no record was kept of detention before the completion of formal detention paperwork in Manston and KIU Dover. All detainees in these facilities were therefore held for longer than records indicated.

2.46 Professional telephone interpreting was not consistently used when required across all the sites. Hand-held devices, used at various stages in the process, were not always effectively translating important information and detention paperwork was not translated. This left many

detainees at all sites with little understanding of their paperwork and of what was going to happen to them.

2.47 There was little useful information in any site on how a detainee could obtain free legal advice. Notices in holding rooms provided contact details of solicitors and advice agencies, but most of the advice agencies were not regulated to provide substantive advice. We contacted solicitors' firms whose details were provided, but they told us they did not offer advice in immigration law.

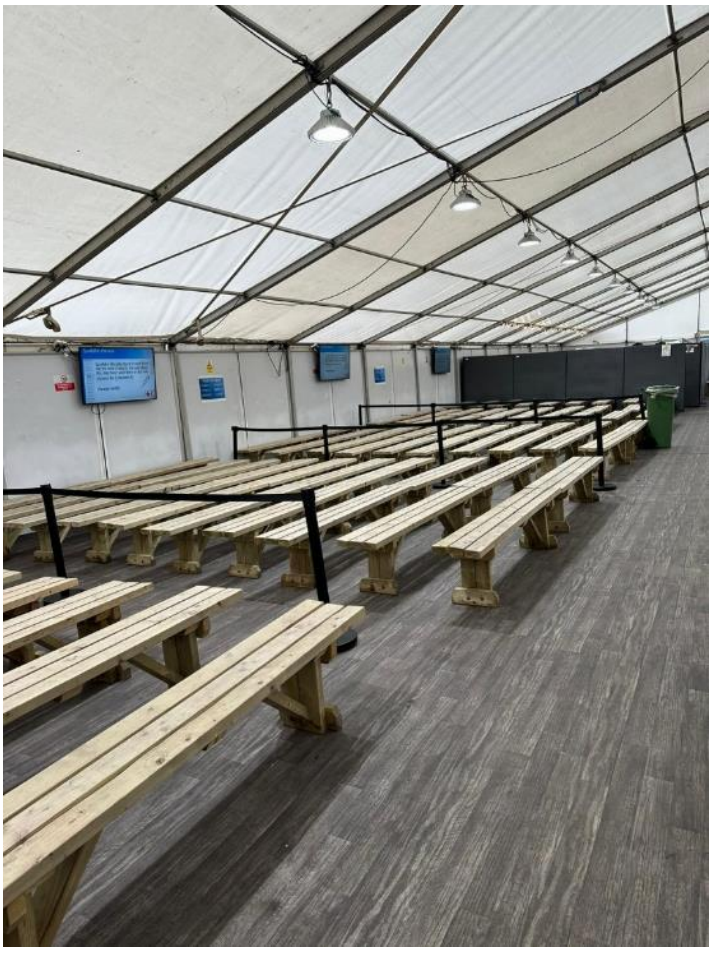
Section 3 Respect

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.

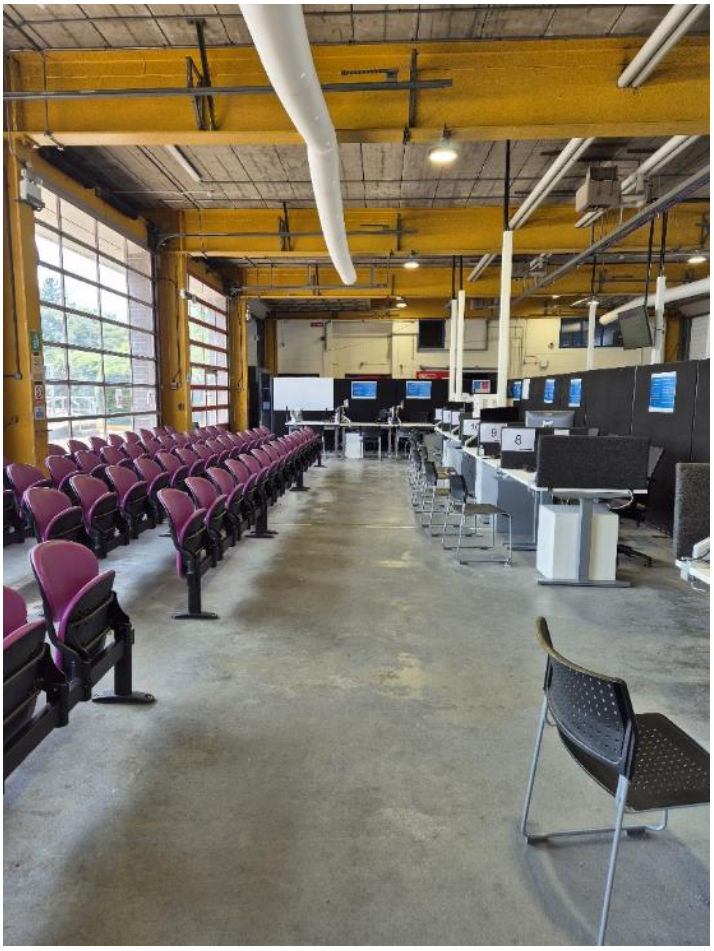
3.1 The accommodation at Western Jet Foil (WJF) remained adequate for short stays and most detainees we spoke to said they stayed there for no more than a few hours. Most of the areas were clean and in good condition, except for the bleak isolation cabins (see paragraph 3.32). Detainees were often exhausted and it was common for them to sleep on the wooden benches.



Initial tent ('red tent')

3.2 Property was placed in bags at WJF and stored safely at the other holding facilities. Wet clothes and valuables, including mobile phones, were kept in the same bag, which could cause damage. There was a large supply of clothing for adults and children, catering for different cultural requirements, and changing areas offered privacy. However, detainees changed into fresh clothes before being able to shower at Manston, where a change of clothes was only offered to babies and young children. Property was returned to detainees when they had moved out of the holding facilities.

3.3 The initial processing areas at Manston were more welcoming and in better condition than we have seen previously. Wooden benches had been replaced with softer seating and toilets were now available in the marquee, rather than in the previous mobile units. The small, curtained area that had previously been made available for baby changing and breast feeding in private had been removed. Facilities for this were now only available in the family marquee which might not be accessible for many hours. Sanitary provisions were readily available in the toilets on all sites.



Manston processing area

3.4 Manston had 16 marquees which were used to process arrivals. Two further marquees were used as staff rest areas. During our inspection, one marquee for women and families and two single adult men's marquees were occupied. They were adequately ventilated with good

air conditioning units. The marquees were well kept and clean, including the showers and toilets. Small outdoor areas were available but, although leaders thought they were in use, staff still did not permit detainees to go outside.

3.5 During busier periods in particular, detainees continued to struggle to get some rest after their long journeys and were only able to sleep on mattresses on the floor. We observed the family marquee become very busy and it would have been beneficial if the empty bedrooms in the new residential holding rooms had been brought into daily use.

3.6 The family marquee provided decent travel cots for babies and younger children to sleep, and there were plenty of toys and activities for all ages. Despite this, some of the décor had become less child friendly with the removal of wall art. Baby-changing facilities were good, but the room for breastfeeding did not allow full privacy, with an open window that looked into the main marquee.

3.7 The new residential holding rooms at Manston could house up to 288 detainees in reasonably comfortable overnight accommodation. There were six housing blocks, each with a small outdoor area and activities room. Each room had a bunk bed, with a desk and storage space. None of the toilets that we saw in the residential holding rooms had lids. There was a separate building for detainees to eat in, which was good. Although this accommodation was for anyone who had been at Manston for over 24 hours, it was not often used and families and single adult females were not given access to it.

Residential holding room bedroom

3.8 The two holding rooms at the Kent Intake Unit (KIU) in Dover were kept in good condition. It was positive that from earlier in 2024, adults were no longer held alongside unrelated children. However, the facilities looked austere and were less child friendly than in the past. There was no natural light. There was a small and unwelcoming caged outdoor area, which was unsuitable for children and did not appear to be used much.

KIU Dover main holding room (left) and cage-like outside area for children

3.9 The KIU Folkestone holding room was in good condition and had attractive murals to create a softer atmosphere. Detainees slept on thin mattresses on a carpeted area and blankets were provided. Although we were told that a shower was available in the non-detained area, detainees whom we spoke to said they were unable to use it. The toilets were clean but were made of steel and had no seats.

Folkestone holding room (left) and detainees sleeping in the room

3.10 The food at all facilities was reasonable for short stays, and the provision at Manston had improved with the on-site catering service and a large supply of storage ovens. Plenty of baby formula and food was available. Both KIUs provided a range of microwave meals, including options for specific dietary requirements. Snacks and hot and cold drinks were readily available at all the holding facilities.

3.11 At the family marquee at Manston there were plenty of activities for children, but there was a much smaller selection of board games for different ages across the other sites. Televisions were available to watch in the main holding room areas, but the reading material was limited and we found magazines at KIU Dover that were not of interest to children.

Respectful treatment

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

3.12 During our inspection, staff from all agencies talked to us compassionately about their roles and the detainees in their care. Most staff had recently completed a new behaviour awareness training package, which had been positively received. We observed more consistently good interactions than in the past with both adults and children across all four sites. Detainees we spoke to felt they were treated with respect throughout their time in detention.

3.13 However, our confidential staff survey, completed mainly by staff at WJF and Manston, suggested that leaders and staff needed to be vigilant in ensuring high standards of professionalism. While staff from all agencies were generally positive about the way that detainees were treated, nearly a quarter (23%) identified poor behaviour from staff towards other staff and 11% indicated poor behaviour towards detainees. Their comments included reference to disrespect, rudeness and a hostile or dismissive attitude towards detainees. Many staff also referred to a lack of discipline and childish and unprofessional behaviour by their colleagues (see paragraph 2.27).

3.14 At Manston, Care & Custody staff now used tablets to complete welfare checks face to face, enabling them to spend less time at the computer behind a desk. We saw positive interactions as a result, although entries remained basic and did not reflect the positive engagement that we observed.

3.15 Professional telephone interpreting was not being used consistently when required across all the sites. Hand-held devices did not always translate the correct information effectively and some did not work at all. Visual aids were used in some areas and we observed hand gestures and staff speaking loudly. There was a small selection of information posters in different languages around the sites and the induction information at Manston was translated on television screens. The Home Office used professional interpreters based at Manston during the initial screening but did not provide a translation of information for detainees who were being bailed and leaving the site.

3.16 Complaint boxes and forms were clearly marked and available in all sites. However, at Manston the forms were held separately from the complaint boxes and were not available in all the different languages in every marquee, as we have previously seen. During the previous six months, one complaint had been submitted regarding lost property which had been substantiated. At the previous inspection, there had been 18 complaints. However, the response had taken six weeks to complete, which was far too long, and by this time the complainant had left the sending address and the response was not sent to him.

3.17 Prayer rooms at Manston and the Kent Intake Units were adequate and it was positive that foot wash facilities had been installed in the accommodation marquees at Manston for use before prayer. Religious materials were made available at all the sites.

Religious texts in KIU Folkestone

3.18 With the exception of the KIU in Dover, protected characteristics (see Glossary) were not being identified on induction. Vulnerable adult warning forms were opened, but their value was unclear as support was not tailored to the detainee's needs and welfare check notes were very basic. All sites remained unsuitable to accommodate detainees with physical disabilities.

3.19 Staff across the sites were mindful of the need to hold women and children separately from unrelated adults. However, a lack of space in some waiting areas in WJF and Manston meant that separation was not always effective and there was only one holding room in the KIU in Folkestone. Pregnant women were being detained and held in the family marquee at Manston.

Health care

3.20 Health services were delivered by three different providers across the sites: Medevent Medical Services, IPRS Aeromed and Complementary Medical Services (CMS). None of the providers was registered or regulated by the Care Quality Commission for immigration processing owing to commissioning exemptions.

3.21 Engaging three health care providers presented a complex situation and we were not confident that levels of communication were effectively coordinated. This was further complicated by marked differences in information governance: Medevent used electronic patient records while IPRS Aeromed and CMS relied on paper records.

3.22 Generally safe and effective health care was delivered 24 hours a day to new arrivals at WJF and the short-term holding facilities at Manston

and Kent Intake Unit Dover. Providers had the ability to upscale and downscale the service according to need and clinicians could cross-cover at all short-term holding facility sites, which was good. Aeromed continued to provide a paramedic aboard Border Force vessels while at sea.

3.23 Providers had excellent links with local clinical specialities such as burns and fractures, with well-developed clinical pathways in place. Links with local maternity services had been maintained and all pregnant women continued to see a doctor on arrival.

3.24 Although not frequently used, there were effective pathways into local psychiatric liaison teams for those suspected of having an acute mental health crisis. We were told it was rare for detainees to present with acute substance use withdrawal symptoms, but symptomatic relief was readily available.

3.25 The United Kingdom Health Security Agency (UKHSA) told us that relationships with providers were good and they attended calls with the UKHSA every two weeks to share information.

3.26 Clinical staff were appropriately trained for their role and met regularly for formal and informal teaching sessions. All clinicians we spoke to felt valued by their organisation and knew how to raise concerns and access emotional support. Important safeguarding processes were understood by all the staff we spoke to.

3.27 Detainees arriving at WJF received a brief medical triage from skilled and experienced paramedics. Good attention was paid to specific health needs associated with the patient group, such as fuel burns and communicable diseases. Although the initial triage was swift, detainees were monitored constantly through the arrival process. This helped to reduce the risk from hidden or undeclared injuries or conditions.

3.28 Medevent continued to provide senior emergency medicine doctors who delivered valuable expertise in urgent medical care. Medevent had a fully-crewed emergency ambulance on site for those requiring blue-light conveyance to hospital.

3.29 The triage of new arrivals that we observed was conducted in a professional and caring manner but relied on security staff interpreting for non-English speakers, which was inappropriate. Individuals requiring further medical examination were seen in private and clinicians had access to a comprehensive range of treatment, diagnostic and transport options to manage almost all medical eventualities.

3.30 Detainees arriving with medication were reviewed and triaged using a traffic light system (red, amber, green) to establish priority. Critical medications such as inhalers or nitrates remained with the detainee. Other medications not assessed as urgent were kept securely until a formal review at Manston.

3.31 Infection prevention and control were generally well managed at WJF given the environment at the quayside. Equipment and treatment areas were clean and well maintained. Regular cleaning was carried out, but it was not clear if this was subject to audits or oversight to ensure compliance. Clinical equipment was serviced in line with expected standards and the resuscitation kit was checked regularly.

3.32 For those who arrived at WJF with suspected communicable diseases, the three isolation cabins in which detainees were held were austere and too small, and one had no windows. They remained unfit for purpose despite their frequent use. Records we were given showed that 290 detainees had been isolated in the previous six months.

Medical Isolation unit 3

3.33 It was poor that clinicians only had access to one shower for detainees presenting with fuel burns, which was accessed through the property search area. When more than one person required treatment, hand pump sprayers were used.

3.34 Detainees arriving at Manston were offered diphtheria vaccinations by IPRS Aeromed staff and were given a patient information leaflet about the vaccination, available in a wide range of languages. Vaccines were stored appropriately and the necessary cold-chain arrangements were maintained effectively.

3.35 Detainees arriving with medicines were reviewed and security staff were informed when they should attend for medicines administration. No further health screening was offered which was a missed opportunity for early identification of further health needs. We were concerned to find three distressed young children in the family tent who had been treated the previous day at WJF for fuel burns to their legs. The plan of care from Medevent clinicians, which gave instruction for changing dressings and reviewing wounds, was attached to their documents but had not been opened or acted on. IPRS Aeromed clinicians rectified this when we alerted them.

3.36 Isolation cabins remained in use at Manston for detainees with suspected contagious communicable diseases. These were reasonably well equipped and detainees had access to a shower in the cabin. Records that we examined showed that isolation had been used at Manston 52 times in the previous six months. Most detainees were sent to identified isolation hotels in the local area.

3.37 Overall, clinical facilities at Manston were clean and fit for purpose, but handwashing facilities for clinicians administering vaccinations did not meet infection prevention standards. IPRS Aeromed and Medevent were based in clinical areas with sufficient rooms and detainees were always seen in private. Additionally, Medevent had an emergency ambulance and rapid response vehicle for detainees requiring emergency conveyance to hospital (see paragraph 3.28).

3.38 Detainees who were to be admitted to the residential holding rooms at Manston were clinically assessed by registered nurses from CMS. The bespoke fitness-to-detain assessment was comprehensive, covering key vulnerabilities, and was conducted in private booths in the admissions tent. CMS had good links with Home Office safeguarding leads and we were told that about 15 detainees had been declared unfit for detention in the previous 12 months. The 24 hours a day service from CMS was due to be enhanced with the introduction of an advanced nurse practitioner from July 2024.

3.39 IPRS Aeromed delivered paramedic cover at both KIUs and facilities were clean and fit for purpose. Detainees were not assessed on arrival and had to ask to see a paramedic. This was a missed opportunity to identify or treat health conditions, particularly in the case of unaccompanied children at the Dover facility. Paramedics held an appropriate range of medicines to treat minor ailments, which were stored securely and subject to audit.

3.40 The isolation facilities remained inadequate and the identified room at KIU Dover was still used as a storage area, but we were told that a mobile storage unit could be removed quickly if the facilities were required. We were told that children who were suspected of having scabies were freely mixing with others.

Section 4 Preparation for removal and release

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

Communications

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

4.1 Detainees still had only limited access to any form of communication with friends or family across all four sites. This was a major concern to detainees we spoke to. Personal mobile phones were removed from them in Western Jet Foil (WJF) and they were given no opportunity to note any of their contact numbers. The phones were stored in their property bag and not returned to them until they had left the holding facilities.

4.2 Detainees were unable to make any calls until they had reached the accommodation marquees in Manston. New phone booths had been installed, which allowed for free and unlimited international calls, but they were underused because most detainees did not have any contact numbers. The residential holding rooms had one mobile phone in each housing block, which could hold up to 48 detainees, but international calls could not be made from these phones.

New phone booths in MITIE marquees at Manston, which were underused because detainees did not have access to contact numbers

4.3 At the KIU Dover, children were told during the induction process that they could use the landline in the interview rooms to make international calls, if they had their contact numbers. The same stock of mobile phones available at the last inspection were still not used because of the poor signal in the holding rooms (see paragraph 2.36). Children were still not allowed to use personal mobile phones even when they had been bailed and were in the Refugee Council area.

4.4 Incoming calls were permitted at KIU Folkestone, if detainees were able to contact their friends and families to let them know the number. Staff told us the stock of mobile phones they had were not used because they were incompatible with modern sim cards.

4.5 There was still no access to the internet across the four detention sites. We were told that there was limited access to the internet in the Refugee Council area at KIU Dover, although we saw no one using it

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.

4.6 Data provided by the Home Office showed that 98% of detainees leaving Manston in the last six months had been bailed to a hotel. We observed families departing from Manston on coaches during the inspection. Most of them did not know where they were going. Interpreters were not used to tell them about their journey and their bail information was only provided in English. Some detainees we spoke to were concerned about not having access to their medication, which was unnecessarily kept with staff at the front of the coach.

4.7 One agency across all the holding facilities was responsible for transporting detainees to their bail accommodation. The same vehicles were used to take families to their next destination, but car seats were not provided for babies or young children who were expected to sit with their parents on long journeys. This was unsafe.

4.8 Activity packs were given to younger children for the journey, which was good. Bottled water was available and detainees were able to take snacks with them from the holding facilities. However, on the journey from WJF to Manston, we saw children being told they had to leave their food behind before boarding the coach. This was unnecessary, particularly if they had not eaten for a long time.

4.9 Unaccompanied children were still released and placed under the supervision of the Refugee Council at the Kent Intake Unit in Dover. Children remained there while they waited for Kent County Council staff to secure foster accommodation.

4.10 Refugee Council staff were experienced and caring and spoke a variety of languages. They provided emotional support and ensured that detainees had food, drinks, access to a shower and welfare bags, with clothes and toiletries. The accommodation was available 24 hours a day, seven days a week for up to 10 children at a time. However, space was very limited and there were only three beds in small, cramped rooms. As a consequence, children regularly slept on the floor on mats and were not allowed to go out into the fresh air.

Section 5 Progress on concerns from the last report

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

Safety

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

Priority concerns

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

Governance of adult and child safeguarding was poor.
Partially addressed

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

Key concern

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

Respect

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

Priority concern

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

Key concerns

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

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

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

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

Preparation for removal and release

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

Key concerns

Detainees had limited access to any form of communication with the outside world at all sites, including contacting their families after their journeys.
Not addressed

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

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 Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)). Section 5 lists the concerns raised at the previous inspection and our assessment of whether they have been addressed.

Inspection team

This inspection was carried out by:

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Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find.

Care Quality Commission (CQC)
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

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

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