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

Larne House, Manchester and Swinderby

by HM Chief Inspector of Prisons

7–11 July 2025

Contents

Introduction

This inspection covers the three residential short-term holding facilities (RSTHFs) at Manchester, Swinderby and Larne House. These facilities are much smaller than immigration removal centres and can normally only hold people for five days. The largest of them at the last inspection, Yarl's Wood, had been repurposed to long-term accommodation and is therefore not included in this report. However, a new RSTHF holding up to 37 detainees had been opened at Swinderby, next to Morton Hall Prison in Lincolnshire. In total, the three sites had received well over 2,000 detainees in the six months to the end of May 2025.

We found generally positive outcomes at all sites. All facilities were calm and well managed, and detainees were very positive about the respect and care they received. We saw some examples of exceptional support from detention staff, and the commitment shown by the local teams was commendable. Violence, use of force and self-harm were rare. All of the accommodation was at least reasonable, although some aspects of Larne and Manchester remained too austere. Detainees could move around the sites freely, and Swinderby offered welcoming green and open spaces, which also helped people to manage anxiety.

However, some significant concerns remained. For example, women were still not given sufficiently separate accommodation at Larne or, to a lesser extent, at Manchester, potentially undermining their security. Identification, and in some cases care, for the most vulnerable individuals was not good enough. The Rule 32 process (see Glossary), which is meant as a protection for the latter, was underused. Some people were also held for excessive periods of time in contravention of the legal time limits, and far too many people were moved around the country in the middle of the night with little regard to their physical and mental health for reasons of operational convenience.

Such issues need to be addressed. However, it was clear that, overall, the Home Office and contractors had worked hard together to ensure well-staffed and well-run facilities that were offering a largely good standard of care for detainees held for short periods.

Charlie Taylor
HM Chief Inspector of Prisons
July 2025

Summary of key findings

What needs to improve at this residential short-term holding facility

During this inspection we identified nine 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. **The Home Office did not always accurately assess detainees' vulnerabilities or communicate them to Care and Custody. The latter opened relatively few vulnerable adult care plans compared to the numbers assessed to be a risk in detention.**

2. **Rule 32 reports were not always submitted when necessary.**

3. **Aspects of the living environment remained austere and unwelcoming, especially some of the cells at Larne and the small, enclosed yards at Larne and Manchester.**

4. **There was not enough separation of women at Larne or, to a lesser extent, at Manchester.**

Key concerns

5. **Too many detainees were transferred overnight for reasons of operation convenience, with little regard to the impact on elderly and otherwise vulnerable people.**

6. **Arriving detainees were not given a meaningful offer of a private interview, and they were not always searched in private.**

7. **At Swinderby and Manchester, interpretation was under-used during induction and welfare checks.**

8. **In the absence of prescribers, many detainees did not receive their prescribed medication in a timely fashion or at all**.

9. **Detainees did not have access to some legitimate websites, including email providers, support organisations and social media.**

Progress on recommendations

At our last inspection in 2021, we made 11 recommendations relating to Larne House and Manchester RSTHFs. At this inspection we judged one recommendation to have been achieved, three partially achieved, and seven not achieved. Our last inspection also included the RSTHF at Yarl's Wood immigration removal centre (IRC), which is no longer designated as such and was not therefore covered during this inspection. Swinderby RSTHF has opened since our 2021 inspection.

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, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other establishments. They show some of the ways our expectations might be met, but are by no means the only way.

Examples of notable positive practice		
a)	Experienced, compassionate and dedicated Care and Custody staff at Larne had created a culture strongly focused on detainee welfare. For example, they gave local prisons useful information for people who were due to be transferred to Larne, which informed and reassured the detainees. Larne staff also used interpretation more than at other sites, promoting good communication and support.	See paragraph 3.8

About the residential short-term holding facilities

Role of the facilities
To hold immigration detainees for up to five days, or seven days if their removal from the UK is imminent.

Locations and total number of detentions, December 2024 to May 2025

Manchester	1,273
Swinderby	700
Larne House	267
Total	**2,240**

Operational capacities

Swinderby	37
Manchester	32
Larne House	19
Total	**88**

Most common nationalities of detainees
Albanian
Romanian
Brazilian
Indian

Lead agencies and contractors
Home Office
Mitie Care and Custody
Spectrum
Nottinghamshire NHS Foundation Trust

Date of last inspection
Larne House and Manchester RSTHFs: 23–26 August 2021.
Swinderby has not been inspected before.

Section 1 Leadership

1.1 There was good communication between Home Office and Care and Custody leaders, and all agencies worked together collaboratively. Experienced Care and Custody leaders were respected by staff, who reported positively on their morale and motivation.

1.2 We were especially impressed by the determination of leaders at Larne to make improvements for the benefit of detainees. For example, they had made contact with prisons and provided them with relevant information to give to detainees before they transferred to Larne.

1.3 Leaders had ensured there were enough staff at each site to provide detainees with sufficient support. While there was a lack of women officers at Manchester, this was being addressed through new recruitment, and we were told that the problem would be resolved imminently. However, leaders had not ensured sufficient separate facilities for detained women at Larne and Manchester, creating potential risks to safety.

1.4 The centres were very different, but there was scope for more cross-learning, for example, in the positive way that Larne staff managed vulnerable detainees, and the openness of the Swinderby site. In general, leaders had made good efforts to improve and maintain the physical environments at each centre.

1.5 Home Office and Care and Custody leaders did not always take sufficient account of detainees' vulnerability before transfer. They had also shown little inclination to address the long-standing problem of exhausting and disruptive late-night transfers, which were undertaken to align with Care and Custody shift patterns.

1.6 Computer data systems did not speak to each other across the different centres. This meant that similar data were collected several times in a short space of time, including fixed information, such as a detainee's allergies, photos and fingerprints, and the number of children they had.

1.7 Data collected by the Home Office and Care and Custody were not reliable enough to help to drive improvement. For example, the detention logs were initially received had substantial inaccuracies. However, in some respects governance was improving; there were now more regular management checks for assessment, care in detention and teamwork (ACDTs; see Glossary) and vulnerable adults care plans (VACPs) and increasing leadership oversight of use of force and Rule 32 reports.

Section 2 Safety

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

Arrival and early days in detention

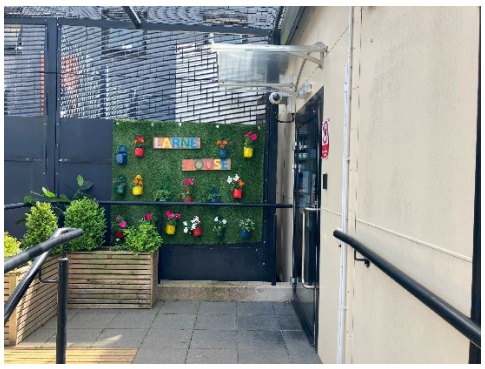
Expected outcomes: Detainees travelling to and arriving at the facility are treated with respect and care. Risks are identified and acted on. Induction is comprehensive.

2.1 A large number of detainees, including some elderly and vulnerable people, were subjected to exhausting overnight transfers for reasons of operational convenience (see paragraph 4.7). On arrival, we saw detainees held in vehicles during hot weather for up to an hour at Swinderby, and subsequent reception processes took over two hours at Swinderby and Manchester. None of the facilities recorded the time detainees spent waiting in vans or in reception.

2.2 Escort vehicles were in good condition, and men and women generally travelled separately. All were provided with snacks and drinks, and some of those travelling over lunchtimes received more substantial food.

2.3 Reception staff were friendly and supportive, and the reception areas were bright, clean and reasonably welcoming. They had been improved with murals, pictures, plants and TVs displaying information about the facilities. The staff at Larne stood out for the exceptional efforts they made to put people at ease on arrival. They had softened the austere main entrance to Larne by making a welcome sign and placing flowers in the vehicle dock.

Reception areas at Manchester (left) and Swinderby



Reception area (left) and entrance to Larne

2.4 All detainees were searched by a staff member of the same sex in a friendly and professional manner, but not always in private. At Larne, detainees were asked if they would like a private search, rather than receiving it automatically.

2.5 Most reception interviews took place at an open desk in the reception area, which undermined confidentiality and did not encourage disclosure. Detainees had the option of a private interview on arrival, but the offer was often cursory and unclear and did not allow them to make an informed decision. For example, one detainee was told he was only going to be asked about his diet before undergoing an extensive reception interview. All interviews we saw used interpretation where needed.

2.6 Health care induction assessments were thorough and included questions to identify key vulnerabilities, such as risk of self-harm and suicidal ideation. We saw good communication between health and reception staff.

2.7 Detainees could take their clothing and cash into the facility, but not toiletries. This applied even when they had been bought from IRCs or prisons, and meant they had to buy new supplies. Detainees transferring from prisons did not always arrive with the money from their prison accounts, which was particularly concerning for those about to depart on charter flights. While we saw staff working hard to resolve this issue, it should have been dealt with at discharge stage.

2.8 Detainees were positive about the care and support provided by reception staff. They were offered cold drinks and snacks, and everyone could have a hot meal after their induction.

2.9 The basic induction tour was useful, but interpretation was sometimes not used where needed. At Larne, but not consistently at the other sites, written induction information was provided during the reception interview. Swinderby and Larne had translated information about the centre available, but it was not always given to detainees on arrival.

2.10 All detainees received three-hourly welfare check-ins, but interpretation was not consistently used where required to help staff explore a

detainee's well-being. Records did not suggest meaningful engagement.

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.

2.11 The Home Office did not always communicate vulnerability to Care and Custody staff in movement and detention documentation. Detainee custody officers (DCOs) opened fewer vulnerable adult care plans (VACPs) than would be expected given the number of detainees assessed to be at risk. In the previous six months, 55 VACPs had been opened across the three sites, whereas the Home Office had assessed 127 detainees to be at one of the two higher levels of risk. In the same period, the Home Office had made 169 national referral mechanism (NRM; see Glossary) referrals. A higher percentage of detainees assessed at the two higher levels of risk were identified in Larne (9%) compared with Manchester and Swinderby (5% and 6% respectively). At Larne, there were sufficient and informative entries in most VACPs, which evidenced use of telephone interpretation. At the other two sites, the brief records did not demonstrate adequate care (see paragraph 3.15).

2.12 The Home Office did not always appropriately assess risk in detention; for example, a detention review wrongly stated that a transgender detainee was not in an at-risk group under its adults at risk policy. In some cases, detainees were assessed to be at risk, but electronic records were not updated, which meant that other Home Office teams were unaware of the detainee's status.

2.13 Rule 32 reports were not submitted whenever necessary. In one case, no report was made for a woman who was placed on constant watch having made repeated suicide threats during her five-day detention (see paragraph 2.25). The Home Office was aware of the low rate of Rule 32 submissions and was monitoring it with a view to driving improvement (see paragraph 3.18).

2.14 DCOs at Larne had a much better awareness of the Home Office's policies on adults at risk and modern slavery than those at Swinderby and Manchester. However, at Manchester, we did note good work by a manager who made a particular effort to develop a relationship with a woman detained there. This woman then subsequently disclosed a history of modern slavery.

Personal safety

2.15 The reasonable physical condition of the facilities; short stays; high levels of staffing; and the friendly approach taken by staff, all

contributed to relatively calm centres. At Swinderby, good access to open green space was especially useful in helping detainees to manage anxiety.

2.16 Violence and intimidation were very rare, and there was no evidence of tension between detainees. Staff spoke positively about detainees from different nationalities and backgrounds supporting each other, and detainees reporting good relations with each other.

2.17 There had been three relatively minor uses of force in the previous six months, none of which were at Larne. Two involved light-touch guiding holds, and one entailed use of handcuffs on a detainee physically resisting an initial search. Recent improvements in governance had drawn on developing practice in the IRC estate. Hot and cold debriefs now took place after each incident, with systematic analysis by the national security team and dissemination of lessons.

2.18 A new generation of body-worn cameras was in use, although a number of staff at Manchester were not wearing them because of a design fault that prevented secure attachment. We were told this was imminently being resolved. The footage was now immediately accessible to the Care and Custody managers as well as to Home Office teams. However, CCTV recordings could only be accessed by Home Office staff, which led to delays in Care and Custody being able to review them. This was more of a problem at Larne, where no Home Office staff were on site.

2.19 Reinforced separation rooms were being introduced. There were two at Swinderby, which were not yet in use, and plans were at an early stage to install one at Larne. It was not clear why these were needed given the low level of violent or disruptive behaviour, and the relatively high level of staffing.

2.20 There had been five instances of self-harm in the previous six months across the three sites. In a particularly serious incident at Manchester, the person smashed a refrigerator shelf to harm himself soon after receiving removal directions. There had been a failure of communication in this case as detention staff had not been informed that the notice of removal had been issued.

2.21 ACDT records suggested a good level of care for those at risk of self-harm at Larne, but there were less thorough entries elsewhere. At Manchester, there were not enough staff trained to carry out the main ACDT assessment. Many of the immediate action plans and ongoing care plans at Manchester and Swinderby showed little exploration of individual circumstances or planning tailored to the individual. We observed one poor ACDT assessment, when the detainee was given little opportunity to share his feelings and was subject to culturally insensitive comments. After we raised our concerns, the detainee was quickly reassessed, and this was done professionally and sensitively. In two cases, a handheld electronic tablet had inappropriately been used for initial ACDT assessment or subsequent case review, instead

of more accurate professional telephone interpretation (see paragraph 3.13).

2.22 Risk of harm was not sufficiently considered in some decisions to transfer people between different places of detention. For example, a man considered to be at risk of suicide was settled and being supported at HMP Morton Hall; despite this, he was moved to Swinderby, next door to the prison, before leaving for Colnbrook IRC the next day. In another case, a detainee in Swinderby was transferred to an IRC less than five hours after he had made a serious attempt at hanging himself, having not slept overnight.

Safeguarding children

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

2.23 There had been no occasions in the previous six months where a detained person had claimed or been suspected of being under 18. We were told that if a person brought to the facility said they were a child, they would always be accompanied by a staff member until social services attended the site. There were appropriate arrangements to safeguard children visiting the facilities.

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.

2.24 Some detainees at Larne were held for too long because of a shortage of airline places, despite efforts by the Home Office to secure more seats. The average length of detention in Larne was over 81 hours, compared with about 47 hours in Swinderby and 35 in Manchester. Sixteen detainees had been held at Larne in breach of the five-day time limit for detention in an RSTHF. There was no indication that any of these detainees were imminently to be removed. Eight detainees had been held in breach of the time limit in the other two facilities, which was a much smaller proportion of those held.

2.25 A Spanish woman in Larne had been held for five days before the Home Office realised she was detained in error with no lawful basis for her detention. Health care staff recorded a rapid deterioration in her mood, and she repeatedly indicated suicidal thoughts. As a result, she was being constantly watched before her unconditional release.

2.26 Detainees had no access to a free duty legal advice surgery. Notices provided contact details for some law firms able to provide substantive immigration advice, but none offered free legally aided advice. Facilities

for legal consultations were good but seldom used. Detainees could send and receive legal documentation.

2.27 Home Office legal documentation was not translated, and some detainees did not understand the contents.

2.28 Unlike those held in an IRC, detainees had no proactive contact with Home Office detention engagement staff, which was mainly an issue at Swinderby as people were being removed directly from that facility.

Section 3 Respect

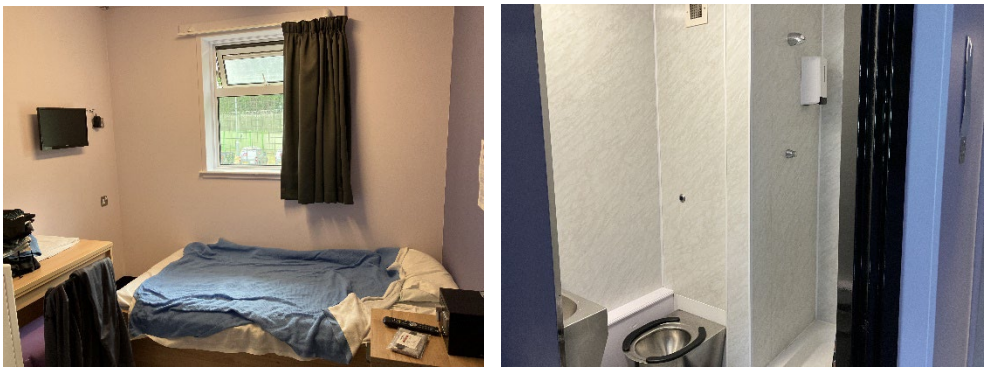
Detainees are treated with respect for their human dignity and the circumstances of their detention.

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.

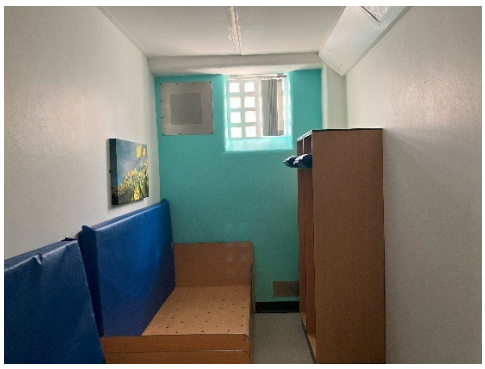
3.1 Communal areas were clean and well maintained, and all areas were in a good state of repair. Cleaners were on site every day, and detainees could also access cleaning materials for their rooms. All centres had a good relationship with the contractors, who were responsible for general repairs. There were problems with drainage at Swinderby and Legionnaires' disease at Larne, but they had been managed well.

3.2 Swinderby had a more open and welcoming environment than the other centres. All cells were single occupancy, well equipped and properly ventilated, with clear windows which could be opened by detainees. Detainees also appreciated the integrated showers and toilets. The heavy cell doors appeared out of place and unnecessary, especially as doors were never locked.



Cell and integrated shower room at Swinderby

3.3 At Manchester and Larne the environment was reasonable, but not as welcoming as Swinderby. However, it was positive that the accommodation at Manchester was entirely non-cellular. Rooms at Manchester and Larne had more basic furniture and many were shared. Windows were also frosted and sealed, reducing the amount of light and making rooms stuffy. Despite attempts to brighten them up, some bedrooms at Larne remained particularly austere.



Room at Manchester (left) and cell at Larne

3.4 Detainees at all three centres had good access to fresh air and outside space. At Swinderby there was a large grassy area with some football goals, exercise equipment and comfortable seating, which was regularly used by detainees. Although attempts had been made to improve the appearance of the exercise yards at Larne and Manchester, they were still small and enclosed, with no green areas or exercise equipment.

Exercise areas at Swinderby

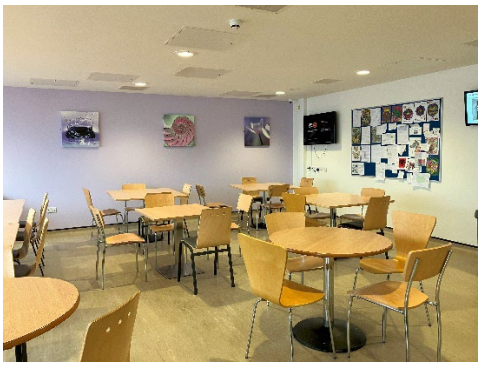
Outside areas at Larne (left) and Manchester

3.5 There were welcoming association rooms at each centre with softer seating, books, TVs, board games and games consoles, which were well used by detainees. There was also a small range of translated books, magazines and newspapers.

Association areas at Swinderby (top), Larne (left) and Manchester

3.6 At each centre, detainees had access to plenty of snacks and hot and cold drinks 24 hours a day. Hot meals were provided three times a day

and mostly involved frozen food cooked in the oven or microwave. Healthy and fresh options, especially for vegan detainees, were limited. Staff said they would go to a local shop to buy food if necessary. Basic clothing was available at all centres to detainees who needed it, and they could buy additional snacks and toiletries from small onsite shops.



Snack and kitchen areas at Swinderby (top), Larne (left) and Manchester

3.7 Regular consultation took place at the three centres, and there was evidence of action being taken in response. For example, at Manchester, detainees requested more crafting activities and supplies, which leaders quickly provided. The centres had also introduced a schedule of social events such as movie and game nights. However, this was only monthly and reached very few detainees.

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.

3.8 At all three centres, detainees were positive about staff, and we saw many examples of caring and empathic interactions. Staffing levels were good, and there was always an officer available to help a detainee or answer any questions. At Larne, we were particularly impressed by the support the experienced and capable staff group gave to detainees. However, at Manchester and Larne, there was a lack of understanding about the potential negative impact of detained women's welfare checks being completed by men, including overnight, when women officers were available.

3.9 Women could be held at both Larne and Manchester but there was insufficient separation from men, creating potential safeguarding concerns. At Larne, there was no separate area or association room for detained women. While they were housed in dedicated rooms which had a door between them and the men, it was not locked. Disabled men were also placed in this area, and shared bathrooms with women.

3.10 At Manchester, there was better separation. Women had their own separate, lockable, corridor with bathroom and a small, comfortable association room. But if they wanted to use any of the larger association facilities, such as the yard, multi-faith room or snack and dining area, they had to share with men. We were not assured that detained men inducted without the use of interpretation had understood that designated areas for women were out of bounds. There were also too few women members of staff, although we were told this was being addressed through new recruitment.

Women's association area at Manchester

3.11 Sanitary products for women were freely available, but there were very few items at the shop specifically for women, and, other than underwear, most of the available clothing was for men.

3.12 Complaint forms were readily available in numerous languages. In the previous six months, there had only been six complaints in total. The responses we reviewed were polite and addressed the issues raised, but they were not always timely. Detainees were not always included in the investigation even when contact details were provided. At Larne, the lack of Home Office staff meant that Duty Managers (DCOMs) emptied the complaint boxes, which compromised confidentiality and could have deterred detainees from complaining.

Complaint forms in multiple languages at Swinderby

3.13 We observed telephone interpretation being used in reception interviews at all sites. Use of interpretation thereafter was routine at Larne and underpinned good communication between staff and detainees. Elsewhere, it was used reasonably well but less often, which was especially problematic during induction and ACDT interviews (see paragraphs 2.9 and 2.21). DCOs also used handheld translation devices which were suitable for simple day-to-day interactions.

3.14 All detainees had access to reasonable multi-faith rooms, although the room at Larne was much less welcoming than the others. At Manchester, religious texts were not available for all main religions.

Multi-faith rooms at Swinderby (top), Larne (left) and Manchester

3.15 There were some deficiencies in the care and management of the two transgender detainees held in the previous six months. While both had a VACP, there was little evidence of meaningful care planning that involved the detainees themselves. In particular, the Home Office did not convene a multidisciplinary team meeting in either of the cases we looked at, to consider the risks associated with detention. Given the challenges of supporting and managing transgender detainees in an RSTHF, this should have been done when they first arrived at the facilities. We found no evidence that staff spoke to the detainees about their vulnerabilities or how confident they were to use shared facilities. Although detainees could in principle shower at separate times, there was no record of this taking place.

Health services

3.16 Health services were delivered by three different providers across the sites. The service at Manchester was provided by Spectrum, at Swinderby by Nottinghamshire NHS Foundation Trust, and at Larne by Mitie Care and Custody. All detainees were seen within two hours of

arrival by a registered health professional who used a standardised assessment template.

3.17 Although many detainees presented with stress and anxiety during their stay, it was rare that someone arrived in a severe mental health crisis; in most cases these were managed before arrival.

3.18 Nurses undertook Rule 32 assessments, but some felt the quality suffered because they rarely completed them. According to health care records at Swinderby, none of the 11 Rule 32 reports submitted in 2024 or the three in 2025 had resulted in a release by the Home Office. No records of Rule 32 reports were provided at Manchester (see paragraph 2.13).

3.19 A small number of medications were available for administration by qualified nurses, but there were no nurse-prescribers at any site. Detainees arriving with their prescribed medicines from another country had them removed for safety reasons, but they were not replaced with the UK version. Detainees who needed critical medicines had to attend a local accident and emergency department for a prescription.

3.20 Medical advice at Manchester and Swinderby was provided over the phone by local prison GPs during working hours. GPs did not visit and were unable to undertake a face-to-face assessment. Medicines were stored safely and stock use monitored well.

3.21 Health records at Manchester and Swinderby were on the same network as prisons and immigration removal centres, which supported continuity of health information. However, detainees coming from Dungavel IRC were reliant on paper records coming with them, which did not always happen.

3.22 We saw some detainees being woken very early to be screened for departure; this involved undertaking mandated activities which had been done only hours before, such as repeating blood pressure and pulse checks, often for detainees with no underlying health conditions.

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 All detainees were offered use of a centre mobile phone on arrival and those without means were given £5 credit. There were landline telephones for incoming calls, and detainees could use an office phone for a free five-minute international or legal call when staff were available.

4.2 All sites had computer terminals in communal areas, but some legitimate sites were blocked, including widely used email providers and some immigration and asylum support organisations. We met one man who normally used email to contact his family and could not do so at Manchester. There was no access to social media for contacting family and friends.

Swinderby computer area

4.3 Domestic visits rooms were comfortable and child-friendly. Visits were available every afternoon and staff were flexible in extending or offering them at ad hoc times for detainees who needed either. Legal visit

rooms had video-calling equipment which could be used for social video calls. Both Larne and Swinderby had suitable external signage, but Manchester was poorly signposted and difficult for visitors to find.

Visits rooms at Swinderby (left) and Manchester

4.4 Each centre had large maps with the location of all immigration facilities prominently displayed, and detainees were given cards showing IRC and RSTHF addresses and contact details. Staff pointed out the address and telephone number of the centres during the centre tour.

4.5 All centres had links with local visitors' groups, which provided advice and signposting to detainees and, at Larne, some practical support. At Manchester, Manchester Immigration Detainee Support Team (MIDST) staff were no longer able to enter residential areas and were reliant on a detainee appointment system which had resulted in fewer contacts with detainees.

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 The lack of access to free legal advice, detention engagement staff or systematic welfare provision meant that the large number of detainees removed from Swinderby had less specialist support than those removed from an IRC.

4.7 Too many detainees were transferred late at night. For example, in June, 25% of detainees were transferred from Manchester between 10pm and 6am and most of them (45 out of 51) were going to IRCs. In one case, a frail and confused 79-year-old woman was picked up in Manchester at 10pm for escort to Yarl's Wood, only arriving there at 1am.

4.8 It was unclear why what were termed 'positional moves' were necessary, and they did not take account of detainees' welfare. For example, a suicidal man was moved a very short distance to Swinderby

from HMP Morton Hall, a day before his scheduled transfer to Colnbrook IRC. The discharge and arrival processes were disruptive and added to his distress.

4.9 All facilities had a good stock of warm clothes for detainees leaving the centre. Those being released were given a small amount of cash and travel warrants for onward journeys.

4.10 Information sheets for detainees released from Manchester and Swinderby provided information on local support groups, but only in English. Information sheets for Larne were translated into commonly used languages.

4.11 It was positive that families and friends could, by appointment, deliver belongings to detainees.

Section 5 Progress on recommendations from the last report

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

Safety

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

Recommendations

Reception interviews should be conducted in private. (Larne House, Manchester)
Not achieved

Staff should record regular information about the person's behaviour and frame of mind in every vulnerable adult care plan. (Larne House)
Not achieved

Onsite managers should be able to retrieve and review closed circuit television footage easily. (Larne House)
Partially achieved

Detainees should be issued with an IS91R form in a language that they can understand. (Manchester and Larne House)
Not achieved

Mitie Care and Custody should make sure that detainee custody officers are aware of the national referral mechanism (NRM), to identify and support potential victims of trafficking. (Manchester)
Not achieved

On site Home Office staff should maintain a record of referrals to the NRM. (Manchester)
Achieved

Respect

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

Recommendations

The improvements to the communal areas should be extended to the bedrooms, to give a simple but adequate private space. (Larne House)
Partially achieved

Men and women should be held separately. (Larne House)
Not achieved

Only women officers should check women's rooms at night. (Manchester)
Not achieved

Preparation for removal and release

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

Recommendations

Detainees should be permitted access to social media.
Not achieved

The entrance to the facility should be signposted for visitors. (Larne House)
Partially achieved

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 recommendations 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 recommendations from the previous full inspection and our assessment of whether they have been achieved.

Inspection team

This inspection was carried out by:

Hindpal Singh Bhui	Team leader
Rachel Badman	Inspector
Deri Hughes-Roberts	Inspector
Martin Kettle	Inspector
Alice Oddy	Inspector
Tania Osborne	Health care inspector

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.

ACDT Assessment, care in detention and teamwork
Case management for detainees at risk of suicide or self-harm.

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

National referral mechanism (NRM)
The framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

Rule 32 Short-term Holding Facility Rules
Provides that:

1. A health care professional at a short-term holding facility must report to the manager in relation to the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
2. If a health care professional suspects a detained person of having suicidal intention, this must be reported to the manager; the detained person must be placed under special observation for so long as those suspicions remain; and a record of the detained person's treatment and condition must be kept throughout that time.
3. Where a health care professional has concerns that a detained person may have been a victim of torture this must be reported to the manager.
4. Where a report has been made under paragraphs 1, 2 or 3, the manager must send a copy of any relevant written reports to the Secretary of State promptly.
5. A health care professional must pay special attention to a detained person whose mental condition appears to require it and make any special arrangements which appear necessary for the detained person's supervision or care.
6. For the purposes of this rule, 'torture' means any act by which a perpetrator intentionally inflicts severe pain or suffering on a victim in a situation in which a) the perpetrator has control (whether mental or physical) over the victim; and b) as a result of that control, the victim is powerless to resist.

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

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