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

Immigration reporting centres

by HM Chief Inspector of Prisons

20 - 29 October 2025

Contents

Introduction

Across the UK, 10 secure holding rooms are located in Home Office buildings and attached to immigration reporting centres. We last reported on these relatively small places of detention in separate reports between 2015 and 2019. We have now returned to all of them within a short period.

Across the three nations, we found experienced staff who show a good level of care and understanding. The rooms are kept in good working order, although physically they are dated and show many signs of wear and tear.

Some progress has been made in identifying risks and vulnerability, especially through the work of the national Detention Gatekeeper, but there is still not a sharp enough focus on safeguarding, whether in decision-making on detention or in invoking the support mechanisms that are available.

Use of several of these holding rooms is rising, as is the average length of detention, and leaders in the Home Office and in the detention contractor Mitie Care & Custody are aware of most of the issues and limitations. They are working together to address many of them, with plans at an early stage and dependent on budgets. They are not yet making sufficient use of data to understand and address what is happening, at specific sites or across the board, but I hope that this report will help to point the way for further improvement.

Charlie Taylor
HM Chief Inspector of Prisons
October 2025

Summary of key findings

What needs to improve at this short-term holding facility

During this inspection we identified nine key concerns, of which two 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. **In some cases, the Home Office took insufficient or no account of known vulnerabilities in deciding whether to detain an individual.**

2. **There was insufficient health care provision, with no routine health screening and delays in access to medication**. Detainees were not routinely seen by health care professionals following use of force and there were some delays in pregnancy testing where it was needed.

Key concerns

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

4. **The use of restraints by Care & Custody staff was not always proportionate.** For example, some detainees were handcuffed when being taken to vans parked in a secure area.

5. **Data on the length of detention were not well analysed or understood.** For example, women were held on average for almost an hour longer than men, and there was a significant variation in the average length of detention in different reporting centres. There were still some gaps in the collection of data, such as inconsistency in use of telephone interpretation, use of force, self-harm and cases of pregnancy.

6. **Many of the holding rooms were not adequately furnished and equipped, especially for rising numbers and longer stays.** Several were in need of refurbishment and few recreational activities were available.

7. **Detainees had no access to fresh air and many holding rooms lacked natural light.**

8. **There was inconsistent use of professional interpretation.**

9. Detainees had no access to the internet or social media at any of the holding rooms.

Progress on recommendations

At our last inspections of the holding rooms in reporting centres, we made a combined total of 62 recommendations in nine individual reports published between 2015 and 2019. At this inspection we judged 28 recommendations had been achieved, 12 partially achieved, 21 not achieved and one no longer relevant.

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 one way our expectations might be met but is by no means the only way.

Example of notable positive practice		
a)	Glasgow offered a wider selection of clothing packs than other sites, including winter jackets.	See paragraph 4.6

About the short-term holding facilities in reporting centres

Role of the facilities

To hold immigration detainees following arrest or reporting and before transfer to residential detention.

Location and total number of detentions, March to August 2025

Capital Building, Liverpool	49
Dallas Court, Salford	83
Drumkeen House, Belfast	108
Eaton House, Hounslow	620
Loughborough	96
Festival Court, Glasgow	92
Ruskin Square, Croydon	663
Sandford House, Solihull	399
Vulcan House, Sheffield	43
Waterside Court, Leeds	83
Total	**2,236**

Most common nationalities of detainees

Indian
Brazilian
Albanian

Lead agencies and contractors

Home Office
Mitie Care & Custody

Date of last inspection

Sandford House, Solihull:	1 December 2015
Festival Court, Glasgow:	25 May 2016
Eaton House, Hounslow:	26 January 2017
Loughborough:	18 April 2017
Waterside Court, Leeds:	20 March 2018
Drumkeen House, Belfast:	5 June 2018
Capital Building, Liverpool:	1-2 May 2019
Dallas Court, Salford:	1-2 May 2019
Vulcan House, Sheffield:	1-2 May 2019

Section 1 Leadership

1.1 There was a positive culture of courtesy and kindness among staff in all the holding rooms, with Care & Custody and immigration enforcement staff working together well to support and give reassurance to those detained. At regional and national levels, leaders in the Home Office and in Care & Custody were cooperating well and had laid some foundations for improvement in delivery across this group of short-term holding facilities (STHFs).

1.2 Nevertheless, detainees were often held for relatively long periods in the STHFs. Pressure on the availability of staff to drive and escort detainees from the STHFs to an immigration removal centre was a major factor in this. Leaders had allowed it to become routine for those detained in the morning – sometimes very early in the morning – to wait until evening for transport.

1.3 The fixtures and fittings in the holding rooms were in most cases dated and showing signs of wear. Home Office managers were planning and implementing a programme of improvement in the holding rooms, but progress was so far limited to the installation of up-to-date telephones for detainee use, a real step forward, and better furnishings at Loughborough. All the facilities were kept clean and tidy.

1.4 There was not always appropriate identification or consideration of vulnerability concerns, which raised questions about oversight and training. The work of the national Detention Gatekeeper had improved the quality of decisions on detention, but those decisions did not always take adequate account of vulnerability, and staff in some of the holding rooms had limited awareness of the Adults at risk policy, the National Referral Mechanism, or even when a vulnerable adult warning form should be opened.

1.5 Leaders had not planned sufficiently for the respectful treatment of detainees in terms of privacy, especially at the points of searching and induction. There was not enough provision for women's privacy to be respected, especially at sites where there was one, generally small, holding room for all those detained.

1.6 There was not sufficiently clear oversight of use of force, including handcuffing, to give leaders and staff confidence to use and report such measures properly.

1.7 Handcuffs were used too often in escorting detainees to vans, and the risk assessment underpinning this was often only a formality. Oversight of use of force was insufficient, and some of the records were unclear, incomplete or inconsistent.

1.8 Collection and use of data were improving, but there were gaps, such as inconsistent figures in different data sources on use of telephone interpretation, use of force, self-harm and cases of pregnancy.

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.

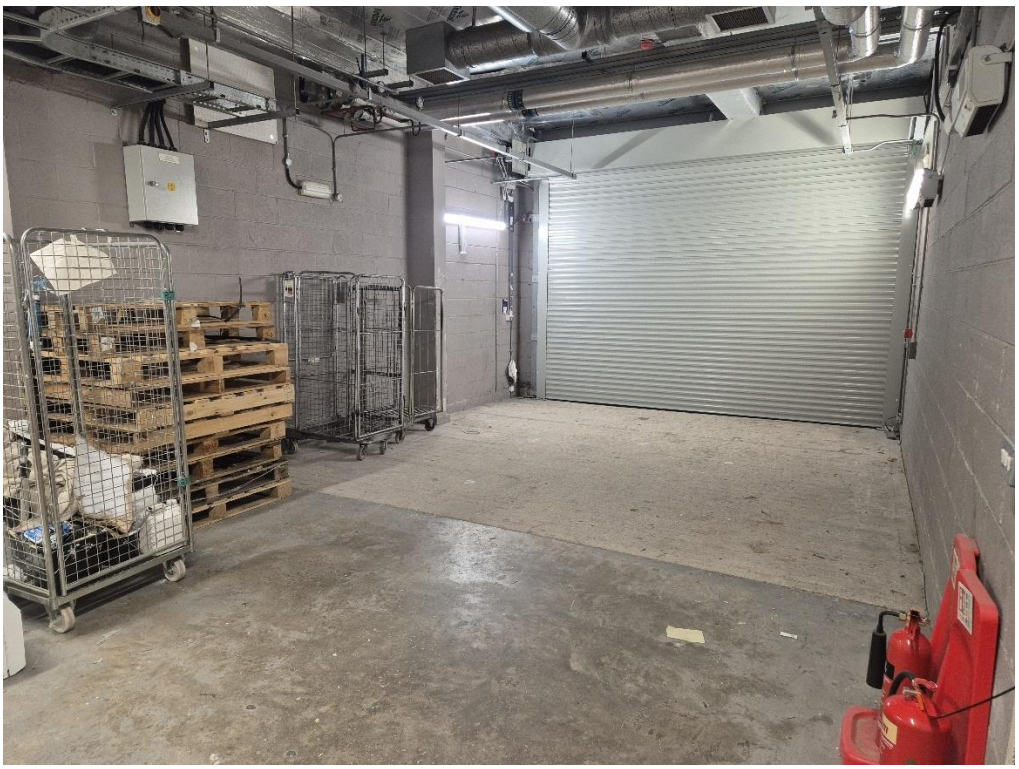
2.1 Home Office records showed that 2,243 detainees had been held across the 10 holding rooms in the previous six months. During that period 670 detainees had been held at Croydon, which was the busiest holding room, while Sheffield was the least used, with 43. Hours of operation for the holding rooms varied, but most were open between 9am and 7pm Monday to Friday, except Belfast which was only opened during the day when needed.

2.2 Detainees arrived at the holding rooms either after being detained and escorted through the building from the adjacent reporting centres, or following arrest in the community. Most escort vehicles were in good condition, but the passenger sections of some older caged vehicles used by arrest teams had no CCTV or seat belts.

Newer style escort vehicle

Older cage style Immigration Enforcement vehicle

2.3 For those brought in following arrest in the community or being transferred elsewhere from the STHF, the point of arrival and departure was not always satisfactory. At Solihull and Loughborough it was in an open area overlooked by large residential buildings. At Sheffield the van bay, although secure, was very cluttered indeed, which staff saw as compromising safety.



Sheffield van bay used for storage

2.4 Often, detainees were arrested early in the morning and arrived at the reporting centres before the holding rooms were open. In these cases, they were held in separate holding areas or in the holding room itself, supervised by immigration staff, before being handed over to Care & Custody staff. Most were offered food and drink by immigration staff while waiting for the holding rooms to open.

2.5 There was often insufficient enquiry into or handover of information about specific health conditions at the point of arrival, unless this was specifically highlighted by immigration staff. Care & Custody staff searched people in a sensitive and relaxed manner, but many of these searches were not conducted in private and some took place in front of large numbers of immigration staff, male and female. There was always a female officer on duty to search female detainees. It was good that personal items such as belts were not routinely removed unless justified by an individualised risk assessment.

2.6 Detainees at all sites received an induction, but professional telephone interpretation was not always used when needed and the interviews were not always conducted in a private or quiet area. While the induction checklist contained some useful items about risk and vulnerability, those questions were not always asked by staff.

2.7 Detainees' property was removed and bagged, but most holding rooms lacked the means to store large items of property securely.

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.

2.8 During the six months to the end of August 2025, 7.6% of detainees (171) had been assessed at one of the higher levels of risk in detention, a much lower percentage than we see in immigration removal centres (IRCs). Four had been assessed at Level 3.

2.9 There was not always appropriate identification and consideration of vulnerability concerns. Care & Custody staff had only made six National Referral Mechanism (NRM, see Glossary) referrals, all from Belfast. Immigration staff had made none. In some cases in our casework sample, detention paperwork failed to specify known detainee vulnerabilities.

2.10 It was evident that Detention Gatekeeper (see Glossary) was playing a productive role in assessing vulnerability and preventing the inappropriate detention of some more vulnerable detainees. However, arrest teams did not always pass on known vulnerability to Gatekeeper staff.

2.11 In one case we examined, the Detention Gatekeeper correctly identified the failure of the Home Office to make a modern slavery referral in 2023 when the detainee disclosed a traumatic history of sexual abuse and torture. It therefore refused to authorise detention. Despite this, local immigration staff in Croydon detained the woman, and she was served with documents informing her of her imminent removal. She then ran into the holding room toilet where she self-harmed and was found in a state of considerable emotional distress. Gatekeeper staff directed her release that day for consideration of her modern slavery claim, and the Home Office later decided there were conclusive grounds that she was a victim of modern slavery.

2.12 In some cases, Detention Gatekeeper took insufficient or no account of known vulnerability in deciding whether to detain an individual. For example, in a case in Hounslow, detention was authorised without reference to a previous conclusive grounds NRM decision (see Glossary). In a case in Solihull, the detention authorisation overlooked that a detainee had been released six weeks earlier, after the Home Office had assessed him to be at the highest level of risk in detention.

2.13 Detainee custody officers (DCOs) were trained in adult safeguarding, but this was not tailored to the immigration setting. Some we spoke to had no knowledge of the Home Office policy on adults at risk (see Glossary) in immigration detention, and most had little knowledge of the NRM.

2.14 Data provided by the Home Office on pregnant detainees were inaccurate and at least three had been held in the previous year. In one case, it was good that a woman who said she was pregnant was tested in the holding room in Leeds and released when her pregnancy was confirmed. In the other two cases, women saying they were pregnant were not tested before their transfer to residential detention facilities. Both were released the next day when their pregnancy was confirmed. In one of these cases, immigration officials in Sheffield dismissed a woman's concern that she might be pregnant, believing she was lying to frustrate her detention. She was driven to Derwentside IRC, arriving after midnight, where her pregnancy was confirmed at 2am. She was released the next day many miles from where she lived.

2.15 In all holding rooms, we were told that there was always at least one female officer on duty. In some, there was only one holding room and women could not be held separately from unrelated men. In Loughborough, women shared the same toilet as men.

2.16 There were hourly face-to-face welfare checks in the holding room, but these were not routinely conducted with interpretation. In Croydon, we observed particularly good care of three more vulnerable detainees, with staff sitting with them in the holding room for extended periods, providing reassurance and support.

2.17 In the last six months, Care & Custody had only opened 42 vulnerable adult warning forms (VAWFs). We were not satisfied that this reflected need, since there were disparities in the level of reporting at each site, and many more than 42 detainees had been assessed as being at the two higher levels of risk.

Personal safety

2.18 Detainees were kept safe and there were very few incidents of self-harm or the necessity for staff to use force. Seven self-harm incidents had been recorded in the last 12 months. We were not satisfied that self-harm incidents were always recorded, as we found two which had not been logged.

2.19 In the year to the end of July 2025, 18 suicide and self-harm warning forms (SSHWFs) had been opened. Of these, 11 had been opened in Glasgow and Belfast, despite these holding rooms having relatively few detainees. Just four forms were opened in Hounslow and Croydon, which together held over five times more detainees than Glasgow and Belfast. It was good that the Home Office had identified and were investigating disparities in the level of VAWFs and SSHWFs opened in each centre.

2.20 In one case we observed in Croydon, Mitie Care & Custody staff did not initially open a VAWF or SSHWF despite detention paperwork indicating the detainee had learning disabilities, depression, anxiety and a history of suicidal ideation. The detainee subsequently informed staff he had swallowed a blade. Thereafter, the incident was handled reasonably well, an ambulance was called immediately and, on

examination in hospital, it was determined that he had not swallowed any item.

2.21 Lessons were not always learnt from incidents. One detainee had attempted to ligature using straps hanging down from a baby changing facility in the holding room toilets in Salford. By the time of the inspection six months later, the straps had not been removed, even though no babies had been held there.

2.22 Incident reports suggested good, timely intervention by Care & Custody staff to prevent serious harm to a detainee who had ligatured himself in the holding room toilet in Liverpool. However, despite being found with a purple face and frothing at the mouth, a chief immigration officer decided not to call for medical assistance, as he considered it would be quicker for the detainee to be seen by health care staff at his destination IRC. He was taken from the holding room four hours 20 minutes later for escort to Yarl's Wood, which took five hours.

2.23 Other cases raised concerns about the lack of medical assistance. For example, a woman detained in Solihull informed staff she was in some pain following an abortion the day before. Nonetheless she was detained and subjected to an arduous nine-hour journey, involving a change of escort vans in Manchester, and arriving at Derwentside at 2.30am.

2.24 Staff could not recall any tensions between detainees and said that if they were upset they would talk to them to defuse potential issues. We were told that force was rarely used and documentation suggested there had only been two incidents. We found a third undisclosed incident and were not satisfied that force was always logged.

2.25 We were told that individual risk assessment always informed decisions on whether to apply restraints, such as handcuffs. However, handcuffs were almost always used by holding room staff in escorting a detainee to a van, with management support, and the risk assessment was generally seen in practice as a formality. For example, in Croydon and Sheffield detainees were often handcuffed when being taken to vans parked in a secure area. Some detainees were handcuffed, including when being escorted in non-secure areas, despite immigration and compliance enforcement (ICE) teams not using them at the time of arrest earlier in the day. We found more proportionate approaches being used at Belfast, where they had moved away from routine handcuffing.

2.26 Some use of force paperwork for the few incidents when force was used lacked clarity or sufficient detail, and managers had not queried some discrepancies between various accounts.

Safeguarding children

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

2.27 On no occasions in the previous 12 months had a detained person claimed to be under 18 or been suspected of being a child. Most of the rooms had baby-changing facilities, stocks of nappies, baby food, toys and games available for children should any be held in the future.

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.

2.28 The average length of detention of detainees held by Care & Custody was four hours 43 minutes. The longest period was almost 13 hours. No detainee had been held overnight.

2.29 Disparities in the length of detention were not properly understood. For example, women were held on average for almost an hour longer than men, and the average length of detention in different holding rooms ranged from about one hour in Loughborough to almost six hours in Sheffield.

2.30 In some cases, detention was prolonged by delays in the Home Office issuing movement orders, and in Care & Custody arranging vans for transfer. There were some unacceptable late-night transfers of detainees who had been held since the morning.

2.31 We looked in detail at the records of 10 detainees held for the longest periods. Seven were women. All had been detained in the morning, with the earliest leaving the holding room at 9.45pm and the latest at 11.33pm. All but one were released from their destination IRC within days.

2.32 In all, 1,187 detainees had been detained in the three months to the end of June 2025. The great majority were transferred to an IRC for removal. At the time of the inspection five remained in detention. Of the rest, 850 (72%) had ultimately been released and 332 (28%) removed.

2.33 All detainees were informed that they could contact a representative by telephone. Staff in Hounslow and some other sites routinely informed detainees they could scan and forward documentation to their solicitors, but staff in some holding rooms were not clear that they were permitted to do this.

2.34 A list of legal representatives was displayed in all holding rooms. However, some firms listed did not offer advice on immigration law, and at some sites no providers were listed that offered free legally-aided immigration law advice.

2.35 Detainees could retain the paperwork authorising their detention and removal. All detention paperwork was issued in English only, but professional telephone interpreters were used to explain the contents when detainees could not speak English.

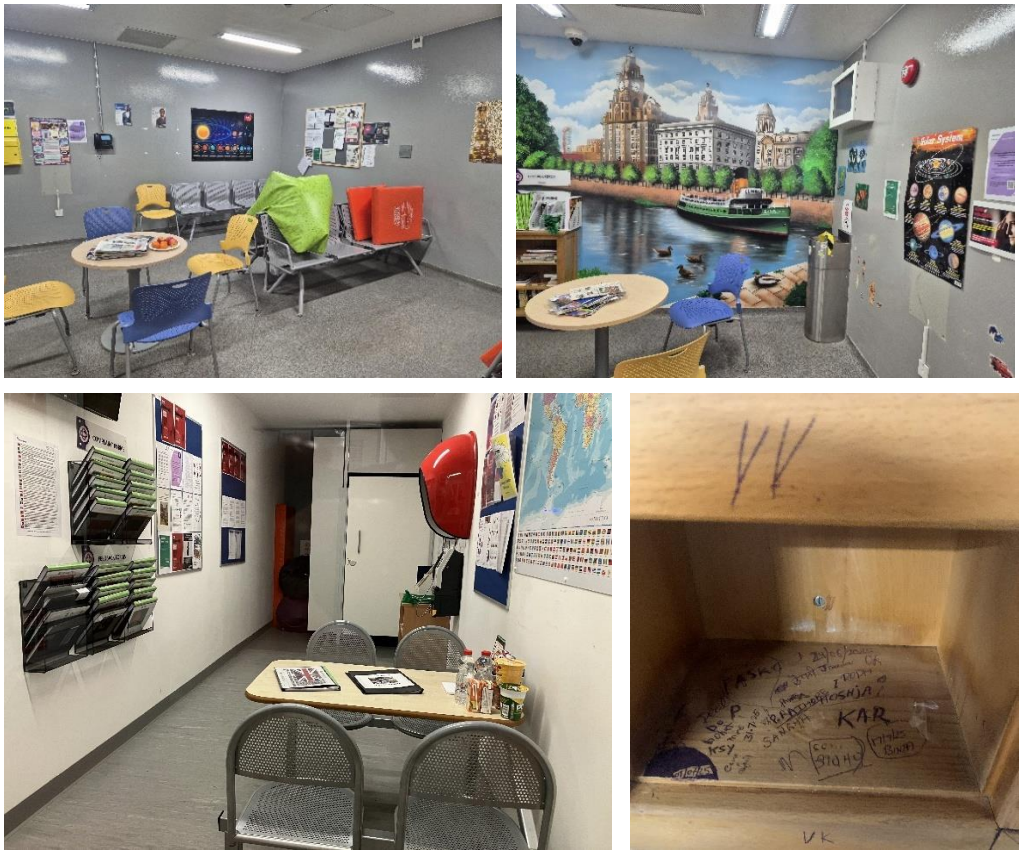
Section 3 Respect

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 All the holding rooms we inspected were kept clean and tidy and most equipment was in working order. Contracted cleaning staff attended to the rooms daily, or twice at busier sites. However, many rooms were shabby and in need of refurbishment. For example, those at Liverpool and Salford had visible wear and walls needed painting. Leaders said they had plans to update the holding rooms, but timescales were generally not clear.



Liverpool male detainee holding room (top left), Liverpool female detainee holding room (top right), Belfast holding room (bottom left) and Solihull graffiti in hatch (bottom right).

3.2 Most reporting centres had two holding rooms, allowing unrelated men and women to be kept separate, but some, including Sheffield and Loughborough, only had one. Privacy for interviews and searches was a concern owing to the lack of space. Croydon, in spite of a recent refurbishment in the last year, had no private space for such purposes and the area designated for them was used as a thoroughfare by immigration enforcement staff.

Croydon refurbished room

3.3 At some of the reporting centres, such as Hounslow and Salford, ICE teams used former holding rooms to hold people after arrest and pending formal detention, during out-of-hours periods when Care & Custody staff were unavailable. These rooms were also in need of refurbishment.

Hounslow Home Office holding room used out of Mitie C&C holding room hours

3.4 Toilet facilities varied in quality. Some lacked seats or had removable gel cushions in place of something more fixed. In Belfast, cubicles lacked privacy with large gaps at the bottom of the door and a removed lock leaving a sizeable hole in the door, while the female toilet at Solihull lacked privacy. Eaton House was the only site with shower facilities.

Loughborough toilet (left) and Liverpool male holding room toilet

3.5 Fixed seating was standard across rooms. Only a few holding rooms had floor mats and bean bags to provide some comfort for those held for extended periods, and in most sites there was no suitable space to rest, even for those arrested in the early hours of the morning. While blankets and pillows were available, only Glasgow provided a small couch-bed.

Salford holding room with no space for floor mats or bean bags (left) and Glasgow holding room with couch-bed

3.6 There continued to be no access to fresh air, despite some detainees spending prolonged periods in small holding rooms, often with no natural light. Rooms were ventilated and at most sites staff could adjust the temperature. Smoking and vaping were prohibited, though nicotine tablets were available. Detainees who smoked expressed discomfort, particularly at Solihull and Belfast.

3.7 Cold snacks, including croissants, fruit pots, crisps and fresh fruit, were readily available in the rooms. Microwave meals were available at any time and dietary needs were accommodated, although the information

pack at Belfast advertised hot meals that were not actually available. Some sites had hot drinks machines, others not, and some staff did not offer drinks regularly.

Salford microwave meal options

3.8 There were limited activities to help pass the time at most sites. Most had televisions but they were often mounted high up and difficult to view from fixed seating. When we visited Croydon, the televisions were not working. There were a few books or magazines at each site, mostly in English, although Loughborough had well-labelled foreign language books. It was good that at most sites staff brought in a current daily newspaper. A small selection of games were available, including some handheld devices, but most were locked away in staff cupboards and rarely offered: some staff said they saw them as a risk to safety.

Sheffield mounted TV (left) and Sheffield magazine selection

3.9 Children's toys and baby food were available in some rooms, although children had not been held in them for some time. Baby change facilities were also still common.

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.

3.10 Staff were welcoming to detainees across all the sites and provided good initial care and support. In several sites, they gave detainees regular updates and attempted to reassure those frustrated by delays. All staff were ready to respond promptly and positively to any requests, although in some places they often did not enter the room unless asked to interact with detainees after the initial phase of settling in.

3.11 There was reasonable CCTV coverage, with monitors in the staff areas of the holding rooms, and a current improvement programme was addressing technical deficiencies in the older systems. In Liverpool, reflective sheets had recently been installed on holding room windows to improve privacy, but at Leeds a CCTV monitor was visible to detainees.

Leeds visible CCTV

3.12 Almost all holding rooms had well-organised information folders in multiple languages. Professional telephone interpretation was quite widely used, but more in some places than others. At Croydon, we observed staff using interpretation to explain the transfer process and reassuring detainees about family contact, which was good. In contrast, at Hounslow, interpretation was not used when explaining procedures such as handcuffing or searching, which could cause distress or confusion. Data provided on interpretation use were unreliable and did not reflect our inspection findings. Tablets were available for e-translation but they were often unused or broken, and signal issues further affected their effectiveness.

3.13 There had only been two complaints in the last 12 months across all the holding rooms. Despite this, it had taken four months to respond to one which was too long for a complaint that could have been dealt with quickly. Complaint forms were available in several languages, although not always clearly visible. The Home Office checked the boxes regularly.

3.14 Staff received equality training and VAWFs were used to support detainees with specific needs. However, the induction process did not address all protected characteristics, including sexual orientation and

disability. Staff at Belfast described good support for transgender detainees. Not all holding rooms were accessible for people with physical disabilities.

3.15 During our inspection, there were always female staff on duty. In some reporting centres, female detainees were held in the same room as unrelated males owing to a lack of space. In Loughborough, women shared the same toilet as men. Menstrual products were available in all toilets used by women.

3.16 Religious items, including prayer mats and Qiblah direction indicators, were available in each room. Due to the lack of space, there was no private place for prayer.

Sheffield religious items and books

3.17 Staff had access to a defibrillator and were trained in first aid. None of the centres had on-site health care and there was no routine health screening on reception into the holding rooms. Detainee custody officers told us they would use the NHS helpline if necessary, and in case of emergency they would call an ambulance. Detainees transferred to immigration removal centres received health screenings on arrival, but this would often be many hours after initial detention. The handover of information about health conditions was not good

enough and some Care & Custody staff told us they were not qualified to complete this section of the escort form.

3.18 Detainees were not generally permitted to have in their possession any medication that they had brought in, although we found some exceptions. Staff sometimes rang 111 for advice. Staff at some sites raised concerns about detainees waiting too long to have their medication or move elsewhere for a health screening. Detainees for whom there was evidence that they might be pregnant were not routinely tested and some were transferred elsewhere for testing, which extended their detention time (see paragraph 2.14).

Section 4 Preparation for removal and release

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

Communications

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

4.1 If a detainee's phone had a camera or internet access, it was removed and stored with their possessions. Detainees were, however, given an opportunity, under supervision, to access and write down numbers they needed from their phone before it was removed.

4.2 Detainees who were not allowed to retain their own phone or did not have one were readily issued with either a mobile phone with no camera in which they could use their own SIM card or were given access to a holding room phone. At Croydon, calls were restricted to the UK only.

4.3 There was no access to the internet or social media in any of the holding rooms. Facilities for staff to send emails, or more rarely faxes, on a detainee's behalf were sometimes offered, mainly for legal purposes (see paragraph 2.33).

4.4 Personal visitors were not allowed at any of the holding rooms, but information about the Independent Monitoring Board was readily available to 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.

4.5 Approximately 80% of detainees were transferred to an immigration removal centre (IRC) or residential short-term holding facility (RSTHF). Except for Belfast, many holding rooms reported long waits for escort vans, which we were told were often due to staff shortages or the prioritisation of other transfers. We found other examples of excessively long journeys, including one detainee being held on an escort van for 10 hours following collection from Solihull.

4.6 In most holding rooms, visitors were permitted to drop off property at the front of the building, although they were not allowed to see detainees. Clothing packs were available if required, which included a

t-shirt, jumper, jogging bottoms and footwear. In Glasgow they offered additional winter clothes, which was positive.

4.7 Staff provided wallet-sized cards with IRC or RSTHF addresses on them to inform detainees of their destination, and some holding rooms displayed maps with IRC locations clearly marked. Glasgow and Belfast offered additional materials, including photos and booklets, available in English only.

Section 5 Progress on recommendations from the last report

The following is a list of all the recommendations made in the last nine reports, 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

All searching should be conducted in private. (Salford)
Not achieved

DCOs should search detainees out of the view of other detainees. (Hounslow)
No longer relevant

Detainees should not be interviewed behind perspex screens. (Glasgow)
Achieved

Items, including belts and cash, should only be removed from detainees following an individual written risk assessment. (Liverpool)
Achieved

Waist restraint belts should not be used solely to prevent self-harm. (Loughborough)
Achieved

Confiscation of clothing items should be based on an individual risk assessment. (Glasgow)
Achieved

DCOs should swiftly book detainees into an adequately sized facility. Detainees should not be held in poorly equipped interview rooms for lengthy periods. (Hounslow)
Not achieved

Detainees should only be handcuffed following an individualised written risk assessment. (Hounslow and Loughborough)
Not achieved

Detainees should not be handcuffed unless there is specific information indicating an increased risk of escape or harm to the detainee, staff or the public. (Solihull)
Not achieved

Detainees should be issued with the reason for detention (IS91R) document in a language they can understand. (Belfast and Liverpool)

Not achieved

The details and telephone numbers of advice agencies and solicitors should be displayed in the holding rooms, in a variety of languages. (Liverpool)
Partially achieved

Notices promoting the Civil Legal Advice helpline should be displayed in the holding room. (Sheffield)
Achieved

Detainees should be able to contact their lawyers by email and fax. (Leeds)
Achieved

Electronic and paper records of detentions should be consistent and accurate. (Leeds)
Achieved

Mitie should publish a safeguarding policy and publicise this to all staff. The policy should include clear links with the Department of Health, Social Services and Public Safety, and the local safeguarding adults partnership board. (Belfast)
Achieved

Data that is important for purposes of accountability should be available regardless of changes in contractor, and should include numbers detained, length of detention and numbers of incident reports. (Belfast)
Achieved

The risk assessment on the authority to detain form IS91 should always be completed. If there are no risk factors, the section should be marked to confirm that the assessment has been completed. (Hounslow)
Achieved

Accurate data should be collected on each individual detention. A detailed analysis of this data should be readily available. (Hounslow)
Partially achieved

Detainees should be held for the minimum time. Onward transportation from the facility should be arranged speedily. (Loughborough)
Partially achieved

Home Office caseworkers should scrutinise and process cases diligently to ensure that detention is only used when absolutely necessary, and for as short a period as possible. (Glasgow)
Partially achieved

Detainee risk factors should be fully described in all escort documentation. (Loughborough)
Achieved

There should be a formal procedure for and liaison with the local authority to safeguard vulnerable adults. (Loughborough)
Achieved

The facility should be redesigned so that men and women can be held separately. (Glasgow)
Not achieved

Unrelated male and female detainees should not be held in the same holding room. (Loughborough and Solihull)
Not achieved

DCOs should receive ongoing training in adult safeguarding. (Glasgow)
Achieved

The baby change facility should be located in a position that offers privacy. (Glasgow)
Not achieved

Immigration staff should not routinely wear protective clothing when interviewing detainees in the holding room, unless documented risks indicate the need for this. (Solihull)
Achieved

Detainee custody officers should always carry anti-ligature knives. (Sheffield)
Achieved

The immigration compliance and enforcement (ICE) team should hold detainees at Waterside Court rather than at a police station, unless an individualised risk assessment shows otherwise. (Leeds)
Achieved

Respect

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

Recommendations

A record should be kept of how often detainees are held in the transit lounge, and the length of their detention. (Salford)
Partially achieved

Detainees should not be held for substantial periods without access to exercise in the fresh air. (Liverpool, Salford, Hounslow, Sheffield and Leeds)
Not achieved

Detainees should have access to time in the fresh air, and nicotine replacement should be available to those who require it. (Loughborough and Glasgow)
Partially achieved

The holding room should be kept clean, tidy and in a good state of repair. (Hounslow)
Achieved

Toilets for detainees should provide suitable privacy, and toilets should have seats. (Salford)
Partially achieved

Toilets should have seats and lids. (Liverpool, Sheffield and Leeds)
Not achieved

Toilets should provide reasonable privacy and should have normal toilet bowls with seats and lids. (Hounslow)
Achieved

Toilets should provide reasonable privacy and should have normal toilet bowls with seats and lids. (Glasgow)
Partially achieved

The toilet in the holding room should have a seat, and be adapted for use by people with disabilities. (Loughborough)
Not achieved

Adequate washing facilities should be available and hygiene packs should be provided to those needing them. (Hounslow)
Achieved

The holding room should have a working television. (Loughborough)
Achieved

Detainees should be offered food of reasonable quality. (Glasgow)
Achieved

Holding room staff should seek to establish a rapport with and offer support to all detainees. (Hounslow
Achieved

Staff should wear visible name badges. (Loughborough)
Achieved

All staff should receive refresher diversity training, including a course on the wide-ranging backgrounds of, and particular issues faced by, detainees in the immigration system. (Solihull)
Partially achieved

DCOs should use professional interpretation to communicate with detainees who speak little or no English when accuracy and confidentiality are required. (Hounslow)
Achieved

Professional telephone interpreting services should be used routinely, to assist detainees with poor spoken English skills. (Salford)
Not achieved

Telephone interpretation should be used to communicate with non-English speakers. (Loughborough)

Achieved

Women should be held separately from men. (Hounslow)
Achieved

The complaints box should be emptied daily, complaints dealt with swiftly and results communicated to detainees wherever possible. (Hounslow)
Achieved

The complaints box should be emptied every day that the facility is open and logs should be maintained to confirm this. (Leeds)
Achieved

There should be arrangements to ensure that detainees have adequate and prompt access to medical services, including medication to manage long-standing conditions. (Liverpool and Sheffield)
Not achieved

Detainees should be able to retain their legitimately prescribed medication, unless a written individualised risk assessment suggests otherwise. (Leeds)
Partially 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 offered the use of suitable mobile phones or easy access to their phones to be able to access contact details. (Liverpool)
Achieved

Detainees should have access to the internet, including e-mail, social networking sites and Skype unless an individual risk assessment indicates otherwise. (Liverpool, Salford, Hounslow and Glasgow)
Not achieved

Detainees should have access to email and the internet. (Belfast and Loughborough)
Not achieved

Detainees should have access to the internet and be able to send and receive emails. (Solihull)
Not achieved

Detainees should be able to contact people outside the facility by fax, email and social networks, and have access to the internet. (Sheffield)
Not achieved

Detainees should have supervised access to the internet, including email, video calling and social networks. (Leeds)
Not achieved

Detainees should be able to receive visits. (Solihull)
Not achieved

The Detainee Escorting and Population Management Unit (DEPMU) should issue movement orders promptly, and escort vehicles should be arranged as quickly as possible. (Solihull)
Partially achieved

Detainees should only be handcuffed on departure subject to an individual risk assessment. They should leave the facility and board escort vehicles out of public sight. (Leeds)
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:

Martin Kettle	Team leader
Rachel Badman	Inspector
Deri Hughes-Roberts	Inspector
Chelsey Pattison	Inspector
Fiona Shearlaw	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.

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.

Conclusive grounds NRM decision
A person who receives a conclusive grounds decision through the National Referral Mechanism is considered to be a confirmed victim of modern slavery.

Detention Gatekeeper
A Home Office team, independent of the operational and casework teams, set up in 2016 to ensure that individuals only enter immigration detention where it is for a lawful purpose and is proportionate on the facts of the case, applying the relevant policies including the Adults at Risk 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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