Report on an unannounced inspection of short-term holding facilities managed by

Border Force

by HM Chief Inspector of Prisons

7 – 15 April 2026

Contents

Introduction

This inspection concerned the 17 short-term holding facilities (STHFs) at seaports and airports that are staffed solely by Border Force officers. None of the facilities had a high throughput of detainees and some had held no one at all in the previous six months. This meant that staff were generally inexperienced in detention practices. Border Force leaders had addressed this problem by providing staff with more support and oversight, and creating a standardised Immigration Detention Record. These measures were improving the consistency of care given to detainees, although significant weaknesses remained and few of the concerns raised at our last inspection had been fully resolved.

Safeguarding practices remained inconsistent and were weak in many cases we examined. Detainees still could not access their own medication, which created considerable risks, and the unsuitable Felixstowe STHF had still not been replaced. Leaders were also not aware of anomalies across the STHFs, such as detainees being held for longer in some facilities than others for no obvious reason.

The conditions in several STHFs had improved and, apart from Felixstowe, they provided decent accommodation for a few hours. There was no recorded self-harm or violence, and force was only used when handcuffs were applied, although some detainees were kept in handcuffs for longer than necessary.

Overall, this inspection showed that detention and the potential abuses that can occur within it are now much more central to Border Force's thinking than in the past. Steady progress was now being made, although some off it was taking too long.

Charlie Taylor
HM Chief Inspector of Prisons
[Month] 2026

Summary of key findings

What needs to improve at these short-term holding facilities

During this inspection we identified eight 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. **Safeguarding processes were not sufficiently robust.** Some officers, including those trained as specialists in safeguarding and modern slavery, did not properly assess significant risks to detainees.

2. **The overall length of detention had increased, and many people were held in controlled waiting areas (see Glossary) without access to the facilities of a holding room, sometimes without relevant detention paperwork being served.** Leaders had inadequate oversight of these issues, and there was no collation or analysis of relevant data.

3. **The Port of Felixstowe remained a poor facility and there was still no timeline for its replacement.**

4. **Detainees were still not allowed access to their prescribed medication, which created significant health risks.** There was no formal health provision at any of the holding facilities.

Key concerns

5. **Border Force staff under-recorded the use of force.** Paperwork to justify the use of handcuffs was often not completed, and some compliant detainees were held in handcuffs for too long.

6. **Care plans were often not completed when needed for both adults and children.**

7. **Detainees did not have easy access to the complaints process.** They were not routinely given complaint forms, and some staff were unaware that forms were available in different languages. Complaint boxes were frequently located outside the holding room.

8. **The range and quality of clothing provided to people leaving the short-term holding facilities were too limited.** Many detainees arrived with few clothes. The only underwear and slippers they could obtain were flimsy disposable items, and no facilities provided coats.

Progress on concerns

At our last inspection we identified 13 concerns. One priority concern and three key concerns were partially addressed, while the remaining nine concerns, including three priorities, were not addressed.

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.

Example of notable positive practice		
a)	Portsmouth Border Force staff invited children's social care staff to see the port and the STHF. This helped to increase their understanding of the environment in which children were held.	See Safeguarding children

About Border Force short-term holding facilities

Role of the facility To hold people detained at ports by Border Force.

Locations and total number of detentions in the six months from September 2025 to February 2026

Leeds Bradford Airport	92
Harwich	67
Felixstowe	37
Bristol Airport	37
East Midlands Airport	22
Hull	16
Portsmouth	16
Aberdeen Airport	13
Southend Airport	8
Cardiff Airport	7
Purfleet	4
Immingham	3
Newhaven	2
Poole	1
Killingholme	0
Teesport	0
Tilbury	0
Total	**325**

Lead agency Border Force

Date of last inspection 9 – 20 January 2023

Section 1 Leadership

1.1 The accuracy of data remained a concern despite low numbers of detentions, and this undermined analysis and planning. Leaders had still not ensured that staff routinely recorded use of force and were not aware of substantial differences in detention times between different ports.

1.2 Staff continued to have variable knowledge about detention and safeguarding practices and some lacked understanding of the procedures they were required to follow. Many inconsistencies remained between facilities.

1.3 National leaders had taken steps to address these problems. An Immigration Detention Record (IDR) guided staff through induction and safeguarding procedures. It was a promising approach but not yet implemented consistently.

1.4 Border Force's Immigration Detention and Customs Custody (IDCC) also conducted regular engagement visits to help improve practice, and local leaders appreciated the availability of ongoing support from IDCC staff. Good practice and concerns were shared through a practitioners working group and a senior leaders strategy group.

1.5 Despite efforts to engage with the Port Authority, leaders had not resolved the problem of the unsuitable Felixstowe STHF. There was still no timeline for its replacement.

1.6 Detainees still had no access to their medication. Leaders told us they were still sourcing healthcare provision and that once a provider had been identified there would be a further implementation period of up to two years.

1.7 Independent Monitoring Board oversight was in place at all sites, but they were often not informed by Border Force when people were detained.

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 total of 325 detainees had been held across the inspected STHFs in the previous six months, compared with 811 at the last inspection. Leaders did not have a clear understanding of the reasons for the decrease.

2.2 A useful induction checklist had recently been introduced, alongside the new IDR (see Safeguarding adults). These were welcome improvements to the arrival process and provided detainees with more information about what to expect while held. Written induction information was available in English.

2.3 In some ports, detainees were held for extended periods under the IS81 authority to detain (see Glossary) in controlled waiting areas (CWAs – see Glossary) before being moved into the STHF (see Legal rights).

Leeds Bradford Controlled waiting area

2.4 Border Force staff across sites did not follow a consistent searching protocol. Most said they would give adults a rub-down search, but

some used a handheld electronic metal detection device. The latter was more commonly used for children, but some staff said they would conduct rub-down searches on children.

Safeguarding adults and personal safety

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

2.5 All officers had basic safeguarding training and security clearance. Teams at all sites had officers with enhanced safeguarding and modern slavery (SAMS) training who had also undergone a Disclosure and Barring Service (DBS) security check. At some sites, these officers were not consistently available (see Safeguarding children).

2.6 Safeguarding practice was inconsistent. Records showed that while some good work was taking place, it was often undermined by a lack of enquiry or action on safeguarding needs, including by some SAMS specialists. Of the 12 detainees considered to be at risk in detention (see Glossary), eight were assessed at a single site, Leeds Bradford Airport. This suggested considerable differences in awareness and practice by Border Force staff.

2.7 Three pregnant women had been detained in the previous 12 months, with the longest detention lasting just over four hours. None had been assessed as an adult at risk (See Glossary), contrary to Home Office policy.

2.8 Only three national referral mechanism (NRM) referrals (see Glossary) had been made in the previous year. In our sample of 22 cases, we identified three where there were obvious risk factors and no evidence that staff had considered making a referral (see case studies 1 and 2).

2.9 Adult detainees claiming asylum were given a full screening interview, containing questions designed to identify and probe safeguarding concerns. In some cases, delays in carrying out these interviews led to vulnerable people being held for excessive periods (see case study 2).

Lack of NRM referral for potential modern slavery cases

Case study 1

A 19-year-old woman had travelled with a 34-year-old man who had leave to remain in the UK. She appeared withdrawn, had few clothes apart from lingerie, and had no money. Her bank card was held by the man. The woman informed immigration officers that she had met the man two months before on social media and in person only half an hour before their journey to the UK. Officers decided it was in the woman's best interests to remove

her to her home country, but failed to comply with their duties under the NRM. They did not inform her of the NRM, the possibility of a referral, or the support and protections it offered. They sent an email to her country's authorities saying they had some concerns about her welfare because she appeared vulnerable and had just met the man she was travelling with. However, they did not mention the other trafficking indicators in her case.

Case study 2

A 27-year-old woman was encountered in Felixstowe in a group of 25 detainees. After 15 hours in the STHF, she was transferred to a police cell as a person with 'no known vulnerabilities'. Her asylum screening interview did not take place until 29 hours after she was first encountered. This was her first opportunity to disclose that she had been forced to marry an abusive man 20 years her senior to pay off her father's debts. No details were asked about the abuse, and it emerged in her substantive asylum interview that she had been repeatedly raped. She was released from the police station at 2.35am the next day after about 35 hours in custody, 20 hours of which had been in a police cell. No Home Office staff considered making an NRM referral.

2.10 We found cases where insufficient enquiries were made about detainees' disclosures of abuse or safeguarding needs. In one case, a detainee said that a people smuggler had done 'terrible things' to him, but this was not explored. This lack of inquiry was a particular concern in cases involving children (See Safeguarding children).

2.11 Detainees frequently spent long periods in police cells, extending total detention times. Two women who had experienced exploitation and abuse had been held in police cells because of staff shortages and a lack of space in Felixstowe. One was held for 20 hours in a police cell, and the other for 29 hours.

2.12 The new IDR process, fully launched in January 2026, was a good initiative that was starting to improve consistency in detainee care. It also had the potential to significantly strengthen safeguarding. However, documented observations frequently did not record any meaningful contact beyond the offer of food and water. In some cases, care plans were not completed when needed; for example, in Bristol Airport, no care plan was completed for a woman who was considered by the police to be at very high risk of honour-based violence (see Safeguarding children).

Personal safety

2.13 There had been no recorded self-harm in the previous year. Officers we spoke to had never witnessed tensions or bullying between detainees and there was no recorded violence.

2.14 Data provided by Border Force suggested force had been used 34 times in the last year. However, this was a substantial underestimate, as staff often failed to document the use of handcuffs.

2.15 Documentation provided by Border Force suggested force seldom extended beyond the use of handcuffs, and incidents that did were generally resolved quickly. However, we saw several cases in which compliant detainees were handcuffed for over 80 minutes while being transported in secure vans, without clear evidence of risk.

2.16 Plans to reduce refresher training in the use of force to once every two years were a concern given staff inexperience in dealing with incidents. Staff still received no dedicated training on the use of force on children.

Safeguarding children

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

2.17 We were told that relationships with local authority children's social care services were improving and we saw evidence of some good liaison with them by Border Force. We noted good practice at Portsmouth, where Border Force staff invited children's social care staff to see the port and the STHF to help increase their understanding of detention and its potential impact on children.

2.18 However, Border Force did not routinely record or monitor children's social care referral and pickup times. While no unaccompanied children had been held over the statutory time limit of 24 hours, the longest detention was 22.5 hours and the average time in detention was 9.5 hours, longer than at the last inspection.

2.19 Where referral times were recorded, they showed variable and sometimes poor practice. One case in Felixstowe was referred to children's social care services immediately, but another took 3.5 hours. In another case, staff at Southend Airport took six hours to make first contact with the local authority and over 17 hours to make a formal referral, which was an unacceptable delay.

2.20 All officers had basic training in child safeguarding. However, specialist DBS-cleared SAMS officers with enhanced training were not always available to interview children. Children were also often interviewed without an appropriate adult.

2.21 Records showed that some officers, including SAMS specialists, had insufficient understanding of child safeguarding policy and practice. Two children in Felixstowe and Southend were interviewed using an asylum screening questionnaire with questions that were only appropriate for adults. The Southend interview was conducted by a SAMS officer. In Bristol Airport, a SAMS officer conducted an asylum screening interview using the applicant's 13-year-old granddaughter as an interpreter, which was inappropriate and potentially harmful for the child.

2.22 Officers did not always pay sufficient attention to the safeguarding needs of children travelling with a parent. For example, in Harwich, a

woman said the German authorities had threatened to take her nine-year-old daughter from her, suggesting they may have had safeguarding concerns, but this was not explored further. A SAMS officer in Felixstowe made no safeguarding referral for a five-year-old victim of child abuse.

2.23 In two cases, concerns about modern slavery were raised but were not acted on appropriately. In one, no NRM referral was made for a 15-year-old boy detained in Tilbury who said he had been forced to work on a fishing boat. In the other, Border Force staff did not discharge their statutory duty to challenge evidence of poor decision-making by Home Office colleagues (see case study 3).

Lack of appropriate challenge of NRM decision-making

Case study 3

A 16-year-old girl arrived in Leeds Bradford Airport with her adult cousin and said she was going to stay at an address in the north of England. Home Office records showed that three men at that address had been arrested for human trafficking and sexual exploitation offences, and that the adult cousin and members of his family had multiple convictions for violence and exploitation.

Despite this, the responsible Home Office team decided that there were no reasonable grounds to believe that she was a victim of trafficking. Local Border Force staff did not question the decision and removed her. This did not reflect a sufficient understanding of their statutory duty to safeguard and promote the welfare of the child. Border Force staff told us, wrongly, that it was not within their remit to question the decision of another team.

2.24 The new IDR directed staff to open care plans for children, but we saw cases in which no such plan was opened.

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.

2.25 The overall length of detention had increased since the previous inspection. On average, detainees were held for 10 hours and 22 minutes, compared with approximately six hours last time. The longest single period of detention was almost 36 hours.

2.26 The detention time at Felixstowe and Harwich was 20.5 hours, far longer than elsewhere; this was not related solely to occasions when multiple people were detained at the same time. The national average reduced to approximately six hours when these ports were excluded from the calculation.

2.27 At Felixstowe, a woman and her 18-month-old child had been detained for over 22 hours in an inadequate facility (see Accommodation and facilities). Instead of using professional telephone interpretation, staff relied solely on Google Translate to communicate with her. This included to serve documentation, conduct interviews, refuse entry and attempt removal, giving little assurance that the woman understood the process or her legal rights.

2.28 Detention authority was not always lawfully established at the point when people were detained. In some cases, IS81 documentation was issued after individuals had already entered holding rooms. Detainees were held on IS81s for an average of over five hours, despite Border Force's two-hour target. While a lack of staff was frequently given as a reason for this, some ports – for example, Aberdeen, Leeds Bradford and East Midlands Airports – had succeeded in minimising the time spent on an IS81 through a more rigorous adherence to prescribed time limits.

2.29 We found examples of IS91 paperwork (see Glossary) not being served on entry to the STHF as legally required, resulting in a lack of formal detention authority for eight to 12 hours. In one incident at Harwich, 23 detainees were served with detention paperwork as a group, using an interpreter on a telephone loudspeaker. This is procedurally poor practice, which may undermine individual detainees' ability to understand and engage meaningfully with the process of detention.

2.30 There were discrepancies between handwritten logs and electronic records, with insufficient quality assurance.

2.31 Information about legal rights in holding rooms was often outdated, poorly located or inaccessible. Most holding rooms did not contain bail application forms, legal textbooks or clear guidance on how to seek legal advice. Information was provided in English only, and there was a lack of confidential phone access. In some facilities, none of the listed legal representatives provided free immigration advice at the appropriate level.

Section 3 Respect

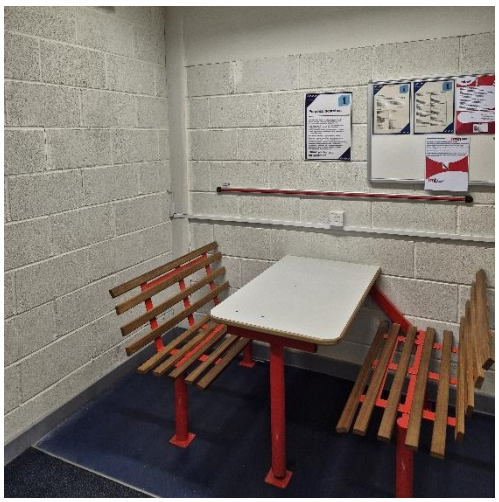
Detainees are treated with respect for their human dignity and the circumstances of their detention.

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 There were new STHFs at Immingham, Leeds Bradford Airport, Purfleet and Teesport, all of which were a substantial improvement on the previous accommodation. In contrast, conditions at Felixstowe were unchanged and remained cold, poorly lit and cramped (see Leadership). At Hull, small interview rooms were used as holding facilities.

Leeds Bradford Family Room (left) and Teesport Holding room one

Felixstowe holding room (left) and Hull interview room (used as short-term holding room)

3.2 All STHFs we saw were clean and generally well maintained. Not all had second rooms to hold families or women detained at the same time as unrelated men, creating potential safeguarding risks.

3.3 Most facilities were adequately ventilated and heated, although few had access to natural light or fresh air, which was a considerable problem if detainees were held for more than a few hours.

3.4 There was better access to showers, as all new facilities included them. However, not all sites had them, and this was particularly problematic for detainees arriving at seaports after long journeys in unhygienic conditions.

3.5 Toilets were generally clean and private, but some still lacked toilet seats or lids. Most sites had accessible showers and toilets for detainees with mobility issues. At Felixstowe, detainees had to be taken to an outdoor portable toilet. Basic toiletries and sanitary products were generally readily available.


Harwich non accessible toilet with no seat (left) and Bristol Airport accessible toilet and shower room

3.6 Fixed seating, tables, thin mattresses, pillows and blankets were provided in all holding rooms. A few sites had camp beds or sofas, which were an improvement on mattresses placed on the floor.

3.7 Most STHFs had basic clothing available for detainees. However, the range and quality of items varied considerably and were not always suitable for people leaving the facility (see Leaving the facility).

Camp bed within East Midlands Holding Room (left) and main holding room Aberdeen Airport

3.8 Most facilities offered cold snacks and ready meals, though not all were able to provide hot food or food that met varied needs, such as gluten-free diets. Allergen information did not always reflect the food actually held on site.

3.9 There were a few activities available to help pass the time. Televisions were available in some holding rooms. There were a few books, some in foreign languages, and some magazines at most sites. A small selection of games and playing cards was available. Most sites had a stock of children's toys, as well as baby food and nappies.

Wall mounted television (left) and selection of books and magazines

Selection of children's toys

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 No detainees were held during our inspection, so we were unable to observe any staff interactions. However, records and discussions with staff indicated an appropriate focus on detainees' welfare.

3.11 Use of professional interpreting services was reasonable overall, but they were not used in a small number of cases where they were required (see Safeguarding adults). The introduction of translation applications on staff mobile devices was a positive development, as this helped with informal communication. Translated visual aids to support detainees in communicating basic needs were available at most sites.

Translated visual aids to assist communicate basic needs

3.12 Some facilities had dedicated multi-faith rooms, allowing detainees to pray and reflect in private. Religious texts and artefacts were available at all sites, although the range varied and items were not always stored respectfully.

Religious texts and artefacts appropriately stored at Portsmouth

3.13 Most sites had enough female staff to search and induct women. Where this was not the case, a hand-held metal detector was used for searching.

3.14 No formal complaints were recorded in the previous year. However, confidential complaints boxes and forms were sometimes located outside the holding rooms and not always accessible to detainees. Complaint forms were available in multiple languages, but not all staff were aware of this or of how to access them. Posters incorrectly stated that written complaints could only be made in English or Welsh.

Complaints notice stating written complaints must be submitted in English or Welsh

3.15 Health care provision was still not readily available at any of the STHFs. At some sites, Border Force was able to request port medical services, but staff were usually reliant on Border Force first-aiders, the NHS telephone advice line, or an ambulance for more serious issues.

3.16 Detainees continued to be denied access to their prescribed medication, including critical medication such as GTN spray (used to treat angina). This posed a potentially serious risk to detainees' health (see Leadership).

3.17 Nicotine replacement therapy was not available at any site, despite some extended periods of detention.

Section 4 Preparation for removal and release

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

Communications

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

4.1 Detainees' mobile phones were removed from them on arrival and stored with their property, but they were able to obtain numbers from them first. They could use Border Force telephones at all sites, and some staff said they also allowed them to use their own mobile phones under supervision.

4.2 The IDR included a prompt to offer detainees a free national or international phone call, but in some records it was unclear whether detainees had been offered this opportunity.

4.3 Detainees were not permitted to access the internet, email, or video calling facilities at any site, including through their personal mobile phones.

4.4 Information on the IMB was readily available at all facilities, but generally only in English. At some locations, including Aberdeen, Poole and Southend, translated information on the IMB's role was placed in the STHFs.

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 In the previous six months, about 19% of detainees were removed from the UK after leaving the STHF, and the remainder were transferred on to further detention or bailed. Some of the individuals who were removed were bailed with conditions to return for the next suitable boat or flight, thereby minimising unnecessary detention.

4.6 As at the last inspection, detention was sometimes extended for those who had claimed asylum, because of long waits for transport to asylum accommodation.

4.7 Basic clothing was available, but disposable paper footwear and disposable underwear were not suitable for those who were leaving the

facility and had no alternative clothing (see Respectful treatment).

Disposable underwear provided to detainees

4.8 Detainees could usually contact family, friends and/or legal advisers when they were due to be released, transferred or removed from the facility.

4.9 Professional interpretation services were not routinely used to inform people of next steps. Basic general information was provided about immigration removal centres, sometimes in multiple languages, but there was no information on specific IRCs.

'What happens next' document containing information about IRCs

4.10 Few facilities had readily available, up-to-date information on sources of support for detainees on release or removal.

Section 5 Progress on concerns from the last report

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

Leadership

Priority concerns

Leaders were not making sure good practice was consistent across all sites. This covered areas such as identifying and managing risks, induction, treatment of children, use of force and searching.
Partially addressed

Data were not being collected reliably enough or used to identify trends so action could be taken.
Not addressed

Safety

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

Priority concerns

Not all detainees with potential vulnerabilities were being identified and information about their vulnerabilities was not always clearly noted in case files.
Not addressed

Key concerns

Not all Border Force staff who came into contact with detainees, including minors, had undergone a Disclosure and Barring Service security check.
Not addressed

Not all use of force was recorded.
Not addressed

There was a lack of formal well-documented care planning for detainees identified as vulnerable, which could have contributed to their vulnerability. They included detainees with protected characteristics, for example women and those with disabilities or serious health conditions.
Partially addressed

Unaccompanied children were held for too long and for over two hours longer on average than adults.
Not addressed

Safeguarding processes were not sufficiently robust, which meant children who were vulnerable to modern slavery might not have been identified.
Not addressed

Legal advice was not readily available to detainees.
Not addressed

Respect

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

Priority concerns

The Port of Felixstowe remained a poor holding facility. No plan had been confirmed for the refurbishment of the site.
Not addressed

Key concerns

Not all facilities had showers.
Partially addressed

Detainees did not have sufficient activities to keep themselves occupied. They could not exercise outside, and children's toys were limited.
Partially addressed

Not all detainees had access to the complaints process and complaints forms were only in English.
Not addressed

Appendix I About our inspections and reports

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

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

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

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

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

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

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

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

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

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

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

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

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

This report

This report outlines the priority and key concerns and notable positive practice identified during the inspection. There then follow sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees* (Version 4, 2018) (available on our website at Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)). Section 5 lists the concerns raised at the previous inspection and our assessment of whether they have been addressed.

Inspection team

This inspection was carried out by:

Hindpal Singh Bhui	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.

Immigration detention record (IDR)
A paper-based, detailed official record of a detainee's time in detention, which documents their full details, rights, welfare and actions taken by detention staff.

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

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

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.

IS81
Allows immigration officers to hold a person for short periods while they carry out further enquiries.

IS91
Formal written notice issued to keep someone in detention under the powers of the Immigration Act 1971.

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

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