Report on an unannounced inspection of

Tinsley House Immigration Removal Centre

by HM Chief Inspector of Prisons

15 June–2 July 2026

Contents

Introduction

Tinsley House, a Serco run immigration removal centre next to Gatwick airport, held 136 men at the time of this inspection and was, overall, a reasonably safe and decent establishment. The function of the centre had recently changed with many detainees being held under the UK–France 'one-in-one-out' arrangement. This meant that it held many men who had very recently arrived in Britain on small boats (who were brought to the centre either directly from Manston, or after being detained from a Home Office reporting centre). Tinsley House often received incomplete health care information from Manston short-term holding facility, from where most detainees arrived. With this much needier population it was particularly disappointing to find that standards in health care had substantially deteriorated, with insufficient oversight and a failure to recruit enough staff in key areas, particularly mental health provision.

Although the centre was generally clean, some of the accommodation was looking very tired and showers and toilets were in an unacceptable condition.

Many detainees spent the mornings asleep, meaning they did not take advantage of activities that were on offer. The gym and the sports hall were better used in the afternoon or the evening. The centre was not doing enough to encourage detainees to attend activities, particularly for those who were suffering from poor mental health, many of whom would have benefited from having more to do. The library, although useful because of internet access, remarkably, held hardly any books.

Detainees were anxious about their cases with many having arrived at the centre having expected to be placed in a hotel. There was very little information about what they could expect in France and the centre had not made contact with French colleagues. Home Office procedures to identify those very vulnerable men who should not have been held at the centre because of their level of need were slow and not thorough enough. Given that more than half of all detainees were eventually released there is a question as to why so many were locked up at a huge cost to the taxpayer in the first place.

The staffing situation at the centre was generally good and there was some work to improve the culture. Most detainees said staff treated them well and we saw generally positive interactions. Language barriers created some difficulties and translation services were not always used enough. We were concerned to find that many staff responding to our survey said they would not blow the whistle on their colleagues, and those who had raised concerns felt that they had not been taken seriously.

Too many detainees were coming to Tinsley House who were later identified as children, not having been identified as such by staff employed at Manston. It had taken too long to arrange some face-to-face age assessments.

Over recent years our healthy establishment scores for Tinsley House have reduced. On this inspection, we dropped the score for respect from 'reasonably good' to 'not sufficiently good', mainly because of insufficient health care

provision and deteriorating accommodation. It was disappointing that the centre had not responded to many of the concerns that we raised last time and it is likely that we will return in the next year for an independent review of progress. We will expect to see the deterioration halted and a renewed energy amongst leaders and staff to address our findings.

Charlie Taylor
HM Chief Inspector of Prisons
August 2026

What needs to improve at Tinsley House Immigration Removal Centre

During this inspection we identified 14 key concerns, of which six 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 HMI Prisons.

Priority concerns

1. **There was poor identification of and action on modern slavery indicators, including where detainees gave repeated accounts of exploitation.** It took too long to produce Rule 35 reports (see Glossary), and they were not always submitted when necessary.

2. **In the previous six months, 21 detainees brought from Manston were subsequently found to be children.** Poor practice and significant delays in dealing with age dispute cases meant that some children were not safeguarded while their claims were resolved.

3. **Detainees lived in poorly ventilated rooms, and communal toilets and showers had a pervasive foul smell due to problems with the drainage.** Many rooms had extensive graffiti, and detainees had little storage space.

4. **There was poor governance of health care services. Staffing, training and staff supervision were all areas of risk, which compromised the provision of safe and adequate care to detainees.**

5. **Despite a high level of need, there were no psychological and therapy services and overall mental health provision was poor.**

6. **The needs of those being removed and released were not systematically assessed or addressed.** Release planning for detainees with complex needs was weak and detainees being removed to France were given insufficient information. Some vulnerable and high-risk detainees had been released homeless.

Key concerns

7. **Many staff remained reluctant to use whistleblowing procedures.** None of the respondents to our staff survey who had raised concerns felt that they had been taken seriously.

8. **Detainees being returned to France needed speedy legal representation, but in some instances, it took up to a week to**

receive a legal advice surgery appointment, and some attended several times before receiving representation.

9. **Some security measures were disproportionate to the risks at the centre, including contact restrictions during visits and overzealous procedures for checking detainees' mail.**

10. **Interpreting services were not always used when needed, and available translated documents were not routinely issued to detainees.**

11. **The library had very few books, and there were no systems to manage stock.** Legal texts were out of date.

12. **Teachers did not have the opportunity to work collaboratively to develop the curriculum, or to strengthen their expertise through ongoing training and professional development.** Teachers planned learning activities in isolation, with limited consideration of detainees' prior learning.

13. **Detainees experienced barriers when trying to communicate with family, friends and legal advisors.** Phone calls were expensive and many detainees had difficulties setting up or accessing their emails.

14. **There was little use of data to understand and respond to detainees' needs, and most of it was still not disaggregated.** This made it impossible for leaders to have a clear sense of the distinct issues facing the centre.

About Tinsley House Immigration Removal Centre

Task of the establishment
To detain people subject to immigration control.

Certified normal accommodation and operational capacity (see Glossary) as reported by the centre during the inspection
Detainees held at the time of inspection: 136
Baseline certified normal capacity: 198
Operational capacity: 187

Population of the centre
- The centre received an average of 33 detainees a week.
- The average cumulative length of detention was 39 days.
- The longest detention in the centre was for 463 days.
- In the last six months, 52% of detainees had been released and 41% had been removed.
- The largest nationality groups were Afghan (13%), Albanian (11%) and Eritrean (11%).

Name of contractor
Serco
Escorting Service Provider: Mitie Care & Custody
Health service commissioner and providers: Practice Plus Group (prime health provider, primary care services including GP services, mental health and substance misuse, with sub-contracted physiotherapy and optician service)
Dentistry services: Time for Teeth
Learning and skills providers: Serco

Location
Gatwick Airport

Brief history
Tinsley House opened in 1996 as the UK's first purpose-built immigration removal centre (IRC). In May 2020, Serco assumed responsibility for the centre and the nearby Brook House IRC. During the COVID-19 pandemic, Tinsley House was largely closed, before reopening as a short-term holding facility until September 2020. It continued in this capacity until 2022, when it resumed full IRC operations. The centre currently holds a large proportion of detainees due to be returned under the UK-France agreement, known as the 'one in, one out' policy. It has recently undergone refurbishment works, increasing its operational capacity from 162 to 198 bed spaces.

Short description of residential units
Tinsley House is comprised of two floors with rooms or, in the newer accommodation, cells accommodating either two, four or six people. The ground floor has a capacity of 64, and the first floor has a capacity of 134. The newer two-person accommodation is based on a prison cell design.

Name of centre manager and date in post
Steve Hewer, May 2020

Independent Monitoring Board chair
David Skinner

Date of last inspection
17 April–5 May 2023

Section 1 Summary of key findings

Outcomes for detainees

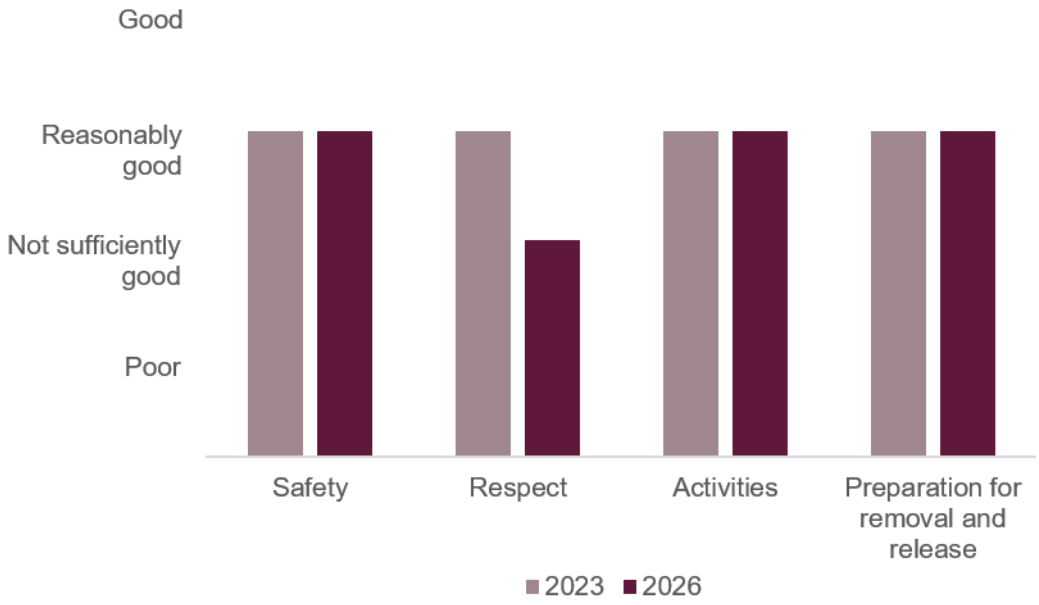
1.1 We assess outcomes for detainees against four healthy establishment tests: safety, respect, activities, and preparation for removal and release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of Tinsley House IRC, we found that outcomes for detainees were:

- Reasonably good for safety
- Not sufficiently good for respect
- Reasonably good for activities
- Reasonably good for preparation for removal and release.

1.3 We last inspected Tinsley House IRC in 2023. Figure 1 shows how outcomes for detainees have changed since the last inspection.

Figure 1: Tinsley House Immigration Removal Centre healthy establishment outcomes 2023 and 2026



Progress on priority and key concerns from the last inspection

1.4 At our last inspection in 2023, we raised eight concerns, four of which were priority concerns.

1.5 At this inspection we found that one of our concerns had been addressed, one had been partially addressed and six had not been addressed. For a full list of progress against the concerns, please see Section 7.

Notable positive practice

1.6 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.

1.7 Inspectors found three examples of notable positive practice during this inspection, which other centres 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)	The centre provided a helpful free minibus for visitors between Gatwick airport train station and the centre.	See paragraph 6.6
b)	Two social workers, who also worked in Brook House, helped detainees to maintain contact with their families. They provided support with complex issues, including applications to the family court and facilitating supervised visits.	See paragraph 6.9
c)	The Wi-Fi smartphones improved detainees' access to emails and applications and allowed them to place food orders. They also allowed easier communication with the Home Office and had a translation app.	See paragraph 6.10

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for detainees.

2.1 Leaders oversaw a reasonably well-functioning centre that received detainees well and delivered adequate care for most. However, neither the Home Office nor Serco had done enough to ensure that provision had kept pace with the needs of a changing population, now mostly comprised of small boat arrivals due to be removed as part of the UK-France agreement.

2.2 Weaknesses in governance, especially in health care and personal safety, had been exposed by these new challenges. Inadequate health care leadership over some time had led to a deteriorating service at a time when needs had increased, especially in relation to mental health. Healthcare staffing, training and supervision were all poorly managed.

2.3 Leaders had increased detainee custody officer staffing and resilience but had not yet developed a sufficiently dynamic and accountable staff culture. Nor had leaders created an environment in which staff felt supported to raise concerns about the centre.

2.4 There was poor oversight of children's safeguarding needs, and there had been a steep rise in age dispute cases at Tinsley House. This was due largely to Home Office leaders not doing enough to prevent children being brought to Tinsley House from Manston.

2.5 The infrastructure of Tinsley House struggled to deal with the demands placed on it, and leaders had not resolved the substantial problem of poor ventilation. However, they informed us that improvements would be made when the centre closed for other essential infrastructure works in October.

2.6 There was generally good oversight of use of force and combined Serco and Home Office quality assurance had identified appropriate concerns. Detention Engagement Team (DET) leaders also continued to oversee good contact with detainees.

2.7 Leaders had done little to promote more use of the adequate but lacklustre activities provision, and overall management of activities was not proactive enough.

2.8 Leaders had not developed sufficiently good partnership working to support safe release and removal.

2.9 There remained little use of data to understand and respond to detainees' needs, and most of it was still not disaggregated from Brook House figures. This made it impossible for leaders to have a clear sense of the distinct issues facing Tinsley House.

2.10 In general, leaders had not focused sufficiently on continuous improvement. This was illustrated by the fact that few concerns from the previous inspection had been fully addressed, while new ones had emerged.

Section 3 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 centre are treated with respect and care. Risks are identified and acted on. Detainees are supported on their first night. Induction is comprehensive.

3.1 Detainees regularly waited in a queue of escort vehicles before they could start the reception process. Over the previous six months, an average of 33 detainees a week had arrived at the centre; far more than at the previous inspection. Many came from Manston short-term holding facility, and they often did not know they were being transferred to Tinsley House.

3.2 However, in our survey, 86% of detainees reported that they were treated well when they were in reception. We saw risks being assessed appropriately with use of interpretation, but the reception interview was usually not confidential. While detainees were offered the chance to go to a private room, staff did not always explain why they made this offer and some detainees may therefore have felt inhibited from disclosing sensitive information.

3.3 A large proportion of detainees continued to arrive overnight. Of the last 100 arrivals, a fifth came between midnight and 6am. Late arrivals and shared bedrooms contributed to widespread reports of sleep disruption (see paragraph 4.6).

3.4 The reception area was clean and appropriately furnished. Detainees were not searched in private, and there was a limited amount of information in the waiting area, in English only.

Seating area in reception (left), looking through to reception booths (middle), and reception booths (right)

3.5 On the day of arrival or within 24 hours, detainees received an individual induction from unit staff, which varied in its extent and quality. We observed some that were too rushed, with a brief tour of the centre and without everything being explained. Induction materials were

available in a number of languages, but staff were not routinely distributing translations to detainees.

3.6 All detainees received a consistently helpful and more extensive welfare induction within 24 hours in the welfare office. The office was busy and not private enough, but staff provided good information and helped detainees to resolve immediate problems (see paragraph 6.1).

Safeguarding

Expected outcomes: The centre promotes the welfare of all detainees and protects them from all kinds of harm and neglect. The centre provides a safe environment which reduces the risk of self-harm and suicide. Detainees at risk of self-harm or suicide are identified at an early stage and given the necessary care and support.

Safeguarding of vulnerable adults

3.7 Levels of assessed vulnerability were lower than in other centres: 13% of detainees were assessed as Level 2 adults at risk (see Glossary) and none as Level 3.

3.8 However, there was insufficient identification or exploration of modern slavery indicators in most of the screening interviews we examined for detainees transferred from Manston to Tinsley House for removal under the French returns agreement. For example, there was little consideration of evidence of the well-known risk of migrants being forced into modern slavery in Libya. From the sample of records we examined, screening interviews at Manston were mainly by video link, often in the early hours of the morning, which did not promote disclosure of vulnerabilities (see paragraph 3.24).

3.9 The failure to explore modern slavery indicators was not identified by the detention gatekeeper (see Glossary) or, in most cases, the DET. Subsequent delays compounded the problem. In one case we reviewed, a detainee's repeated account of modern slavery was not acted upon by the Home Office until they obtained legal support.

Case study: Failure to act on account of modern slavery

A detainee disclosed in his screening interview that smugglers made him work on a construction site in Libya to pay for his boat crossing. He was not asked either how he was treated, or to explain why he found France unsafe. On arrival in Tinsley House, he had informed health care staff that he was tortured in Libya, but this information was not passed to the Home Office. He then had an age assessment interview with Home Office staff in which he described being beaten and degraded by smugglers in Libya. He subsequently wrote to the Home Office to say he was exposed to violence and constant threats in France. It was only three weeks later, when he found a lawyer and representations were made on his behalf, that an NRM (National Referral Mechanism) referral was made.

3.10 Detainees frequently experienced waits of up to three weeks for a Rule 35 assessment. In one case, it took a GP four weeks to report on a man due to be removed to France who was found to have profound psychological trauma and physical injuries.

3.11 We learned that 177 Rule 35 reports concerned torture, six were opened as a result of health concerns, and just one because it was suspected that a detainee was suicidal. In the same period, concerns about self-harm risk for 28 detainees were so high that they were placed on constant watch. One suicidal detainee had been observed on constant watch for 19 days without a Rule 35 report, and another for 14 days. In both cases, the casework teams were informed of the detainees' vulnerability but did not request a review of the person's health, with a view to possible referral for a Rule 35 appointment.

3.12 In our sample of Rule 35 reports concerning torture, most lacked detail and evidenced little psychological assessment beyond recording the symptoms the detainee had described. However, we saw an impressive Rule 35 report concerning the impact of detention on a detainee's health.

3.13 The Home Office accepted the detainee had been tortured in seven of the 10 reports on torture, but only one detainee was released as a result. In the previous six months, 19% of detainees were released because of a Rule 35 report, compared with 50% at the last inspection.

3.14 Custodial staff we spoke to had limited understanding of adult safeguarding, modern slavery or the policy on adults at risk. Vulnerable adult care plans did not document sufficient care for detainees, but it was positive that more health care staff were attending care reviews than we usually see.

3.15 The weekly vulnerable adults meeting was a good forum for the exchange of information on detainee vulnerability. However, staff from case working teams did not always attend when necessary, and minutes and action planning were poor.

3.16 It was worrying that only half of frontline operational staff responding to our survey said they would raise whistleblowing concerns and none of those who had raised them thought they had been taken seriously. The national Serco Speak Up whistleblowing line had been used just three times in the previous six months. However, in the same period, staff had formally raised 62 concerns about staff corruption.

Self-harm and suicide prevention

3.17 In our survey, 43% of detainees said that they had felt suicidal at some time in this centre. There had been 46 incidents of self-harm in the previous six months, which was higher than at the last inspection, and three of them required hospital treatment. Investigations had been conducted into each of these, but they did not always identify or disseminate necessary learning. For example, an officer assigned to a constant watch tried to radio for assistance three times without success because he was on the wrong radio channel; this was not communicated at future briefings relating to constant watch.

3.18 In the cases we reviewed, length of detention and lack of information about immigration case progression were the main reasons for opening assessment, care in detention and teamwork (ACDT; see glossary) case management documents.

3.19 Staff had opened 45 ACDT documents in the previous six months and used constant supervision on 28 occasions because they believed there was an imminent risk of self-harm. The amount of time detainees spent under constant supervision was very long, with an average of 4.5 days and a longest period of over 19 days. It was an intrusive process, with staff sitting in shared bedrooms overnight, for example; ACDT documents did not always evidence why it was still required.

3.20 Most ACDT documents we reviewed suggested good staff engagement and reasonable levels of care, but there were some shortcomings, including some weak care planning and inconsistent case management. Staff in the safer communities team checked ADCTs daily and told colleagues how they could improve their practice. There was regular attendance by mental health staff and the Home Office DET at ACDT reviews, which contributed to good consideration of risk. Reviews were held in rooms that were quiet and felt relaxed.

Discharge suite – one of the rooms used for ACDT reviews

3.21 Staff had opened food refusal logs on 71 occasions in the last six months to monitor and support detainees who had missed six or more meals over a three-day period. Unit staff monitored these individuals, but it was not always clear what support had been provided, and managers did not attend case reviews.

3.22 Self-harm data was considered at appropriate meetings, but there was little minuted discussion of data or evidence of any actions being raised.

Safeguarding children

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

3.23 The pre-departure accommodation had not been used between December 2023 and the end of the inspection in early July 2026. We were subsequently informed that a family was held later in July 2026. The accommodation remained appropriate for families staying for short periods.

3.24 There had been a number of child safeguarding failures in French returns cases. In the six months before the inspection, 21 detainees brought from Manston were subsequently released to the care of West Sussex Children's Services following an age assessment. We reviewed the records for five of these cases and found that all had been interviewed in Manston by video link, and three interviews were in the early hours of the morning following an arduous channel crossing. For example, one detainee arrived in Dover at 1.26pm and was taken for a

video conference interview at 4.52am the following morning. Such practices were unlikely to promote full and accurate disclosure of potential concerns and vulnerabilities.

3.25 Age assessment practices by both the Home Office and Children's Services were also weak in the cases we reviewed. Home Office staff from the Illegal Migration Intake Unit attended Tinsley House promptly to conduct age assessment interviews, but interviews were conducted without appropriate adults (see Glossary). In three of the five cases, Home Office staff assessed the children to be adults and detention was maintained. All three requested their cases be reconsidered by social workers from Children's Services. In one case, social workers attended promptly, assessed the detainee to be a child and accepted them into care. However, in the other two, social workers did not attend in person but nevertheless assessed the detainees to be adults on the basis of the Home Office's interview records. In both cases, legal intervention forced a face-to-face age assessment, which then identified the detainees to be children. Both had been held in Tinsley House for about a month since first telling the Home Office they were children.

3.26 Those who said they were children, but whose age was disputed, were placed in a single room, but care planning was limited and there was little documented evidence of ongoing meaningful support. Poor communication, usually from Home Office casework teams but sometimes from DET, meant that Serco was unaware of some children who were awaiting an age assessment. Two were held for over two weeks with no safeguarding arrangements before their release to Children's Services. In some cases, repeated breakdowns in communication left detainees unsafeguarded.

Case study: Poor communication creating safeguarding risks

Centre staff thought that an age dispute had been resolved while it was still ongoing. The care plan for the detainee in question was closed, and he was moved from a single room to one shared with five men. His legal representatives then wrote to the casework team to protest the withdrawal of safeguarding arrangements. However, this was not passed on to the centre and the detainee remained in the shared accommodation for two weeks before the mistake was identified. Social workers then assessed him to be an adult, but this was thrown into doubt when a judge found it was arguable that the age assessment was unlawful. This should have triggered further safeguarding measures by the centre, but the judge's concerns were not passed on to the centre. Safeguarding arrangements were only reinstated six days later when inspectors made a child safeguarding referral.

3.27 No multi-agency case review had been held to understand and learn lessons from the high number of children transferred to the centre. Nor had any reviews been conducted on safeguarding failures in individual cases.

Personal safety

Expected outcomes: Everyone is and feels safe. The centre promotes positive behaviour and protects detainees from bullying and victimisation. Security measures and the use of force are proportionate to the need to keep detainees safe.

3.28 As at the last inspection, the centre remained a calm and safe environment. The number of violent incidents remained low, and none were classed as serious. There had been six assaults on detainees, six assaults on staff and four fights in the last six months. All assaults were referred to the police and detainees of concern were routinely moved to the more secure environment at Brook House IRC to manage their risk.

3.29 A new anti-bullying and violence reduction policy had been implemented since our last inspection but was not being used effectively or in all relevant cases. Antisocial behaviour investigations were weak, and intervention plans to address poor behaviour or provide support were limited.

3.30 In our survey, 54% of detainees reported feeling unsafe now, which was higher than at other IRCs. Some detainees we spoke to reported intimidation, bullying and disruptive behaviour from others, and we were told about tensions between different groups by both detainees and staff. However, psychological insecurity and anxiety were the most prevalent safety-related concerns. In our confidential interviews, no detainees said they had been assaulted by staff or other detainees. Many told us they felt unsafe because of the threat of imminent removal and not knowing what would happen following their arrival in France. This was compounded by problems in getting adequate health care and legal representation.

3.31 While relevant data were reported at monthly meetings, there was little evidence that individual incidents were discussed or analysed to understand issues or drive improvements. Actions set out in the safeguarding policy, such as detainee and staff safety surveys, had not been progressed.

Security and freedom of movement

Expected outcomes: Detainees feel secure. They have a relaxed regime with as much freedom of movement as is consistent with the need to maintain a safe and well-ordered community.

3.32 Detainees' freedom of movement was good (see paragraph 5.1). The two daily roll checks were conducted without undue restrictions. They were confined to residential corridors but were never locked in their room and could move around these corridors freely. However, some security restrictions were disproportionate and not always in line with the centre's own policies (see paragraph 6.7).

3.33 Leaders had identified and appropriately investigated 22 incidents involving professional standards in the previous 12 months. Robust action had been taken to respond to identified concerns, although we were concerned by the lack of confidence in whistleblowing procedures (see paragraph 3.16).

3.34 Four detainees had been strip-searched in the previous six months, and closed visits had been authorised once. In all cases, the actions were appropriate and taken on the basis of potential harm to themselves or others. However, this was not clear from the poorly completed authorisation paperwork for strip-searching.

3.35 The change in population had led to an increase in external escorts to hospital. Positively, detainees were not routinely handcuffed on escort, but for those who were, we did not always find clear individual risk assessments justifying the use of restraints.

3.36 There was now a dedicated security team based at Tinsley House which had helped to improve the efficiency of security processes and visibility of security staff. Intelligence was processed and actioned promptly with no backlog, although the number of security intelligence reports was similar to the last inspection despite a much larger population (281 compared to 276 at the last inspection).

3.37 The prevalence of illicit substances remained low with one find in the past six months. In our survey, few detainees (8%) said it was very or quite easy to get illicit drugs. Regular area searches and searching of staff took place, and intelligence-led searching was actioned promptly.

3.38 Leaders met regularly to review security intelligence, but this was often aggregated with Brook House, and emerging trends were not explored well enough to set security priorities and drive improvements at Tinsley House. Monthly strategic threat assessments also covered both sites, increasing the risk that Tinsley House-specific issues were not identified or addressed.

Use of force and single separation

Expected outcomes: Force is only used as a last resort and for legitimate reasons. Detainees are placed in the separation unit on proper authority, for security and safety reasons only, and are held in the unit for the shortest possible period.

3.39 There had been 47 uses of force in the previous six months, which represented a 28% increase since the last inspection. Nearly all of these were spontaneous, and most were low level. Two-thirds were related to disruptive behaviour (such as damage to centre property, and altercations between detainees) and force had been used on eight occasions to prevent self-harm.

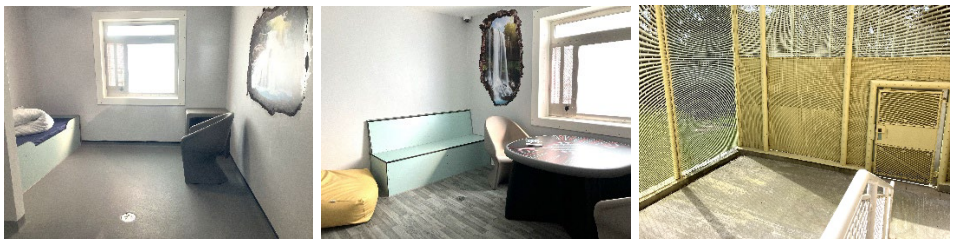
3.40 Body-worn video camera footage was available for 77% of incidents, and the centre's CCTV covered all but one. However, cameras were

sometimes switched off too early, including in one case when a detainee remained handcuffed.

3.41 The recordings we reviewed showed generally appropriate techniques, and there was calm and clear supervision of incidents by shift managers, which offered opportunities for force to cease if detainees became compliant. However, staff did not always use interpreters when needed and, in some cases, this escalated situations. In one case, a detainee was told an interpreter would not be provided until they calmed down, and in another incident another detainee was inappropriately asked to interpret. We were told that post-incident debriefs with detainees were routinely completed, but we found no records of this.

3.42 Monthly use of force committee meetings were held, and a weekly assurance meeting had recently been established. Identified issues were now logged and actions tracked, which enabled leaders to respond to emerging concerns. Serious concerns about a use of force incident had been identified by Serco, and an investigation was currently ongoing.

3.43 The separation unit was in good condition, having recently been refurbished and extended; there were now two rooms and a social space with comfortable seating and a television. We were told access to the centre regime and the association room on the unit were available to detainees on request, but records did not evidence this.



Separation unit room (left), separation unit association room (centre), and separation unit exercise yard (right)

3.44 Separation rates were low at 23 in the previous six months. In about half of cases, this was to facilitate removal directions, and authorisation paperwork adequately justified the decision. However, detainees were sometimes moved into the separation unit unnecessarily early before removal. We found some examples where detainees were moved between 3–4pm and then spent nearly 11 hours there before they left the centre.

Legal rights

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

3.45 The average cumulative time spent in detention (including time spent in other centres) was 39 days, compared to 79 days at the last inspection; reflecting the high number of detainees now held for short periods before removal to France. However, two detainees had been held for over six months, with the longest held for 463 days.

3.46 Over one half of detainees had arrived in small boats and were detained for removal to France. French returns cases were not progressed with sufficient urgency or attention to safeguarding (see paragraph 3.14 and paragraph 3.24). These cases had increased the need for speedy legal representation, but detainees had to wait up to a week for the first available detention surgery appointment, and some had to attend several surgeries before their case was taken on. Concerns had emerged about the quality of specific lawyers, but these had not been raised with the Legal Aid Agency.

3.47 We found insufficient case progression in cases we reviewed where detainees were in prison before their detention. There were further delays after they had been detained. In one case, it took the Home Office three months to confirm that a detainee had not appealed a refusal of asylum, during which time there was no case progression. In another, the detainee had so far been waiting three months for a decision on his asylum claim.

3.48 There was some long delays in obtaining travel documents. The Home Office estimated it take would take one month in a case we looked at, but it took six. In other cases, detention was prolonged excessively by the lack of available release accommodation. As in other inspections we found that poor understanding of complex legislation contributed to the length of detention.

3.49 Two detainees were held unlawfully for over 72 hours after being granted bail and were only released after DET escalated their cases.

3.50 As in other inspections, poor action planning in monthly detention and casework progress reviews contributed to delay. Most actions were to monitor the work of other Home Office teams, and none had a time limit for an action to be completed.

3.51 The work of the DET had improved since the last inspection. Contact was carefully monitored and all detainees had met face-to-face with the DET within the last 21 days. DET now ran daily surgeries each weekday in the legal advice corridor. Managers also regularly walked about the centre to meet specific detainees and make themselves available to others. ACDT case reviews were now well attended by DET staff, although they were not attending vulnerable adult care plan reviews. DET was working proactively to resolve problems with casework teams and generally escalated matters appropriately.

Section 4 Respect

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

Staff-detainee relationships

Expected outcomes: Detainees are treated with respect by all staff, with proper regard for the uncertainty of their situation and their cultural backgrounds.

4.1 In our survey, 70% of detainees said staff treated them with respect all or most of the time, which was similar to other IRCs. In our confidential interviews, detention staff were one of the most commonly mentioned positive aspects of the centre.

4.2 We saw many positive interactions between detainees and unit officers, and staff generally had good knowledge of the detainees in their care. However, staff often did not actively maintain positive standards by challenging low level behaviours, such as inappropriate dress.

4.3 Detainees were allocated a care officer who met with them regularly, but the review meetings we observed were brief and superficial and detainees did not consistently have the same officer, which meant that they could not easily build a rapport.

4.4 In view of the changes and challenges faced by the centre, it was positive that leaders were continuing to engage with the positive detention culture initiative, which was a long-term project seeking to improve culture and staff capability.

Daily life

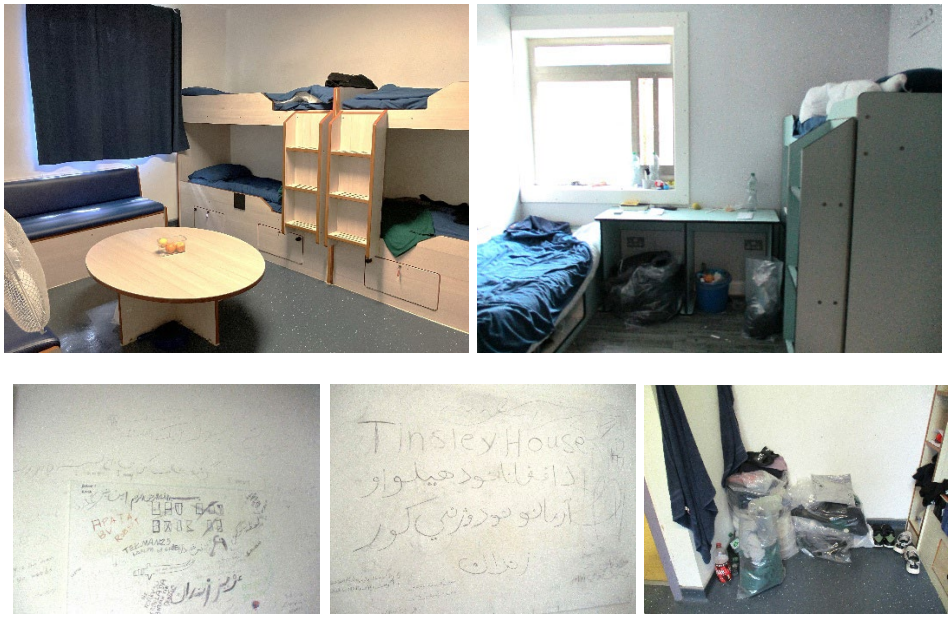
Expected outcomes: Detainees live in a clean and decent environment suitable for immigration detainees. Detainees are aware of the rules and routines of the centre. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair. Food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

Living conditions

4.5 Detainees were housed in two, three, four and six-bed rooms on two separate levels with separate communal toilet and shower facilities on the corridors. Since the last inspection, a refurbishment project had increased the available living accommodation by an extra 36 beds provided in two-person cells based on a prison design.

4.6 Living conditions across the centre were not good enough. The older rooms were poorly ventilated with windows that did not open. Fans had been issued during recent hot weather, but these only partly mitigated the problem, and many sleeping areas were stiflingly hot. Only 41% of detainees in our survey said it was quiet enough to sleep or relax at night, which was worse than at the last inspection. This was partly due to the centre receiving people throughout the night (see paragraph 3.3).

4.7 Many rooms and cells had extensive graffiti in different languages and standards of cleanliness were variable. Detainees had little storage space, and a number of rooms did not have curtains. In our survey, only 37% of detainees said they could get enough cleaning materials every week.



Top: Tidy four-bed bedroom (left), and crowded three-bed new cell with no curtains (right)

Bottom: Extensive graffiti in room (left and centre), and lack of storage space (right)

4.8 Communal toilets and showers were reasonably well screened, but some had broken tiles and taps, and they were foul smelling because of drainage problems and poor ventilation.

Broken taps in bathroom (left), and broken and missing tiles in bathroom (right)

4.9 We were told that many of these concerns would be addressed during a scheduled temporary closure for electrical works and other essential repairs.

4.10 Communal areas were reasonably clean and clear of litter. The central courtyard was a popular meeting place. It was kept clean and had plenty of outdoor seating and some exercise equipment.

Central courtyard (left) and central courtyard main seating area (right)

4.11 The rarely-used family rooms in the pre-departure accommodation (PDA) were welcoming and bright, and a range of activities were available to keep children occupied.

PDA main living area (top, left), PDA kitchen (top, right), PDA bedroom showing bunk beds (bottom, left), and PDA outside area (bottom, right)

Detainee consultation, applications and redress

4.12 Weekly wing forums and a monthly residents consultative committee meeting were chaired by the deputy director but were often poorly attended by detainees. They were in English only and there were no sessions using interpretation. Minutes did not always provide an update on issues raised.

4.13 Complaint forms were easily available in many languages, but all replies we saw were in English. In the previous six months, 45 complaints had been lodged, and they were well handled. Those we reviewed were responded to within appropriate timescales, findings appeared reasonable and replies were polite and empathetic.

4.14 However, many detainees told us they had little trust in the complaints system. Some did not know how to make a formal complaint. Others said it took too long to get a response and/or they did not believe the issue would be resolved. In our survey, 55% of detainees said they had been too afraid to complain. During our interviews, several detainees told us they were afraid of potential negative repercussions if they made a complaint.

Residential services

4.15 Detainees received three hot meals daily and, in our survey, 56% said the food was very or quite good. The catering staff took an active part in the monthly consultation meetings (see paragraph 4.12). However, many detainees told us that the food included too many starchy foods, such as potatoes, rice and pasties. The food that we observed was of

reasonable quality and portion sizes were adequate, but there were few vegetable options.

4.16 Detainees took their meals in a large communal dining hall, and food was served directly from the kitchen. The kitchen was clean and well-equipped but lacked storage space. Detainees could use a microwave and toasters in the dining room throughout the day.

Lunch

4.17 A cultural kitchen was available for detainees to cook for themselves and their friends during morning and afternoon sessions, but it was under-used (see paragraph 5.4).

4.18 The shop provided a good service and was responsive to requests to stock items suiting specific cultural preferences. In our survey, 67% of respondents agreed that the shop sold things they needed, better than at other IRCs. Detainees could also buy goods online.

Centre shop

Fair treatment and inclusion

Expected outcomes: There is a clear approach to promoting equality and diversity, underpinned by processes to identify and address any inequality or discrimination. Distinct needs arising from detainees' protected characteristics are recognised and addressed.

4.19 Two equality workers continued to organise events and encourage inclusion. They issued regular newsletters and had a programme of special events to celebrate diversity, supported by food and activities relating to the specific theme.

4.20 In our survey, only 44% of respondents said that they understood spoken English well. There was reasonable use of telephone interpretation, especially for formal conversations. However, we found a number of situations where it was not used enough. These included during use of force incidents and when staff needed to speak to detainees to de-escalate situations that might result in a use of force. In one case, a member of staff inappropriately used another detainee to interpret what should have been a confidential care officer conversation (see paragraph 3.41).

4.21 While much useful information had been translated into the most common languages, it was not consistently issued to detainees and many notices throughout the centre were still only in English.

4.22 Despite many younger men now being held at Tinsley House under the UK-France returns agreement, there was little evidence of any focus on

the needs of this group, to help promote the good running of the centre and address their anxieties.

4.23 The equality staff gave some good, discreet support to gay and bisexual detainees, but very few were identified compared to numbers self-reporting in our survey (19%). There were few detainees with visible disabilities, but 37% of respondents to our survey said that they had a disability. In the monthly presentations and meetings about equality issues, there was little evidence of analysis or discussion of what the figures showed, or what actions might be considered in response.

Faith and religion

4.24 The chaplaincy team were well known and respected by detainees, being highly visible around the centre. Chaplains were supportive and spoke a number of languages between them. In our survey, 85% of detainees who said they had a religion said their beliefs were respected.

The facilities for worship remained good and catered for all the main faiths. They had been improved with refurbishment of the faith room in the PDA and renewal of the ablutions areas. Dietary and other needs were met for all religious groups.

Health services

Expected outcomes: Health services assess and meet detainees' health needs while in detention and promote continuity of health and social care on release. Health services recognise the specific needs of detainees as displaced persons who may have experienced trauma. The standard of health service provided is equivalent to that which people expect to receive elsewhere in the community.

4.25 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC; see Glossary) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC took enforcement action, and this will be followed up with the health care provider.

Governance arrangements

4.26 Governance of health provision was unnecessarily complex because data and risk information were not routinely disaggregated from Brook House IRC. Some important risks relating to urgent specialist appointments, staffing, training and supervision had not been adequately addressed (see paragraphs 4.41, 4.42 and 4.46).

4.27 The new head of health care was transparent about concerns identified during their short tenure and had updated the risk register to better reflect the challenges. Provision of training was improving but there were gaps in safeguarding training. Clinical and managerial supervision

was largely absent, despite staff supporting detainees with complex and often traumatic experiences. This posed risks to staff resilience, well-being, and the overall effectiveness and sustainability of the service.

4.28 Health care was the strongest negative theme in our interviews with detainees. The speed of appointments, quality of care and dismissive attitude of health care staff were all strongly and regularly expressed as concerns.

4.29 Regular audits placed insufficient emphasis on detainee outcomes at Tinsley. Staffing lacked stability, with heavy reliance on bank and agency workers. Several vacancies were the result of an inexplicable lack of leadership action to fill them. There were consequent gaps in expected staffing levels to manage arrivals, departures and unplanned care interventions, affecting service delivery and continuity of care.

4.30 For detainees who received health care services, we observed appropriate nurse-led care, but care planning and general record-keeping was often poor quality. A patient experience lead had recently been appointed, but there was as yet little focus on understanding and responding to detainees' experiences. There was no structured advocacy provision to support the patient voice being heard in an environment where communication could be difficult. Complaints were generally handled well, but patients would have benefited from a process that attempted to resolve concerns less formally and more promptly.

4.31 There was no mental health lead despite high demand (see paragraph 4.44). Primary care leaders were very stretched, and no one had specific responsibility for service delivery at Tinsley House. However, clinical incidents were being reviewed and appropriate learning was identified.

4.32 Detainees' primary languages were recorded in the clinical record and we saw evidence of professional interpreting services being used for confidential discussions.

4.33 There was limited clinical space and a shortage of health keys. There were some shortcomings in infection control, particularly in one multi-purpose room which supported clinics and medicine administration.

4.34 Emergency equipment was well maintained and arrangements to respond to medical emergencies were embedded. However, we found items in the emergency bags that were outside of PPG's standardised equipment list. These items required additional staff competencies and more training. They were removed by the provider during the inspection.

Promoting health and well-being

4.35 There was no overall health promotion strategy covering the centre, but a Patient Engagement lead used the NHS calendar to raise awareness

about important issues. Input was sporadic, but posters and general information were displayed, though mostly in English. We were advised that detainees could use their phones or kiosk for more bespoke information.

4.36 A range of vaccination and disease prevention initiatives were offered with variable take-up. They included access to sexual health services and barrier protection, and smoking cessation support. The rapid turnaround of detainees and different communities served meant that developing peer support networks was impractical.

4.37 Communicable disease risks had been safely managed in the past, but communications surrounding a recent potential case of scabies had not been effectively disseminated.

Primary care and inpatient services

4.38 Detainees received a full health care screen on arrival with appropriate referrals made to other services as required. They were offered a Rule 34 GP appointment (see Glossary) within 24 hours of their arrival. It was offered again if they did not attend, and attendance was monitored. However, in the six months before the inspection, only 45% of detainees had attended, which undermined its safeguarding function for vulnerable detainees. We saw no evidence of action being taken to understand or address low attendance. Moreover, greater professional curiosity during early interactions, particularly regarding trafficking and modern slavery indicators, would have strengthened assessments and safeguarding.

4.39 Waiting times to see a GP or nurse were short, with detainees waiting no more than a day for an urgent non-specialist appointment and two weeks for a routine one. Waiting times for other services, such as the optician and physiotherapy, were also short and better than in the community.

4.40 However, patient records were poorly managed and record-keeping was not contemporaneous. Despite our requests, quality assurance reports and audits of note-taking were not provided. We were concerned to find several patient records where urgent suspected cancer referrals were mishandled, causing delays to treatment or no treatment at all. Other records demonstrated a lack of appropriate prioritisation of care for acutely unwell patients.

4.41 We were not assured that safe care and treatment for all patients was achieved following the identification of clinical risks. The provider was not routinely following up agreed actions, meaning patients were at increased risk of deterioration. As a result, patients experienced avoidable worsening of symptoms, unmanaged risks, and delays in receiving necessary treatment.

4.42 There were pathways to provide care and treatment to patients with long-term conditions, such as asthma or diabetes. While the need for such services was low, care plans were not always completed

promptly, personalised or clearly discussed with the patient. In our sample, one was completely blank and two had inappropriate information for a detention setting: to call 999 in an emergency and for the patient to self-order medicine online.

4.43 There was no demand for the use of social care at Tinsley House.

Mental health

4.44 An experienced, patient-centred mental health team worked collaboratively with colleagues across the centre to support detainees' needs. However, a 42% vacancy rate impacted on capacity, continuity of care and the availability of interventions. This reduced the scope of the service, limited the therapeutic support available and contributed to a poor overall service.

4.45 The lack of one-to-one crisis support and structured psychological group work, both of which had previously been available and valued by detainees, represented a notable gap in expected provision. Instead, pharmacological interventions were commonly used as the first-line response, particularly for sleep-related difficulties.

4.46 Mental health concerns were explored during reception screening with referrals triggered where appropriate. The early days in detention meeting reviewed all new arrivals, but discussions we observed lacked sufficient focus on risk, vulnerability and action planning. Detainees had good access to a psychiatrist, and there was appropriate physical health monitoring for those prescribed psychotropic medication, such as antidepressants and antipsychotics.

4.47 Referral pathways worked well with the use of mental health screening and risk assessment tools. Mental health triage appointments were conducted face-to-face using professional interpretation where necessary. The mental health team attended most ACDT initial and review discussions (see paragraph 3.20) and made meaningful contributions to the documentation.

4.48 Waiting time targets were not always met, and appointments were commonly and wrongly recorded as 'did not attend' when staff workload was the reason for the session not being facilitated. We could not establish if detainees who missed these appointments were monitored and reviewed.

4.49 Some detainees' mental health had deteriorated over time, and a comprehensive reassessment had not taken place until further referrals were made by the GP. This suggested that monitoring and escalation processes were not sufficiently responsive and opportunities to intervene earlier missed.

4.50 Rule 35 appointments were delayed by up to three weeks. Once detainees had been seen, reports were usually completed and submitted the same day (see paragraph 3.11).

Substance misuse treatment

4.51 There was low need for substance misuse services with only one person receiving good support from the psychosocial and clinical team.

4.52 We found tailored care plans to reduce dependence on methadone to a level safe for transfer, flight or medical conditions. Patient notes we saw captured the detainee's voice well, and there were clear records of each clinical contact.

4.53 All new arrivals were screened by a registered nurse for any substance misuse issues and referred to the team. We saw levels of patient monitoring appropriately undertaken and reviewed. The psychosocial team had a range of interventions to support clients, including self-management and recovery training groups, one-to-one sessions and work packs, and art therapy sessions. The team had information on harm minimisation and specific drug information in various languages and could source more for additional languages. Custody staff and health professionals could refer detainees, and detainees could also refer themselves.

Medicines optimisation and pharmacy services

4.54 Medicines were supplied by Boots Pharmacy and arrangements on site were managed by a small team working across Tinsley House and Brook House IRCs. Services were well led by a senior pharmacy technician and the team worked diligently to ensure that transportation, storage, administration, disposal and governance of medicines management was safe and patient focused.

4.55 Patient medicine histories and reconciliation occurred promptly, but it was not uncommon for GPs to determine prescribing needs based purely on patient accounts and professional judgement of need. An out-of-hours cabinet held a comprehensive range of stock, including critical medicines; though some items should have been stored elsewhere and there was no log to monitor out-of-hours access. We found gaps in the recording of fridge temperatures and no evidence of action to ensure medicines were safely managed when the correct storage temperatures were exceeded.

4.56 The pharmacist visited the site weekly, and we were assured any urgent medicines could be accessed next day if required.

4.57 Medicine administration was delivered by the on-site nursing team and pharmacy technicians. Medicines arrangements were safe, and a good range of over-the-counter remedies was available. Detainees could ask questions about their prescriptions or request medication via their mobile phones. The process was arduous for those who spoke limited English, especially if health professionals required further information before processing a request.

4.58 There was limited supervision by detention officers of administration, but queues were short, and there was little evidence of any illicit trading

of prescribed drugs. Many detainees received medicines in possession following appropriate assessment of risk. Detainees leaving the centre were given an appropriate stock or script depending on their circumstances.

4.59 The senior pharmacy technician led medicine governance arrangements and there was good, multi-disciplinary oversight of the service provided to detainees.

Oral health

4.60 There was no on-site dental suite at Tinsley House, but detainees accessed a mobile dental service funded by NHS England. The service enabled timely access to dental care and reduced pressure on primary care. Detainees could request appointments using a paper form or through the primary care team. Waiting times for routine appointments were short, typically within two weeks. The mobile unit was clean, well maintained, and supported by effective equipment servicing, governance and assurance processes.

Section 5 Activities

The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.

Access to activities

5.1 Detainees were free to move around the centre and access activities for up to 13 hours a day. During this time, they had unrestricted access to a pleasant outdoor courtyard with seating and two exercise bikes.

5.2 Attendance at activities was not consistently recorded by staff, and leaders did not analyse the available data to inform future planning or improve engagement. Apart from the library, participation in morning activities was particularly low.

5.3 The promotion of activities lacked creativity and effectiveness. These were advertised through posters, but only in English. Few education staff engaged directly with detainees outside the classroom to encourage participation.

5.4 The range of recreational activities was adequate, with most available on a drop-in basis. Regular competitions organised by activity staff were popular, well attended, and offered opportunities to win prizes. The cultural kitchen was a particularly positive and popular resource, bringing detainees from different nationalities together to cook and share meals. However, it was poorly promoted and under-used, with sessions taking place on only eight days in June and 12 in May.

Education and work

5.5 Education provision was limited to English and arts and crafts, but teachers met detainees' needs and interests well within this narrow curriculum. In English classes, teaching methods and activities were adapted to suit varying ability levels, supported by imaginative, high-quality learning resources. Arts and crafts projects incorporated cultural themes, including African mask-making and T-shirt painting inspired by the Football World Cup emblems and logos.

5.6 Detainees spoke positively about education, and in our survey, participation rates were higher than at other centres (41% compared with 25%). However, many more said they wanted to participate but could not do so. There was classroom space for only 10 detainees at a time, restricting participation. A wide range of online accredited vocational courses were available, with 21 being completed in the previous six months.

5.7 A lack of continuity in teaching staff affected detainees' progress and confidence. Teachers worked across two centres, with their schedules and locations varying each week, and they tended to work at Tinsley

House for only one day each week. Some detainees attended lessons only when the teacher they knew was present.

5.8 In English classes, detainees' skills were assessed during their initial session, but teachers did not consistently record starting points, lesson content or progress in individual learning plans. As a result, subsequent teachers were unable to build effectively on prior learning or reinforce progress made in earlier sessions. For example, during an arts and crafts session, a detainee wished to continue a pottery project started the previous day. The teacher leading the session had prepared a different topic for the day and was unaware of where the piece had been stored because no handover notes had been provided.

5.9 Leaders did not provide sufficient opportunities for teachers to collaborate on curriculum development or to maintain and enhance their skills through regular training and professional development.

5.10 There were insufficient work opportunities, and vacancies took up to three weeks to fill, which was too long given the short stays of many detainees. During the inspection, Home Office-directed changes led to the consolidation of job roles and a reduction in related working hours and pay. These changes were implemented without prior communication to detainees, resulting in dissatisfaction and prompting some individuals to leave their roles.

5.11 Detainees in work had received an induction into their role and most completed their jobs diligently.

Library provision

5.12 The library was accessible and well used but functioned mainly as a computer suite and video-calling area, with four booths available for detainees to contact family members (see paragraph 6.12).

5.13 Although some e-readers were available, they were not well publicised, with only seven loans recorded since January. Detainees could request a specific book in their own language for download to an e-reader. The library's physical book stock was minimal and disorganised, with no system in place for cataloguing, lending or replenishing the materials. Foreign-language dictionaries were kept in the education classroom for reference only, restricting access for detainees not attending classes. The stock of DVDs was plentiful, but detainees did not have DVD players in their rooms.

5.14 Immigration law books were outdated but remained available for reference, creating a risk that detainees could rely on obsolete information.

Fitness provision

5.15 Detainees had access to a range of fitness facilities, including a sports hall, gym and an Astroturf football pitch. Gym equipment was mostly in good condition. The outdoor Astroturf pitch was popular for cricket and

football games but needed cleaning and became slippery and unsafe in wet weather, restricting its use.

5.16 A varied programme of activities was well publicised and available seven days each week during the day and in the evening. The use of the facilities was high in the afternoons and evenings, but low in the mornings.

5.17 Detainees received a gym induction shortly after arrival and were provided with appropriate footwear if required. Health care recorded specific health conditions that staff should be aware of before the detainee participated in sport and fitness activities. Accidents and incidents were appropriately recorded. Five activities staff held fitness qualifications and carried out inductions to the facilities.

Section 6 Preparation for removal and release

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

Welfare

Expected outcomes: Detainees are supported by welfare services during their time in detention and prepared for release, transfer or removal before leaving detention.

6.1 The welfare team supported detainees with a range of issues, including legal appointments, lost property and referrals to external organisations. Detainees had good access and could drop in during association times, seven days a week. We observed a generally positive and caring staff approach. However, although welcoming and accessible, the office was next to the busy resource centre, had no private space and was often noisy, making sensitive conversations difficult. There was little management oversight of the quality of welfare services.

6.2 There were four welfare officer vacancies and on most days only two staff were available, putting further pressure on the service. Although detainees appreciated the help they received from welfare staff when they saw them, in our survey only 62% said it was very or quite easy to get welfare advice.

Welfare office

6.3 Positively, in early 2025, welfare staff received bespoke training from the Office of the Immigration Services Commissioner to help them better understand the needs of immigration detainees. However, there was no further training planned for newer staff.

6.4 The welfare team met detainees within 24 hours of arrival for an induction which covered outstanding needs and available support. The induction we observed was good, and staff used professional telephone interpretation for interviews and complex conversations (see paragraph 4.20).

6.5 Detainees received good support from external organisations. Bail for Immigration Detainees ran a monthly surgery and Gatwick Detainees Welfare Group (GDWG) attended twice a week. GDWG services were well used, and in the last six months they provided 197 clothing packs and nearly 300 £10 phone credit top-ups to detainees. Demand had increased and often outstripped supply, which meant that detainees sometimes waited 5–10 days for this support.

Visits and family contact

Expected outcomes: Detainees can easily maintain contact with their families and the outside world. Visits take place in a clean, respectful and safe environment.

6.6 Social visits provision was good. Visitors could book online or by phone for the next day, and visits ran daily from 2pm to 9pm, with plenty of spaces. In the absence of public transport, it was positive that the centre provided a free minibus service between Gatwick Airport train station and the centre.

6.7 There was no dedicated visitors' centre, so visitors were searched and stored their possessions in reception. We saw a respectful rub-down search, but some security procedures were excessive. Children still wore wristbands and there were unnecessarily strict rules limiting physical contact, which meant visitors and detainees could not sit next to each other (see paragraph 3.32).

6.8 The visits hall was small but sufficient to meet demand due to the extensive visiting times, with soft furnishings and toys for children. Free tea and coffee were available, and a small selection of drinks and snacks from a vending machine. Detainees could also buy items from the centre shop to bring into visits, and have family photos taken, but neither initiative was well promoted.

Visits hall (left), and vending machine (right)

6.9 Positively, two social workers provided family contact support in both Tinsley House and the nearby Brook House IRC. They helped detainees with family court paperwork, supervised visits and visits involving newborns. GDWG also supported more isolated detainees who did not receive visitors; nine volunteers attended social visits each week.

Communications

Expected outcomes: Detainees can maintain contact with the outside world regularly using a full range of communications media.

6.10 Following a successful pilot, all detainees were loaned a Wi-Fi-enabled smartphone on arrival. The phone helped them access emails, make applications and order food, and included apps to improve Home Office communication and provide translation. Detainees could also buy a basic non-smartphone or, if they already had this type of phone, they were allowed to keep it.

6.11 Detainees received £5 phone credit on arrival to contact family, friends and legal advisors. However, staff and detainees raised concerns about higher call costs because they could no longer buy bundles for phoning abroad. The centre had also stopped selling SIM bundles for basic non-smartphones, although these were reinstated during the inspection.

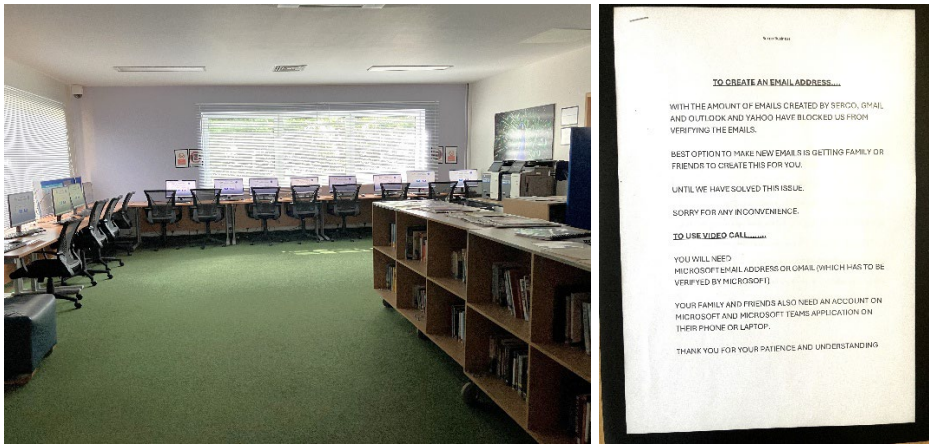
SIM bundles available in the shop

6.12 Video calling had improved. Four booths in the resource library could be booked for the next day if both parties had an email address. Detainees had good access, with many daytime and evening slots, and more than 500 calls had taken place in the last six months.

Video calling booths

6.13 In our survey, only 21% of detainees said it was very or quite easy to access what they needed online, compared to 42% at other IRCs. Twelve computers were available during association times, but demand was high and detainees could wait for long periods. Leaders did not do enough to ensure fair access. Most computers were working, but internet speeds were slow when demand was high. There was no homepage providing information about the centre or links to Home Office guidance.

6.14 Detainees could use computers to check emails, browse the internet and print documents, but social media was still blocked. AI sites had recently been restricted in line with Home Office policy, although the rationale was unclear to staff and detainees. Detainees were finding it more difficult to write letters and find information as a result. Staff and detainees also reported ongoing problems setting up emails; making it difficult to contact solicitors, family and friends.



Computers and poster about emails in resource centre

6.15 Detainees could send one free letter a week but, in our survey, 42% reported problems sending or receiving mail. Detainees had to attend reception and open all post in front of staff, which was excessive and contrary to policy. Parcels were sometimes delayed because too few officers were trained to X-ray them.

Leaving the centre

Expected outcomes: Detainees leaving detention are prepared for their release, transfer or removal. Detainees are treated sensitively and humanely and are able to retain or recover their property.

6.16 In the previous six months, 886 detainees had left the centre: 41% were removed, 7% went to further detention and 52% were released into the community. There was still no systematic approach to ensuring pre-departure and release needs were met and, in our survey, only 17% said someone had helped them prepare to leave the centre.

6.17 Detainees often had limited information about their removal or release, and available support. Many removals were to France, but staff and detainees had poor knowledge of what would happen next and what conditions would be like, increasing anxiety and uncertainty.

6.18 Release planning for complex and vulnerable detainees was insufficient. In the previous six months, three detainees had been released homeless, two of whom were considered to be adults at risk. Only one had received a multi-disciplinary team meeting before release, which health care staff did not attend.

6.19 At the time of the inspection, two detainees granted bail were still awaiting release because they lacked suitable accommodation. In both cases, poor Home Office and HM Inspectorate of Probation communication was causing delays. A third detainee, considered to be a high-risk sexual offender, was released homeless during the inspection after being granted bail two months earlier. Home Office and Probation release planning was inadequate.

6.20 Practical release planning support was reasonably good. Reception staff explained licence or bail conditions and gave detainees clothing or a bag if needed. Detainees were also offered a lift to Gatwick airport train station with a travel warrant. GDWG offered good post-release support, but staff and leaders were unaware of this, and the group had only supported three detainees post-release in the last six months.

6.21 Leaders had limited understanding of the experiences of detainees who were leaving the centre. An exit interview was available on the kiosk, and staff supported detainees to fill it in; many of whom had completed it in good faith. However, leaders did not read the responses or establish what they could improve as a result of detainee feedback.

Section 7 Progress on concerns from the last inspection

Concerns raised at the last inspection

The following is a summary of the main findings from the last inspection report and a list of all the concerns raised, 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.

At the last inspection, in 2023, we found that outcomes for detainees were reasonably good against this healthy establishment test.

Priority concerns

Casework, including decision-making and obtaining travel documentation for detainees' removal, was often not progressed promptly. Many were not released on bail despite long delays and barriers to removal.
Not addressed

Most Rule 35 assessments (see Glossary) contained insufficient detail, some reporting was vague and most made no clear finding on the likely impact of detention on detainees' health. Detention engagement team (DET) staff no longer monitored the timeliness of Home Office responses and there was evidence of some excessive delay.
Not addressed

Key concerns

IT problems meant staff could not access a reliable report of detainees assessed to be at risk in any immigration removal centre. Staff in Tinsley House were not aware of all detainees assessed to be at risk.
Addressed

Respect

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

At the last inspection, in 2023, we found that outcomes for detainees were reasonably good against this healthy establishment test.

Priority concerns

Interpreting services were not used consistently with those who did not know English well. Translated documents were available but not routinely issued to detainees when required.
Not addressed

Fair treatment was not being promoted through effective use of data or consultation with members of minority groups.
Not addressed

Activities

The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.

At the last inspection, in 2023, we found that outcomes for detainees were reasonably good against this healthy establishment test.

Key concerns

The provision of education was limited and oversight was weak. There was no monitoring of education attendance, measuring of progress or professional development of teachers.
Partially addressed

The library was poorly organised and lacked oversight. There were still no systems to manage borrowing, monitor use or replenish stock. The range of books in the library did not meet the needs of the detainees.
Not addressed

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.

At the last inspection, in 2023, we found that outcomes for detainees were reasonably good against this healthy establishment test.

Key concerns

The needs of those leaving the centre were not always met. There were delays in securing bail accommodation, and the needs of vulnerable detainees and those released homeless were not systematically assessed and addressed.
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 prisoners/detainees, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For immigration removal centres 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.

Activities
The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.

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

Under each test, we make an assessment of outcomes for detainees and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the Home Office.

Outcomes for detainees are good.
There is no evidence that outcomes for detainees are being adversely affected in any significant areas.

Outcomes for detainees are reasonably good.
There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for detainees are not sufficiently good.
There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for detainees are poor.
There is evidence that the outcomes for detainees are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for detainees. Immediate remedial action is required.

The tests for immigration detention facilities take into account the specific circumstances applying to detainees, and the fact that they are not being held for committing a criminal offence and their detention may not have been as a result of a judicial process. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees: in a relaxed regime; with as much freedom of movement and association as possible consistent with maintaining a safe and secure environment; to encourage and assist detainees to make the most productive use of their time; and respecting in particular their dignity and the right to individual expression.

The statutory instrument also states that due recognition will be given at immigration removal centres to the need for awareness of the particular anxieties to which detainees may be subject, and the sensitivity that this will require, especially when handling issues of cultural diversity.

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.

Five key sources of evidence are used by inspectors: observation; detainee and staff surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. 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.

All inspections of immigration removal centres in England are conducted jointly with the Care Quality Commission. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy establishment tests. There then follow four 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 7 lists the concerns raised at the previous full inspection and our assessment of whether they have been addressed.

Findings from the survey of detainees and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief inspector
Hindpal Singh Bhui	Team leader
Rachel Badman	Inspector
Martin Kettle	Inspector
Deri Hughes-Roberts	Inspector
Fiona Shearlaw	Inspector
Chelsey Pattison	Inspector
Alice Oddy	Inspector
Sheila Willis	Inspector
Sana Zahid	Researcher
Jasjeet Sohal	Researcher
Alicia Grassom	Researcher
Joe Simmonds	Researcher
Stephen Eley	Lead health and social care inspector
Angela Star	Health and social care inspector
Mark Griffith	Care Quality Commission inspector
Emily Hempstead	Care Quality Commission 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.

AA
Appropriate adult (independent individual who provides support to children and vulnerable adults in custody).

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

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.

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

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except rooms in segregation units, health care rooms or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged rooms, rooms affected by building works, and rooms taken out of use due to staff shortages. Operational capacity is the total number of detainees that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Detention gatekeeper
The detention gatekeeper's role is to provide an additional layer of assurance that detention decisions are appropriate and in accordance with the Home Office's suitability criteria.

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

Protection of adults at risk
Safeguarding duties apply to an adult who:
- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and

- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Rule 34 Detention Centre Rules
Requires a medical examination of every detained person by a GP within 24 hours of their arrival at an immigration removal centre.

Rule 35 Detention Centre Rules
Provides that:

(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
(2) The medical practitioner shall report to the manager on the case of any detained person they suspect of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of their treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.
(3) The medical practitioner shall report to the manager on the case of any detained person who they are concerned may have been the victim of torture.
(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.
(5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for their supervision or care.

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are:

Detainee survey methodology and results

A representative survey of detainees is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Survey of centre staff

Staff from the centre are invited to complete a staff survey. The results are published alongside the report on our website.

Appendix IV Summary of detainee interviews

Every detainee at Tinsley House was offered a confidential individual interview with an inspector. We conducted 33 interviews; 23 with interpretation. We also issued an invitation, through various voluntary and community groups, for recently released detainees to speak to us. We had no referrals by this route. The interviews were semi-structured and were held on 17 and 18 June 2026. What follows is a brief summary of the key messages that emerged. The opinions of interviewers are not included, and this represents only the views of interviewees.

These interviews were used as one source of evidence to inform the rounded judgements made by inspectors in the body of this report. The principal objectives were to identify concerns about safety and safeguarding of individual detainees, and to deepen inspectors' understanding of the culture in the centre. The detainees we spoke to were self-selecting and the findings below should be seen as supplementing our detainee survey findings. We followed up any allegations of concern and have reported on outcomes in the main body of the report where we were able to corroborate.

Key themes from 33 detainee interviews

Reception experiences were generally positive

Detainees reported being seen by health care staff shortly after arrival, and by Home Office staff within a few days. Interpretation was being used where necessary. Most said they were given information about what to expect in the centre. Some had long journeys before they arrived at the centre and a few were critical of their treatment for reasons including: long waits in escort vehicles, not being allowed to keep belongings previously allowed in possession, and not getting their normal medication.

Detainees reported low levels of violence, but high levels of stress and fear

Many detainees had been selected for detention while in asylum hotels and were surprised at their detention. Most were upset about the threat of imminent removal and did not know what would happen following removal to France. Several men became upset while speaking to inspectors about these issues during interview.

'…told I will be sent back. What is going to be my fate? It makes me very stressed'.

Anxiety, depression, and sleep disruption were widely reported. Many detainees said their situations were made worse by having to share noisy bedrooms with strangers with whom they did not share a common language. Some reported hostility between different nationality groups, and a few people with no previous experience of custody were nervous about sharing living spaces with ex-prisoners. Only one person had personally seen a fight and said staff quickly intervened to stop it. One man said staff had been verbally abusive to him and

others mentioned staff sometimes being rude, but none reported assaults by staff, and the vast majority had no awareness of illicit drugs.

Health care was the strongest negative theme in detainees' accounts

Many men we spoke to said they had mental or physical health problems, and several said they were taking substantial amounts of medication. The speed of appointments, quality of care and dismissive attitude of health care staff were all strongly and regularly expressed concerns. Some told us they had no response to their requests for physical and mental health support. Others said that they would have been removed before they could attend arranged health appointments.

Many detainees felt uninformed about their immigration case

Many men reported delays in case progression, including for those who wanted to be removed. One of the main concerns raised by interviewees was that they were not being kept up to date about what was happening in their case. They also reported difficulty in getting speedy legal support, especially representation. Most detainees said they saw Home Office staff soon after their day of arrival, but a few said it took several days or that they had not seen them at all.

Detention staff were seen as polite and helpful

Most detainees reported that detention staff treated them with respect and many had examples of positive experiences. Staff were one of the most commonly mentioned positive aspects of the centre. However, some concerns were raised, such as not knocking before entering a room and, in some cases, detainees felt that centre staff redirected rather than resolved issues.

There was low confidence in the complaints system

Many detainees had little trust in the complaints system and the reasons they gave for not complaining included: not knowing how to complain, it taking too long to get a response, no confidence that the issue would be resolved, and fear of repercussions.

The quality of food and, to a lesser extent, cleanliness were significant concerns

Many detainees said the food was unhealthy with too much starchy food, such as potatoes, and not enough vegetables. Standards of hygiene and cleanliness were also raised consistently, especially around toilet and shower areas.

Detainees cited the provision of activities as the most positive aspect of the centre

The gym; organised distraction activities, such as football; and the provision of education were widely valued by detainees. They said that access was good and activities staff were helpful.

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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