Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons

A follow-up report to the Home Office by [redacted]

July 2018



Cm 9661

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A follow-up report to the Home Office
by [redacted]

Presented to Parliament
by the Secretary of State for the Home Department
by Command of Her Majesty

July 2018

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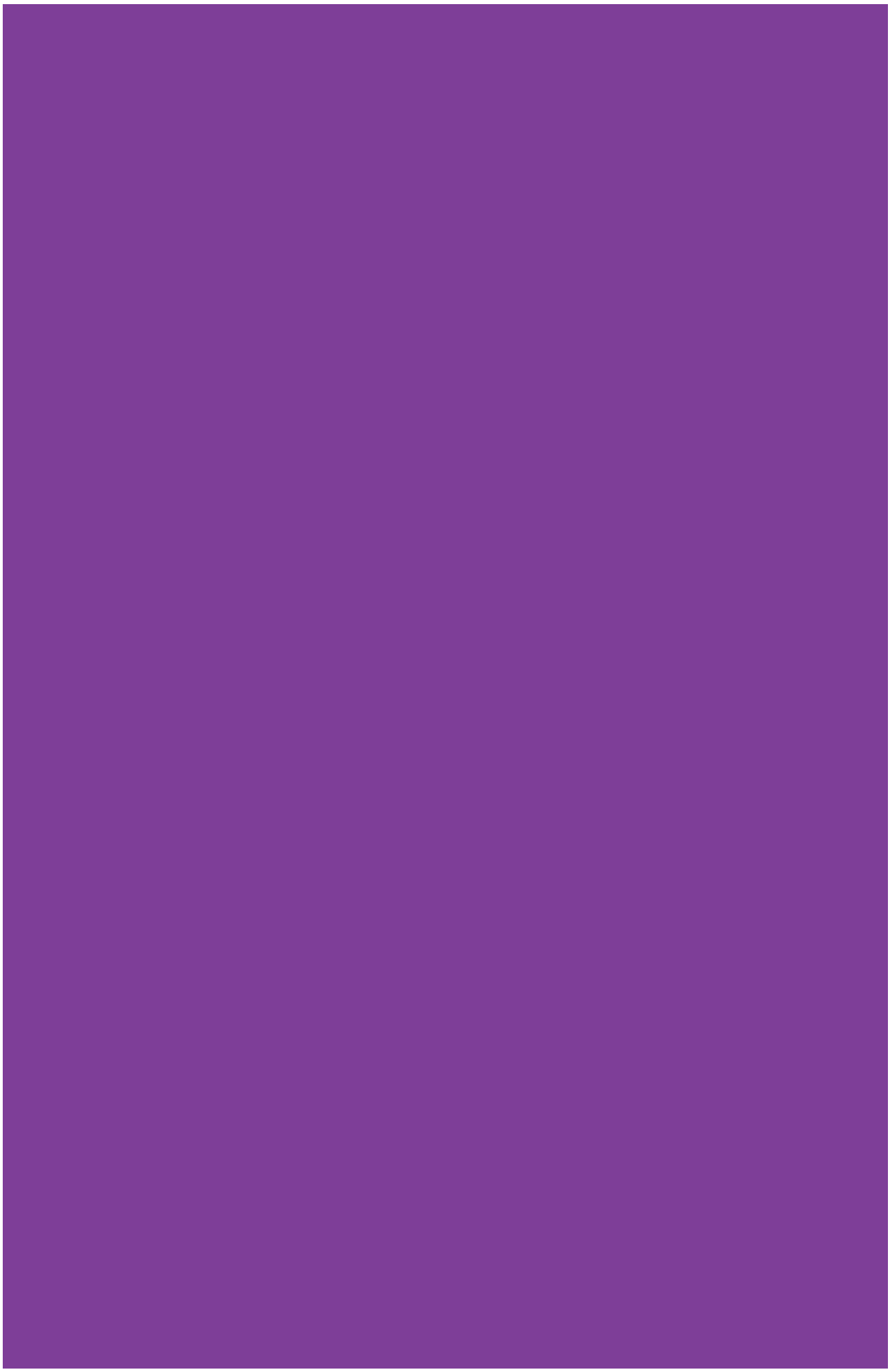
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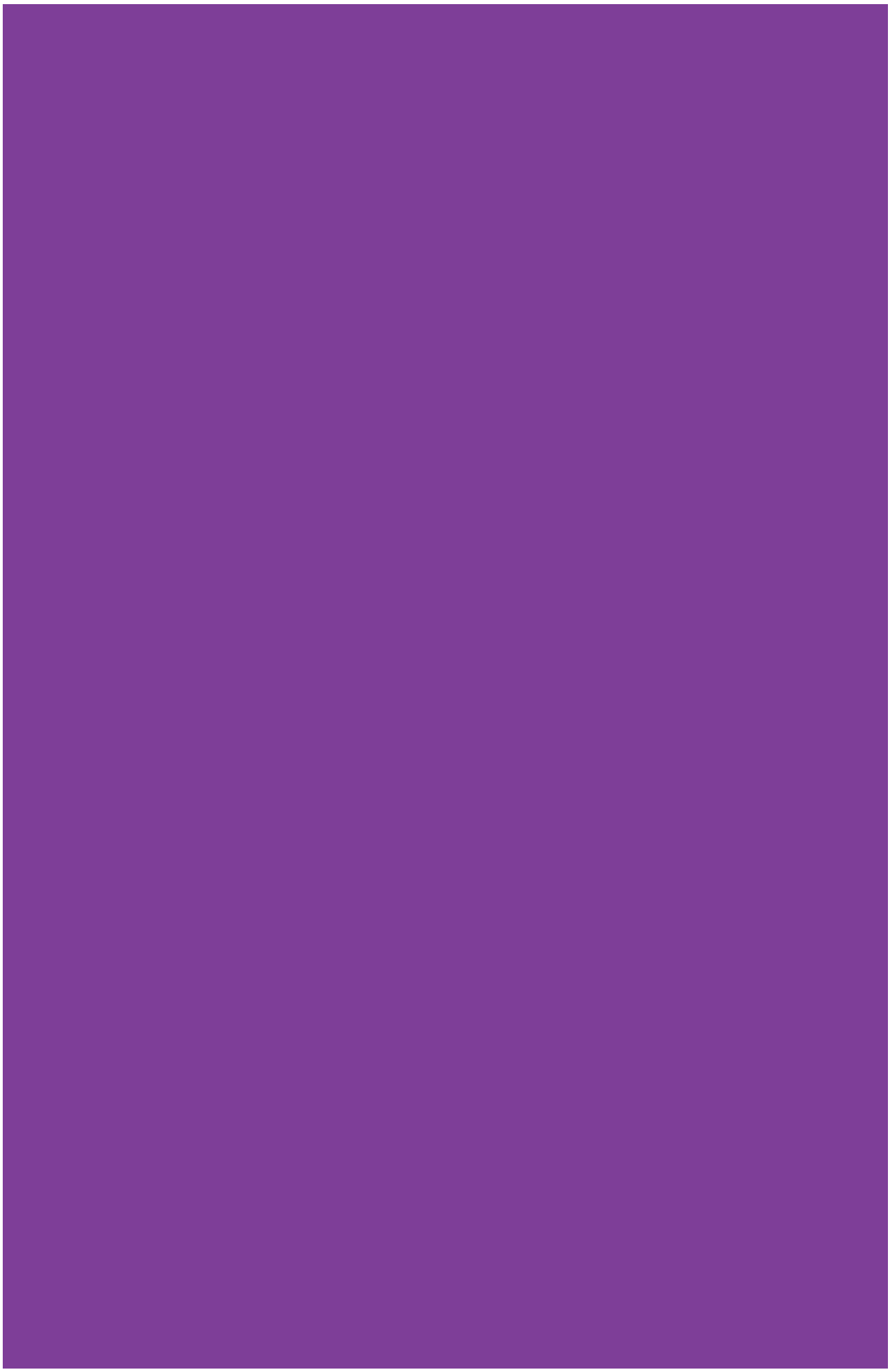
I have been very fortunate in carrying out this follow-up review to have worked alongside the five colleagues seconded to assist me. Mr Nick Hearn has proved a consummate team leader, and he has been most ably assisted by Ms Mary Halle, Ms Lorraine O'Hagan (Home Office) and Ms Meg Trainor (Cabinet Office). I am also indebted to Mr Anthony Nichols, on secondment from NHS England, who has contributed significantly to the healthcare section of this report as well as more broadly.

As with the initial review, I must also express my deep gratitude to Professor Mary Bosworth, Director of the Centre for Criminology at Oxford University, for contributing a specialist sub-review on Alternatives to Detention that I have annexed to this report. In addition, Professor Bosworth co-chaired a seminar on immigration staff culture that formed part of my programme of work, and prepared a discussion paper that I have also annexed. Altogether she has added immeasurably to both the first and second reviews.

Ms Clare Checksfield, Director, Detention and Escorting Services, Immigration Enforcement, was the Home Office sponsor of both this and my earlier work, and – while properly respectful of my independence – she and her senior colleagues have been consistently interested and supportive of the review, and the approach I was taking. Indeed, it was made clear by them all that I was entitled to take a broader approach than a strict reading of my terms of reference would have allowed. I am grateful too to all those who have contributed evidence to the review, and am very conscious of the demands that my requests for information have placed upon both the Home Office and its partners and stakeholders. I have also been given free and immediate access to every part of the immigration detention estate, and have spoken with many detainees and those who have left detention.

It goes without saying, however, that I take sole responsibility for the findings and judgements in the pages that follow.

[redacted]
April 2018



FOREWORD

In my first review of the welfare in detention of vulnerable persons (Cm 9186), I consciously began by setting out the historical development of the system of immigration detention. This was in part to provide some context for what I had found and what I went on to recommend. But it was also to help expand political, media and public understanding of institutions and processes that are frankly little known and little understood. I remain of the view that public policy is not assisted when there is so little informed interest and debate.

Nonetheless, my approach in this second review has been rather different. My principal task was to reach a view on the extent to which the Home Office had adopted the recommendations of my first report, and – more significantly – what impact this had had in practice. Amongst my colleagues, I referred to this as 'marking the Home Office's homework'. However, I was also conscious that – despite its length – my first review had areas that were less well developed than others. I had made many recommendations about healthcare and caseworking, for example, but the evidence base had been limited and non-specialist. Perhaps surprisingly given my former responsibility as Prisons and Probation Ombudsman for investigating every death in detention, the section of the first report on safer detention was rather limited. And I was also aware that what I had said about 'alternatives to detention' (a very broad and possibly misleading term) would have benefited from a more detailed examination.

Most significantly, given that the start of this review coincided with revelations by the BBC *Panorama* programme of appalling misconduct by some staff at Brook House Immigration Removal Centre,[1] I knew that I needed to say much more about staffing and staff culture, and the impact they have on detainee welfare.[2]

In consequence, this report is much more than a stocktake of what I previously proposed, what the Home Office has implemented, and what impact any of it has had. There is much new information, and new recommendations as well as a small number that are repeated.

I have not directly considered the case for a time limit on detention. This did not form part of my original review, and I wanted to concentrate my time on those areas where I could make the most distinctive contribution. However, this did not prevent many of those who submitted evidence or with whom I spoke from raising the issue with me.

[1] *Undercover: Britain's Immigration Secrets*, broadcast on September 4 2017. If I may be forgiven the observation, the reference to immigration secrets reinforces what I said in the first review about the benefits that would follow if the Home Office adopted a policy of greater proactive openness in respect of the detention estate.

[2] Subsequently, I was expressly asked by the Home Office to confirm that "staff culture, recruitment and training, the sufficiency of the complaints mechanisms; and the effectiveness of whistle-blowing procedures" were matters I would consider as part of my second review. (See paragraph 1.2 below.)

Support for a time limit has coalesced around a period of 28 days, but I have yet to see a coherent account of how this figure has been arrived at. It is not so long ago that Parliament was presented with a proposal for a 60 day limit,[3] and it is clear that there must be exceptions (it would surely be unacceptable for someone who disrupted a flight on the 27th day of their detention to be released the next day). Indeed, the proposals considered in 2016 during the passage of that year's Immigration Bill specifically excluded those subject to deportation (in other words, the very foreign national offenders (FNOs) who make up the vast majority of those held in detention the longest).

The current Government position is to oppose a time limit (whether of 28 days or any other period),[4] but Parliament may at some point take a different view.[5] My point is that, at present, the case for a time limit has been articulated more as a slogan than as a fully developed policy proposal.

Be that as it may, I have obviously been pleased to note a reduction in the average length of detention since 2015. I also welcome the substantial fall in the overall detained population since I conducted my first review. These are significant steps forward. Nevertheless, the number of people held for over six months has actually increased. The time that many people spend in detention remains deeply troubling.

Furthermore, over half of those detained are still subsequently released back into the community. And virtually all of the population reduction has been on the male side, while the number of women in detention (who do of course make up a far smaller proportion of the overall detained population) has fallen by a much smaller percentage. Given the levels of vulnerability amongst women detainees, I hope that their numbers can also follow a strong downward path.

Much of this report concerns the Adults at Risk (AAR) policy, introduced by the Home Office in response to my proposals to reduce the numbers of vulnerable people in detention. Yet many of the NGOs who submitted evidence said that AAR had made matters worse and should be abandoned. And it is the case that in my visits to IRCs I found many people whom I felt should not be there. Indeed, I think every one of the centre managers told me that they had seen no difference in the number of vulnerable detainees (and, in some cases, that the numbers had actually increased). My own view, however, is that it would be folly to give up on the Adults at Risk policy. It is best thought of as an exercise in cultural change, and like all such programmes it will take time to reach full fruition. The focus on vulnerability that AAR has engendered is a genuine one, although there is no doubt that the policy remains a work in progress. I have made recommendations to strengthen the protections of AAR.

Another theme of this review is the need for a more joined-up approach between the Home Office and its partners across Government. This applies particularly to the Ministry of Justice with its responsibilities for prisons and probation. In the chapter on alternatives to detention, I also point out some of the consequences of the policies restricting access to services that go under the umbrella of the 'compliant environment'.

Other themes include the need for the Home Office to develop its assurance mechanisms, and for the further promotion of voluntary returns.

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[3] Baroness Williams of Crosby moved an amendment to the then Immigration Bill in the House of Lords on 1 April 2014. It was heavily defeated (https://hansard.parliament.uk/Lords/2014-04-01/debates/14040169000826/ImmigrationBill). I understand that 60 days is the limit in both Spain and Portugal; a similar limit of two months applies in Belgium.

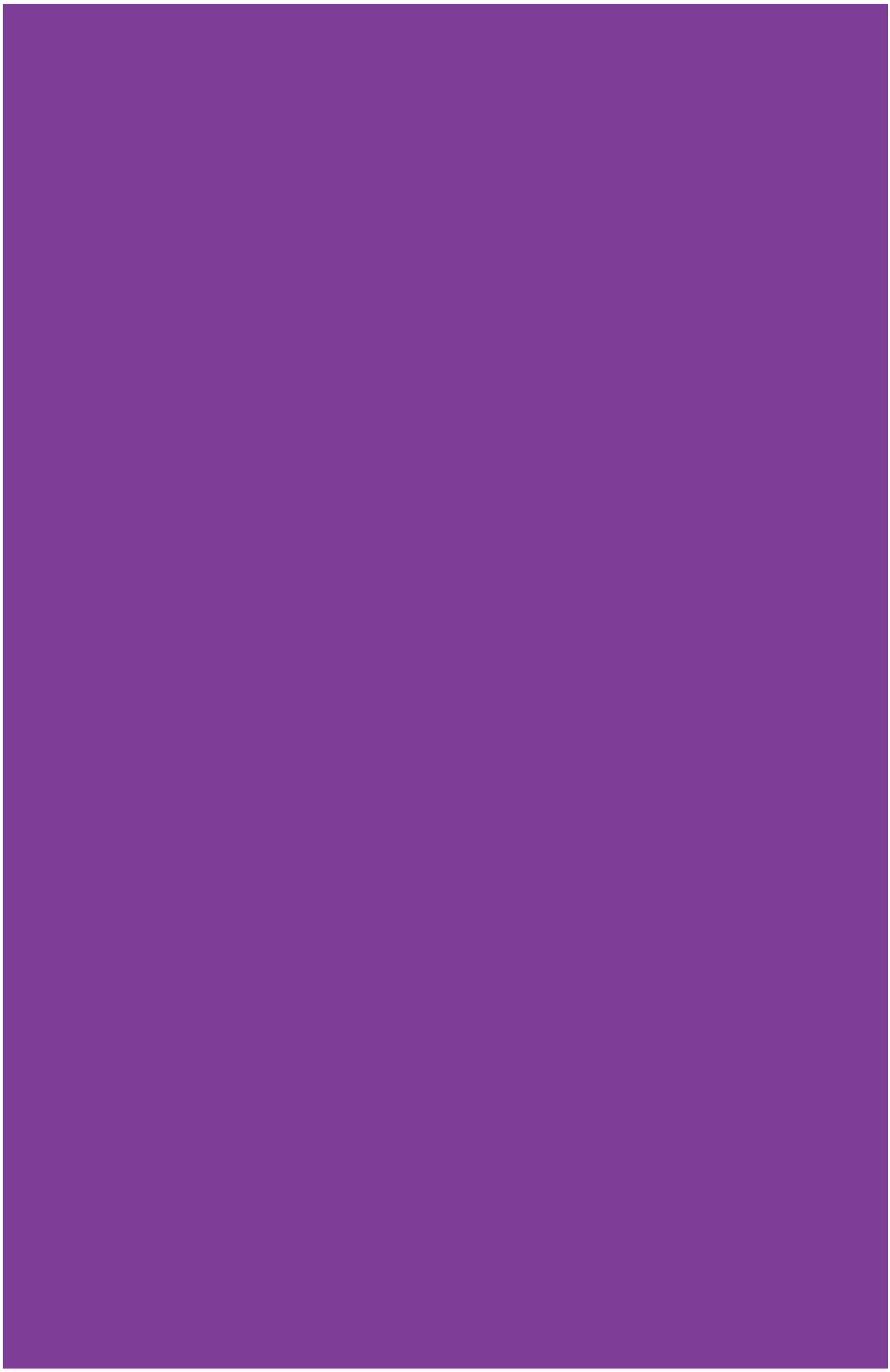
[4] On the grounds that any limit would encourage individuals to frustrate immigration and asylum processes, or to engage in non-compliant behaviour, in order to reach the point at which they must be released from detention and thereby avoiding their enforced removal from the UK.

[5] In July 2016, the Home Affairs Select Committee (HASC) noted: "further legal interventions, such as a statutory time limit on detention, will need to be considered if there has not been a significant impact on the length of detention." (*The work of the Immigration Directorates (Q4 2015)*, HC 22, https://publications.parliament.uk/pa/cm201617/cmselect/cmhaff/22/22.pdf).

Some of what I say in the pages that follow reflects very well upon the Home Office, the Department of Health and Social Care, and NHS England, and is testament to the diligence that has been shown in following through the Government's commitment to the broad thrust of what I proposed more than two years ago. But I have found a gap between the laudable intentions of policymakers and actual practice on the ground.

Students of public administration will be familiar with this phenomenon in many walks of life, and I intend no criticism of those involved. Indeed, I take heart from the energetic way in which the recommendations of my first review have been taken forward. This gives me confidence that the findings of this follow-up report, some of which are very challenging, will be treated with no less urgency.

[redacted]
April 2018



EXECUTIVE SUMMARY

1. This is the report of a review commissioned on behalf of the Home Secretary. Its focus has been upon the Government's response to my previous report (*Review into the Welfare in Detention of Vulnerable Persons*, Cm 9186, published in January 2016), and what impact this had had in practice. I have also looked in more detail at healthcare, caseworking, safer detention, oversight and staff culture, and alternatives to detention.

2. I have conducted the review with the assistance of five colleagues, three seconded from the Home Office, one from the Cabinet Office and one from the NHS. I have visited each of the immigration removal centres, along with other facilities, considered a range of written evidence and other material, and met with a wide range of officials and stakeholders.

3. I asked Professor Mary Bosworth to conduct a literature survey to help inform my thinking on the use of alternatives to detention.

4. I co-hosted with Professor Bosworth a seminar on staff culture. To draw from experience in other walks of life, this brought together experts on the police, prisons, and the NHS, as well as Home Office officials and their contractors in immigration detention.

5. In Part 1 of the report, as well as detailing my terms of reference and the methodology I followed, I summarise themes emerging from the written evidence I received and from my meetings with officials and stakeholders.

6. In Part 2, I look in more detail at the Government response to my earlier report. The majority of my recommendations were accepted and I outline where further reforms may be required. I also summarise what I found on my visits to immigration removal centres and elsewhere.

7. I record that there has been a reduction in the number of those detained for immigration purposes, and say that conditions in IRCs have generally improved from when I visited three years ago. But in some centres the Home Office's strategy of expanding capacity by adding extra beds into existing rooms has exacerbated overcrowding, and created unacceptable conditions.

8. I indicate a need for a more joined-up approach between the Home Office and its partners across Government. This applies particularly to the Ministry of Justice with its responsibilities for prisons and probation, and is especially relevant to time-served foreign national prisoners.

9. I examine the Adults at Risk (AAR) policy that was introduced by the Home Office in response to my proposals to reduce the numbers of vulnerable people in detention. While it is not clear that AAR has yet made a significant difference to those numbers, it has engendered a genuine focus on vulnerability. The policy remains a work in progress and I have made recommendations to strengthen the protections it offers.

10. In Part 3, I present my impressions of healthcare in immigration removal centres. I say that much has been done by NHS England in partnership with the Home Office, and by the healthcare contractors, and plans are in place to continue this process. I note that detainees' take-up of healthcare provision remains very high, and have made additional recommendations.

11. In Part 4, I look in more detail at caseworking. I examine the new policies and procedures introduced under the Home Office's Detained Casework Transformation Programme and welcome many of these developments. However, I remain concerned that more needs to be done to ensure that individuals who are at risk are not detained, and suggest improvements to the new policies. I note that almost all of the safeguards against excessive use of detention introduced since my first review are internal, and there remains a need for robust *independent* oversight.

12. In Part 5, I examine the way in which the Home Office manages safer detention procedures against the background of a recent increase in the number of self-inflicted deaths. By and large, the processes for managing those at risk of self-harm are being delivered appropriately, but more needs to be done to uncover the specific vulnerabilities of those in immigration detention and to develop a strategy in the light of any findings.

13. In Part 6, I give more detailed attention to oversight and staff culture, subjects of particular resonance given the BBC *Panorama* programme demonstrating grave misconduct on the part of a number of staff at Brook House. I consider issues of staff recruitment, retention, training and moral resilience, and have drawn upon lessons from other services. The systems for recruitment, training and whistle-blowing used by the individual contractors, and the processes for handling complaints and ensuring independent monitoring, are all satisfactory so far as they go. But manifestly they have not prevented abuses of the kind revealed by the BBC. I make suggestions to improve assurance processes and strengthen oversight.

14. Part 7 of my report focuses upon alternatives to detention. There remains limited evidence of the effectiveness (and cost-effectiveness) of those schemes that have been implemented across the globe. There are also difficult issues to resolve as to how former detainees can be supported in light of policies introduced in the Immigration Act 2016. Nonetheless, I have made specific proposals for how the Home Office can take forward the alternatives to detention agenda.

15. I then list the specific recommendations from this follow-up review.

16. There are twelve annexes.

PART 1: INTRODUCTION

Terms of reference

1.1 This review was commissioned in September 2017 on behalf of the Home Secretary, the Rt Hon Amber Rudd MP. I was given the following terms of reference:

> "To assess the Home Office response to the findings in the report: *Review into the Welfare in Detention of Vulnerable Persons*, published in January 2016 (Cm 9186), including the implementation of all recommendations. As part of that, you are commissioned to:
>
> - Lead the review, setting the timetable for action and identifying areas for consideration in line with the terms of reference
> - Undertake fact finding visits to Immigration Removal Centres and any other locations which are applicable to the review
> - Consult interested parties as appropriate, ensuring that there are means by which individuals and organisations can submit evidence for consideration
> - Make a report to the Home Secretary on the findings of the review, including recommendations which address the terms of reference."

1.2 These terms have not been formally amended, but I received a further letter on 21 November 2017 when I was asked to confirm that staff culture, recruitment and training, the sufficiency of the complaints mechanisms, and the effectiveness of whistle-blowing procedures were matters that would be considered as part of my second review. I confirmed this to be the case in my reply of 22 November.

1.3 I have reproduced this second letter and my reply at Annex 1.

How I conducted the review

1.4 With the support of the Home Office, I have taken a broad approach to my terms of reference. I have both assessed how the recommendations of my first report were put into operation, and the impact thereof, and offered more detailed consideration of five key areas: healthcare, caseworking, alternatives to detention, safer detention (the prevention of suicide and self-harm), and staff culture, performance, and oversight. I have endeavoured to feedback my emerging findings as the review has proceeded.

1.5 I have been assisted throughout by three colleagues seconded from the Home Office: Mr Nick Hearn, Ms Mary Halle and Ms Lorraine O'Hagan, a colleague seconded from NHS England, Mr Anthony Nichols, and a colleague seconded from the Cabinet Office, Ms Meg Trainor.

1.6 In outline, I have carried out this review as follows:

- I have visited each of the immigration removal centres (IRCs) at least once.
- During each visit I spoke with detainees, managers and staff.
- I also met with Immigration Enforcement staff and with representatives of the Independent Monitoring Boards (IMBs).
- I held forums with groups of detainees in a number of IRCs.
- I visited Huntercombe, Maidstone, Peterborough and Thameside prisons, meeting staff and prisoners.
- I have also visited Becket House reporting centre and the port holding facility at Heathrow, Cayley House.[6]
- Observations were made at Croydon and Sheffield holding rooms.
- In depth observations of reception were conducted at Yarl's Wood and Brook House.
- Detailed observations of healthcare were made at every IRC, and a conference call was held with healthcare staff at The Verne shortly before it closed as a removal centre.
- Observations were made on a charter flight to Nigeria and Ghana.
- I asked for submissions of written evidence and have carefully considered all of those received.
- I met with many stakeholders both one-to-one and in groups.
- I met with a small group of former detainees at the offices of the organisation, Women for Refugee Women.
- I received representations from solicitors on behalf of those detainees who had been abused at Brook House and whose cases had been highlighted on the *Panorama* programme. I have also been shown anonymised copies of the Home Office Professional Standards Unit investigations into a number of the allegations made.
- I visited accommodation for asylum seekers in the community.
- I asked Professor Mary Bosworth, Director of the Centre for Criminology at the University of Oxford, to conduct a review of the literature on alternatives to detention. Her review is summarised in the text of this report and is annexed in full.
- I met with the Chief Inspector of Borders and Immigration, HM Chief Inspector of Prisons, and the Prisons and Probation Ombudsman, and members of their respective teams.
- I had a series of meetings with senior officials in the Home Office, National Health Service and HM Prisons and Probation Service (HMPPS).
- I conducted meetings with Home Office caseworkers and the gatekeeping team.
- My team and I observed the meetings of a number of case progression panels.

[6] Members of my team also visited Larne House short term holding facility (STHF) in Northern Ireland, and the short term holding facilities at Heathrow Terminals 2, 3, 4 and 5.

- I met with senior managers from the current escort contractor and the new provider.[7]
- I made formal requests for statistics and other information from the Home Office.[8]
- I believe I have enjoyed unbridled access to Home Office documents.[9]
- With Professor Bosworth, I co-chaired an academic seminar on staff culture.

1.7 A full list of meetings and visits is attached at Annex 2.

Formal Government response to my previous report

1.8 I have reproduced the 64 formal recommendations that I made in my first report at Annex 3. The Government responded to the report on publication by accepting "the broad thrust" of what I had proposed. In a statement[10], the then Immigration Minister, Mr James Brokenshire, announced reforms in three key areas.

1.9 First, Mr Brokenshire said that the Government accepted my recommendations to adopt a wider definition of those at risk, including victims of sexual violence, individuals with mental health issues, pregnant women, those with learning difficulties, those suffering from post-traumatic stress disorder, and elderly people, and to recognise the dynamic nature of vulnerabilities. In consequence, a new concept of Adults at Risk (AAR) would be introduced.

1.10 Second, the Government would carry out a more detailed mental health needs assessment and publish a joint Department of Health, NHS and Home Office mental health action plan.

1.11 Third, the Government would implement a new approach to the case management of those detained, ensuring "the minimum possible time is spent in detention before people leave the country without the potential abuse of the system that arbitrary time limits would create".

1.12 Mr Brokenshire said he anticipated that the effect of the Government's reform programme would be "a reduction in the number of those detained, and the duration of detention before removal, in turn improving the welfare of those detained".

1.13 In the two years or so since that Ministerial Statement, further work has been undertaken by the Home Office focussing on the individual recommendations I had made. A spreadsheet summarising the responses to those recommendations is attached at Annex 5. Here I need simply note that of the 64 recommendations, 56 were accepted or

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[7] The new contract comes into force in May 2018.

[8] The Home Office data within this report have been differentiated into three categories based on source, availability and integrity. They are categorised as:

[1] – *These statistics have been taken from a live operational database and as such numbers may change as information is updated.* This is data that has been provided through the Performance Reporting and Analysis Unit (PRAU) from central Home Office live data bases. It is, generally used for internal reporting and in response to standard queries to the Home Office.

[2] – *These statistics have been taken from live internal management information and as such numbers may change as information is updated.* This is data taken from Home Office databases that are based on live management information that is not routinely or centrally collated due to the changeable nature of the data contained.

[3] – *This analysis has been collated by the Adults at Risk Assurance Returns Team (ARRAT) upon request from my review team to provide indicative trend analysis.* This is analysis that I specially commissioned from the Home Office and is not routinely collected or monitored.

[9] As part of my first review, I commissioned Mr Jeremy Johnson QC to assess recent cases in which the domestic courts had found the Home Office to be in breach of Article 3 of the European Convention on Human Rights in respect of individual detainees. At that time Mr Johnson found five such cases. I therefore asked the Home Office to identify any further cases where a breach of Article 3 had been found. They have identified no additional cases where the facts in question were after publication of my first report, and I have not pursued the matter further. (One recent Article 3 case (*Arf and SSHD* [2017] EWHC 0010 (QB)), relates to events between 2011 and 2014.)

[10] HCWS470, 14 January 2016. I have reproduced the Written Ministerial Statement at Annex 4.

partially accepted, five were rejected, two are deferred and one remains under review. Of the 56 that were accepted or partially accepted, 31 have been implemented, and the rest are being delivered.

1.14 As noted above, as part of the evidence gathering I have had a range of meetings with senior officials in the Home Office, NHS England and HMPPS. All those with whom I met stressed how seriously the Home Office had taken the findings of my first report, and that this had led to a change in both policy and attitude towards detention. Formal mechanisms had been established to work through the individual recommendations. This had proved challenging, especially regarding those time-served foreign national offenders who make up over a third of the detained population.

1.15 It was also stressed that lessons were still being learned about how best to manage new processes, and I should say at the outset that I entirely accept this. I am conscious that what I say in this follow-up report captures a moment in time, and that many of the changes that resulted from the first review are still in their infancy.

Evidence received

1.16 A list of those who submitted written evidence and a brief synopsis of what I was told is at Annex 6. A total of 25 submissions were received, the majority from Non-Governmental Organisations with an interest in detainee welfare and/or the rights of immigrants. I also held a seminar with many of these bodies. Below is a summary of issues of particular interest.

Adults at Risk Policy

1.17 Almost all those making submissions argued that the intentions of the AAR policy had not been realised, with little overall change in the numbers of vulnerable persons detained. In particular, there were concerns about evidence levels for vulnerability, and the balancing of vulnerability against 'immigration factors'. Many respondents called for a greater use of a vulnerability screening tool, such as the one developed by the UNHCR and International Detention Coalition[11], to screen individuals prior to the decision to detain. Use of such a tool would also assist in detention to identify vulnerabilities that subsequently develop.

Time limit on detention

1.18 The majority of organisations making representations called for the introduction of a time limit on detention. Uncertainty as to the length of detention was argued to have a significant impact on detainees' welfare. It was also noted that the UK is currently one of only a handful of countries that does not have such a time limit.

Rule 35 Reports

1.19 Rule 35 of the Detention Centre Rules requires the medical practitioner to report on any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention (rule 35(1)), on any detained person suspected of having suicidal intentions (rule 35(2)), and any detained person whom the doctor is concerned may have been the victim of torture (rule 35(3)). Almost all of those who submitted evidence felt that Rule 35 was not working and should be replaced.

[11] UNHCR and the International Detention Coalition (2016) *Vulnerability Screening Tool – Identifying and addressing vulnerability: a tool for asylum and migration systems* (Geneva; UNHCR and International Detention Coalition).

Detention decision making

1.20 There were a number of concerns about the new caseworking processes the Home Office had introduced. It was noted that the gatekeeping arrangements did not involve representations from the detainee or his/her legal representative. It was also argued that case progression panels were made up entirely of Home Office officials, and there was no opportunity for detainees or their representatives to provide evidence.

Greater use of alternatives to detention

1.21 There was strong support for the greater use of alternatives to detention.

Initial observations

1.22 It may be helpful if I offer some initial comments on the main areas covered by this review to provide some context for what follows.

Adults at Risk policy

1.23 In my original report I recommended radical changes to the existing guidance on immigration detention to take much greater account of the levels of vulnerability amongst detainees that I had found. The Home Office responded to this challenge by fundamentally altering its policy through the introduction in the Immigration Act 2016 of the AAR approach. This came into force in September 2016.

1.24 As I have said, in the written submissions to this review I was presented with much criticism of AAR – both as to its principles and its impact in practice. It was said that AAR had actually weakened the safeguards against inappropriate detention of vulnerable people, and that 'immigration factors' were allowed to outweigh vulnerability and risk. For its part, Home Office told me that AAR provided enhanced protection for vulnerable people, whilst achieving the right balance with legitimate issues of immigration control. I look at the implementation of AAR in more detail in Part 2 of this report.

1.25 In the early stages of this review, the definition of torture employed under AAR was the subject of a successful challenge by way of Judicial Review. Essentially, the High Court found that AAR itself was sound but that the definition of torture employed between September 2016 and December 2016 had been unlawful. The Home Office engaged with interested parties and, in March 2018, implemented the court judgment by laying statutory instruments in Parliament to introduce a new definition of torture. It also revised the statutory guidance on the Adults at Risk policy, which includes the new definition and clarifies the intention to provide an additional safeguard for those who do not fall within any of the vulnerability indicators listed in the policy. The revised policy will come into force on 2 July 2018.

Healthcare

1.26 Healthcare was central to my first review, and no issue caused me more concern than the levels of mental ill-health that I discovered.

1.27 Two years ago, I welcomed the benefits that had followed from NHS commissioning. The commissioning responsibilities have now passed fully to NHS England, in the expectation that clinician-led approaches will drive up the quality of care.

1.28 It is clear that much has been done to improve healthcare in IRCs, and plans are in place to continue this process. Nonetheless, there remain significant concerns about the current levels of demand and the provision of healthcare services. I have thus made additional recommendations related to evidence of performance and quality improvement, information sharing, environment, closer working, training, and capacity and capability.

1.29 I examine healthcare in detail in Part 3.

Caseworking reforms

1.30 A further major focus of my first report was on caseworking processes and detention decision making. Amongst other things, I wanted to see greater independence in that decision making.

1.31 In response, the Home Office has introduced new policies and procedures under the auspices of the Detained Casework Transformation Programme.

1.32 Included in the work undertaken by this programme are the following:

- Rolling out a gate-keeping process for all cases, with the aim of bringing a degree of internal independence into initial detention decision making
- Case progression panels, designed to introduce further internal independence into decision making and to add a safeguard against excessive periods of detention. Cases go before these panels at three-monthly intervals
- Pre-departure teams, intended to improve contact between caseworkers and detainees by increasing the presence of Home Office staff at IRCs with specific responsibility for helping detainees prepare for their return
- The establishment of an Adults at Risk Returns Assurance Team (ARRAT) to support the Home Office detained casework commands in managing potentially vulnerable adults through to return and making lawful decisions throughout any period of detention.

1.33 In addition, new Immigration Bail provisions set out in schedule 10 to the Immigration Act 2016 came into force on 15 January 2018. These include a duty on the Secretary of State to arrange for the First Tier Tribunal to consider whether to grant immigration bail after a specified period of detention, where there has been no previous judicial oversight. This 'auto-bail' arrangement takes place after four months (and any subsequent period of four months), but does not apply to ex-offenders facing deportation.

1.34 I look at the implementation of these caseworking reforms in Part 4 of this report.

Safer detention

1.35 I have also revisited the issue of safer detention (the prevention of suicide and self-harm) in the light of a recent increase in the number of apparently self-inflicted deaths in the IRC estate. There have been four such deaths since publication of my first report. I look at this in more detail in Part 5.

Oversight and staff culture

1.36 I consider issues of staff recruitment, retention, training and moral resilience in Part 6. I have drawn upon lessons from other services including the prisons, police and NHS. I have also considered how the processes for oversight and assurance can be strengthened.

Alternatives to detention

1.37 I commissioned what I believe to be the most extensive review of international research on Alternatives to Detention. A summary of that review and my own observations on the next steps the Home Office should take may be found in Part 7.

PART 2: GOVERNMENT RESPONSE TO MY EARLIER REPORT

2.1 The recommendations from my previous report are outlined at Annex 3. I also made a number of observations, short of formal recommendations, in particular concerning the individual IRCs I had visited.

2.2 The Home Office took a programme planning approach to my proposals, brigading the recommendations under strategy, policy, detained casework, healthcare, and major and minor operational. All of this was overseen by a steering committee, chaired at a senior level. The Home Office has provided me with a spreadsheet setting out progress on implementing my recommendations that I have reproduced at Annex 5.

2.3 I cover some of the subject areas in more detail in the following chapters of this review, but it is worth outlining some general comments at this stage. I have grouped the recommendations into the same categories that the Home Office has used in the spreadsheet.

Strategy

2.4 Recommendation 1 was that the Home Office prepare and publish a strategic plan for managing immigration detention.

2.5 The Home Office formally accepted this recommendation although I note that the actions are said to be ongoing. In his response to my original report the then Immigration Minister wrote:

> "Immigration Enforcement's Business Plan for 2016/17 will say more about the Government's plans for the future shape and size of the detention estate."

2.6 I have found no evidence that this has been done.

2.7 The Home Office has told me, however, that it believes the most significant strategic change since my first report is the priority now placed upon voluntary returns. From what I have seen during this second review, the promotion of voluntary returns still has a long way to go. But any shift in this direction is hugely to be welcomed, although I emphasise it must be on an individual basis rather than through the targeting of particular communities.

Recommendation 1: The Home Office should strengthen its promotion of voluntary returns.

2.8 The Home Office also pointed me towards its broader Immigration Enforcement strategy in support of its vision "to reduce the size of the illegal population and the harm it causes". Within this strategy is an assertion that detention is an essential part of the overall approach. However, nowhere is there any indication of a plan for the use of immigration detention to meet the Home Office's broader aims.

2.9 In particular, I am not aware of any work examining the number of beds needed to implement the wider enforcement strategy. More to the point, I have seen no analysis explaining why around 3,500 detention beds in the IRCs and prisons are regarded as necessary for the strategy to be successful. In the absence of such an analysis, the current system must be regarded as happenstance. Moreover, the size of the detained population is determined more by the available bedspace, rather than any in-depth analysis of need.

2.10 Likewise, it is not clear to me why around 450 beds are needed for female detainees. There has been a significant reduction in the overall number of male beds due to the closure of Dover, Haslar and The Verne, but this has not been matched in the female estate.[12] Given the levels of vulnerability amongst women in detention, this needs to be addressed as a priority.

2.11 Furthermore, the location and design of the immigration detention estate remains problematic. The estate has developed in a piecemeal fashion and there is little logic to the location of the IRCs – save those closest to the airports in the South East from where the majority of removals take place.

2.12 It is public knowledge that plans had been in place to close Dungavel and replace it with a smaller holding centre near Glasgow. Given the number of detainees in Dungavel with family ties in England, it remains an incongruous part of the estate (notwithstanding its generally good reputation).

2.13 However, new investment now promised in relation to the findings of my first review (see below, paragraph A7.64) is a commitment to its retention at least in the medium term. The plans for a short term holding facility in Glasgow encountered significant political opposition. The paradoxical consequence is that there will continue to be significantly more immigration detention in Scotland than would otherwise have been the case.

2.14 Assuming that the development of a third runway at Heathrow goes ahead, Harmondsworth and Colnbrook IRCs (together constituting Heathrow IRC[13]) will be demolished. The requirement for a replacement IRC is set out in a Department for Transport document, *Revised Draft Airports National Policy Statement: new runway capacity and infrastructure at airports in the South East of England*, October 2017 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/654123/revised-draft-airports-nps-web-version.pdf). Further details are in the document produced by Heathrow Airport, *Heathrow Expansion – Our Emerging Plans* (https://www.heathrowconsultation.com/wp-content/uploads/2018/01/2263-Heathrow-OEP-and-Annex-FINAL-RGB-200dpi.pdf) which says that a single replacement site will need to be identified, and four possible locations have been identified.

[12] Although I acknowledge that Yarl's Wood has not been running at full capacity.

[13] In this report, I have adopted the practice of HM Chief Inspector of Prisons in referring to Harmondsworth and Colnbrook as two institutions, albeit both are now managed jointly by the company Mitie Care and Custody as Heathrow IRC, and there is some cross-deployment of staff and just one joint Independent Monitoring Board.

2.15 If it is to be re-built, a new Heathrow IRC will offer an opportunity to look afresh at the nature and facilities available for those to be removed, and I was pleased to learn of some of the initial thinking. There are lessons to be learned from design failures of the past.

2.16 The key thing is that flexibility must be built-in to any new design. A multi-purpose prison like HMP Peterborough may provide some guide. This will allow for the certainty that needs will change over the lifetime of the building – in part, reflecting political decisions on the purpose of detention and any limits on its use. The Home Office should also plan for the contingency that, at some point in the future, the Prison Service may no longer be willing or have the capacity to provide hundreds of spaces for immigration detention, or the practice of using prisons (which has been criticised in many quarters) may become politically unacceptable.

2.17 What I do not think is in any doubt is that the houseblocks and perimeter security should be to category B standards (although I hope that security can be maintained with more subtlety than the reliance on razor wire that is such a feature of the current estate). Having conducted the Government's inquiry into the riot and arson at Yarl's Wood in 2002 that resulted in the almost total destruction of the then centre, I need no persuading of the dangers – not least to detainees themselves – if the fabric of the building is not robust. Public confidence is also a factor. The original buildings at Harmondsworth some 30 years ago were almost laughably insecure, and at the now closed Oakington there were some 64 escapes in 2003 alone.

2.18 But within the perimeter, or as an annex to the centre proper, it should be possible to have a range of different buildings offering different opportunities. The focus should be on activities that are consistent with the overall purpose of an IRC: to encourage return and best prepare people for life in their home country.

2.19 Issues such as room size and sharing, the amount of outside space, the range of activity spaces, the type of healthcare provision etc, should be addressed strategically, and in acknowledgement of the complexity of the population. I would hope it would be possible to canvass the views of former detainees on at least some of these matters.

Recommendation 2: The Home Office should develop a strategic plan for the type and scale of immigration estate it thinks necessary, bearing in mind the priority now attached to voluntary returns, so that the number and location of beds is proportionate to carrying out its wider aims.

Caseworking

2.20 I made a number of recommendations (20, 59-62) about the caseworking process, including the introduction of gatekeeping for all those entering detention, an independent element in decision making, and strengthening the legal safeguards against excessive use of detention. These were all accepted.

2.21 I welcome the progress in introducing improved safeguards, including the gatekeeper, case progression panels, the development of an Adults at Risk Assurance Team, and automatic bail consideration at the four-month point of all those not subject to deportation.

2.22 I examine these matters in Part 4. However, I must note that almost all of the safeguards against excessive use of detention are internal mechanisms – although of course it is open to individuals to apply for immigration bail. I am concerned that more needs to be done to ensure that individuals who are at risk should not be detained. While I welcome the improved internal oversight mechanisms, there remains a need for robust *independent* oversight of the caseworking process.

Policy issues

2.23 Much of the Home Office response to recommendations relating to vulnerability (Recommendations 9, 11, 12, 13, 14, 15, 16, 21 and 29) has been covered by the introduction of the Adults at Risk (AAR) policy. I address this in considerably more detail later in this chapter. I have no doubt that AAR is a genuine attempt to reduce the numbers of vulnerable people in detention, but I have concerns about the way in which it is currently operating in practice.

Healthcare

2.24 Recommendation 29 was that the Home Office and Department of Health should work together to consider whether current arrangements for safeguarding were adequate. In response, I am told that there remains a lack of clarity over relevant legislation and local authority responsibilities for vulnerable adults released from detention, but work is underway. I am also told that Standard Operating Procedures (SOPs) are being drafted to embed best practice and ensure clear ownership. This is welcome so far as it goes, but I am concerned that it is taking so long to clarify the organisational responsibilities. In the meantime, vulnerable people within IRCs lack the protections they would enjoy in the community.

2.25 Recommendation 45 invited the Home Office to seek the views of the Ministry of Justice and Department for Health on extending section 75 of the Sexual Offences Act 2003 to include IRCs, prisons and mental hospitals. The recommendation was implemented, but I have simply been told that consensual sex between detention staff and detainees is already illegal under the law relating to misconduct in public office. Given the pressure on Parliamentary time, I do not believe I can sensibly pursue this matter further.

2.26 Recommendation 48 was that Home Office staff should be reminded that, to ensure continuity of care, detainees should not be transferred when there is clinical advice to the contrary. DEPMU (Detainee Escorting and Population Management Unit) instructions now incorporate provisions for medical holds on transfer and removal where detainees are receiving treatment or are deemed unfit to fly. I am pleased to note this progress.

2.27 Recommendation 49 was that the Home Office and NHS England should promote the self-administration of drugs where risk assessments support that approach. I understand that what is termed an IRC medicines optimisation programme was agreed during 2016/17, and that mechanisms are in place to support the safe administration of medications across the estate. New standards were published in February 2017, and again I welcome the progress made.

2.28 Recommendation 50 also involved the Home Office in consultation with NHS England. It was to the effect that guidelines should be drawn up to confirm what informed consent looks like, and what information can be shared between all parties in the event that informed consent to the release of clinical information is granted by a detainee. I understand that a new Detention Services Order (DSO 01/2016) on medical information sharing was published in April 2016. However, staff interviewed during the course of this review seemed unaware of the DSO, with a likely knock-on effect on decisions by caseworkers.

2.29 Recommendation 51 called for an alternative to SystmOne to be pursued for those detention facilities not in England. I understand that this is not straightforward (manifestly, NHS England has no responsibility for commissioning in other parts of the UK), but I am concerned that there remain substantial difficulties in exchanging information when detainees move to and from Dungavel in particular.

2.30 Recommendation 53 focussed on the disturbing use of New Psychoactive Substances (NPS). I understand that workshops were held with suppliers in 2015 and a full NPS Action Plan was developed. Since then NHS England has commissioned bespoke training for IRC staff, with the aim of enabling staff to advise detainees of the effects of NPS. In response to the growing concern over NPS in prisons and IRCs, Public Health England (PH(E)) has also published a toolkit for staff, supported by a national training programme. IRC contractors and healthcare suppliers are now required to develop a joint local strategy for reducing and disrupting the supply of illegal substances, including NPS. (I say more on NPS in Part 3.)

2.31 Recommendation 57 was that talking therapies should become an intrinsic part of healthcare provision in IRCs. The recommendation fed into a revised specification of healthcare requirements published in September 2017.

2.32 Recommendation 52 concerned the filling of permanent healthcare vacancies in IRCs as a priority. This remains a problem. In this review I found that, to ensure adequate nursing provision, bank and agency staff were often required. The risk to continuity of care may be less than might otherwise be assumed as IRCs have access to a pool of staff who regularly work in the centres. However, I understand that NHS England is keen to avoid the use of short-term agency staff wherever possible, and is working with Health Education England to develop career pathways for all healthcare roles within the criminal justice system and IRCs. The NHS England Health and Justice team has commissioned a review of the current market, and management of recruitment and retention (which remains an acute concern across the entire NHS). While I am disappointed by the continued difficulties, I am pleased to note that a strategic approach has been developed.

2.33 Recommendation 55 was that the Home Office and NHS should conduct a clinical assessment of the level and nature of mental health concerns in the immigration detention estate. This work has been completed with delivery overseen by the IRC Assurance Group (NHS, Home Office, PH(E)). The audit was published by the Centre for Mental Health in January 2017.

Operational Recommendations

2.34 I made a number of operational recommendations in my first report and the responses to these in Annex 4 are mainly self-explanatory. I have combined the major and minor operational responses and address those where I think further comment is needed.

2.35 Recommendations 8, 17 and 22 directly concerned those immigration detainees held in prison post-sentence expiry. The Home Office has now established joint strategic and operational boards with HMPPS, part of whose role is to identify opportunities to concentrate foreign national offenders in fewer prisons. Although I encountered some opposition to foreign national offender-only prisons amongst prisoners in both HMP Huntercombe and HMP Maidstone (principally on the grounds that the policy was discriminatory), in general I think that specialism of this kind has more advantages than disadvantages.

2.36 Recommendation 8 was that the Home Office should review the adequacy of the numbers of immigration staff embedded in all prisons. In my meetings with officials in HMPPS during this review, it was felt that the numbers of immigration staff remained an issue. Following a review of the work of immigration staff based in prisons, I understand that the head of criminal casework in the Home Office has commissioned a detailed analysis of staffing with a view to ensuring the right numbers of staff in the right establishments. Ensuring there are sufficient immigration staff in contact with foreign national offenders while in prison custody is in the interests of successful removal, and should help in the identification of vulnerability.

2.37 However, it did not appear that staffing levels featured on any of the recent performance dashboards used at the joint Home Office/HMPPS board meetings, and this may be a missed opportunity.

2.38 In my visits to the three specialist foreign national offender prisons – Huntercombe, Maidstone and the female hub at Peterborough – I was greatly impressed by the care and compassion shown for prisoners by both staff and managers. Nonetheless, at Huntercombe I was concerned by the lack of work to prepare prisoners for return to their own countries. This was the view too of HM Chief Inspector of Prisons in a recent inspection report.[14] At Maidstone, I saw that valuable developments designed to prepare prisoners for return were not separately funded.

2.39 In his 2015 report on Maidstone (*Report on an unannounced inspection of HMP Maidstone (3 –14 August 2015)*), the Chief Inspector said that prison was a reasonably decent place where people were treated respectfully. Nonetheless he also found that:

> "The prison had not been designated a resettlement establishment and had comparatively few resettlement resources and a very weak focus on this key responsibility. The management of resettlement overall was poor and not well understood, with no local strategy or effective coordination of services."

2.40 On my visit to Maidstone, I was impressed that since this inspection the prison's management had invested considerable resources into resettlement. All prisoners had an interview on arrival to assess their skill levels and needs, to provide them with a peer mentor, and to discuss setting up arrangements for their return. This discussion drew upon a foreign-national tailored Virtual Campus facility providing information on the country to which prisoners were returning. However, this important activity was delivered without explicit funding, and I felt that further progress would be hampered as a result.

2.41 Prisoners should be helped, so far as is possible, to prepare for return to their own countries, and resources should be available to the specialist prisons to enable them to do this. While my remit in this review does not extend formally to the Ministry of Justice, my strong view is that foreign national offender-only prisons should be allocated sufficient resources to enable them to carry out resettlement work that prepares prisoners for their return. This is both in the prisoners' interests, but also a reflection of Britain's responsibilities to the countries (many of them much poorer than our own) to which the ex-offenders will be returned. I saw good examples of how this could be done at HMP Peterborough, where the contractor – Sodexo – itself funded a foreign national co-ordinator, who was clearly making a substantial difference to the lives of the women with whom he was working.

2.42 Recommendation 17 was that the Home Office consider establishing a joint policy with the then National Offender Management Service on provision for those held in prison under immigration powers. However, when I asked HMPPS officials about this, they were unable to point to anything beyond the fact that foreign national offenders were held under remand conditions post-sentence. While they were considering further work to improve access to legal advice, they were clear that the Home Office was responsible for overall policy. I

[14] The Chief Inspector said that managers and staff of Huntercombe should be praised for maintaining a safe, decent and purposeful institution that, in the main, treated its prisoners with respect. Nonetheless, he also said:

> "The key challenge the prison faced was how it was able to assist prisoners prior to their departure or release. In the six months before our arrival just 12 men had been released into the community. Some 185 had been deported, repatriated or sent to an IRC. Many of this latter group would be subsequently deported. Prisoners often arrived without a basic custody screening and developed resettlement services were lacking, except for the interest of a small number of supportive third sector organisations. Despite some prisoners posing significant risk, offender risk management and sentence planning was under-resourced and ineffective. Public protection arrangements were reasonable, especially in relation to prisoner released in the UK, but it was unclear how risk in general was being addressed. We have made a main recommendation to the Ministry of Justice (MOJ) that it clarifies Huntercombe's role in offender management and particularly how it deals with the risks posed by those to be released or deported." (*Report on an unannounced inspection of HMP Huntercombe (6-17 February 2017)*.)

remain of the view that it is unsatisfactory that the rights and regime of time-served foreign national offenders are so different to those held in IRCs (access to phones, the internet, fax machines, legal advice, etc).[15] I also want to see much more focus on preparation for removal, and on resettlement, and believe this requires a clear idea at a strategic level on the part of both the Home Office and HMPPS about what the objectives are. I therefore repeat this recommendation.

Recommendation 3: The Home Office should establish a joint policy with HMPPS on provision for those held in prison under immigration powers.

2.43 Recommendation 22 was that Detention Centre Rule 35 (or its replacement) should apply to those detainees held in prisons as well as those in IRCs. This was rejected on the grounds that a broadly equivalent provision (Rule 21) exists in the Prison Rules. (This provides that medical officers must report to the governor on the case of any prisoner whose health is likely to be injuriously affected by continued imprisonment or any conditions of imprisonment.) It was also pointed out that prisons have their own well-established healthcare provision, and mechanisms for reporting any concerns, and that the Adults at Risk policy applies to individuals held in prisons under immigration powers as well as to those in the immigration estate.

2.44 Following my discussions with senior prison officials, I am much less confident that Rule 21 is an adequate substitute. There are fewer full-time healthcare staff to make assessments, and less regular contact with detainees given the larger prison population numbers.

2.45 Indeed, I was unable to find any information on how often Rule 21 is used in prisons, and suspect that it is rare in the extreme.

2.46 Prisoners held under immigration powers may well be subject to wider vulnerability issues, and I do not believe the current system is likely to pick this up. This is a worrying gap and needs to be remedied.

Recommendation 4: I remain concerned about the position of detainees held in the prison estate and recommend that a policy be developed to equate to Detention Centre Rule 35.

Updating Guidance Recommendations

2.47 Recommendations 3 and 4 concerned the remedying of policy weaknesses identified in an audit attached to my original report. I am pleased to note that revised Detention Services Orders were published in May 2016 on the service of removal directions, property, blades, detainee risk assessment, and safeguarding children.

2.48 Recommendation 7 was that the discussion draft of the Short Term Holding Facility (STHF) Rules be published as a matter of urgency. The Home Office then carried out a targeted external consultation on a draft of the STHF Rules between February and April 2016. The consultation included the detention oversight bodies, interested NGOs and the relevant service providers. The draft Rules were revised, and further consultation was subsequently undertaken within the Home Office.

[15] Holding detainees in prisons has been criticised by the European Committee for the Prevention of Torture: "A prison is by definition not a suitable place in which to detain someone who is neither suspected nor convicted of a criminal offence." (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Factsheet March 2017 CPT/Inf(2017)3: Immigration detention). My own view is that the Home Office's reliance upon HMPPS in respect of at least some detainees is a sensible safeguard. I have not separately considered whether the current number held under the Home Office's Service Level Agreement with HMPPS is optimal.

2.49 The Rules were finally laid in Parliament on 27 March 2018, the same day as statutory changes to revise the definition of torture following the case of *Medical Justice & Ors v SSHD, EHRC intervening* [2017] 2461 (Admin)[16], in which the court declared that the use of a definition of torture based on the definition in Article 1 of the UN Convention Against Torture ('the UNCAT definition') in the Adults at Risk Statutory Guidance was unlawful. Both will come into force on 2 July 2018.

2.50 I think it is regrettable that the process for amending the STHF Rules has taken so long.

2.51 I note that the Rules provide that individuals may be detained in holding rooms for a maximum of 24 hours, although in exceptional circumstances this can be extended beyond that point. I am concerned about the possibility that holding rooms could be used for detention for more than one night, albeit rarely. While the holding rooms my team visited had improved significantly since my last report, the lack of suitable sleeping accommodation means they are not appropriate for stays beyond that period.[17]

Recommendations that were not accepted

2.52 Five of my original recommendations were rejected, one is under review and two have been deferred. I think it worth expanding on a few of these.

Detention of pregnant women

2.53 Recommendation 10 was that the Home Office amend its guidance so that the presumptive exclusion from detention for pregnant women be replaced with an absolute exclusion. The response was that this now formed part of the Adults at Risk policy, and a 72-hour time limit on detention of pregnant women had been enacted as part of Immigration Act 2016.

2.54 For my first review, the Home Office provided me with a snapshot over a five-month period between August and December 2015. These figures omitted any individuals detained at ports but suggested that 52 pregnant women were detained in IRCs, 29 of whom were detained for at least two months.

2.55 The Home Office has now provided me with updated management information for the period between July 2016 and November 2017, and the numbers are reproduced in Figure 2.1 below. These indicate that the change in the law has led to a significant reduction in the number of pregnant women detained. I do appreciate that it may not be immediately obvious that a woman is pregnant, especially at the border on entry to the United Kingdom. Nonetheless, I think it would assist decision making if the default position were to be an absolute exclusion of pregnant women from detention. Having said that, I do of course, very much welcome the change to the law and the subsequent reduction in overall numbers.

[16] https://www.judiciary.gov.uk/judgments/medical-justice-and-ors-v-secretary-of-state-for-the-home-department/.
[17] The rooms mostly had hard plastic loungers or seating similar to those found in airports and were not suitable for use beyond 24 hours.

Fig: 2.1: Pregnant Women entering detention[18]

Month	Removed	Released	Total
July 2016	0	3	3
August	0	5	5
September	2	2	4
October	0	3	3
November	2	4	6
December	2	5	7
January 2017	0	3	3
February	0	6	6
March	1	2	3
April	0	0	0
May	1	5	6
June	0	1	1
July	0	10	10
August	2	2	4
September	3	4	7
October	0	4	4
November	2	1	3
Total	15	60	73

Access to social media

2.56 Recommendation 30 proposed that the internet access policy should be reviewed with a view to increasing use of sites that enable detainees to pursue and support their immigration claim, prepare to return home, and enable them maximum contact with their families.

2.57 I was surprised and disappointed that this recommendation was originally rejected, and am very pleased to see it is now again under review. Permitting access to suitable sites would enable detainees to obtain up-to-date information about the countries to which they are returning, and allow them to plan more effectively for their eventual journey. This is particularly important as many of those detained have been in the UK for a long time. The inability to access certain sites can also add to detainees' feelings of isolation and limit their opportunities for support or legal advice.

2.58 It remains the case that there is no security objection on the part of centre operators to such sites,[19] assuming local risk assessments remain in place. One senior manager remarked that controlled access to social networking sites for the reasons outlined above would pose fewer risks to the security of the establishment than those associated with social visits.

[18] Data provided on the basis of internal management information, validated against the Home Office caseworking database. Number of pregnant women held under immigration detention in an immigration removal centre or residential short term holding facility between 12 July 2016 (implementation of Section 60 of the Immigration Act) and 30 November 2017. This data has been provided by and assured by the Home Office's Performance Reporting & Analysis Unit (PRAU). The data have been provided for comparative purposes only and contain previously unpublished datasets. Official Home Office statistics are published quarterly based on reconciled and quality assured data. Numbers can change, especially when drawn from live caseworking systems.

[19] When I visited HMP Thameside, I discovered that the in-cell technology was to be refreshed during 2018 to include a capability for Skype. I was told it has already been used in HMP Grampian in Scotland, and is allowed by the Australian authorities at its Christmas Island Immigration Detention Centre.

2.59 I continue to be of the view that there is no rational case for continuing the blanket ban on these services, or for preventing access to websites that support detainees in their immigration claims, help prepare them for return, or facilitate contact with their families and friends. Indeed, from that point of view the current restrictions may actually be counter-productive.

2.60 I also saw examples in my visits where individuals who were deemed at risk of self-harm or suicide (i.e. those on open Assessment, Care in Detention and Teamwork – ACDT – documents) would have benefited immeasurably from regular contact with their families, particularly their children. In two cases in particular, it was the lack of contact with children that seemed to be a prime factor in their risk of self-harm. In one case, I was told that the man's young son had told his detained father that he had rejected him as he was never at home. This was understandably very distressing for the man concerned, and face-to-face contact via social media might have alleviated this and reduced his vulnerability.

2.61 Amending the current approach to one that is based on an individualised risk assessment would, in my view, immediately help to enhance welfare provision. It would also have the potential to facilitate returns by helping to restore, maintain and strengthen links between detainees and their countries of origin.

Recommendation 5: I repeat my recommendation that the internet access policy should be reviewed with a view to increasing access to sites that enable detainees to pursue and support their immigration claim, to prepare for their return home, and to maximise contact with their families.

2.62 In my previous review, I recommended closing IRC receptions for some period at night. This recommendation was rejected on the basis that it was an operational necessity for night-time movements at IRCs used for removals, and qualitative work had indicated there would be a detrimental detainee impact due to increased time in vans, holding rooms and police cells. However, I continue to be concerned about at least some night-time moves given the impact of late arrivals on detainee wellbeing, on the quality of the information on vulnerability gleaned in the reception process, and on the availability of medical support. I was told throughout my visits that detainees can still arrive at IRCs late into the night, including on transfers within the estate for what seemed to be reasons of operational convenience. The management of the existing contractor, Tascor, noted that they were now rejecting 10 per cent of night-time moves on welfare grounds.

2.63 My recommendations about night-time closures and the number of transfers between IRCs and STHFs will be subject to the new escorting contract that is due to come into force later in 2018. I strongly encourage the new contractor, Mitie Care and Custody, and the Home Office to work together to end unnecessary night-time transfers within the estate.

2.64 I was told by Tascor that the location of STHFs and IRCs across the country contributed to night-time moves and the length of the journeys involved, and believe that the location of STHFs should form part of the Home Office's wider strategic look at immigration detention that I have recommended. It was suggested to me that an alternative (and cheaper) course would be to make greater use of certain police stations, although the use of police stations presents its own problems, not least in how they are perceived by detainees.

2.65 I was pleased to learn that there would be a partnership model for the new escorting contract in which the Home Office will work closely with new contractor to ensure that a reliable and effective service is delivered. This approach should also facilitate welfare improvements.

2.66 I also welcome what I have been told about improvements in training for escort staff, including the design and delivery of all safeguarding training by an independent training provider.

2.67 Members of my team observed a charter flight from London to Nigeria and Ghana (see Annex 8 for full details), where they saw examples of good practice by escort staff who quickly formed rapport with detainees and de-escalated situations with skill. However, they also saw examples of what could be considered to be the intimidatory crowding of detainees by the escorts. My colleagues were also concerned by an apparently complacent approach to the transfer of risk information. The muster briefing focussed on the high level of general risk expected, but did not mention individual risk (beyond saying that such information was held by coach commanders and staff could ask to see it if they wished) or reinforce the importance of de-escalation. Few staff had sight of the risk assessment document giving details on each detainee, and the document itself was of a poor standard. On the flight itself, my colleagues were also dismayed by the handling of a medication transfer issue (see paragraph A8.11).

The detention estate

2.68 Since my previous review there have been a number of changes to the immigration detention estate, in particular, the closure of The Verne and Dover, and Cedars pre-departure accommodation. This has reduced the overall capacity to around 3,500, a reduction of some 25 per cent, albeit exclusively in places for men. Figure 2.2 below updates the information in paragraph 2.12 of my first report, with the original bedspace figures (if different) shown in brackets.

Fig 2.2: Detention Estate capacity

Contract	Service Supplier	Contract Length[20]	Bedspace Capacity[21]	Healthcare Provider
Brook House IRC	G4S Custodial & Detention Services	8	508 (448)	G4S Medical Services
Campsfield House IRC	MITIE Care & Custody	8	282	Care UK Health and Rehabilitation Services
Cedars PDA (part of Tinsley House contract)	G4S Custodial & Detention Services	6	Closed 31 Dec 2016	G4S Medical Services
Dover IRC	HM Prison Service	5	Closed Nov 2015	Integrated Care 24
Dungavel IRC	GEO	8	249	Med-Co Secure Healthcare Services
Heathrow IRCs (Colnbrook and Harmondsworth are run as one site)	MITIE Care & Custody	11	1,065 (1,061)	Central North West London NHS Foundation Trust (CNWL)
Morton Hall IRC	HM Prison and Probation Service	5	392	Nottingham Healthcare NHS Foundation Trust
Tinsley House IRC	G4S Custodial & Detention Services	8	162 (153 – additional beds due to closure of Cedars)	G4S Medical Services
The Verne IRC	HM Prison Service	5	Closed 31 Dec 2017	Dorset Healthcare University Foundation Trust
Yarl's Wood IRC	Serco	8	410	G4S Medical Services
HMPPS Service Level Agreement	HM Prison and Probation Service	5	400	n/a
Larne House STHF	Tascor E & D Services Limited[22]	7	19	Mitie Medical Services Limited
Pennine House STHF	Tascor E & D Services Limited[23]	7	32	Spectrum(Closed March 2017; a replacement is planned to reopen in June 2018)
Escorting Services	Tascor E & D Services Limited[24]	7	n/a	IPRS (sub-contractor to Tascor)
Total No of Bedspaces			3,519 (4,916)	

2.69 During this review, I conducted visits to all IRCs as well as a number of short-term holding facilities and prisons. The purpose of these visits was threefold:

- to review progress on my previous suggestions for each establishment
- to review how steps taken to implement my previous system-wide recommendations had affected operations; and
- to investigate four of my deep-dive areas, namely healthcare, casework, safer detention, and oversight and staff culture.

[20] Without possible extensions.
[21] Maximum numbers as per contracts. Bed capacity can be affected by room usage, accommodation issues, etc.
[22] Mitie Care and Custody Limited is replacing Tascor E & D Services Limited from 1 May 2018.
[23] Footnote 22 also applies.
[24] Footnote 22 also applies.

2.70 A record of my updated impressions is attached at Annex 7.

2.71 My overall conclusion was that conditions in the immigration estate had improved since my earlier review.

2.72 I was encouraged that action had been taken to address many of my proposals. The old induction unit at Colnbrook now had half its previous occupancy level, and Colnbrook's assessment and integration unit had been removed. Campsfield's care and separation unit had been somewhat improved and the smoking cage dismantled. Dungavel was shortly to undergo a large-scale refurbishment. Cedars had been closed and the new pre-departure accommodation at Tinsley House was broadly appropriate and much more cost-effective. Yarl's Wood had improved its culture and regime. The holding rooms in Heathrow terminals 2, 3 and 4 had been upgraded.

2.73 I saw some examples of good practice in particular centres that would be valuable to roll-out more broadly; in particular, the regular multidisciplinary complex case review meeting at Harmondsworth and Colnbrook. Uniquely, caseworkers were dialled into this meeting, helping to bridge the gap between casework decisions and the individuals those decisions concerned.

Recommendation 6: Weekly multi-disciplinary review meetings should be held at all IRCs to review and progress cases and ensure appropriate care for the most vulnerable individuals in each centre. These meetings should include a range of managers and staff, and crucially should involve the dialling in of the relevant caseworker for each detainee discussed.

2.74 I spoke with management and staff across the estate whom I judged were committed to making the best of the facilities available. However, the efforts of staff were hampered by a number of factors. The estate is overcrowded and there are too many individuals crammed into each centre.

2.75 I was disappointed that the suggestion in my previous review that the Home Office should stop the planned introduction of a third bunk in some rooms at Brook House had been rejected. I did not find conditions in those rooms remotely acceptable or decent.

2.76 There were other centres where the Home Office's strategy of expanding capacity by adding extra beds into existing rooms had exacerbated overcrowding and created unacceptable conditions. Campsfield, although well-regarded generally, had rooms that were not decent. This was exemplified by one room with seven very narrow beds, clothes hanging from bunks, and poor ventilation. To be frank, it resembled a doss house.

2.77 In some centres, such as Brook House, Colnbrook and Harmondsworth, overcrowded, cell-like rooms with prison doors had the unacceptable feature of in-room toilets separated only by a curtain. It is troubling that such an arrangement was deemed acceptable when these institutions were designed and commissioned just a decade or so ago. In light of a recent High Court ruling relating to Brook House[25], these conditions must be addressed. The Home Office has accepted the ruling and is putting in place measures to prohibit the practice of smoking inside immigration removal centres. In his ruling the case judge did not deem the practice of restricting detainees to their rooms as unjustified, and the impact is being assessed by the Home Office.

[25] *Queen on the application of Mohammad Ahmed Hussein and Muhammad Rafiqur Rahman and Secretary of State for the Home Department and G4S and National Council for Civil Liberties ("Liberty")* [2018] EWHC 213 (Admin).

2.78 Separately, I was concerned about inconsistent facilities across the immigration estate. The number of detainees per room varied from single rooms at Morton Hall to the room for seven men I found at Campsfield. The only inpatient bed provision is at Harmondsworth, with no beds at Yarl's Wood (and many of the other centres). Likewise, the provision of care suites still varied across the estate.

Recommendation 7: No immigration detention facility should be built in future with a barely screened toilet inside a shared room, and this set-up should be upgraded in all existing facilities.

Recommendation 8: In future, capacity in the immigration estate should not be increased by adding extra beds to rooms designed for fewer occupants. Where this has already occurred (e.g. Campsfield House, Brook House), these extra beds should be removed, and capacity reduced or extra space created.

2.79 In many IRCs, I felt the regimes were unnecessarily restrictive, with extended night-time periods when detainees were locked in their units or – where there were toilets within rooms – locked in the rooms themselves. In some centres, I was disappointed to learn that the lock-down period had been extended, presumably due to staffing requirements. In this respect, Campsfield and Tinsley House demonstrated best practice: the rooms themselves were not locked and detainees retained access at all times to showers and toilets in their units. Moreover, at Campsfield the units were not locked overnight until 23:00. This is far more decent than the situation in other IRCs, and the proportion of FNOs at Campsfield shows that it is possible to manage diverse populations within relatively open conditions.

Recommendation 9: Detainees should have improved access to facilities on their units at night, and night-time lock-in periods should begin as late as possible.

2.80 Reception areas in many IRCs were inadequate, particularly in their inability to ensure privacy for detainees as they were checked-in. In the overnight reception at Yarl's Wood observed by a member of my team, women were asked questions relating to their vulnerability while sitting within earshot of others. I was, however, impressed by the reception space at Harmondsworth, and by Tinsley House's arrangement whereby men waited in a separate waiting room and only one entered reception itself at a time. Although I recognise this would be challenging in centres with a higher throughput, it is something that other IRCs should investigate.

2.81 In some cases staff felt unsafe as a result of staffing levels, particularly when constant watches took some staff off the units. In one case – on a wing at Brook House – there seemed to be a lack of control as a result. (I should acknowledge that Brook House was actively recruiting to increase staff and management levels.) Observations at other centres, such as at Yarl's Wood during my team member's overnight visit, and Harmondsworth when a colleague observed a night-time charter collection, raised concerns that current staffing levels are not sufficient to cope with any unforeseen circumstances.

2.82 At the time I visited Yarl's Wood, I was disappointed that the overall targeted proportion of 60 per cent female staff had not been reached, although I understand that the proportion of female staff on women only residential units is considerably higher.[26] All three staff on reception were male during the night my colleague carried out observations and, while female officers were called to conduct any searches, this should not be the case.

[26] In evidence to the Home Affairs Select Committee on 20 March 2018, it was stated by Serco managers that in the two residential units that are female-only, 88 per cent of the staff who work on one unit are female with 100 per cent on the other. In the units overall, 57 per cent of staff are female and 43 per cent male.

2.83 While the large outdoor space at Morton Hall poses issues for security, at all other centres I was again struck by the lack of access to the outside. In particular, I was concerned that the recommendation in my previous review to ensure ready access to the outside for women held in the Sahara unit at Colnbrook had not been heeded.

2.84 I was pleased to learn that Morton Hall tracked its detainees' length of time in detention by including time in other institutions. This should be replicated across the estate given its implications for detainees' vulnerability. Morton Hall was also notable for its education provision. It was the best I came across on my visits, with courses focussed on skills that could be used outside the centre and designed in a modular format. While Harmondsworth had ambitions to launch such a programme, they had not yet been able to recruit and thus at the time of my visit there was little education provision at all.

2.85 Across all IRCs, I felt that information on easing the process of leaving the UK was lacking. I commend the resettlement services provided by the charity, Hibiscus. These were highly valued and should be extended.

2.86 As already noted, the holding rooms in the Heathrow terminals had improved markedly as a result of recent refurbishment. While I understand that the inflatable beds that I suggested for these holding rooms in my previous review proved unpopular, I do not consider the narrow, hard plastic loungers in place in many of the holding rooms to be sufficient. The cushioned loungers in the Heathrow Terminal 2 holding room were far preferable. Privacy in the reception and search areas also remained a concern. The Terminal 4 search area had been mistakenly located outside the secure area and could not be used. Instead – as in other search areas we saw – an inappropriately short curtain was in use. This highlights the importance of staff consultation ahead of capital investment. The Terminal 5 holding rooms needed attention, particularly the location and size of the family room – which required occupants to enter the main room to use all facilities and lacked a shower.

2.87 As is too often the case, I felt there was a lack of provision for older children in the airport and reporting centre holding rooms.

2.88 While the Larne House residential STHF was in the best condition of all the facilities seen during this review, I am concerned by the austere bedding and the apparent absence of any immigration advice during what could be a detainee's five-day stay. I would strongly encourage the Home Office to provide immigration surgery opportunities for detainees held at Larne House, potentially via video-conferencing link.

2.89 The reporting area at Becket House was not fit for purpose: it was far too small for the numbers involved, and a queue snaked around the block. It was also entirely unsuitable for conversations around vulnerability (or, for that matter, around voluntary departure).

Population

2.90 At my request, the Home Office has provided updated figures on the tables I used in my last report. The most significant change affecting these figures has been the decision in July 2015 to suspend the Detained Fast Track (DFT) process. This followed a High Court decision, upheld by the Court of Appeal, that the 2014 Fast Track Rules for appeals were *ultra vires*.

2.91 Following the suspension of DFT and the discontinuance of the 'quick decision' basis for DFT detention, a new process has been introduced for deciding asylum claims for those in detention. These cases are managed by the Detained Asylum Casework (DAC) team. I am

told that the majority of those people managed by DAC have claimed asylum only after being detained for removal (and so most cases entering the detained asylum process should have been removable, but for the consideration of the asylum claim).[27]

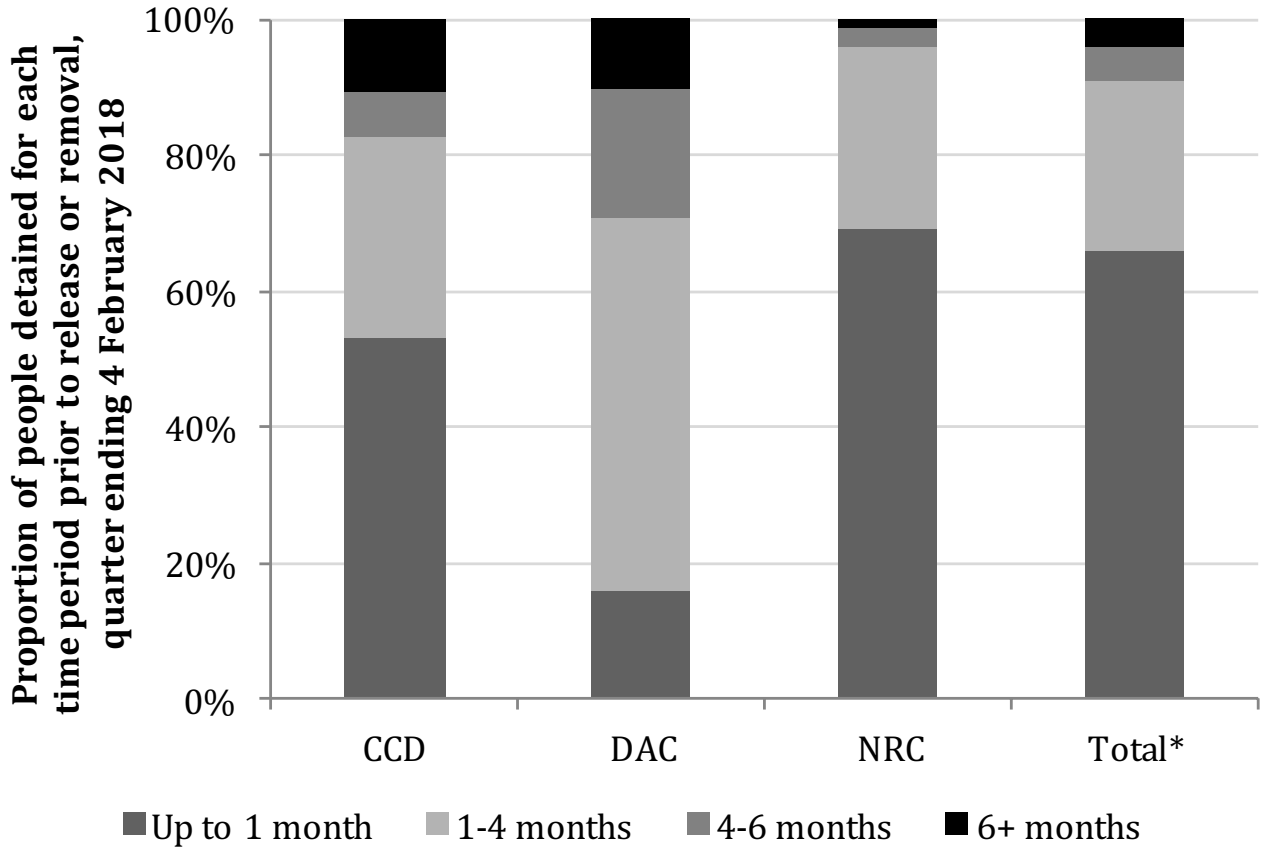
2.92 The Home Office has provided me with a snapshot of those held in detention at the beginning of February 2018. It is worth comparing these figures with those in March 2015 when I began my first review. In March 2015, 3,532 people were in immigration removal centres. At the beginning of February 2018, the population of the IRCs was 2,332, a reduction of 34 per cent. (There were an additional 383 foreign national offenders detained under immigration powers in prisons beyond their release date for whom there is no historic data with which to compare.) Of the total in IRCs in February 2018, there were 2,050 men and 282 women.

2.93 In the three months to February 2018, 45 per cent of those leaving detention were removed from the UK. This is an increase on the figures when my first report was published (42 per cent). However, it is apparent that more than half of those subject to immigration detention are eventually released back into the community. I remain of the view that, very frequently, detention is not fulfilling its stated aims.

2.94 At the end of December 2017, of those currently held in detention (excluding those held in prison), 305 people had been held for over six months, compared to 275 at the beginning of January 2016, despite the decrease in the overall number detained. The number of asylum seekers held for more than half a year had actually increased from 35 to 64 (i.e. by over 80 per cent, albeit the actual numbers remain small). This is largely explained by the loss of the Detained Fast Track and its replacement by a separate cohort of cases managed by Detained Asylum Casework, the majority of whom have claimed asylum whilst in detention. The length of detention thus includes the period before the asylum claim was made, but this remains an area of concern. Figures 2.3 and 2.4 show the length of detention prior to release or removal. They indicate that 29 per cent of those managed by DAC and 17 per cent of those detainees assigned to Criminal Casework are detained for over four months before leaving detention. In the quarter ending 4 February 2018, 34 people were released or removed from detention having been detained for 12 months or more.

[27] There is much cynicism within the Home Office about such claims. However, it is also the case that many detainees may not have realised that their circumstances could give rise to an asylum claim until receiving legal advice in detention.

Fig. 2.3: Time spent in detention prior to release or removal by Home Office casework area, quarter ending 4 February 2018[28]

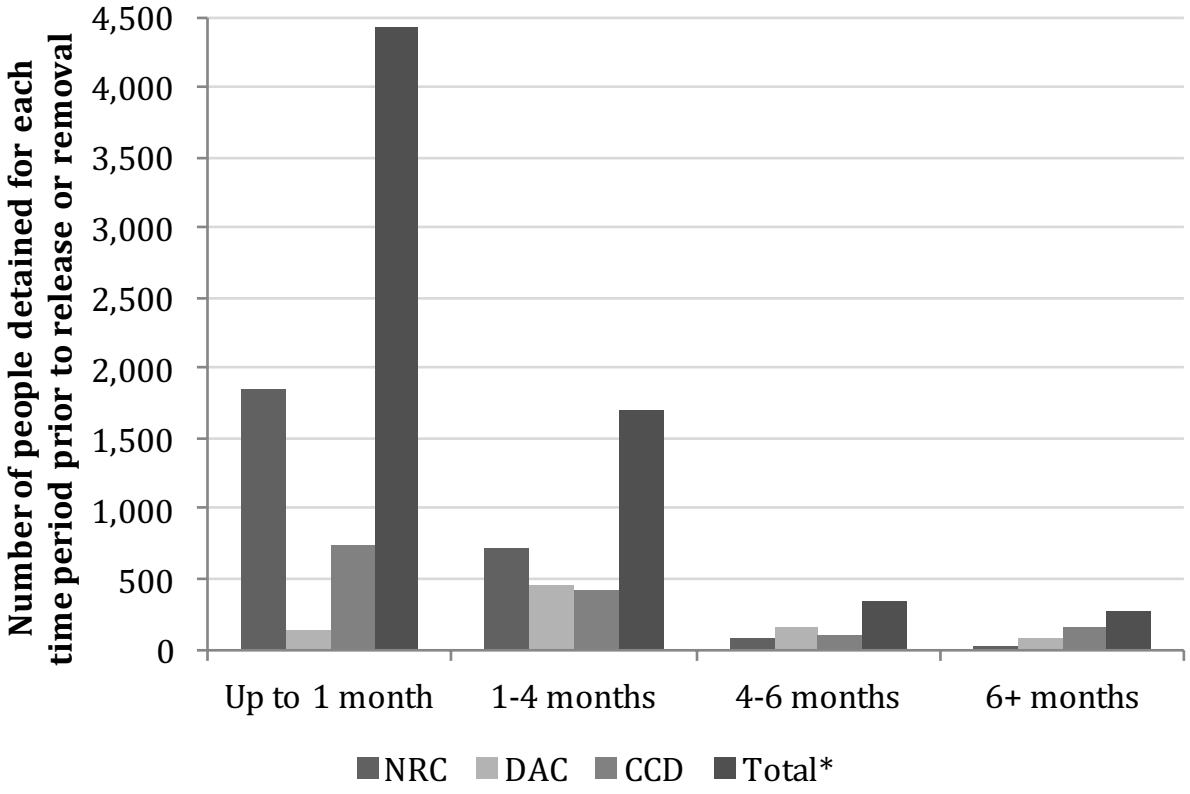


*Total is heavily impacted by Border Force cases who do not enter IRCs.

(Note: Excludes those recorded as being held in prison; Home Office casework area is given as at the date the detention period ended. DAC cases may well have previously been managed in another area of casework.)

[28] The statistics have been taken from a live operational database and, as such, numbers may change as information is updated.

Fig. 2.4: Time spent in detention prior to release or removal by Home Office casework area, quarter ending 4 February 2018[29]



* Total is heavily impacted by Border Force cases who do not enter IRCs.

(Note: Excludes those recorded as being held in HM Prisons; Home Office casework area is given as at the date the detention period ended.)

2.95 I thought it might be instructive to update the tables I produced in my first report. These tables show average time spent in detention for those either released or successfully removed from the country. It should be noted that the average bed nights per release has remained relatively unchanged, although it has increased for those claiming asylum now managed by DAC. The average nights detained per removal has decreased in overall terms although it has increased for those claiming asylum.

Fig 2.5: Average Bed Nights per Release

Average Bed Nights per Release[30]	Mar-15	Jan-18
National Removals Command (NRC) total	38	31
Third Country Unit (TCU)*	53	17
Operation Nexus*	152	90
Criminal Casework	125	120
Detained Asylum Casework (previously DFT cases)	63	89
Other	3	–
Border Force	13	10
Total estate	44	46

* Numbers are small and should be treated with caution.

[29] Footnote 28 also applies.

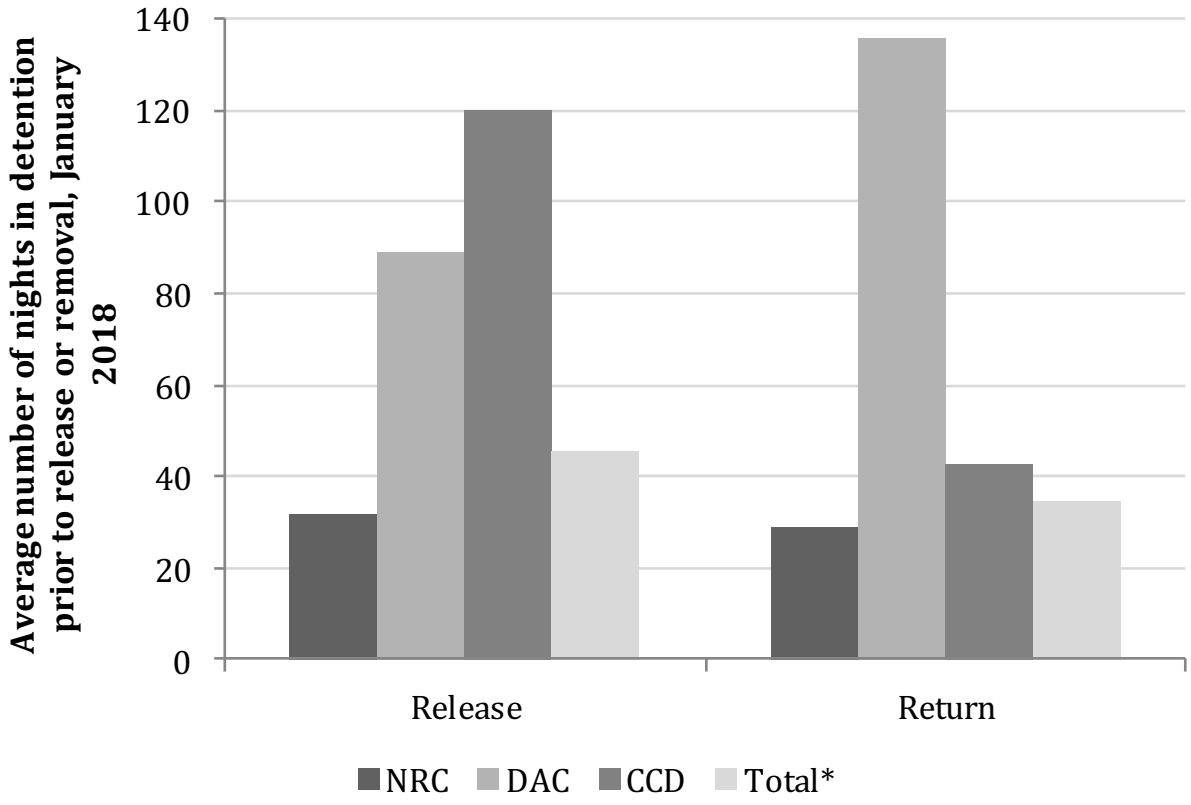
[30] For consistency with other data provided, those recorded as being held in prison have been excluded from the figures. Where occupancy figures are small (<50) for particular categories, averages should be treated with caution and are indicated by an asterisk. These statistics have been taken from a live operational database and, as such, numbers may change as information is updated.

Fig 2.6: Average Bed Nights per Removal

Average Bed Nights per Removal[31]	Mar-15	Jan-18
NRC total	43	29
TCU*	49	13
Operation Nexus	75	55
CC	38	42
DAC (previously DFT cases)	115[32]	136
Other	12	–
Border Force	5	3
Total estate	**44**	**35**

* Numbers are small and should be treated with caution.

Fig. 2.7: Average number of nights in detention prior to release or removal, January 2018[33]



* Total is heavily impacted by Border Force cases who do not enter IRCs.

(Note: Excludes those recorded as being held in prisons; Home Office casework area is given as at the date the detention period ended.)

2.96 The updated tables also show there has been a significant decrease in the number of men held in immigration detention across all areas (36 per cent decrease), with the most significant decrease being seen in the number of those claiming asylum (45 per cent decrease). The number of women in detention has also reduced, although the reduction is much less marked (10 per cent decrease). I also note that there has been an increase in the number of women detained while their asylum claims are processed (20 per cent increase).

[31] Footnote 28 also applies.
[32] Previous figures in this and subsequent tables for DAC refer to those detained under the former Detained Fast Track system.
[33] Footnote 28 also applies.

Fig 2.8: No. of Men Detained[34]

No. of Men Detained	Mar-15	04-Feb-18
NRC	1,111	699
TCU	165	30
Operation Nexus	62	71
CC	939	753
DAC (previously DFT cases)	798	440
Other	61	13
Border Force	83	44
Grand Total	**3,219**	**2,050**

(For consistency with other data provided, those recorded as being held in prison have been excluded from the figures).

Fig 2.9: No. of Women Detained[35]

No. of Women Detained	Mar-15	04-Feb-18
NRC	162	137
TCU	4	2
Operation Nexus	1	2
CC	48	33
DAC (previously DFT cases)	75	90
Other	3	2
Border Force	20	16
Grand Total	**313**	**282**

(For consistency with other data provided, those recorded as being held in prison have been excluded from the figures).

2.97 Figure 2.10 shows average length of time in detention for those currently detained. The most welcome feature of the table is that it shows that average time in detention has fallen by eight days (nearly 9 per cent) since early 2015. The table also shows that those assigned to criminal casework continue to spend the longest time in detention, but the average time has also fallen significantly. In contrast, there has also been an increase in the length of detention for those claiming asylum, but I believe this again should be read in the context of changes to the processes for those claiming asylum from detention.

Fig 2.10: Average Bed Nights per Currently Detained[36]

Average Bed Nights per Currently Detained	Mar-15	04-Feb-18
NRC total	41	31
TCU	46	11
Operation Nexus	205	122
CC	162	130
DAC (previously DFT cases)	88	102
Other	–	–
Border Force	53	6
Total Estate	**91**	**83**

(Data based on those in detention as at 4 February 2018. For consistency with other data provided, those recorded as being held in prison have been excluded from the figures. Methods of calculating average detention times have changed since my first report. The figures have been adjusted so that the data are comparable).

[34] Footnote 28 also applies.
[35] Footnote 28 also applies.
[36] Footnote 28 also applies.

2.98 As the following tables demonstrate, the number of detainees who are released from detention continues to exceed those who are removed (albeit some of those released may be subsequently re-detained and may then be removed at a later date). I do understand that the very act of detention and impending removal can precipitate legal challenge, and there does appear to have been a greater willingness to consider release more promptly when someone is no longer suitable for detention. Nonetheless, in the quarter until 4 February 2018, only 45 per cent of those leaving the detention estate were removed from the country – the rest were released. While I welcome the overall decrease in the numbers of those detained, these figures continue to call into question the extent to which the current use of detention is cost effective or necessary.

Fig 2.11: No. of People Released[37]

No. of People Released	Mar-15	Monthly average in quarter to 4 Feb-2018
NRC	654	511
TCU	87	71
Operation Nexus	11	22
CC	104	165
DAC (previously DFT cases)	225	210
Other	213	188
Border Force	58	58
Grand Total	**1,352**	**1,225**

(For consistency with other data provided, those recorded as being held in prison have been excluded from the figures).

Fig 2.12: No. of People Removed[38]

No. of People Removed	Mar-15	Monthly average in quarter to 4-Feb-17
NRC	452	381
TCU	61	26
Operation Nexus	26	21
CC	385	301
DAC (previously DFT cases)	155	60
Other	57	5
Border Force	211	224
Grand Total	**1,347**	**1,019**

(For consistency with other data provided, those recorded as being held in prison have been excluded from the figures).

2.99 I note that there has been a small reduction in the overall number of women in detention. However, I still have significant concerns. Although it is rarely full, the biggest determinant of the number of women in detention is the capacity of Yarl's Wood. Moreover, the figures provided by the Home Office suggest that very high numbers of detainees who go on to claim asylum – no fewer than 84 per cent – are subsequently released. Given what I have also seen as significant vulnerability levels, I cannot find any justification for the current levels of detention of these women.

[37] Footnote 28 also applies.
[38] Footnote 28 also applies.

2.100 In their report *We are still here* published in October 2017, Women for Refugee Women made the following observations based on a sample of 26 women who had been detained at Yarl's Wood:

- Despite Adults at Risk, survivors of sexual and gender-based violence were routinely being detained
- Women who were already vulnerable as a result of sexual and gender-based violence were becoming even more vulnerable in detention
- Survivors of sexual and gender-based violence were being detained for significant periods of time
- Some pregnant women were still being detained unnecessarily.

2.101 While this was a very small sample, it chimes with my experience when meeting a group of women who had been detained at Yarl's Wood. They had been held for between three to eight months before being released. I had no doubt when listening to their accounts that all had been damaged by the experiences of detention and carried it with them on release.

Recommendation 10: While the recent decrease in the overall number of women in detention is welcome, the Home Office should at the earliest opportunity take further steps to identify women who claim asylum in detention and whose case would be better processed in the community.

Adults at Risk Policy

2.102 In my first report, I recommended changes to the existing guidance on immigration detention to ensure much more attention was paid to vulnerability. The Home Office responded with the Adults at Risk (AAR) policy, in essence, a development of recommendations 9 -16 of my original report. Specifically, it brought within the definition of vulnerability (in the context of immigration detention) groups of individuals such as those with learning difficulties, those suffering from PTSD, victims of sexual or gender-based violence, and transgender people. The intention was to create a more dynamic approach to changing circumstances, as I had recommended.

2.103 However, AAR also represented a different approach to detention. Instead of the principle of detaining vulnerable people only in "very exceptional circumstances" (as had been the case under the previous policy), AAR is based on balancing evidence of risk against immigration considerations, and detaining only when the latter outweigh the former.

2.104 As the implementation of AAR forms a key part of the response to my original report, I will outline below the principles upon which the policy is based. (This is taken from the guidance issued to caseworkers making decisions on detention.)

2.105 AAR came into effect on 12 September 2016. The main principles are as follows:

- The intention is that fewer people with a confirmed vulnerability will be detained in fewer instances and that, where detention becomes necessary, it will be for the shortest period necessary[39]
- There will be a clearer understanding of how the government defines 'at risk' and how those considerations are weighed against legitimate immigration control factors to ensure greater transparency about who is detained and why

[39] See the foreword to *Improving Mental Health Services in Immigration Detention: An Action Plan* where the relevant Home Office and Department of Health Ministers signed up to this objective.

- Individuals should leave the UK when they have no permission to enter or stay in the UK. The Government expects individuals to leave the UK on the expiry of any valid leave they may have, and to comply with any requirement or instruction to leave the UK
- For the purposes of removal, individuals can be detained if there is a realistic prospect of removal within a reasonable timescale and if there is evidence which suggests that the individual would not be likely to be removed without the use of detention
- Detention will not be appropriate if an individual is considered to be at risk in the terms of this guidance unless and until there are overriding immigration considerations
- Consideration will need to be given to the weight of evidence in support of the contention that the individual is at risk, and the level of risk that is supported by the evidence
- Assessment of risk is based on the evidence available, ranging from a self-declaration of risk to authoritative professional opinion. The level of evidence available dictates the level of evidence-based risk into which any given individual will fall
- Where professional evidence is not immediately available, but where observations from Home Office officials lead to a belief that the individual is at a higher level of risk than a simple self-declaration would suggest, an individual can be allocated to a higher risk category in the terms of this guidance on the basis of that observational evidence
- In each case, the evidence of risk to the individual will be considered against any immigration factors to establish whether these factors outweigh the risk
- The greater the weight of evidence in support of the contention that the individual is at risk, the weightier the immigration factors need to be in order to justify detention.

2.106 The guidance says that an adult will be regarded as being at risk:

> "if they declare that they are suffering from a condition, or have experienced a traumatic event (such as trafficking, torture or sexual violence), that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention; or if a case owner considering or reviewing detention becomes aware of medical or other professional evidence, or observational evidence, which indicates that an individual is suffering from a condition, or has experienced a traumatic event (such as trafficking, torture or sexual violence), that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention. In these circumstances the individual will be considered as an adult at risk whether or not the individual has highlighted this themselves."

2.107 On the basis of the available evidence, the Home Office case owner will reach a view on whether a particular individual should be regarded as being at risk. Once an individual has been identified as being at risk, caseworkers are to consider the level of evidence available in support, "and the weight that should be afforded to the evidence in order to assess the likely risk of harm to the individual if detained for the period identified as necessary to effect their removal":

- a self-declaration of being an adult at risk should be afforded limited weight, even if the issues raised cannot be readily confirmed. Individuals in these circumstances will be regarded as being at evidence Level 1

- professional evidence (e.g. from a social worker, medical practitioner or NGO), or official documentary evidence, which indicates that the individual is an adult at risk should be afforded greater weight. Individuals in these circumstances will be regarded as being at evidence Level 2
- professional evidence (e.g. from a social worker, medical practitioner or NGO) stating that the individual is at risk and that a period of detention would be likely to cause harm – for example, increase the severity of the symptoms or condition that have led to the individual being regarded as an adult at risk – should be afforded significant weight. Individuals in these circumstances will be regarded as being at evidence Level 3.

2.108 The policy says there are a number of factors or experiences indicating that an individual may be particularly vulnerable to harm in detention. These include:

- suffering from a mental health condition or impairment
- having been a victim of torture
- having been a victim of sexual or gender-based violence, including female genital mutilation
- having been a victim of human trafficking or modern slavery
- suffering from post traumatic stress disorder (which may or may not be related to one of the above experiences)
- being pregnant
- suffering from a serious physical disability
- suffering from other serious physical health conditions or illnesses
- being aged 70 or over
- being a transsexual or intersex person.

2.109 The policy makes clear that it cannot be ruled out that there may be other factors that may render an individual particularly vulnerable to harm if placed in detention or remaining in detention. In addition, the nature and severity of a condition, as well as the available evidence of a condition or traumatic event, can change and must be regularly assessed.

Immigration factors

2.110 The presumption of AAR is that, once an individual is regarded as being at risk in the terms of the guidance, they should not be detained. However, the risk factors and evidence in support are then 'balanced' against any immigration control factors. The guidance says that the immigration factors to be taken into account are:

- Length of time in detention – there must be a realistic prospect of removal within a reasonable period. What is a 'reasonable period' will vary according to the type of case but, in all cases, every effort should be made to ensure that the length of time for which an individual is detained is as short as possible. In any given case it should be possible to estimate the likely duration of detention required to effect removal. This will assist in determining the risk of harm to the individual. Because of their normally inherently short turnaround time, individuals who arrive at the border with no right to enter the UK are likely to be detainable notwithstanding the other elements of this guidance

- Public protection issues – consideration will be given to whether the individual raises public protection concerns by virtue of, for example, criminal history, security risk, decision to deport for the public good
- Compliance issues – an assessment will be made of the individual's risk of absconding, based on the previous compliance record.

2.111 The guidance says that someone "should be detained only if the immigration factors outweigh the risk factors such as to displace the presumption that individuals at risk should not be detained. This will be a highly case-specific consideration." (Indeed, it should hardly need stating that the presumption of liberty applies to everyone in detention, ex-offenders no less than overstayers with no criminal record.) Consideration should also be given to whether there are alternative measures, such as residence or reporting restrictions, which could be taken to reduce to the minimum any period of detention that may be necessary:

> "All reasonable voluntary return options should be pursued before consideration is given to detaining at risk individuals. Where it is believed that the individual would not return without the use of detention to support enforced removal (e.g. has previously been offered the chance to pursue a voluntary return and not taken it up or complied with the process or, for instance, has been living and working illegally in the UK for some time or has made attempts to frustrate their return), this should be regarded as a matter of non-compliance."

NGO criticisms

2.112 The Adults at Risk policy is a fundamental transformation in the way the Home Office assesses and manages vulnerability. I have no doubts that the intentions of those who developed the policy are that it should significantly reduce the numbers of vulnerable people in detention.

2.113 It should also be understood that the policy remains in its infancy, and that no one in the Home Office to whom I have spoken regards it yet as the finished article.

2.114 Nonetheless, I must also record that almost all of the interested parties making submissions to this review expressed concerns that the aims of AAR had not been realised in practice. Many argued that the previous policy set out in Chapter 55 of the Enforcement and Immigration Guidance (EIG), that is: a general presumption against detention, and that vulnerable persons should not be detained in the absence of exceptional circumstances, represented a stronger safeguard.

2.115 I do not need to reference every submission received. The views of the Association of Visitors to Immigration Detainees may be taken as representative:

> "The new Adults at Risk (AAR) policy increases the burden of evidence on vulnerable people and balances vulnerability against a wide range of immigration factors. We, like other NGOs, are concerned that this leads to more vulnerable people being detained for longer – something that is hard to evidence given the absence of any baseline figures for numbers of vulnerable people held prior to the policy's introduction, and the ongoing difficulties in accessing data from the Home Office on vulnerable people since the policy was implemented. Unlike previous policy guidance, the new policy introduces the concept of 'balancing' or weighing up vulnerability factors to be carried out by those making the decision to detain. Vulnerability is ranked on three levels, based on the types of evidence one can provide … This is then weighted against immigration factors, such as length of detention, public protection issues and compliance issues, or a late asylum claim. It is important to note that a late asylum claim or other poor 'immigration factor' related to immigration history may be directly related to, or a consequence of, someone's

> vulnerability, the experience of trauma, or the mental ill health they experience. There is no requirement for the decision maker to provide evidence that this detention may be injurious to health of the person being detained: the burden of proof falls disproportionately on the person being considered for detention. Imposing an additional evidential burden in this way is inconsistent with the objective to reduce the numbers of vulnerable people detained; we are worried that it is leading to more vulnerable people being detained for longer, because they cannot provide adequate 'evidence' ...
>
> "Further, we have found the guidance itself to be opaque and difficult to understand …
>
> "It is our experience that those who are in immigration detention having previously served a prison sentence are at the greatest risk of long term detention, and are therefore facing a range of multiple vulnerabilities themselves. However, the AAR guidance at page four outlines that *'the public interest in the deportation of foreign national offenders (FNOs) will generally outweigh a risk of harm to the detainee.'*[40] This element of the policy is clearly guiding caseworkers to find that the evidence of vulnerability will be outweighed by the fact of having served a criminal sentence of 12 months or more, and does not reflect an individualised approach – the need for which was emphasised throughout AVID's first submission, was prioritised in the first Shaw Review, and is a supposed objective of the AAR policy …"[41]

2.116 I was also sent a copy of a small study by Bail for Immigration Detainees of the cases of 25 detainees whom they had represented. The results were summarised as follows:

> "... the AAR policy does not appear to have made any tangible improvement in the protection of vulnerable persons from harm in detention either in substance or practice. Indeed, we have observed a worsening of health in the cases examined through the application of the AAR policy. The stated objective of the government's response to the Shaw report was to reduce the number of vulnerable people detained and treat those in detention with dignity and respect. The experiences of our clients have shown that these objectives have not been met.
>
> "Our findings show that not one individual in either sample group was released as a result of the application of the AAR policy, despite being confirmed as at risk by medical practitioners in Rule 35 reports … Vulnerable detainees in the study were only released from detention after we represented them in an application for bail; they were not released through the application of the AAR policy."

Analysis

2.117 At my request, the Home Office has provided statistics on the number of AAR cases. As at 4 February 2018, some 1,189 Adults at Risk were in detention. Of those identified as AAR cases:[42]

- 396 were Level 1
- 782 were Level 2
- 11 were Level 3

[40] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/574970/adults-at-risk-policy-guidance_v2_0.pdf.
[41] As with other NGOs, AVID criticised the definition of torture used in the initial AAR guidance that has now been found unlawful.
[42] Data includes everyone recorded with an open AAR special condition on Home Office database as at 4 February 2018. For individuals with more than one open special condition, the classification is based on the highest recorded AAR level. Note that, in contrast to elsewhere, these figures include individuals held in HM Prisons under Immigration Act powers.

2.118 The total detained population at 4 February 2018, including FNOs detained under immigration powers in prisons beyond their release date, was 2,715. These figures mean that as at February 2018, just under 44 per cent of the overall detained population – including those held in prisons – were identified as at risk under AAR. If those who have self-declared are omitted (Level 1), the percentage of Level 2 and Level 3 cases in the total population was 29 per cent.

2.119 While the figures suggest it is relatively rare for a Level 3 individual to be placed or kept in detention, the numbers of cases at Level 2 are significantly higher than I had expected or believe to be appropriate. I examine in more detail some of the factors behind this in the chapters dealing with healthcare and casework.

2.120 I have been told by the Home Office that it accepts there have been some difficulties with the implementation of AAR, with the result that some people have entered detention when this would not have been the policy intention. I have also been told that the Home Office is reviewing how it can manage the cases of those with vulnerabilities, including the elderly, further upstream in the decision making process than is currently the case. I understand that consideration is being given to the concept of 'control points' where risk will be assessed and decisions made. The National Returns Command has also recently established a pre-planning team, to which all those within the reporting population identified as Level 2, where the needs of the detainee cannot initially be met in detention, or Level 3, will be allocated ahead of any proposed detention. This specialist team, supported by the Adults at Risk Assurance Team, should help ensure that all relevant information is obtained and considered before any decision to detain.

2.121 These initiatives are clearly welcome. Nonetheless, I am concerned that AAR as currently drafted has led to the problems outlined above.

2.122 While I have seen for myself that AAR Level 1 is given negligible weight in determining whether an individual should be detained, I believe it is sensible to retain a category of self-declared but non-evidenced need. Level 1 draws attention to potential vulnerability, and is helpful in flagging the need for further investigation. I think it is simply not true to suggest that AAR has not led to improvements in the identification of vulnerability – and this was confirmed in my visits to both IRCs and caseworking units.

2.123 At the other end of the spectrum, I have seen that while AAR Level 3 is given weight in determining whether an individual should be detained and for how long, it is problematic in its current form. Clinicians find it extremely difficult to determine whether detention will cause specific harm in the future, beyond the generalised deterioration that we know is the result of detention (with the degree of deterioration rising the longer the detention period). It is arguable that this criterion should be redrafted. If it is to be retained in its current form, then the detention of anyone at AAR Level 3 should be subject to the previous approach of 'exceptional circumstances'.

2.124 It is at AAR Level 2 that the most change is required. In my view, the broad definition of Level 2 is at the heart of why the policy as a whole is not functioning as was envisaged. In its current form, Level 2 is no more than a catch-all label for evidence of illness. Critically, it does not give any indication of the degree of an individual's vulnerability. I regard the category as far too broad. It captures evidenced illness ranging from asthma[43] to paranoid schizophrenia. (One extreme case was drawn to my attention. The man's schizophrenia had led to him being deemed AAR Level 3 and he was sectioned. However, his AAR level was reduced to Level 2 when he returned from psychiatric hospital.)

[43] Although asthma is one of many illnesses that are exacerbated by stress and therefore likely to worsen in detention.

2.125 Given the broad spectrum of need encompassed by Level 2, its impact has been diluted. My strong impression is that Level 2 is given insufficient weight by caseworkers in making detention decisions, and the outcome is that approaching one-third of the detained population is at AAR Level 2.

2.126 One option to address the issues posed by the AAR Level 2 category might be to formally acknowledge the wide spectrum of need it encompasses, and to create subdivisions for the degree of vulnerability represented. This would be akin to the informal tasking system I saw in operation amongst caseworkers in Sheffield, where an internal categorisation of Level 2 and Level 2 Complex was used to prioritise cases – although this additional categorisation was made for general safeguarding purposes and not for making decisions on immigration detention.

2.127 An alternative would be to acknowledge that caseworkers are not medically qualified and cannot assess vulnerability associated with medical conditions, and for this reason AAR categorisation should be moved to a specialist team.

2.128 These options might work well in tandem. If adopted, they should be combined with an intensified presumption against detention particularly for those in the upper division of AAR Level 2.

2.129 I should also draw attention to the Vulnerability Screening Tool developed by the United Nations High Commissioner for Refugees (UNHCR). This aims to guide decision-makers on the relevance of vulnerability factors in detention decisions. The tool can be used flexibly, and could be adapted to specific UK conditions. It would be sensible for the Home Office to keep its possible deployment under active consideration. Crucially, it would strengthen the mechanisms for identifying vulnerability prior to detention.

Recommendation 11: The current Adults at Risk policy should be amended. Detention of anyone at AAR Level 3 should be subject to showing 'exceptional circumstances'.

Recommendation 12: Consideration should be given to AAR Level 2 being sub-divided and, if adopted, the presumption against detention for those in the upper division should be strengthened. The Home Office should consider the merits of the UNHCR Vulnerability Screening Tool.

2.130 I should also report some lack of clarity as to who had ownership of AAR inside the IRCs. I think the truth is that all staff of whatever grade and profession have a shared responsibility, but I am not convinced that this is fully understood or that there are processes in place to make this effective. The Home Office should consider if there is further advice it should offer or action it needs to take.

Older detainees

2.131 I have particular concerns over one group of vulnerable people: the elderly. I was very surprised in my visits to IRCs to learn of the detention of people over the age of 70. I was especially concerned by the cases of two detainees whom I came across personally. One was a 77 year old woman detained at Colnbrook who had complex health needs.[44] The other was a 71 year old man who had been detained initially at Brook House – but then moved to Tinsley – for a proposed return on a charter flight. Having made further inquiries, I did not see how either of these detentions was possibly justified.[45]

[44] For more details, see paragraph 4.6 below.
[45] Nor was it at all clear why the man needed to leave on a charter flight. I suspected it was simply to fill an available space.

2.132 I asked for statistics on the age distribution of all cases where the detention gatekeeper had agreed detention since the inception of the AAR. The results are set out in Figure 2.13.

Fig 2.13: Accepted Cases by Age Group – Gatekeeper[46]

	Age Group		
	18–54	55–69	70+
September 2016	2,065	62	0
October 2016	1,952	64	3
November 2016	2,104	78	2
December 2016	1,816	55	4
January 2017	2,272	88	5
February 2017	1,790	72	7
March 2017	2,196	82	3
April 2017	1,887	51	4
May 2017	2,103	64	1
June 2017	2,105	82	3
July 2017	2,168	96	2
August 2017	1,975	103	3
September 2017	1,997	73	3
October 2017	2,212	76	7
November 2017	2,053	90	3
Total	**30,695**	**1,136**	**50**

2.133 The number of people detained when aged 70 or over is of course low. Only 50 individuals (0.15 per cent of all detentions) fell into that category in the period covered by Figure 2.13. Nevertheless, I find it hard to conceive of many circumstances where the detention of elderly people could ever be justified. Perhaps the only example would be someone who had been convicted of the most grievous offences and was deemed still to present a risk to the public.

2.134 In the period covered by Figure 2.13, I understand that nine people aged 70 years or over had been referred for detention but were refused. A further 39 were referred in advance of a proposed detention and were rejected as unsuitable.

Recommendation 13: The Home Office should no longer detain any adults over the age of 70 except in 'exceptional circumstances'.

Assurance

2.135 I am very conscious that the Home Office is still in the process of introducing the new policy and the recent establishment of an Adults at Risk Assurance Team is welcome. I was concerned, however, about the level of monitoring of the implementation of Adults at Risk – even allowing for some of the difficulties in accessing management information – given this is such a key part of the Home Office's response to my earlier report. My view is that the policy should be subject to much greater openness and external scrutiny.

2.136 In two discussions with Mr David Bolt, the Independent Chief Inspector of Borders and Immigration, we agreed that regular review of AAR could properly fall within his remit. This would provide the independent assurance that I regard as essential going forward.

[46] Footnote 28 also applies.

Recommendation 14: The Independent Chief Inspector of Borders and Immigration should be invited to report annually to the Home Secretary on the working of the Adults at Risk process.

Rule 35

2.137 Rule 35 of the Detention Centre Rules 2001, was established to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. Under Rule 35(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. Under Rule 35(2), the medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions. Under Rule 35(3), the medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture. The information contained in the report is then considered by the caseworker and a decision made on whether continued detention is appropriate, or whether the detainee should be released.

2.138 In my first report I noted widespread criticism of Rule 35, and recommended that the Home Office immediately consider an alternative. In response, the Home Office has said that steps have been taken to improve the use of Rule 35 during the development of AAR, and following its implementation. For example, DSO 09/2016 – Detention Centre Rule 35 – sets out the process in detail and makes links to AAR. In addition, I understand that officials have engaged with IRC doctors in workshops to promote understanding of AAR and how to complete Rule 35 reports to provide the best possible evidence. Formal and informal training has also been provided to Home Office caseworkers to improve the management and response to Rule 35 reports.

2.139 However, once more almost all the bodies who submitted representations to me felt that Rule 35 was not working and should be replaced. It was said that Rule 35 reports were routinely rejected for minor errors, and that they enjoyed the confidence of neither the doctors who complete them nor the caseworkers who receive them. It was pointed out that, following publication of the AAR policy, the number of Rule 35 reports dropped – probably because of the narrowing of the definition of torture. Since the torture definition reverted to the wider definition, the figures have picked up. But despite this, the release rate has continued to decline.

2.140 I asked for some statistics and analysis from the Home Office on the use of Rule 35. The entries in Figure 2.14 are the number of releases due to Rule 35 reports between March 2016 and June 2017.

Fig 2.14: Detainees released from detention following a Rule 35 report completed by a medical professional[47]

2016	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Brook House	4	9	9	4	5	4	4	7	12	14	72
Campsfield	2	2	5	3	5	2	0	6	3	2	30
Colnbrook	6	11	11	11	21	7	1	0	2	4	74
Dungavel	5	11	12	8	6	17	4	6	7	6	82
Harmondsworth	24	15	39	36	31	9	18	3	5	10	190
Morton Hall	4	7	11	4	11	15	6	8	8	8	82
Tinsley House	1	2	5	10	8	7	7	0	0	0	40
Yarl's Wood	3	19	27	20	23	18	12	3	6	17	148
The Verne	16	4	10	10	6	1	4	6	5	9	71
Others	0	0	2	1	1	1	2	1	2	1	11
Total	65	80	131	107	117	81	58	40	50	71	800

2017	Jan	Feb	Mar	Apr	May	Jun	Total
Brook House	23	22	7	5	4	6	67
Campsfield	9	4	7	5	8	7	40
Colnbrook	5	4	1	3	6	2	21
Dungavel	5	3	8	4	7	8	35
Harmondsworth	8	9	3	4	4	8	36
Morton Hall	6	6	7	5	5	4	33
Tinsley House	0	0	0	0	1	1	2
Yarl's Wood	7	6	4	1	9	11	38
The Verne	5	7	5	3	11	11	42
Others	0	1	0	2	0	0	3
Total	68	62	42	32	55	58	317

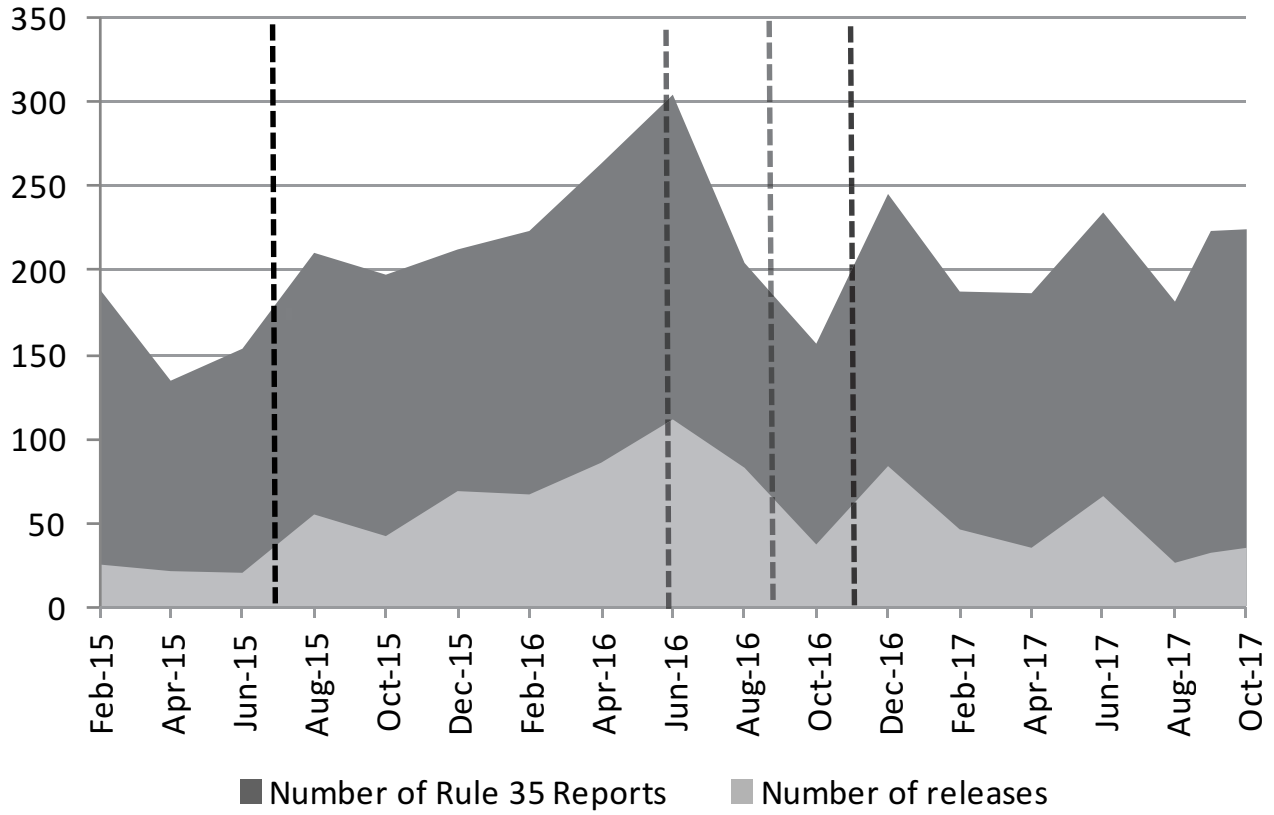
2.141 Figure 2.15 shows the numbers of reports received against the number of releases. I asked for analysis of these figures and the headlines were:

- the numbers of releases over time vary in proportion to the number of Rule 35 reports received
- Operational milestones, including (from left to right) (i) the cessation of Detained Fast Track (DFT), (ii) introduction of a single independent Detention Gatekeeper, (iii) introduction of the Adults at Risk policy and (iv) the changing of the definition of torture applied in Rule 35 reports[48], appear to have affected trends in both the short and long term; the peaks in the graph appear to correspond to these milestones.

[47] This data has been provided by and assured by the Home Office's Performance Reporting & Analysis Unit (PRAU). The data has been gathered by analysis of releases of detainees recorded in the case information database (CID) as subject of a Rule 35 report. Reasons for release in individual cases contained in this data may come from a combination of factors and not exclusively from consideration of a Rule 35 report. This data may contain previously unpublished datasets.

[48] Including the change from the EO case-law definition of torture to the UNCAT definition on 12 September 2016 and the reversion back to the EO definition of torture on 6 December 2016 following the High Court injunctive relief on 21 November 2016 for the AAR policy challenge.

Fig 2.15: Total Rule 35 Reports vs. Number of Releases[49]



(Analysis compiled using previously unpublished internal management information.)

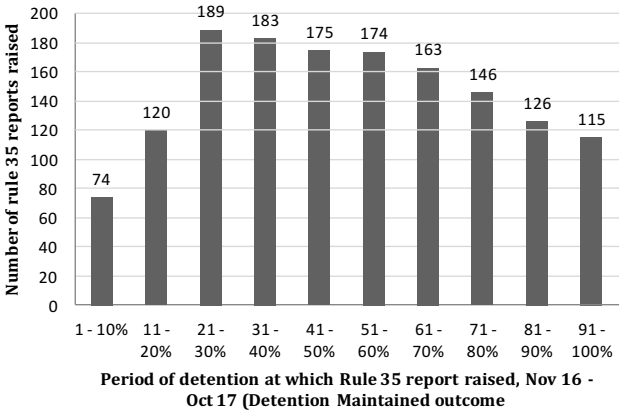
2.142 I also asked for information about the stage of detention at which Rule 35 reports had been raised. The summary is outlined in Figure 2.16 for those cases between November 2016 and November 2017.[50]

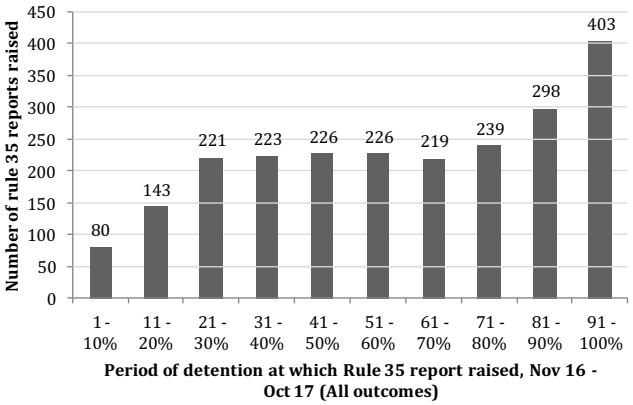
2.143 More Rule 35 reports were raised at the 91-100 per cent stage of detention during the sample period than in any other 10 per cent stage, but I think this is mainly driven by those who are released soon after their Rule 35 report because the report itself evidences that they should be released. For those reports which resulted in continued detention only, more were raised in the 21-30 per cent stage of detention during the sample period than in any other 10 per cent stage.

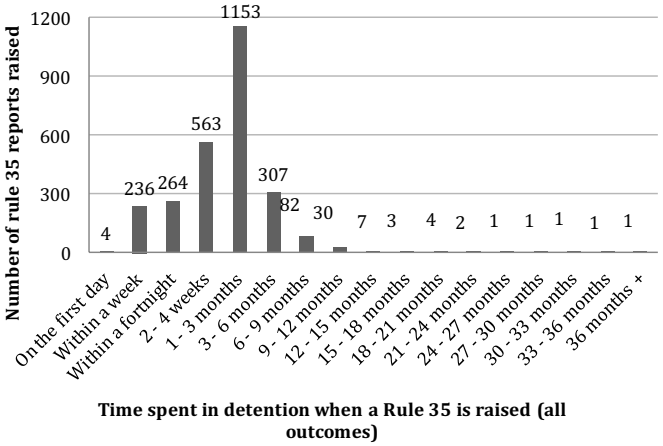
2.144 I was encouraged to learn from Figure 2.17 that, of those released as a result of their Rule 35 report, 90 per cent were released within seven days of the report being raised. (I am told that the one per cent apparently released after more than three months are all data errors, caused by re-detention at a later date.)

[49] This graph has been collated by the Adults at Risk Assurance Returns Team (ARRAT) upon request from my review team to provide indicative trend analysis.
[50] Footnote 49 refers.

Fig 2.16: Stage of detention period at which Rule 35 reports raised: By percentile stage of detention period for detention maintained outcome only (upper left), by percentile stage of detention period for all outcomes (upper right), by time spent in detention for all outcomes (lower), Nov 2016 – Oct 2017[51]



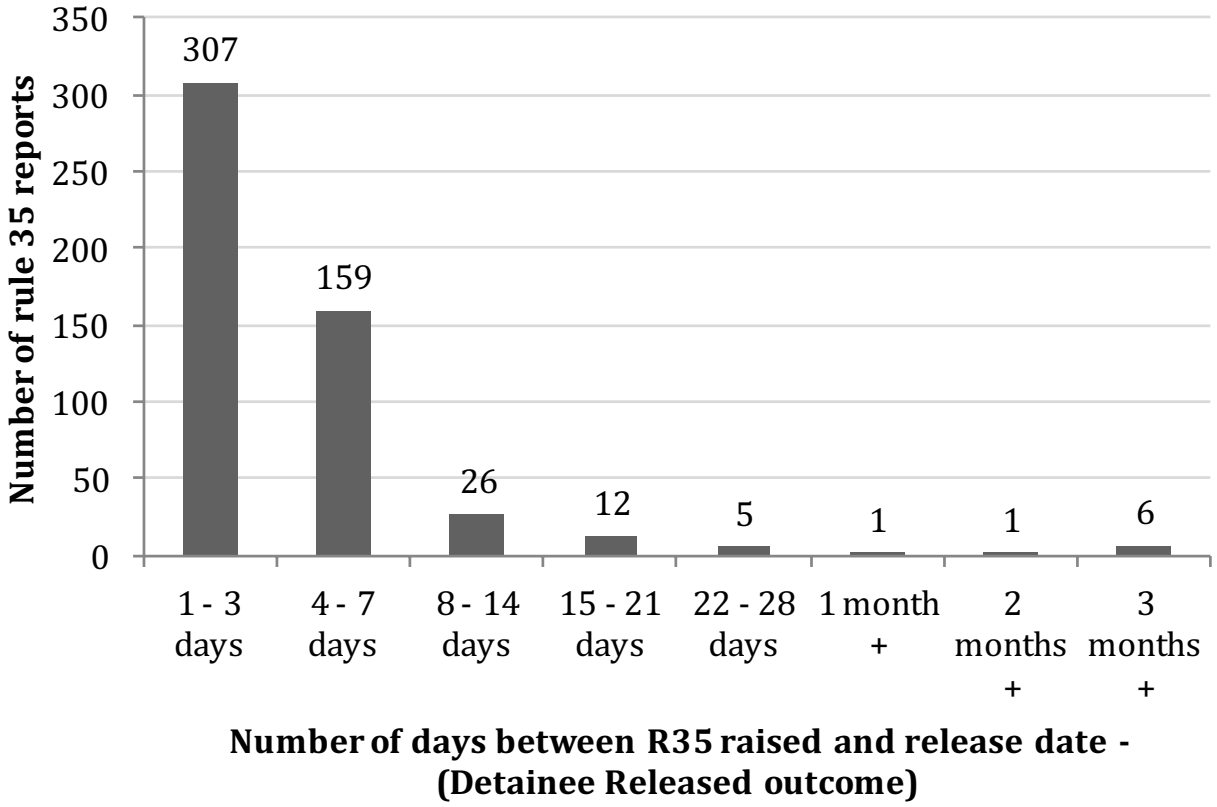




(Analysis compiled using previously unpublished internal management information.)

[51] Footnote 49 refers.

Fig 2.17: Number of days between Rule 35 report being raised and release date for those with detainee released outcome, Nov 2016 – Oct 2017[52]



(Analysis compiled using previously unpublished internal management information.)

2.145 In my first report I argued that Rule 35 did not do what is what intended to do, and that the Home Office did not trust the mechanisms it had created to support its own policy (in particular, that there was a lack of trust placed in GPs to provide independent advice). Despite improved training for clinicians, and improved monitoring of the process, nothing I have seen has suggested any fundamental change to this position.

2.146 I think it anomalous that, in considering vulnerable people in detention, decisions relating to Rule 35 reports are made by those responsible for both progressing the case and for detention.

2.147 In looking for alternative mechanisms, I noted the system that has been developed for identifying and supporting victims of human trafficking or modern slavery – the National Referral Mechanism (NRM). The NRM was introduced in 2009 to meet the UK's obligations under the Council of Europe Convention on Action against Trafficking in Human Beings. From 31 July 2015, the NRM was put on a statutory basis following implementation of the Modern Slavery Act 2015. The Competent Authority (trained decision makers) decides whether individuals referred to them should be considered to be victims of trafficking according to the definition in the Convention.

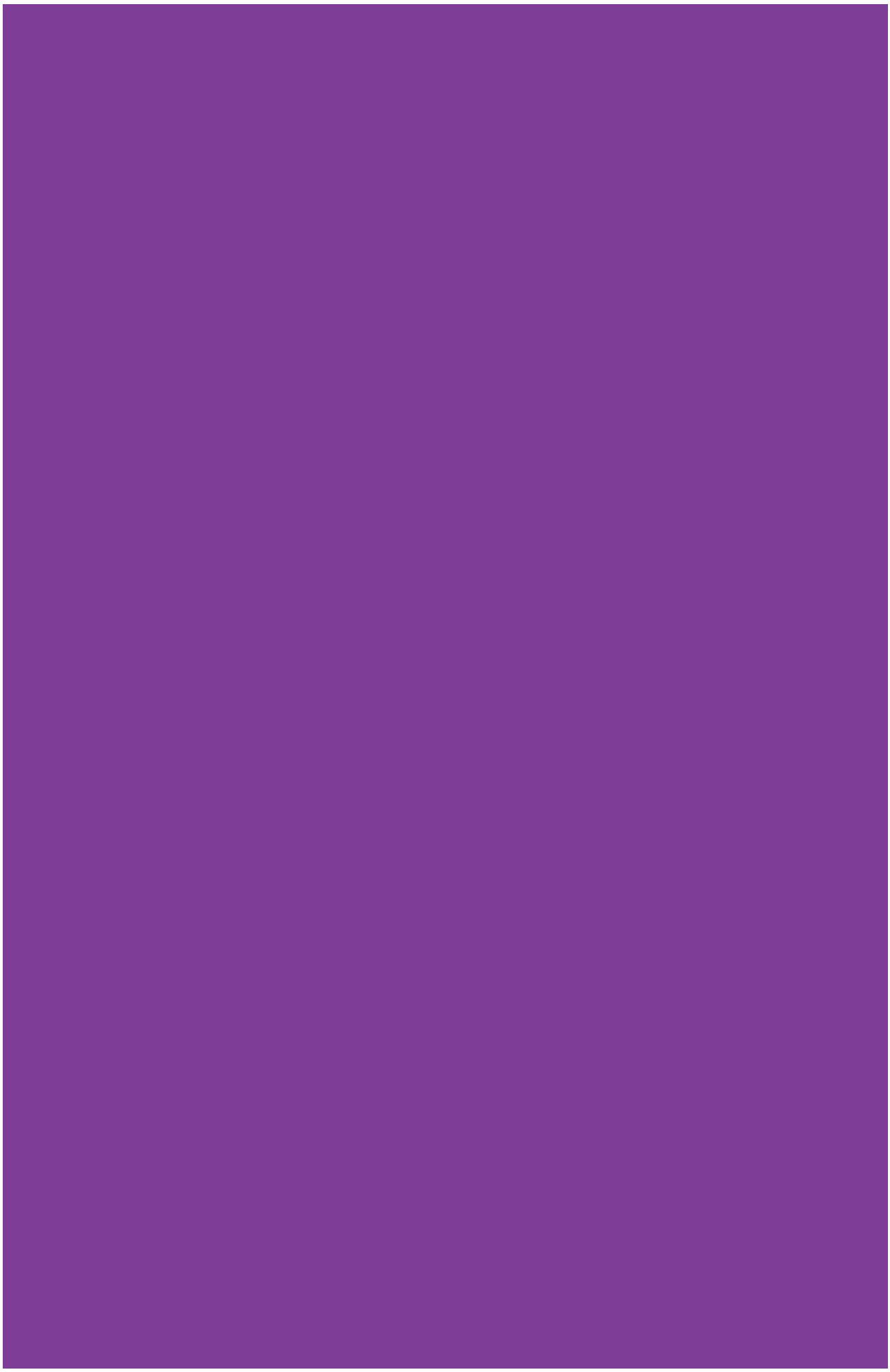
2.148 In England and Wales, if someone is found *not* to be a victim of trafficking, the Competent Authority must go on to consider whether they are the victim of another form of modern slavery, including slavery, servitude and forced or compulsory labour. The NRM grants a minimum 45-day reflection and recovery period for victims of human trafficking or modern slavery. The trained decision makers' threshold for a Conclusive Decision is that on the balance of probability "it is more likely than not" that the individual is a victim of human trafficking or modern slavery.

[52] Footnote 49 refers.

2.149 I have little expectation that further tweaks to the current Rule 35 process – such as yet more training or monitoring – will be sufficient to deliver confidence for any of the parties. It requires a more fundamental shift in practice. I consider the system used for potential victims of human trafficking and modern slavery to be a template that could sensibly be followed.

Recommendation 15: I recommend new arrangements for the consideration of Rule 35 reports. This should include referrals to a new body – which could be within the Home Office but separate from the caseworker responsible for detention decisions.

2.150 In the next two chapters of this report, I will address the Government response to my recommendations on healthcare and caseworking respectively.



PART 3: HEALTHCARE

Introduction

3.1 Nothing is more central to the detainee experience than healthcare. Whether this is because of pre-existing conditions that have not been treated, or detention exacerbating ill-health, or simple boredom or other reason, is not to the point. The extent to which detainees use the healthcare facilities is extraordinarily high by the standards of the community at large.

3.2 I included a number of recommendations relating to healthcare in my first review. In particular, I proposed that the Home Office and NHS England (NHSE) should undertake a clinical assessment of mental health need across the immigration detention estate, and that there should be a joint action plan to improve mental health services. I also recommended access to talking therapies, said that healthcare staffing vacancies should be addressed, and covered issues such as patient consent, self-administration of medication by detainees, and a strategy to reduce the use of New Psychoactive Substances (NPS).

3.3 In preparing this chapter of the report, I have listened to health commissioners, and healthcare professionals, as well as the views of those who work in and monitor the IRCs.

3.4 I have been told of significant progress across a number of areas identified in my first review, but obtaining data to verify this has proved challenging. In every IRC I visited, the demands on healthcare remained significant and I also found considerable patient dissatisfaction. I was pleased, however, to note in a recent survey commissioned by NHSE that most detainees feel they are treated with respect.

3.5 The Home Office view is that the NHS commissioning model is the best option for IRC healthcare. While IRC managers have told me that they regret the loss of control over healthcare provision, I share the Home Office's judgement. All providers are now part of a national framework of care, standards and inspection, which I believe to be an improvement on the previous system of subcontracting via custodial suppliers. IRC needs are being better specified and understood – not least because there is a community of interested clinicians who want to improve care. All IRCs have reviewed Health Needs Assessments (HNAs) over the previous three years.

3.6 Recent reports from the Chief Inspector of Prisons and the Care Quality Commission have found improvements in healthcare at Yarl's Wood and the two Heathrow centres.

Update

3.7 I am grateful to the Director of Health and Justice, NHS England, Ms Kate Davies, for an update in which she summarised the work undertaken in response to my previous report. I have reproduced what she told me in full:

> "NHS England is in the process of reviewing the commissioning processes in relation to Health and Justice commissioning responsibilities. This will be completed from a regional and national perspective.
>
> "The outcome of the review will inform how we can improve our commissioning functions in this area to ensure better consistency, continued quality of care and positive health outcomes for our patient populations. The high level partnership agreement between NHS England, Public Health England (PHE) and the Home Office has been completed and was approved by the NHS England Chief Executive in November 2017.
>
> "In the period between the first Shaw review and this current review, NHS England has focussed on mental health improvements across the estate. The Centre for Mental Health analysis of mental health services was completed in 2016 and published on their website in January 2017.
>
> "This work informed the revised Mental Health service specification which was completed after extensive stakeholder consultation in 2017. This specification is beginning to inform operational delivery through contract variations and will inform future contracts as they are re-procured. In addition to the mental health specification we are now planning to review the entire suite of specifications across the IRC estate. We have a revised substance misuse specification for the secure estate which has a significant element in relation to NPS use. This is aligned to the PHE toolkit and from the learning in an IRC specific training event on NPS we facilitated last year we will develop the substance misuse specification for IRC's along similar lines.
>
> "Infection control and the management of communicable disease remains a priority and features as such in the National Partnership Agreement. The Home Office, NHS England and PHE work very effectively together in relation to this work, never more clearly defined than in the current approach PHE have been managing in relation to the current outbreaks we have had at Tinsley House, Brook House and Heathrow.
>
> "After a two year multi-organisational, planning and development period, via a working group chaired by NHS England and including providers, NGO representation, clinical steer, the Home Office and PHE we have rolled out a HASI[53] non-verbal screening tool to identify learning disabilities for people within the estate. Morton Hall agreed to be a pathfinder for testing this approach completed in January 2018. The results of this pathfinder are being considered at the moment. This work supports the premise of the Adults at Risk policy, which NHS England was involved in the development of.
>
> "In addition there has been significant progress, now in its final stages of sign off, in relation to mental health transfers to secure hospitals, covering both the secure and detained estates.
>
> "Alongside this, work is being undertaken on the review of deaths in custody and deaths in the detained estate with a dedicated multi-agency group addressing commonalities across the two regimes, as well as a separate but aligned two year research programme on deaths in custody being delivered by Manchester University (the ROSIe project) which includes the IRC estate.

[53] Hayes ability screening index.

"NHS England regional commissioners for IRCs have completed or are in the process of commissioning further Health Needs Assessments for their establishments to ensure services remain fit for purpose.

"Yarl's Wood IRC has recently been successful in securing the support of the One Small Thing Foundation which will provide whole system training in Being Trauma Informed. The initial training is scheduled to start in May of this year.

"Since the last Shaw review NHS England has successfully engaged with a service user from the detained setting, who is a member on the IRC Assurance Group and brings a direct service user perspective to our strategic discussions. In addition we have a specific health and justice lived experience group made up of people who have experienced the CJS and detention. This group is supported by Revolving Door Organisation and provides support to the commissioning process for service development and to contribute to help NHS England deliver improvements.

"Over the past 18 months NHS England has rolled out patient questionnaires across the estate as a pathfinder. This year we are procuring a two-year patient questionnaire programme of work which is currently going through our organisational procurement processes but we are hopeful will be in place from April 2018 and will enable patients within the IRCs to answer questions about their experiences of care and treatment in healthcare in real time which will enable a more immediate response to challenges than is available from the retrospective quarterly patient feedback reports that providers present at performance and contract management meetings."

3.8 Instrumental in the NHS successfully undertaking the actions above has been the demonstrable strengthening and formalising of the partnership between NHS England, the Home Office, Public Health England and HM Prison and Probation Service. This is illustrated in both Ms Davies' narrative and the development of policies and processes I have seen on my visits. I have noted improved management of communicable diseases, work on preventing suicide and self-harm, and expertise in supporting smoking cessation.

3.9 I have also seen tangible joint working with the establishment of the Immigration Removal Centre (IRC) Assurance Group, NHS England's national executive leadership forum providing systemic assurance and performance oversight. It meets quarterly.

Stakeholder Views

3.10 I have received a number of representations from interested NGOs regarding healthcare. The themes arising from these submissions include concerns about clinically informed casework decisions, access to and quality of healthcare assessments on reception, harm to health caused by continued detention, and inconsistent diagnosis.

3.11 Another concern has been about access to healthcare in the community. Asylum Welcome told me:

"There are also difficulties for detainees in accessing health services outside detention. In addition to the 'normal' delays that other UK residents experience in accessing NHS services, there are additional delays due to bureaucracy and the unreliability of escorts to hospital. Poor access to external healthcare is doubly concerning because of the shortcomings of the internal healthcare provision."

3.12 The British Medical Association (BMA) said it was developing its own specific guidance to support their members working in IRCs. The BMA's report, *Locked up, locked out: health and human rights in immigration detention*, published in December 2017, included proposals to reconfigure current healthcare provision to better achieve equivalence of care. These included:

- Greater consideration should be given to how mental health therapies and interventions which may be more widely available in the community, can be provided in a detention setting
- Greater recognition should be given in policy and guidance to the fact that there will be circumstances where a person's health needs can no longer be adequately met in detention, and that this should trigger a review of the appropriateness of detention
- Problems with recruitment and retention across the IRC workforce must be addressed in order to prevent staff shortages negatively affecting the health and wellbeing of detained individuals
- In order to ensure that the health needs of detained individuals are being identified correctly, a standardised screening assessment tool should be developed and implemented
- Healthcare staff should be given as much notice as possible ahead of the release or removal of a detained individual so that they can ensure, as far as possible, that individuals leave detention with the appropriate medication and health information. Where they are being released to the UK, this should include information about accessing healthcare in the community
- Consideration should be given to how healthcare provision can be arranged and commissioned to ensure consistency across the immigration detention estate.

3.13 I was told by Medact that in their view:

> "There were high hopes that the transfer of the commissioning of healthcare in IRCs to the NHS would result in rapid and significant improvements in its practice. These remain largely unrealised as yet. We suggest that when the transfer occurred, NHS bodies were unaware of the extent of the task they were taking on and unprepared for complex practical and ethical issues (including dual loyalties)[54] which are unusual in every day NHS practice, and it is not clear that the responsible entities (NHS England and its local bodies, but also the CQC, GMC and NMC) have yet taken the necessary steps to identify (through conducting or mandating audit) and to direct (by contractual or other means) effective action to reduce risk and harm to vulnerable detainees."

3.14 Medact recommended the introduction and publication of cyclical audits, overseen by HM Chief Inspector of Prisons, the Care Quality Commission, and the Chief Inspector of Borders and Immigration.

3.15 I was told by Medical Justice:

> "The care provided fails to meet equivalence with that provided in the community, mental health services continue to be inadequate or inappropriate. There has been little change in the healthcare provision following the Shaw Review, that we are aware of, and we continue to see serious failings in healthcare provisions, around the quality of care, around the attitude of staff and in particular in relation to mental health services."

[54] NHSE told me that they have provided training on dual loyalties.

Healthcare impressions at individual IRCs

3.16 The healthcare providers at each IRC are outlined in the chart below along with the length of their contracts. Healthcare at Dungavel is contracted directly by GEO rather than commissioned by the NHS.

Fig 3.1: Healthcare providers at each IRC

Healthcare Providers			
IRC	**Healthcare Provider**	**Contract Length**	**Contract End Date**
Heathrow IRC (Colnbrook and Harmondsworth	CNWL	5 years	August 2019
Morton Hall	Nottinghamshire Healthcare NHS Foundation Trust	5 Years	April 2020
Yarl's Wood	G4S Medical Services	5 years	September 2019
Campsfield	Care UK Health and Rehabilitation Services	5 years	April 2020
Brook House/Tinsley House	G4S Medical Services	5 years	April 2019
Dungavel	Med-Co Secure Healthcare Services*	8 years	September 2019

3.17 As part of my programme of visits to IRCs, the team member seconded from the NHS undertook full day visits to each of the healthcare units. A consistent set of discussion topics and questions was prepared for each visit. In each centre the patient pathway from detainee arrival was walked, with observation of clinical rooms and accommodation en route. Individual and group interviews were conducted with healthcare staff, associated clinicians, practitioners and GPs, with security staff included where relevant. Patients were interviewed informally where present and appropriate. It was made clear to all parties that I was conducting neither an investigation nor audit.

3.18 The impressions I had of each of the centres are outlined below.

Campsfield House

3.19 I was concerned by the environment in healthcare, where clutter and poor cleaning posed infection control risks, exacerbated by a severe lack of space. Campsfield was not on the SystmOne[55] digital records system. (IRC Campsfield is a "Greenfield" site for SystmOne so implementation should be imminent.) The fact that some of the minimal storage was taken up by ten years of paper records emphasised the need for a digital solution, and to provide more storage and administration space. There are currently three medical rooms, and two administration rooms converted from bedrooms, along with a very small waiting area serving both pharmacy and healthcare appointments. An officer was present in the waiting area for security but takes up one of the five seats available. I felt that healthcare management was not taking sufficient action to address these practical issues, perhaps distracted by the hope that there would be a full refurbishment in the medium term.

3.20 There had been an unusual spike of 36 complaints regarding healthcare, although the consensus amongst staff was that this had been led by one detainee who had been challenged by a nurse about his medication and others had felt coerced into making a complaint . Within healthcare itself, a complaints box was available in the waiting area, and there had been six direct complaints in the preceding three months. Two of these complaints

[55] SystmOne is the existing health records sharing technology system that enables most prisons and some health premises to access summary care records for their patients.

had concerned waiting times for the doctor, and I was pleased to learn that healthcare had changed its routine as a result, moving Rule 35 interviews to the end of the day. Staff had responded to complaints within the set time limits.

3.21 At the time of my team's visit Campsfield's healthcare was fully staffed, with two members having served for sixteen years, one for nine years, and one for four years.

3.22 The GP believed staff to be courteous and respectful, while the healthcare manager felt that the centre's relatively small size made it easier to exercise oversight. She noted that they have regular one-to-one meetings in which professionalism can be examined. However, a number of detainees in the forum I held felt there was a culture of disbelief among medical staff. They did not feel that their health was being properly screened.

3.23 Healthcare use is high: Campsfield's healthcare has a throughput of 100-120 patients per day, out of a maximum detainee population of 284. Detainees could see a GP within 48 hours, with nurse triage available immediately. There was next-day prescription delivery with the longest wait being two days. I found that the inability to have medication in-possession frustrated detainees, particularly those who had been able to have medication in-possession in prison.

3.24 There was no on-site dentist, and I understood that waiting times were four to five weeks. An optometrist ran a clinic at Campsfield once or twice a month, but the environment was unsuitable, requiring the use of the corridor in order to achieve the requisite distance for tests of visual acuity. A dietician clinic was scheduled monthly but not used as most of this work was conducted by nurses. As part of commissioning arrangements, HMP Huntercombe's mental health nurse, psychiatrist and counsellor visited twice per month, and Campsfield's healthcare manager had asked for a psychologist to attend monthly. I was told that in a couple of months a new staff member would commence talking therapies, which I welcome. Healthcare management noted that a key concern for detainees was hospital waiting times.

3.25 The commissioning relationship with NHSE was viewed as good. However, centre management raised concerns that, as healthcare is commissioned by the NHS in a cluster with prisons, Campsfield works to some prison performance indicators. This is even if the information monitored and reported is specific and relevant to the IRC i.e. DSO compliance. They also said that they take part in meetings with prisons despite the contrasting populations.[56] Healthcare management expressed similar concern about CareUK's bi-monthly meeting, which they said was dominated by prison issues. It was felt that it would be beneficial, in terms of sharing best practice, that the group of IRC healthcare heads should resume their former meetings.

3.26 As at all other IRCs, healthcare staff were concerned about the care detainees would subsequently receive if released. Healthcare staff often struggle to identify GPs, and release is often at very short notice making it difficult to pass on records.

3.27 Big Word phone translation service was fully used in healthcare, though there were issues with detainees trusting these third parties. Written material was translated in various languages, but plain English and easy-read versions should be made available for anyone with a learning disability. Healthcare was aware of minimal numbers of detainees with learning disabilities (LD), but I am concerned that as there is a reliance on previous screening processes (such as those at prisons), people with LD may be going unnoticed.

[56] I am told by NHSE that Camspfield holds is own regular Local Delivery and Quality Board meeting to monitor internal issues and resolve barriers to delivery.

3.28 I was pleased to see that the smoking cage had been removed in line with the suggestion in my previous report. Smoking was still allowed inside and reception staff noted that they relied on cigarettes to influence behaviours and build rapport. However, management was looking at going smoke free.

Dungavel

3.29 Healthcare at Dungavel is directly commissioned by the centre director, rather than through any health commissioning manager. The head of healthcare noted that the quality of incoming patient notes was poor, particularly from Scottish prisons, although they ensured that outgoing information was good. GPs raised concern about clinical views not being taken seriously by Home Office caseworkers, with the perception that decisions were undermined. Escorts for medical appointments were raised as a serious concern (in October 2017 I was told that nine out of ten appointments had been missed as a result).

3.30 The general healthcare environment was not clean, and one room in particular would be closed in the community. My team raised this with the head of healthcare. Waiting areas were small and crowded, with wooden benches and no windows. The current pharmacy hatch was very small with a lack of privacy (while it was being relocated, it was unclear when the new hatch would be used). While the size of the healthcare space quadrupled in 2010, it was still inadequate. Although I was pleased to learn of significant capital investment to support the new contract, the plans did not include healthcare, which is disappointing.

3.31 Several members of healthcare staff noted that there had been increasingly challenging behaviour by detainees in recent months, and they felt unsafe.

3.32 Dungavel's Secure Unit was bleak and excessively bare. I understood that three different contractors had bid for funding to refurbish this area but had failed. The Rule 42 accommodation in particular had nothing but a slightly raised platform on the floor. I welcome its relocation as part of the imminent refurbishment, and the creation of care suites. However, I was concerned to learn that the current Secure Unit was last used two weeks before my visit for a man with very poor mental health as it had taken a number of days for him to be sectioned. This was not unusual; I was told that the Unit had held three very serious cases recently, the worst in the manager's 16 years' experience. The Secure Unit is wholly unsuitable for accommodating those suffering from mental health conditions.

Brook House

3.33 The clinical rooms' cleanliness required attention, with inappropriate storage in clinical areas. We observed a fresh blood splatter on a stairwell, but cleaners seemed unclear about how to clean up bodily fluids appropriately and safely. While cleanliness is a custodial responsibility, it was not apparent to me that staff in healthcare had raised their concerns.

3.34 At the time of my visit, there were multiple wheelchair users detained at Brook House.

3.35 I was told that mental health staff see patients they believe are unfit for detention, but whom outside hospitals will not accept.

3.36 Rule 35 was highlighted by healthcare staff as a key issue. The volume had increased, and healthcare staff suggested it was outside their competence to interpret what constituted torture. They felt that caseowners dismissed reports too readily, and that unsuccessful reports damaged relationships with patients. The impact on clinical time was clear, taking a GP up to two hours per day.

3.37 Several healthcare staff members entered the clinical room during our GP discussion to access a storeroom, which raised concerns for patient privacy. The lack of a dental suite in such a large facility should be addressed.

3.38 Healthcare management covers both Brook House and Tinsley House. Staff raised concerns about their computer system (SystmOne), including the 'prisoner' label on patients' medical records (see paragraph 3.93 below), the lack of mandatory patient consent, and the increase in training and time required for the roll-out of HJIS.[57] Staff also highlighted their concern that Detention Services Orders were introduced without an understanding of the impact or changes required to support them. They noted that sharing best practice across IRCs with different healthcare providers is challenging, as it is seen as business sensitive. Staff told me that they felt detainee demands on healthcare can be unrealistic, and that exaggerated health needs were used to delay deportation or maximise benefits before removal.

3.39 I found that a high proportion of detainees' written healthcare complaints related to medication (either not available or not available as 'in possession'). While all complaints appeared to have been answered within the appropriate timeframe, I observed some unnecessary delays due to the requirement for NHSE Locality Director sign off, and the fact that there was no healthcare complaints box (it had been torn down by detainees, but should be replaced).

3.40 The most common mental health presentation at Brook House was said to be Post Traumatic Stress (PTSD). The lack of a trauma therapist and community-equivalent counselling services is challenging for staff and detainees alike. Healthcare staff raised concerns about the quality of the phone interpreter service, with examples of poor conduct including when an interpreter hanging up half-way through a mental health session, and background noises suggesting the interpreter might not be in private.

3.41 I was told that immediate releases made it almost impossible to put care packages in place, especially when detainees are released to no fixed abode.

Tinsley House

3.42 Healthcare staff had concerns about the Rule 35 process. In particular, they expressed frustration that caseworkers ignore Rule 35 reports and challenge medical views on fitness for detention, while the low success rate – with only 10 per cent said to result in release – damaging relationships with patients. It was suggested that the Home Office should share feedback with the GP where the GP's rationale for release was not accepted.

3.43 Tinsley House was exploring whether nurses could draft the Rule 35 reports, meaning less impact on GPs' clinical time. But while I understood this rationale, and that the GP would continue to review and sign off the reports, assessing claims of torture should continue to be prioritised. I was pleased to hear that the typical wait for a Rule 35 assessment at Tinsley House was five days – far lower than the 15-day wait at Brook House – and that the head of healthcare was on a Royal College of Physicians Rule 35 working group.

3.44 Both Tinsley House and Brook House have recruitment challenges. There were no nurse prescribers and, while the centre had a new group therapy room, this was used for storage as staff had not been recruited to run the sessions. Tinsley House used many agency staff, although those concerned had been at the centre for a couple of years. I was told that it was difficult to bring staff across from the agency on a permanent basis, and more broadly that it was hard to recruit healthcare staff to IRCs. While this message is consistent

[57] I note that while the term HJIS is used by the national NHS England team, Systm2 is the phrase used to describe the evolving process by all healthcare staff on the ground.

with what I heard across the estate, it had been exacerbated for Tinsley House following the *Panorama* programme, after which the centre had lost applicants through its association with Brook House. The recruitment difficulties were exacerbated by clearance issues, and good recruits were lost as a result: it had taken over six months to obtain clearance for a healthcare assistant despite an existing CRB check.

3.45 Tinsley House healthcare had received few complaints since re-opening, and notably all eleven comments from patients in October 2017 stated that care was good. However, there were many typing errors in the complaint response I saw. The IMB felt that improvements had been made to healthcare, although there remained a problem with the blanket use of paracetamol.

3.46 I was told that medical holds generally prevented transfers within the IRC estate. However, I was concerned to learn that the Home Office has sometimes ignored advice from Public Health England, for example accepting a family during a flu epidemic when the centre was in quarantine.

3.47 The cleanliness of clinical areas, availability of storage, amount of clinical space, and staff desensitisation to these issues, were all of concern. There was a dirty toilet directly next to a clinical room. Provision of two clinical rooms, one mental health room and a care suite was not sufficient, while I was told the pharmacy hatch queue is not supervised. However, I was impressed by the care suite, which is used for constant observations.

3.48 There was no dental suite, with dental triage provided once a month and dental appointments provided in hospital. Similarly, the optometrist visited every month.

3.49 There were two escort slots for hospital appointments per day; this was considered adequate, although routine dental appointments were sometimes cut.

3.50 I was told that healthcare staff found it challenging to set up post-release care, as they were often given just two hours notice – and therefore only able to give medication and notes. As elsewhere, I found that the healthcare staff understanding of entitlements to healthcare on release was not up-to-date, nor was the printed information on this topic given to detainees on release.

Colnbrook

3.51 The commissioned healthcare provider is Central North West London NHS Foundation Trust (CNWL), operating across Colnbrook and Harmondsworth with one workforce. The mental health team is based at Colnbrook, where there are six in-house mental health beds. However, in each centre there is only one mental health clinical room, which is insufficient. On the other hand, there is some duplication of healthcare facilities as detainees cannot be moved between centres for appointments. [58]

3.52 The volume of mental health referrals means they are now categorised as 'urgent' (to see within 24 hours) or 'routine' (to see within 72 hours). Only one-third of mental health posts across Colnbrook and Harmondsworth are filled currently, and primary care is heavily reliant on bank and locum staff with 46 per cent vacancies in permanent posts. However, a pool of regular internal CNWL bank staff has been increased to reduce the reliance of the service on locums. When the contract was originally let, there were 55 whole time equivalent (WTE) posts in the service model, but NHSE invested in provision so there are now 65.3 WTE posts in that service model. Although a number of these are unfilled, overall staffing levels at the Heathrow IRCs have been increasing.

[58] NHSE say there is a full stepped model of care for mental health at the Heathrow IRCs. Psychology-led talking therapies and Phoenix Futures provide lower level psycho-social interventions as part of this model.

Harmondsworth

3.53 Harmondsworth has three inpatient units, each with six beds, staffed by both a Detention Custody Officer and a nurse. These units appeared underused, and it struck me as wholly inconsistent that Harmondsworth had 18 inpatient beds but other centres, such as Yarl's Wood, had none. This is an illustration of my concern that the detention estate has lacked any strategic direction. Given Harmondsworth's facilities, there was previously a misunderstanding across the estate that it provided a hospital facility and – as a result – food and fluid refusal cases referrals were high. Harmondsworth's healthcare also has two isolation rooms.

3.54 I was concerned by the location of the pharmacy hatch on the main healthcare corridor, affording little privacy. The waiting area was cramped, but I was pleased to learn that funding was available to renovate three of the clinical rooms.

3.55 The relationship between IRC healthcare management and the NHS commissioner was said to be close, with structured monthly meetings. This seemed particularly important given that some staff had had six different employers in ten years. Healthcare management felt the sharing of best practice with other IRCs was limited and that the IRC forum had been valuable when it existed. Harmondsworth is, however, fully integrated into the London secure environments forum so they have an opportunity to share learning and best practice with other secure providers in London. IRC staff are also able to participate in London cross-establishment Blood Borne Virus training. It was not clear how often this was done.

Morton Hall

3.56 The healthcare environment was large and generally clean, with a separate dental suite, although some issues were noted such as confidential information left out in a locked dental suite. A new group room was in the process of being developed. The pharmacy hatch was private with adequate seating and an effective screen. Medication reviews were robust and in-possession assessments were also in place.

3.57 Sadly, there had been increased levels of violence. The impact could be seen in the boarded windows in healthcare, and plans for increased security measures including bricking-in windows, bolting down chairs, adding metal doors, and creating a barrier in front of the reception desk.

3.58 I saw good examples of healthcare leadership, and there was a positive relationship with the NHSE Commissioner. Healthcare was also well engaged with the centre's senior management, although I felt that links with the on-site Home Office team could be strengthened.

3.59 The latest IMB report had noted a difference between patients' poor perceptions of Morton Hall healthcare and the IMB's views of a quality service.[59] I was pleased that healthcare had held focus groups following the report, and a healthcare peer supporter now asks for feedback in healthcare reception. This seems good practice that could be followed elsewhere.

3.60 The healthcare complaints reviewed by my team related to: concern about the translator for a Rule 35 assessment; behaviour of staff escorting to hospital; the medication given after leaving prison; a concern that treatment was not the same as that received before; request for same day GP appointment; request for operation; and an incorrect entry on the medical record suggesting NPS use. All had received appropriate responses and actions where required.

[59] *Morton Hall Immigration Removal Centre IMB Annual Report 2016.*

3.61 There was significant confusion regarding AAR. Some of the men who were on ACDTs were not categorised as AAR (this was not unusual across the estate, although I think it is simple common sense that someone deemed at danger of suicide or self-harm must also be an Adult at Risk). I was told at Morton Hall this was because staff believed that the Home Office only wanted information about vulnerability on release rather than in detention, so did not flag any vulnerability they felt caused by detention itself. The IMB felt mental health needs had increased and centre management did not think the policy was translating into practice. Centre management told me there had been little change in the vulnerability profile of the detainee population, and that there had been cases of men in wheelchairs and others with significant health issues. In one case, Morton Hall healthcare had been adamant that an individual was not fit for detention for mental health reasons. Nevertheless, he had been detained and ultimately had to be sectioned.

3.62 Morton Hall's mental health team described highly effective processes for setting up care in the community for detainees prior to release, even at extremely short notice, with which I was very impressed. However, I was told of reluctance on the part of local social services to conduct the centre's only recent social needs assessment. All mental health referrals were seen within five days. The last two transfers to secure mental health facilities had taken five weeks from first assessment.

Yarl's Wood

3.63 The level of healthcare demand in Yarl's Wood remained very high. However, the IMB told me that there had been a significant improvement in healthcare provision, a view endorsed in the most recent inspection report by HM Chief Inspector of Prisons.

3.64 In general terms, cleanliness in the healthcare unit was of an acceptable standard, with rooms in good repair. However, there was too much clutter on surfaces, inappropriate storage of materials in clinical areas, and posters and papers on notice boards requiring lamination to support infection control. I also noted that in the dental suite the chair was dirty, and it was not clear what equipment and schedule was used for cleaning in clinical areas.

3.65 At the time of my visit, reception's healthcare consultation room was staffed by a male nurse. I questioned whether this was appropriate, and was pleased to learn that a new rota would prevent it happening again.

3.66 In the month prior to my visit, I was told that the waiting time for the GP was three days, with nurse triage available within two days. A dentist and optician were available every fortnight. The pharmacy was fully staffed. Staff acknowledged there had been issues of delayed medication deliveries from their supplier, but told me this had been resolved. Patient compliance in terms of collecting medication was said to be mixed.

3.67 The SystmOne electronic records system had been in use at Yarl's Wood for around two years. Those records I reviewed showed that staff at Yarl's Wood were not able to register patient consent to care plans, an issue I also saw at other IRCs and which should be addressed in the next iteration of the system.

3.68 Talking therapies and mindfulness techniques were provided at Yarl's Wood by the charity, Kaleidoscope, as part of a two-year pilot. The commissioner felt that outcomes were good and that detainee feedback on the service had been positive, and I saw that Kaleidoscope had created a welcoming environment. Indeed, the service had been commended as good practice in the latest HMIP report in June 2017.[60] The most common low-level presentations to the service were anxiety and reactive depression. More complex

[60] *Report of an unannounced inspection of Yarl's Wood Immigration Removal Centre by HM Chief Inspector of Prisons, 5-7, 12-16 June 2017.*

or multiple mental health issues were referred back to the in-house team. Detainees at Yarl's Wood can access the Reading Well service, and NHSE offers small grant funding to befriending organisations in recognition of the therapeutic benefit of their work.

3.69 Centre staff felt the commissioning relationship was good with monthly contract review meetings, although they would like to have greater provision for sexual health and drug treatment.

3.70 Yarl's Wood's reputation had affected staff recruitment and retention. One clinician noted that no specific IRC training had been offered, and that a network for sharing learning and best practice would be invaluable.

3.71 There was a complaints and compliments box in the healthcare area, and the sample reviewed by my team suggested written complaints were dealt with appropriately. I was pleased to learn of the development of a monthly detainee forum specifically on healthcare, which I regard as good practice and commend to other IRCs.

Healthcare impressions at STHFs

3.72 I was told that the Port Medical Inspector (PMI) was now used by the Heathrow terminal holding rooms. Where detainees showed signs of health issues, the PMI would make an assessment. Detainees could take medication if their name was on it, and staff could go to PMI if there were difficulties in identifying the medication such as the language on the label.

3.73 As a residential STHF, Larne House had excellent healthcare provision, with 24-hour nurse cover and a GP available when necessary.

3.74 The key issue raised by Tascor staff in the Lunar House holding rooms was medication. They had recently been told that they should agree to detain individuals who did not have their medication if the immigration officer had given permission. But staff had very limited options when people were unwell while in the holding rooms, as there was no medical assistance on site. Instead, staff used NHS 111 for advice. This raises concerns both about the availability of medical assistance in the holding rooms, and the effectiveness of vulnerability screening methods prior to this stage.

Commissioning of Healthcare Services

3.75 The partnership agreement between NHS England, Public Health England and the Home Office has the following priorities:

- better mental health assessment and treatment for detainees
- proactive detection, surveillance and management of infectious diseases and suitable treatment paths
- strengthened multi–agency approaches to managing detainees at serious risk of harm with better learning, process improvements and a multi-agency approach to ACDT
- aligned commissioning systems, including information governance
- an ambition to make the estate smoke-free
- to prioritise effective interventions in the management of novel psychoactive substances.

3.76 As I have said above, each of the IRCs has healthcare provision that is commissioned through a national procurement framework. This framework is locally informed by Health Needs Assessments. This competitive procurement process is designed to ensure that the best providers are engaged to deliver best quality and best value.

Health Needs Assessments and why they are required

3.77 A Health Needs Assessment is one of several approaches regularly used across clinical commissioning to help improve health and reduce health inequalities. Other tools include: a health impact assessment, integrated impact assessment, and health equity audit. A HNA is intended to provide the information necessary to meet policy objectives and to support the implementation of various Department of Health and Social Care policy documents, including *Saving lives: our healthier nation*[61] and *Shifting the balance of power within the NHS: securing delivery.*[62] The Wanless report, *Securing good health for the whole population*[63]*,* emphasised the importance of high levels of public engagement in order to achieve best health outcomes. In many cases, it is a mandatory part of the clinical commissioning process to inform regional and local strategic plans.

3.78 IRC Healthcare is within the commissioning portfolio of Health and Justice. There are nine regional teams spread across the four regions of NHS England, although NHS England remains a single accountable organisation. Health and Justice teams are mandated to complete HNAs every two or three years, and they are refreshed annually. HNAs may also be completed or refreshed if a service is to be re-procured, or if service changes are about to take place. In the event that prisons or IRCs are re-roled, HNAs sometimes have to be carried out at short notice.

3.79 Notwithstanding my view that the new commissioning processes are a distinct improvement on previous practice, and procurement processes aim to ensure best value and highest quality services, I remain concerned that Health and Justice commissioning teams in NHS England may lack the expertise or resource to undertake the HNAs of detainee patients. This role had previously been undertaken by Public Health; however, the function did not transfer at the initiation of NHS England in 2013. Consequently, where HNAs are required, external support is bought in, usually at considerable expense, given the need for specialist advice.

3.80 This can be further complicated as clinical commissioning assessment services are very often interpreted as either consultancy or as professional services. I understand this leads to a more protracted procurement timeframe, and to delays.

3.81 The different contract lengths can also add complexity to the healthcare landscape but in practice the contract end dates are relatively similar (see paragraph 3.16 above). I have been told by NHSE that, twelve months post award, contracts can be varied as long as the new function does not materially change the contract and function. This seems to be a sensible option for embedding improved practices, rather than waiting for contract changes.

3.82 NHSE recently received a report on the current health and justice healthcare supplier market, specifically focussed on prisons and IRCs.[64] In essence, the review took three main lines of enquiry:

[61] Department of Health 1999.
[62] Department of Health 2001.
[63] Derek Wanless et al 2004.
[64] NHS England Health and Justice Commissioning, *Prison and IRC Market Development Programme: Market Management and Workforce Review*, October 2017.

- What does the current commissioning landscape look like and the key risk and issues faced by commissioners in delivering effective health solutions for the prison population
- How procurement and commercial models are impacting on competition in the health and justice healthcare supply market
- Actions commissioners can take to address the risks and challenges posed by the issues above.

3.83 The report talks generally of the difficulties faced by providers in terms of recruitment and retention (personal safety and the "high level of challenge in the event of a death in custody" were amongst the factors cited, although it must be assumed that most of this reflected prison rather than IRC experience), and that the market tends to favour the larger providers. The report has little on IRCs specifically, beyond noting that one IRC provider stated "that some community services are unaware of the healthcare rights that detainees have and the lack of NHS numbers can make the arrangement of secondary care a challenge."

3.84 From this analysis, NHS England Health and Justice now has the opportunity to review how best to maximise the use of its budget. Given wider budgetary pressures on the NHS, it is commendable that healthcare provision in IRCs continues to be given priority.

Quality improvement

3.85 On a number of my visits, I was told by clinicians about the lack of best practice and lessons learnt sharing. There is an inevitable risk that commissioning a range of different providers of healthcare can lead to a silo mentality when it comes to best practice and innovation. This is especially so in a competitive market environment and at the time of contract procurement. In particular, best practice can be viewed as a unique selling point in a competitive process, when it should be open to all in pursuit of the joint goal of improving care.

3.86 Given the concerns raised with me by clinicians, I have looked for evidence that best practice is shared. However, I have found little sign of this, nor of encouragement to healthcare professionals to meet and learn from each other. This should be remedied as a priority.

Recommendation 16: A best practice forum should be established across IRC healthcare providers.

Sharing information

3.87 I have also observed that, while data may have improved somewhat in quality and accuracy, its sharing has not. It is clear that information transfer remains poor. All IRCs in England except Campsfield House have access to SystmOne. But Dungavel does not, as its healthcare is not commissioned by NHSE. I have seen no evidence that my previous recommendation that an alternative to SystmOne be developed for immigration removal facilities in other parts of the UK has been taken forward. This remains a matter of concern.

3.88 I was told by NHS England that the new Health and Justice Information Service (referred to by staff as Systm2, see footnote 57) will change how data is shared between the community and IRCs, to enable the patient's medical record to be joined up, and end the situation where, for example, a patient's IRC healthcare record remains entirely separate from their GP record in the community.

3.89 HJIS utilises a core IT product, SystmOne, provided by The Phoenix Partnership, which is a variant of the primary care clinical IT tool used by many GPs. Following further development of the system, patients will register with the IRC healthcare provider. Their full medical record will then be transferred from their community GP at reception, and they will be de-registered from the community practice. When a patient leaves an IRC, they will register with a community GP, and their full clinical record will be transferred back. This will enable information about all of the patient's medical history to be shared, including mental health diagnoses, long-term physical health needs, and potentially any history of drug misuse.

3.90 I understand the first release of this new functionality will be the Personal Demographics Service, which will enable healthcare providers to register patients on the NHS Spine, and ensure that accurate NHS numbers are recorded for each patient. This is a necessary precursor to the introduction of General Medical Services (GMS) registration and GP2GP transfer of clinical records. The timetable for the introduction of the new functionality is:

- Personal Demographics Service (PDS), First of Type (pilot) from August 2018
- PDS Rollout from October 2018 to April 2019
- GMS Registration and GP2GP data-sharing, First of Type from May 2019
- GMS & GP2GP rollout from July 2019 to February 2020
- Phase 3 (electronic referrals, electronic prescribing, GP extraction service) First of Type, from March 2020
- Phase 3 rollout from May to October 2020.

3.91 I further understand that, in preparation for the first phase, the HJIS programme team is working with healthcare providers to improve the quality of data in the system by removing duplicate records and validating NHS numbers. Training is also continuing, with current efforts focussed on strengthening knowledge and skills regarding the baseline system. This will switch to PDS-specific training in the lead up to the rollout in October 2018.

3.92 However, I am concerned that printed SystmOne healthcare records currently identify detainees as *prisoners* on the template. In the case of those detainees released from detention, this record constitutes the handheld notes that they provide to community services. I was told that some detainees do not present their care records to community GP practices because they are described incorrectly as prisoners. Indeed, I was informed of detainees destroying or placing their handheld notes in a refuse bin as they left upon release because of this issue. This presents a very real block to community care. Regrettably, no clear deadline has been provided for when the false 'prisoner' identification will be addressed.

Recommendation 17: SystmOne templates should be urgently amended so that detainee healthcare records no longer identify detainees as prisoners.

3.93 Concerns were also raised to me by healthcare staff in several IRCs regarding the rollout of HJIS. They reported that:

- IRCs were not included in any pilot
- HJIS includes additional templates, which were said to be time consuming and in some part irrelevant
- The system remained prison-centric.

3.94 When my team raised this with NHSE, they challenged the view that no engagement has taken place, and said that there had not yet been any piloting, which will not start until August 2018. Updates had been circulated to IRC leads since the data quality work commenced in August 2016, and representatives had been seen from each IRC on four occasions. The new templates are closer to National Institute for Health and Care Excellence (NICE) clinical standards in order to enhance quality. Nevertheless, it was clear from my visits that more needs to be done to improve communication at a local level.

3.95 Knowledge of SystmOne appears varied across IRCs. For example, despite the existence of a Detention Services Order on Consent, my team observed that patient consent to treatment was often not completed in SystmOne records. I was told that staff would sometimes complete this on paper instead due to difficulties in accessing the system and this is an issue of concern. Consent should be a mandatory field and its completion should be straightforward for staff.

Recommendation 18: NHS England should continue to roll out staff training on SystmOne/HJIS, and should make sure that patient consent is consistently recorded by conducting a national case file audit and ensuring that this is a mandatory field in HJIS.

3.96 The version of SystmOne deployed in prisons is the same as the version in IRCs, and therefore there should be instant transfer of clinical records between prisons and most IRCs when someone moves from one to the other. However, staff told me that the transfer of patient information between prisons and IRCs remains poor. It is arguable that this would be assisted by a formal sharing protocol involving HMPPS, the Home Office and NHSE.

Supported Living Plans

3.97 My team and I observed good examples of Supported Living Plans at Brook House and Tinsley House, with strong contributions from healthcare staff (in particular at Tinsley). However, there is some confusion in the use and nomenclature of these plans, the terms Adults at Risk plan or Supported Living Plan appeared to be used interchangeably by staff. These plans essentially deliver the same goal: that is, the additional support needs for vulnerable individuals identified under AAR. But in some cases these were completed in addition to ACDTs, in others they were standalone.

3.98 The Home Office is also piloting a Vulnerable Adult Care Plan (VACP), designed as a single care monitoring and planning system for use across all IRCs. The VACPs may mean there is no longer a need for multiple observations to be entered on separate forms, and make it easier to transfer documents between centres. But care will be needed to ensure that information is transferred between sequentially opened documents (i.e. when a VACP is closed and an ACDT opened, or vice versa). This would all be a lot simpler were one talking about digital and not paper documents.

3.99 I was told that the number of open care plans from August 2016 – August 2017 was as follows:[65]

IRC	No. of care plans	Comments
Yarl's Wood	54	
Joint Heathrow response (Harmondsworth and Colnbrook)		Practice in the IRC at Heathrow would be that anyone with a long term condition or being treated by the mental health team or the substance misuse nurse would have a care plan drawn up.
Morton Hall	67	As at 16.09.17
Campsfield	6	These patients are on Assessment Care in Detention and Teamwork plans (ACDT) Other clinical care plans are in-place (i.e. to manage long term conditions) however it was not possible to count these without SystmOne.
Gatwick Estate (Brook House and Tinsley)	57	In addition, Supported living plans 12 ACDT 15.

Interpreting/translation services

3.100 Clinical discussions with patients are extremely difficult if the patient has little or no use of English. In these circumstances, the use of interpreters is commonplace. The main service providers are Big Word and Language Line.

3.101 In my original review I expressed concern that professional interpreters were not used widely enough. During this follow-up, my observations and the evidence received suggest that use is now widespread but that quality remains an issue.

3.102 I was told during my visits that eight per cent of triages at Harmondsworth and 6.3 per cent of triages at Colnbrook required an interpreter in the year spanning the second quarter of 2015/16 to the second quarter of 2016/17. The total number of triages requiring an interpreter across both sites for this period was 932. Across the two Gatwick IRC centres, healthcare placed 1,617 calls to the telephone interpretation provider for the period April 2016 to May 2017. At Yarl's Wood, 31 patients had required interpreters in October 2017, and this was a representative monthly total.

3.103 On all visits I was told there were issues with detainees trusting a third party on the telephone, and disclosing sensitive information when using interpretation services. Other problems include the presence of domestic noise in the background, and unwillingness on the part of the interpreter to describe sensitive subjects such as the details of sexual assault. Hibiscus told me:

> "The experience and expertise of interpreters is regularly a cause for concern, with some either being unable/unwilling to discuss matters relating to sexual orientation in asylum interviews because of cultural/religious bias. A lack of literacy skills amongst interpreters is also a cause for concern."

3.104 It was reported that it was not always possible to reach an interpreter when required to translate particular languages and dialects, or at particular times of day. This can be especially problematic when detainees arrive throughout the night and urgent assessment of their needs is required. Sometimes this led to the use of peer translators (fellow detainees) or staff members.

[65] This table is derived from management information, collected locally, and not subject to other validation.

Recommendation 19: The Home Office and Ministry of Justice should conduct a review of the quality of interpreter services in IRCs.

Environment and Resources

3.105 In my observations on individual IRCs above, I have noted that a number of clinical rooms were not compliant with Care Quality Commission (CQC) expectations or infection control guidelines. These issues are symptomatic of healthcare facilities that may not have been built for their current purpose, and were often cramped and lacking in storage.

3.106 I observed some examples of desensitisation in that longstanding members of staff did not notice or respond to poor and insanitary conditions that were unacceptable, and clearly not equivalent to clinical areas in the community. My team member seconded from the NHS was so concerned in one establishment that he reminded the head of healthcare of the infection control and CQC guidance relating to safe care and treatment.[66] The standard of cleanliness was not acceptable in many areas, and much more needs to be done to improve this.

3.107 In my first review I recommended that care suites be created urgently across the immigration estate. I was pleased to learn that a proposal was being considered to create a six-bed care suite to serve Colnbrook and Harmondsworth, and that Dungavel's refurbishment plans also included the creation of care suites.

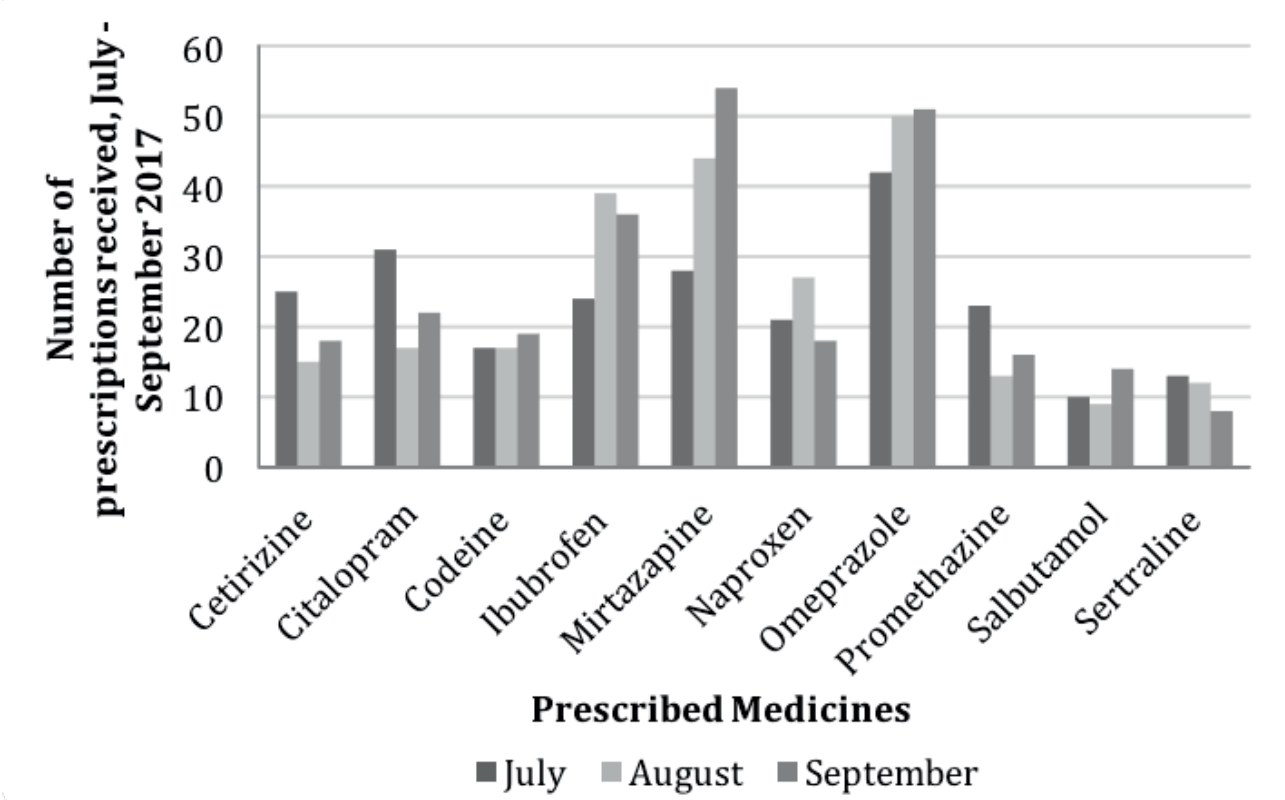
Recommendation 20: An action plan should be drawn up to address the shortcomings I found in healthcare facilities within the immigration estate to ensure a clinically safe, compliant and appropriate environment for the delivery of care to detainees.

[66] Health and Social Care Act 2014: Regulation 12, safe care and treatment; Regulation 15, premises and equipment.

Pharmacy and medicines management

3.108 The use of medication is very high in all IRCs. Figure 3.2 illustrates levels of use of commonly prescribed medication at Brook House and Tinsley House:

Fig 3.2: Number of prescriptions received for the most commonly prescribed medicines in Tinsley House and Brook House IRCs, July – September 2017



3.109 NHS England agreed the delivery of an IRC medicines optimisation programme during 2016/17. However, mechanisms to support the safe administration of medications were not in evidence during my visits, nor did staff make reference to them. I was not satisfied that the healthcare facilities I observed offered appropriate dispensing arrangements. Examples included:

- Waiting rooms that were also used by those awaiting appointments and which were too small
- A lack of privacy at dispensing hatches
- Additional security at hatches that was a barrier to patient compliance and which was not risk based
- Variable provision for medication storage
- Inconsistent opening hours which sometimes overlapped with work, education or activity sessions that could impact on attendance.

Recommendation 21: Waiting environments for medication distribution should be reviewed to ensure privacy and dignity, and support personal safety.

3.110 I was also concerned that the handover of medication on removal or release can be inconsistent. Furthermore, while best clinical practice dictates regular medication reviews, these were not consistently in place.

3.111 The guidance on in-possession medication – one of NHS England's responses to my last review – does not appear to be consistently embedded and was not referenced by 50 per cent of the pharmacy staff interviewed. While I was informed that some detainees were deemed able to have in-possession medication, this was not as widespread as I would have anticipated (and will be influenced by irregular medication reviews).

Smoking cessation

3.112 There was some inconsistency between IRCs and STHFs in the manner in which they were addressing the issue of smoking. None of the IRCs was yet entirely smoke- free. Nevertheless, I commend the work that is underway to support detainees to stop smoking. This can be challenging given different national and cultural attitudes towards smoking – for example, at Morton Hall nearly two-thirds of detainees were smokers. However, my own view is that all IRCs should become smoke-free as soon as is practicable. This has proved successful in prisons given proper planning, provision of cessation support for detainees, and guidance for staff.

3.113 Detention Services Order 02/2014 (smoke free legislation) was withdrawn on 6 February 2018 and the whole immigration detention estate, with the exception of Morton Hall IRC which will follow shortly, will have been smoke free indoors by 1 April 2018 and therefore compliant with Chapter 1 of the Health Act 2006. The Partnership Agreement between the Home Office, NHS England and Public Health England 2017-19 sets out the Government's commitment to implement a smoke free estate, subject to scoping work to identify risks, benefits and likely costs. A programme of work has started between the Home Office and NHS England to deliver this commitment.

Recommendation 22: As set out in the NHSE, Home Office and PH(E) National Partnership Agreement, all centres should become smoke-free as soon as possible, subject to proper planning and support for detainees and staff.

Primary Care

3.114 Primary care is provided in all IRCs. Waiting times for GP appointments vary between one and six days, however a nurse-led triage[67] is in place in all centres. In general, I believe this degree of access to a GP access is equivalent to, and in some areas superior to, that in the community.

3.115 However, this is not to compare like-with-like. Detainees do not have access to over the counter medication, as they would in the community, although they would if a selection of over the counter medicines were made available via an IRC shop. Detainees do have access to Accident and Emergency if they require emergency hospital triage, but are not able to access drop-in services while in detention. Manifestly, detainees are also denied the normal support mechanisms of family and friends.

3.116 I was pleased to find that the opening hours of healthcare units appeared more consistent than I had observed in my initial review. However, there remains some variance in the range of services on offer. All healthcare teams interviewed were achieving the Detention Service Order targets for initial healthcare screening and assessment (to be seen by a nurse for an initial assessment within two hours of admission; to be seen by a GP within 24 hours of admission). Nonetheless, health screenings are still often short, especially where multiple or late-night arrivals take place.

[67] The first stage on arrival where the nurse evaluates patients' condition and determines priority.

3.117 I was impressed by the aspiration of the Brook House healthcare team to develop a discharge plan from arrival for those likely to be released, a process that takes place routinely in acute hospital care. This included liaison with GP practices and other community health providers. However, a realistic time for these discussions is required, and depends on a clearly identified release address to engage the appropriate stakeholders. Unfortunately, this is thwarted by the short notice often given for release; this can sometimes be two hours or less, whereas a realistic minimum timescale for organising onward care would be 48 hours.

3.118 I heard many examples where care pathways into the community were challenging, especially where those released have been, or become, of no fixed abode (an address is required for GP registration).

Long-term conditions (LTC) and end-of-life (EoL) care

3.119 IRCs are not commissioned nor equipped to deal with EoL conditions, as release should surely follow such a prognosis. In regard to LTC the information set out in Figure 3.3 was received.

Fig 3.3: Long-term conditions (LTC) policies at each IRC

IRC	Comments
Yarl's Wood	G4S states that they follow NICE template pathways. IRC plans one LTC clinic each week, however sometimes not required. Ten named nurses covering the following: older people, drug and alcohol issues, disability, infection control, tuberculosis, sexual health, mental health, smoking cessation, travel, asthma, epilepsy, diabetes, wound care, coronary heart disease
Colnbrook and Harmondsworth joint response	Offer services to detainees with a wide range of long-term conditions
Brook House and Tinsley House response	LTC clinics in place
Dungavel	Chronic disease stats and clinics in place. For EoL Dungavel has utilised established links with a local hospice as required.
Morton Hall	Morton Hall has lead nurses for each of the following LTCs –diabetes, coronary heart disease, respiratory (asthma, COPD and tuberculosis) and blood-borne viruses.
Campsfield	Services for LTCs and End of Life are catered for on a case-by-case basis. The unit has a register of all patients with a LTC. Detainees who are EoL are discharged from IRC Campsfield. There are six nurses who able to deliver a range of clinics including asthma, diabetes and hypertension, delivered when required.

3.120 The evidence above assures me that, from a healthcare perspective, patients with LTCs have their needs catered for in groups and clinics. However, I am much less certain how care for these conditions translates to community provision on release.

Mental Health

3.121 I expressed great concern in my last review about provision for those with mental health problems. In response, the Centre for Mental Health was commissioned by NHS England to conduct a rapid mental health needs analysis of IRCs in England. The aim was to support NHS England and the Home Office in planning to meet the wellbeing and mental health needs of people held in IRCs.

3.122 The subsequent report acknowledged (unsurprisingly given the wealth of research evidence summarised so ably by Professor Bosworth in my first review) both that immigration detention has a negative impact on mental health, and that the longer someone spends in detention, the more negative an impact it has upon their mental wellbeing.

3.123 The report highlighted that the most commonly reported problem was depressed mood and anxiety, and the most severe problems were hallucinations or delusions. It made a series of recommendations that I do not need to reproduce here.

3.124 I very much welcome the work that has been carried forward so far, and note that the Centre for Mental Health review has informed the revised mental health service specification that was completed in 2017.[68] (See Ms Davies' comments in paragraph 3.7.) However, the process is not without its critics. MIND told me:

> "The NHS England *Service Specification: Immigration Removal Centre Mental Health Services* sets out in great detail over 20 pages the mental health services NHS England propose to supply in IRCs. There is very little here however about assessing mental health needs and lots about managing them."

3.125 This is particularly relevant in light of the Centre for Mental Health's analysis that: "there is currently a missing component in the process of making a decision to detain someone. At the moment there is no screening in place to detect vulnerability before the decision is made to detain."

3.126 All those in IRC healthcare interviewed for this review said that onward referrals to mental health beds remained difficult, and delays were evident pre- and post- assessment. This was flagged as a specific concern at Brook House. It was noted that transfers into secure mental health provision involved multiple assessments and time lags between each stage. There were examples of detainees moving backwards and forwards between secure mental health services and IRCs.

3.127 However, with a waiting time of five to six weeks on average, transfer to mental health facilities from IRCs appears faster than the equivalent referrals from prison referrals. NHS England told me that the latest figures suggested a fall in numbers awaiting transfer.

3.128 I asked each healthcare provider to list the number of people returned to immigration detention after being sectioned in the last 24 months. I received the data set out in Figure 3.4.[69]

[68] *Service Specification: Immigration Removal Centre Mental Health Services: August 2017*. NHS England Publications Gateway Reference Number: 07038. (https://www.england.nhs.uk/wp-content/uploads/2017/09/irc-mental-health-service-specification.pdf).
[69] Data provided by suppliers and not otherwise validated.

Fig 3.4: Number of people returned to immigration detention after being sectioned, by IRC

IRC Estate	Number of patients	Additional observations
Joint Heathrow response	18	18 went to the Psychiatric Intensive Care Unit (PICU[9]) treated and brought back in the last 24 months
Yarl's Wood	1	
Joint Gatwick response	2	
Morton Hall	1	
Campsfield	0	
Dungavel	10	Of whom: 5 were sectioned 4 were returned 1 released following inappropriate detention

Patients with limited capacity

3.129 In regard to those detainees who may have limited or no capacity[71] due to mental ill health or other impairment, Liberty told me:

> "Outside of immigration detention, the system for detaining those without capacity to consent to treatment or care includes a series of safeguards. These include a mental capacity assessment and a best interest's assessment to determine whether Deprivation of Liberty Safeguards (DoLS)[72] should be granted.
>
> "By contrast, the Centre for Mental Health has observed that screening in detention centres for learning disability, autism spectrum disorder or acquired brain injury was weak or very limited and that they would recommend reviews of a detainee's well-being after 30 days and thereafter at 3-month intervals."

3.130 Disclosure of learning difficulties may well not take place at the initial IRC assessment. Language barriers and lack of information may mean a full picture of the individual's needs is unavailable. Moreover, unless someone is aware of, or can describe, their own issues as a learning disability, the road to clear diagnosis can be a long one. If the detainee is an FNO, one might expect a learning disability screening to have been completed in prison, but if the detainee has come direct from the community this is less likely.

3.131 Healthcare staff at Yarl's Wood said that the test for Learning Disability (LD) identification is that the detainee is asked whether they can read or write. However, staff did accept that those with learning disabilities may not be able to articulate their needs, especially if their first language is not English. Ms Davies refers above to the development of the HASI non-verbal learning disability screening tool at Morton Hall, although staff there told my team that it was not suitable for those whose first language was not English.

3.132 I welcome the fact that improvement in the identification of learning disability and support for those with LD is specifically included in the new service specification for IRC mental health services. This includes a requirement that:

[70] A PICU is a type of psychiatric unit designed to provide care and treatment for people whose acute distress, absconding risk, suicidal ideation, or challenging behaviour requires a secure environment that cannot be provided on an open psychiatric ward.
[71] Mental capacity means being able to make your own decisions – this may be impaired by illness or disability (mental ill health, dementia or learning disability). Those without capacity cannot do one or more of the following: understand information, retain information, weigh up information or communicate their decision.
[72] The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only.

> "Individuals identified with a learning disability will be given a comprehensive physical and mental health assessment using an appropriate tool, which staff are fully trained to use. Patients identified with a suspected or confirmed learning disability must be clearly identified on a central IRC healthcare database and appropriate information shared with the establishment operator and other healthcare services."

3.133 I acknowledge that LD covers a very wide spectrum. I would simply add that in my first report I recommended that those with learning difficulties should be presumed as unsuitable for detention.

Healthcare complaints

3.134 Figure 3.5 shows healthcare complaints received in the period August 2016 – August 2017.[73]

Fig 3.5: Healthcare complaints

IRC	Numbers of complaints	Comments
Yarl's Wood	33	None received
Colnbrook and Harmondsworth joint Heathrow response	37	In addition there were 99 concerns raised. These are low-level complaints but dealt with locally rather than going through the whole complaints process – as per CNWL's complaints policy.
Brook House and Tinsley Joint Gatwick estate	38	None received
Morton Hall	2	12 concerns/local resolution
Campsfield	17	All were managed in accordance with NHS complaints policy
Dungavel	6	None was upheld after investigation

3.135 When comparing this data to that supplied to inform my previous review, I note that Yarl's Wood reported 111 complaints for the twelve months between April 2014 and April 2015. The 2016-2017 figure represents a reduction of over 70 per cent.

3.136 However, complaints data may be an inexact proxy for what detainees actually feel and believe. I was therefore pleased that NHSE had commissioned a wider patient survey in June 2017. This found:

- 68 per cent of patients felt that they were treated sympathetically to their cultural and religious needs.
- 79 per cent of patients were referred to by their preferred name.
- Staff only introduced themselves to 49 per cent of patients.
- 83 per cent of patients felt that the clinic staff treated them with kindness and respect.
- 59 per cent of patients were not offered a choice of the gender of the member of staff who would care for them.
- 70 per cent of patients felt that they were able to discuss their healthcare needs with staff.

[73] Table collated from local sources and not otherwise validated.

- 46 per cent of patients indicated that they thought they had or had been diagnosed with a Long Term Condition, of which depression (22 per cent), asthma (18 per cent) and mental health (11 per cent) where the most common conditions.
- 48 per cent of patients with a Long Term Condition received treatment, of whom 44 per cent received the treatment they expected.
- 49 per cent of patients with a Long Term Condition received medication, of whom 37 per cent received the medication they were expecting.

3.137 I think it may fairly be said that the findings are mixed, but they chime with the more impressionistic observations from my visits to IRCs.

3.138 The regular collection of patient views is a key factor in driving up quality. I understand that NHSE are indeed in the process of procuring a two-year programme of questionnaires. In addition, there is a contractual obligation for providers to gather patient satisfaction reports that are shared at quarterly performance and contact review meetings. I welcome these developments.

Escorts and Bedwatches

3.139 I was told by heads of healthcare of their concerns about insufficient escort slots to support hospital treatments for those complex health needs. One IRC claimed that only ten per cent of appointments were supported in October 2017. However, at the Gatwick IRCs there were two escort slots per day for each centre, and this was viewed as adequate.

3.140 Healthcare played an active role in prioritising these appointments on the basis of clinical need.

3.141 I learned at Morton Hall of the resource pressure that can be caused by providing constant hospital bedwatches. There was a concern that the new escorting contract might not include the first four hours of constant hospital bedwatches as provided currently.

Access to care services in the community

3.142 All heads of healthcare expressed concerns about care pathways if or when detainees were released into the community. Additionally, the complex care needs of detainees are not consistently identified across the 44 national Sustainability and Transformation Plans (STPs),[74] or the subsequent Accountable Care Systems (ACSs),[75] These describe and form the only basis for funding the continuing delivery of healthcare by Clinical Commissioning Groups (CCGs).[76] This runs the risk of very vulnerable detainees being left without access to care following release.

3.143 I was concerned by a lack of understanding about the healthcare entitlements for detainees released into the community. When asked, no member of staff seemed to be fully on top of the detail, and indeed some explanations were inaccurate. I suspect that, in consequence, information provided to detainees was also incorrect.

[74] These are the way in which the NHS is developing its own locally appropriate improvements for the health and care of patients – there are currently 44 covering England. They aim to address the triple challenge set out in the *NHS Five year forward view* (better health, transformed quality of delivery and sustainable finances).
[75] A system of integrated healthcare provision, merging the funding of primary care with that of hospital care. An Accountable care organisation is one that ties payments to quality metrics.
[76] A clinical commissioning group is responsible for implementing commissioning as set out in Health and Social Care Act 2012.

3.144 However, I understand that these systems are being reviewed in relation to direct commissioning responsibilities, and am encouraged to note the new mental health service specifications in which it is stated that:

> "The Mental Health Team will engage with community services where possible to facilitate continuity of care and provide a discharge coordination service for patients where appropriate. For those individuals who are so poorly they cannot remain in detention it is important that the mental health team work alongside the Home Office to support the person is released [sic] to an environment that better meets their needs.

3.145 I hope these specifications will lead to genuine improvements in care pathways. I have heard too many examples of this process not working at present. I expect the needs of former detainees in the community to be identified and acknowledged in care planning within the evolving NHS Sustainability and Transformation Plans.

Recommendation 23: The Home Office and Department of Health and Social Care should prepare a joint communication to IRC healthcare teams clearly laying out health-based entitlements for former detainees released into the community.

Culture and staffing

3.146 During my visits to healthcare, I observed appropriate behaviours from staff in their interactions with detainees and colleagues. However, only half the staff interviewed by my team stated that if they observed inappropriate behaviour they would know how to report it, and would do so.

3.147 There was concern about increased levels of threats of violence, and some healthcare staff said that relationships with DCOs were variable.

3.148 I asked how many healthcare staff in the last 12 months have been reported to professional standards and the information given in Figure 3.6 was provided.[77]

Fig 3.6: Healthcare staff reported to Professional Standards in past 12 months

IRC Estate	Numbers of staff
Joint Heathrow response	3 Nursing and Midwifery Council (NMC) referrals in the last 12 months – two for substantive staff and one for an agency staff member.
Dungavel	0
Yarl's Wood	1
Morton Hall	1
Campsfield	0
Brook House	1

3.149 Many of the healthcare teams were short of full-time staff. Retention rates differed between centres. Delays in security clearance remain a problem, as they seem to be across the public sector. I can only repeat what I said in my last report that NHS England needs to ensure the filling of permanent healthcare vacancies in IRCs as a priority.

3.150 Based on the feedback I received, I would strongly suggest greater use of nurse prescribers. This would be equivalent to community practice, and would support the work of GPs. Additionally, it is a welcome form of staff development and capability, and likely to encourage staff retention.

[77] The data in this table has come from local sources and has not been validated centrally.

Summary of my healthcare findings

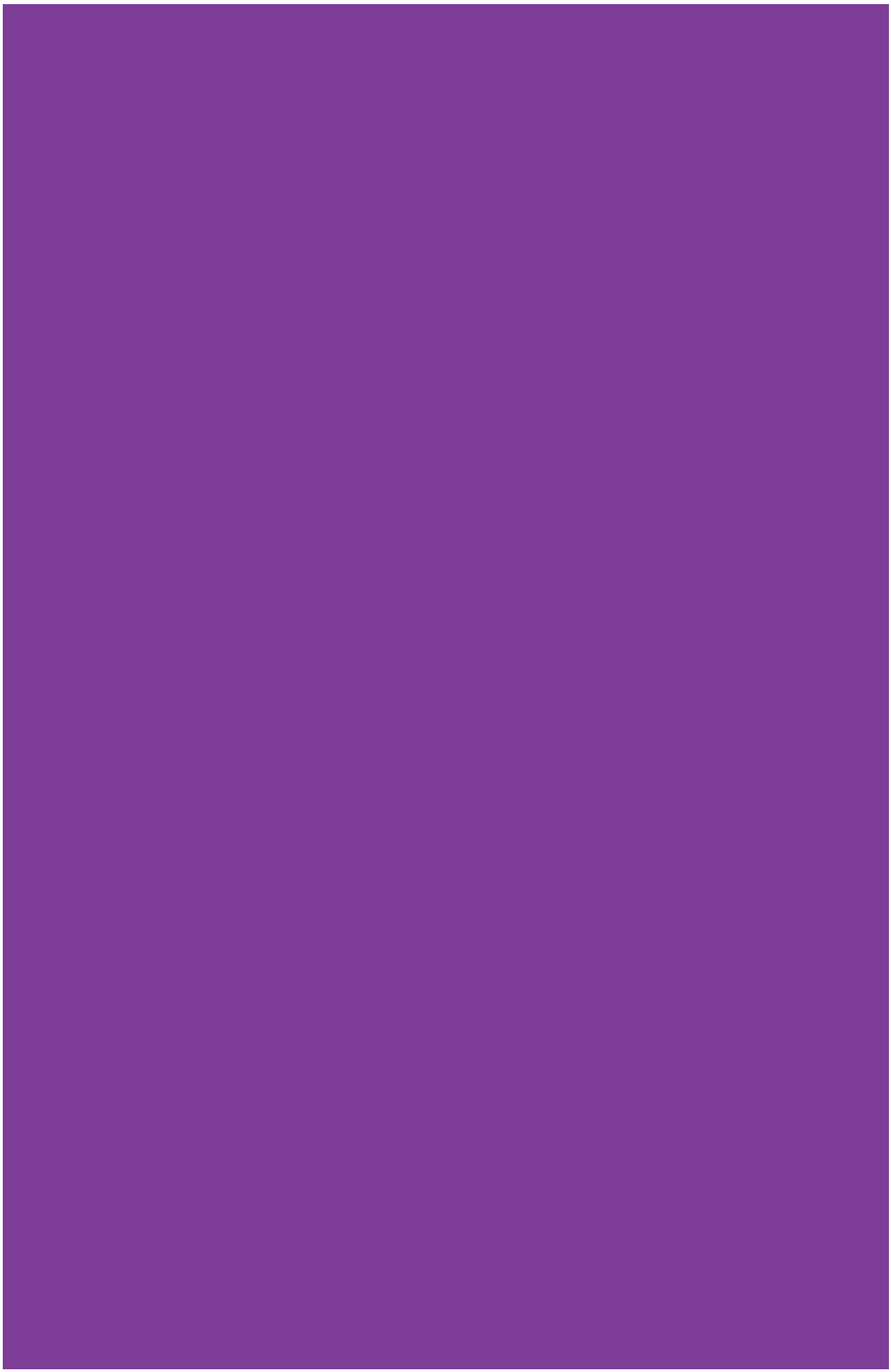
3.151 It is very apparent that much has been done since my first report to improve provision of healthcare in IRCs, with significant plans in place to do more. Nonetheless, there remain significant concerns arising from the current levels of demand. Patient dissatisfaction also remains high. While there has been progress against the recommendations of my first report, there remains much to do.

3.152 The new commissioning approach has introduced more consistency, expertise and clinical involvement in the provision of services. However, there remains a risk that a competitive market, and the current absence of any regular forum for exchanging good practice, creates silos between providers. I have seen some really interesting developments, but the fragmentation of medical providers may not be best designed to ensure the spread of good medical practice.

3.153 The delivery of care in sometimes insanitary and unsuitable conditions raises serious concerns. In some quarters, there appears to be poor awareness of basic hygiene and cleaning regimes. Some staff seem either to be desensitised or unable or unwilling to do anything to improve the situation. There is a strong regulatory oversight point, given Care Quality Commission involvement in inspections by HM Chief Inspector of Prisons. And for clinically qualified staff, failure to report poor physical conditions could impact upon their professional registration.[78]

3.154 While I was heartened by the plans to improve mental health care – of absolutely central importance given what we know about the impact of detention on mental wellbeing – I am concerned that the benefits may not be felt for some time to come. I would encourage the NHS and Home Office to look closely at how they might be able to push forward improvements ahead of any contractual changes.

[78] The code of conduct for nurses (Nursing and Midwifery Council, *The Code: Professional standards of practice and behaviour for nurses and midwives*), includes this passage (emphasis in original):
"17. **Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection.**
To achieve this, you must:
17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information, and
17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people."



PART 4: CASEWORKING

Introduction

4.1 This chapter references detained casework commands and at times describes what are known as ring fence owners (RFOs). Detained casework commands are the names of the different teams that manage the detention of different cohorts of detainees. The term RFO refers to the proportion of the total detention bedspace for which each of the commands is responsible. The Home Office describes the detained casework commands as follows.

- Border Force (BF) is a Home Office directorate and as an operational command manages detainees for a short period from arrival. The detention period is from day one.
- Criminal Casework (CC) is part of Home Office Immigration Enforcement and as an operational command manages foreign national offenders through the deportation and removal process. The detention period is from day one and can follow custodial detention.
- Operation Nexus is a specialist team within Criminal Casework. The team manages high harm foreign national offenders referred predominantly from the Police Service, usually on an intelligence basis. Referrals also emanate from Immigration Compliance and Enforcement (ICE) teams. The detention period is from day one and can follow custodial detention.
- The National Returns Command (NRC) is part of the Home Office Immigration Enforcement directorate and as an operational command manages immigration offenders through the removal process. The detention period can be from day one or can follow a period of detention with Border Force.
- Third Country Unit (TCU) is part of the UK Visas and Immigration directorate and as an operational command manages those subject to the Dublin III regulations through to removal. The detention period can be from day one or can follow a period of detention with Border Force or the National Returns Command.
- The Detained Asylum Casework (DAC) team is part of the UK Visas and Immigration directorate and as an operational command manages those who claim asylum while detained within the National Returns Command or Border Force. The detention period is rarely from day one and predominantly follows detention in the National Returns Command and or Border Force.

4.2 My team and I have visited a number of caseworking teams across the country to look at how the Adults at Risk policy and other changes has been put into practice. I have met both frontline staff and middle and senior management from those Home Office directorates that manage the larger part of the casework of those detained: the National Removal Command (NRC) and Criminal Casework (CC). I also had the opportunity to meet with staff and managers from the teams which refer individuals for detention, including an Immigration Compliance and Enforcement (ICE) team, a Reporting and Offender Management (ROM) team, and the referral casework directorate, Returns Preparation (RP), based in Sheffield. The team and I have also met with a number of staff from Detained Asylum Casework (DAC) during our visits to the immigration removal estate, as well as observing case progression panels and meeting DAC senior managers.

4.3 I have been struck by what caseworking means within the immigration system. Generally, casework is based on a single case owner who has personal responsibility for an individual until the case is concluded (social work is an example of this). In the Home Office, this is not the case. By and large, with the exception of criminal casework, staff make specific decisions on an aspect of a case and then hand the matter over to another part of the Home Office to make the next decision. Other than asylum interviews, most Home Office casework decision making is completed with no face-to-face engagement. Assessments on individual vulnerability are made at different decision points, by different staff with different knowledge, skills and training.

4.4 The only staff who have regular face-to-face contact with individuals within the system are the ROM (Reporting and Offender Management), ICE (Immigration Compliance and Engagement) and Home Office staff based in IRCs and prisons. However, since my last report, the Home Office has sought to strengthen individuals' access to Home Office staff through the creation of pre-departure teams (I discuss these in more detail later).

4.5 My visits to caseworking teams happened after the initial IRC visits had been conducted. I found this useful as it meant I had already met a number of detainees on my visits, and this enabled me to frame the questions I asked of the caseworkers and their managers.

4.6 I outline the circumstances of one particular individual I encountered in Colnbrook. I was utterly bemused and appalled to find she had been detained, given what I believe to be the clear Home Office policy intentions on the detention of the most vulnerable. I have used this case in my discussion with a range of caseworkers. This case sums up for me the inability of the current system to reliably recognise vulnerability indicators and act in a proportionate manner. Detention too often appears to be the default position.

> Ms A is a 77-year-old Bangladeshi female overstayer, assessed as adults at risk level 2 due to her age. In addition to her age she had also recently been subject to a cataract operation and had prescribed medication. She had been offered voluntary removal on two occasions but as she had refused to leave, she was detained on reporting with pre-set removal directions in place four days later. It did not appear any removal action without detention had been explored.
>
> When she was detained she did not have her prescribed medication with her but a decision was made by the detaining staff not to go to her home to obtain the medication before travelling from the North East to London. The IRC was not aware of her arrival as the appropriate paperwork had not been completed and when she arrived at the IRC she was left for five hours in the induction area while the paperwork was sorted out.

On her first night she was physically sick and unable to move herself around the unit. Other detainees and IRC staff had to assist her due to her frailty. Healthcare assessments were that her vulnerability could be managed in detention, even without medication. I understand other detainees complained about the level of support and care she needed.

When I saw Ms A she was clearly very old, frail, in poor health and not remotely suitable for detention. Detention staff and the Home Office staff at the IRC did not consider her suitable for detention and continued to push for a fresh assessment by healthcare, which eventually led to her release. She was finally assessed as too vulnerable for detention and was released.

Views of Non-Governmental Organisations

4.7 A number of NGOs who made representations during the course of this review were concerned that the changes to caseworking processes were exclusively internal with no independent or judicial oversight. They also criticised a lack of transparency that they said made the impact of any changes difficult to quantify. I am not sure that this derives from any absence of will on the part of the Home Office, and I am aware of ongoing work to improve information management relating to the casework changes.

4.8 The Immigration Law Practitioners Association (ILPA) told me:

"The purpose of the Detention Gatekeeper (DG) is to screen out those who are particularly vulnerable to harm in detention before they enter detention. However, it is an entirely internal process, with the DG reliant on information provided by the Home Office casework team. Representations from the detainee or his/her legal representative are not invited and the DG consideration is usually before a Rule 34 assessment and Rule 35 report. The Home Office casework team may not provide medical records or reports that are sitting on the Home Office's files. The DG consideration, and its effectiveness as a screening mechanism, will be limited by the quality of the information and evidence available. Unless the Home Office casework team already have medical records or a medical report, it is likely that the DG will at most have level 1/self-declaration evidence, which will be afforded very limited weight.

"Detention review/case progression panels have been introduced to meet the recommendation that there should be more independent oversight of decision making, and in order to ensure the detention does not continue longer than is necessary. However, these panels are entirely made up of Home Office officials and there is no opportunity for detainees or their representatives to provide evidence and oral or written representations. It is ILPA members' experience that like ordinary detention reviews, decisions are often made on an incorrect understanding of the factual situation."

4.9 I was also sent representations and a recent report by Amnesty International.[79] Amongst other things, Amnesty said that:

- Detention policy had shifted from detention as a last resort towards detention as routine.
- Detention was often based on flawed decision making. Decisions to detain were, in many cases, based on a limited search for and application of information about the person's case-history; a lack of rigour in applying policy and law when justifying detention decisions; a failure to consider alternatives to detention; and an at-best cursory engagement with the wider context of a potential detainee's history and circumstances, including the best interests of children affected by the decision.

[79] Amnesty International, *A matter of routine: The use of immigration detention in the UK*, December 2017.

- Once detention had commenced, in many cases it was maintained "as a matter of default or convenience". The justifications offered were frequently based on strained reasoning, and unrealistic assessments of the prospect of removing someone from the UK. Casework often sought to justify continued detention unless release cannot be avoided – "reversing the appropriate position of detention as the last resort."

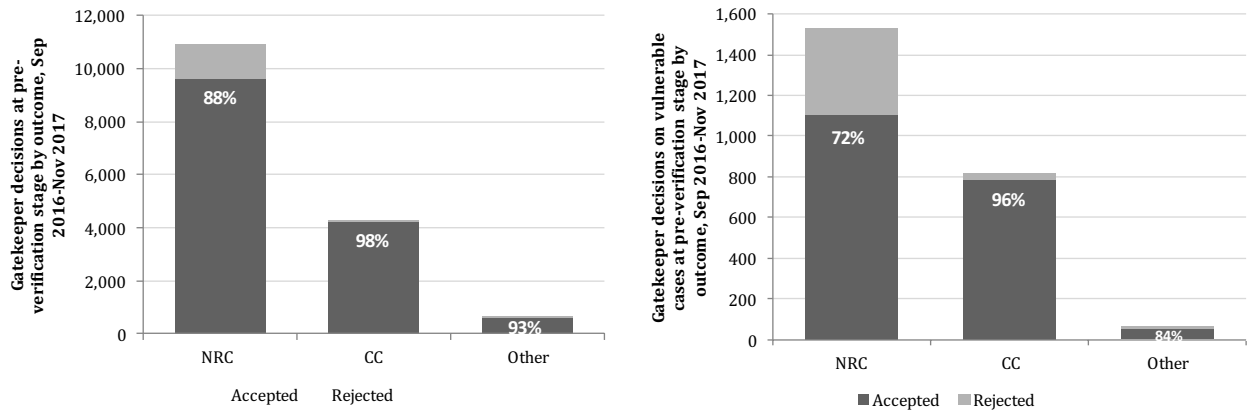
Detention Gatekeeper

4.10 In my first report, I recommended a single gatekeeper for detention. The Home Office fully accepted this, and a cross-system detention gatekeeper has been in place since autumn 2016. During the review, I was repeatedly told by the Home Office how well this function was working: that it was indeed ensuring vulnerable individuals did not enter immigration detention inappropriately, or if they were detained it was for the shortest time possible.

4.11 I have seen first-hand the effort and work put into the detention gatekeeper function to maintain a consistent approach to decision making. The team balances a number of factors when making a decision on detention. These include the availability of beds; the individual's circumstances and case history; the prospect of removal within a reasonable timescale; and assessments under the Adults at Risk policy and the impact that detention could have. For all individuals who come within an AAR level there are specific levels of authority for detention. These rise as the AAR level increases, with only a more senior detention gatekeeper manager being able to authorise detention for those who are most vulnerable.

4.12 Figures 4.1 and 4.2 provide details of gatekeeper decision making. Between September 2016 and November 2017, at the pre-verification decision stage in advance of the planned day of detention, 9 per cent of gatekeeper decisions were rejections. This rose to 19 per cent for decisions concerning vulnerable cases only. At the live intake decision stage on the day of the planned detention – which looks at cases approved at pre-verification and cases brought in by Immigration Enforcement teams – 4 per cent of decisions were rejections and 3 per cent were requests for further steps to be taken before detention would be permitted. These figures were 9 per cent and 3 per cent respectively for decisions concerning vulnerable cases only.

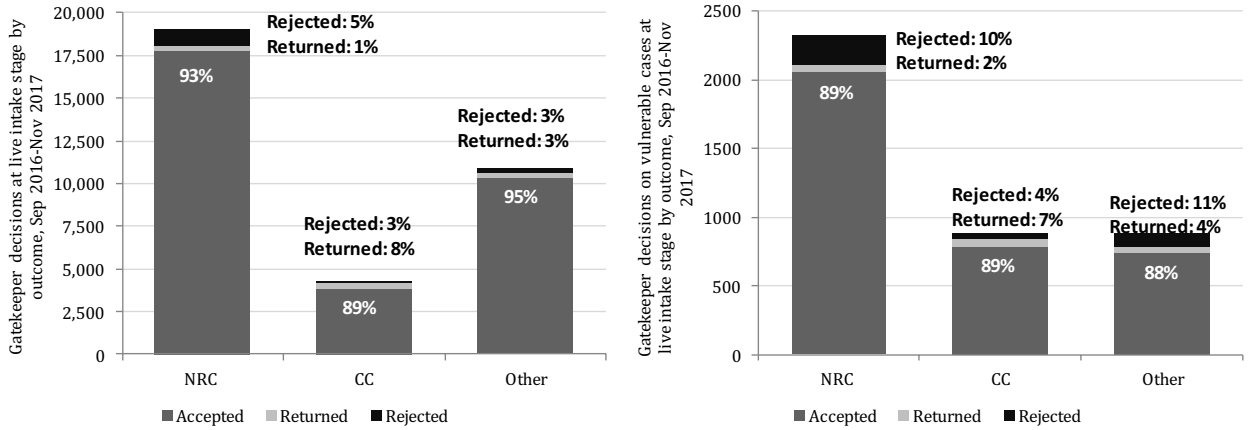
Fig 4.1: Gatekeeper decisions at pre-verification stage by outcome, Sep 2016-Nov 2017; (left-hand side all cases, right-hand side vulnerable* cases only)[80]



* Vulnerable cases include those categorised as AAR, pregnant or 'Other – Chapter 55.10'.

[80] These statistics and those cited in paragraphs 4.12, 4.13 and 4.15 have been taken from live internal management information and, as such, numbers may change as information is updated.

Fig 4.2: Gatekeeper decisions at live intake stage by outcome, Sep 2016-Nov 2017; (left-hand side all cases, right-hand side vulnerable* cases only)[81]



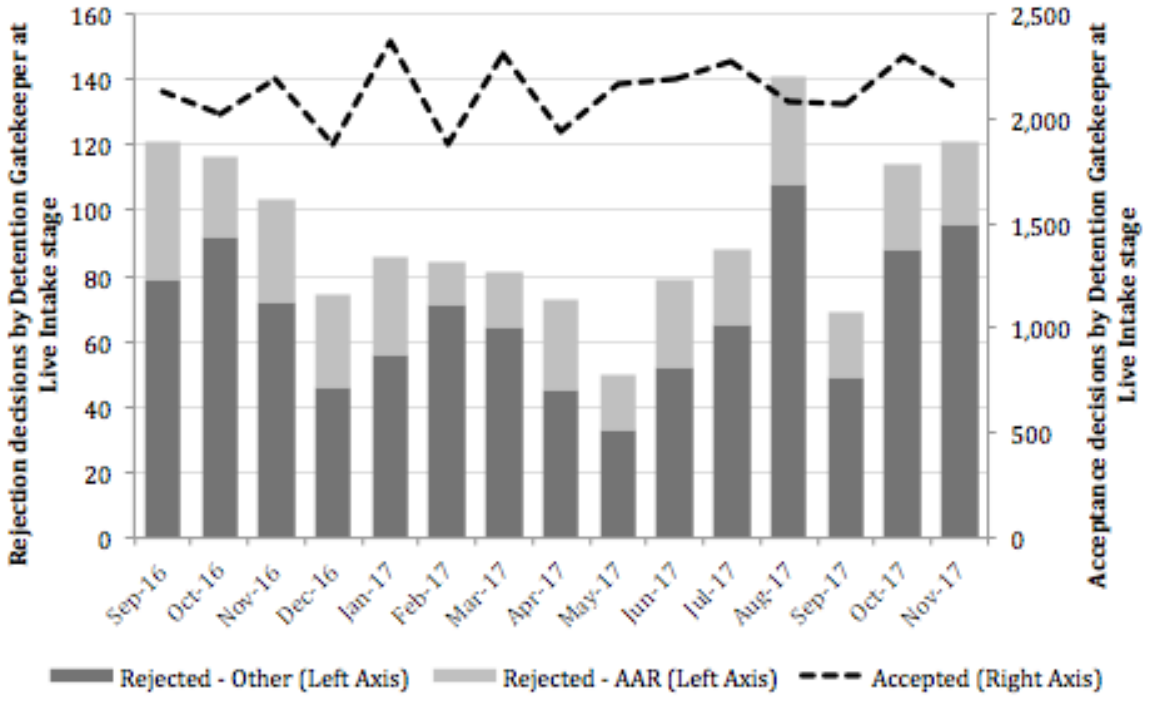
* Vulnerable cases include those categorised as AAR, serious illness, mental health, physical disability, over 65/70, 'Other – Chapter 55.10' or pregnant.

4.13 Vulnerability factors appeared to have a greater impact on gatekeeper decisions for NRC cases than for CC cases. At pre-verification stage, 12 per cent of all decisions on NRC cases were rejections, while this rose to 28 per cent for NRC cases categorised as vulnerable. This will have been influenced by the fact that only 14 per cent of NRC cases had been flagged as vulnerable at that stage – demonstrating the need for more thorough pre-screening. For CC cases, only 2 per cent of decisions were rejections at the pre-verification stage, and I was disappointed to learn that this proportion rose only to 4 per cent when looking at decisions on vulnerable cases only. At live intake stage, 5 per cent of all decisions concerning NRC cases were rejected; 10 per cent of all NRC decisions concerning vulnerable cases were rejected, and a further 2 per cent of all NRC decisions concerning vulnerable cases required additional steps. Notably, for CC cases at live intake stage there was a far greater proportion requiring additional steps rather than rejection.

4.14 While I do understand that the introduction of new caseworking processes remains ongoing and is supported by an IT system that is soon to be replaced, this has meant that the quality of data management across the gatekeeper (and case progression panel) functions has hitherto been unsatisfactory. Gatekeeper data is inconsistent in the categorisation of vulnerability and the reasons for rejections both over time and between decision stages. This makes it very difficult to monitor decision making in respect of vulnerability. Additionally, data has been recorded by decision rather than by case (I understand there are steps being taken to resolve this, which should be prioritised). While the Home Office has provided evidence in Figure 4.3 that shows that it does consider vulnerability prior to detention, and does reject cases based on this fact, I remain concerned about the quality of the data management.

[81] Footnote 80 also applies.

Fig 4.3: Gatekeeper decisions at live intake stage by outcome, Sep 2016-Nov 2017; (left-hand side rejections, right-hand side acceptances)[82]



4.15 Recording by case will assist in examining why gatekeeper decisions change, and particularly in determining how many gatekeeper decisions are overturned by officials. This is an issue that should be actively monitored going forward. My team was able to establish that between September 2016 and November 2017, 25 per cent of gatekeeper decisions were changed from reject at the pre-verification stage to accept at the live intake stage. This figure rose to 42 per cent for criminal casework and fell to 18 per cent for cases classified as vulnerable (includes as vulnerable those cases rejected at pre-verification stage and accepted at live intake stage which were classified as vulnerable at live intake stage only). However, there are many reasons why decisions can change between stages, and identifying the driver – particularly where this was intervention by official – is important. The quality of current analysis is also hampered by the fact that some cases returned to the gatekeeper on more than one occasion, and that some cases had no reference numbers. I was also very surprised that data was not recorded for the actual outcomes following recommendations made by case progression panels.

Recommendation 24: The Home Office should strengthen its data monitoring processes and quality assurance for the detention gatekeeper and case progression panels. In particular, it should ensure that the outcomes following case progression panels are tracked and reported.

4.16 A clear challenge for the detention gatekeeper concerns their (in)ability to make clinical assessments on the impact of detention. But even when there is a medical assessment there can also be consistency issues. An example was provided of a person with a previous heroin addiction who was encountered at police custody. An assessment by a clinician in the police station was to the effect that the man was suitable for detention, and he was detained. However, upon arrival at the IRC he was refused entry due to his history of addiction. The man was taken to hospital where he was again assessed as fit for detention. This confusion

[82] Footnote 80 also applies.

resulted in the detainee being moved over a number of hours between different locations and services. More consistent assessment criteria and decision ownership would ensure all those detained by the Home Office are treated appropriately.

4.17 The gatekeepers had particular frustration with those within AAR Level 2 due to the huge range of circumstances, types of illness, and associated risk. The evidence being relied upon is often in note form, incomplete and not from a medical practitioner. One member of the gatekeeper team felt that nearly all referrals now came through as Level 2. The definition of "serious medical condition" within the Adults at Risk policy was a particular difficulty as it meant those on any medication whatsoever were being assessed as AAR Level 2.

4.18 I was told that the quality of referrals to the gatekeeper varied greatly depending on the part of the Home Office from which the case was being submitted. Unsurprisingly, those where detention was pre-planned tended to be significantly better than for those who were encountered by chance. In these latter cases, the information was generally of a poorer quality and the timeframe for a detention gatekeeper decision shorter. My team and I saw many people where it appeared that detention was not suitable, but the gatekeeper function had not prevented entry to the detention estate.

4.19 The gatekeepers believed that more training was required for those on the front line. From the examples I have seen, I agree.

4.20 Within the gatekeeping function, training has been designed to build consistency among those making decisions. However, I do not believe this process is yet working as well as it should. Throughout this review, I was told by IRC staff and managers that there has been little change in the number of vulnerable individuals in detention following the introduction of AAR. The policy does not yet seem to be delivering the expected outcomes.

4.21 Home Office staff have felt under significant pressure to maximise the number of removals, and there may be a tension between this and dealing appropriately with vulnerable people. The current AAR policy itself is focussed more on the levels of evidence provided in relation to a medical condition than it is to an assessment of the risks of detention and how they may change over time.

4.22 A common theme amongst caseworkers I met was that there needed to be increased engagement with illegal migrants about returning home voluntarily, before enforced removal and any required detention was considered. There was a concern that voluntary departure conversations sometimes appeared to be little more than tick box exercises, the result of an increased focus on enforced removals at the expense of other work.

4.23 Some caseworkers believed that the detention gatekeeper was allowing the detention of those who should not be detained, and it was then for the caseworker to release them. One example related to a man who was accepted by the detention gatekeeper even though he had provided evidence of already having bought a ticket to travel home. The caseworkers did not understand why the man had been arrested and referred to the detention gatekeeper by the ICE team, and then detained by the gatekeeper. (The man was released by the NRC and returned home on the ticket he had purchased.)

4.24 Prisoners coming to the end of their custodial sentence are referred by criminal casework to the detention gatekeeper in order for them to be assessed for suitability for immigration detention. A weekly list of individuals detained under immigration powers (or coming to the end of their custodial sentence) who are held within prisons is provided to the detention gatekeeper for a second level of assurance. The detention gatekeeper will then contact the relevant criminal casework team for information and to begin the consideration

process. If the detention gatekeeper does not think immigration detention is appropriate, criminal casework will begin the release referral process through the Home Office Strategic Director. However, this does not seem to encourage CC to ensure that those coming to the end of their custodial sentence are deported at the end of their sentence, or released under relevant provisions whilst deportation is progressed. In the cases I have seen, it did not appear to me that the considerations of individual circumstances were always given sufficient weight when considered along with the immigration factors. Given my concerns about the length of time individuals managed by CC spend in detention, I consider it important that the gatekeeper has an enhanced role in decision making in all cases entering detention.

Recommendation 25: The Home Office should ensure casework management processes allow for the detention gatekeeper to make decisions on all FNO cases entering immigration detention, including those transferring directly from prison at completion of a custodial sentence.

Returns Preparation (RP)

4.25 Returns Preparation is a casework unit responsible for progressing the cases of immigration offenders outside of the detention estate. Foreign national offender cases and those whose asylum claim has been rejected are not within its remit. I met with caseworkers and managers from a number of teams, including a safeguarding team who dealt with those assessed as the most vulnerable.

4.26 The Directorate prioritises cases on the basis of an individual's removability. Once someone is being actively 'caseworked', an assessment of vulnerability is made in line with the Adults at Risk (AAR) policy.

4.27 Following my first report, RP introduced a local Vulnerable Case Network (VCN) among casework teams. The VCN aims to ensure the AAR policy is applied with care, and that individuals with vulnerability indicators are risk-assessed appropriately, using medical and professional evidence where it is possible to obtain.

4.28 Returns Preparation caseworkers refer all individuals who appear to have a vulnerability indicator to the VCN for advice on how to proceed. Additional information may be sought from medical practitioners. However, the information used by caseworkers to make decisions relating to vulnerability is not routinely informed by expert medical information. When medical information was requested, it is usually provided on the basis of current medication and fitness to fly. This is not an assessment of suitability for detention and caseworkers were making decisions without suitable training and support. Some caseworkers, who had attended training delivered by social workers and the Samaritans about identifying vulnerability, spoke of feeling overwhelmed and unskilled in terms of some of the vulnerability decisions and assessments they were making. There was huge frustration with the time to obtain information from GPs, and the costs associated. This gap needs to be closed urgently if the system is to work effectively.

4.29 Where an individual is identified as being an AAR, the VCN will assign one of the levels of risk as outlined in the policy. I was told that an estimated 60 per cent of cases managed by RP may have some vulnerability factors.

4.30 Given these large numbers with vulnerability factors, the VCN and safeguarding team had introduced an internal process to mark out those cases that should be referred to the AAR team at the point of tasking – this introduced a categorisation of Level 2 (complex). For these cases, the team work with colleagues across other parts of the Home Office to

plan for a removal, including reception arrangements in the country of return. This internal categorisation allows the Directorate to prioritise the limited resource on those cases with the most complex requirements when planning for return.

4.31 I was told categorically that this internal categorisation did not conflict with published policy, and that all cases are properly assessed at the correct AAR level.

4.32 I was very pleased to see that members of the safeguarding teams did not have specific enforced removal targets. Their focus instead was on progressing cases and planning difficult returns. The team valued voluntary removals as much as enforced removals. They worked with ICE and ROM teams to progress cases without the use of detention using a process referred to as Operation Perceptor. This was often removal on the same day as initial arrest, with the intention either not to use detention or to only do so for 72 hours.

4.33 Planning for the removal of vulnerable individuals was said to differ between ROM and ICE teams across the country. The RP caseworkers relied on vulnerability assessments by ROMs and ICE teams, but the quality of these assessments varied significantly.

4.34 Another issue was said to be negative responses to requests for ICE teams to conduct 'pastoral visits' to obtain information. It would seem that a system focussed on removal means that visits to make vulnerability assessments have become unattractive to ICE teams. However, I favour the 'pastoral visits' as offering the chance of candid discussions with vulnerable people, and those around them, about the choices they must make in terms of their returning home.

Immigration Compliance and Enforcement (ICE) and Reporting and Offender Management (ROM) Teams

4.35 The ROM and ICE teams undertake the majority of face-to-face contact with those facing removal. The teams make the initial decision to detain, and are responsible for a large number of the referrals to the detention gatekeeper. I was struck by the difference in flows of work and ways of working at the different locations the team and I visited.

4.36 Staff in ROM and ICE wanted better and more consistent joint working on individual cases, to be confident that removal of the most vulnerable people was properly planned. However, ROM and ICE staff also described differences in the assessments (and how they were recorded) across the different caseworking units. There was particular concern about how the use of medication was interpreted in terms of risk in detention.

4.37 It was of concern that some staff said they had not been trained in the Adults at Risk policy. It was certainly clear that more was required to equip ROM and ICE staff to assess vulnerability indicators.

4.38 I was told in my meeting with the Director of Resettlement, Asylum Support and Integration of the development of specific training for asylum caseworkers on dealing with vulnerability. It would seem sensible if this could be adapted for all staff needing to make assessments of this kind.

Recommendation 26: All relevant Home Office staff should be trained in making assessments of vulnerability within the parameters of the Adults at Risk policy.

National Removal Command (NRC)

4.39 The NRC manages the bulk of caseworking for those detainees who are not foreign national offenders. Within the directorate are teams dealing with detained casework, as well a voluntary removals service (VRS) and a recently formed pre-planning team.

4.40 The VRS assists those who wish to return on a voluntary basis to their country of origin. This can include funding and arranging tickets, help in obtaining travel documentation, and financial support for resettlement and reintegration. The current levels of financial support range from £1,000 to £2,000 per person depending on the programme and criteria. Those who return via these processes have a reduced re-entry ban to the United Kingdom.

4.41 The VRS team had recently updated their internal and external communications to promote the services they offer.

4.42 I attach as much importance to the internal communications as to the external. I was told of a man who was wheelchair bound and had contacted VRS looking to return home. The VRS team recognised that he qualified for additional assistance due to vulnerability, and would benefit from financial support to assist in his reintegration in the country of origin. However, the man was forcibly removed via an Operation Perceptor same-day removal, and accordingly received neither additional support nor a reduced re-entry ban.

4.43 The VRS team were currently training other Home Office colleagues, and hoped that this (along with a new external web application and promotional material) would increase the number of assisted voluntary returns. It is manifestly preferable if removals can be voluntary, and the number of vulnerable people in detention using this route needs to increase. The key here is more candid discussions about options before detention is considered, enabling vulnerable people to make the best decisions for themselves.

4.44 I judged that the NRC detained casework teams were well trained and engaged with the AAR policy. They said it had significantly changed how they approach and organise their work. The teams had clear sight of all their cases based on the AAR levels, and prioritised their work against these assessments. All those assessed as AAR Level 3 were reviewed on a daily basis, and those assessed at Level 2 were reviewed weekly. But the focus was on the level of evidence provided rather than assessments of risk in detention. Many caseworkers believed that the evidence requirement, and lack of clarity around what constituted a “serious medical condition”, resulted in excessive numbers of AAR Level 2 cases being recorded.

4.45 A new team within the NRC – the Pre-Planning team – had recently been established. Its role was to assess all those ready for removal – via the detention gatekeeper – who were AAR Level 2 or AAR Level 3, not an FNO, and who had been considered fully for voluntary removal without success. The team works with local ICE or ROM teams, and the feeder casework teams, to develop a removal plan without using detention or only using detention as a final resort.

4.46 When I met with members of the Pre-Planning team, they were clear they had no removal target but were focussed on “safe removal”. I was impressed by their understanding of vulnerability, and awareness of their obligations. The team had a current caseload of 180 cases, and worked with partners within the countries of return.

4.47 An example related to a Belgian national with significant mental health issues. The Pre-Planning team had worked with the Belgian authorities and the Red Cross to provide appropriate support. While it was disappointing that the man then remained in detention

for around a month while the logistics were finalised, it seemed to me that this was a good example of what can be done to ensure continuing support for a vulnerable person on return to their home country.

4.48 In nearly all cases, the Pre-Planning team had needed to arrange medical escorts in addition to the normal escort requirements. I was told that requests for non-medical escorts had been made by those providing the medical escort, but there was considerable doubt whether this was really justified. Out-of-country escorts are an expensive resource, and the Home Office should ensure that they are only used when appropriate.

Criminal Casework (CC)

4.49 CC manages all foreign national offenders (FNOs) within the immigration system. They tend to manage their cases from start to finish, although decisions are not always made by the same caseworker. The FNO population is a mix of detained and non-detained cases. Cases are progressed towards deportation and those who are not detained are tasked to ICE and ROM teams for detention when and if appropriate.

4.50 CC operates a facilitated return scheme (FRS), a voluntary scheme that resettles FNOs to their country of origin if outside the EU/EEA and if their sentence was less than four years. The scheme provides some initial financial support (£500), and additional funds on return (£1,000).[83]

4.51 For those prisoners still serving their sentences, there is an early release scheme (ERS) that allows FNOs to return home up to nine months before sentence expiry. Additional payments are made to single parents for every child who returns, and those with partners and children can make an application in their own right under the Home Office Voluntary Returns Service process, and efforts would be made to arrange the return together.

4.52 Those managed by CC are a mix of serious and less serious offenders. Whatever their offending history, a number are also very vulnerable with complex needs. The following two case studies illustrate the difficult choices that have to be made:

> Mr B is a 29-year-old Zimbabwean national convicted of the rape of a child. He had no remaining avenue of appeal to stay in this country, but there was little prospect of removal as he had no travel document and the Zimbabwean authorities will not issue one without the individual's consent. Unsurprisingly, Mr B was considered to present a high risk of harm to others, but in detention had been judged at risk of suicide. Once release was agreed it took six months to find suitable accommodation in the community to enable the authorities to best manage his risks.
>
> Mr C is a 36-year-old Algerian man who had served a 21 month sentence for burglary. He has a total of 19 convictions. Mr C had a poor history of reporting and there were no current casework barriers to his removal but it was not proving possible to obtain a travel document. Mr C had been in detention for six months and was assessed as AAR Level 2 due to substantial mental health problems. There was also clear advice from a doctor that he should be released if removal was not deemed imminent. Mr C has now been released as there is no imminent prospect of his removal.

[83] The FRS is currently part funded by the European Union. The eligibility criteria were tightened in July 2014, and I understand that the numbers benefiting have shrunk accordingly.

4.53 Cases like these have meant that CC detainees can only be released by a Home Office official at the level of Strategic Director or above, although the detainees themselves can of course apply for bail. However, this means the process can be lengthy, even once a caseworker or manager proposes the detainee's release.

4.54 CC often has to consider specific release criteria if the detainee is beyond the period when they would have been subject to supervision at the end of their custodial sentence. I encountered great frustration from staff at all levels regarding the difficulties that can result. A particular concern was the delay in finding a suitable address that a probation officer would authorise. This was not an issue for those FNOs who were released directly from a custodial sentence as the systems for managing resettlement in the community were in place and tested.

4.55 I suspect that there is a real lack of knowledge about immigration detention on the part of some probation staff. Bail for Information Detainees (BID) shared with me an email they had received from Sodexo Justice Services in which the offender manager seemed not to realise either that BID was not the detaining authority, or that FNOs can apply for release and are subject to post-release supervision, meaning any release address must be approved by the offender manager. (I have set out the relative responsibilities of the National Probation Service and the local Community Rehabilitation Companies in Figure 4.4.)

Fig 4.4: Responsibilities of National Probation Service and Community Rehabilitation Companies

		National probation service	Community Rehabilitation Companies
Oversight		National Offender Management Service (NOMS), Ministry of Justice	Run by eight providers, mostly private sector; overseen by NOMS
Approximate proportion o cases		20%	80%
Geography		England and Wales (divided into seven regions)	England and Wales (divided into 21 areas; each with its own CRC)
Who?	Foreign nationals ho are to be deported?	Yes	No
	Risk	Higher risk of serious harm or prior history of domistic violence or sexual offences	Low to medium risk of harm
	Sentences less than t elve months?	No	Yes

4.56 Where possible, CC caseworkers use OASyS (Offender Assessment System) reports to inform their risk assessments, but these are not always available. Overall, I have seen few signs of a joined up approach, and I have been told that different Community Rehabilitation Companies have different approaches. This is an issue that might be of interest to HM Chief Inspector of Probation.

Recommendation 27: I recommend that a copy of this report be shared with HM Chief Inspector of Probation for her consideration.

4.57 It is understandable that caseworkers and their managers should be risk-averse when it comes to possible re-offending and harm to the public. But I am concerned that issues of vulnerability may not be given sufficient weight in consequence. I was provided with an example by CC where it seemed to me that the right balance had not been struck. This concerned a 73 year old man, who had been in a wheelchair and was noted as having mobility issues with what could be signs of dementia. He had also been assessed as lacking mental capacity by an Immigration Officer who had visited him in detention. The man had been convicted of a sexual offence with a sentence of two months, but had already spent a significantly longer period in immigration detention. He had been assessed as AAR Level 3 but this had recently been reduced to Level 2 after he was confirmed by healthcare to have a personality disorder. It was unclear why this had been done. I saw no signs that the caseworker and manager were considering releasing the man, despite his deportation being some way off because of his vulnerabilities.

4.58 The anxiety of many CC caseworkers and managers regarding the risk of re-offending derives in part from FNOs' inability to access support upon release from detention. FNOs who are not currently removable, but who are beyond the period of post-sentence supervision, are not able to access support that would assist in helping to prevent re-offending. This is in contrast to those released directly from a custodial sentence, who have statutory probation supervision in the community. Moreover, the provisions of the Immigration Act 2016 – designed to strengthen controls on illegal migrant access to employment, benefits, and public services – mean that those with no lawful basis in the UK cannot rent a home, drive, be employed, have a bank account, access secondary health care without paying, or access the benefits system. I am aware that some detainees are released to street homelessness. All in all, it would be difficult to think of circumstances more likely to lead an offender back into crime.

Recommendation 28: The Home Office, working with the National Probation Service and Community Rehabilitation Companies, should consider how far vulnerable detainees released from detention can be offered appropriate support and supervision.

4.59 Within Criminal Casework, I met with a team that had been set up as a pilot to improve the management of vulnerable cases. Team members eloquently described the changes they had made to rule 35 processes and the quality of responses from within CC. The level of cultural change needed within some casework areas remains significant, but I thought the establishment of this team was much to be welcomed.

Detained Asylum Casework (DAC)

4.60 4.60 In July 2015, the then Immigration Minister suspended the previous Detained Fast Track (DFT) system following a High Court decision, upheld by the Court of Appeal, that the 2014 Fast Track Rules for appeals were *ultra vires*.

4.61 A new process was then introduced for deciding asylum claims for those who are detained. These cases are managed by the Detained Asylum Casework (DAC) team. I met with senior managers but not caseworkers from DAC.

4.62 I am told that the majority of those individuals managed by DAC have claimed asylum only after being detained for removal. Thus, most people entering the detained asylum process should be removable, but for consideration of their asylum claim. (As I commented earlier, it is betraying no secrets to say there is much cynicism on the part of Home Office staff regarding late asylum claims. But many people may not know their experiences represent grounds for asylum until advised to that effect when in detention.)

4.63 I note from the statistics in Part 2 of this report that only around 20 per cent of those managed by DAC at the time their detention ended were removed rather than released into the community.[84] This may well reflect their being released in consequence of their asylum claim. However, I was concerned at the quality of the consideration given to DAC cases at the case progression panels that my team and I attended, and what I felt was a lack of consistency in decision making.

Caseworker contact with detainees

4.64 My earlier report proposed that all caseworkers should meet at least once with the detainees about whom they were taking decisions or writing detention reviews. Such meetings could be face-to-face or by video link or telephone. The spirit of this recommendation was partially accepted with the development of the Pre-Departure Teams that are currently being rolled out nationally. Nonetheless, it remains the case that NRC and CC caseworkers do not meet those they are managing, and rely on information provided from other parts of the Home Office and IRC healthcare providers.

4.65 Caseworkers told me that they did try to liaise with those they were managing via letters, and some of the CC caseworkers had regular contact via telephone (and all detainees are able to contact a case owner by telephone or see Immigration Officers at the IRC). They also engaged on occasion with local Home Office immigration staff who provided information from the IRCs. Some caseworkers had been asked to dial into the case review process currently run in Harmondsworth and Colnbrook, and were very positive about what they learned, specifically from healthcare.[85] This approach to managing the needs of detainees is something I hope continues and is shared across the IRC estate.

4.66 Whilst the Home Office did not fully accept my recommendation for caseworkers meeting detainees face-to-face, I still believe that all caseworkers should understand more about the operational realities of detention and the impact their decisions have upon detainees. I acknowledge that some caseworkers from the NRC and CC do visit IRCs and prisons, although this is far from the case for all staff. Whether it is done through visits or secondments or some other means is not for me to determine, but those I met who had seen inside an IRC were clearly affected by the experience. One caseworker said, somewhat ruefully, that her job had been easier before the visit as it had been possible to consider detainees just as case files rather than as people.

Recommendation 29: I recommend that all caseworkers involved in detention decisions should visit an IRC either on secondment or as part of their mandatory training.

4.67 As noted, the way in which the Home Office has responded to my recommendation is through the development of Pre-Departure Teams (PDTs). At the time of writing, PDTs are operating in the IRCs at Gatwick and Heathrow, and the plan is that all other IRCs will have PDTs during 2018. The purpose of the PDTs is to have staff embedded in IRCs to increase face-to-face interaction, to promote compliance and voluntary departure, and to facilitate communication between casework units and detainees. The PDT staff are not themselves caseworkers, and they are not able to make decisions on cases, but they act as a conduit between the caseworkers and the detainees.

[84] They may of course be subsequently removed.
[85] See below, Annex 7, paragraph A7.48.

4.68 My team and I have spoken to staff working in the new teams, but they are still a work in progress and I do not feel able to measure their impact thus far. Nonetheless, I welcome the establishment of PDTs as a genuine effort to improve the flow of information between caseworkers and detainees.

4.69 One observation I would make is that I hope that PDT staff go into the main parts of the IRCs, and take every opportunity to engage with detainees there, rather than relying on formal meeting rooms. I believe this will help build rapport and better understanding. I also hope that the Pre-Departure Teams, their processes and links to Home Office caseworkers, can form part of the regular reviews I have recommended the Independent Chief Inspector be invited to conduct on detention casework.

Detention reviews

4.70 I recommended in my first report that the Home Office examine its processes for carrying out detention reviews, including looking at training requirements, arrangements for sign-off at senior levels, and auditing arrangements. This was accepted by the Home Office, but I believe there is further work to do. The review process is much the same as previously: although there is now specific reference to AAR, I am not sure how far this has altered outcomes. In a number of the cases I saw, immigration factors such as travel documentation, the availability of escorts, and ongoing legal barriers, were given a higher weighting than vulnerability indicators.

4.71 The Home Office has undertaken a review of the detention review form and now has a detention and case progression review form. At the time of writing, a review is taking place concerning levels of authority for detention and release, and it is hoped that a consistent approach across all casework areas will result. A training programme is being developed for all caseworkers and managers who will be part of the reviews and authorisation process.

4.72 I am supportive of these intentions, and it is clear that significant effort is involved in the formulation of this process. But real change will only follow when new processes are embedded as business as usual. The role of the Adults at Risk Assurance Team (AARAT), to which I have referred earlier, is likely to be crucial.

Case progression panels

4.73 I also proposed in my first report that the Home Office consider introducing an independent element into detention decision making. While this has not been implemented as I had envisaged, the Home Office has developed increased *internal oversight* via a system of case progression panels that look at detention decisions independently of the case owner. The panels are held for all detained cases at specific time periods with specifically graded panel chairs. Panels are held to consider the cases of those held for periods of three months, six months, nine months and twelve months detention. Any detainees held for longer than twelve months are reviewed by a panel chaired at a senior level every subsequent three months, complemented by an internal monthly Director-chaired Criminal Casework Internal Review Panel. The team and I have attended five of these panels during the course of the review and covered all the different timescales.

4.74 The panels usually took place over two to three hours, and generally consisted of between 20-30 cases. It was clear that each case, regardless of detention duration, was complex and involved considerable background information. Among the materials considered were the most recent detention reviews, and other information taken electronically on a screen from the Casework Information Database (CID).

4.75 The panels did not always consider AAR factors as part of the decision making process. Indeed, the paperwork did not reference information about AAR. This is a matter of considerable concern. I found evidence of inconsistent interpretation of AAR levels by caseworkers that then led to inconsistent recommendations at panel level. There was also little consideration of the fact that prolonged detention can lead to increased levels of vulnerability.

4.76 The panels the team and I observed did not always have the same departments represented. For example, on one 12-month panel there was no representation from CC, despite all the cases being FNOs.

4.77 The volume of cases meant that there was often only limited time for the panel to discuss each detainee's case. The panel we attended with the fewest number of cases was a twelve month panel with 22 cases over a two hour period, permitting an average of nearly six minutes per case. But even this did not seem remotely sufficient given the complexity of the cases (which frequently involved significant vulnerability issues as well as immigration factors including the potential risk of harm to the public).

4.78 The secretariat for the panel provide a list of the cases in advance that includes basic information, such as name and the date the detainee entered detention, to enable attendees to prepare. At the meeting itself, information on the different cases is displayed on a screen, but I observed that it was often difficult for panel members to follow – especially as some members were dialling in. Indeed, on occasion, panel members were discussing a different case to the one on the screen.

4.79 Members of the secretariat were very well prepared, with good knowledge of the cases being discussed. In contrast, the preparations made by the chairs – and the quality of input and make-up of membership of the panels – varied greatly. I was concerned to see that the information presented was not always up-to-date, and a number of cases were 'adjourned' for another panel whilst more current information was obtained. This is the record I made of one person considered by a case progression panel:

> At the six and nine month panel, a DAC case was considered. It was found that the wrong detention review form had been used, which meant information was missing. This had not been picked up prior to the panel. The updated information on the screen suggested that the Home Office had accepted a Rule 35 report and that, due to suicidal thoughts and previously self-harm, the detainee was being monitored on the ACDT process. The detainee was recorded as an AAR Level 2 but there was an injunction in place against removal and a Judicial Review application had been made six weeks before the panel. The detainee had no harm factors, had not previously been tested on reporting, and therefore compliance had not been tested. It appeared that the detainee was vulnerable and not currently removable. Nonetheless, given the uncertainty about status, the panel maintained detention as they wanted to clarify timescales on the Judicial Review. They asked that the case be brought back to panel in a week. This panel did have a DAC representative, but there had been no preparation and the member was not aware of the details of the case.

4.80 The panel chair has a key role in the process, and it is crucial that the chair is of sufficient competence to carry out the role effectively. The chair needs to ensure a proper debate takes place and that all members take part. The evidence my team and I saw was decidedly mixed, but tended to be better for panels considering the cases detained for longer periods of time where the chair was more senior and experienced. At the best panel, the chair ensured there was sufficient time to discuss cases, even though this meant the length of the meeting had to be extended.

4.81 The performance of the chairs needs to improve and be more consistent. It is for consideration whether this should be through better training and support, or if there is a case for a different recruitment model. Experience has not taught me that seniority is always a reliable measure of competence, but everyone undertaking the role must ensure they are prepared properly and have sufficient knowledge of Home Office procedures.

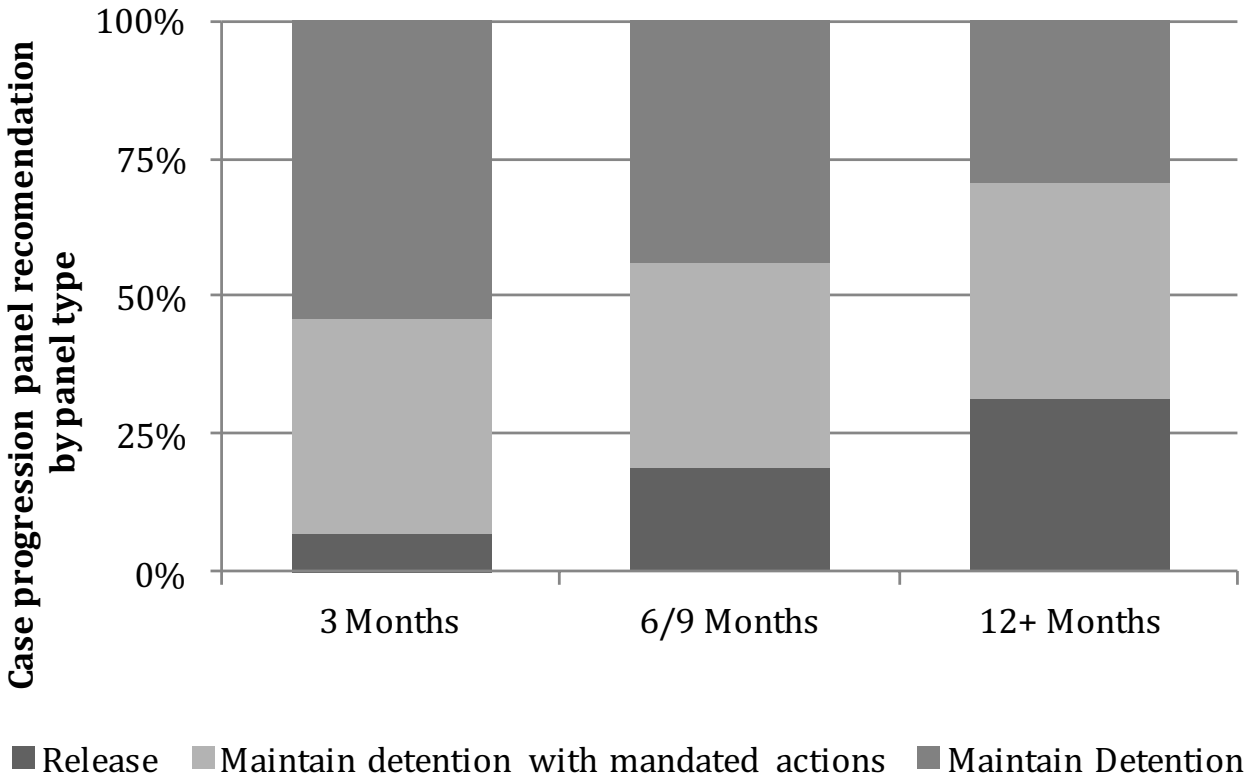
4.82 A theme across all the panels was that there had been missed opportunities to progress towards removal earlier in the detention period. An example was a detainee who had claimed asylum on day 55 of detention when they were interviewed for a travel document. But it was not clear why it had taken the Home Office 55 days to process the travel document. Another example was a CC case where the stage 1 deportation papers had been served in July 2017 and the detainee became an AAR Level 2 in early August due to mental health problems. The detainee did not respond to the stage 1 deportation letter (he had ten days to do so), but the deportation had not been progressed to stage 2 and the detainee had remained in detention without any case progression despite his significant vulnerability. Only at the six and nine month panel in January was his release considered.

4.83 These failings were leading to detainees being detained for longer periods than was necessary. This is an area where I hope the new AARAT and Detained Casework Assurance and Audit Team can quickly make an impact. I also noted that some chairs and panel members did not seem confident in the policy and procedures they are bound by. In a number of cases, detention was maintained whilst the relevant information was obtained when release should have been recommended. This included not knowing if an appeal was a barrier to removal, the timescales for travel document, or what the Detention Action project was for a CC case.

4.84 The panel about which the team and I had the greatest concerns was the three month panel. We observed two such panels, which are chaired at a more junior level. We noted much more reluctance to recommend release. Indeed, the presumption of liberty seemed in practice to have been replaced by a presumption to maintain detention on the basis that more information was needed. A number of detainees were AAR Level 2, yet the most frequent decision at these panels was to review in a set time period. One detainee was AAR Level 2 due to post-traumatic stress, and had already been detained for three months yet had no removal directions in place. Detention was maintained with a review in a further month.

4.85 The outcomes of the three-month panels that I observed are corroborated by the statistics in Figure 4.5 which detail the release rates from panels at different stages. The three-month panels recommended release in only seven per cent of cases, compared to 31 per cent at the twelve-month stage.

Fig 4.5: Case progression panel recommendations by type, Feb – Nov 2017[86]



4.86 It is a feature of the case progression panels that they can only make recommendations, and I therefore tried to discover how frequently recommendations for release or for specific casework actions were rejected. The Home Office has been unable to provide this information. This needs to be remedied.

4.87 Given the level of resource devoted to the case progression panels, and the critical importance of the recommendations they make on liberty or detention, I am not satisfied they are yet working as they should do. While the panels do not meet my original wish for a truly independent element in decision making, I regard case progression panels as a welcome development. However, the number of cases per panel, inconsistent attendance, the lack of preparation, and the mixed quality of both the chairing and the members' contributions, means they are not working as effectively as either I or the Home Office would wish to be the case.

Recommendation 30: Case progression panels should have fewer cases per panel to consider. The Home Office should ensure that all required information, including information on vulnerability and AAR levels, is available and that all panel members are properly prepared on the cases before them.

Recommendation 31: Case progression panel chairs should be of sufficient competence for the role. Attendance from all relevant parts of the Home Office should be ensured.

4.88 The argument for an independent element (perhaps an independent chair) for case progression panels becomes stronger the longer someone is held in detention.

Recommendation 32: The Home Office should review the case for an independent element in case progression panels considering those detained for more than six months.

[86] These statistics have been taken from live internal management information and, as such, numbers may change as information is updated.

Automatic bail provisions

4.89 Following my previous recommendation that the Home Office give further consideration to ways of strengthening the legal safeguards against excessive length of detention, automatic bail provisions were included in the Immigration Act 2016 and implemented on 15 January 2018.

4.90 Schedule 10 of the Immigration Act introduces a new duty on the Secretary of State to arrange for the First Tier Tribunal to consider whether to grant immigration bail after an extended period of detention – four months – where there has been no previous judicial oversight. Under this "automatic referral" duty, the Secretary of State is required to arrange an individual's case to be referred to the Tribunal so that it may consider whether bail should be granted. This duty applies to all detainees other than those detained pending deportation (i.e. FNOs) and persons detained pending removal in the interests of national security. The duty applies after an initial period of four months from the date on which detention began, and then every four months from the date of their last bail hearing by the Tribunal. This duty does not prevent immigration bail being considered at other times if a detainee submits an application themselves. I hope these provisions will make a difference to those who have not otherwise been able to make representations on their cases. However, I remain concerned about the lack of safeguards for FNOs, the majority of whom are subject to deportation procedures, and who are specifically excluded from this process. Whatever their past crimes, they surely have an equal right to independent consideration of the detention decision.

4.91 It is clear from Figure 4.6 on the length of detention that those within the CC cohort (that is, foreign national offenders) are those who are most likely to have excessive length of detention – the average on 4 February 2018 was 130 days. It is not difficult to argue that, in consequence, there need to be more safeguards in place rather than fewer.

Fig 4.6: Average bed nights per person currently detained[87]

Average bed nights per person currently detained	4-Feb 2018
NRC	31
TCU	11
CC	130
DAC	102
Total estate	**83**

4.92 I hope that, at a suitable legislative opportunity, the automatic bail provisions can be extended to those in detention awaiting deportation.

Those criminals who are more British than foreign

4.93 As was the case during my first review, I found during my visits across the immigration estate that a significant proportion of those deemed FNOs had grown up in the UK, some having been born here but the majority having arrived in very early childhood. These detainees often had strong UK accents, had been to UK schools, and all of their close family and friends were based in the UK.

4.94 Many had no command of the language of the country to which they were to be 'returned', or any remaining family ties there.

[87] For consistency with other data provided, those recorded as being held in prison have been excluded from the figures. Data based on those in detention as at 4 February 2018.

4.95 The removal of these individuals raises real ethical issues. Not only does their removal break up families in this country, and put them at risk in countries of which they have little or no awareness. It is also questionable how far it is fair to developing countries, without the criminal justice infrastructure of the UK, for one of the richest nations on earth to export those whose only chance of survival may be by way of further crime.

4.96 Having said that, I acknowledge that the 2007 UK Borders Act is in very strong terms.[88] Moreover, since 2013, when the Legal Aid, Sentencing and Punishment of Offenders Act 2012 came into force, legal aid is not available for people facing deportation to argue that it would be disproportionate to deport them because they have established a private and family life in the UK.

4.97 However, the twelve month sentence criterion for deportation in the UK Borders Act is not a very good guide to criminality, given the one-third discount for guilty pleas. One man I met who was held on an IS91 (the warrant of detention) at HMP Maidstone had arrived in the UK aged two. He had received a sentence of fifteen months that would have been below twelve months had he pleaded guilty. It was planned to 'return' him to North Africa, although he spoke no Arabic.

4.98 Like that man some of those facing removal had not committed violent or sexual offences, nor did they have a long record of criminality. However, the moral case against expelling those who are, to all intents and purposes, made in the UK, applies even to the most serious offenders. The case of this man caused me particular concern:

> Mr D had been at Campsfield for over 14 months at the time of my visit, and as of February 2018 he had still not been released. After serving a sentence for involvement as a teenager in a gang-related killing, the Home Office wished to deport him to Nigeria. However, as he was born and raised in the UK, Nigeria refused to accept him as its citizen. Given the length of detention and nationality dispute, there seemed to me no realistic prospect of removal. A case progression panel had recommended release in September 2017 but this had not been carried through. When he spoke to me, Mr D said he had received no reply from the Home Office to his application for temporary release. I understood subsequently that this had been refused.[89]

4.99 In short, I find the policy of removing individuals brought up here from infancy to be deeply troubling. For low-risk offenders, it seems entirely disproportionate to tear them away from their lives, families and friends in the UK, and send them to countries where they may not speak the language or have any ties. For those who have committed serious crimes, there is also a further question of whether it is right to send high-risk offenders to another country when their offending follows an upbringing in the UK.

Recommendation 33: The Home Office should no longer routinely seek to remove those who were born in the UK or have been brought up here from an early age.

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[88] In respect of automatic deportation the Act says in part:
(1) In this section "foreign criminal" means a person—
(a) who is not a British citizen,
(b) who is convicted in the United Kingdom of an offence, and
(c) to whom Condition 1 or 2 applies.
(2) Condition 1 is that the person is sentenced to a period of imprisonment of at least 12 months.
(3) Condition 2 is that—
(a) the offence is specified by order of the Secretary of State under section 72(4)(a) of the Nationality, Immigration and Asylum Act 2002 (c. 41) (serious criminal), and
(b) the person is sentenced to a period of imprisonment.

[89] A note on the Home Office CID database regarding this man indicates that, despite being born in the UK and growing up here, it was not accepted that he was socially/culturally integrated in the UK given that he was involved in crime. The implication seems to be that Britons do not commit crimes, something that would come as a surprise to most police officers.

PART 5: SAFER DETENTION

Introduction

5.1 The first responsibility of any institution is to ensure that those in its charge are safe. Safe from the actions of others, and safe from the actions of themselves.

5.2 In the time since my first report was published, there have been twelve deaths in or shortly after immigration detention, four of which appear to have been self-inflicted.

5.3 I attach as Annex 9 to this report what I believe to be the most accurate and comprehensive account of deaths in, or shortly after, immigration detention since 2010. The details have kindly been collated for me by the Home Office. I should emphasise that this has the status of management information and not all deaths after detention may be reported to the Home Office.

5.4 In the media and elsewhere, I have seen other figures for the number of deaths, and it seems to me that the Home Office should follow the example of the Ministry of Justice and consider a more systematic release of this information. So far as is possible, the Home Office should say whether the cause of death is apparently self-inflicted (a formulation that avoids the use of the word suicide – a legal judgment that is a matter for the Coroner), from natural causes, or unknown.

Recommendation 34: The Home Office should review whether figures relating to deaths in and after detention should be issued on a regular basis.

5.5 All deaths in detention result in an investigation by the Prisons and Probation Ombudsman (PPO) and a Coroner's inquest. In these circumstances, it is not for me to examine the individual details of recent cases.

National strategy

5.6 The Government published a national strategy, *Preventing Suicide in England*, in September 2012. This identified six key objectives:

1. Reduce the risk of suicide in key high-risk groups
2. Reduce access to the means of suicide
3. Tailor approaches to improve mental health in specific groups
4. Provide better information and support to those bereaved or affected by suicide

5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

5.7 The latest Progress Report, issued in January 2017, identified five areas for improvement:

1. Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan in 2017, with agreed priorities and actions
2. *Better targeting of suicide prevention and help seeking in high risk groups such as* middle-aged men, *those in places of custody/detention* or in contact with the criminal justice system and with mental health services (my italics)
3. Improving data at national and local level and how this data is used to help take action and target efforts more accurately
4. Improving responses to bereavement by suicide and support services, and
5. Expanding the scope of the National Strategy to include self-harm prevention in its own right.

The ACDT process

5.8 The formal process in IRCs to assist in the prevention of suicide and self-harm remains the Assessment, Care in Detention and Teamwork (ACDT) system. This is closely aligned to the Prison Service Assessment, Care in Custody and Teamwork (ACCT).[90]

5.9 I have written elsewhere that I believe ACCT and ACDT to be world-class systems. However, an exclusive focus upon the formal mechanics of suicide prevention risks underplaying factors that may be more important: the quality of staff-detainee relationships, the range of activities, family contact, anxiety and uncertainty about the future.

5.10 There is also a legitimate worry that ACCT and ACDT were designed when the numbers of staff were more generous than is the case today. The Prisons and Probation Ombudsman has written:

> "I also remain concerned that current prison suicide prevention measures were designed when prisons had many fewer prisoners and many more staff … suicide prevention procedures are still badly in need of updating and streamlining without which I continue to question their fitness for purpose."[91]

5.11 Of IRCs visited in 2016-17, the Chief Inspector of Prisons has said:

> "The implementation of the assessment, care in detention and teamwork (ACDT) case management system for detainees in crisis was not effective enough to provide consistently good support at any centre."
>
> "At all IRCs, detainees reported feelings of depression or despair. In our surveys, 43%, 48% and 49% of detainees at Brook House, Colnbrook and Morton Hall respectively said they had problems with depression or suicidal feelings on their arrival."[92]

[90] ACCT has recently been the subject of review by the Ministry of Justice. The review focussed both on compliance and the quality of care. It found that the ACCT process continues to be an effective system to identify, manage and support those at risk of suicide or self-harm, but made recommendations on developing better communications for staff and prisoners, revising policy, and updating training packages. The Home Office has been closely associated with this work.
[91] *Annual Report 2016-17*, Cm 9461, p.9.
[92] *Annual Report 2016-17*, HC 208, p.72.

5.12 Other observers have also identified a gap between the numbers reporting suicidal thoughts and those identified as such under ACDT. Bosworth and Gerlach found "an ongoing gap between the formal ACDT programmes used in Harmondsworth relative to the numbers who reported persistent suicidal thoughts on our measure of distress."[93]

5.13 The Home Office has provided me with statistics on the number of detainees on open ACDTs between January 2016 and December 2017. Figure 5.1 demonstrates the very high numbers, particularly at Brook House, Harmondsworth, Colnbrook, Morton Hall and Yarl's Wood.

Fig 5.1: Number of detainees on ACDTs per IRC per quarter

	Q1 – 2016	Q2 – 2016	Q3 – 2016	Q4 – 2016	Q1 – 2017	Q2 – 2017	Q3 – 2017	Q4 – 2017	TOTAL
Brook House	128	113	106	104	113	146	150	96	956
Campsfield House	48	40	46	23	35	33	35	26	290
Colnbrook	99	91	74	78	59	84	70	72	627
Dungavel	24	31	43	22	40	24	16	26	206
Harmondsworth	148	182	104	111	65	43	109	133	927
Morton Hall	43	71	78	94	85	68	59	93	591
The Verne	68	15	78	80	62	101	101	54	560
Tinsley House*	26	35	23	–	–	7	16	34	141
Yarl's Wood	77	57	94	86	33	10	50	13	430
Larne	8	10	3	6	5	6	3	1	42
Pennine House**	1	5	3	2	3	–	–	–	14

* Tinsley House was closed for refurbishment from October 2016 – May 2017

** Pennine House was closed in March 2017. A replacement is due to reopen later in 2018.

(Data provided on the basis of internal management information. All data from July 2017 onwards has not been previously released or published and must be considered as provisional management information that has not been assured to the standard of Official Statistics.)

5.14 At the end of December 2017, some 67 ACDT documents were open as shown in Figure 5.2.

Fig 5.2: Open ACDTs (as of December 2017)

Open ACDT cases by IRC	
Brook House	8
Tinsley House	3
Colnbrook	14
Harmondsworth	28
Campsfield House	2
Yarl's Wood	5
Dungavel	2
Morton Hall	5

[93] Mary Bosworth and Alice Gerlach, *Quality of Life in Detention Results from MQLD Questionnaire Data Collected in IRC Heathrow (Harmondsworth), July 4–6, 2017,* Oxford: Centre for Criminology, August 2017, Criminal Justice, Borders and Citizenship Research Paper No. 3012171. The authors report: "The level of distress reported by the survey population was substantial. Many respondents reported disruptions to their sleep, including bad dreams. They reported having less appetite than is usual, suffering from apathy, feeling lethargic and that they were unable to enjoy the things they used to enjoy and many reported that they 'never' felt happy or only some of the time." Levels of uncertainty about what could happen in their case were extremely high, with over 50 per cent saying they were very unsure. Some 30 per cent said they had thoughts of ending their life all of the time (table 13, p.18) and many said they had experienced torture (table 15, p.19).

5.15 During the course of this review, I asked that all open ACDTs be analysed as part of my team's visits to IRCs. By and large I was pleased to see that, in most cases, ACDTs had been opened and closed appropriately. However, a risk adverse approach sometimes meant that they were opened too readily. I saw this particularly at Harmondsworth, which was likely to be the result of a recent death there.

5.16 This chimed with a finding that I had made separately in a report commissioned by the Ministry of Justice in early 2017 following a series of deaths at HMP Woodhill.[94] I found a remarkable focus on prisoner safety in Woodhill. However, it had coincided with a culture of risk aversion that itself placed a great strain on ACCT processes and the wider regime. I said that the continuing weaknesses in ACCT procedures that I observed were unlikely to be overcome until the number of open ACCTs was significantly reduced.

5.17 Another feature both of Woodhill and of the IRCs is a reliance upon constant watch (sometimes inelegantly and inaccurately described as suicide watch). Constant watch is used in psychiatric hospitals and in other closed institutions, but it is acknowledged to be very draining on staff (especially if the person being observed is asleep or uncommunicative, and at night), and potentially intrusive and demeaning.

5.18 Constant watches are also very staff-intensive, and run the risk of undermining the wider regime. I understand that this is a difficult balance for centre managers, but the number of constant watches should be kept to a minimum and assessed carefully.

5.19 Figures obtained for this review suggest at least 30 detainees per month are on constant watch across the detention estate. I strongly suggest that, if a detainee is on constant watch, there must be serious questions about the justification for their continued detention.

5.20 More positively, I found the quality of the ACDT documents themselves to be reasonably good in most cases.[95] Records of interaction with detainees and staff were recorded in some detail, and most caremaps were satisfactory. They included meaningful actions designed to reduce risk, although the time frames for completion were not always established.

5.21 There were frequent references in the documents to appointments with healthcare[96] and the chaplaincy, although my team and I noted very few direct comments on an individual's behaviour and demeanour from staff in education or workshops.

5.22 I personally reviewed a set of closed ACDT documents at Tinsley House, and my contemporaneous notes were as follows:

> Case 1: Found with sheet rolled as ligature. On constant watch. Good quality observations. Released the next day so ACDT closed with no caremap started.
>
> Case 2: Nine days on ACDT on reducing observations until released on bail. History of self-harm and expressing suicidal thoughts. Alleged torture with cigarettes by police (partner also detained). Reviews reasonably multidisciplinary.

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[94] *Independent professional advice on the prevention of self-inflicted deaths and self-harm at HMP Woodhill*, May 2017, http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2018/02/Advice-on-self-inflicted-deaths-and-self-harm-at-HMP-Woodhill-[redacted].pdf. The report was commissioned following four deaths in 2013, two in 2014, five in 2015 and seven in 2016. Acts of self-harm had also increased very substantially.

[95] Albeit based on a much smaller sample, this finding was more encouraging than that of an internal review conducted by the Immigration Enforcement Compliance Monitoring Team in March 2016. That review had found significant levels of non-compliance – in particular, multi-disciplinary attendance at case reviews was sporadic, and care maps were frequently not completed or updated. The Prisons Inspectorate has also been critical of the completion of ACDT paperwork.

[96] However, one case reported by the Prisons and Probation Ombudsman of an apparently self-inflicted death of a detainee by overdose found a lack of input from healthcare staff, no care management plan and no direct clinical oversight. *Annual Report 2016-17*, op. cit., p. 46.

Case 3: Four days on ACDT then released. ACDT opened by Healthcare after the detainee told doctor he was having suicidal thoughts. Multidisciplinary reviews and good quality observations.

Case 4: Five days on ACDT. Stated wanted to kill himself. Past history of attempts at hanging. "Bad dreams" about past torture. Been in detention for six months; seeks transfer to Morton Hall.

Case 5: Seven days on ACDT. Very tearful during Home Office interview, at times stated he wished he was dead.

Case 6: Five days on ACDT. Placed on ACDT after making threats to end his life as he has been in detention for five months and was missing his daughter. Good quality caremap.

5.23 Case conferences were a regular feature of the ACDT record, and by and large these were conducted on a multi-disciplinary basis with representation from unit managers and staff and healthcare at a minimum. (My impression was that the multi-disciplinary aspect of ACDT compared well with much practice in prisons.)

5.24 I was also pleased to see that there has been an increase in Home Office attendance at ACDT reviews. However, it remains the case that this representation is by a locally based member of Home Office staff rather than by the case decision maker. I am strongly of the view that input from a decision maker would benefit the ACDT process – since so many of the detainees' concerns relate to the uncertainty over the time in detention and future prospects. I would certainly expect the involvement of staff from Pre-Departure Teams as these are rolled out. An alternative would be for caseworkers to be involved by telephone.

5.25 It remains the case, however, that ACDT is a paper-based system, and this limits the extent to which all parts of an IRC can contribute.

Recommendation 35: The Home Office should encourage moves to develop a digital version of the ACDT document.

5.26 I am also concerned that the relationship between ACDT and the Adults at Risk policy should be clarified. Being placed on an open ACDT should immediately trigger a review of a detainee's AAR level. I did not find that this was predictably the case.

The need for research

5.27 I reported above that there have been four apparent self-inflicted deaths in detention since publication of my first report. While Coroners' findings on the causes of death are yet to be determined, my team have looked at some of the information available to see if there were any evident common features.

5.28 There were only two points to emerge. Two of those who apparently took their own lives were Polish nationals.[97] And three had previously been admitted to a mental hospital for treatment.

5.29 So far as I am aware, there has to date been no published Home Office research into the deaths in IRCs, partly I suggest as the numbers have until recently been mercifully low. However, NHS England has commissioned a study from Manchester University as part of a

[97] Cultural factors do appear to be correlated with suicide and self-harm. In my Woodhill report (see above, paragraph 5.16), I noted that both in this country and the United States prisoners with African heritage are much less likely to die at their own hands than white prisoners. Foreign nationals currently make up around 12 per cent of the prison population, but in 2015-16 accounted for nearly 20 per cent of apparently self-inflicted deaths.

review of prison deaths. This also includes deaths in IRCs. I am aware that there is also work underway by the Home Office in conjunction with HMPPS and NHSE to review deaths in, or shortly after, immigration detention from 2015 onwards. This would not qualify as research, but is sharply focussed on lessons learned and will be used with centre managers and safety leads across the estate to strengthen preventative work. I have not seen any outcomes as the work is at an early stage, but I understand it covers both deaths from natural causes and those that were apparently self-inflicted.

5.30 I have, however, drawn upon a 2013 report from the Commonwealth and Immigration Ombudsman in Australia on suicide and self-harm in immigration detention.[98] This was based on an investigation lasting over two years, and prompted by an escalation in self-harm and significant concerns about the mental health and wellbeing of detainees. While there are obvious differences in systems and processes – not least Australia's use of offshore detention – I noted in particular the following recommendations:

- That the immigration authorities review and improve their data collection and management reporting so that the physical and mental health of people held in immigration detention can be measured and monitored to enable effective management and response to the risk of suicide and self-harm
- That the authorities review and improve policies and governance frameworks for managing the risk of suicide and self-harm
- That the authorities review and improve processes in the status resolution and placement of people in immigration detention, particularly for those people detained for long periods
- That the authorities, in consultation with service providers, immediately and systematically review the circumstances of all future deaths and serious incidents of self-harm in immigration detention to determine if there are policies, processes or practices that need to be revised or addressed to prevent future occurrences.

5.31 Closer to home, I have been aided by research carried out by Mr Dominic Aitken, a Ph.D student at Oxford. Mr Aitken spent approximately one month during the summer of 2017 in Brook House conducting observations, speaking informally to detained men and members of staff, attending meetings, and shadowing individual employees. He also carried out 18 semi-structured, qualitative interviews with G4S employees, including detainee custody officers, managers and senior managers. The interviews typically lasted around an hour. I am grateful to Mr Aitken for allowing me to reproduce his findings in this report:

> "One senior manager noted that there was a significant problem with Brook House not receiving open ACDT forms from other centres: 'When we have detainees who are on ACDT plans come to us, we should have a Safer Communities referral from the sending IRC. We don't always get that. So in May and June [2017], I know that we received 20 people on ACDT. We received eight Safer Community referrals, so 40 per cent. My message to my […] colleagues was, that's not adequate. Forty per cent is not adequate […] that's just not acceptable to receive no Safer Community referrals for 60 per cent of your ACDTs coming in.'
>
> "It follows from this testimony that there needs to be a stronger focus on information sharing between IRCs across the immigration detention estate, in addition to good information sharing within each IRC. There is clear evidence from Prisons and Probation Ombudsman reports that information sharing and teamwork are essential to effective suicide prevention work.

[98] *Suicide and Self-harm in the Immigration Detention Network – May 2013 – Report by the Commonwealth and Immigration Ombudsman, Colin Neave, under the Ombudsman Act 1976.*

"Words such as 'manipulation' and 'attention seeking' came up in several interviews during discussions of self-harm, including with some (former) senior managers. Similarly, a number of interviewees observed that many men 'did not really mean to hurt themselves' or were 'faking it'. In some cases, staff acknowledged that they were 'not supposed to say this', but there was an undercurrent of suspicion or disbelief in how they spoke about detainees who harmed themselves. Whether or not these attitudes affect how employees work, they go against best practice and may have a chilling effect on detainees' willingness to report their vulnerability to staff."

5.32 Mr Aitken made the following suggestions and recommendations:

- There are relatively few deaths in IRCs, so it is difficult to draw meaningful conclusions about themes and patterns across the cases. Given the small number of suicides and the associated problem of statistical inference, one option would be to conduct formal investigations into 'near misses' and/or attempted suicides, including interviews with the survivor, if possible. Numerous interviewees had dealt with 'near misses' and/or attempted suicides, which are often substantively similar to completed suicides. It is likely that important lessons can be learned about prevention from looking in greater depth at these cases.
- Staff should be reminded regularly about what constitutes good practice, ideally through formal follow-up training or more informally by relevant members of staff. IRCs are generally high-risk environments and all detainees are vulnerable to some extent, so employees must be equipped to deal with these issues in a professional, multi-disciplinary way. Adequate staffing levels, particularly at night, are an important part of effective suicide prevention. Several employees suggested that the healthcare team should make greater efforts to help custodial staff understand issues such as post-traumatic stress disorder, schizophrenia, depression, and alcohol/drug withdrawal.
- Staff should also be reminded that a person's appearance and demeanour are not necessarily reliable indicators of underlying levels of risk (e.g. 'he seemed fine', 'he said he was okay'). Similarly, self-harm and suicidal behaviours cannot be understood purely in terms of the events that preceded them (e.g. he cut himself because 'he got refused bail', 'he had an argument with his wife' or 'he has been frustrated with his solicitor'). Meaningful engagement with those at risk of self-harm or suicide is important, rather than mere monitoring or observation (e.g. of detainees on constant watch).
- Some employees (especially DCOs) noted that they did not feel rewarded or recognised for the extra work involved in carrying out ACDT assessments and reviews. Given the emotional toll of such work, perhaps they would benefit from some formal recognition or incentive. In particular, staff who can speak foreign languages (e.g. Arabic, Urdu, Polish) are responsible for a lot of unrecognised work in immigration detention, including work related to ACDT.
- ACDT reviews should ideally take place in calm, quiet, private settings, rather than in a wing office.

5.33 I endorse Mr Aitken's proposals in respect of research into 'near misses', additional training for staff,[99] the value of recognition schemes, and the need for ACDT reviews to take place away from the hubbub of most IRC units.

[99] Mr Aitken found that staff were not always aware when disruptive behaviour could be symptomatic of mental illness and a subsequent risk to the individuals themselves.

Recommendation 36: I recommend that IRC staff who have regular contact with detainees should receive mandatory safer detention training on an annual basis.

5.34 I also agree with him that appearance and demeanour are fallible guides to suicidal ideation (indeed, research has shown that prisoners who take their own lives have often seemed rather happier in the immediate period beforehand). Perhaps the strongest possible predictor of self-harming is not the way someone looks at a particular time, but if they have a history of previous self-harming behaviour. However, this insight may be of less practical use in IRCs than in prisons when information about previous self-harming (especially if it was abroad) is simply not available.

5.35 What Mr Aitken reports about failures in the transfer of information on the risk of self-harm is consistent with what I also found. IRCs receiving detainees from other centres were not always aware that the detainee had been the subject of an open ACDT. This is clearly unacceptable, and the Home Office should investigate this as a priority and remedy any weaknesses. The electronic transfer of information would clearly assist.

5.36 The wider point is that transfer between institutions is itself a risk factor, and transfer of those who have recently been the subject of ACDT monitoring should be kept to an absolute minimum.

Recommendation 37: I recommend that the Home Office commission research into deaths in immigration detention, 'near misses' and incidents of serious self harm.

Recommendation 38: The Home Office should devise and publish a strategy for reducing the number of deaths from natural causes and those that are self-inflicted in, and shortly after, immigration detention.

PART 6: OVERSIGHT AND STAFF CULTURE

Introduction

6.1 The catalogue of recent scandals involving institutions that care for the vulnerable is a long and depressing one. It has included hospitals and care homes, orphanages and schools, and institutions as celebrated as the NHS, the Church, and the BBC. Neither public nor private sector has been immune.

6.2 What all had in common was the power imbalance between staff and those in their charge, and the failure of both management and oversight arrangements.

6.3 Just as I commenced this review, a BBC *Panorama* programme was aired about the behaviour of a number of staff at Brook House, run by G4S. The revelations of malpractice echoed those that had been found in two other immigration removal centres over the last 15 years: Yarl's Wood and Oakington.[100]

6.4 Following the BBC programme, I received a letter on 21 November 2017 from the Home Office in which I was asked to confirm that staff culture, recruitment and training, the sufficiency of the complaints mechanisms, and the effectiveness of whistle-blowing procedures, are matters that would be considered as part of my second review. I confirmed this to be the case in my reply of 22 November. I have reproduced the exchange of letters at Annex 1.

6.5 In my first report I touched more briefly than I should on the staff of the immigration detention estate. What I did say was that the behaviour and moral resilience of staff is of critical importance in looking at the vulnerability of those detained. However, I did not look at the recruitment and training of detention centre staff, nor their sense of vocation (nor that of Home Office caseworkers).

6.6 Although I do not believe it is for me to discuss rewards and recognition, or the exact staffing model that the contractors should apply, in this follow-up review I have considered more generally how to recruit and retain people with the very best skills and behaviours,

[100] As I recorded in my first report, I carried out two enquiries for the Home Office into the allegations of mistreatment. One concerned Yarl's Wood: *Investigation into allegations of racism, abuse and violence at Yarl's Wood Removal Centre,* Prisons and Probation Ombudsman, March 2004. The other involved Oakington, an institution that closed in 2010: *Report into allegations of racism and mistreatment of detainees at Oakington immigration detention centre and while under escort,* Prisons and Probation Ombudsman for England and Wales, July 2005. (Both are available on the Prisons and Probation Ombudsman website.) In March 2015, Channel 4 News broadcast further allegations about staff at Yarl's Wood which was the subject of a report for the Serco Board by Kate Lampard and Ed Marsden of the company, Verita: *Independent Investigation into concerns about Yarl's Wood immigration removal centre.* (This latter report is available on the Verita website.)

and how a decent and professional staff culture can be established and maintained. It goes without saying that the quality of relationships between staff and detainees is crucial to any idea of detainee welfare, as is the case in all institutions.

6.7 I have spoken to both the Home Office and the contractors about their procedures, and solicited the views of staff on my operational visits. I also discussed these issues with Independent Monitoring Boards at each IRC. Most helpfully, I also hosted a seminar that brought together experts in institutional behaviour from the police, prisons, NHS, and the Home Office.

6.8 I have discovered that there is a wealth of academic material on this subject, and multiple definitions of the term 'culture' in organisational terms. However, authors appear in agreement that the culture is how organisations *do* things, and represents the values and beliefs that govern how individuals behave: most commonly described as 'how we do things around here'.

6.9 It is of course recognised that 'good' culture is key to success in all organisations. It influences behaviours and performance, and is reflected in staff motivation and engagement, organisational reputation and delivery. Culture is demonstrated in many ways, including how staff are recruited (and how long they stay), how employees feel, the quality and delivery of communication, their involvement in decision making, and how visible leaders are and how they react or behave.

Recruitment and Training

6.10 The recruitment and training of Detainee Custody Officers (DCOs) is exercised through a process of certification that has a legal basis in the Immigration and Asylum Act 1999:

- Part VIII of the Act sets out the principles of certification, whereby individuals are recognised as DCOs by the Secretary of State
- Part VIII of the Act sets out the requirements for the certification of DCOs undertaking custodial and escorting duties on behalf of the Home Office.

6.11 Section 154 sets out that:

- A person must apply to the Secretary of State for a certificate – a certificate cannot be issued automatically
- The Secretary of State may not issue a certificate unless he is satisfied that the applicant:
  - Is a fit and proper person to perform the functions to be authorised (section 154, 2a), and
  - Has received training to such standard as the Secretary of State considers appropriate for the performance of those functions (section 154, 2b).

6.12 A Home Office manager is able to suspend a DCO's certification in certain prescribed circumstances where it appears that he or she is no longer a fit and proper person to carry out the functions of a DCO (Schedule 11, 7[2]). Likewise, the Secretary of State may revoke a DCO's certificate where it appears that he or she is no longer a fit and proper person (Schedule 11,7[1]).

6.13 The core criteria on what constitutes a fit and proper person on recruitment are:

- DCOs must have the right to work for the Home Office – looking at nationality or immigration status in particular
- DCOs must pass security vetting which among other things will consider any known previous convictions
- DCOs are prohibited from being members of or affiliated with groups or organisations that have racist or anarchic philosophies, principles, aims or policies, or which overtly campaign against immigration controls or the Home Office's policies.

6.14 Before issuing a DCO certificate, the Home Office requires confirmation that an individual has completed, and (where appropriate) passed, all elements of an initial training course.

6.15 A DCO's certificate may be suspended by a relevant Home Office manager where:

- There is an allegation of serious or gross misconduct behaviour made against a DCO. These include but are not limited to inappropriate, excessive or unnecessary use of force on a detainee; offensive personal behaviour; and any behaviour which brings or is likely to bring serious discredit on the Home Office
- The DCO is by reason of physical or mental illness or for any other reason incapable of satisfactorily carrying out his or her duties
- The DCO's immigration status changes and he or she no longer has the right to take employment in the UK.

6.16 In short, I am content that the Home Office already has significant powers to determine who is fit to be a DCO, and whether they are able to keep working following any allegation of misconduct. However, recruitment and training are not centrally provided – with the exception of control and restraint training provided by HM Prison and Probation Service for those DCOs working on escorts – and individual companies have their own arrangements.

Staff Recruitment

6.17 I have been provided with copies of the recruitment plans, and some indications of how they select staff, by each of the companies responsible for running IRCs. Unsurprisingly, all the companies use selection polices that seek to weed out those with unacceptable views or behaviours, and all applicants must pass a central vetting system.

6.18 The companies told me that they reinforced the cultural aspects in training, and applicants who did not demonstrate appropriate behaviours had been dismissed during the training period.

6.19 It is of course part of the rationale for contracting-out that private companies are able to innovate and develop their own practices. Nonetheless, I think it might be advantageous if there was a standard set of recruitment principles across the estate. I note, for example, that there are role-play exercises used for the recruitment of prison officers that aim to test:

- Non-verbal listening skills
- Suspended judgement
- Displaying understanding
- Assertion
- Respecting others
- Acting with integrity.

6.20 There is a school of thought amongst many occupational psychologists that a generic competency-based model will favour staff who are good in theory and not in practice. In contrast, a strength and value based approach will lead to a better fit with the values of an organisation and the specific role, reducing attrition levels, and increasing staff motivation, engagement and performance. Strength based approaches are also considered to support diversity within recruitment, and this is particularly relevant in an IRC context.[101] Most IRCs have a diverse workforce at the DCO level, but this is much less apparent amongst both middle and senior managers.

Staff training

6.21 While each contractor carries out its own training, it does need to cover a number of basic areas as outlined below:

- First Aid at work (three year duration – only required for DCO Escorts)
- Minimising and Managing Physical Restraint (MMPR) (six month duration – only required for DCOs who work specifically with children and/or families)
- An overview of Detention Centre Rules 2001
- An overview Detention Service Operating Standards for IRCs and escorts
- An overview of Detention Services Orders
- An overview of the Human Rights Act 1998 and European Convention on Human Rights
- Powers and duties of a Detainee Custody Officer
- Diversity (including race relations and cultural awareness)
- Interpersonal skills and communication
- Report writing
- Self-harm and suicide prevention
- Safeguarding of children, including section 55 of the Borders, Citizenship and Immigration Act 2009
- Control and restraint (C&R)
- Home Office Manual for Escorting Safely (HOMES)[102] (only required for DCO escorts)
- An overview of the work of the Home Office
- Data protection and information management.

6.22 I have reviewed copies of individual induction training packages. Again not surprisingly, there are substantial similarities: a mixture of classroom training, C&R training provided by HMPPS, as well as job shadowing. However, the length of the initial training varies from supplier to supplier. I found it ranged between four weeks and eight weeks, although this is explained to some extent by whether mentoring and shadowing was regarded as part of the formal training process.

6.23 I was pleased to see that all the courses appear to cover issues of cultural awareness, equality and diversity, and human rights. However, I was less certain how much time and resource was devoted to embedding professional standards and whistle-blowing. I regard

[101] In prisons, likewise. The recruitment processes at HMP Thameside, a privately run prison in South London I visited during the course of this review, is intended to recruit on values. Amongst other things, this seems to have resulted in a very diverse workforce.
[102] I chaired the independent committee that oversaw the development of the HOMES package.

this as a key element of any strategy to any further abuse of the kind revealed at Brook House. It is important that any training explicitly addresses issues of ethical behaviour and the dangers of negative staff cultures.

6.24 I was impressed with the professional standards document developed at Yarl's Wood that seeks to identify and clarify the key standards of professional and personal conduct expected of all staff. The document outlines clearly what actions staff must take if they witness any wrongdoing, or have knowledge of suspected wrongdoing. It details the support services available, and how whistle-blowing staff will be protected. In addition, there is a designated senior manager who is responsible for monitoring the process. I regard this as very good practice, but more critical is that all managers are active in the promotion of professional standards of conduct and model such behaviours themselves.

Whistle-blowing procedures

6.25 While investigations into the misconduct at Brook House are ongoing, it seems evident that G4S's whistle-blowing procedures were not sufficient to bring that misconduct to the attention of managers.

6.26 In March 2015, the Department for Business, Innovation and Skills (BIS, now BEIS) published a guide for businesses, *Whistle-blowing: Guidance for Employers and Code of Practice.* The document outlined the following principles of an effective whistle-blowing system:

> "It is important that employers encourage whistle-blowing as a way to report wrongdoing and manage risks to the organisation. Employers also need to be well equipped for handling any such concerns raised by workers. It is considered best practice for an employer to:
>
> - Have a whistle-blowing policy or appropriate written procedures in place
> - Ensure the whistle-blowing policy or procedures are easily accessible to all workers
> - Raise awareness of the policy or procedures through all available means such as staff engagement, intranet sites, and other marketing communications
> - Provide training to all workers on how disclosures should be raised and how they will be acted upon
> - Provide training to managers on how to deal with disclosures
> - Create an understanding that all staff at all levels of the organisation should demonstrate that they support and encourage whistle-blowing
> - Ensure the organisation's whistle-blowing policy or procedures clearly identify who can be approached by workers that want to raise a disclosure. Organisations should ensure a range of alternative persons who a whistleblower can approach in the event a worker feels unable to approach their manager. If your organisation works with a recognised union, a representative from that union could be an appropriate contact for a worker to approach
> - Create an organisational culture where workers feel safe to raise a disclosure in the knowledge that they will not face any detriment from the organisation as a result of speaking up
> - Undertake that any detriment towards an individual who raises a disclosure is not acceptable

- Make a commitment that all disclosures raised will be dealt with appropriately, consistently, fairly and professionally
- Undertake to protect the identity of the worker raising a disclosure, unless required by law to reveal it and to offer support throughout with access to mentoring, advice and counselling
- Provide feedback to the worker who raised the disclosure where possible and appropriate subject to other legal requirements. Feedback should include an indication of timings for any actions or next steps."

6.27 In light of this official advice, I asked to see copies of whistle-blowing procedures for each of the companies running IRCs.

6.28 I discovered that each of the companies has clear written processes in place, including the ability to raise a concern with an external body. I also concluded that all of them appeared to meet best practice outlined in the BIS guidance. It was not clear to me, however, how often the whistle-blowing procedures are actually invoked.

6.29 Cultural forces may be at work here as well. (In the police, this has become known as a 'blue code of silence'.) Uniformed services where there is a potential for danger and close reliance on colleagues (the fire service, the army, and Immigration Enforcement, are three other examples) generate a tightly-knit environment with strong loyalties. The use of whistle-blowing procedures may cause staff to feel that they will be shunned by others, or risk their support in difficult situations. In short, this is not a problem unique to IRCs.

6.30 To supplement whistle-blowing arrangements, I suggest that staff would benefit from being afforded safe spaces in which they can discuss what they have done well (and less well) without fear of disciplinary repercussions. Staff need to be honest about their own coping strategies.

Complaints

6.31 Detention Services Order 03/2015 – updated in February 2017 – sets out the process for responding to complaints in IRCs.

6.32 Complaints raised by or on behalf of detainees are normally made on a form that I found to be readily available in all detention facilities. Completed forms are placed in a locked complaints box provided by the supplier (clearly marked "Immigration Enforcement Complaints"). Again, I found these were in good supply. There are separate procedures for complaints about healthcare. Once more, I saw these in each of the IRCs I visited.

6.33 Depending on the nature and seriousness of the complaint, there is a range of options for its resolution.[103]

6.34 The Home Office has provided me with data on the number of detainee complaints it has recorded in 2016 and 2017. The details are given in Figure 6.1.

Fig 6.1: Volume of complaints by centre per quarter January 2016 – December 2017

IRC	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Total
Brook House	40	39	40	31	54	45	46	91	386
Campsfield	9	7	9	8	3	5	8	9	58
Colnbrook	54	69	66	61	72	43	72	48	485
Dungavel	15	4	5	5	3	5	2	3	42
Harmondsworth	100	71	82	65	46	54	58	41	517
Morton Hall	22	43	36	41	42	31	55	45	315
Tascor	29	23	21	39	30	29	37	30	238
The Verne	8	11	9	40	21	41	42	52	224
Tinsley House	10	3	1	Closed	Closed	2	6	6	28
Unknown	3	2	1	1	1	2	1	8	19
Yarl's Wood	28	48	26	16	17	22	27	18	202
DEPMU	0	2	4	1	0	2	9	0	18
Total	318	322	300	308	289	281	363	351	2, 532

[103] For issues that are relatively minor, easily resolved and require little or no investigation:
- Detainee gets immediate response and, where appropriate, an apology
- Action taken to put the matter right
- Resolved by any appropriate staff member (Home Office, contractor, healthcare provider)
- Recording in line with local procedures.

Where the issues cannot be resolved informally:
- Complaint is copied to IMB (unless clinical complaint or complainant refuses)
- Details of investigating officer and target date for response provided to detainee
- Written response within 20 working days following investigation including details of escalation process to Ombudsman.

For issues of minor misconduct:
- Complaint is copied to IMB (unless clinical complaint or complainant refuses)
- Details of investigating officer and target date for response provided
- Investigated by IRC supplier manager or Immigration Enforcement manager or escorting manager
- Written response within 20 working days including details of escalation process to Ombudsman
- If substantiated, guidance given to staff member. Disciplinary action may be considered.

For issues of serious misconduct:
- Complaint copied to IMB (unless clinical complaint or complainant refuses) and immigration caseowner
- Allocated to Professional Standards Unit for investigation
- Detainee Custody Officer (DCO) certification considered for suspension
- Criminal allegations referred to police
- Security/corruption allegations referred to Home Office Corporate Security
- Response within 12 weeks copied to IE manager and (where appropriate) to IMB
- If substantiated, DCO certification (Home Office) and disciplinary action (employer) considered.

Complaint relates to healthcare (treatment or staff) in England:
- Referred to local healthcare provider in accordance with NHS procedures for investigation and response.

Complaint relates to healthcare (treatment or staff) in Scotland or Northern Ireland:
- Referred to local healthcare manager for investigation and response
- Outcome of complaint notified to DS CSU, IMB and IE manager
- Reply provides details of escalation process.

Complaint not resolved to satisfaction of complainant:
- Complaints progressing to either Ombudsman will have been thoroughly investigated through Home Office or NHS complaints process
- PPO will investigate appeals against responses to complaints concerning detention or escorting (within three months of the complainant receiving the response)
- PHSO will investigate healthcare complaints (England) or (via an MP) complaints relating to other aspects of immigration
- DS CSU will facilitate the escalation of healthcare complaints in detention (Scotland and Northern Ireland) to the appropriate Ombudsman.
- In addition to the formal complaints process, detainees can also make applications to the Independent Monitoring Board.

6.35 The Home Office complaints team conducts a quality assurance of 20 per cent of all complaint responses closed per month. This is on top of the quality assurance of a separate 20 per cent of responses conducted by delivery managers in each centre. Any issues raised are fed back as learning points to the contractor's complaints clerk. The Home Office Detention and Escorting Services complaints team also arranges a weekly conference call with the complaints clerk at each IRC to discuss all open complaints.

6.36 This system has already been subject to review in March 2016 by the Chief Inspector of Borders and Immigration, Mr David Bolt. In his report, *An Inspection of the Handling of Complaints and MPs' Correspondence*, Mr Bolt examined the efficiency and effectiveness of the system for handling complaints.

6.37 The review found:

- For individuals in immigration detention whose first language was not English, explanatory information was available in a range of languages and they were able to write their complaint in their own language. Although all responses were written in English, detainees could ask centre staff, the centre's Independent Monitoring Board or detainee welfare groups to assist in translating the response. Service provider staff must make arrangements to help detainees who may find it difficult to understand a response due to English not being their first language
- Most substantive responses to complaints (over 80 per cent of the cases sampled) were written in plain English and in an appropriate tone
- IRC managers had responsibility for checking responses to complaints from immigration detainees. In roughly three-quarters (27 out of 35) of the complaints sampled, the response had been attached to the Complaints Management System (CMS) record. Most of the responses were well-structured, addressed all of the issues raised in the complaint and referred the complainant to their right to pursue the matter with the Prisons and Probation Ombudsman if not satisfied.

6.38 HM Chief Inspector of Prisons has also looked at complaints systems within IRCs. I understand that the Inspectorate's view is that monitoring and analysis is improving across the estate, and that investigations for the most serious complaints, handled by the Professional Standards Unit, are particularly thorough. However, there are concerns about the timeliness of responses given the significant turnover of detainees.

6.39 In considering the complaints process, I also spoke to my former colleagues in the office of the Prisons and Probation Ombudsman (PPO). I was told that the volume of complaints from detainees was relatively low and was decreasing. It was accepted this might reflect issues of accessibility and visibility of the PPO as a conduit for complaints, and I hope it will not seem disloyal if I report that I did not see much PPO literature or other promotional material in any of the IRCs.

6.40 It was felt that detainees might find the formal complaints process difficult, but given detainees' better access to phones and emails than prisoners, the PPO did receive some email complaints.

6.41 Where the PPO did see IRC complaints, they had usually been well investigated by the Home Office. Complaints appeared to be mainly about the use of force in attempted removals, and about property. The uphold rate is very low.

6.42 Given these findings and my own observations, it would be difficult to argue that the formal complaints process is not a robust one. There is a good system for monitoring and responding to complaints, and the emphasis is on dealing with them at a local level

and as quickly as possible. Nonetheless, no written complaints system is best designed for detainees with a limited grasp of English. Moreover, some nationalities may have little experience of the authorities engaging honestly with grievances from those in prison or detention.

6.43 For these reasons, I suspect that complaints data affords only a very partial insight into the detainee experience. I was pleased to see that most IRCs have developed detainee forums. I think it would be helpful if the Home Office and the contractors looked to buttress these initiatives with other means of gauging detainee views such as the use of anonymised surveys.

Independent oversight

6.44 In all closed institutions, the oversight mechanisms play a crucial part in ensuring that standards of performance and conduct are maintained. I concluded in my first report, and repeat here, that the principal oversight mechanisms for IRCs (HM Inspectorate of Prisons, the PPO, and the local Independent Monitoring Boards) represent a very strong system of independent audit.

6.45 However, no more than my own visits to IRCs for my 2016 report or here, were these mechanisms sufficient to prevent the abuses at Brook House revealed by the BBC.

6.46 In my discussions with HM Chief Inspector of Prisons, Mr Peter Clarke, it was clear that he and his staff had reflected closely on what had happened at Brook House where the behaviours had not been exposed to them. They were developing a new survey methodology to better identify any such failings in future inspections. I very much welcome this development. (The new methodology was first deployed in a subsequent inspection at Harmondsworth.)[104]

6.47 I met with an IMB representative on each of my visits. In the main, the Home Office is very fortunate in the personal qualities and diligence of IMB members, all of whom are unpaid volunteers.

6.48 However, the availability of IMB members varied from centre to centre and it was not always obvious that this was sufficient resource, especially at night. I was also unclear if there had been any analysis of the number of IMB member-hours needed in each IRC, given the differences in terms of population size, mix and need.

6.49 I found it frankly bizarre that Brook House and Tinsley House had exactly the same resource even though the centres had such a different population mix and levels of vulnerability. Both Brook and Tinsley had a budget of 191 visits a year (which, when Board meetings are taken into account, means in reality just one or two visits per week). This does not evidence resource following risk.

6.50 I do not know how these budgets of visits were calculated, but I am concerned that not every IMB is able to carry out its role effectively in consequence. This needs to be remedied quickly.

Recommendation 39: The Home Office should review with the Ministry of Justice the resource allocated to each IMB in the immigration detention estate.

[104] Although not a matter I discussed with Mr Clarke, I am aware of the urgent notification process that has been agreed between the Inspectorate and the Secretary of State for Justice empowering the Chief Inspector to demand urgent action by the Secretary of State to improve gaols with significant problems. Once the lessons have been learned, a similar process in respect of the Home Office and IRCs should be considered.

Learning from other services

6.51 To draw upon experience in other walks of life with distinctive staff cultures, I co-hosted with Professor Bosworth a seminar on staff culture. This brought together experts on the police, prisons, and the NHS as well as immigration detention. I also asked the Independent Chief Inspector of Borders and Immigration to reflect upon culture amongst immigration caseworkers.

6.52 My aims for the seminar were to look at lessons for recruitment and training, the protection and development of staff to prevent desensitisation, corruption or harmful behaviour, and the development of an environment where any staff misconduct is detected and reported.

6.53 A list of those who attended is at Annex 12 but I have outlined some of the key findings below. I have also attached at Annex 10 the extremely helpful briefing paper that Professor Bosworth prepared in advance.

6.54 Professor Bosworth reiterated a number of points from her paper at the seminar. Many staff are deeply committed individuals (as I have experienced for myself), and they are pivotal to the delivery of a safe and decent regime. However, frontline officers often feel embattled, underappreciated and ambivalent about aspects of their work. In her paper, Professor Bosworth writes: "Officers are both the primary resource and risk for the sector."

6.55 She also shared the comments of those working in IRCs to illustrate some of the issues faced:

> "I love my job. I mean, there's days where I think, 'What am I doing here?' I could be doing a million other things. But actually, I love the guys. And I've got a fab team; I really have. I think I've got one of the best teams in the centre. And we all just get on. So if you're having a rubbish day, or you're having a good day, they just kind of all carry you." (DCM, IRC Heathrow)

> "Although the badge says detention custody officer. It's more like a care worker to be honest. A social worker… Citizen's Advice Bureau. 'Can you help me? Do you know...?' Yes. Not a prison officer certainly. No. We've got keys, but ain't that many doors to open now… No, I don't feel like a prison officer, or any custodial officer if you like. It's like a care worker…. we are care workers. That's the way I see it. We just provide a safe environment for our ladies." (DCO, Yarl's Wood)

> "I try just to put them out of my head. I just put that out of my mind. For them, I think my job is to look after them while they're here and to keep them safe while they're here. And then what happens next, well, I don't think about.' (DCM, Heathrow IRC)

> "After the first couple of months on the wing, you sort of grow a bit of a thicker skin I think. Get used to it… when it happens it's, it's less of a shock now, because it's happened before. I think through time and from experiences of having people self-harm or do certain bad stuff, you just grow immune to it. It's just part and parcel of the job. It's what we're here to do, so ..." (DCO, Brook House IRC)

> "Some days, majority of the days, you come to work, and you don't get thanks, you don't kind of... there's no appreciation there. Everything you say is wrong. Everything you do is wrong. However, there's an odd time when you do something, and you can actually see it means something to the individual, you can actually see it's made a difference. And it could be something that's really, really simple, like helping them write a letter, or helping

them do something, or just chatting to them about some random stuff. I think that's the, the most rewarding. I think that's when you come home and you've had a good day." (DCO Heathrow)

6.56 Professor Bosworth drew attention to the issue of secondary vicarious trauma[105] for those working in IRCs. She said this was a particular concern for staff in IRCs given the complexity of the detainee population, including those who may have a past involving torture or other trauma as well as a number of complex mental health needs. She said there was little research into the impact this can have on staff and their ability to distinguish between empathy and sympathy.

6.57 I understand that support of this type is already in place for asylum caseworkers and operational staff in ICE teams. It should be looked at for staff working in IRCs too.

6.58 In summary, Professor Bosworth made the following points:

- Staff are crucial to good order and discipline, but also to the culture of the institution
- This is made more complicated in IRCs by multiple layers of governance where communication and relationships between custody staff and Home Office staff often unclear
- There is a lack of clarity over the purpose and nature of the job
- The impact of managing complex needs of detainees should not be under-estimated and there is a need for more investment in secondary trauma counselling and trauma awareness programmes.

Prisons

6.59 In his contribution, Dr Ben Crewe from the Institute of Criminology at the University of Cambridge spoke more widely about the use of power in a number of public and privately run prisons.[106] In the public sector prisons, the risk was more often that power was over- rather than under-used, but prisoners were generally more positive about the reliability and consistency of staff, the degree to which they created an environment that was stable and predictable, their overall grip on institutional order, their knowledge of the intricacies of the prison system, their ability to mentor prisoners, and their confidence and competence in using authority.

6.60 At their best, public sector officers provided a form of 'supportive limit-setting', in which prisoners soon learned which kinds of behaviours were and were not tolerated, diminishing the possibility that they could get into trouble inadvertently, reducing the likelihood of them engaging in boundary-testing, and lessening the chance that they would risk trying to assault or exploit other prisoners. The willingness of staff to intervene quickly in the event of fights or other disruptions also had an important reassurance function. Prisoners had faith that staff were holding power in reserve, but could use it if necessary, and that not doing so was a conscious choice rather than a form of 'avoidance'. Prisoners could feel at least as free, and as safe, in an environment that was slightly over-supervised as in one that was somewhat under-supervised.

6.61 The better private prisons were characterised by a staff culture that was *powerless-professional*. Staff were somewhat resentful towards prisoners and managers because they felt powerless and beleaguered – isolated on the wings, nervous about the number

[105] Vicarious trauma has been defined as "the process of change that happens because you care about other people who have been hurt, and feel committed or responsible to help them. Over time this process can lead to changes in your psychological, physical and spiritual well-being." Ann Brown, *Post Traumatic Stress Disorder (PTSD) Awareness*, Page Publishing, 2017.

[106] Dr Ben Crewe is currently Deputy Director of the Prisons Research Centre, Reader in Penology and Director of the MSt Penology Programme at the Institute of Criminology, University of Cambridge.

of prisoners that they were managing, and lacking in collective power. Despite these feelings, they were operating in a fairly professional manner. He concluded that the best establishments were those in which staff exercised control but there was no overuse of power.

Policing

6.62 Dr Paul Quinton from the College of Policing[107] talked more broadly about police culture but focussed on strategies for reducing police wrongdoing drawing on research from Professor Tim Newburn.[108] He noted that the evidence was not strong with only a small number of studies, weak evaluation designs, with few directly testing the effect on wrongdoing. There were no identified off-the-shelf solutions, although none of the initiatives was found to be counter-productive. There were some promising interventions focussed on:

- Procedural justice policing
- Being held to account
- Body worn video
- Training
- Targeted problem-solving and early intervention.

6.63 Organisational context appeared to be crucial to wrongdoing and to have the strongest influence on attitudes and behaviours. A multi-pronged approach was likely to be required because of the influence of organisational, situational and individual factors.

6.64 Dr Quinton identified a number of strategies that would assist in preventing poor behaviour including:

- Reforming the institution and providing resources for prevention
- Increasing the risk of detection and sanction
- Encouraging whistle-blowing
- Monitoring risks
- Changing selection processes
- Improving training
- Setting and enforcing standards
- Ensuring robust internal supervision and accountability
- Promoting an ethical culture
- Establishing robust external supervision and accountability.

6.65 These insights mirrored a College of Policing paper that I found particularly helpful.[109] No ready-made solution exists ("The mere existence of a code of conduct, on its own, was found not to have a significant influence on unethical decision making"), but the importance of strong and effective leadership is highlighted as encouraging ethical behaviour. The paper also stresses the importance of strong and effective leadership – leaders who are open, act as role models, but are also 'firm' in terms of setting and enforcing standards, and

[107] Dr Paul Quinton is currently an Evidence and Evaluation Advisor at the College of Policing. He will shortly take up a position as visiting research fellow at the University of Surrey.
[108] Adapted from Newburn, Tim (2015) *Literature review: police integrity and corruption*: Her Majesty's Inspectorate of Constabulary, London.
[109] College of Policing, *Promoting ethical behaviour and preventing wrongdoing in organisations – A rapid evidence assessment*, http://whatworks.college.police.uk/Research/Documents/150317_Integrity_REA_FINAL_REPORT.pdf.

encouraging ethical behaviour. Promising interventions tended to be broadly preventive or remedial in their approach, rather than focussed on apprehending and disciplining those responsible for wrongdoing.

6.66 Individual characteristics – "such as being male, younger, less experienced" – were associated with some types of wrongdoing. Situational factors, in particular the use of force, were also relevant.[110]

NHS

6.67 Ms Julie Bolus[111] outlined the NHS response to a number of scandals including the Bristol Heart Scandal in the 1990s, maternal and infant deaths at Morecambe Bay, and the negligent care leading to many deaths at Mid-Staffordshire Hospital between 2005 and 2009.

6.68 She drew attention to a number of causes:

- A culture focussed on doing the system's business – not that of the patients
- An institutional culture that ascribed more weight to positive information about the service than to information capable of implying cause for concern
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else
- A failure to tackle challenges to building a positive culture, in nursing in particular but also within the medical profession.

6.69 She then emphasised a number of improvements being made to the NHS Constitution including:

- Better patient involvement
- Feedback
- A duty of candour for staff
- Improvements in end of life care
- Integrated care
- Better complaints systems
- Improved patient information
- Staff rights, responsibilities and commitments
- An emphasis on dignity, respect and compassion.

Discussion points

6.70 I do not need to labour the implications from these contributions for both the Home Office and its contractors. Other points that emerged in discussion included:

- The importance of setting a clear leadership example by not letting small things go such as minor instances of misbehaviour
- The need to balance continuity with moving staff around to prevent the build-up of negative cultures

[110] I may mention in passing that on my visit to HMP Huntercombe I saw what I think is the most robust system for overseeing use of force paperwork that I have ever encountered. There was in fact little use of force, but the monitoring processes were excellent. The staff write-ups were first rate and were properly overseen by managers.

[111] Julie Bolus was an NHS Director of Nursing and Quality for over 13 years. Her last permanent NHS role was with NHS England Nottingham and Derby Area Team where she was the Director of Nursing and Quality as well as the national lead for quality assurance associated with prison healthcare and Immigration Removal. Since leaving the NHS she has undertaken a number of roles including chairing the national work looking at whistle-blowing.

- The challenge of developing and sustaining empathy in a difficult environment
- The positive use of body worn video cameras as a check on behaviour by both staff and those in their charge
- The limitations of some of the monitoring processes – it is unlikely that misbehaviour will take place in front of independent monitors. Cultures are really hard to police and need significant effort
- The importance of promoting whistle-blowing and then supporting staff who are going through the process.

6.71 In respect of the fourth of the bullet points above, I have seen increased use of body worn cameras in individual IRCs, and note that in research on the police this has been found to be a useful tool for reducing wrong-doing. I understand that body worn cameras are used in all IRCs except Dungavel and would encourage their full roll out as a protection both for detainees and for the staff themselves. The Home Office should also ensure keep a close eye on how frequently and in what circumstances they are used.

Recommendation 40: The Home Office should roll out the use of body worn cameras to all IRCs and robustly monitor their use.

Conclusions

6.72 No organisation, including the Home Office itself, is immune from abusive behaviours. Indeed, in respect of all closed institutions my starting point is that the potential for abuse is ever-present.

6.73 It is a mistake to believe that the answer is to be found in ever more complex oversight and assurance. In my report on the abuses at Oakington more than a decade ago[112], I contrasted what successive inspections by the Chief Inspector of Prisons had found ("the most common comment was that officers were polite and kind"; "Oakington was still largely a safe place, with excellent staff-detainee relationship"; "staff demonstrated a caring and professional attitude") with evidence uncovered by the BBC of detainees being physically and racially abused while officers made sure violence was not captured on CCTV. I did so not in criticism of the Inspectorate, but in acknowledgement that independent oversight alone is never likely to prove sufficient when malpractice is conducted out of sight.

6.74 This is not to decry independent audit (and in the course of this review I have made proposals for how it can be strengthened), or more effective management and leadership. But it is difficult to overstate the significance of staff culture. I have found much to ponder in an Australian report, *Inquiry into the Circumstance of the Immigration Detention of Cornelia Rau*, July 2005.[113]

> "The concern for the Inquiry lies not in any lack of instructions and processes. A large number of Migration Series Instructions and Immigration Detention Standards provide instruction and guidance for the care and management of immigration detainees. Rather, the Inquiry is seriously concerned about the culture and attitudes that determine the way in which these instructions and processes are applied and business is done.
>
> "There is a management attitude that does not question the instructions and processes and seems to attach little value to explaining to staff the operating context and the purposes of the instructions and processes. The attitude emphasises process and is silent on outcomes. This is dangerous in a volatile portfolio.

[112] See footnote 100.
[113] https://www.border.gov.au>palmer-report.

"Rigorous rules and processes often create a false sense of security …"[114]

6.75 In my own contribution to the seminar, I suggested that the succession of abuse scandals in IRCs suggested there was little collective memory, and little evidence of lessons being learned. I think that Home Office understanding of those places of detention for which it is ultimately responsible would be enhanced if it had within its own ranks a higher proportion of staff with direct operational experience.

6.76 The contracting out of IRC management is expressly intended to provide considerable autonomy for the companies concerned to put their own practices in place and encourage innovation, and it is right that they carry responsibilities as employers. However, my view is that the Home Office needs to take a much closer role in monitoring what takes place.

6.77 In other walks of life, this might be provided by 'secret shopper' type arrangements. However, there would be significant ethical and other objections to such techniques in IRCs as in any place of custody.

6.78 I have been impressed by the assurance processes in Border Force. The Border Force Assurance Team carries out a regime of announced and unannounced visits to test compliance with the Border Force Assurance Standards, progress on previous review recommendations, and to inform process improvements. It also conducts in-depth reviews of specific ports and operational teams. I understand that, amongst other things, these assess staff culture and engagement, as well as training and development and performance management.

6.79 Within the Detention & Escorting Services Directorate there are two distinct teams that undertake an audit and assurance role. The Detention and Escorting Services Audit and Assurance Team (DESAAT) is a fully audit trained team based at Yarl's Wood IRC who undertake second line assurance across the detention estate. DESAAT are responsible for undertaking contract compliance reviews in IRCs, providing independent oversight of suppliers' delivery in accordance with contract requirements. Part of this role includes oversight of the IRC supplier self-audit processes. The team also monitors and drives implementation of third party recommendations (HMCIP and IMB) and undertakes risk-based reviews in IRCs, providing assurance that published guidance and instructions (DSOs, Operating Standards, DC Rules) are adhered to.

6.80 The second team is based at DEPMU (DEPMU contract monitoring) and provides first and second line assurance to ensure that the escorting contract is being complied with, and detainee welfare standards are being maintained and improved at STHFs. The team also leads on lessons learned, and provides assurance that oversight body recommendations are considered and implemented where applicable. Their focus on indicators of professional standards of contracted staff, however, could be strengthened.

6.81 It is clearly right that each IRC contractor has its own monitoring processes in place to uncover poor behaviour. Nonetheless, I believe that one outcome from events at Brook House should be that the Home Office strengthens its second level of assurance. The details of how this is done are a matter for the Home Office, but among the areas I would expect to be monitored are recruitment, training and development, performance management, the adequacy of whistle-blowing arrangements, the monitoring of formal and informal complaints, the gender/ethnicity mix of staff, the numbers and visibility of managers, as well as the methods for recording and monitoring use of force. It would also be valuable to assess contractors' processes for monitoring detainee views.

[114] A remark that could apply equally to IRC staff and to Home Office caseworkers. All quotes are from paragraph 7.3.3 p.169. I was also struck by this comment on one Australian immigration facility: "It's appearance is severe … It looks like a prison, the activities … are similar … the untrained observer could not tell the difference" (paragraph 4.3.1, p. 67).

Recommendation 41: The Home Office should increase the number of its staff who have direct operational experience in closed institutions.

Recommendation 42: The Home Office should strengthen its own assurance processes to examine adherence to professional standards and staff culture in IRCs on a regular basis.

PART 7: ALTERNATIVES TO DETENTION

Introduction

7.1 In a 2016 report entitled *Without Detention: Opportunities for alternatives*, the organisation Detention Action wrote as follows:

> "… the story of alternatives to detention so far in the UK is one of limited progress and false starts … it is clear that alternatives have not yet reached their potential."
>
> "It is striking that, in the UK, alternatives pilots designed to reduce the use of detention have focussed exclusively on families with children. No such attention has been paid to the complex needs of vulnerable individuals whose physical or mental health may make them unsuitable for detention … Indeed, globally, there has been little discussion or evaluation of the extent to which the learning from the family projects could be adapted to reduce the detention of adults."

7.2 Recommendations 63 and 64 of my first report were that the Home Office should investigate the development of alternatives to detention (ATDs) as well as considering how electronic monitoring might contribute to immigration control. These recommendations were accepted by the Home Office but in the context of the wider Immigration Enforcement strategy, which sought to use a suite of interventions to reduce illegal migration. It was also pointed out that the vast majority of those individuals subject to removal are already in the community.

7.3 I accept this is true, but it was not what I had in mind when I submitted my first report. I have already made clear my view that too many vulnerable people were held in detention, but was conscious of the limited options for managing and assisting them effectively in the community. In my first report I thought there might be scope to build on existing practices whereby those not detained are required to report regularly to immigration reporting centres. My report recommended "a combination of residence and reporting restrictions, community support, the pursuance of voluntary return options, and sureties". I am not certain that there has been any significant investment in what I meant by alternatives to detention since my first report.

The Home Office view

7.4 In my meetings with Home Official officials it was reiterated that the vast majority of those with no right to remain in the UK are already managed in the community, and that detention is reserved for a relatively small proportion. I was told of a number of strategies aimed at embedding an environment to increase compliance with immigration procedures. Among the measures already in train were:

- A push on increasing voluntary returns
- An increase in same day removals – going straight from reporting centre to airport[115]
- Tagging – there remained concerns about the management of foreign national offenders in the community but the tagging options were now more sophisticated, including the tracking of more serious offenders[116]
- Looking at a wider range of interventions for those with no right to remain in the UK, including improving reporting processes and limiting access to essential services such banking, private housing and driving licences (the compliant environment), and supporting NHS trusts to ensure those who are not entitled to free healthcare are charged and pay upfront.

7.5 It was an essential element of this work that the Home Office should be able to manage casework in the community more effectively, and part of this process was finding an address to enable bail or release. It had been difficult to find suitable addresses because of wider cross-governmental failures, with different bodies being responsible for release decisions and implementation.

7.6 When a detainee was due to be released, the Home Office was tasked to find accommodation with suitable safeguards for risk management. However, for FNOs whom it was proposed to release in the community, the Ministry of Justice (MoJ) had a gatekeeping role on suitable accommodation when there is a valid licence. The MoJ would sometimes refuse Home Office-sourced accommodation on the grounds of risk management, but was then unable to assist in finding alternative accommodation in approved premises, unless the risk to the public was seen as significant. This lack of clarity had been criticised in the judgment in *Suthakar Sathanantham & Ors* [2016] EWHC 1781 (Admin) on 21 July 2016. In that case, while the Secretary of State was not held to be acting unlawfully, Mr Justice Edis said that:

> "… the system which the SSHD has established, is trying but failing, to offer suitable bail accommodation to the small number of high risk bail applicants within a reasonable period of time. The policy which she established is not irrational or unreasonable, it is simply not working very well."

7.7 Those responsible for this policy within the Home Office made the point that caseworkers should be able to make use of a range of voluntary bodies, working hand-in-hand with new technology including electronic monitoring.

The NGO view

7.8 A majority of those making submissions to this follow-up review agreed that the Home Office should make greater use of ATDs, and encouraged me to explore the important role of ATDs in reducing reliance on detention.

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[115] The merits or otherwise of same day removals were beyond the scope of this review, but would benefit from further inquiry.
[116] This refers to satellite tracking, a technology used in the United States. I understand that facial recognition technology is also under consideration.

7.9 The UNHCR asked me to explore the important role of ATDs in reducing reliance on detention, including for vulnerable individuals. They argued:

> "UNHCR recognises that there are a number of processes in the UK currently which are considered ATDs. These include Temporary Admission and Immigration Judge/ Immigration Officer Bail, which are applied relatively broadly. In UNHCR's view, while these ATDs are positive in that they provide a framework through which individuals can avoid/be released from detention, they are limited in the sense of the case management and support they provide to individuals benefiting from them. In the experience of UNHCR … community based case management and support is critical to both addressing the needs of what can be a highly vulnerable population and cultivating compliance, including with respect to voluntary return for those individuals found not to be in need of international protection.
>
> "In UNHCR's experience, the following elements are always present in successfully implemented alternatives:
>
> - treating asylum-seekers and migrants with dignity, humanity and respect throughout the relevant asylum or migration procedure
> - providing clear, concise and consistent information about rights and duties under the alternative to detention and the consequences of non-compliance
> - providing asylum-seekers with legal advice, including on their asylum applications and options available to them should their asylum claim be rejected. Such advice is most effective when made available at the outset of and continuing throughout relevant procedures
> - providing access to adequate material support, accommodation and other reception conditions; and
> - offering individualised 'coaching' or case management services."

7.10 I met with Grant Mitchell, Director of the Immigration Detention Coalition, a global network of over 300 civil society organisations and individuals in more than 70 countries. He told me that the three key benefits of ATDs are effectiveness in terms of high compliance rates, cost-effectiveness (being significantly cheaper than detention), and respect for human rights ("respect for fundamental human rights … allows individuals to contribute fully to society if residency is secured or to better face difficult futures, such as the possibility of return.")

7.11 Detention Action recommended that:

- Alternatives to detention should be developed with the capacity and range to meet the needs of all migrants for whom less coercive measures than detention are appropriate
- The Home Office should reinvest savings from the closure of The Verne to develop alternatives based on specialist case management that can support migrants with vulnerabilities or complex situations to resolve their cases in the community, in particular adults at risk and victims of trafficking
- Alternatives to detention should be based on evaluation and learning from existing national and international models, and should themselves involve thorough evaluation so that learning can be built on

- Civil society should be involved in designing and delivering alternatives to detention, based on their experience and expertise in supportive migrants and vulnerable people
- Migrants with experience of detention should be involved in the design and development of alternatives to detention.

7.12 Detention Action also advocated a system of case management to support individuals in the community.

> "Case management is a social work approach which is 'designed to ensure support for, and a coordinated response to, the health and wellbeing of people with complex needs.' Many countries use this approach in their alternatives to detention programmes, including Sweden and Australia. Case management models involve a case manager, who is not a decision-maker, working with the migrant to provide a link between the individual, the authorities and the community. The case manager ensures that the individual has access to information about the immigration process and can engage fully, and that the government has up-to-date and relevant information about the person.
>
> "The case manager also facilitates access to support and services in the community, enabling the migrant to meet their basic needs and addressing any particular vulnerabilities. Migrants are screened and assessed as early as possible in the process, and the level of case management support is adjusted according to the level of vulnerability through regular assessment.
>
> "Case management can enable migrants to work towards the resolution of their cases in the community, either through grant of status or voluntary return. The case manager uses information gathered in the assessment process to work with the migrant on case planning, setting goals and developing agreed action plans. The case manager supports the migrant to explore all immigration outcomes, including the possibility of return. As a result, migrants are in a better position to integrate into the community if they are granted status, or to return to their country of origin if refused."
>
> "Alternatives to detention based on case management can fill the gap in terms of options for migrants with vulnerabilities or risks. Specialist case managers can work with mentally ill people and victims of trafficking whose vulnerabilities may increase their risks of absconding, or with ex-offenders with barriers to return to manage risk of reoffending and absconding."

International experience

7.13 From the evidence submitted, and from my own wider observations and reading, I knew there were ATD projects in a number of countries. I was also aware of some research on their effectiveness, although it appeared that these had focussed principally on compliance with the programmes themselves, and the cost of ATDs in comparison to detention. It was less clear on the issue of how successful these programmes had been in persuading those subject to removal procedures to leave, a subject of understandable interest to the Home Office.

7.14 As was the case with my first review, I therefore sought the assistance of Professor Mary Bosworth[117], and asked if she would assess the research on my behalf.

[117] As well as being Director of the Oxford Centre for Criminology, Professor Bosworth is Director of Border Criminologies, an interdisciplinary research group focusing on the intersections between criminal justice and border control. She is a Fellow of St Cross College at the University of Oxford and, concurrently, Professor of Criminology at Monash University.

7.15 I have appended Professor Bosworth's review as Annex 11. As was the case in my first review, I am hugely indebted to Professor Bosworth for what is again a ground-breaking study.

7.16 Her key finding perhaps is that we still do not know a great deal about what has been tried in countries across the globe, or the effectiveness and cost-effectiveness of various approaches. Professor Bosworth acknowledges that there is little or no academic research on the relative effectiveness of detention and alternatives to detention in enforcing immigration control. Nonetheless:

> "Evidence on compliance levels for alternative to detention programmes finds that well-funded, and well-supported case-management programmes offering legal advice, housing and access to social and health care have high levels of compliance with all stages of the immigration system, including removal."

7.17 However, Professor Bosworth cautions against net-widening: "There is no consistent evidence that 'alternatives to detention' decrease the use of immigration detention other than in instances where there has been a prohibition on detention for specific populations, e.g. with children." She notes the criticism that some forms of ATD like tagging extend the use of coercive supervision in the community.

7.18 Professor Bosworth's principal findings are outlined below:

- Most people subject to immigration control, in any jurisdiction and whatever their immigration status, are not detained
- Governments across the world deploy a diverse range of programmes and practices under this rubric including: temporary admission, reporting requirements, parole, bail, appointment of a guarantor, open, semi-open centres, or alternative places of detention (including family detention and community detention), house arrest, curfew, voluntary return incentives, electronic surveillance, caseworker support, surrender of identification and travel documents, and assisted voluntary returns schemes (AVRs)
- Like immigration detention, there is no common set of agreed principles underpinning ATDs. Yet, without agreement on the rationale(s) for alternatives to detention, it is difficult to determine the form they should take their goal, nor the measure of their success or failure
- Only a small number of ATD programmes have been independently evaluated
- Evidence suggests that the vast majority of individuals in ATD programmes comply with the immigration process
- Evidence suggests that ATDs are cheaper than immigration detention, although such cost-analysis does not take into account the net-widening effect of alternatives
- Evidence about the impact of alternative to detention programmes on physical and mental-health is mixed. Casework based alternatives to detention engender better outcomes than immigration detention, whereas temporary admission and bridging visas generates mental distress that may be similar to that caused by immigration detention. Those who have been subject to electronic monitoring report feelings of shame and criminalisation
- Official statistics on removals suggest that ATDs can assist governments enforce immigration control although there is no academic scholarship explicitly comparing removal rates under both schemes of comparable populations
- Evidence on compliance levels for ATDs finds that well-funded, and well-supported case-management programs offering legal advice, housing and access to social and

health care have high levels of compliance with all stages of the immigration system, including removal

- A range of studies from all jurisdictions identify a consistent set of concerns about ATDs including: the difficulty or absence of monitoring and regulation of these programmes; their expansionist impact (net widening) on migration control; the growing role of the private sector in delivering these programmes; the potential economic incentives for NGO involvement in border control; the blurring of populations (asylum seekers, former offenders, economic migrants); the reliance on criminal justice practices, particularly electronic monitoring; the de facto detention caused by restrictions on residence; the difficulty of residing in the community without leave to work; and the negative impact of the uncertainty of visa regimes (i.e. temporary admission).

An ATD project in the UK

7.19 In the time available to me, I have not been able to conduct my own research on this topic, hence my indebtedness to Professor Bosworth. The subject of ATDs might well be one that the Home Affairs Select Committee would wish to explore.

7.20 However, I did meet with Detention Action specifically to consider an ATD for young male ex-offenders who have been released due to intractable barriers to removal, on which they are working closely with criminal casework within the Home Office. I met with the project leader and one of the participants. The pilot programme is relatively small, and is charitably funded, with a total of 26 ex-offenders having completed the programme. The project consists of outreach work by a former probation officer with FNOs who are in section 4 (asylum support) accommodation or in their own housing. The project operates nationwide (although most of the housing is in the North East) and is aimed at male ex-offenders aged 18-30. The men are referred by the Home Office and selected via an assessment process that includes levels of insight into their offending. Around 15 people are on the scheme at any one time.

7.21 So far the project has reported only two failures out of 26 – both for minor offending – and levels of compliance are high.

7.22 As I have said, I met one participant on the scheme. He had committed a very serious offence as a teenager, but his circumstances were such that return to his 'home' country (he had in fact been living in the United Kingdom from a young age, and spoke unaccented English) was inconceivable in practice, if not as a strict matter of law. He explained his frustration at being unable to support himself or access decent housing, but said he had benefited enormously from the support offered on the scheme.

7.23 He told me he had not reoffended since his release, and I believed him. Nonetheless, the Detention Action scheme itself is limited to a year and I have concerns about the options open to those such as this man when the support ends. I understand the intentions of the 'compliant environment' policy, but this man faces years and years of no work or income.

7.24 The uncomfortable truth appears to be that the compliant environment does not fit well alongside ATDs for ex-offenders who cannot be removed from the country. The Home Office should think further about how it can manage the risks that its own policy may inadvertently encourage.

7.25 I share the view that Detention Action expressed in its evidence to this review:

> "If it is recognised that return will be impossible for a given period, it would make sense to enable migrants to support themselves during this period, rather than rely on Section 4 support. The status could be made conditional on cooperation with the returns process, so would provide a strong incentive to compliance, as well as reducing reoffending. The lack of options for constructive activity has been the greatest challenge in supporting participants to comply and avoid reoffending."

Analysis

7.26 The Home Office is right to say that the majority of those in the UK with no right to remain are already in the community and, in that limited sense, the beneficiaries of Alternatives to Detention. But my use of the term is directed expressly at those vulnerable individuals, who continue to be detained for long periods and who in my view could be managed more effectively in the community. Indeed, because of net-widening and in view of the cost implications, the sensible approach would be to focus initially on the small, difficult to remove, population like ex-offenders without travel documents etc.

7.27 There may well be fiscal benefit to the use of alternatives to detention[118], although my own view is that the sort of intensive case management approach that has greatest benefits will demand significant resources. Professor Bosworth draws attention to a significant casework based community alternative run in the late 1990s by the Vera Institute of Justice in New York City that I find particularly compelling.

7.28 I note the ongoing work on establishing a tagging programme, but highlight the danger that this may be used to manage the risk of those who should be in the community anyway, as it is no longer possible to justify detention, rather than as a genuine alternative to detention.

7.29 I have also seen that release into the community does not always mean that vulnerability issues are addressed. I have met a number of women – including some who had been subjected to sexual violence – who had been released to hostels around the country with little access to support or where safeguarding appeared to be mostly absent. I was told that men would simply walk into these women's rooms and, even if there was no ill intention, it made them feel vulnerable. Some told me they felt less safe than had they remained in detention. The Home Office must ensure that providers are fully seized of their safeguarding responsibilities.

7.30 I argued two years ago that the Home Office should demonstrate much greater energy in its consideration of alternatives to detention. Given my concern that too many vulnerable people continue to be detained, that remains my view.

7.31 What I have drawn from my analysis is that a well-managed case management approach is most likely to have positive outcomes in terms of managing vulnerability and achieving removals. I am very conscious that balancing these two elements will be very difficult – indeed when I asked this question of those running the Detention Action scheme, they were clear that it would undermine the rapport they had built with their service-users. I am also aware that even limited access to supporting services in the community will be extremely complex given the terms of the Immigration Act 2016 and current Home Office policy.

[118] The most recent figures show that the average daily cost of holding someone in detention is £85.92 (https://www.gov.uk/goveernment/publications/immigration-enforcement-data-november -2017).

7.32 This is not an area where it is sensible for me to be too prescriptive. Despite this, I think there would be merit in pushing forward in two respects. First, the pilot project run by Detention Action appears to have had a positive impact on a very difficult cohort of men who might otherwise pose a risk of offending. I think there is considerable merit in seeking to expand this programme. To scale up may well require the involvement of larger organisations who assist those who are homeless. It will certainly require funding from within the Home Office itself.

Recommendation 43: I recommend that the Detention Action project for ex-offenders in the community be expanded.

7.33 Second, there is also scope for a project for those individuals who would otherwise meet the criteria for detention but have specific vulnerabilities that mean continued detention will be harmful. I am particularly concerned for those with serious mental health problems. Any pilot should include an intensive case management system offering support but also progressing the case.

Recommendation 44: I recommend the Home Office establish an Alternative to Detention project for vulnerable persons who would otherwise be at risk of being detained.

7.34 I would just add one caveat. As in criminal justice, excessive conditions on release may simply set people up to fail. As Amnesty International has argued:

> "While published Home Office policy discusses re-detention almost exclusively in relation to the circumstances of a person 'becoming removable', it can arise for many reasons. It may be a consequence of the excessively onerous conditions and destitution that some ex-detainees are exposed to. The chaotic reality of homeless life makes regular attendance at Home Office reporting centres extremely difficult, while onerous curfew and reporting requirements are likely eventually to be violated, either unavoidably or inadvertently. Missed appointments or breaches of conditions potentially lead to being recalled to detention." (Amnesty International, *A matter of routine, op. cit.*, p.41.)

PART 8: LIST OF RECOMMENDATIONS

Recommendation 1: The Home Office should strengthen its promotion of voluntary returns. (Part 2, paragraph 2.7)

Recommendation 2: The Home Office should develop a strategic plan for the type and scale of immigration estate it thinks necessary, bearing in mind the priority now attached to voluntary returns, so that the number and location of beds is proportionate to carrying out its wider aims. (Part 2, paragraphs 2.18 – 2.19)

Recommendation 3: The Home Office should establish a joint policy with HMPPS on provision for those held in prison under immigration powers. (Part 2, paragraph 2.42)

Recommendation 4: I remain concerned about the position of detainees held in the prison estate and recommend that a policy be developed to equate to Detention Centre Rule 35. (Part 2, paragraphs 2.43 – 2.46)

Recommendation 5: I repeat my recommendation that the internet access policy should be reviewed with a view to increasing access to sites that enable detainees to pursue and support their immigration claim, to prepare for their return home, and to maximise contact with their families. (Part 2, paragraphs 2.57 – 2.61)

Recommendation 6: Weekly multi-disciplinary review meetings should be held at all IRCs to review and progress cases and ensure appropriate care for the most vulnerable individuals in each centre. These meetings should include a range of managers and staff, and crucially should involve the dialling in of the relevant caseworker for each detainee discussed. (Part 2, paragraph 2.73)

Recommendation 7: No immigration detention facility should be built in future with a barely screened toilet inside a shared room, and this set-up should be upgraded in all existing facilities. (Part 2, paragraph 2.77)

Recommendation 8: In future, capacity in the immigration estate should not be increased by adding extra beds to rooms designed for fewer occupants. Where this has already occurred (e.g. Campsfield House, Brook House), these extra beds should be removed, and capacity reduced or extra space created. (Part 2, paragraphs 2.75 – 2.76)

Recommendation 9: Detainees should have improved access to facilities on their units at night, and night-time lock-in periods should begin as late as possible. (Part 2, paragraph 2.79)

Recommendation 10: While the recent decrease in the overall number of women in detention is welcome, the Home Office should at the earliest opportunity take further steps to identify women who claim asylum in detention and whose case would be better processed in the community. (Part 2, paragraphs 2.99 – 2.101)

Recommendation 11: The current Adults at Risk policy should be amended. Detention of anyone at AAR Level 3 should be subject to showing 'exceptional circumstances'. (Part 2, paragraphs 2.122 – 2.129)

Recommendation 12: Consideration should be given to AAR Level 2 being sub-divided and, if adopted, the presumption against detention for those in the upper division should be strengthened. The Home Office should consider the merits of the UNHCR Vulnerability Screening Tool. (Part 2, paragraphs 2.124 – 2.128)

Recommendation 13: The Home Office should no longer detain any adults over the age of 70 except in 'exceptional circumstances'. (Part 2, paragraphs 2.131 – 2.134)

Recommendation 14: The Independent Chief Inspector of Borders and Immigration should be invited to report annually to the Home Secretary on the working of the Adults at Risk process. (Part 2, paragraphs 2.135 – 2.136)

Recommendation 15: I recommend new arrangements for the consideration of Rule 35 reports. This should include referrals to a new body – which could be within the Home Office but separate from the caseworker responsible for detention decisions. (Part 2, paragraph 2.149)

Recommendation 16: A best practice forum should be established across IRC healthcare providers. (Part 3, paragraph 3.87)

Recommendation 17: SystmOne templates should be urgently amended so that detainee healthcare records no longer identify detainees as prisoners. (Part 3, paragraphs 3.88 – 3.93)

Recommendation 18: NHS England should continue to roll out staff training on SystmOne/HJIS, and should make sure that patient consent is consistently recorded by conducting a national case file audit and ensuring that this is a mandatory field in HJIS. (Part 3, paragraph 3.96)

Recommendation 19: The Home Office and Ministry of Justice should conduct a review of the quality of interpreter services in IRCs. (Part 3, paragraphs 3.102 – 3.105)

Recommendation 20: An action plan should be drawn up to address the shortcomings I found in healthcare facilities within the immigration estate to ensure a clinically safe, compliant and appropriate environment for the delivery of care to detainees. (Part 3, paragraphs 3.106 – 3.107)

Recommendation 21: Waiting environments for medication distribution should be reviewed to ensure privacy and dignity, and support personal safety. (Part 3, paragraph 3.110)

Recommendation 22: As set out in the NHSE, Home Office and PH(E) National Partnership Agreement, all centres should become smoke-free as soon as possible, subject to proper planning and support for detainees and staff. (Part 3, paragraph 3.114)

Recommendation 23: The Home Office and Department of Health and Social Care should prepare a joint communication to IRC healthcare teams clearly laying out health-based entitlements for former detainees released into the community. (Part 3, paragraphs 3.144 – 3.146)

Recommendation 24: The Home Office should strengthen its data monitoring processes and quality assurance for the detention gatekeeper and case progression panels. In particular, it should ensure that the outcomes following case progression panels are tracked and reported. (Part 4, paragraphs 4.14 – 4.15)

Recommendation 25: The Home Office should ensure casework management processes allow for the detention gatekeeper to make decisions on all FNO cases entering immigration detention, including those transferring directly from prison at completion of a custodial sentence. (Part 4, paragraph 4.24)

Recommendation 26: All relevant Home Office staff should be trained in making assessments of vulnerability within the parameters of the Adults at Risk policy. (Part 4, paragraphs 4.37 – 4.38)

Recommendation 27: I recommend that a copy of this report be shared with HM Chief Inspector of Probation for her consideration. (Part 4, paragraph 4.56)

Recommendation 28: The Home Office, working with the National Probation Service and Community Rehabilitation Companies, should consider how far vulnerable detainees released from detention can be offered appropriate support and supervision. (Part 4, paragraphs 4.57 – 4.58)

Recommendation 29: I recommend that all caseworkers involved in detention decisions should visit an IRC either on secondment or as part of their mandatory training. (Part 4, paragraph 4.66)

Recommendation 30: Case progression panels should have fewer cases per panel to consider. The Home Office should ensure that all required information, including information on vulnerability and AAR levels, is available and that all panel members are properly prepared on the cases before them. (Part 4, paragraphs 4.77 and 4.87)

Recommendation 31: Case progression panel chairs should be of sufficient competence for the role. Attendance from all relevant parts of the Home Office should be ensured. (Part 4, paragraphs 4.79 – 4.81)

Recommendation 32: The Home Office should review the case for an independent element in case progression panels considering those detained for more than six months. (Part 4, paragraph 4.88)

Recommendation 33: The Home Office should no longer routinely seek to remove those who were born in the UK or have been brought up here from an early age. (Part 4, paragraph 4.99)

Recommendation 34: The Home Office should review whether figures relating to deaths in and after detention should be issued on a regular basis. (Part 5, paragraph 5.4)

Recommendation 35: The Home Office should encourage moves to develop a digital version of the ACDT document. (Part 5, paragraph 5.25)

Recommendation 36: I recommend that IRC staff who have regular contact with detainees should receive mandatory safer detention training on an annual basis. (Part 5, paragraph 5.33)

Recommendation 37: I recommend that the Home Office commission research into deaths in immigration detention, 'near misses' and incidents of serious self harm. (Part 5, paragraph 5.33)

Recommendation 38: The Home Office should devise and publish a strategy for reducing the number of deaths from natural causes and those that are self-inflicted in, and shortly after, immigration detention. (Part 5, paragraphs 5.35 – 5.36)

Recommendation 39: The Home Office should review with the Ministry of Justice the resource allocated to each IMB in the immigration detention estate. (Part 6, paragraphs 6.48 – 6.49)

Recommendation 40: The Home Office should roll out the use of body worn cameras to all IRCs and robustly monitor their use. (Part 6, paragraph 6.70)

Recommendation 41: The Home Office should increase the number of its staff who have direct operational experience in closed institutions. (Part 6, paragraph 6.74)

Recommendation 42: The Home Office should strengthen its own assurance processes to examine adherence to professional standards and staff culture in IRCs on a regular basis. (Part 6, paragraph 6.80)

Recommendation 43: I recommend that the Detention Action project for ex-offenders in the community be expanded. (Part 7, paragraph 7.32)

Recommendation 44: I recommend the Home Office establish an Alternative to Detention project for vulnerable persons who would otherwise be at risk of being detained. (Part 7, paragraph 7.33)

Annex 1: Exchange of letters in respect of this review's ambit regarding staff conduct

(i) Letter from Home Office

21 November 2017

I am writing in the context of correspondence to the Home Office from representatives of current and former detainees at Brook House, which has followed the broadcast on 9 September 2017 of the *Panorama* programme entitled "*Undercover: Britain's Immigration Secrets*".

As part of our duty under Article 3 of the European Convention on Human Rights the Home Office must ensure that, where there is "*credible evidence*" suggesting that one or more individuals has been subjected by or with the complicity of the state to treatment sufficiently grave to come within Article 3, an effective investigation is instituted.

As you are no doubt aware, there is currently a police investigation in connection with several allegations arising out of the programme and there are also concurrent investigations by the Professional Standards Unit and G4S as well as on-going civil litigation.

Your Terms of Reference are: *"To assess the Home Office response to the findings in the report: "Review into the Welfare in Detention of Vulnerable Persons", published in January 2016 (Cm 9186), including the implementation of all recommendations"*.

That earlier report made far-reaching recommendations, with obvious relevance addressing systematic questions for the whole immigration detention estate: healthcare, policy relating to the detention of adults at risk, avenues of complaint for detainees, and the adequacy of oversight and scrutiny of immigration detention.

The original terms of reference included consideration of the appropriateness of current policies and systems designed to, for example, *"(g) safeguard adults and children (h) manage the mental and physical health of detainees"* and, importantly *"(i) other matters the review considers appropriate*".

Without in any way seeking to influence the matters that you consider are appropriate for consideration, I am writing to ask you to confirm that staff culture, recruitment and training, the sufficiency of the complaints mechanisms; and the effectiveness of whistleblowing procedures are matters which will be considered as part of your second review.

As you are aware, the Home Office is managing this review in the spirit of transparency and openness and you and your team have free access to all immigration detention centres, with meetings with custodial, healthcare and Home office staff, as well as detainees. For the avoidance of doubt, this extends to Brook House and all of the materials which have been specifically preserved in connection with the *Panorama* allegations subject, of course, to any police requirements.

In addition, I am aware that you have invited external submissions from interested parties, and are managing a series of individual and group meetings as part of the fact-finding for your review. It is, of course, open to individual complainants to contact you.

With apologies, I would be grateful for an indication of whether you agree with my clarification point above, by the end of the week, if possible.

Clare Checksfield
Director

(ii) Reply to Home Office

22 November 2017

Thank you for your letter of 21 November relating to the terms of reference for my second review of welfare in detention.

I can confirm that, as you suggest, staff culture, recruitment and training, the sufficiency of the complaints mechanisms, and the effectiveness of whistleblowing procedures are matters I will consider as part of my review.

While I am looking at these matters across the UK's immigration detention estate, I can confirm that I have had free access to Brook House. I am also grateful for your commitment that, if required, I will have access to all materials specifically preserved in connection with the *Panorama* allegations.

I have been meeting a number of interested Non-Governmental Organisations with an interest in this area, but individual complainants are of course free to contact me at WelfareinDetention@homeoffice.gsi.gov.uk.



Annex 2: List of meetings and visits undertaken during review

I list below a full list of meetings and visits undertaken by my Team and I. I attended all meetings and visits unless the entry specifically refers to my team.

September 2017

13 September 2017 – Meeting with [redacted], Second Permanent Secretary, Home Office

13 September 2017 – Meeting with [redacted] Director-General Immigration Enforcement, Home Office

13 September 2017 – Teach-in with senior Home Office Officials on the Government response to my first report

15 September 2017 – Meeting with [redacted] – Representative to UK, United Nations High Commission for Refugees

15 September 2017 – Meeting with [redacted], Independent Chief Inspector of Borders and Immigration, Home Office

22 September 2017 – Meeting with [redacted], Director, Asylum and Detention

22 September 2017 – Meeting with [redacted] – Head of Immigration and Border Policy, Home Office

22 September 2017 – Meeting with [redacted] – Director, Returns, Home Office

26 September 2017 – Visit to Brook House IRC

29 September 2017 – Meeting with [redacted], HM Chief Inspector of Prisons

29 September 2017 – Meeting with [redacted], Director of Strategy, Immigration Enforcement, Home Office

29 September 2017 – Meeting with [redacted], Director for Resettlement, Asylum Support and Integration, Home Office

October 2017

2 October 2017 – Meeting with [redacted], Strategy Director,[redacted] Operational Lead for FNO prisons and Mark Taylor, FNO Policy Lead – HM Prison and Probation Service (HMPPS)

2 October 2017 – Meeting with [redacted] Head of National Removals Command and Dan Smith, Project Leader, Casework Transformation Programme, Home Office

2 October 2017 – Meeting with [redacted], Acting Head of Custodial Health & Wellbeing, Rehabilitation and Assurance Directorate, HMPPS

5 October 2017 – Meeting with [redacted], Head of Strategy and Planning, and [redacted], Head of Criminal Casework, Home Office

5 October 2107 – Meeting with [redacted] and [redacted], Safer Custody Team, HMPPS

12 October 2017 – Meeting with [redacted] and [redacted], Prisons and Probation Ombudsman

12 October 2017 – Meeting with [redacted] Head of FNO Tagging Programme, Home Office

12 October 2017 – Team meet with Medical Justice

13 October 2017 – Visit to [redacted] IRC

18 October 2017 –Visit to Campsfield House IRC

20 October 2017 – Team member attends HM Chief Inspector of Prisons inspection feedback session for Harmondsworth IRC

25n October 2017 – Visit to Harmondsworth IRC

26 October 2017 – Visit to Colnbrook IRC

30 October 2017 – Visit to Becket House Reporting Centre and Short Term Holding Facility, London

30 October 2017 – Meeting with [redacted] and [redacted], NHS England

31 October 2017 – Team visit to casework teams in Solihull

November 2017

1 November 2017 – Team visit to casework teams in Croydon

2 November 2017 – Team attended case progression panel – 3 months

2 November 2017 – Team meet with British Medical Association

7 November 2017 – Meeting with NGOs – [redacted], *UNHCR,* [redacted], *Association of Visitors to Immigration Detainees*, [redacted], *British Red Cross,* [redacted], *Migrant Resource Centre/Asylum Aid*, [redacted], *MEDACT*, [redacted], *Women for Refugee Women,* [redacted], *Refugee Council,* [redacted], *UK Lesbian and Gay Immigration Group*, [redacted], *Immigration Law Practitioners' Association,* [redacted] *Gatwick Detainees Welfare Group,* Konstantinos Antonopoulos,

Doctors Without Borders, [redacted], *Bail for Immigration Detainees*, [redacted], *Freedom from Torture*, [redacted], *Liberty* , [redacted] *Detention Action,* [redacted] *Medical Justice*, Tom Southerden, *Amnesty International*

8 November 2017 – Visit to Brook House IRC

9 November 2017 – Visit to Tinsley House IRC

16 November 2017 – Team members attended All-Party Parliamentary Group on Refugees meeting on immigration detention

16-17 November 2017 – Visit to Morton Hall IRC

22 November 2017 – Meeting with [redacted], International Detention Coalition and Jerome Phelps, Detention Action

23 November 2017 – Visit to Dungavel IRC

28 November 2017 – Visit to Cayley House Holding Centre, Heathrow

28 November 2017 – Meeting with [redacted], Head of Border Force Operations, Home Office

28 November 2017 – Meeting with senior operational managers at Tascor

29-30 November 2017 – Team members observed charter flight to Lagos, Nigeria and Accra, Ghana

December 2017

1 December 2017 – Visit to Home Office-provided community accommodation, Birmingham

4-5 December 2017 – Team member overnight at [redacted] IRC

6 December 2017 – Team visited Lunar House Reporting Centre and Short Term Holding Facility, Croydon

8 December 2017 – Team visit to Larne Short Term Holding Facility

13 December 2017 – Meeting with Women for Refugee Women and women formerly detained at Yarl's Wood

13 December 2017 – Meeting with Dame Caroline Spellman MP

15 December 2017 – Visit to HMP Huntercombe – FNO only prison

19 December 2017 – Visit to HMP Peterborough – FNO female hub prison

January 2018

8 January 2018 – Meeting with Independent Chief Inspector of Borders and Immigration

10 January 2018 – Team member attended event hosted by the All-Party Parliamentary Group on Migration and Amnesty International UK to launch Amnesty International UK's report *A Matter of Routine: The Use of Immigration Detention in the UK*

18 January 2018 – Visit to caseworking teams in Sheffield

22-23 January – Visit to caseworking teams in Croydon

23 January 2018 – Team visit to Heathrow Holding Rooms, Terminals 2, 3, 4 and 5

24 January 2018 – Staff Culture seminar

26 January 2018 – Meeting with [redacted], [redacted] and a service-user – Detention Action – regarding ATD project

26 January 2018 – Visit to HMP Thameside

30 January 2018 – Meeting with senior operational managers at Mitie.

31 January 2018 – Team member attended case progression panel – 3 month panel

31 January 2018 – Team member visited Brook House IRC to look at charter flight pick-up and overnight reception

February 2018

6 February 2018 – Team attended case progression panel – 12 month panel

6 February 2018 – Team member visit to caseworking teams in Croydon

7 February 2018 – Team member attended event sponsored by Lord Dubs on *Vulnerable People in Immigration Detention* and hosted by Medical Justice, Freedom from Torture and the Helen Bamber Foundation

15 February 2018 – Visit to HMP Maidstone

27 February 2018 – Meeting with [redacted], [redacted] Institute of Crime Science

Annex 3: List of recommendations from previous report

Recommendation 1: I recommend that the Home Office prepare and publish a strategic plan for immigration detention.

Recommendation 2: The Home Office should consider how far it can encourage a more cohesive system through more joint training and planning, shared communications, and a recognition scheme.

Recommendation 3: Where weaknesses in particular policies have been identified in Mr Cheeseman's audit, I recommend these be remedied at their next iteration.

Recommendation 4: I recommend that work to amend the Detention Centre Rules commence following the Home Office's consideration of this review.

Recommendation 5: I recommend that the Home Office draw up plans either to close Cedars or to change its use as a matter of urgency.

Recommendation 6: Given my observations at each of the Heathrow terminals and at Cayley House, Tascor should arrange for refresher training for its staff on their duty of care, and the need for proper and meaningful engagement with detainees.

Recommendation 7: I recommend that a discussion draft of the short term holding centre rules be published as a matter of urgency.

Recommendation 8: The Home Office should review the adequacy of the numbers of immigration staff embedded in all prisons.

Recommendation 9: I recommend that there should be a presumption against detention for victims of rape and other sexual or gender-based violence. (For the avoidance of doubt, I include victims of FGM as coming within this definition.)

Recommendation 10: I recommend that the Home Office amend its guidance so that the presumptive exclusion from detention for pregnant women is replaced with an absolute exclusion.

Recommendation 11: I recommend that the words 'which cannot be satisfactorily managed in detention' are removed from the section of the EIG that covers those suffering from serious mental illness.

Recommendation 12: I recommend that those with a diagnosis of Post Traumatic Stress Disorder should be presumed unsuitable for detention.

Recommendation 13: I recommend that people with Learning Difficulties should be presumed unsuitable for detention.

Recommendation 14: I recommend that transsexual people should be presumed unsuitable for detention.

Recommendation 15: I recommend that the wording in paragraph 55.10 of the EIG in respect of elderly people be tightened to include a specific upper age limit.

Recommendation 16: I recommend that a further clause should be added to the list in paragraph 55.10 of the EIG to reflect the dynamic nature of vulnerability and thus encompass 'persons otherwise identified as being sufficiently vulnerable that their continued detention would be injurious to their welfare'.

Recommendation 17: I recommend that the Home Office consider establishing a joint policy with NOMS on provision for those held in prison under immigration powers.

Recommendation 18: I recommend that the Home Office consider what learning there is for IRCs from the Prison Service's experience of operating 'first night centres' for those initially received into custody.

Recommendation 19: The Home Office should consider the need for a separate DSO on LGBI detainees. Anti-bullying policies should include explicit reference to LGBTI detainees.

Recommendation 20: The Home Office should consider introducing a single gatekeeper for detention.

Recommendation 21: I recommend that the Home Office immediately consider an alternative to the current rule 35 mechanism. This should include whether doctors independent of the IRC system (for example, Forensic Medical Examiners) would be more appropriate to conduct the assessments as well as the training implications.

Recommendation 22: I further recommend that rule 35 (or its replacement) should apply to those detainees held in prisons as well as those in IRCs.

Recommendation 23: Once the NOMS review of ACCT is complete, there should be an urgent review of ACDT and DSO 06/2008, informed by the NOMS review and by the findings of this report.

Recommendation 24: I note that DSO 03/2013 on food and fluid refusal is currently the subject of internal review within the Home Office. I recommend that the review consider alternatives to treatment within a prison or IRC in light of my discussion of this issue.

Recommendation 25: I recommend that the Home Office commission a formal review of the quality of PERs and that any deficiencies are addressed. In the meantime, all staff should be reminded of the importance of completing PERs fully.

Recommendation 26: I recommend that the Home Office consider how rapidly it can move towards a system of electronic record keeping for the PER[119] and IS91RA.

Recommendation 27: I recommend that the Home Office conduct an annual audit (or ask for an independent audit) of the RSRA process so that it remains an effective means of ensuring detainee safety.

Recommendation 28: The Home Office should consider if the allocation criteria and processes to which DEPMU operates could be strengthened.

Recommendation 29: I recommend that the Home Office and the Department of Health work together to consider whether current arrangements for safeguarding are adequate.

Recommendation 30: The internet access policy should be reviewed with a view to increasing access to sites that enable detainees to pursue and support their immigration claim, to prepare for their return home, and which enable them to maximise contact with their families. This should include access to Skype and to social media sites like Facebook.

Recommendation 31: I recommend that the Home Office reconsider its approach to pay rates for detainees in light of my comments on the benefits of allowing contractors greater flexibility.

Recommendation 32: I recommend that all IRCs should review the range of activities offered to detainees; in particular, those that could provide skills to detainees that would be useful on their return to their home country.

Recommendation 33: I recommend that the Home Office review detainees' access to natural light and to the open air, and invite contractors to bring forward proposals to increase the time that detainees can spend outside.

Recommendation 34: The Home Office should no longer require contractors to operate an Incentives and Earned Privileges Scheme.

Recommendation 35: I recommend that the service provider at Yarl's Wood should only conduct searches of women and of women's rooms in the presence of men in the most extreme and pressing circumstances, and that there should be monitoring and reporting of these cases.

Recommendation 36: I recommend that Home Office Detention Operations carry out an audit of reception and holding environments to ensure that the policy on searching out of sight of other people is properly followed.

Recommendation 37: I recommend that the Home Office consider amalgamating and modernising rules 40 and 42.

Recommendation 38: The Home Office should review all the rule 40 and rule 42 accommodation to ensure that it is fit for purpose. All contractors should be asked for improvement plans to ensure that the name Care and Separation Unit is something more than a euphemism.

[119] Person Escort Record. I have not revisited this issue on this occasion. However, I note the comments in the *Lay Observers Annual Report to the Secretary of State for Justice 2016-2017* (these are the independent monitors of court custody and escort that: "The PER is not a reliable medium for the transfer of risk management between the various bodies with a duty of care to the Detained Person." (p.14). The report refers to trials of a new electronic PER, and I hope these proceed speedily.

Recommendation 39: I recommend that the Home Office should routinely publish statistics on the number of transfers of detainees between IRCs and STHFs.

Recommendation 40: The Home Office should review the use made of regional airports for removals.

Recommendation 41: I recommend that the Home Office negotiate night--time closures at each IRC, the times of which should reflect local circumstances.

Recommendation 42: I recommend that the practice of overbooking charter flights should cease.

Recommendation 43: I recommend that the Home Office consider if the inspection arrangements for IRCs can ensure the involvement of the ICI.

Recommendation 44: I recommend that the Home Office liaise with the Ministry of Justice to ensure that all IMBs in IRCs have sufficient membership at all times.

Recommendation 45: I recommend that the Home Office seek the views of the Ministry of Justice and the Department of Health on extending section 75 of the Sexual Offences Act 2003 to IRCs, prisons and mental hospitals.

Recommendation 46: I recommend that the Home Office review the use of fellow detainees as interpreters for induction interviews.

Recommendation 47: I recommend that the Home Office remind service providers of the need to use professional interpreting facilities whenever language barriers are identified on reception.

Recommendation 48: Home Office staff should be reminded that, to ensure continuity of care, detainees should not be transferred when there is clinical advice to the contrary.

Recommendation 49: The Home Office and NHS England should promote the self-administration of drugs where risk assessments support that approach.

Recommendation 50: I recommend that the Home Office, in consultation with NHS England, draw up explicit guidelines as to:

- What informed consent looks like
- What information can be shared between all parties in the event that informed consent to the release of clinical information is granted by the detainee.

Recommendation 51: I further recommend that an alternative to SystmOne be pursued for those detention facilities not in England.

Recommendation 52: As part of its response to future growth in the demand for healthcare, NHS England needs to ensure the filling of permanent healthcare vacancies in IRCs as a priority.

Recommendation 53: I recommend that the Home Office, in association with service providers, consider what can be done to reduce the use of new psychoactive substances and to advise detainees on the effects of their misuse.

Recommendation 54: The Home Office should draw up a research strategy for immigration detention. In particular, it should consider commissioning clinical studies on the impact of detention upon women, and research aimed at improving models of care.

Recommendation 55: The Home Office and NHS England should conduct a clinical assessment of the level and nature of mental health concerns in the immigration detention estate.

Recommendation 56: I recommend that the creation of care suites across the IRC estate should be taken forward as a priority.

Recommendation 57: I recommend that talking therapies become an intrinsic part of healthcare provision in immigration detention.

Recommendation 58: I recommend that the Home Office, NHS England, and the Department for Health develop a joint action plan to improve the provision of mental health services for those in immigration detention.

Recommendation 59: I recommend that all caseworkers should meet detainees on whom they are taking decisions or writing monthly detention reviews at least once. The meeting should be face-to-face, or by video link, or by telephone.

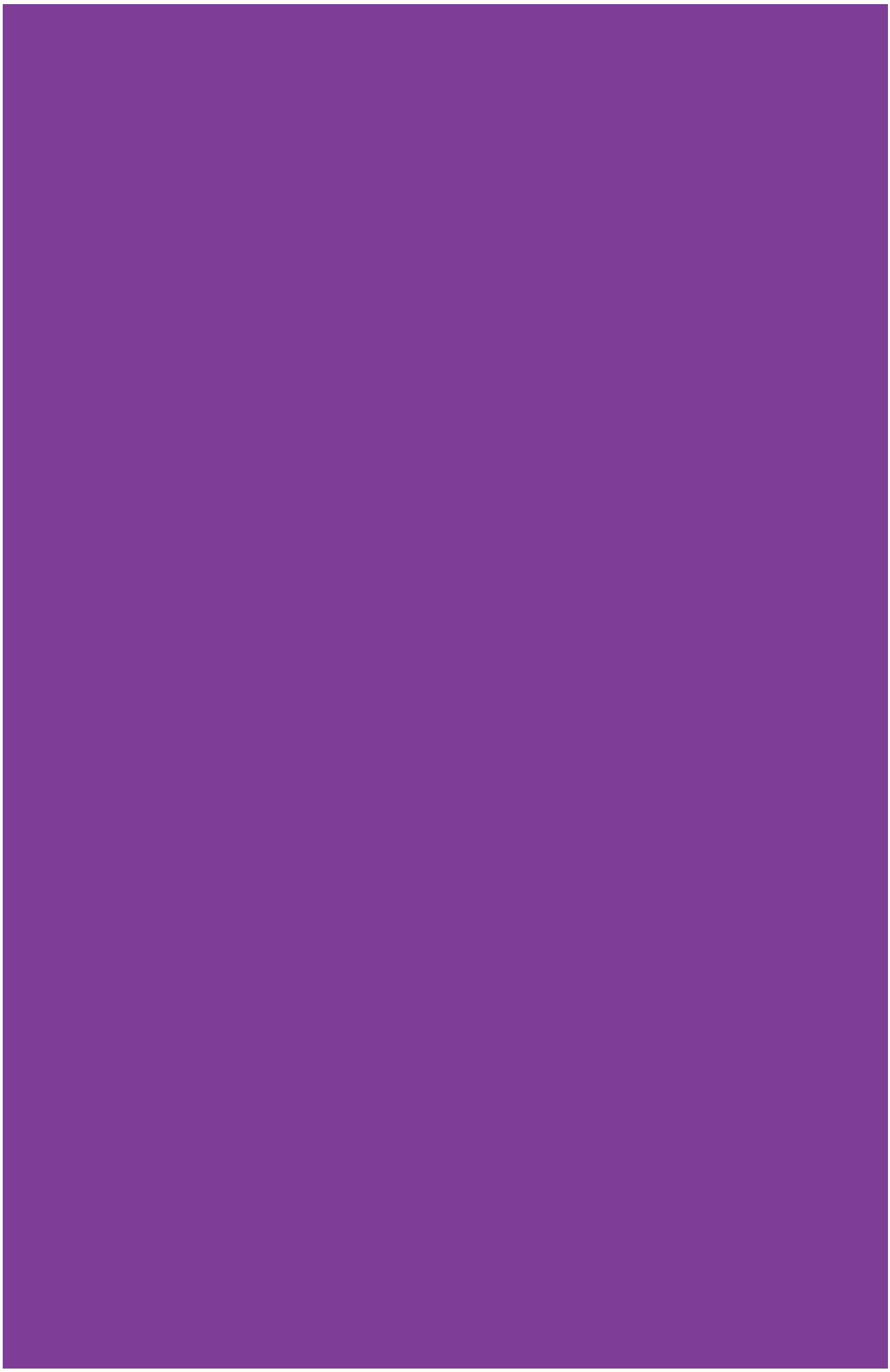
Recommendation 60: The Home Office should examine its processes for carrying out detention reviews, including looking at training requirements, arrangements for signing off cases at a senior level, and auditing arrangements.

Recommendation 61: As part of the examination of its own processes that I have proposed, I recommend that the Home Office consider if and what ways an independent element can be introduced into detention decision making.

Recommendation 62: I recommend that the Home Office give further consideration to ways of strengthening the legal safeguards against excessive length of detention.

Recommendation 63: I recommend that the Home Office investigate the development of alternatives to detention.

Recommendation 64: I recommend that the Home Office consider how far electronic monitoring can contribute to the goal of fair and efficient border control.



Annex 4: Government initial response to my first report

Written statement laid in Parliament on 14 January 2016 (HCSS470) in response to the publication of my report: "Review into the Welfare in Detention of Vulnerable Persons", published in January 2016 (Cm 9186).

The Government is committed to an immigration system that works in Britain's national interest, and commands the confidence of the British people. Coming to the United Kingdom to work, study or visit is a privilege, not an unqualified right. Accordingly, the Government expects anyone who comes to the UK to comply with their visa conditions and, if they do not, to return home voluntarily at the first opportunity.

We have put in place a robust legal framework, which prevents the abuse of appeals procedures and encourages timely and voluntary departures by denying access to services, such as bank accounts, rental property, the labour market and driving licences, to those with no right to be here. Where individuals nonetheless fail to comply with immigration law, and refuse to leave, we will take enforcement action to remove them from the UK. Where it is necessary for the purposes of removal, and taking into account any risk that an individual may abscond, this will involve a period of detention (which of course can be avoided if the individual departs voluntarily). The Government is clear that in these circumstances it is in the public interest to detain and remove such individuals, and the vast majority of those in detention are, accordingly, those who have made their way to the United Kingdom unlawfully or breached their conditions of entry, have failed to make their case for asylum, or are foreign criminals.

It is a long-established principle, however, that where an individual is detained pending removal there must be a realistic prospect of removal within a reasonable time. Depriving someone of their liberty will always be subject to careful consideration and scrutiny, and will take account of individual circumstances. It is vital that the system is not only efficient and effective but also treats those within it with dignity and respect, and takes account of the vulnerability of those detained.

It is against this background that in February last year the Home Secretary asked [redacted] to conduct a review of the welfare of vulnerable individuals in detention. His review is being published today (Cm 9186). It makes recommendations for operational improvements, for changes to the policy on detaining vulnerable people, and for changes to the provision of healthcare services in detention. Copies have been laid in the House. The Government is grateful to Mr Shaw for his review, welcomes this important contribution to the debate about effective detention, and accepts the broad thrust of his recommendations.

Strategy Recommendations

In response to the strategic recommendations, the government will follow up the written ministerial statement today with a more detailed strategy for detention in due course.

Policy Recommendations

[redacted] makes a number of recommendations relating to the definitions of and policy for managing vulnerable individuals in detention. In response, the government is developing a new policy defining "adults at risk". This will recognise the breadth and dynamic nature of vulnerabilities and which will have a clear presumption against detention of vulnerable people, unless there is evidence that matters such as criminality, compliance history or imminent removal outweigh the vulnerability factors.

Casework Transformation Recommendations

In order to maximise the efficiency and effectiveness of the detention estate, the government will implement a new approach to the case management of those who are detained. It will implement the new "adult at risk" policy to ensure more rigorous assessment of those entering detention through a new gate-keeping function, maintaining this rigour through the adoption of individual removals plans for all detainees, which will maintain a strong focus on and momentum towards removal.

Health Recommendations

The government will carry out a more detailed mental health needs assessment in Immigration Removal Centres, using the expertise of the Centre for Mental Health. This will report in March 2016, and NHS commissioners will use that assessment to consider and revisit current provision to ensure healthcare needs are being met appropriately. In the light of the review the government will also publish a joint Department of Health, NHS and Home Office mental health action plan in April 2016.

Operational Recommendations

The report makes a number of major and minor operational recommendations including a review of Detention Centre Rules 40 and 42, relating to care and separation and associated accommodation, consideration of the closure of Cedars pre-departure centre, night time closures at some centres, a review of guidance and update of the Detention Service Orders and linked reviews of population management and regime. These will be considered carefully on a case by case basis taking account of available resources.

The Government expects these reforms, and broader changes in legislation, policy and operational procedures, to reduce the number of those detained, and the duration of detention before removal, in turn improving the welfare of those detained.

More effective detention, complemented by increased voluntary returns without detention, will safeguard the most vulnerable while helping reduce immigration abuse and reduce costs.

Annex 5: Home Office's action plan response

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
STRATEGY RECOMMENDATIONS				
1	Home Office to prepare and publish a strategic plan for immigration detention.	Accepted	May 2017	The Home Office strategic plan for immigration detention sits as part of its internal business plan to 2020, last updated for internal use in May 2017. This refreshed plan communicated a new set of strategic ambitions for Immigration Enforcement, published on the Home Office website, to reduce the size of the illegal population and the harm it causes, by: • preventing migrants from entering the UK illegally and overstaying; • dealing with threats associated with immigration offending; and • encouraging and enforcing the return of illegal migrants from the UK. An update against key milestones was contained within a letter from the Immigration Minister to the Chair of the Home Affairs Select Committee in October 2017.
54	Home Office to draw up research strategy for immigration detention. In particular it should consider commissioning clinical studies on the impact of detention upon women and research aimed at improving models of care.	Partially accepted	April 2017	Home Office Immigration Enforcement's Research and Analysis Strategy has been in place since April 2017. NHS England has commissioned Manchester University to review evidence from deaths in custody across the criminal justice system, including immigration removal centres.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
63	Home Office to develop alternatives to detention.	Accepted	Ongoing	Immigration detention remains an essential element of immigration enforcement, but Home Office plans also consider the development of alternatives, with a primary focus on encouraging compliance with immigration laws. Beyond compliance, these plans place the majority of those who become immigration offenders on monitoring in the community through improved reporting arrangements, supported by additional scope and flexibility in powers of applying conditions to an individual's release from detention further to the commencement in January of the immigration bail provisions in schedule 10 of the Immigration Act 2016, alongside the support of a Voluntary Returns Service. Further work is taking place with representatives of the United Nations High Commissioner for Refugees to discuss best practice and opportunities with faith and community groups. For foreign nationals convicted of a crime, more offenders are being removed directly from prison, so they do not enter immigration detention, electronic monitoring is already used and the Detention Action Community Support Project, since October 2015, has been expanded to work with male ex-offender migrants aged 18-30 to prepare for potential release and encourage compliance should release be agreed.
64	Home Office to consider how far electronic monitoring can contribute to the goal of fair and efficient border control.	Accepted	October 2017	A programme of work has been agreed and is funded to deliver in May 2020.
CASEWORK TRANSFORMATION RECOMMENDATIONS				
20	Home Office to consider introducing a single gatekeeper function.	Implemented	September 2016	

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
59	All caseworkers should meet detainees on whom they are taking decisions or writing monthly detention reviews at least once. The meeting should be face-to-face or video link or telephone.	Partially accepted	March 2018	Pre Departure Teams (PDTs) are operating in Gatwick and Heathrow immigration removal centres (IRCs). Remaining centres will have operational PDTs introduced throughout 2018. PDTs are embedded within IRCs to increase face-to-face interaction with detainees, work to promote compliance and voluntary departure and facilitate communication between casework units and detainees.
60	Home Office to examine its processes for carrying out detention reviews, including looking at training requirements, arrangements for sign off cases at senior levels and auditing arrangements.	Accepted	Ongoing	Detention Reviews have been replaced with Detention and Case Progression Reviews. A review of the levels of authority for detention has been completed and the Detained Casework Assurance and Audit Team will provide a specialised function for conducting second line assurance audits.
61	Home Office to consider what ways an independent element can be introduced into detention decision making.	Partially accepted	June 2016	Increased internal oversight of case progression and adult safeguarding introduced by the Detention Casework Transformation Programme.
62	Home Office to give further consideration to ways of strengthening the legal safeguards against excessive length of detention	Implemented	March 2018	Auto bail provisions went live on 15 January 2018. These provisions ensure detainees, who are not subject to a deportation order, are referred to First Tier Tribunal for consideration of bail after 4 months in detention and every 4 months thereafter. Additionally assurance and review measures have been put in place under the Detained Casework Assurance and Audit Team.
POLICY RECOMMENDATIONS				
7	Discussion draft of the short term holding centre rules be published as a matter of urgency.	Implemented	March 2018	A draft of the Short-term Holding Facility Rules was subject to consultation in 2016 and the finalised Rules were laid in late March 2018. The Rules are due to come into force on 2 July 2018.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
9	There should be a presumption against detention for victims of rape and other sexual or gender-based violence. (For the avoidance of doubt, I include victims of FGM as coming within this definition.)	Implemented	September 2016	Part of adults at risk policy.
10	Home Office amend its guidance so that the presumptive exclusion from detention for pregnant women is replaced with an absolute exclusion.	Rejected	July 2016	Rejected, although new controls were introduced in the Immigration Act 2016 by 72 hour time limit on detention of pregnant women.
11	The words 'which cannot be satisfactorily managed in detention' are removed from the section of the EIG that covers those suffering from serious mental illness.	Implemented	September 2016	Part of adults at risk policy.
12	Those with a diagnosis of Post Traumatic Stress Disorder should be presumed unsuitable for detention.	Implemented	September 2016	Part of adults at risk policy.
13	People with Learning Difficulties should be presumed unsuitable for detention.	Implemented	September 2016	Part of adults at risk policy.
14	Transsexual people should be presumed unsuitable for detention.	Implemented	September 2016	Part of adults at risk policy.
15	Wording in paragraph 55.10 of the EIG in respect of elderly people be tightened to reflect to include a specific upper age.	Implemented	September 2016	Part of adults at risk policy.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
16	A further clause should be added to the list in paragraph 55.10 of the EIG to reflect the dynamic nature of vulnerability and thus encompass 'persons otherwise identified as being sufficiently vulnerable that their continued detention would be injurious to their welfare'.	Implemented	September 2016	Part of adults at risk policy.
21	Home Office immediately consider an alternative to the current rule 35 mechanism. This should include whether doctors independent of the IRC system (for example, Forensic Medical Examiners) would be more appropriate to conduct the assessments as well as the training implications.	Accepted	Ongoing	The Rule 35 guidance and process were revised alongside the introduction of the adults at risk in immigration detention policy in September 2016. In March 2018 the Home Office amended Rule 35(3) of the Detention Centre Rules (DCRs) 2001 in order to introduce a new definition of torture, further to a High Court judgment handed down in October 2017. This will come into force on 2 July 2018. Broader changes to Rule 35will be considered as part of a wider review of the DCRs which the Home Office is planning later in 2018, and after [redacted] has reported. The changes to the DCRs will be subject to consultation in due course.
22	Further recommend that rule 35 (or its replacement) should apply to those detainees held in prisons as well as those in IRCs.	Rejected	July 2016	A broadly equivalent provision (Rule 21) exists in the Prison Rules. Rule 21 provides that medical officers must report to the governor on the case of any prisoner whose health is likely to be injuriously affected by continued imprisonment or any conditions of imprisonment. Prisons have their own well-established healthcare provision and the mechanism for reporting any concerns. The adults at risk policy applies to individuals held in prisons under immigration powers as well to those held in the immigration estate.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
29	Home Office and the Department of Health work together to consider whether current arrangements for safeguarding are adequate.	Accepted	Ongoing	For people in detention: An interim Detention Services Order on the care and management of adults at risk in detention was published in September 2016, setting out safeguards for vulnerable detainees, including arrangements for ensuring their care whilst in detention which goes beyond decisions on the detention of vulnerable people. Following detention: A cross-IE discussion was held on 10 January 2018. Consensus was reached to look at embedding existing tools (guidance and good practice), to share learning and to ensure clear ownership before seeking any strategic agreements with the Department of Health or local authorities. Standard Operating Procedures are being drafted to embed best practice.
45	Home Office to seek the views of the Ministry of Justice and the Department of Health on extending section 75 of the Sexual Offences Act 2003 to IRCs, prisons and mental hospitals.	Implemented	March 2016	Advice was that prosecution within IRCs, prisons or mental hospitals could still proceed against staff who abused their position.
HEALTH RECOMMENDATIONS				
48	Home Office staff should be reminded that, to ensure continuity of care, detainees should not be transferred when there is clinical advice to the contrary.	Implemented	August 2016	Guidance issued to staff in immigration removal centres and the Detainee Escorting and Population Management Unit 23 August 2016.
49	Home Office and NHS England should promote self-administration of drugs where risk assessments support that approach.	Implemented	March 2017	Professional Standards for optimising medicines for people in secure environments (edition 1 for IRCs) published February 2017 followed by implementation of assessment tool March 2017.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
50	Home Office, in consultation with NHS England, to draw up explicit guidelines as to: • What informed consent looks like • What information can be shared between all parties in the event that informed consent to the release of clinical information is granted by the detainee.	Implemented	April 2016	Publication of DSO 01/2016 – Medical information sharing.
51	Alternative to SystmOne to be pursued for those in detention facilities not in England.	Rejected	June 2016	NHS England is not resourced to fund works outside England.
52	As part of its response to future growth in the demand for healthcare, NHS England needs to ensure the filling of permanent healthcare vacancies as a priority.	Partially accepted	December 2017	NHS England and IRC Market Development Report produced October 2017.
53	Home Office in association with service providers to consider what can be done to reduce the use of new psychoactive substances and to advise detainees on the effects of their misuse.	Implemented	March 2017	Publication of joint agency substance management guidance paper in February 2017. Written substance management strategy in place at each IRC – March 2017
55	The Home Office and NHS England should conduct a clinical assessment of the level and nature of mental health concerns in the immigration detention estate.	Implemented	September 2016	The report of the Centre for Mental Health's analysis was published in January 2017 entitled "Immigration Removal Centres in England, A Mental Health Needs Analysis".

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
57	Talking therapies become an intrinsic part of healthcare provision in immigration detention.	Implemented	August 2017	Revised specification of healthcare requirements for IRCs completed.
58	Home Office, NHS England, and the Department for Health to develop a joint action plan to improve the provision of mental health services for those in immigration detention.	Implemented	December 2016	Department of Health, NHS England and Home Office Joint Mental Health Action Plan published 1 December 2016.
MAJOR OPERATIONAL RECOMMENDATIONS				
5	Home Office to draw up plans either to close Cedars or to change its use as a matter of urgency.	Implemented	July 2016	Announcement July 2016 to move pre departure accommodation. Cedars closed 31 December 2016. Pre departure accommodation (discrete wing within footprint of Tinsley House) opened in June 2017.
18	Home Office to consider what learning there is for IRCs from the Prison Service's experience of operating 'first night centres' for those initially received in to custody.	Implemented	August 2016	Publication of DSO 6/2013 – Reception, Induction and Discharge.
28	Home Office should consider if the allocation criteria and processes to which DEPMU operates could be strengthened.	Implemented	August 2017	
32	All IRCs should review the range of activities offered to detainees; in particular, those that could provide skills to detainees that would be useful on their return to their home country.	Accepted	Ongoing	Supplier led workshops have been held to discuss various options and recommendations made are being taken forward. A collation of activities within each IRC has been completed and further workshops are scheduled to take place in March 2018.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
33	Home Office to review detainees' access to natural light and to the open air, and invite contractors to bring forward proposals to increase the time that detainees can spend outside.	Implemented	June 2016	Suppliers have reviewed regimes to assess adequacy of access to natural light and fresh air. The open nature of regimes at all IRCs enables frequent and regular access to open air areas for detainees.
37	Home Office to consider amalgamating and modernising rules 40 and 42.	Partially accepted	July 2017	Rules modernised but not amalgamated. Publication of DSO 02/2017 Removal from Association (Rule 40) and Temporary Confinement (Rule 42).
38	The Home Office should review all the rule 40 and rule 42 accommodation to ensure that it is fit for purpose. All contractors should be asked for improvement plans to ensure that the name Care and Separation Unit is something more than a euphemism.	Accepted	April 2017	Review of Rule 40 and Rule 42 accommodation undertaken with all suppliers. Options developed to provide alternative, assisted living accommodation where care and separation unit is not appropriate. This is addressed in recommendation 56.
41	Home Office negotiate night-time closures at each IRC, the times of which should reflect local circumstances.	Rejected	July 2016	It is an operational necessity for night time movements at IRCs used for removals from Gatwick and Heathrow. Qualitative work has indicated there is a detrimental detainee impact associated with increased time in vans, holding rooms and police cells if this recommendation is accepted.
56	The creation of care suites across the IRC estate should be taken forward as a priority.	Accepted	Ongoing	Assisted living accommodation is in place at Yarl's Wood, Tinsley House and Campsfield House. Work at the remaining centres is planned so that their accommodation will be open for operational use by the end of 2018, with the majority to do so before the summer.

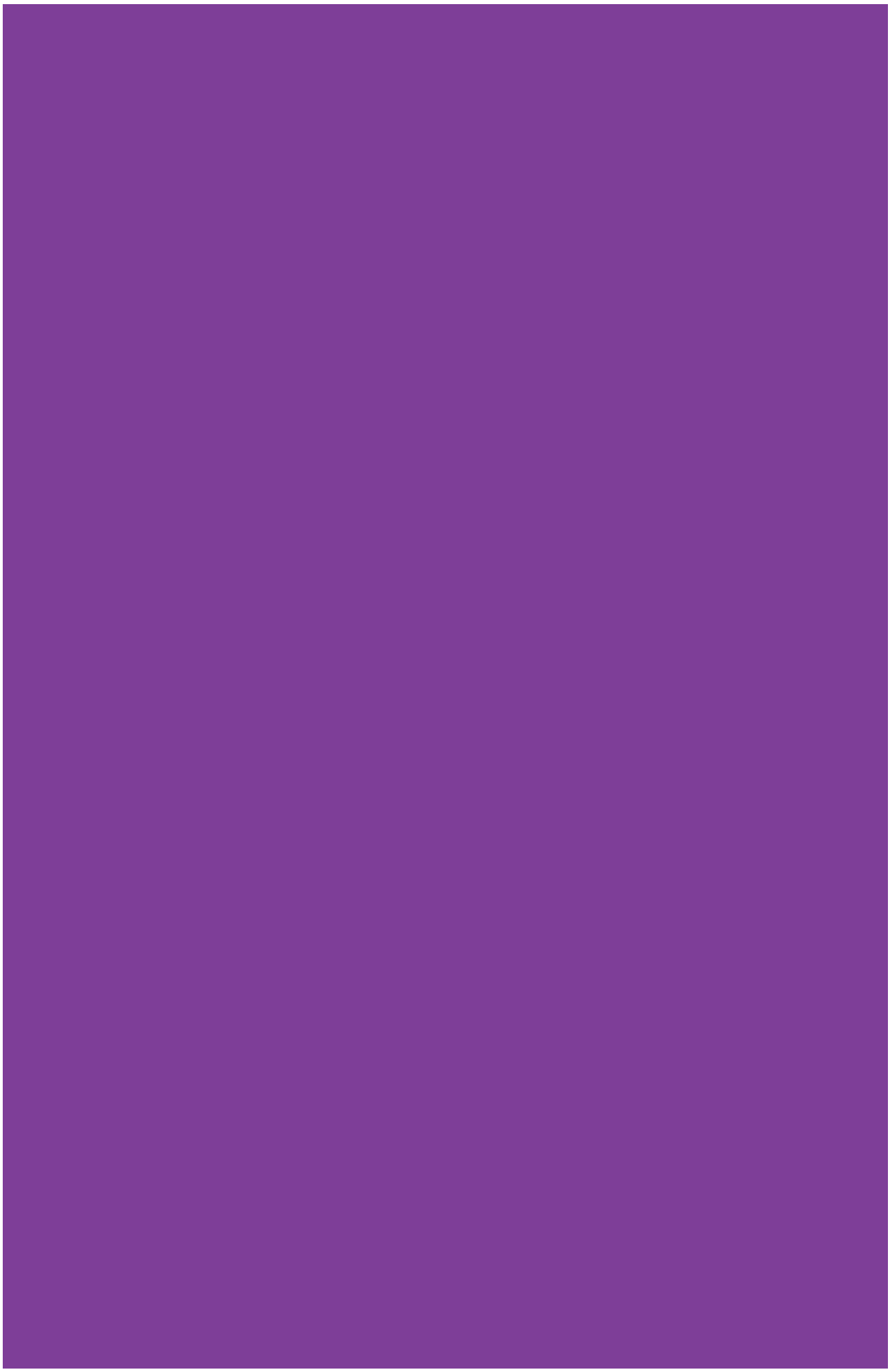
No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
MINOR OPERATIONAL RECOMMENDATIONS				
2	Home Office to consider how far it can encourage a more cohesive system through more joint training and planning, shared communications and recognition scheme.	Partially accepted	Ongoing	Quarterly meeting with centre managers held. Lessons learned bulletin with all suppliers relaunched January 2018. Closer co-operation on security questions introduced during 2017, with planned introduction of shared access to Mercury from April 2018.
6	Tascor arrange for refresher training for its staff on their duty of care and the need for proper meaningful engagement with detainees.	Accepted	March 2016	A module was designed and placed into the Tascor annual 1 day refresher training.
8	Home Office to review the adequacy of the numbers of immigration staff embedded in all prisons.	Accepted	Ongoing	Immigration Enforcement (IE) has established a joint operational board with HM Prisons and Probation Service (HMPPS) to review performance and blockers, including levels of staffing within the prison estate. IE continues to work with HMPPS to ensure staffing levels remain appropriate to the number of foreign national offenders of interest to the Home Office in prisons. IE also continue to work very closely with HMPPS as part of their wider estate configuration review to identify opportunities to concentrate foreign national offenders in fewer prisons, and to ensure that levels of immigration staff embedded in "FNO-only" prisons, current and future, are correct. The current staffing levels within the prison estate are considered adequate to need; however IE is undertaking a detailed workforce review in 2018 to include productivity assessments and adjustments will be made to staffing levels if requirements arise from that review.
17	Home Office to consider establishing a joint policy with HMPPS on provision for those held in prison under immigration powers.	Accepted	Ongoing	The Home Office and HMPPS have worked together to decide issues arising from individuals who have served their sentence but who remain detained in prisons under immigration powers.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
19	Home Office to consider the need for a separate DSO on LGBI detainees. Anti-bullying policies should include explicit reference to LGBTI detainees.	Accepted	April 2016	Publication of DSO 02/2016 – Lesbian, gay and bisexual detainees in the detention estate.
23	Once HMPPS review of ACCT is complete there should be urgent review of ACDT and DSO 06/2008, informed by the HMPPS review and by the findings of this report.	Accepted	Ongoing	The HMPPS review of Assessment, Care in Custody and Teamwork (ACCT) has been completed and new procedures are being developed. This is currently being piloted at selected prisons, and there are plans to include Morton Hall IRC. ACDT DSO is being redrafted with a view to publication in 2018.
24	DSO 03/2013 on food & fluid refusal currently under review; the review to consider alternatives to treatment within a prison or IRC.	Implemented	October 2017	Publication of DSO 03/2017 – care and management of detainees refusing food and/or fluid.
25	Home Office commission a formal review of the quality of PERs and that any deficiencies are addressed. In the meantime, all staff should be reminded of the importance of completing PERs fully.	Implemented	Ongoing	Publication in March 2017 of updated DSO 18/2012 Person Escort Record (PER) Report following a review into completion of the forms. Suppliers tasked on 3 May 2017 with ensuring proper completion of the form and asked in December 2017 to evidence steps taken to improve quality. This will be kept under review.
26	Home Office to consider how rapidly it can move towards a system of electronic record keeping for the PER and IS91RA.	Consideration deferred	To be planned into innovation for 2018/19	This is part of a wider piece of work be developed in conjunction with the new escort provider, Mitie Care and Custody, who take over the escorting contract from May 2018.
27	Home Office to conduct an annual audit of the RSRA process so that it remains an effective means of ensuring detainees' safety.	Implemented	September 2016	Publication of updated DSO 12/2012 – Room Sharing Risk Assessment, which is part of audit workplan.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
30	The internet access policy should be reviewed with a view to increasing access to sites that enable detainees to pursue and support their immigration claim, prepare to return home and enable them maximum contact with their families. This should include Skype and social media sites (Facebook, Twitter).	Under review	February 2018	DSO 04/2016 – Detainee access to the internet – does not allow for access to social media sites. The Minister for Immigration has asked for a review of current policy, including costs.
31	Home Office to reconsider its approach to pay rates for detainees (following comments on the benefits of allowing contractors greater flexibility).	Accepted	April 2018	Pay rates reviewed and to be retained at current rate.
32	All IRCs should review the range of activities offered to detainees; in particular, those that could provide skills to detainees that would be useful on their return to their home country.	Accepted	Ongoing	Supplier-led workshops have been held to consider the range and use of activities offered within IRCs. A report from these workshops makes a number of recommendations which have been considered by the Home Office and a timetable of action drawn up, to be completed by the summer of 2018.
34	The Home Office should no longer require contractors to operate an Incentives and Earned Privileges scheme.	Accepted	Ongoing	We do not require our commercial providers to implement IEP schemes and IEP schemes are no longer being used across the estate.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
35	Service Provider at Yarl's Wood should only conduct searches of women and of women's rooms in the presence of men in the most extreme and pressing circumstances, and that there should be monitoring and reporting of these cases.	Implemented	June 2016	Publication of DSO 06/2016 – Women in the detention estate.
36	I recommend that Home Office Detention Operations carry out an audit of reception and holding environments to ensure that the policy on searching out of sight of other people is properly followed.	Accepted	September 2016	Home Office review completed of searching procedures in reception areas at every IRC. Report includes information from Tascor concerning the short term holding facilities and holding rooms.
39	Home Office should routinely publish statistics on the number of transfers of detainees between IRCs and STHFs.	Consideration deferred	To be planned into innovation for 2018/19	This is part of a wider piece of work be developed in conjunction with the new escort provider, Mitie Care and Custody, who take over the escorting contract from May 2018.
40	Home Office should review the use made of regional airports for removal.	Implemented	Ongoing	A review was carried out in June 2017, and this remains under review.
42	Practice of overbooking charter flights should cease.	Rejected	March 2016	There is attrition between charter referrals and departures which is in part the result of last minute legal challenges. Overbooking charter flights delivers value for money. The practice of overbooking should not be confused with the use of reserves i.e. the process where detainees are advised they are in reserve for the flight and may not travel. Immigration Enforcement has kept the use of reserves under constant review and reduced its use.

No.	Recommendation	Accepted/ Implemented/ Rejected	Date of Implementation	Comment
43	Home Office to consider if inspection arrangements for IRCs can ensure the involvement of the Independent Chief Inspector.	Implemented	June 2017	The Independent Chief Inspector and HM Chief Inspector of Prisons finalised a Memorandum of Understanding in September 2016 and have since agreed to co-operate on topics falling within their respective remits.
44	Home Office to liaise with Ministry of Justice (MoJ) to ensure that all IMBs in IRCs have sufficient membership at all times.	Accepted	August 2016	The Home Office meets regularly with MoJ and the IMB Secretariat to ensure and support the effective function of IMBs. This includes ensuring that IMBs have sufficient membership and that timely recruitment takes place when required.
46	Home Office to review the use of fellow detainees as interpreters for induction reviews.	Implemented	April 2016	Publication of DSO 6/2013 – Reception, Induction and Discharge.
47	Home Office to remind service providers of the need to use professional interpreting facilities whenever language barriers are identified on reception.	Implemented	April 2016	Publication of DSO 6/2013 – Reception, Induction and Discharge.
UPDATING GUIDANCE RECOMMENDATIONS				
3	Where weaknesses in particular policies have been identified in Mr Cheeseman's audit, these be remedied at their next iteration.	Implemented	May 2016	
4	I recommend that work to amend the Detention Centre Rules commence following the Home Office's consideration of this review.	Accepted		Review of the Detention Centre Rules will begin in 2018 after the Short Term Holding Facility Rules are in force.



Annex 6: Written submissions received and NGO seminar

A6.1 Twenty-five separate written submissions were received from Non-Governmental Organisations (NGOs) with an interest in detainee welfare and/or the rights of migrants.

List of NGOs who submitted written evidence	
1	Amnesty International
2	Asylum Aid
3	Asylum Welcome
4	Association Visitors to Immigration Detention (AVID)
5	Bail for Immigration Detainees (BID)
6	British Medical Association
7	British Red Cross
8	Detention Action
9	The Detention Forum
10	Freedom from Torture
11	Gatwick Detainees Welfare Group
12	Helen Bamber Foundation
13	Hibiscus
14	Immigration Law Practitioners Association (ILPA)
15	Jesuit Refugee Service UK
16	Liberty
17	Medact
18	Medical Justice
19	Mind
20	Royal College of Midwives
21	Royal College of Psychiatrists
22	United Kingdom Lesbian and Gay Immigration Group (UKLIG)
23	United Nations High Commission for Refugees (UNHCR)
24	University of Bristol
25	Women for Refugee Women

A6.2 In addition, I received representations from three people in detention, one of whom was detained at Campsfield (and whom I had met on my visit), one of whom was detained at Morton Hall and one of whom was detained at Yarl's Wood. I was very grateful for the first-hand experiences they have given me of detention conditions in the respective IRCs and the manner in which they were treated, and greatly appreciated hearing their concerns about indefinite detention and caseworking. I have read and considered their accounts carefully.

A6.3 I also received a submission from Dr [redacted], a retired GP who has worked with asylum seekers in detention since 2006. In particular, she outlined her concerns about the impact of detention on mental health. The trade union, Community, shared with me their worries about staffing levels at Dungavel.

A6.4 Representations were received from two firms of solicitors, [redacted] and [redacted] on behalf of those detainees who had been abused at Brook House and whose cases had been highlighted on the *Panorama* programme. These representations covered both the specific abuses and their wider implications, and have formed part of the evidence base for this review. I have read the representations with great care. However, I made clear to the solicitors that I was not investigating the specific circumstances of the abuses, which are subject to other action. As noted earlier, I was subsequently shown anonymised copies of the Home Office Professional Standards Unit investigations into a number of the allegations raised. I have taken all of this information into account in my wider findings.

A6.5 I provide below a summary of the NGO submissions.

Amnesty International UK

A6.6 Amnesty International UK argued that:

> "… detention decision makers (that is, caseworkers but also more senior officials with oversight responsibilities) continue to use immigration detention as a matter of routine rather than as a tool of last resort. The presumption of liberty that is required by law was either missing in many cases, or only tacitly acknowledged as an afterthought. In its place, detention was either treated as an inevitability, and therefore not requiring of detailed justification, or was considered through a process that operated with an end goal of finding grounds for detention rather than starting from liberty. This approach was regularly not picked up or corrected by gatekeeping staff and senior officials. Instances of active consideration of alternatives to detention were rare."

A6.7 Amnesty said that there was serious concern that the Adults at Risk had done little to improve on the failings of the former Chapter 55.10 of the Enforcement Instructions and Guidance (EIG): "Thus, while the form of the decision to maintain detention has changed, the end result is the same for the detainee."

Asylum Aid

A6.8 Asylum Aid commended the Government's introduction of a procedure allowing stateless persons to be granted leave to remain in the UK, and the Government's commitments to reducing the use of immigration detention. However, "more must be done to ensure that stateless persons are offered the protection they need and not detained unlawfully, namely: Home Office detention officials need to have adequate knowledge of statelessness; make appropriate decisions about detention; provide necessary information and assistance to stateless persons; and improve data collection and publication."

Asylum Welcome

A6.9 Asylum Welcome is an Oxford based charity who have worked both with immigration detainees at Campsfield House and with asylum seekers and refugees living in the community. They submitted that they had not seen "any improvements at Campsfield in the response to victims of torture or those with physical and mental health difficulties, compared with two years ago." They were concerned that Adults at Risk had not been thoroughly implemented, and argued that the healthcare centre at Campsfield has "shortcomings that result in failures in timely identification of medical conditions, inability to provided urgent response to urgent needs, inadequate treatment of long term illnesses and unacceptable number of cases neither treated nor released."

Association of Visitors to Immigration Detainees (AVID)

A6.10 AVID is the national network of volunteer visitors to immigration detainees in the UK. They too argued that Adults at Risk was not succeeding in preventing the detention of vulnerable people. Like the majority of those who submitted written evidence, AVID called for the greater use of alternatives to detention, and for a time limit on detention.

Bail for Immigration Detainees (BID)

A6.11 Bail for Immigration Detainees submitted an initial paper outlining their concerns in relation to FNOs as well as decisions to detain – accompanied by an analysis of the Adults at Risk policy. A further submission summarised their "casework tweets" over the last six months. Amongst other things, they said that legal aid should be available to all detainees, and that no detainees should be held in prisons.

British Medical Association (BMA)

A6.12 The BMA submitted a hard copy of their report: *Locked up, locked out: health and human rights in immigration detention*. The following paragraphs lifted directly from the report summarise their views:

> "…the detention of people who have not been convicted of a criminal offence should be a measure of last resort. Detention should be reserved for individuals who pose a threat to public order or safety. Ultimately, we believe that the use of detention should be phased out and replaced with alternate more humane means of monitoring individuals facing removal from the UK."
>
> "As long as the practice continues, however, we believe that there should be a clear limit on the length of time that people can be held in detention, with a presumption that they are held for the shortest possible time. The state must also meet its obligations to those it detains: detained individuals should not experience infringements of their health-related rights and must be able to access high-quality healthcare, commensurate with their needs. Where doctors are unable to meet their obligations to patients, systems and processes must be scrutinised and restructured."

A6.13 The BMA made the following recommendations:

- Revise detention policies to address the significant health effects indeterminate detention can have on individuals.
- Address aspects of the detention environment which affect the health and wellbeing of those detained.
- Reconfigure current healthcare provision to better achieve equivalence of care.

- Provide training and continued support in health and wellbeing issues for all those working with detained individuals.
- Recognise the importance of doctors acting with complete clinical independence and ensure that that principle is enshrined and respected across the immigration detention estate.

British Red Cross

A6.14 The British Red Cross Society submitted a report outlining their findings from research undertaken in 2017. They made a range of recommendations, including the following:

- The process of being detained should be made more humane, including by prohibiting the use of handcuffs when people being detained are in transit. People should be told where they are being taken to, and how long it will take to get there. People should not be made to feel like criminals by being made to stay in police stations after being detained.
- Vulnerable people should never be detained. To prevent the detention of vulnerable people, a vulnerability screening tool, such as the one developed by UNHCR-IDC, should be used when screening individuals prior to the decision to detain. The tool should also be suitable for use in detention to identify vulnerabilities that develop whilst people are detained.
- There should be greater access to social media, which would reduce the isolation for those detained in Immigration Removal Centres. The use of services such as Skype should be utilised to help people stay in contact with friends and family, as well as offering the potential for visiting groups to contact a greater number of people.
- Where people are subject to a reporting requirement, they should not be detained when reporting without prior knowledge. All individuals with reporting requirements should have their travel costs covered by the Home Office, and the distances people are expected to travel should be minimised by providing more locations at which people can report. People should be provided with end-to-end asylum support so that they are able to meet their basic needs and live in dignity, while effectively engaging with their immigration case.

Detention Action

A6.15 The position of Detention Action is summarised as follows:

> "The Home Office has not acted with sufficient urgency to address the criticisms of the Shaw Review and implement the reform programme outlined by the former Minister. Neither the scale of detention, nor individual periods of detention, have reduced since the Minister responded to the Shaw Review. Flaws in the drafting and implementation of new policies and processes mean that vulnerable people continue to be routinely detained and continue to experience serious harm in detention. Victims of trafficking are prevented from accessing the protection of the National Referral Mechanism by a combination of the fact of detention, procedural flaws and a conflict of interest in the Home Office. However, alternatives to detention could address the range of policy objectives sought by detention without harm to migrants."

A6.16 Detention Action's recommendations included these:

- A clear monitoring process should enable assessment of how the adults at risk policy is fulfilling the Government's commitments to safeguard the most vulnerable people.
- Vulnerable people and their legal representatives should be informed if detention centre staff alert the Home Office to their vulnerability, and of the Home Office response.
- An appropriate process should be developed to ensure that people who lack capacity are identified and not detained.
- The adults at risk policy, and an equivalent to Rule 35, should apply to people held under immigration powers in prisons.
- A referral to the NRM should trigger release from detention, since it is only made when there are indicators of trafficking. Potential victims of trafficking should not wait in detention for a positive reasonable grounds decision, which evidence suggests is difficult to obtain in detention.
- Migrants with experience of detention should be involved in the design and development of alternatives to detention.

Detention Forum

A6.17 The Detention Forum, a network of over 30 organisations, submitted representations which principally drew attention to the Vulnerability Screening Tool, developed by the United Nations High Commissioner for Refugees (UNHCR) and the International Detention Coalition (IDC).

Freedom from Torture

A6.18 Freedom from Torture argued that the Adults at Risk framework afforded a "significantly lower level of protection" to torture survivors than that which it replaced. They continued:

> "The policy introduced three significant concepts which have had a seriously negative impact on torture survivors and other vulnerable detainees: the definition of 'at risk' and the use of indicators on a case-by-case basis, the idea that evidence can be weighed to establish level of risk, and the act of balancing immigration considerations against risk. These three elements constitute a profound step backwards in the government's approach to the detention of vulnerable individuals."

A6.19 The recommendations from Freedom from Torture included:

- Replace the 'torture' and 'victims of sexual or gender based violence' categories with a more inclusive category modelled on the UNHCR detention guidelines, namely 'victims of torture or other serious, physical, psychological, sexual or gender based violence or ill-treatment'.
- Return to a policy with categories presumed to be particularly vulnerable to harm in detention, with an effective catch-all covering those identified as otherwise particularly vulnerable to harm in detention.
- Remove the evidence levels from the Adults at Risk policy. A self-declaration of vulnerability can still carry less weight than documented vulnerability, but should always trigger further investigation into the claimed vulnerability.

- Remove the requirement to comment on the likely impact of ongoing detention from the Rule 35(3) template, and from the Adults at Risk policy so that Rule 35(3) reports can be afforded the appropriate level of weight when considering whether to continue detention.
- Restore the threshold of 'very exceptional circumstances' to justify the continued detention of those identified as particularly vulnerable to harm in detention.

Gatwick Detainees Welfare Group

A6.20 The Gatwick Detainees Welfare Group (GDWG) provides support, through its volunteer visitors, to asylum seekers and immigration detainees held at Tinsley House and Brook House. They submitted three documents to the review, namely an evidence paper; an analysis of information sharing between IRC healthcare departments and the Home Office; and a summary of case studies concerning HO decision making.

A6.21 Amongst other things, GDWG said there should be for a regular opportunity for a systemic review of the Home Office's use of immigration detention. Noting that in my first review I had identified a lack of research, strategy and planning for the immigration detention estate, GDWG said these lacunae could not be addressed by the present system of scrutiny based on individual, localised assessments of detention centres. They added: "Given the longstanding problems concerning the Home Office's exercise of the power to detain migrants, the opportunity for a regular and thematic approach to gathering evidence is essential."

Helen Bamber Foundation

A6.22 The Helen Bamber Foundation (HBF) focussed on the impact of the Adults at Risk Policy on their own client base of the HBF. They had collated data from a sample of referrals between 2016–2017 and concluded that: "detention, often for lengthy periods, is still being maintained by the Home Office in the cases of vulnerable adults who qualify under the Adults at Risk Policy."

A6.23 HBF said a 'presumption of vulnerability' should be established, so that the onus was upon the Home Office to demonstrate the absence of a risk of harm for each detainee. They also called for a review of all the relevant secondary legislation, including the Detention Centre Rules, most specifically Rule 35 (1), (2) and (3) to create a system that is 'fit for purpose'. HBF too said that a referral to the NRM should trigger immediate release from detention, since it was only made when there are indicators of trafficking.

Hibiscus Initiatives

A6.24 In contrast to most of those submitting evidence, Hibiscus Initiatives commented that:

> "A year after your original report we have seen a reduction in the numbers of vulnerable people whom we come into contact with in detention, however for those who remain detained, we would welcome an increase in support."

A6.25 Hibiscus recommended a review of safeguarding procedures and processes for victims of gender based violence, women with children, those who experience repeated detention and those with learning difficulties, and a review of the Home Office internet access policy.

Immigration Law Practitioners Association

A6.26 The Immigration Law Practitioners Association (ILPA) argued that

> "… the AAR framework is fundamentally flawed, does not meet the objective of building upon improving the previous policy framework and does not significantly reduce the risk of further breaches of Article 3 ECHR."

A6.27 Noting that the Home Office is required to review and re-issue the AAR guidance in response to the Medical Justice judgment, ILPA said the opportunity should be taken to return to a version of the former policy "with categories presumed to be particularly vulnerable to harm in detention, with an effective catch-all covering those identified as otherwise particularly vulnerable to harm in detention". ILPA said that the AAR evidence levels should be dispensed with, "save that a self-declaration should trigger further investigation into the claimed vulnerability", and called for restoration of the threshold of "very exceptional circumstances" to justify the detention of this identified as particularly vulnerable to harm in detention.

A6.28 ILPA called for a redrafting or replacement of rule 35. They said that lesbian, bisexual and gay detainees were particularly vulnerable to harm in immigration detention, and should be recognised as an at risk category. In respect of staff culture, ILPA said that my review should look at broader issues that contribute to the abuse of detainees, "including whether Government arrangements for contracting incentivise poor practice, and whether other aspects of Government policy or practice contribute to a discourse that demonises migrants, including through the 'hostile environment policy'."

Jesuit Refugee Service UK

A6.29 The Jesuit Refugee Service said that the misuse of detention could not be curtailed "unless indefinite detention in ended, and alternatives to detention are urgently sought".

Liberty

A6.30 Liberty also focussed on a time limit for detention. They called for the Adults at Risk guidance to be reformulated: "As a bare minimum of protection the new policy should: (i) incorporates a lawful definition of torture, (ii) reincorporate the 'very exceptional circumstances' threshold for detaining those falling within categories of risk, or those who display vulnerabilities not included within a recognised category, and (iii) abandon the counter-productive 'evidence level' model."

A6.31 Liberty also suggested that the Detention Gatekeeper should have:

> "(i) the independence and authority to make decisions, (ii) access to all relevant information, and (iii) takes representations from the individual and their representative. An administrative check will, however, never be a proper substitute for meaningful judicial oversight."

Medact

A6.32 Medact, an organisation of doctors, nurses and other clinical professionals, submitted an evidence paper, supplementary statistical information, and additional representations relating to Brook House. In summary they felt that

> "The available evidence shows that the objectives of significantly reducing the number of vulnerable individuals detained and the duration of their detention have not been achieved by the changes to policy and practice introduced since [my first review]; in some respects these changes have actively impeded progress. A major factor in this failure (to date) is the lack of quality improvement processes based on competent audit and feedback to the key actors – UK Visas and Immigration (UKVI) decision makers and Immigration Removal Centre (IRC) healthcare staff."

A6.33 Medact recommended the introduction and publication of cyclical audits, overseen by HM Chief Inspector of Prisons, the Care Quality Commission, and the Independent Chief Inspector of Borders and Immigration, and carried out (at least initially) by independent clinicians with the requisite expertise reporting to them: "These audits should seek to identify cases of vulnerability and harm, to understand the mechanisms through which they have occurred, and lead to practical and demonstrably effective means of harm reduction."

A6.34 Medact criticised the Rule 35 process, but said that – as per my first report – it should be re-drafted rather than done away with.

Medical Justice

A6.35 Medical Justice suggested that the Home Office's reforms "seem to have led to more vulnerable people being detained for longer in contradiction to the stated intention of the Government". They called for reinstatement of a category-based approach to identifying vulnerability: "In addition, there should be an effective catch-all category which captures those who are particularly vulnerable to harm in detention but who do not fall within one of the pre-set categories."

A6.36 Amongst other things, Medical Justice looked to the period beyond my completion of this follow-up review:

> "Ensure that there are robust independent monitoring mechanisms in place to ensure that the operation of policies achieves their stated aim and to avoid unintended consequences. To move towards a culture of transparency and openness around Home Office processes where independent oversight is welcomed, external input recognised as a valuable opportunity to improve processes and safeguard the wellbeing of vulnerable people in immigration detention. This must include a commitment to future reviews of the impact of detention policy beyond this current review."

Mind

A6.37 Mind referred to three documents: (i) *Improving Mental Health Services in Immigration Detention: An Action Plan*; (ii) *Immigration Act 2016: Guidance on adults at risk in immigration detention*; and (iii) *NHS England Service Specification: Immigration Removal Centre Mental Health Services*. In summary, they had concerns about Adults at Risk and said they were disappointed with the Government's overall plan.

The Royal College of Midwives

A6.38 The Royal College of Midwives submitted representations on the detention of pregnant women. They still sought an absolute exclusion of pregnant women from detention, and questioned some aspects of the Detention Services Order – Care and management of pregnant women in detention.

Royal College of Psychiatrists

A6.39 The Royal College of Psychiatrists welcomed the recognition by the Home Office of the particular vulnerability to detention of people with mental disorders:

> "We are, however, concerned at the process whereby 'levels' of risk are identified and by the lack of transparency as to how 'immigration factors' are weighed up against such risk. Level of evidence does not equate to level of risk/vulnerability. People with significant mental illness may have particular difficulty in being effective self-advocates. Their very vulnerability may prevent them from providing adequate evidence for that vulnerability."

> "Recent experience suggests that persons with significant mental illness as well as those with evidence of past torture, sexual or gender-based violence and those with PTSD remain detained despite their mental health-related vulnerability and that their mental health deteriorates in detention."

> "We strongly support the principle, as accepted in the recently published Service Specification for Immigration Removal Centre Mental Health Services, that the standard of health care provision should be same for detainees as is found in other NHS settings".

A6.40 The Royal College said that the new mental health service specifications for IRCs provided for better treatment facilities, although this has not yet been implemented uniformly. However, even with improved mental health support available, detention centres were not appropriate therapeutic environments to promote recovery from mental ill health:

> "We would like to emphasise that the current ethos of mental health services is on recovery and community rehabilitation, and this cannot be provided in a detention centre.

> "It remains of great concern that there are repeated cases where asylum seekers are detained despite a clear and documented history of mental illness and against the specific advice of mental health professionals.

> "It is therefore crucial that clinical and other staff working in detention centres are given adequate training and support to identify mental disorder when it does arise or deteriorate in a detention centre setting, and clear guidelines on how to manage this appropriately, this should include specific attention to appropriate monitoring and management of risk. The provision of care in IRCs should link with existing local mental health provision outside the detention centre, with clear protocols for communication of clinical information and transfer of care if required.

> "There should be regular training for all Home Office and healthcare staff on the circumstances in which capacity assessments should be triggered; this should be linked to safeguarding training along with the development of a screening tool for assessment of capacity for all detainees."

UK Lesbian and Gay Immigration Group (UKLGIG)

A6.41 UKLGIG said that all LGBTQI+ people should be recognised as a vulnerable population in the context of immigration detention. The government should end the detention of all LGBTQI+ people, and in particular LGBTQI+ asylum seekers. Furthermore, Home Office documents should refer to "trans" detainees rather than "transsexual".[120]

United Nations High Commission for Refugees (UNHCR)

A6.42 A6.42 UNHCR submitted a paper with a number of recommendations as follows:

- UNHCR recommends that any process or policy concerning the Gatekeeper process be published. Where the same are under-development, UNHCR would suggest that some consultation take place with external stakeholders to ensure that the Home Office is able to benefit from their experience and expertise in the design of the Gatekeeper process. Additionally, if the abovementioned concerns are accurate, UNHCR would suggest that they be addressed by the Home Office to ensure more holistic consideration of evidence, including from the person being considered for detention, and more prominent consideration/weight given to ATDs.
- UNHCR recommends that any process or policy concerning the Gatekeeper process be published. Where the same are under-development, UNHCR would suggest that some consultation take place with external stakeholders to ensure that the Home Office is able to benefit from their experience and expertise in the design of the Gatekeeper process. Additionally, if the abovementioned concerns are accurate, UNHCR would suggest that they be addressed by the Home Office to ensure more holistic consideration of evidence, including from the person being considered for detention, and more prominent consideration/weight given to ATDs.
- UNHCR recommends that in determining the required steps for assessing whether or not an individual is suitable for release to an ATD, the Home Office should require that all relevant and up-to-date information is submitted to the CPP. This should include the building in of a mechanism to allow the detainee an opportunity to submit further evidence so as to ensure that the CPP have all the necessary and available information upon which to make their recommendations and decisions.
- UNHCR recommends that the Second Review explore these issue and provide additional guidance to the Government on reforming the Adults at Risk policy so as to better identify at the earliest possible stage those people at risk by using tools such as the VST and reviewing the Rule 35 mechanism.
- UNHCR recommends that the Second Review consider carefully the merits of the VST methodology and, where appropriate, commend consideration of the tool to the Home Office to facilitate strengthening of its response to vulnerability.
- It is UNHCR's continued and strong recommendation that the UK changes this position to ensure compliance with international standards pertaining to detention, avoid harm associated with the lack of a time limit and ensure the humane treatment of those detained.

[120] See also *No Safe Refuge: Experiences of LGBT asylum seekers in detention*, UK Lesbian and Gay Immigration Group and Stonewall, 2016.

Women for Refugee Women

A6.43 Women for Refugee Women made submissions via their research report, entitled *We are still here*. The report contained the recommendations below:

- The government should work with the voluntary sector to develop and implement alternatives to detention, focussed on support and engagement.
- Implement a proactive screening process to ensure that survivors of sexual and gender-based violence, and others who are vulnerable, are being identified before detention.
- Implement the stated presumption against the detention of survivors of sexual and gender based violence, and other vulnerable people.
- Introduce an absolute exclusion on the detention of pregnant women.
- Introduce a 28-day time limit on detention.
- Stop detaining people while their asylum claims are in progress.
- Implement a monitoring framework and an accountability mechanism for detention reform.

NGO seminar summary 7 November 2017

A6.44 A6:44 In addition to inviting written submissions, I met with a group of NGO representatives at the Refugee Council offices in Stratford. The event was jointly chaired by myself and Rachel Robinson from Liberty, and had been organised by Ali McGinley from AVID, to whom I am greatly indebted.

A6.45 The list of attendees is shown below.

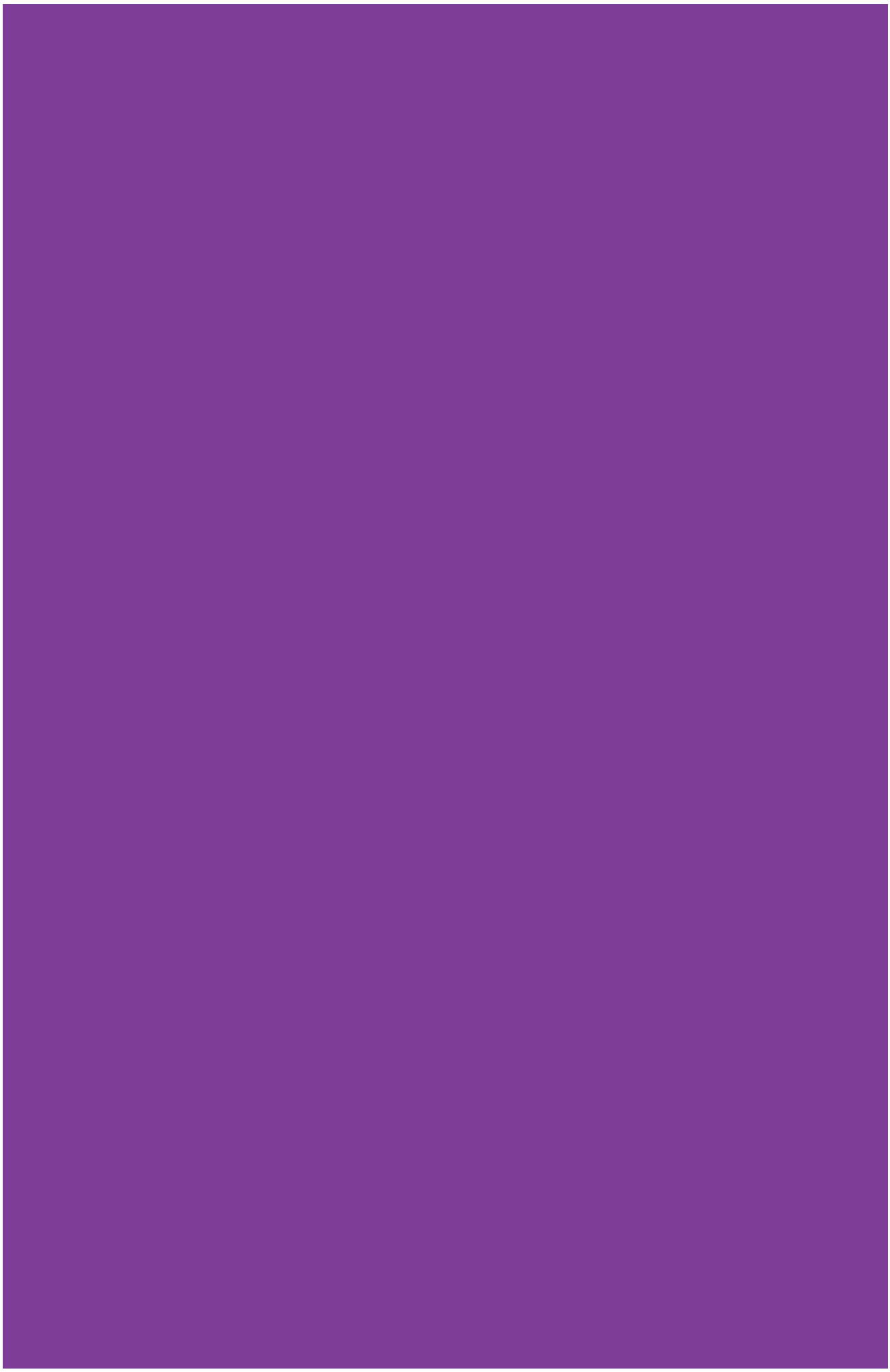
[redacted]	Shaw Review Team
	Amnesty International
	Liberty
	AVID (Association of Visitors to Immigration Detainees)
	BID (Bail for Immigration Detainees)
	Detention Action
	Doctors Without Borders
	Freedom From Torture
	Gatwick Detainees Welfare Group
	Helen Bamber Foundation
	Hibiscus Initiatives
	ILPA
	Liberty (note taker)
	Medical Justice
	Asylum Aid/Migrant Resource Centre
	British Red Cross
	Refugee Council
	UKLGIG (UK Lesbian and Gay Immigration Group)
	UNHCR
	Women for Refugee Women
	MEDACT

A6.46 The discussions focussed on my terms of reference and the areas I would be considering: implantation of the Adults at Risk policy; the use of alternatives to detention; the quality of casework including detention reviews; and the overall management of vulnerability in IRCs in terms of healthcare, suicide prevention and the detainee mix.

A6.47 There was broad agreement from the NGO representatives at the meeting on the following points:

- The Adults at Risk policy was not implementing my call for greater protection for those at risk, and in some areas, has resulted in a downgrading of protection mechanisms. There was a call for new guidance based on the presumption that vulnerable people should be routed away from detention into community based alternatives to reduce the use of detention. There should be a presumption of vulnerability, and those detaining should demonstrate the absence of vulnerability.
- For there to be confidence in the effectiveness in any new framework to protect vulnerable people, it was essential that meaningful data was provided so that monitoring and audit can be carried out. The Government should introduce a transparent, consistent monitoring process to assess the impact of any policy to protect vulnerable people, including the current AAR.
- Government should be encouraged to consider the use of alternatives to detention taking into account the need for greater community integration and involvement.

- I should consider recommending a time limit on immigration detention, in particular that the Government consider this for vulnerable groups.
- I should consider the need for ongoing scrutiny once the follow-up review had concluded.
- I should call for the Rule 35 process to be reformed including the appointment of an external clinically qualified expert for Rule 35.



Annex 7: Updated impressions of the immigration estate

A7.1 During the course of my first review, I visited every Immigration Removal Centre (IRC) and all other principal places of detention. During this review, I conducted follow-up visits across the immigration detention estate. Of the sites visited previously, Dover House IRC had closed (November 2015), Cedars Pre-Departure Accommodation had closed (December 2016), Pennine House Short-Term Holding Facility (STHF) had closed (March 2017) and its replacement was still to re-open, while The Verne IRC closed during the review period (December 2017).

A7.2 The purpose of these follow-up visits was threefold: a) to review progress on my previous suggestions for each establishment; b) to review how steps taken to implement my previous system-wide recommendations had landed operationally c) to investigate four of our deep-dive areas, namely healthcare, preventing suicide and self-harm, staff culture and casework.

A7.3 In order to fulfil these goals, my visits involved speaking to detainees, speaking to staff, speaking to management, speaking to Independent Monitoring Board members, touring facilities and observing operations. As before, these visits were not inspections. However, for each visit my colleagues and I drew up a tailored list of issues to cover. The learning from these visits informs this entire report; this Annex details my findings and organises it by institution. The general conclusions and specific recommendations stemming from these visits were highlighted in Part 2, and healthcare commentary was in Part 3.

Immigration Removal Centres

Brook House (visited 26 September 2017, 9 November 2017 and 31 January 2018)

A7.4 I visited Brook House before any other IRC, and conducted three visits in total. I had also received submissions from solicitors representing the detainees who were seen to have been abused in the Panorama programme (see paragraph A6.4). While I have not investigated these specific events, they have informed my review of staff culture across the immigration detention system (see Part 6). Brook House IRC is operated by G4S, as is its healthcare (commissioned by NHSE).

A7.5 At the time of my previous review, it was planned to introduce a third bunk in a number of the rooms at Brook House but I urged that this should not proceed. I was very disappointed, therefore, to see that it had indeed taken place in 60 of the 238 bedrooms.

A7.6 That decision has had further consequences. On 1 February 2018, the High Court ruled that conditions and aspects of the regime in Brook House contravened the European Convention on Human Rights and were discriminatory. The practice of locking detainees in small (4m x 3m) shared cells (each man had two others in their room[121]) with an open lavatory for 11 hours a day, and thereby forcing practising Muslim detainees to pray in these conditions, was found (i) to contravene detainees' right to worship under Article 9 of the European Convention on Human Rights read with Article 14 which is unlawful unless justified; and (ii) unless justified, constitutes unlawful to indirect discrimination against Muslim detainees contrary to section 19 of the Equality Act 2010. It was noted that Claimants found that the rooms were 'smelly and dirty' and 'disgusting', and distracted them from prayer. No justification had yet been shown by the Home Secretary. This judgment also found that, by allowing smoking in rooms indoors and any area which is enclosed or substantially enclosed at Brook House, the Home Secretary had acted unlawfully, and that the regulations permitting exemptions to the smoking ban in public places did not extend to privately run IRCs (though could be amended to do so if the Government wished).[122]

A7.7 The Brook House site is cramped for the number of men it holds, and it remains prison-like in both appearance and regime. During my first visit, I felt the fabric of rooms was shabby, although communal areas within units seemed relatively clean (I understand that all bedrooms were refurbished by December 2017). The men I spoke to were upset by the fact the conditions were so akin to prison.

A7.8 Rooms were essentially cells, with prison doors and – most notably – in-room toilets separated only by a curtain. This is not decent.

A7.9 Detainees used bags to prop open their doors, as they could not be opened from the inside once shut. (In December 2017, handles were fitted to the inside of the doors.)

A7.10 The prison-like appearance of the personal spaces was echoed in the unit's communal areas where there were double layers of netting between the landings to reduce the risk of suicide.

A7.11 Brook House had experienced a haemorrhage of staff (I was told this was ranging between eight and fifteen departures per month), an issue exacerbated by the *Panorama* broadcast. Staff reported that another contributing factor was the higher salary offered in prisons. At my second visit I was told that there was typically one manager covering two units, with three staff in each unit, although I heard from staff that they were used to working with two staff per unit, and indeed I saw this for myself. Management had dealt with the staff shortage in the short-term by cross-deploying from Tinsley House, and allowing staff to work rest days, both of which raise concerns given their potential impact on continuity of detainee-staff relationships and staff resilience. However, I learned that G4S is recruiting additional staff and aims to increase levels to one manager and three staff per unit (that is, a total of four per unit). I welcome this. DCOs to whom I spoke said that current staffing levels made them feel unsafe. Staff also noted that a lack of experience in the workforce made mentoring difficult. Given that G4S is a large organisation, it is arguable that it could be doing more to fully utilise its company-wide staffing resource in support of Brook House.

A7.12 The low staff numbers in Brook did not give the impression of control. One unit in particular was described as 'lumpy', and certainly a number of detainees were not happy with the presence of my team. I observed what appeared to be a drug deal taking place, and one man refused to go into his room for lock-up. At the time of my second visit, I was told that

[121] This applied in 60 of the 238 rooms.
[122] The Home Office has accepted the ruling and is putting in place measures to prohibit the practice of smoking inside immigration removal centres. In his ruling the case judge did not deem the practice of restricting detainees to their rooms as unjustified, and the impact of this regime is being assessed by the Home Office.

FNOs made up 37 per cent of the population,[123] but accounted for 50 per cent of violence in the centre. I was concerned that – given that current staff levels seemed to be struggling with the current level of disruption – an increase in the FNO proportion following The Verne's closure could cause further problems.

A7.13 Reception staff observed that while some privacy was provided by screens in the reception area, it can be noisy and hard to hear detainees when discussing personal matters. They noted that there are usually no more than two men in the area at one time, although two still seems too many given the importance of reception in identifying vulnerability. Reception staff had a good understanding of AAR, but found phone interpretation challenging, with examples given of background noise including children and a dog. Information leaflets were unavailable in some languages and were not available in easy read for those with learning disabilities.

A7.14 The rooms in the Care and Separation Unit (CSU) rooms were larger and cleaner than is often the case in IRCs and prisons; there were two beds in each room although – rightly – none of the second beds was used. The CSU had been painted. There were four CSU occupants during my visit. I observed exemplary handling by a manager during the morning review with each CSU occupant. Two of the men had been moved to the CSU as a result of a fight. A reconciliation was proposed, and the two men apologised to each other, shook hands and kissed cheeks.

A7.15 Less happily, I was told that only two-thirds of staff had received the new Rule 40 and Rule 42 DSO training, and I observed and that the staff member conducting the constant watch on Eden Wing was female, and did not have experience in the wing or in conducting constant observations.

A7.16 Eden Wing provides double-room accommodation for detainees with a blend of complex needs, with occupants during my visit including those with substance misuse issues, medical conditions, and those awaiting beds. As at my previous visit, I was unconvinced that these different uses were complementary, and I was struck by the lack of natural light. Those I met on the Eden Wing illustrate the vulnerabilities that were still present within the detainee population at the time of my review:

- One man had a back brace
- Mr A has been in the UK since age 11 when he arrived from Jamaica. He had been detained at Brook House previously when he had significant periods of food and fluid refusal, which he had recommenced. One of his legs was very thin and weak and his movement was restricted as a result. He had returned to Brook House ten days ahead of the planned charter, which had since been cancelled
- Mr B had already been detained at Brook House twice during 2017. He had undertaken a 33-day food refusal period and self harmed when the possibility of room sharing was raised. He had been moved from CSU to Eden Wing, but staff were now facing the challenge of how to move him into general association
- During my time in Eden Wing, a man was brought in who had been due to fly that day and had cut his trousers and his leg. I was told by healthcare he would still be fit to fly.

A7.17 Waiting space for welfare was limited and the waiting times were a source of frustration to detainees. While the library had a selection of 'Country of Origin' reports, more information should be available across the centre on going home. Healthcare told me that

[123] I understand that, more recently, the figure had been as high as 49 per cent.

they struggle to prepare detainees for care beyond the centre given the frequency of release with little or no notice, and given the challenge of providing for those released to no fixed abode.

A7.18 I was told about the cases of two detainees with severe mental health needs that demonstrated the impressive work of IRC staff when faced with challenging circumstances. They also illustrate the fact that IRCs and their staff are often forced to deal with people with needs beyond both their remit and expertise:

- Mr C was a Romanian trafficking victim and rough sleeper, who recently arrived at Brook House with symptoms of Huntingdon's disease, including repeated charging at the wall. He had to be restrained, and there were ten instances of use of force in one day and around 300 hours of constant watch. He was compliant and voluntarily went home with a medical escort
- Mr D had a large number of convictions including for violence against women and children, and firearms offences, and was aggressive and racist. He required 500-600 hours of constant watch. He is now sectioned.

A7.19 At the time of my visit, there were a number of wheelchair users detained at Brook House.

Campsfield House (visited 18 October 2017)

A7.20 Despite its generally favourable reputation, living conditions at Campsfield were poor. Originally opened as an IRC with 199 beds in 1993, by the time of my visit this had increased to 282. Only seven men could be accommodated in single rooms (and the difficulties ex-prisoners faced in transitioning from a single cell to a dormitory, that I noted in my first report, were still in evidence). The result was a degree of squalor.

A7.21 I was pleased to see that there had been improvements made to the CSU, including decorative touches, the conversion of one cell to a shower and the addition of a Playstation. However, the CSU's location in a separate hut beside bins remained bleak.

A7.22 Campsfield continues to operate one of the more open regimes in the immigration estate, although roll counts four times per day still seem to me excessive. While accommodation areas were locked overnight, rooms were not locked and detainees retained access to showers and toilets in their units. Lock-up did not take place until 23:00. The proportion of FNOs at Campsfield shows that it is possible to manage a diverse population within relatively open conditions.

A7.23 Campsfield's reception was unchanged since my original review; it was cramped and dirty, and offered little privacy or confidentiality. Arrivals and departures used the same small area causing congestion. I was therefore pleased to hear that management will soon be submitting plans for its refurbishment. The visitor centre was also small, allowing two sessions totalling seven hours per day.

A7.24 The IMB was concerned by the standard of activity provision, noting that the gym was not fit for purpose with limited equipment, while the pool room was too small for the population. The IMB also raised concerns regarding detainees' access to legal services in the centre, describing one of the three solicitor firms operating at the centre as 'hopeless'.[124]

[124] The Campsfield House IMB annual report is especially impressive. I understand that the Board's latest report (as yet unpublished) finds that "'cleaning work has also improved substantially, and this is apparent on a daily basis in the overall condition of the main blocks."

A7.25 While detainees could do paid jobs, in my detainee forum the £1 per hour pay was described as 'slave labour' – a sentiment echoed across the estate.[125]

A7.26 The library at Campsfield has been replaced by an IT suite, and most books replaced with Kindles. The suite was fully used and should perhaps be expanded to cater to the size of the population and the level of demand. Some legal texts were out-of-date, and indeed one I saw dated from 2005.

A7.27 I welcome the expansion of Campsfield's welfare function.

A7.28 I had previously observed that relationships between the IRC and local NGOs were poor and adversarial, and was pleased to note improvements.

A7.29 I was told that Campsfield had around 300 arrivals and departures in a month, and that those who leave split roughly 50:50 between transfers/returns and release. The average length of stay at Campsfield is 30 days. At the time of the visit, I was told that nine or ten men had been there for over six months, two of whom had been in residence for over a year.

A7.30 Notably this data is for time spent at Campsfield, rather than total time in detention. I would encourage all centres to track the total time during which detainees have been in detention.

A7.31 There were 28 detainees (ten per cent of the maximum capacity) classified as AAR Level 2 at the time of my visit. Some had been detained for significant periods, including a Sudanese man who had been at Campsfield since May 2017 (i.e. six months). As elsewhere, I was concerned by this number, and the fact that Home Office staff and custodial management alike had observed little change in the number of vulnerable people detained since my previous review. However, while management felt that initial detention decisions had not improved in terms of preventing vulnerable people coming into detention, they did feel that once vulnerability was identified there was now a clearer pathway to release. The IMB had concerns on the identification of minors.

A7.32 There were eight men on ACDTs, two of whom were on constant watch; this was considered unusually high. The standard of ACDT documents was good, and case reviews were multidisciplinary with Home Office and healthcare presence.

A7.33 Healthcare demand was high: a throughput of 100-120 patients per day.

A7.34 I spoke with a number of men both in a forum and informally as I toured the centre. With some exceptions, they were generally positive about staff. However, the anxieties about their status that I found amongst detainees across the estate were not mitigated by the fact that Campsfield is essentially a very decently-run institution.

Colnbrook (visited 26 October 2017)

A7.35 Colnbrook IRC is operated by Mitie with healthcare commissioned by NHS England and provided by Central and North West London NHS Foundation Trust (CNWL). Both custody and healthcare management teams operate across the two IRCs forming the Heathrow estate, and in the case of healthcare there is one workforce operating across both centres. The observations on Colnbrook in this section should be considered in tandem with my observations on Harmondsworth below, as many apply across the two sites.

[125] It is disappointing that, following a Home Office review triggered by Recommendation 31 of my first report, it has been decided that pay rates will be retained at their current rate.

A7.36 At the time of my previous review, my principal concern at Colnbrook was with the ground floor rooms of the male intake unit, which I recommended be decommissioned. On this return visit, I welcomed the fact that the former induction unit area had been converted to single-room occupancy three months before, and that the ground floor had been re-designed to allow free-flow access into the main centre without an escort. The induction function had now moved to a new area. Shared rooms had been maintained, on the acceptable rationale that if detainees initially move into a single induction room it may be hard for them to adapt to the double accommodation that makes up the bulk of Colnbrook's rooms.

A7.37 At my previous visit the assessment and integration unit had lacked a clear purpose. I was pleased that the unit had been abolished.

A7.38 Colnbrook has a female accommodation area – the Sahara unit – used for stays up to five days. It has a capacity of 27 but I understand that numbers rarely reach three-quarters of this level. During my previous visit I was concerned by the women's limited access to the outside, and was sorry to note that this was unchanged.

A7.39 I was pleased to be told that processes had improved to ensure that detainees are only in Sahara for the shortest possible period of time. Anyone detained there for four days or more is now discussed at management's daily morning meeting, and the on-site Home Office team now encourage DEPMU to arrange transfer to Yarl's Wood in case a removal fails.

A7.40 However, the status of the Sahara Unit needs clarifying. So far as I can see, it does not count as a short term holding facility, although that is its purpose. Such are the limitations on the facilities (albeit the shared space is nicely appointed) that no woman should be held there for more than a few days.

A7.41 I welcomed the improvement to facilities in a number of areas: the cultural kitchen had been renovated, showers were being refurbished, and new commercial washing machines (which had proved successful at Harmondsworth) would be arriving shortly. I was pleased to learn of plans to provide more privacy in the welfare area and hope this will be delivered promptly.

A7.42 Colnbrook's CSU has 16 rooms, but there were no detainees there at the time of my visit. Colnbrook has had problems with prolonged and inappropriate use of their CSU for detainees with severe mental health needs. In 2016, a man who was refusing to wash was held in Colnbrook's CSU for two months.

A7.43 The use of NPS was a serious problem at Colnbrook. A number of men had gone to hospital due to NPS days before my visit, and there had been instances of some people being used as guinea pigs to test batches.

A7.44 I was disappointed to understand that the blanket use of handcuffs ahead of escorts (e.g. to hospital appointments) criticised by the Inspectorate had continued.[126] This seemed to be more the result of contract penalties should anything go wrong than any individualised risk assessments. Penalty levels across contracts should be reviewed to address similar perverse consequences.

A7.45 Staffing levels were a critical issue in healthcare. Only one-third of mental health posts across Colnbrook and Harmondsworth were filled at the time of my visit, and primary care was heavily reliant on bank and locum staff with 50 per cent vacancies in permanent posts.

[126] *Report of an unannounced inspection of Colnbrook Immigration Removal Centre by HM Chief Inspector of Prisons, 29 Feb – 11 Mar 2016.*

A7.46 As elsewhere across the estate, I observed little information on going home.

A7.47 I attended the weekly Detainee Consultative Committee that was well run and was held jointly with Harmondsworth. However, I was surprised that no representative from DAC's onsite team attended (given that the team is responsible for many of the areas of detainee concern – from the Harmondsworth population in particular).

A7.48 I also attended the one example across the IRCs of a regular (weekly) multi-disciplinary meeting to discuss the most vulnerable cases, in which – crucially – caseworkers dialled in. The meeting covered both Colnbrook and Harmondsworth and was attended by on-site healthcare, on-site Home Office and on-site custody staff including management and the safer custody lead. At the beginning of each case discussion the caseworker was asked to update on progress, and they were always prepared. This was very good practice and should be replicated across the IRC estate.

A7.49 Examples of other cases discussed included:

- Mr E was a wheelchair user with sickle cell disease on ACDT and eating only intermittently. These characteristics were noted by different attendees (healthcare, custody management, custody safer detention) ensuring all were aware of the full picture of vulnerability. The caseworker was asked how close arrangements were to removal; it was noted there was an outstanding asylum claim and the caseworker was tasked to discover whether travel documents were a problem. Healthcare noted Mr E's complaint that he did not feel there were enough vegetables available (he was vegetarian), and custody staff were to pick-up on this concern.
- Mr F and Mr G had both had transfers to other IRCs set up (Mr F refused as solicitor was in the Colnbrook area). It became clear that no one but the caseworkers had been aware they were being moved, and that neither should have been asked to move for medical reasons (Mr G was already on medical hold and was under the care of local social services). The Home Office on-site team took away the action to ensure the move did not take place.
- Mr H was awaiting determination of his appeal. The safer custody lead noted his background of prior ACDTs and previous serious self harm. Mr H wished to go to Dungavel, but the move had been refused because of his history of domestic violence. It was noted that removal directions were likely to be a trigger for self-harm and that he would need a medical escort.
- Mr I's travel documents had stalled. Mr I was wheelchair bound, and his caseworker was trying to obtain a section 4 address for his release but there was a delay. The safer custody lead noted that recent advice was that Mr I just needed a ground floor flat – the caseworker took away an action to chase section 4 accommodation. One of my team asked whether a social care assessment had been completed – again the caseworker agreed to chase. The safer custody lead also noted that a secreted blade had been found in Mr I's mobile phone two weeks earlier, and that there would be a risk of self-harm if there was bad news.
- Mr J had been a candidate for a move to psychiatric hospital, although this was no longer necessary due to medication. The caseworker flagged that they would need consent and risk assessment information from healthcare to determine if Mr J needed medical escort. A psychiatrist had previously thought Mr J did not have capacity but healthcare staff were to discuss removal with Mr J the next week.
- Mr K was a paraplegic, wheelchair-bound, Criminal Casework detainee, who had had removal directions set but had refused to go. Contact was being made with the National Tactical Response Group to see whether force could be used. The

need for nine escorts and possible use of force raised the question of whether Mr K was removable.

- Mr L was hearing voices. The Rule 35 assessment from the psychiatrist to the caseowner had said detention was injurious to health but had not received a response. The caseowner was not on call in this case, illustrating how little can be progressed in their absence (and as is the case at all similar meetings across the estate).

Harmondsworth (visited 25 October 2017)

A7.50 At the time of my previous visit, Mitie had just taken over and it was not a very healthy institution. This return visit did not begin in auspicious circumstances; HM Inspectorate of Prisons had completed their inspection on 20 October, and a member of my team had kindly been allowed to attend the feedback session with management. Overall findings were poor,[127] with the following key conclusions:

- Progress had been slow and limited since the last inspection in September 2015, and in some areas highlighted by the Inspectorate the situation has worsened
- The Inspectorate saw safeguarding of vulnerable detainees as ineffective at Harmondsworth. There was a very high level of mental health need that healthcare in the centre was unable to meet. Rule 35 reports lacked rigour, and in nearly all cases examined detention was maintained by the Home Office although evidence of torture was accepted. There were delays in referring potential trafficking victims to the National Referral Mechanism. A high number of detainees felt unsafe
- Some detainees had been there for excessive periods; one man had been held for four-and-a-half years. Despite work in some units, accommodation remained below decent standards with issues around bed bugs, cleanliness and ventilation
- Detainees were subject to disproportionate security restrictions and were being routinely handcuffed for outside appointments without evidence of risk
- Activity provision was limited with only 29 per cent of detainees able to fill their time. The Inspectorate found staff/detainee relations to be worse than those at other IRCs. Concerns were expressed regarding staffing levels staff training.

A7.51 I found that the overall environment continued to closely resemble that of a category B prison. The razor wire was much in evidence, although patrol dogs were no longer used. There was very little outdoor space: only one courtyard has any greenery. More positively, I was pleased to note improvements to the centre that reflected comments made in my first report.

A7.52 Two of Harmondsworth's six accommodation units had been refurbished, and in these units the toilets and showers were separate to the rooms, with corridor access therefore allowed at night. Even here, however, rooms were for three or four people, and had very narrow beds. In much of the centre, accommodation was not of an acceptable standard. As at Brook House, toilets in most units were in shared rooms and separated only by a curtain. Shower cubicles led directly onto the main landing, lacking privacy. No windows in the centre could open, and the poor ventilation was epitomised by a room in one unit where detainees kept a fan on constantly, and in another unit where detainees told me they were always cold. I had safety concerns in some rooms. In a room equipped for a disabled detainee (who was indeed in residence), the mirror allowing staff to check on the resident's safety had been covered, and this had not been addressed.

[127] *Report of an unannounced inspection of Harmondsworth Immigration Removal Centre by HM Chief Inspector of Prisons, 2-20 Oct 2017.*

A7.53 While all accommodation units included IT rooms and TV rooms, these were not always in good repair. Equipment was broken in two of the internet rooms, and TV rooms were locked in several of the units at times when they should have been available for use. The association rooms in some units were entirely bare and therefore unused.

A7.54 Harmondsworth had had a problem with mice for some months. It also had a longstanding infestation of bed bugs. I was told that 300 beds were being removed and rooms stripped in a six-month programme.

A7.55 At the time of my visit, the Home Office was considering a plan to create six dedicated care suites centralised at Colnbrook to serve both Harmondsworth and Colnbrook. I was pleased to understand that management had visited Brook to see their model, and consulted other providers. Harmondsworth's CSU is used less frequently than that at Colnbrook, and there is less long-term use. There were two occupants during my visit. I observed the arrival of a detainee from Morton Hall who had made threats on the journey. This was handled calmly and proportionately by staff, who dealt sensitively with the property concern which had caused the man's unrest.

A7.56 Harmondsworth's reception area was the best I encountered in the estate: clean, with a large desk, a separate departure area, and room for individual searches and storage.

A7.57 Detainees usually left the induction accommodation within two weeks, although welfare conducts induction sessions daily. This accommodation was in single rooms and there was an active buddying system to help signpost the services available. However, each room was locked at night, with toilet facilities within each shared room and separated from the beds only with a curtain.

A7.58 On my visit I saw exceptional rapport between the welfare officer showing me around and the detainees. As noted above, equally very impressive was the Detainee Consultative Committee organised jointly with Colnbrook. The proceedings were comprehensively minuted, and an action log was kept and reported back upon.

A7.59 I was told the staff attrition rate was one per cent per month, i.e. four to five staff departures per month. Management has recently adjusted the shift pattern in response to staff demand to one of four days each of twelve hours. While assisting with staff consistency, I am concerned that shifts of this length do not assist staff to give of their best.

A7.60 As of 31 October 2017, 18 men had been at Harmondsworth for over six months, of whom four had been there for over twelve months. All these long-term cases were FNOs with pending legal challenges.

A7.61 A man had died in September 2017. The Inspectorate were to describe the quality of ACDTs as 'variable' during the October 2017 inspection.[128] In the ACDTs reviewed by my team, observations suggested a lack of staff understanding of the ACDT's purpose. However, management noted that self-harm had reduced and that fewer detainees were being sectioned; the local secure mental hospital had two beds ring-fenced for detainees, but they were currently unused – this had been unheard of previously.

A7.62 Harmondsworth was changing its education provision at the time of my visit. Language taught on its own had had poor uptake, so management was introducing short-term courses that prepared for removal or release, and were tied to paid work, and that could incorporate the learning of English. I welcome this approach and understand that attendance at the cleaning courses offered so far was encouraging, while the presence

[128] Ibid.

of tutors at inductions was also a good step. However, the centre was having issues with the recruitment of instructors, and external providers had experienced vetting issues. Unfortunately, there was also a waiting list for paid work opportunities. There were two IT rooms, one of which was for teaching and one for individual internet use; these appeared fully used. As at other IRCs, website blocking technology inappropriately prevented access to some sites, but I was pleased to see signs encouraging detainees to report such instances. I also welcome the improved fax machine provision in the welfare area. While the reliance of the immigration casework system on paper records has to change, in the interim detainees must have access to good fax facilities to communicate with their legal representatives in particular. Welfare was open daily, operated a buddy system and ran inductions. The induction software was available in thirteen languages and would be expanded, although the use of Google Translate in the welfare area itself did not seem ideal. This area was also used for the provision of services by Hibiscus and for daily immigration surgeries offered by the on-site Home Office team. I was told that increased involvement from DAC representatives at these surgeries would be valued given the high proportion on DAC detainees at Harmondsworth.

A7.63 There had been a reduction in violence at Harmondsworth since the previous year. Home Office management had tried to source more comprehensive de-escalation training but an external provider proved too expensive. I was encouraged to hear that the existing on-site Home Office team felt there might be more scope for oversight of use of force once the Pre-Departure Teams come into the centre. Custodial staff used body-worn cameras; the Home Office funded these, and Mitie had asked for more. Healthcare staff did not wear body cameras, nor did Home Office staff. It was suggested to me that a DSO may be required to clarify whether cameras should be on all the time, where information is stored and for how long. Staff found the link between Harmondsworth and Colnbrook helpful for managing behaviour, allowing detainees to be moved between sites where issues occurred.

Dungavel House (visited 23 November 2017)

A7.64 In my previous review I noted that: "if Dungavel is to have a long-term future within the immigration estate, the living accommodation should be refurbished to more acceptable standards, with particular attention paid to the sleeping arrangements in the women's dormitories". While little had yet changed in terms of the standard of accommodation on offer at Dungavel, I was impressed by plans for substantial building work and refurbishment. These plans have been approved, and reflected in large part what I said in my first review. Crucially, the women's accommodation will be relocated and redesigned, moving from dormitories to single rooms.

A7.65 At the time of my visit there were eight women detained. While men and women's accommodation were separate, women were allowed to mix with men in communal areas if they chose to do so. Women were able to access all services outside the times that men used them, but it was unclear how this worked in practice. I am concerned that there is risk of exploitation, or of vulnerable women being left without access to services and facilities, due to their shared use by men. The general accommodation for men was of a good standard with two detainees in each room and – critically – a separate toilet. The induction dormitory, however, was crowded and basic with eight to ten bunks.

A7.66 The GEO Group's contract had been extended and now runs until 2019 for the current capacity of 249 detainees. The contract had previously had a one-year extension, during which time there was a lack of investment and a lack of clarity for staff, exacerbated by the announcement (September 2016) and reversal (February 2017) of plans to close the centre. Although there were only three uniformed staff vacancies at the time of my visit, there had been turnover and a loss of expertise due to the uncertainty. Both the IMB and

a representation I received from the union, Community, suggested that the centre was understaffed. Despite this, it was at Dungavel that I heard the most consistently positive comments from detainees about staff throughout the entire estate. I was told that, in general, staff tended to remain at the centre long-term given a challenging local jobs market. Notably, Dungavel operated a staffing model of constant cross-centre patrols, rather than assigning staff to individual units. This mirrors detainee movements in what is an open regime.

A7.67 Dungavel's secure unit was bleak and excessively bare; I understood that three different contractors have applied for funding to refurbish this area but failed. The Rule 42 accommodation in particular had nothing but a slightly raised platform on the floor to suffice as a bed. I welcome its move as part of the imminent refurbishment, and the creation of care suites. The current secure unit had last been occupied two weeks previous to my visit by a man with mental health problems while there was a wait for him to be sectioned. I was told this was not unusual; it does not make it remotely acceptable. The secure unit was wholly unsuitable for those suffering from mental health conditions.

A7.68 Dungavel's arrival area was small, with wooden benches only and limited privacy. I am pleased that the building works should resolve this. As at all other IRCs, arrivals and departures take place during the night. Staff and managers were frustrated by what they believed to be unnecessary moves around the estate, particularly those transferred for embassy interviews, when the embassy official could travel to Dungavel.

A7.69 There was a poster promoting voluntary departure in the visits room, but I saw little else focussed on preparing detainees for return. However, as elsewhere, I encountered the excellent work of Hibiscus Initiatives. I note that this is part-funded by the EU Asylum, Migration and Integration Fund, and strongly urge that domestic resources are found so that it continues post-Brexit.

A7.70 Managers did not believe there had been any reduction in the number of vulnerable people; while AAR was a helpful tool for identifying vulnerability, there needed to be a robust system for identification of vulnerability pre-detention. Healthcare staff also felt that AAR had not reduced the number of vulnerable patients, and that in fact complex presentations had risen. At the time of my visit there were three people at AAR Level 3 at Dungavel, all of whom had mental health problems. While there were ad hoc multidisciplinary meetings for more complex cases as well as ACDT reviews, there was no systematic meeting of any sort looking at all vulnerable cases regularly. I was concerned to learn that caseworkers sometimes requested assessments by staff after the detainee arrived, rather than gauging vulnerability ahead of the decision to detain.

A7.71 ACDTs were generally of good quality at Dungavel. There was an unusual system of monitoring to reflect the staffing model, but it appeared to work. A single member of staff was responsible for any open ACDT, but the documents themselves were left in an office to allow access to any cross-centre patrol. Most reviews were multi-disciplinary and showed good observations and interaction. There were two constant watches at the time of my visit; one was taking place in a dormitory with no privacy.

A7.72 Dungavel's IMB has been through a period of upheaval in recent years, and I was pleased there were now some new board members. I hope that this will allow the board to function as it should going forward; in particular, an annual report of substance must be produced.

Morton Hall (visited 17 November 2017 and 9 January 2018)

A7.73 Morton Hall is now the only IRC operated by HMPPS, with healthcare commissioned by NHS England and provided by Nottinghamshire NHS Foundation Trust. At the time of my initial visit the centre had 381 detainees.

A7.74 Morton Hall has a very long perimeter enclosing a footprint at least twelve times the size of Brook House. Its facilities are spread across different buildings in grounds that I found to be tidy, and which allow detainees far more access to the fresh air. However, there is much use of razor wire (including in some trees to prevent climbing).

A7.75 The general accommodation is composed of single rooms which were basic but of an acceptable standard. The regime at Morton Hall also felt less prison-like than at other IRCs. There was flexibility around daily schedules, whereby a detainee could wait for a later lunch slot in order to go at the same time as friends. Detainees were locked in from 20:45-07:30 with a roll check at 11:45 lasting around twenty minutes.

A7.76 I conducted two visits to Morton Hall: the first with my full team and a second follow-up visit to observe any impact following the closure of The Verne. At my initial visit, I was told by management and staff that there had been a marked increase in challenging behaviour over the preceding one to two years. I also received a representation from a current detainee expressing serious concerns about levels of violence and self-harm in the centre. I understood that violence was predominantly between detainees and drug or debt related, and that staff faced daily verbal abuse.[129] The long perimeter of the site makes Morton Hall particularly vulnerable to items being thrown over the fence[130], and drugs and NPS seemed to be driving many of the behavioural problems. NPS had also increased pressure on healthcare.

A7.77 On my return visit following The Verne's closure, the proportion of the population who were FNOs had risen to 58 per cent from 45 per cent shortly before my initial visit. However, while behavioural challenges seemed to have continued, they had not worsened. I was told in healthcare, however, that levels of anxiety were increasing among those with no prior experience of detention or imprisonment.

A7.78 On the day of my initial visit, twelve men were scheduled to transfer to Dungavel and five were scheduled to arrive from Dungavel. Many of Morton Hall's moves continued to take place between 22:00-04:00. Morton Hall's reception was spacious, although the environment was rather shabby and I was pleased to learn of plans, subject to funding, for it to be refurbished. Reception staff had a good understanding of AAR and thought it a useful framework. Unusually, iPads were sometimes used as a supplement to the Big Word service for translation, and occasionally peers were used to translate where the information required was not medical in confidence or sensitive. The healthcare reception assessment room was suitable if small, and all men were able to see a GP within four to five days with nurse triage available immediately if needed. (In line with the Detention Centre Rules, detainees can see a doctor within 24 hours of reception if they ask to do so.)

[129] As in prisons, there is sometimes a false understanding that the criminal justice authorities are loath to pursue crimes committed in IRCs: "The CPS is aware that Immigration Removal Centre (IRC) management do not report certain crimes to police for investigation because they take the view that the police or CPS will not consider a prosecution. There is a belief that such a decision would be made on public interest considerations and the fact that any prosecution could potentially delay a detainee's removal from the UK. This has led to some inconsistency in reporting … This is not in fact an accurate reflection of the CPS stance in such cases. The CPS starting point is that offences in an IRC are … serious." (Greg McGill, Director of Legal Services, CPS, in *Independent Monitor*, September 2017.)

[130] At the end of October, the establishment had successfully intercepted a huge package of cannabis, spice, and mobile phones that had come over the perimeter fence. Some might think it rather odd that the centre manager does not personally have the authority to ban visitors believed to be involved in smuggling items into the centre.

A7.79 Morton Hall's education provision was the best I came across on my visits. Courses focussed on skills that could be used outside the centre, and provided training in a modular format. The sports facilities and gym were also very good. The peer supporter scheme was impressive and I was pleased to see a board with information for detainees about going home. I was told that Morton Hall was a developing a welfare appointment system to replace its drop-in service to address waiting times. It seemed to me that a combination of drop-in and appointments would be optimal.

A7.80 Shortly after my initial visit to Morton Hall, a man had died at the centre. In the month prior to my visit there had been nine acts of self-harm with two men requiring transfer to hospital. At the time of that first visit there were twelve open ACDTs which was considered quite high; I was told levels were normally about half of this. ACDTs reviewed by my team were generally to a satisfactory. ACDT review meetings were not always multi-disciplinary, with the sheer size of the site making this difficult. I was alarmed to learn that one man had been on constant watch on-and-off for four months, as his bail address kept being deemed unsuitable.

A7.81 Morton Hall held a weekly multi-disciplinary safer detention meeting to review complex cases. While there was good attendance from across the IRC including healthcare, on-site Home Office staff, welfare, security, activities manager and the residential supervisor, caseworkers were not dialled-in (unlike at Colnbrook and Harmondsworth). In addition to the participation of caseworkers, such meetings could be improved with more background on why each individual discussed is at a given AAR level, and the overall number of detainees at each AAR level. At the time of my first visit there were over 70 men classified as AAR Level 2, although there was only scope to discuss the twenty most vulnerable detainees at the meeting.

A7.82 Morton Hall had conducted nineteen Rule 35 assessments in October. In the past, these had been completed by other healthcare staff, and reviewed and signed off by a GP. However, they were now completed by GPs only. As elsewhere Rule 35s affect GP clinic time, and staff reported breakdowns in therapeutic relationships where the reports had not resulted in release.

A7.83 The IMB noted that their allocation for visits of around 200 days per year (plus a little extra for new members) was below the level for prisons, and did not cover CSU visits within 24 hours. The key areas of detainee complaints highlighted by the IMB included those that were deportation related, those concerning solicitors, and those concerning healthcare, particularly where detainees had not received the same medication as at previous establishments.

A7.84 The key concerns of the men I spoke with included searches, length of detention and the whole immigration process. As in many of the other IRCs, I encountered anxiety on the part of those without a criminal background because of what they found to be an intimidating atmosphere. As was the case at The Verne during my first review, there were some men at Morton Hall who would not have been allocated to such an open establishment when it operated as a prison.

Tinsley House (visited 8 November 2017)

A7.85 Tinsley House is run by G4S and at the time of my visit there were 147 detainees. I was told that the average length of stay was low compared to other centres.

A7.86 The general accommodation was a little cramped with rooms with either four or six beds. However, if a vulnerable person required a single room this was accommodated, and healthcare felt custodial staff did listen to their suggestions on room allocations. Furthermore,

the rooms were larger than those at Brook House, and all toilets were in separate rooms accessed from the corridor. As a result, while units were locked at night, individual rooms were not. The lock-up was now between 21:00-08:00 having previously begun at 23:00; this earlier lock-up was disappointing. There remained issues with men being woken up in the night as reflected in complaints made to the IMB. The corridors in the residential unit were very warm and stuffy.

A7.87 Reception was welcoming, and benefited from relatively low throughput in comparison to other centres. I was pleased by Tinsley House's system whereby detainees waited in a waiting room and only one man entered reception itself at a time, ensuring privacy. Although I recognise this would be challenging in centres with higher throughput, given the importance of detainees sharing potentially sensitive personal information relating to vulnerability, it is something that other centres should investigate. Reception staff were aware of AAR and how they would escalate new vulnerability concerns. They felt that more men were mentioning torture on arrival and that they receive detainees unsuitable for the centre, e.g. those dependent on heroin or a threat to women and children. Tinsley continued to have problems with late arrivals at reception, although charter flights no longer included detainees from Tinsley.

A7.88 There was one man on an ACDT and seven men on Tinsley House's Supported Living Plan (SLP) – the same care document used at Brook House, and broadly equivalent to the Vulnerable Adult Care Plan now being piloted by the Home Office. SLPs were used for all men with a long-term or uncontrolled condition, and were held by either healthcare or uniformed staff depending on the nature of the individual's needs. I reviewed six SLPs; all appeared to be of good quality with meaningful interactions recorded. However, as at Brook House and at other IRCs with their own care plan systems, I was concerned by the risk of overlap or gaps between ACDTs and SLPs. The ACDTs I reviewed were also generally well completed, showing evidence of multi-disciplinary reviews in most cases, good observations and interaction, and appropriate closure. Healthcare staff stated that the reviews were arranged around their commitments to allow them to attend – in some contrast to the message I received elsewhere, where healthcare staff were often unable to attend due to short notice. However, the ACDT caremaps were sparse with no timescales.

A7.89 While there was a weekly AAR review of Level 3 cases with centre and Home Office staff, multi-disciplinary meetings with caseworker involvement were only held on an *ad hoc* basis. This was consistent with the observation of healthcare staff that individuals with complex medical needs were still being detained, including some at AAR Level 3. Management felt that action was not taken sufficiently quickly in response to Part C information (the risk assessment section of the IS91).

A7.90 Following the Brook House *Panorama* programme, Tinsley House IMB had put its practices under review. With five new members, I was told that the board was looking to increase its visibility with detainees, to ensure they were not seen as part of management, and to be more systematic about what they looked at. I was encouraged by this approach, and the fact that board members would also now be giving talks to all new officers. The on-site Home Office team was also undertaking a staff culture diagnosis following the programme, looking at wider efforts to ensure good culture such as recruitment and training, as well as improving the Home Office's auditing in this area.

A7.91 I felt that there was a good spread of activities relative to the size of the population, including education, gym, access to library and IT.

A7.92 In my previous review, I recommended that the Home Office draw up plans either to close the Cedars Pre-Departure Accommodation (PDA) or find for it an alternative use. Cedars was closed in December 2016 and Pre-Departure Accommodation for families was opened at Tinsley House instead. Families can be held in immigration detention at Tinsley House for up to 72 hours, unless there is Ministerial authorisation to extend to up to seven days. From its opening in late June 2017 until November, it had accommodated seven families, two of whom had been returned.

A7.93 The Tinsley House Pre-Departure Accommodation is inescapably part of the IRC, but I felt that efforts had been made to maximise the differences, albeit some physical aspects of the IRC remain in view and mainstream detainees can be heard from the PDA's garden. The reception area, rooms and facilities were very well thought through, and staff took great pride in making the environment as comfortable as possible. Decoration was cheerful; families could choose to cook for themselves or to have meals made for them; staff uniform was un-branded; beds had proper mattresses and bedding. Toys were swapped ahead of a family's arrival to ensure they were age-appropriate, and educational sessions could be provided on request. However, I felt that, as in STHFs, there needed to be greater provision for older children. Welfare support had transferred from Barnardos to Hibiscus, and Hibiscus's immigration expertise had had positive results. I was pleased to learn that staff in the Pre-Departure Accommodation receive five days' notice of a family's arrival, allowing for planning.

A7.94 The average cost per detainee in the Pre-Departure Accommodation at Tinsley House will be significantly less than at Cedars, particularly as staff are able to work in Tinsley House when the PDA is not in use. And the facilities are no longer so ludicrously disproportionate to their usage or need as was the case with Cedars. However, given the small number of families who use the PDA, and the poor results so far in terms of successful removals, it remains open to question whether any PDA represents a reasonable use of taxpayer funds.

Yarl's Wood (visited 13 October 2017)

A7.95 Yarl's Wood IRC is operated by Serco, with healthcare commissioned by NHS England and provided by G4S. At the time of my last review, mistreatment of detainees at Yarl's Wood had been exposed in an undercover documentary, Serco had commissioned an external enquiry focusing on staff culture at the centre[131], and the Prisons Inspectorate had been highly critical in a report arguing that "Yarl's Wood is failing to meet the needs of the most vulnerable women".[132]

A7.96 In June 2017, the Chief Inspector of Prisons returned to Yarl's Wood, finding that:

> "... there had been significant improvements at the centre, and on this occasion assessments in three of our inspection areas were higher than in 2015. The most noticeable change, in broad terms, was that whereas in 2015 there had been large numbers of detainees showing evident signs of distress, on this occasion the atmosphere across the centre was far calmer, respectful and relaxed."[133]

A7.97 However, the Inspectorate did find weaknesses, particularly in NHS-commissioned healthcare, in welfare provision, and in Home Office casework, noting the high proportion of women detainees who were released. Their detailed observations were consistent with my

[131] See footnote 100 for details.
[132] *Report of an unannounced inspection of Yarl's Wood Immigration Removal Centre by HM Chief Inspector of Prisons, 13 April–1 May 2015.*
[133] *Report of an unannounced inspection of Yarl's Wood Immigration Removal Centre by HM Chief Inspector of Prisons, 5–7, 12–16 June 2017.*

own general impression. On my visit I also felt that centre seemed much improved, crucially in having established a more open, relaxed culture. However, the immense clinical needs continued, and there were some women who had been detained for a long time.

A7.98 I welcomed the fact that Yarl's Wood had dropped all non-risk based searches. However, I was disappointed to discover that the staffing mix was still not at the 60 per cent female targeted by Serco for the end of 2015.[134] There had been an increase in managers and officers since my previous review, but unit staff observed that there was often one of them covering one unit or more, which they felt was inadequate and made them feel unsafe, particularly at night.

A7.99 I was told of a number of initiatives since my last visit to improve internal processes and assurance regarding staff culture:

- Ethics training for staff
- Whistle-blowing initiatives including 'talk to Steve', an anonymous programme on the intranet in which staff could report concerns to the centre manager
- A pay rise had helped reduce staff attrition significantly
- Opening up of the regime allowing detainees free movement around the centre.

A7.100 I met with the IMB which was a little below complement, as it has been for many years. The IMB representative felt the centre was as good as it had been in their seven-year experience, although raising concerns including rule 35s, the number of detainees needing to be sectioned, failed removal rates and the quality of legal advice.[135] The IMB member observed that – as I heard across the estate – the detainee population had changed with increased numbers of eastern Europeans.

A7.101 The overall environment remained cramped and claustrophobic, with poor ventilation resulting in unpleasant smells. In the Hummingbird (family) unit, the rooms were hot and bedding was very basic. One detainee had an extremely hard pillow – apparently from the segregation unit – which they should not have had to use. The unit walls across the centre were decorated with colourful information and art. I met two detainees who had been in the centre for over three months. Their beds were very small and the mattresses were thin. They noted that the centre was very hot at night and neither slept well. Their rooms were airless which was not helped by the fact that they had blocked the air vents due to the noise and smoke that travelled through the system.[136]

A7.102 The supported living area (Nightingale Unit) was used for those who were waiting to be sectioned, for those who were waiting for removal directions to be actioned but required additional support, for those with Learning Disabilities and for families (with grown-up children) who needed to be together. The unit was nicely decorated and looked in good condition. There was an outside area with a metal picnic table and some bushes, although the high fences made the area far less pleasant.

A7.103 All detainees who were recognised as Adults at Risk, were on ACDT, were transgender or were otherwise deemed high risk, were reviewed weekly at a multi-disciplinary meeting, although individual Home Office caseworkers were not involved. A member of my team attended one of these meetings, at which there were 54 cases eligible for consideration out of a population of 330. She felt that more could be done in discussion to drive towards return or release of the detainee.

[134] But see footnote 26 for the much more encouraging figures for female staff on the women's residential units.
[135] In many of the IRCs, detainees themselves criticised the quality of legal advice they received, and the fees they or their family incurred.
[136] Yarl's Wood has subsequently introduced a non-smoking policy.

A7.104 At the time of my visit there were four open ACDTs, with no constant watches. Eighteen ACDTs were opened during the previous month, during which time there had been one self-harm incident. I was surprised, but pleased, to hear that most ACDTs were initiated through self-reporting on reception. Management flagged that one woman had arrived three weeks before and was still on an ACDT with four observations per shift. My team reviewed ACDT documentation and found that ACDTs at Yarl's Wood were generally completed to a satisfactory standard. Review meetings were not always multi-disciplinary.

A7.105 Hibiscus had been in Yarl's Wood for a significant period and, as elsewhere in the estate, they did valuable work preparing detainees for removal by drawing on the charity's links in the detainees' countries of return.

A7.106 I held a forum with detainees which was very well attended, with over 50 women and four men present. Key points raised included the high level of healthcare need; concerns on quality of healthcare (though some positive examples also); sums paid for legal representation; concerns about the standard of food provided; limited communication from caseworkers; one complaint on staff behaviour and one case of a detainee who had arrived in the UK as a young child.

A7.107 Yarl's Wood continued to have many people arriving at night: I was told that 16:00-17:00 and 00:00-01:00 were the busiest times in reception. This had been a concern during my previous review, and a colleague had spent a night observing Yarl's Wood's reception. A team member repeated that exercise during this review, and their findings are detailed below.

Overnight in Yarl's Wood reception, 21:15-03:45, 4 December 2017

I was told by an officer that they felt there were more moves in the night time than in the day, and that recently on one night there had been 24 arrivals. On the night I observed, three women arrived in the evening but were taken to their rooms at night, while three women arrived during the night and three women left during the night.

My overnight visit was to Yarl's Wood's reception area for women and adult families; the reception area for their Bunting unit, which accommodates men for short-term stays, was separate. Three women had arrived at Yarl's Wood at 19:00 on a Tascor escort. At least one of them – and likely all of them – had had to wait in a van for at least 30 minutes before entering reception. Upon my arrival at 21:15, one of these women had been to healthcare and was at reception, while the remaining two women were still to go through reception and healthcare. Two of these women were ultimately taken to their rooms at 22:37 (3 hours and 37 minutes following their arrival), and one of these women was taken to her room at 22:55 (3 hours and 55 minutes following her arrival). Two women arrived at Yarl's Wood at 00:27, and the first waited until 01:18 to be seen by G4S healthcare despite acute need flagged in advance. The final woman arrived at 02:23 and I was shocked to hear that she had departed Yarl's Wood at 04:52 that morning. She was ready to go to room at 03:00, 25 hours after she had had to get up that day.

Two Tascor escorts arrived to collect three women at 02:20. They were brought down at 01:50 and departed at 03:00, with all three detainees in good spirits. They had been scheduled to collect at 01:30. I was surprised to learn that this pick-up time was for the following flights: two women were flying on an 11:10 flight from Luton to Romania (9 hours and 40 minutes after the scheduled pick-up bearing in mind Luton's proximity to Yarl's Wood), and one woman was flying on a 12:30 flight from Gatwick to Jamaica (11 hours after the scheduled pick-up). This seemed an excessively long period in advance of the flight, and was consistent with reports I heard across the estate of early pick-ups. The officer overseeing the departure noted that sometimes medication was not there when detainees were departing, and observed that follow on care was "not great".

The result of an ongoing constant watch, which required female staff, meant that during my visit all three staff on reception were male. The male-only staffing was concerning; officers had to ask key questions to identify vulnerability, and so it was vital that women felt comfortable to disclose personal, traumatic experiences. Furthermore, there were small elements that could have made a woman arriving feel uncomfortable: one woman had a sanitary pad in her belongings that the male officer went through during the property search.

At one stage, the first three women in reception were all at seats in a row going through the reception process, and this occurred again for the fourth and fifth women to arrive. There were partitions between the desks but all discussion was audible between them, including when they were asked if they had had 'any thoughts of self harm or tried to hurt yourself'. Given the importance of making detainees feel comfortable enough to answer that question honestly, I would urge centres to invest in their set-up or process to ensure privacy, for example by creating private booths for the reception interview.

The walls of the reception area were very dirty. There were three women's waiting rooms and two family waiting rooms. Three of these had posters on voluntary departure but two did not. One woman arriving at reception was a Mandarin speaker and did not speak or understand English. The officer used the Big Word phone translation service and this was answered quickly. I observed that this was a far more lengthy process and it seemed unlikely that a detainee would have felt comfortable to be open and honest when asked through the phone whether she had a past of abuse or domestic violence. The woman was given an information sheet about the centre in English.[137]

Serco officers knew from the movement order that one of the women due to arrive at 00:27 had HIV and would need medication on arrival. I was pleased to see that they tried to alert healthcare in advance, but disappointed that healthcare did not come to reception until 01:18 – 51 minutes after her arrival. As there was just one G4S nurse on duty, she had been unable to attend more quickly as four men had arrived at the Bunting reception and she had had to attend to a detainee who was unwell on a unit. Should night-time arrivals continue, healthcare staffing must be increased to prevent this happening in future. Furthermore, this case raised serious concerns on the management of medication through the initial stages of detention; this woman had her medication and clearly understood when she needed to take it, but missed a dose because she was in transit with Tascor. I was pleased to see that an officer, on finding cholesterol medication in one woman's bag, notified her that she had to go to pharmacy in the morning to get that medication. I was told that the GP was only available on goodwill at night, and healthcare staff confirmed that they would use the GP more at night if it was in the contract.

Short-Term Holding Facilities

Heathrow Airport Holding Rooms: Terminals 2, 3, 4 and 5 (visited 23 January 2018)

A7.108 The Heathrow terminal holding rooms hold individuals and families (including children) who have arrived on flights and whose immigration status requires investigation. In 2017, 11,742 people were held in the terminal holding rooms, of whom 67 per cent were there less than eight hours, sixteen per cent were there between eight and twelve hours, sixteen per cent were there between twelve and 24 hours, and two per cent were there longer than 24 hours. Some of those I encountered on my visits in the Heathrow holding rooms would have been there for over twenty hours by the time they departed. Figure A7.1 suggests that the proportion of those detained in the terminal holding rooms held

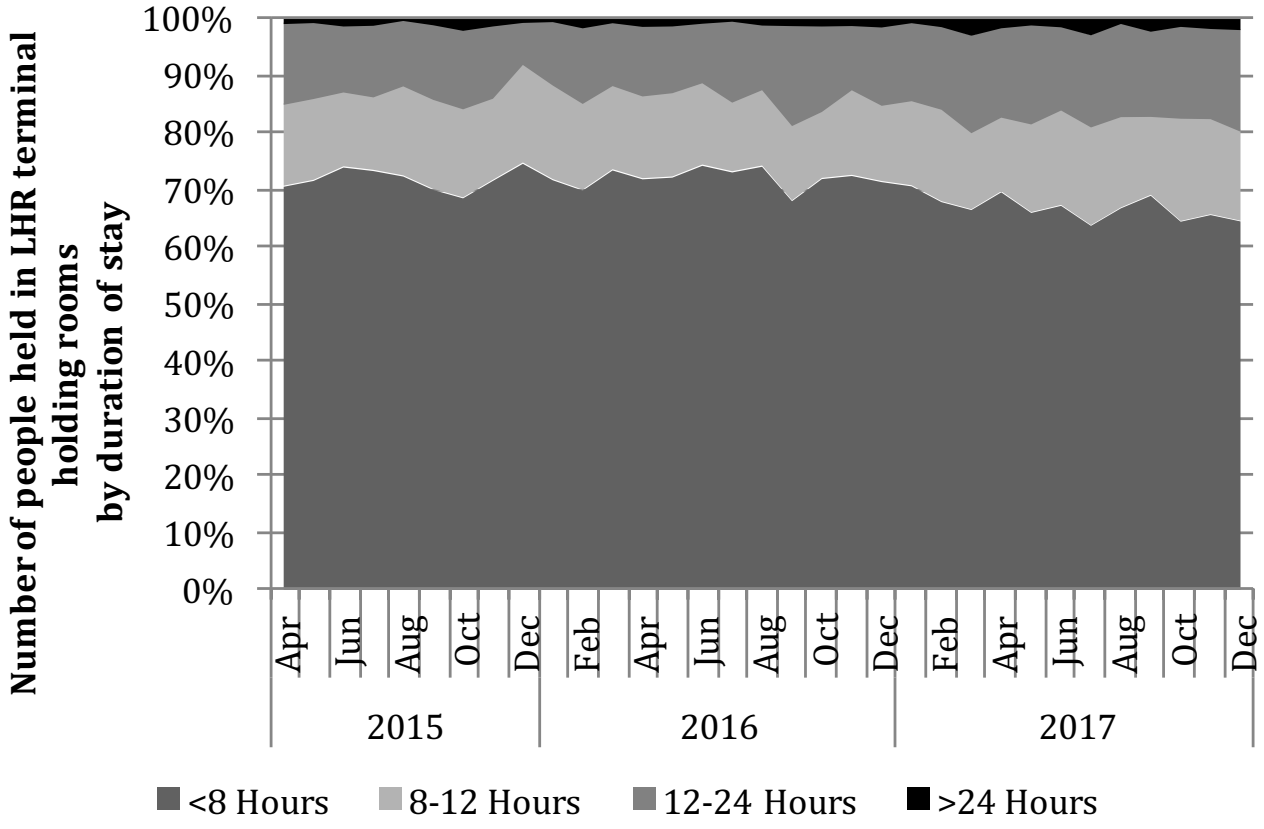
[137] Yarl's Wood has told me that she was also provided with information in Mandarin and pictorial form during her induction.

for more than eight hours has been gradually rising. Between September and December 2017, 461 children were held in the Heathrow terminal holding rooms, of whom 94 were unaccompanied.[138]

A7.109 All Heathrow terminal holding room facilities are provided by Heathrow Airport as part of its contractual obligations. There had been a recent programme of renovations in holding rooms in terminals 2, 3 and 4. Terminal 5's holding room was the only one of Heathrow's terminal holding rooms that had not been refurbished, and I understand that this may be some way off. There continued to be no natural light in any of the terminal holding rooms.

A7.110 I was pleased to see that the reception areas in the terminal 2 and 4 holding rooms had full-length curtains for searching, and – in the case of the former – that this was in a deep alcove. However, although the terminal 3 holding room had recently been refurbished, having re-opened in December 2016, I was disappointed by the poor design of the search area. The designated search space had been built outside of the secure area and was therefore unusable; consequently, searches instead took place behind a short curtain in the main reception area at the centre of the facility that did not enable sufficient privacy. Officers used an induction checklist and the Language Line telephone translation service.

Fig A7.1: Number of people held in Heathrow terminal holding rooms by duration of stay[139]



A7.111 The terminal 3 family room was now far more spacious following the refurbishment, while the terminal 5 family room was extremely small with frosted glass. The latter was positioned off the main room, which meant that families would have to go through the main room to use facilities including the toilet, baby change and phone. The other family rooms had directly accessible showers, toilets and baby change areas. While there was no one in any of the terminal family rooms at the time of my visit, I was told that terminal 4 had

[138] Note that data for September – December 2017 was provisional at the time of the visit.
[139] Footnote 138 also applies.

recently had one family of six and one family of ten at the same time. Officers were required to conduct welfare checks on families every fifteen minutes, and were able to call for more officers without difficulty if there was pressure. While Childline posters were displayed, most information was stored in boxes to make the walls of the family rooms – in some cases decorated with cheerful stickers – more appealing. I was interested to see a tailored children's complaint form in one of the information boxes, while Home Office complaints boxes were easily accessible across the terminal family rooms. Books and toys were available for younger children. While there was a games console and TV in each family room, there was a gap in provision for older children. There was fixed seating, bean bags and play mats in most family rooms, but some lacked loungers; in terminal 4, all four hard plastic loungers were out of use as they had not been secured to the floor properly. (This has since been rectified.) While there were few religious texts or books for adults in some of the family rooms, staff told me these could be brought through by staff from the main room.

A7.112 The main areas in the holding rooms in all terminals had the appropriate general appearance of airport lounges. In most terminals there were multi-faith rooms leading off from the main areas, and in terminal 3's multi-faith room the lack of chairs highlighted in a recent Prisons Inspectorate report had been addressed.[140] Terminals 2 and 5, however, did not have multi-faith rooms. Throughout the holding rooms there were payphones with a number on it which would allow others to call in from the UK or abroad, and I was told there were also a small number of sim-free phones and international phone cards available. Detainee access to their own phone and email was restricted to providing details for Border Force interviews. Blankets and pillows were available, as was clothing for both men and women. There were posters with information on modern slavery and with the contact details of legal services. Complaints boxes and forms were available, as were posters promoting Tascor's complaints service. Fruit was available in some of the rooms.

A7.113 The showers and toilets I saw were clean, and sanitary products were available in all but one instance. However, in terminal 3 a number of the toilets were out of order, as was the shower (I understand that was because of Legionella testing protocols carried out by Heathrow Airport Ltd's provider). Terminal 5 was the only terminal holding room without a shower, and staff would try to take detainees to terminal 2 for showers if they wished. This should be addressed as soon as possible.

A7.114 I was told there were always both male and female staff on duty, and indeed this was consistent with what I saw in all of the terminal holding rooms. There appeared to be good staff retention; one of the Tascor officers on duty had been working in the Heathrow holding rooms for almost twenty years.

Heathrow Airport Holding Rooms: Cayley House (visited 28 November 2017)

A7.115 Cayley House is used to accommodate detainees ahead of their flight's departure when they have been in the UK beforehand. During the 27 days prior to my visit, 478 people were held at Cayley House, of whom 78 per cent were men and 22 per cent were women. One was a child. Of the 468 cases in which data on length of detention was available, on average people were held at Cayley for 3 hours 20 minutes, with a maximum detention time of 14 hours 35 minutes. A total of 14 people were held for eight hours or more. All arrivals at Cayley House are pre-planned.

A7.116 The reception area had a small waiting room. I was told that there would typically only be one detainee at a time in the main reception area for induction, and that this usually lasted ten to fifteen minutes. There was a curtain in the reception area, which was normally

[140] *Unannounced inspection of the short-term holding facility at Heathrow Airport Terminal 3 by HM Chief Inspector of Prisons, 13 May 2015*.

used for searches on arrival. I was told that the movement notifications received by Cayley House in advance of a detainee's arrival would give risk factors but not AAR levels, and that 14:00 was the peak time for arrivals.

A7.117 There was no natural light in the facility. There was a very small room off of the main holding room which doubled as a resting and multi-faith room, but which had graffiti on the wall. It had one narrow, hard plastic lounger secured to the floor, and a leather cushioned mattress that was on the floor with a flannel sheet on top; this was not sufficient. The main waiting area had a TV, hard secured seating, a Home Office complaints box and payphone. I was told that mobile signal at Cayley House was poor, which I hope can be addressed given the importance of allowing detainees to contact the country to which they are returning in order to make arrangements. Packet meals could be heated in a kitchen by officers for detainees. While there was a shower in Cayley House, it was out of order (as at terminal 3, the result of Legionella testing protocols). I was told that detainees would be escorted to the holding rooms in terminal 2 if they wished to use a shower in the meantime. One set of toilets had a bad smell and it was clear that one of the detainees had just been smoking in the other set. I understand that Tascor staff at Heathrow have a supply of nicotine lozenges – provided by the Home Office – and should be providing them as a matter of course across the short-term holding facilities, which are all smoke-free.

A7.118 The room for women, families and vulnerable detainees was refurbished in 2014. It remained rather barren, and would benefit from a carpet, and pictures on the wall. If a family's case was handled by the Family Returns Unit then a Home Office family team would be with them. There were video games, DVDs and children's books available, though as elsewhere provision for older children could be improved. It was confirmed that a female officer would always be on duty if a woman was scheduled to come to Cayley House.

Larne House (visited 8 December 2017)

A7.119 Larne House is a residential short-term holding facility north of Belfast operated by Tascor. Detainees can be held at Larne House for five days, or up to seven if they are to be removed during the further two days. There were no detainees present at the time of my team's visit, although two had left that morning and at one point during the preceding week there had been no fewer than sixteen detainees.

A7.120 The majority of staff at Larne House had worked there since it opened in 2011, and staff were split evenly between genders for each shift. The Home Office contract manager visited Larne House unannounced three times per month. I was pleased to learn that Larne's IMB – which also covers Glasgow and Edinburgh – now had a local member.

A7.121 Staff felt that the number of vulnerable people had increased, although they agreed there was now a greater understanding about vulnerability. They were opening more ACDTs than in the past, and knew to open them when they had concerns on vulnerability. There had been twelve ACDTs opened so far in 2017.

A7.122 Immigration enforcement staff came to Larne House to conduct interviews but there was no immigration advice immediately available to detainees. Staff believed it would be helpful to have a Pre-Departure Team presence, but the low occupancy levels at Larne House may demand a different solution such a video conferencing. My team was told that information on release often came to Tascor at the last minute when detainees were nearing the five-day detention limit, resulting in release to no address. Tascor staff did provide those detainees who were released with local support information.

A7.123 The security cage around the van drop-off area was inappropriate for immigration security purposes, as was the metal grate over the top of the courtyard (although I acknowledge that the STHF is attached to a police station, and this is the main reason). I was pleased to learn that there was now free access to the courtyard, and detainees did not have to be escorted as at the time of my previous review.

A7.124 I understand that there are typically one or two detainees in the reception area at a time. Officers ask questions on vulnerability at an open desk very close to the waiting area, but while this is disappointing given the importance of ensuring detainees feel comfortable to disclose personal information, I gather that more detailed questions are asked separately if the officer has concerns. The search area with a security camera was separated by curtains only, but was out of sight from the waiting area. Officers used Big Word in the reception process, and reported that problems were rare.

A7.125 The dining room, which was open to detainees 24 hours per day, had hot and cold drinks, cereal and fruit available. Detainees could choose from a menu that had been translated. The association room had small high windows and was well-equipped. It had a games console, two computers, as well as books and DVDs which were labelled with language and number; I did not see such care and thought paid to books available in any other STHFs. Larne House was also extremely clean.

A7.126 The bedrooms are flexible and can be used to house exclusively male or female populations as well as a mix. Three rooms on a separate corridor are generally allocated to women, but there is mixed association in communal areas. The room for vulnerable individuals was a single room, with an intercom and TV. If a detainee is on constant observations the officer will be positioned outside with the door open. This is a poor design. The bedding throughout the facility was plastic-covered and hard – exactly the type used in separation units in IRCs. While soft pillows were available on request, this should be addressed.

A7.127 Only one of the actions I had suggested at Larne had been taken (free access to the courtyard – see above A7.124). In particular, no action had been taken on my formal recommendation to reduce capacity. However, given the uncertainties regarding the Irish border following Brexit, maintenance of the status quo at Larne House is probably sensible for the time being.

Reporting centre holding rooms at Becket House and Lunar House

(i) Becket House (visited 30 October 2017)

A7.128 There are fourteen reporting centres in the UK, and Becket House is the largest. At any one time, approximately 84,000 people are responsible for reporting to these centres (and to police stations). Some 1,100 people report to Becket House each day. Reporting is a significant source of detentions, and 100-120 people were detained when reporting per week. The holding rooms within the centre were operated by Tascor.

A7.129 Becket House has ten counters, but the space is not fit for handling the number of people who attend. At the time of my visit, the queue of those reporting stretched outside and around the corner on the street. I was told that it could take an hour to get to the front. This was not a conducive environment in which to have in-depth conversations either about vulnerability or about voluntary departure, especially given that reporting itself is a stressful experience given the uncertain outcome.

A7.130 People were required to bring their medication when reporting, and detention planning should take medication into account. Staff said that the number of people coming to the reporting centre with health needs regularly required them to call paramedics and first aiders.

A7.131 Detention typically took place when a travel document became available. The caseworker would refer the case to the gatekeeper, highlighting if the individual was an AAR when making the referral. In such cases, the caseworker would need to provide a care plan and further information in order for the gatekeeper to accept the detention. Becket House staff have a weekly meeting where all cases for the upcoming fortnight are considered, including those people with specific risks. On the day of detention, a mitigating circumstance interviews would be carried out by the ROMS team, which was considered as a further check to uncover vulnerability once the duty manager had approved detention. This information would then go to the gatekeeper and they would decide whether to make the second decision to approve detention. Management observed that they still saw many people with mental illness, but felt that staff now looked in more depth when it was flagged as a result of AAR. I regard the interview stage between the ROM team and potential detainee as crucial.

A7.132 Once the IS91 is served by Home Office staff in the holding room reception area, detainees are handed over to Tascor and taken into the holding rooms themselves. At the time of my visit (late morning) there was no one in the holding rooms, but sixteen men and three women were due to be detained through the rest of the day. There was one room for men and a separate room for women and vulnerable people, each with their own toilets. Both were very small – the smallest I saw throughout my visits. Distractions were limited; there were some magazines and a motley selection of books in each room. Blankets were available. Detainees were offered a mobile phone allowing them to get in touch with their solicitor, but there would not be any privacy for such a call.

A7.133 Holding rooms shut for incoming detainees at 18:00. The first evening escort van arrives at approximately 18:00 and, if required, a second escort van which typically arrives around 20:00. Women and men are escorted in separate vehicles unless there is specific authorisation for mixing. The records for a day sampled in the week prior to my visit showed that, while some people had been detained for 30 minutes, there were some long stays. One person had been detained in the holding rooms for close to nine hours, one for eight hours and 40 minutes, and four for eight hours. This seemed broadly typical: on another day sampled there was an average wait of roughly five hours, including three people who were there for eight hours, two people for seven hours and two people for six hours. I found Tascor's list of those scheduled to arrive, and their risks and vulnerabilities, very confusing.

A7.134 Specific concerns, including those related to self harm, were recorded by Tascor on the suicide/self harm warning form on initial detention in the holding room. An ACDT was then likely to be opened once the detainee reached an IRC.

A7.135 Overall, my observations were in line with those of HM Chief Inspector of Borders and Immigration in a recent report.[141] Like the Chief Inspector, I found that the idea that reporting should have some value beyond compliance and that reporting events should be meaningful was "seriously compromised by the practical difficulties of managing a large reporting population". I too found that interviews in London lasted just two or three minutes. I too felt that the promotion of voluntary returns was poorly developed.

[141] *An inspection of the Home Office's Reporting and Offender Management processes December 2016 – March 2017.*

(ii) Lunar House (visited 6 December 2017)

A7.136 The reporting area at Lunar House was far more appropriate than at Becket House. There was sufficient space for people to sit in the waiting area immediately beside the reporting desks, although I understood there were substantial queues prior to reaching this area. As at all other reporting centres, detention must be pre-verified through the detention gatekeeper after the caseworker makes the referral, and every case is also assessed by the gatekeeper on the day.

A7.137 There was no one being held in the holding rooms at the time of my visit. There was a main room and a family room, which was used for families or adults who needed to be separated. As a result, it was not always possible to separate men and women, although there was always a male and female member of staff on duty. Windows were covered and there was very little natural light. There was a bad smell in the main room. Crisps, packed croissants and water were available, and hot meals could be made for detainees by staff. Detainees could make two calls when they entered the holding rooms, and staff told me they would bring detainees a landline if they had no money for the payphone. A fax machine was available. There was a complaints box in the main room.

A7.138 I was told that the last vans typically arrive between 20:00 and 20:30. The majority of stays in the holding rooms were for eight hours or less.

Prisons

A7.139 HMPPS provides the Home Office with up to 400 places for immigration enforcement purposes. I wanted to understand the role of embedded immigration staff in prisons, the extent to which immigration status is determined before the end of sentence, and how far the prisoner's choices are explained. I also wanted to see whether prisoners were assessed for suitability for detention prior to transfer to an IRC.

A7.140 I visited the Prison Service's two FNO-only prisons (Huntercombe and Maidstone), along with the privately-managed Peterborough and Thameside.

A7.141 The official consensus seems to be that FNO-only prisons are desirable (I understand that HMPPS plans to convert at least one other gaol for such a role). However, prisoners to whom I spoke were critical of being defined on the basis of nationality alone. For example, one prisoner I met had served in the British army, and at a previous prison had benefited by being part of a support group for veterans. No such support was available at an FNO-only gaol.)

HMP Huntercombe (visited 15 December 2017)

A7.142 Huntercombe is a category C training prison holding only foreign national prisoners. It has an operational capacity of 480 and prisoners of 80 different nationalities. Prisoners are transferred to Huntercombe a maximum of two years prior to their release date. The Prisons Inspectorate has reported favourably upon Huntercombe, albeit with a very poor marking on resettlement (this is somewhat unfair given that it is the result of a policy decision rather than anything directly in the control of the establishment itself).[142] Indeed, I found it to be a well-run and decent prison (albeit rather isolated in terms of domestic visits), where staff were frustrated that they could not currently contribute more in terms of resettlement.

A7.143 I learned that 64 per cent of prisoners were deported straight from Huntercombe, 29 per cent transferred out on IS91s, five per cent were released and two per cent were repatriated. Very few whose sentence had expired were kept in Huntercombe on IS91s; they were instead moved to local prisons or IRCs.

[142] *Report on an unannounced inspection of HMP Huntercombe by HM Chief Inspector of Prisons, 6–17 February 2017.*

A7.144 There are evident weaknesses in terms of public protection. I was presented with the case of high-risk sex offender from South Sudan, where a late decision had been made to release into the community. There were no plans in place and he was picked up by the police to be taken to his accommodation. Prison management also told me of the risks they perceive for possible UK victims when FNOs are deemed as 'of interest' but released into community unable to work or claim benefits. They cited an untreated MAPPA[143] 3 sex offender, who preys on drunk victims, who was released homeless. A further case involved an arsonist (also subject to MAPPA) intended to be released to Approved Premises but whose accommodation was withdrawn by probation due to lack of access to public funds. Huntercombe said these were the result of Home Office decisions but likely to be judged as a Ministry of Justice failure (a matter of academic interest to the victims themselves).

A7.145 I believe there needs to be a clearer national strategy on the handling of FNOs, including a better system of triage to ensure Huntercombe can work with the right prisoners. I met some prisoners who were evidently not going to be deported and they should not have been at Huntercombe. For their own sakes and for public protection reasons, such prisoners should be at prisons where they can benefit from rehabilitation services.

A7.146 There was too large a void between prisoners and Home Office caseworkers. There was no system for passing information on vulnerability to caseworkers making decisions on detention. The on-site Offender Management Unit was unaware of AAR. While they would flag ACCTs, for which there were good management systems at Huntercombe, there did not appear to be any process for identifying vulnerability and passing this on to casework, prison healthcare or IRC healthcare. The Home Office team at Huntercombe had good relationships but did not make decisions. It was noted that casework teams for foreign-national jails were being considered. I would suggest that a serious pilot of such a scheme – as had been planned to take place at Maidstone during 2017 – would be valuable.

A7.147 The immigration teams consisted of warranted officers who conducted asylum interviews, as well as serving paperwork. Prisoners could make applications to see them although this did not seem to be heavily used. The team felt they were properly resourced but found it difficult to answer prisoners' queries that were for caseworkers.

A7.148 Huntercombe was supposed to receive a decision on detention at least seven days before release, but too many – roughly 30 per cent – were served late. As I heard subsequently at HMP Maidstone, it appeared that priority was given to those who want to leave the country, and there is a lack of support and preparation for those being released into the community.

HMP Peterborough (visited 19 December 2017)

A7.149 HMP Peterborough is operated by Sodexo. It is a mixed prison with separate male and female accommodation units.

A7.150 The female prison is the hub for women foreign nationals in the prison estate. Its maximum capacity is 408, and at the time of my visit held 388 prisoners. There were 70 female FNOs, with 40 in the FNO spur (E Wing). Eight of the women in E Wing were in single rooms and all others in doubles. Two women were being held on IS91s. A mother and baby unit holds up to twelve mothers in a separate unit; one of these women was an FNO when I visited.

[143] Multi-Agency Public Protection Arrangements.

A7.151 I felt there might be some learning for the Home Office from HMP Peterborough's flexibility in the use of its accommodation, Separate units housed different populations, such as under-25 year olds, those undergoing detoxification, those going through induction, long-term prisoners and FNOs.

A7.152 In the course of a short visit, it was hard to judge how much preparation there was for return to another country. Pleasingly, the charity Hibiscus operated in the prison. Sodexo also had two FNO managers who had been trained by the Home Office and clearly provided an extremely valuable service. In 2017, 67 foreign nationals had been removed direct from Peterborough. Others had been released into the community or transferred to an IRC.

A7.153 The FNO manager to whom I spoke was aware of AAR, and noted that there were many victims of trafficking. Peterborough had carried out a pilot for HMPPS to check on the likely immigration decision two weeks and two days before the end of sentence. Nonetheless, they often experienced late detention decisions.

HMP Maidstone (visited 15 February 2018)

A7.154 HMP Maidstone is a foreign national-only prison operated by HMPPS. It has capacity for 611 men. Prisoners come to Maidstone between 30 months and three months before the end of their sentence. During my visit Maidstone had thirteen men held on IS91s.

A7.155 The Governor has told me that 70 per cent of prisoners are removed/deported from Maidstone (including those who have just a short stay at an IRC). Eighteen per cent are transferred out on IS91s; five per cent are released (including on Home Detention Curfew); six per cent are released on bail; and 1 per cent are repatriated. The prison's offender management unit reported that a recent survey showed 75 per cent of Maidstone prisoners wanted to leave the UK.

A7.156 Managers had recognised that FNOs were especially vulnerable, and felt Maidstone had a moral responsibility to prepare FNOs for lives in countries to which they were returned. However, like Huntercombe it did not have funding from HMPPS for resettlement services. More positively, the new offender management in custody model would give Maidstone an extra sixteen officers and a key worker who would lead on FNO issues.

A7.157 As at Huntercombe, the Prisons Inspectorate had given Maidstone a very poor resettlement score in its inspection in 2015.[144] However, I was impressed by the efforts taken locally, in the absence of central funding, to develop a focus on resettlement. Maidstone held people from nearly 100 countries, and its work on resettlement had concentrated on the five most represented, albeit there were plans to broaden this out. I felt Maidstone worked in a way that might have implications for IRCs. In particular, I was impressed by an adapted Virtual Campus facility that gave information on the countries to which prisoners were returning, and a programme commissioned by HMPS called Praxis that helped answer questions on foreign nationals and deportation.

A7.158 Previously, fewer than half of prisoners were in education, but Maidstone had now adjusted the courses, for example by ensuring that no course was longer than seven weeks and that all provided internationally recognised qualifications. Education attendance at Maidstone was now the best in the South East.

A7.159 All prisoners had an interview on arrival to assess their skill levels and needs, to give them a peer mentor and referrals, and to discuss arrangements for their return using the foreign-national tailored virtual campus resource and Praxis. Maidstone Citizens

[144] *Report on an unannounced inspection of HMP Maidstone by HM Chief Inspector of Prisons, 3–14 August 2015*.

Advice Bureau provided assistance on debt and money management, while Hibiscus – which currently helped on resettlement two days per week – was likely to increase to a full time presence.

A7.160 Maidstone had also brought in Spurgeons – a children's charity – to provide services for children and families, given that deportation would lead to the separation of families. Where there was a family referral from induction, the charity held one-to-one meetings with prisoners, worked on family courts matters and liaised with children's services from across the UK. They also helped prisoners to make videos for children they were leaving behind. I was impressed with this service, which I felt could be replicated elsewhere.[145]

A7.161 Prison management felt the on-site Home Office team was excellent but that the timeliness of caseworking decisions remained a problem. There were many last minute releases into the UK or last minute IS91s. I was also concerned that the cases of prisoners who did not want to leave were apparently not treated as a priority by caseworkers. This meant that those prisoners whose removal it would be difficult to enforce might miss out on the rehabilitative services available in other prisons, and those who moved to immigration detention did not have their cases progressed.

A7.162 The on-site Home Office team saw prisoners within 24 hours of their arrival, excluding weekends. They informed prisoners that they might be detained at the end of their sentence, and asked whether they intended to challenge their removal from the UK. However, my discussions with prisoners suggested that these conversations were fleeting (five minutes only), 'tick-box' affairs, and that further contact was limited. As at IRCs, men I spoke to were frustrated that the Home Office staff could not answer their questions.

A7.163 The offender management unit dealt with challenges around the availability of approved premises (probation hostels) and section 4 accommodation. It was noted that a probation officer will not check release addresses until a prisoner is approved for release, making arrangements very difficult when late decisions are made by caseworkers. Cases were often incorrectly assigned to Community Rehabilitation Companies, when the National Probation Service was responsible for provision for foreign nationals whom the Home Office is looking to deport.

HMP Thameside (visited 26 January 2018)

A7.164 HMP Thameside is operated by Serco. The gaol has capacity for up to 1,232 men. At the time of my visit there were roughly 300 FNOs, and seventeen men on IS91s. There was a foreign national representative on each wing.

A7.165 I was particularly keen to see how Thameside had developed a healthy staff culture. When the prison first opened in 2012, 90 per cent of staff were new to custodial work. This meant they brought no previous behaviours or expectations, even though they had lacked experience. Staff at Thameside were allocated through the day to where prisoners were engaged in activities rather than posted to static roles on units. I observed that staff-prisoner relationships seemed mutually respectful; prisoners and staff were on first name terms. The prisoners I spoke to felt safe and they were complimentary about staff. Levels of violence had stayed flat.

[145] The impact of detainees' separation from their children is rarely acknowledged (Melanie Griffiths and Candice Morgan, *Detention of fathers in the immigration system*, University of Bristol Policy Briefing, October 2017.) Amongst other things, the authors call for a Family Fund to assist visitors (the Home Office currently runs no equivalent to the Assisted Prison Visits Scheme that operates in prisons to enable family contact). See also Melanie Griffiths and Candice Morgan, *Immigration enforcement and Article 8 rights: Mixed immigration status families*, University of Bristol Policy Report 19, November 2017.

A7.166 I was also impressed by Thameside's excellent in-cell IT. Although it was linked only to a prison intranet, it allowed prisoners to access information about the regime and to book visits, courses and meals, giving them a degree of control over their day-to-day lives. It also freed up staff time from paperwork enabling more meaningful interaction. Prisoners also had an in-cell phone.

A7.167 I was told that on-site Home Office staff attended ACCT reviews, and caseworkers attended if necessary; this was the only institution I visited where I heard that this happened.

Annex 8: Escorts and charter flights

A8.1 On 1 May 2018, Mitie Care & Custody will assume responsibility for the provision of escorting services from Tascor. I am pleased to note that this contract has been developed around a partnership model in which the Home Office will work closely with Mitie to ensure that a reliable and effective service is delivered. There will be a strategic joint welfare board, attended by senior representatives from the Home Office and Mitie.

A8.2 In addition, Mitie have secured the services of an Independent Safeguarding Advisor who will report to the Care & Custody governance board. This role will be pivotal in advising on general safeguarding policies and procedures, as well as providing independent oversight of child, family and vulnerable adult services.

A8.3 Mitie have told me that they will be refreshing their people, processes and infrastructure, and that there will be additional managers and better terms and conditions for staff. There will also be enhanced training for all staff working within residential short term holding facilities to ensure they are equipped to identify and manage welfare issues.

A8.4 In light of the change in contractor, I have not thought it sensible to assess the arrangements as of late 2017-early 2018. However, I report below on a charter flight that members of my team accompanied in November 2017.

Charter flight to Lagos, Nigeria and Accra, Ghana

A8.5 Two of my team observed a charter flight from London to Nigeria and Ghana. They joined the Tascor escort team at muster, continued to pick-up at Harmondsworth and Brook House, through to boarding and the flight itself. Some 55 detainees were on the flight, of whom 35 flew to Lagos and 20 flew to Accra. They included fourteen women. There were 116 escorts on the flight and three medics (my team estimated that about one-fifth of the escorts were female). A member of my team also observed collection for a separate charter at Brook House. Notably, one detainee was deaf and mute.

A8.6 It was a very long experience for staff and detainees alike. The Tascor muster was at 1830. The collection of detainees at Harmondsworth began at 21:50 but the coach did not leave Harmondsworth until 00:10. The disembarkation from the Harmondsworth coach onto the plane lasted from 03:10-03:30 and the flight took off around 05:30. This was consistent with the observations of my team member who observed the charter collection at Brook House at a later date. He noted that some people had to wait on the coach for almost

three hours before departing the IRC. Given the impact such a long night would have on the wellbeing and behaviour of detainees and staff alike, I hope that this schedule can be curtailed.

A8.7 I was disappointed to learn that the briefing at the muster focussed on the high level of general risk expected, but did not mention individual risk or reinforce the importance of de-escalation.[146] Overall my colleagues were concerned by a complacent approach to the transfer of risk information. An escort noted that, when he met the detainee he was assigned to on the coach at the IRC, the detainee was already in a waist restraint belt. However, the escort was not told why the detainee had been put in the belt, and not given sight of the risk assessment document giving details on each detainee. He said he was not aware of AAR. More broadly, the typeface used on the risk assessment document was so small that it was dismissed as illegible by many escorts, and information was not captured in a consistent format. On the coach, the Tascor team leader offered escorts the chance to look at his documents but few did so.

A8.8 Fourteen detainees were scheduled to travel from Harmondsworth, of whom eleven actually flew. Escort staff at the Harmondsworth collection were impressive: they quickly formed rapport with each detainee, shaking their hand, calling them by their first name and asking if they understood what was going on when they first entered the departure area. There was a good example of de-escalation when a detainee became agitated. Likewise, good de-escalation skills were used with a very disturbed detainee who attempted to harm himself on a coach. The IMB had expressed concern that Harmondsworth used a staircase as departure area – I was pleased to learn that a different space was now being used, with a separate search room.

A8.9 However, my team members also witnessed examples of what could be considered to be intimidatory crowding of detainees by escorts. During one collection, twelve staff had surrounded one detainee, and the same detainee was observed by five security staff while being searched in a small area. This was not based on any risk factors that my colleague could ascertain. As part of a final asylum plea, one individual was surrounded by at least ten security staff in uniform while he was asked intimate questions about his sexuality.

A8.10 On the flight, detainees speaking to the Chief Immigration Officer (CIO) as part of the on-board immigration surgery were surrounded by up to six escorts. While there are understandable safety concerns, this was excessive. I was also concerned that while 39 detainees had requested a slot, the CIO saw just twenty of them, asking the escorts to prioritise. My team member was told that the remaining queries all related to travel documents, and the CIO felt able to answer through the Tascor staff.

A8.11 My colleagues were especially concerned by a medication error they discovered, and by the poor response to it when escalated on the flight and subsequently. A detainee with schizophrenia, who had been collected at Harmondsworth, had been taken off a maximum dose of an anti-psychotic medication when he arrived at the IRC from prison a day before the charter. He would be arriving in Lagos with no medication, and at the time of the flight had been un-medicated for a minimum of 24 hours. The escort medic at the collection did not question why the detainee had suddenly been taken off such a high dose of an anti-psychotic. The on-board medic was shocked when my team member highlighted the issue, confirming that patients should be taken off this medication gradually. However, while he had raised incidents in the past with management at AeroMed (the medical escort provider), he said he no longer did so due to a lack of response. He did not think it necessary to identify

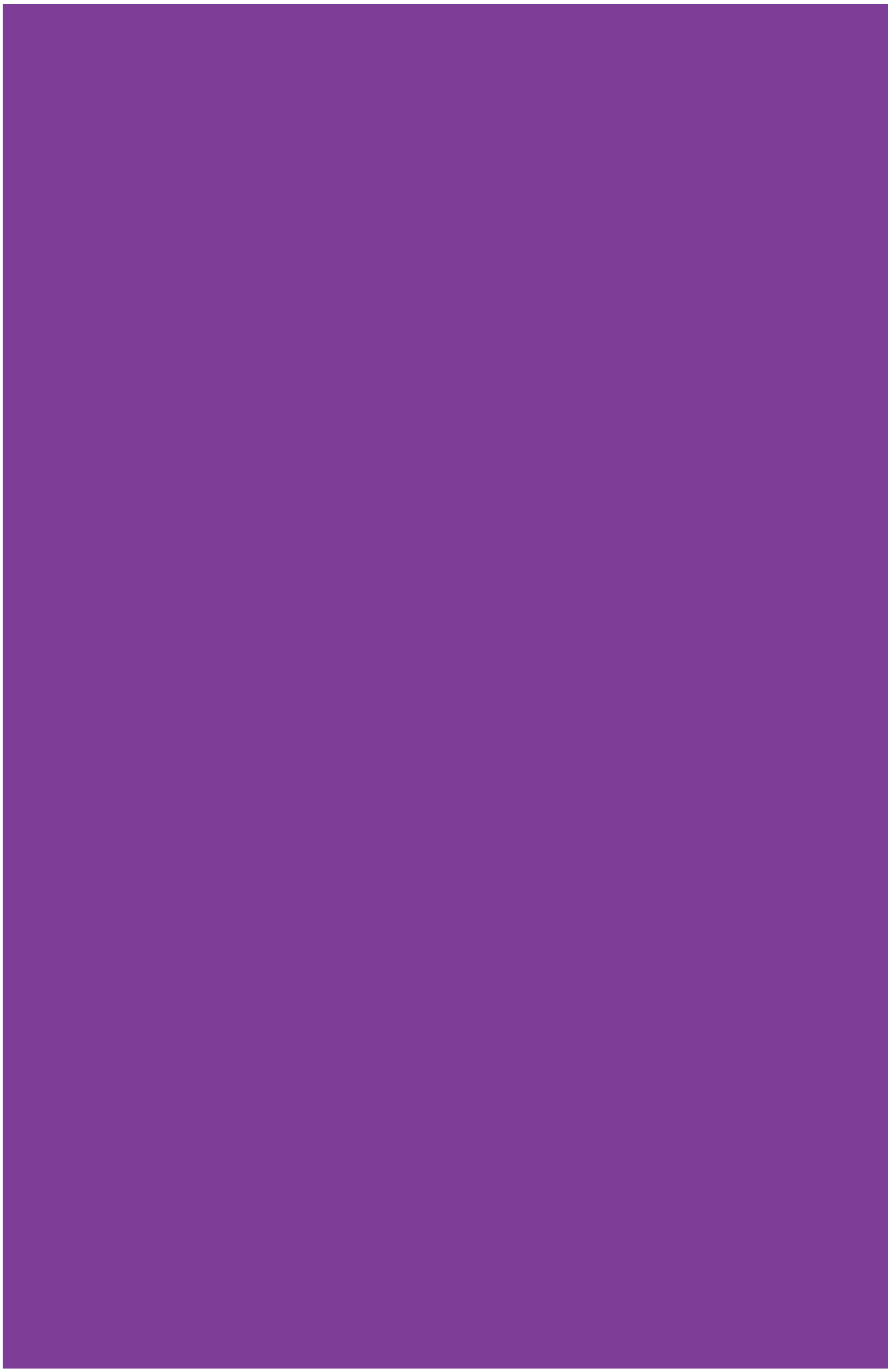
[146] The Home Office has subsequently told me that a contract monitor was present at the muster and reported that, during the briefing given by the senior Tascor officer, it was explained that detainee risk information was held by individual coach commanders and staff could request sight of this if they wished.

the detainee on the plane to make his escort aware, nor did he think it would be productive to flag to the Nigerian authorities that the detainee may need support. The Home Office CIO and Tascor management also did not act when my team members raised their concerns (nor did High Commission or Home Office staff when this was flagged following the flight). It was left to my team members to alert the relevant escort of the potential risk. I am very concerned by the decision to end the medication itself, by the fact that my team members had to identify and escalate this issue, and by the fact that no one in Tascor, the Home Office or the High Commission seemed willing or able to investigate.

A8.12 Nine waist restraint belts were used in the flight to Nigeria and Ghana. One man was carried onto the plane, although his restraint was removed soon after the plane was airborne. The detainee kept in the belt the longest had it removed at 0700. My team member who observed a charter pick-up at Brook House at a later date noted that of 24 detainees there was use of one guiding hold and one person was put in a waist restraint without it being pulled tight.

A8.13 When I met with Tascor management, they felt that HOMES training for overseas escorts had led to safer removals and less use of force. This was consistent with what my team members saw on the charter they observed, and I am aware of a recent Albanian charter where there was no use of restraints.

A8.14 However, during a third country charter operation in June 2017, Home Office monitoring arrangements had identified five detainees being placed into waist restraint belts without an individualised risk assessment justifying the decision. For all subsequent third country charters, the Home Office told Tascor to ensure that individual risk assessments were made. Any blanket application of restraints is unnecessary, unacceptable, and almost certainly unlawful. This should not be allowed to happen. As a response to concerns about the use of restraints on recent charter operations, a member of the HMPPS's training team has observed every third country charter since June 2017.



Annex 9: Summary of deaths in immigration detention or shortly after release 2010-17

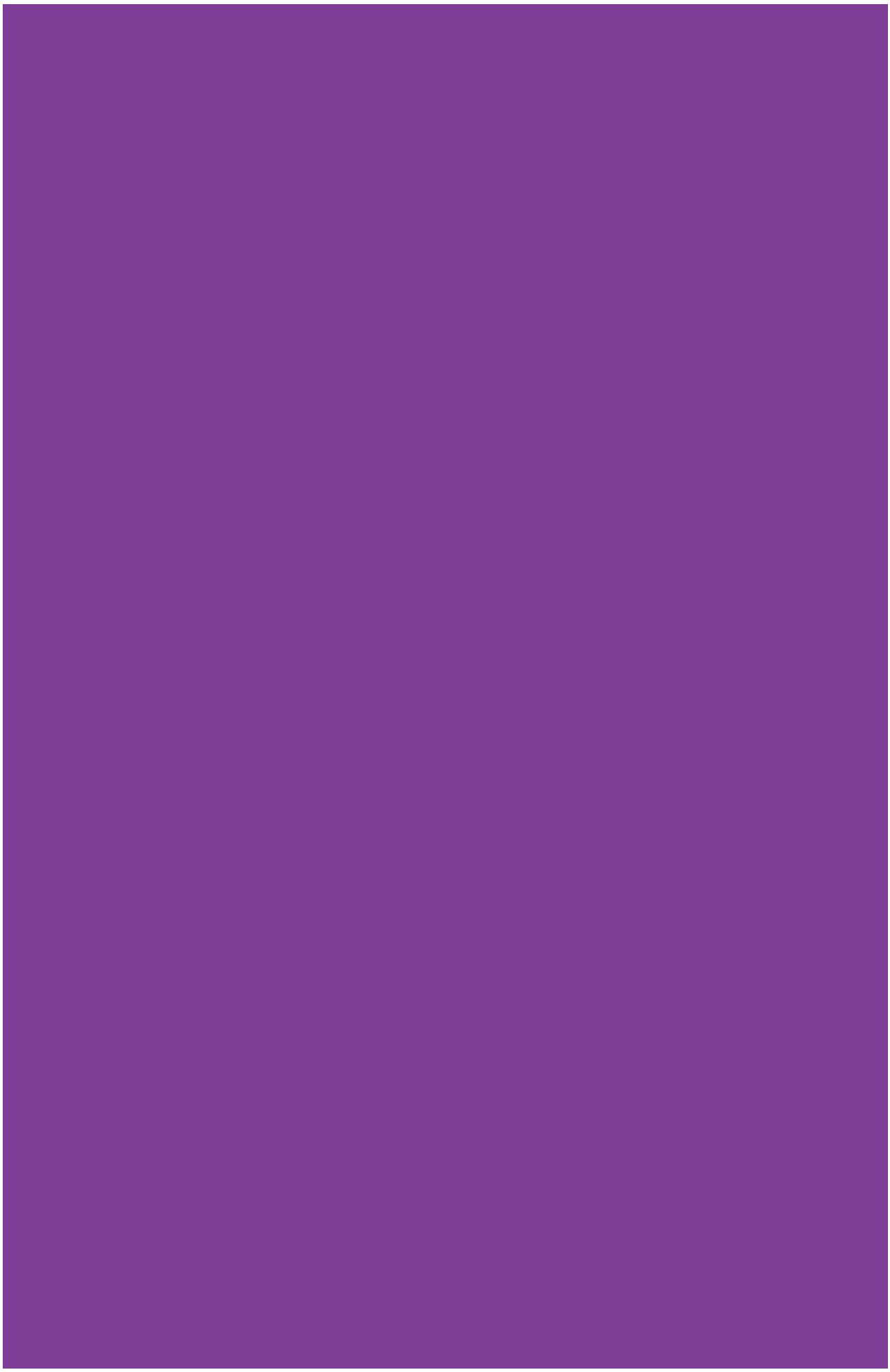
	Name	Date of death	Died while under immigration detention powers	Date released from immigration detention (if applicable)	Country of origin	Gender	Age	Location of death	Cause of death
1	EN	15 April 2010	Yes		Kenya	Male	39	Oakington Reception Centre	Natural Causes
2	JM	12 October 2010	Yes		Angola	Male	46	Hillingdon Hospital (admitted from escort)	Unlawfully killed
3	MS	2 July 2011	Yes		Pakistan	Male	46	Hillingdon Hospital (admitted from Colnbrook IRC)	Natural causes
4	BD	31 July 2011	Yes		United States	Male	36	Colnbrook IRC	Natural causes
5	ID	2 August 2011	Yes		Moldova	Male	31	Campsfield House IRC	Self inflicted
6	GJ	6 December 2011	Yes		France	Male	40	Hillingdon Hospital (admitted from Harmondsworth IRC)	Natural causes
7	PF	30 October 2012	Yes		Ghana	Male	31	Harmondsworth IRC	Natural causes[147]
8	JC	17 November 2012	No	16 November 2012	Bangladesh	Male	43	Hillingdon Hospital (Released from Harmondsworth IRC)	Natural causes
9	AD	10 February 2013	Yes		Canada	Male	84	Hillingdon Hospital (admitted from Harmondsworth IRC)	Natural causes
10	KS	30 March 2013	No	30 March 2013	Pakistan	Male	31	Wilmslow Train Station (released from Colnbrook IRC)	Natural causes
11	TM	26 July 2013	Yes		Pakistan	Male	43	Pennine House short term holding facility (STHF)	Natural causes
12	CC	30 March 2014	Yes		Jamaica	Female	40	Yarl's Wood IRC	Natural causes
13	RA	6 September 2014	Yes		Bangladesh	Male	26	Morton Hall IRC	Self inflicted (open inquest verdict)
14	PP	20 April 2015	Yes		India	Male	33	Yarl's Wood IRC	Natural causes
15	TK	6 August 2015	Yes		Uganda	Male	30	The Verne IRC	Self inflicted
16	AS-T	17 February 2016	Yes		Morocco	Male	41	Colnbrook IRC	Drug related[148]
17	SS	26 April 2016	No	25 April 2016	Iran	Male	30	Manor House Tube Station (Released from The Verne IRC)	Drug related death

[147] Inquest not yet held.
[148] Inquest not yet held.

18	TC	1 December 2016	No	01 December 2016	Bangladesh	Male	64	Hillingdon Hospital (Released from Colnbrook IRC)	Injuries received during a serious assault by another detainee in Colnbrook[149]
19	B BK	6 December 2016	No	06 December 2016	Sierra Leone	Male	49	Lincoln County Hospital (Released from Morton Hall IRC)	Natural causes (Stroke/brain haemorrhage)[150]
20	LD	11 January 2017	Yes		Poland	Male	28	Morton Hall IRC	Self inflicted[151]
21	AM	6 March 2017	No	02 March 2017	Poland	Male	37	Rough sleeping in Liverpool (Released from Morton Hall IRC)	Positional asphyxia (due to drug overdose)
22	TD	23 March 2017	No	22 March 2017	Poland	Male	33	Southampton General Hospital (Released from The Verne IRC)	Collapsed and hit head while being admitted to the IRC.[152]
23	BZ	9 April 2017	Yes		Slovenia	Male	42	The Verne IRC	Self inflicted[153]
24	MMJ	7 September 2017	No	4 September 2017	Poland	Male	28	Hillingdon Hospital (released from Harmondsworth IRC)	Self inflicted[154]
25	GBH	19 September 2017	Yes		China	Male	53	Dungavel IRC	Natural causes[155]
26	CS	3 October 2017	No	1 October 2017	Jamaica	Male	38	QMC Nottingham Hospital (released from Morton Hall IRC)	Natural causes[156]
27	SA	19 November 2017	Yes		Iraq	Male	27	Morton Hall IRC	Self inflicted[157]
28	KK	23 February 2018	Yes		Sri Lanka	Male	45	HMP Wormwood Scrubs	Self inflicted[158]

- Shaded entries denote deaths that occurred of individuals not detained under immigration powers at the time of death.
- Where footnotes indicate that inquests are still to be held, causes of death provided in this table are provisional.[149150151152153154155156157158]

[149] Inquest not yet held.
[150] Inquest not yet held.
[151] Inquest not yet held.
[152] Inquest not yet held.
[153] Inquest not yet held.
[154] Inquest not yet held.
[155] Inquest not yet held.
[156] Inquest not yet held.
[157] Inquest not yet held.
[158] Inquest not yet held.



Annex 10: Staff culture in immigration removal centres

Mary Bosworth, University of Oxford

As with much about immigration detention, there is only limited academic literature available about staff (Hall, 2010; 2012; Bosworth, 2016; 2014; Bosworth and Slade, 2014). Other than brief accounts in HMIP reports, there is even less produced by the NGO or government sector (Although see Lampard and Marsden, 2016 and Shaw, 2016). Although the custodial companies regularly survey their employees, they have not published any of their results.

As a result, and standing in some contrast to the complexity of the job with which they are charged, we know very little about the experiences, motivations, challenges, or opinions of IRC staff. Put another way, we have little evidence about the qualities of a good officer, nor of a bad one.

Some questions about staff that could be asked are quite practical: Who are DCOs? Where are they from? What do they do all day? Other questions might be more wide- ranging: What is the purpose of a DCO? What motivates someone to work in a detention centre? Who is well-suited to this profession, who might not be? Why?

As the prisons literature reminds us, officers play a crucial role not just in creating and maintaining safe penal regimes but in operating (or failing to operate) decent ones as well (Crewe, 2011; Liebling, 2011). Through building relationships of trust, and wielding their discretionary power carefully, prison officers can make a huge difference to the lives of detainees. So too, criminological literature emphasises the importance of expertise and discretion in addressing legitimacy deficits in prison and elsewhere. Part of what an effective officer and senior manager can do, is manage that legitimacy deficit (Bennett, 2016; Bennett et al, 2008). Prisons, like IRCs, operate with a legitimacy deficit, yet we have far less information about how officers respond (Bosworth, 2013).

While evidence about staff in detention is slight in comparison to that on prisons, academics have identified a set of consistent issues. The first research monograph that concentrates solely on IRC staff draws on research from 2001. This work, by political scientist, Alexandra Hall (2010; 2012), was conducted in an IRC that had recently switched from being a prison. In this establishment, that Hall does not identify but refers to as ‘Locksdon’, staff often struggled with their new role, unclear about the men in their care, or their new responsibilities. While staff and detainees sometimes experience what Hall (2012: 20) refers to as an ‘ethical encounter’, ‘grounded in shared capacities such as empathy and embodied vulnerability,’ for the most part, the officers in her study interpreted the detainees as potential risks and referred to them in prison slang as ‘Cons’.

While shaped by the particular biography of the institution in which she was based, Hall's research identified issues that persist. Thus, more recent academic scholarship (and work by NGOs and others) has found an enduring confusion about the relationship between the prison and the IRC, and thus between prisoners and detainees. Other matters too, have been documented by the Oxford research group, including: staff ambivalence and uncertainty about their role that sometimes extends to the practice of detention itself; a generalised suspicion of the Home Office, particularly caseworkers; communication and trust gaps between DCOs and the SMT; and a reliance on national stereotypes to make sense of detainees; stress and anxiety (see, for example, Bosworth, 2014; 2016; Bosworth and Slade, 2014; Bosworth, Gerlach and Aitken, 2016).

There is some evidence of specific work cultures in individual institutions, although more research is needed to map this systematically. Those who work in prison service IRCs, for instance, worry about a perceived loss of status in their role-change from prison officers to detainee custody officers. Their professional identity is usually closely aligned to HMPPS (Bosworth and Slade, 2014). In contrast, DCOs in the private sector articulate loyalty to the establishment, rather than the company (Bosworth, 2014). Some are resentful of changes in corporate ownership, others simply indifferent (Bosworth, Gerlach and Aitken, 2015).

Despite sharing an SMT and potentially being deployed in either establishment, officers in Brook House and Tinsley House commonly express views of the distinct nature of each facility. Such views are not always complimentary. In a 2015 study of staff culture at IRC Heathrow, we likewise found considerable scepticism among officers in Harmondsworth and Colnbrook about their colleagues in the neighbouring institution (Bosworth, Gerlach and Aitken, 2016). Although such views sometimes dissipated when people were cross-posted, that was not always the case. Such opinions stretched to views of the detainees, even though they too, could be (and were) moved between the two institutions.

Trust and relationships

According to the prisons literature, the best prison officers exercise particular forms of expertise in building meaningful relationships with prisoners (Crewe, 2011; Liebling, 2011). These relationships, Alison Liebling and colleagues (Liebling, et al, 2012; Liebling, 2008; Bennett et al, 2008) have found, are crucial not only in building 'decent' establishments, but also in creating a consensus about what that decency might mean. Although bound by prison rules, service orders, and the law, prison officers exercise important levels of discretion. In exercising this discretion, for instance in selecting people for work detail, or merely just in how they greet and interact with prisoners on the wing, actions need to be transparent and consistent (Sparks, Bottoms and Hay, 1996).

Academic studies of prisons and IRCs are clear: working in a custodial environment, is emotionally draining. Staff speak of the pressures involved in leaving work behind, when their shift ends. They seek to 'empathise' not 'sympathise' by which they mean to listen to detainees without being affected. Some claim, the only solution is to 'switch off' altogether.

In an era of financial cuts and enhanced scrutiny, IRCs like many other institutions, rely on technology and metrics. Such matters, Jamie Bennett observes in the prison sector (2016), has made aspects of management clearer, by enumerating them, building targets, and generating a set of administrative tasks, creates new challenges. Yet, as we found in interviews with staff at IRC Heathrow, some more experienced officers believe that it is easier to go through the motions, rather than to think about what the job entails. Whereas those who meet their targets are rewarded, others who do not achieve their goals may be penalised.

In one prison study concentrating specifically on race relations, authors found prison officers struggled to fully adopt prison service policies on diversity. The problem was not straightforward, but rather related to perceptions of competing goals of the policy, and the emphasis on process rather than outcome (Spencer et al, 2009; see also Cheliotis and Liebling, 2010). Such matters are worth considering in the IRC environment. While many IRCs have active diversity schemes in operation, in a bid to recognize and celebrate difference, evidence suggests that officers often rely on cultural and national stereotypes to make sense of the diverse population in ways that are not always helpful or positive.

Much of the prisons literature provides a useful starting point for examining the work of detainee custody officers. Even so, it is important to appreciate key institutional, legal and practical differences between the two roles. For, notwithstanding some important overlap between them, prisons are not IRCs. Not only are most prisons (and certainly those which researchers study) public sector establishments, but, reflecting the statutory framework in which prisons are situated, prison officers have additional punitive powers and prisoners are serving a defined sentence. The absence of both of these matters in IRCs creates distinctive institutions marked out by high levels of uncertainty for staff and detainees (Bosworth, 2014). Corporate competition acts as a significant barrier to sharing best practices as well as resources. Whereas at an Oxford Knowledge-Exchange event in 2015, it was agreed that companies would try to share information about staff training, for instance, it is unclear whether that has happened.

In an IRC, in which detainees are often highly anxious and unsure about how long they will be there, interpersonal skills and the ability to exercise discretion as well as the capacity to communicate compassion and openness are crucial. While officers frequently refer positively to their initial training on ‘interpersonal skills’, few are able to articulate a clear statement about the content or nature of such abilities. So, too, while many speak of the importance of ‘empathy’, they are often quite nervous about articulating ‘sympathy’. In detention questions of proximity (Bosworth, 2016) – how close to get to detainees and to colleagues – often generate confusion and concern.

Conclusion

It is this final area, that the 2017 BBC *Panorama* exposé on Brook House suggest may be the most crucial and the most urgent. Staff are pivotal to the delivery of a safe and decent regime, yet as an increasing amount of research finds that frontline officers feel embattled, underappreciated and ambivalent about aspects of their work, their capacity to deliver safe and decent regimes is drawn into question. IRCs are difficult places to work for many reasons. These are highly politicised sites. The steep hierarchy means that many DCOs have limited career development options. Staff turnover is high.

Most detainees are unhappy about their loss of liberty. They are vulnerable and many are angry or distressed. Some have multiple and complex needs. Communication is difficult, and nobody knows how long anyone will be held (Shaw, 2016). Under these circumstances, it is not surprising to find that some staff may find it hard to cope.

The question remains what is to be done. In addition to wider consultation with front line officers, as well as with detainees, it makes sense to draw on expertise and examples of good practice from elsewhere. In this regard, recent work in the prison service on trauma awareness has indicated the need and potential for assisting prison officers in their work. Similar work could be trialled in detention.

Since 2009, I have spoken to many officers who are clearly affected by their work and want to talk to someone about it, but feel unable to do so either because they do not trust the formal services, or because they are unsure how to access them. People feel as though they simply 'should' be able to manage their work. Staff need to be more comfortable trying to look after themselves or saying that they are struggling. Without it, they may become demoralised, resentful or withdrawn, all of which will affect their ability to forge relationships and build trust with detainees and one another.

Officers are both the primary resource and risk for the sector. Many are deeply committed individuals. Working with them to develop a sector-wide discussion about the career, its challenges and potential, will benefit everyone. This event on staff culture is an important step in that direction.

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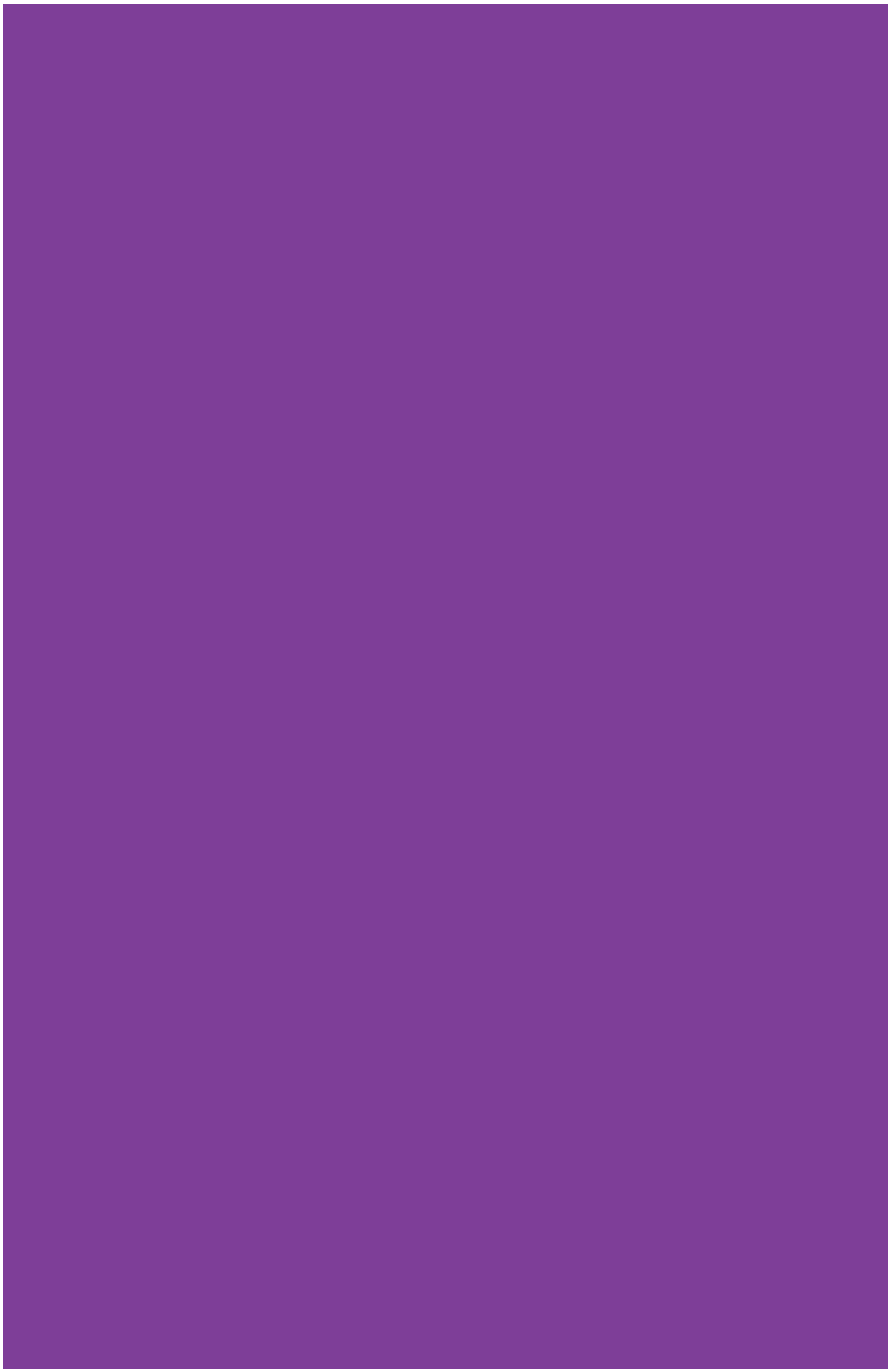
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Annex 11: Alternatives to Immigration Detention – A Literature Review

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Executive Summary

Background

This literature review was commissioned as part of the follow-up independent review of policies and procedures affecting the welfare of those held in immigration removal centres, by [redacted] CBE. This review examines a range of literature on alternatives to immigration detention according to the following terms reference:

Summary

To provide a literature review of reputable academic work and government and NGO reports that may provide insight into implemented and piloted alternatives to immigration detention and their outcomes, both internationally and within the UK.

Detail

- To outline the models of alternatives to immigration detention which have been implemented or piloted internationally and in the UK.
- So far as possible, to assess the outcomes of these programmes in terms of overall number of removals in comparison to those kept in immigration detention.
- So far as possible, to outline compliance levels for those on such programmes.
- So far as possible, to consider the overall financial cost of these programmes in comparison to immigration detention.
- So far as possible, to consider the outcomes of these programmes in terms of the physical and mental wellbeing of those involved in comparison to immigration detention.

Methods and Summary of Evidence

This report draws on relevant qualitative and quantitative academic literature along with statistics and reports produced by governments and NGOs in the UK, USA, Australia, Canada and a selection of European Union (EU) Member States. Initial research informed later searches. In compiling the material used in this review, I conducted an extensive online search using academic databases, e.g. ProQuest, Lexus Nexus, Thomson Web of Science, as well as academic journal data bases like http://journals.sagepub.com and http://taylorandfrancis.com. I searched www.ssrn.com and https://www.academia.edu to locate working papers. I also searched government websites, the EU commission, and Hansard debates. Finally, I consulted a selection of international experts to ensure that material was as up to date as possible.[159] Studies based solely on media analysis were excluded, as were those whose methodology was unclear or not robust. These searches yielded over 100 reports, briefings, book chapters and articles on practices in Australia, the UK, Canada, and the US, as well as material about a number of European Union (EU) member states. All works cited appear in the reference section at the end of the review.

[159] I would like to thank, in particular, Dr Michael Flynn at the Global Detention Project, Dr Leanne Weber at Monash University, Prof. Juliet Stumpf at Lewis & Clark University, Dr Efrat Arbel at the University of British Columbia, Andrew Crosby at Vrije Universiteit Brussel, Dr Stephanie Silverman at Trinity College Toronto for their assistance. Any errors remain, of course, my own.

Main Findings

1. Most people subject to immigration control, in any jurisdiction and whatever their immigration status, are not detained.
2. Alternatives to detention (ATDs) refer to a set of measures that are employed only after a detention determination of some kind has been made in the individual case, and the government has determined that a less coercive measure than confinement and the loss of liberty could be applied. ATDs are part of immigration and asylum law.
3. Governments across the world deploy a diverse range of programmes and practices under this rubric including: temporary admission, reporting requirements, parole, bail, appointment of a guarantor, open, semi-open centres, or alternative places of detention (including family detention and community detention), house arrest, curfew, voluntary return incentives, electronic surveillance, caseworker support, surrender of identification and travel documents, and assisted voluntary returns schemes (AVRs).
4. Like immigration detention, the justification of which is contested and unclear, there is no common set of agreed principles underpinning ATDs. Yet, without agreement on the rationale(s) for alternatives to detention, it is difficult to determine the form they should take their goal, nor the measure of their success or failure.
5. Only a small number of ATD programs have been independently evaluated.
6. Evidence suggests that the vast majority of individuals in ATD programs comply with the immigration process.
7. Evidence suggests that alternatives to detention are cheaper than immigration detention, although such cost-analysis does not take into account the net-widening effect of alternatives, but rather assumes a like-for-like substitution.
8. Evidence about the impact of alternative to detention programmes on physical and mental-health is mixed. Casework based alternatives to detention engender better outcomes than immigration detention, whereas temporary admission and bridging visas generates mental distress that may be similar to that caused by immigration detention. Those who have been subject to electronic monitoring report feelings of shame and criminalisation.
9. Official statistics about removals suggest that alternatives to detention can assist governments enforce immigration control although there is no academic scholarship explicitly comparing removal rates under both schemes of comparable populations. Indeed, there is very little academic literature on the impact of border controls on removals at all.
10. Evidence on compliance levels for alternatives to detention programs finds that well-funded, and well-supported case-management programs offering legal advice, housing and access to social and health care have high levels of compliance with all stages of the immigration system, including removal.
11. A range of studies from all jurisdictions identify a consistent set of concerns about ATDs including: the difficulty or absence of monitoring and regulation of these programs; their expansionist impact (net widening) on migration control; the growing role of the private sector in delivering these programs; the potential economic incentives for NGO involvement in border control; the blurring of populations (asylum seekers, former offenders, economic migrants); the reliance on criminal justice practices, particularly electronic monitoring; the de-facto detention caused by restrictions on residence; the difficulty of residing in the community without leave to work; and the negative impact of the uncertainty of visa regimes (ie temporary admission).

12. There is no consistent evidence that 'alternatives to detention' decrease the use of immigration detention other than in instances where there has been a prohibition on detention for specific populations, e.g. with children.
13. Literature from across all the different bodies of work and jurisdictions consistently reveals the need for more independent academic research to better understand these practices, their justification and their impact.

Conclusion

This review reports on a wide-range of international academic research, government and non-governmental literature relating to alternatives to immigration detention. Studies include a range of sample sizes and use a variety of research methods. They report on current projects as well as ones that have ceased to operate some years ago.

Whereas NGOs, the government and the private sector, as well as a number of academics broadly support ATDs, their reasons offer differ. For governments, the appeal of alternatives tends to rest almost entirely in their cost-effectiveness; they are cheaper and often efficient mechanisms of border control. They are also less controversial and are relatively quick to set up, as there is considerable appetite in the private and voluntary sector to be involved in their design and delivery. For NGOs, by contrast, there is a widespread belief that alternatives to detention offer a more 'dignified' treatment of migrants and asylum seekers (IDC, 2013). ATDs, in their view, offer a humane approach to border control that minimises the negative impact on the mental health and wellbeing of irregular migrants (see, for example, IDC, 2015; Detention Action, 2016; Katz, et al, 2013).

Alternatives to detention are not without their critics. Together, the literature, which spans over two decades, and a number of legal systems, tells a complex albeit familiar story about the challenges of balancing care and coercion in the community. Although designed for use instead of detention, there is little evidence that ATDs actually reduce the reliance on confinement (Acer and Magner, 2013). Instead, in part because of their lower costs, as well as their relatively uncontested nature, alternatives to detention potentially expand the administration of border control. Electronic monitoring offers a clear example: it is relatively inexpensive and easy to use, with a wide range of people. As such it can be, and is, deployed against people who were previously not subject to methods of control (Khoulish, 2015; Beyens, 2017; McNeill, 2017).

Alternatives raise other challenges. Certain strategies, like home curfew for example, have been contested in court, generating new costs and risks for the government. Questions are also raised about scale. Evidence from the criminal justice system suggests mass supervision raises new challenges of administration in structures that are already under financial and operational strain. In quite practical terms, increasing the number of participants in programs without increasing the staff to manage them, undermines effectiveness (van der Vennet, 2015).

In order to move forward, the report concludes by sketching some key principles that inhere in any alternative to detention, the most important one of which is the right to liberty. In addition to this basic premise, ATDs remind us of the obligations faced by governments to safeguard vulnerable people, whatever their citizenship, and the complexity of doing so while enforcing border control. Fairness and transparency are key, in this area of public policy as in any other. So too is a robust system of monitoring, complete with a clear structure of accountability, complaints and legal redress. These matters co-exist with those of cost-efficiency and effectiveness.

Underpinning them all, are issues of community and fellowship. Under conditions of border control, not everyone may live where they wish. States retain the right to determine this matter. The task then is to design programs which do the least damage not only to those who must leave, but to the communities they will leave behind in the UK, and those they will rejoin, abroad. ATDs have an important part to play in this discussion, and there is much reason for optimism. At the same time, familiar risks remain about coercion, expansion and efficiency. Bringing such matters into balance remains a challenge.

Definition of Terms

Alternatives to Detention: A wide category of practices used by governments as part of managing asylum seekers, refugees and irregular migrants in the community, instead of placing them in closed confinement. These measures, which are inscribed in immigration and asylum law, are employed only after a detention determination of some kind has been made in the individual case, and the government has determined that a less coercive measure than confinement and the loss of liberty could be applied.

Assisted Voluntary Return and Reintegration: Also known by the acronyms AVR and AVRR, Assisted Voluntary Returns schemes are funded and delivered by national governments and transnational agencies like the International Organization for Migration (IOM). They offer foreign nationals within the immigration and asylum systems financial incentives to return to their state of national origin. Sometimes they are twinned with employment opportunities or other schemes in the countries to which people are returned.

Asylum Seeker: An asylum seeker is someone who has applied for asylum and is waiting for a legal decision on refugee status.

Bail: The temporary release of a person from immigration detention for a specific period of time. Detainees can apply for bail from an immigration tribunal. Bail is usually set with restrictions over residence and reporting and recognisance. Those on immigration bail do not have the right to engage in paid work.

Case Management: Unlike much of the terminology of Alternatives to Detention, Case Management is an idea taken from social work. It refers to a collaborative process of assessment, planning and advocacy. In the immigration system, case management schemes allow residence in the community, and operate alongside more coercive methods of control, such as reporting requirements.

Community Detention: Terminology taken from the criminal justice system that has been used in immigration control in Australia. Also known as 'Residence Determination' or as 'alternative places of detention' community detention is legally considered to be a form of detention that allows irregular migrants and asylum seekers to live in the Australian Community while they await resolution of their immigration status (or removal). It is primarily used for families with children, with unaccompanied minors and with vulnerable adults who live in the community with support from welfare agencies who provide access to health and community services as well as to social support networks.

Electronic Monitoring: Also known as 'Tagging' this surveillance practice is drawn from the criminal justice system to monitor the location and movement of people instead of or after a prison sentence. Electronic monitoring can rely on radio frequency and GPS tracking systems. It is often twinned with intensive supervision and/or home curfew.

Home Curfew: A practice common in a number of criminal justice systems, whereby individuals who have been convicted of a criminal offence may serve some or all of their sentence outside a prison, in a residential setting. It usually comes with restrictions on time spent outside the residence area, (the 'home'), and often includes electronic monitoring. Curfew practices for ex-offenders under immigration control in the UK were subject to a successful legal challenge in 2016 (*R (on the application of Abdiweli Gedi) vs Secretary of State for the Home Department, [2016] EWCA Civ 409 (Admin)*, 17 May 2016).

Intensive Supervision: Terminology taken from the criminal justice system where it typically refers to community-based sentences such as probation or parole. In the immigration system, as it does in the criminal justice system, intensive supervision includes regular reporting requirements, either in person or via the telephone.

Net widening: A concept developed by sociologist Stanley Cohen (1985) in relation to the criminal justice system, net-widening refers to administrative or practical changes that, often unintentionally, result in a greater number of people being subject to systems of state control.

Pilot project: A small-scale experiment or study that is usually conducted to explore the feasibility, cost and effectiveness of a practice, in order to determine whether it should be rolled out more widely.

Qualitative Research: Qualitative research is often more exploratory than quantitative research. It typically includes observations and interviews, which may be semi-structured or unstructured, drawing together testimonies from participants to better understand the object of study.

Refugee: A refugee is a person who, 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country,' as defined in Article 1, of the *1951 Convention relating to the state of refugees*.

Risk Assessment: A process for determining the potential risks involved in undertaking an activity. In the immigration system risk assessment tools are used to determine the likelihood of absconding and the suitability for placement in specific programs.

Status Resolution Support Services (SRSS): Funded by the Australian Department of Immigration and Border Protection (DIBP) (now Home Affairs), the SSRS refers to a single integrated programme designed to provide flexible support services to people seeking to resolve their immigration status. Through SRSS individuals who are detained under the Immigration Act are accommodated in the community under Residence Determination where they receive assistance from social welfare agencies for varying lengths of time depending on their status.

Temporary Admission/Temporary Release: Refers to a particular legal status in immigration law in which a person liable to detention or detained, may, under the written authority of an immigration officer be temporarily admitted into the United Kingdom to live in the community, either instead of being detained, or following release from detention. Those who are temporarily admitted face a number of restrictions e.g. on residence, reporting and on work, and may be detained (or re-detained) at any point.

Vulnerability: In psychological terms vulnerability refers to the susceptibility of people to mental disorders and distress. Certain characteristics and populations are associated with higher levels of mental distress.

Methodology: Search terms and years of review

This literature review draws on a wide array of studies from a number of jurisdictions and time periods. While care must be taken to acknowledge distinct national practices, as well as variety in the scale and nature of the populations subject to ATDs, this aspect of border control, like immigration detention has experienced considerable policy transfer. Consequently, even within different systems, important similarities exist. For all these reasons, this report draws on literature from a variety of countries, to understand better the nature and effect of alternatives to immigration detention.

Search terms and types of literature

In compiling this review, I identified and consulted relevant qualitative and quantitative academic literature from the UK, USA, Australia, Canada and a selection of EU Member states. Initial research informed later searches. In compiling the material I conducted an extensive online search using academic databases, e.g. ProQuest, Lexus Nexus, Thomson Web of Science, as well as academic journal databases like http://journals.sagepub.com and www.ssrn.com to locate working papers. I also searched government and NGO websites, the EU commission, and Hansard debates. Finally, I sought advice from a range of international experts to ensure that material was as up to date as possible.

Publications fell into three main groups: academic literature, government reports, NGO and voluntary sector reports. Within the academic literature I included qualitative and quantitative studies from law and a range of social sciences. These were supplemented by statistics and reports produced by governments, NGOs and the voluntary sector. All works cited appear in the reference section at the end of the review.

Years of the review

The research for this literature review was conducted in December 2017 and January 2018. Most items consulted date from the past decade. Reflecting the fluid nature of immigration policy, a number of the programs which have been evaluated are no longer in operation. However, it is hoped that broader issues can be learned from synthesising literature on previous practice.

Introduction: What are Alternatives to Detention?

As governments around the world pursue border control in the face of mass mobility, they turn to a variety of methods of population management. Unlike immigration detention, which has attracted considerable (critical) attention in recent years (AAPG, 2015; Shaw, 2016), non-custodial methods of border control have often been overlooked (although see Klein and Williams, 2009; Noferi, 2015; Turk and Edwards, 2011). As a result, it is easy to forget that the vast majority of people subject to immigration control, in any jurisdiction and whatever their immigration status, are managed in the community. Detention, it is worth recalling, is the exception; liberty, albeit with restrictions, is the norm (see also Flynn, 2017; 2013).

States manage and process foreign nationals without custody through a variety of programs that, together are known as ‘alternatives to detention’ or ATDs (Tardis and Morovan, 2010). The grounds on which someone may be placed in an alternative to detention is set out in immigration and asylum law, with most countries advocating the least coercive form of management in order to enforce immigration control.

While ATDs can be grouped into a series of common forms, there is considerable debate over their definition, its goal and justification. In the broadest view, ATDs may refer to “any of a range of policies and practices that States use to manage the migration process, which

fall short of detention, but typically involve some restrictions" (Costello and Kaytaz 2013: 10). More narrowly, the UNHCR reminds us, ATDs are used only when a person has been ordered detained but has been diverted into a less coercive measure than detention that is deemed adequate to ensure fulfilment of their immigration or asylum procedure (UNHCR, 2014). In all cases, alternatives to detention are rooted in the legal framework of immigration detention and removal and allow "asylum-seekers, refugees and migrants to reside in the community while their migration status is being resolved or while awaiting deportation or removal from the country, albeit subject to some restrictions on movement or liberty." (Costello and Kaytaz, 2013: 10 – 11).

Current practices include: temporary admission, reporting requirements, parole, bail, appointment of a guarantor, open, semi-open centres, or alternative places of detention (including family detention and community detention), house arrest, curfew, voluntary return incentives, electronic surveillance, case management, caseworker support, surrender of identification and travel documents and assisted voluntary returns (AVR). In a recent document produced by the European Commission (2017), the UK was among the most wide-ranging in its adoption of ATDs, offering examples of nearly all of these programmes.

Unlike immigration detention, which is deeply contested around the world on a range of grounds from cost to the impact on mental health, access to justice and efficiency (Shaw, 2016; Costello, 2015; Chacon, 2014; Ceccorulli and Labanca, 2014), alternatives to detention currently enjoy a wide-range of support within government, the NGO sector and the academy (see, inter alia, IDC, 2015; Detention Action, 2016; Amnesty International, 2009). The UNHCR (2012; 2014; 2015a; 2015b), among others, has published guidelines on their form and development, urging states around the world to adopt them instead of administrative confinement, while the private sector has taken on the development of new partnerships and programs enthusiastically (GEO, 2017). Thus, despite extensive evidence from the criminal justice system (Aebi et al, 2015; McNeill and Beyes, 2013) concerning the net-widening effect of non-custodial alternatives (Cohen, 1985), and notwithstanding similarly negative accounts of 'care in the community' within the health sector literature (Killaspy, 2007), for the most part the literature on ATDs is upbeat (although see Rutgers School of Law and American Friends Service Committee, 2011; Flynn, 2017).

What do we know?

On the one hand, as this literature review makes clear, there is a large body of international work on alternatives to detention. Much of it is produced by governments and NGOs (see, for example Bieska et al, 2011; EMN, 2014). While there is a body of academic work, it is still, largely, in development (Noferi, 2015; Costello and Kaytaz, 2013; Sampson and Mitchell, 2013).[160] Evaluations and systematic analysis are, likewise, few in number (although see ODS Consulting, 2011; Stockmans et al, 2013; Detention Action, 2016). Perhaps most problematically, there has been little attempt to theorise or justify these practices. As a consequence, the goals, form and legitimacy of ATDs, remain unclear, as do their impact on broader detention policy. Do these programs reduce reliance on custody or merely expand the options available to the state? (Flynn, 2017; Doering-White, 2018)

Nonetheless, certain themes can be identified in the literature. Where figures exist, alternatives are typically cheaper than detention (ACLU, 2014; Edwards, 2011). Mainly, they are less harmful on mental and physical health of migrants (Costello and Kaytaz, 2013; IDC, 2015; Wisher, 2011). Examples from around the world suggest that community-based case-management interventions, when accompanied by sufficient legal and other assistance,

[160] For a good overview of practices around the world see Issue 44 of *Forced Migration Review* from 2013.

including education, housing and healthcare, generate high levels of compliance with immigration decisions (see, for example, Katz et al, 2013; van der Vennet, 2015; Edwards, 2011; Mitchell and Kirsner, 2004).

There are, of course, exceptions and caveats. In border control terms, evaluations have found that some ATDs fail (ODS Consulting, 2011). In legal terms, certain programs or practices have been subject to successful legal challenge (see, for example, *R (on the application of Abdiweli Gedi) v Secretary of State for the Home Department, [2016] EWCA Civ 409 (Admin)*, 17 May 2016). In political terms, too, programs adopted under one administration have been abandoned under another. Like other aspects of immigration policy, ATDs are subject to shifts in political discourse and finances.

Advocates of ATDs do not necessarily support all programs. Interventions based on criminal justice practices like electronic monitoring, for instance attract extensive critique (CCR, 2015; JRS, 2010; Khoulish, 2015; AILA, 2008). Concerns about such practices range from the impact of tagging on civil liberties – the manner in which people may be placed under surveillance without compelling reason – to fears about the pressure these programs place on the overall system. In quite practical terms, given the conditions of enduring fiscal restraint, expanding options may put the whole system under pressure; such has been the experience in many criminal justice systems (McNeill, 2017).

So too, critics raise questions about the potential financial incentives ATDs offer to the private sector (Rutgers School of Law and American Friends Service Committee, 2011) and NGOs (Bosworth, 2017), while the growth in schemes has lead some to ask about the dangers inherent in eliding quite different populations (Flynn, 2017). What might be some unintended consequences of extending formal oversight to a wider-range of people? Can the distinct legal needs and protections of groups be managed?

From a legal and human rights perspective, there is some evidence to suggest that there may be problems in accountability and transparency of some programs. Who best holds the legal responsibility or expertise to monitor non-custodial alternatives is not always clear. The Royal Commission into Institutional Responses to Child Sexual Abuse (Commonwealth of Australia, 2017) for example, found worrying levels of child abuse in community detention, with fears that even higher levels were going unreported (see also Child Protection Panel, 2016; Australian Human Rights Commission, 2016). Without robust monitoring systems, this abuse was very hard to root out.

Governments too, tend to prefer certain schemes over others, although practices can shift suddenly. Whereas Belgium, for many years, for instance, was committed to lowering its closed detention population through operating open detention facilities (Schockaert, 2013), it has recently abruptly changed tack, ending its scheme of family houses (Cartuyvels et al, 2017; Global Detention Project, 2017a). Similarly, in 2016, under the Trump Administration, the US federal government terminated a family casework scheme that had witnessed some success with women and children (GEO, 2017), in favour of expanding its reliance on electronic monitoring. Critics draw into question the appropriateness of this strategy for all claimants (Khoulish, 2015).

A number of NGOs and the UNHCR advocate case-management based programs in the community (IDC, 2015; UNHCR, 2015a; 2015b; Detention Action 2016). These programs, which take a number of forms and examples of which can be found across a number of years and jurisdictions deploy a social work model to support people in the community who are subject to immigration control. These schemes, which generally have high levels of compliance, are based on the belief in early and sustained engagement. Participants

are offered guidance on their legal matters along with assistance on matters of social care, health, education and housing (IDC, 2015; Detention Action, 2016; Mitchell and Kirsner, 2004).

In immigration, as in the criminal justice system, which has a longer and more developed field of practice and research on non-custodial outcomes (McNeill and Beyens, 2013), alternatives to detention offer the government a choice in population management. They are cheaper and, for the most part, less controversial. Far less clarity exists over their goal, however, or their impact.

Why alternatives?

After 2010, when the coalition government announced the end of child detention in the UK, Britain pursued a series of alternatives for families who were subject to deportation. For this group, the justification of alternatives was clear; detention had been ruled incommensurate with contemporary values about children. Its negative impact on their physical and mental health was too great, and the law changed (Crawley and Lester, 2006; Campbell et al, 2011). Alternatives had to be developed.

Other populations may be placed into alternatives for similar reasons, some of which have also been inscribed in law. Pregnant women in Britain can no longer be detained for more than 72 hours, for instance, and following recommendations from the 2016 Shaw Review (Shaw, 2016) other vulnerable people should also be diverted under the 'Adults at Risk' policy (Home Office, 2016). For the most part, however, the decision to detain, and, therefore, the choice not to detain, remains discretionary, and unless challenged in court, unexplained.

The sheer numbers of people who remain in the community under Immigration Act powers (estimated at around 80,000) reminds us, that, for the most part, immigration officers decide not to confine. It is worth recalling that the immigration detention estate, relatively speaking, is modest. There simply is not room to detain everyone. The gap between the number of beds in detention and those in the community, however, is not just evidence of resources, but also, of the appetite to detain. That is to say, despite an increasingly tough rhetoric over the past decade, which has been thoroughly documented in the academic, NGO and policy literature, the immigration system does not seek to confine everyone. Despite much criticism of its reliance on immigration detention, the Home Office does, for most, follow its own guidelines that detention should be used as a last resort. Case law, if not always public opinion, is clear: liberty is valued and protected.

In the next section, I lay out a series of national case studies that demonstrate the range of alternative to detention programs. Each is considered in practical terms of immigration compliance, cost and outcome as well as in terms of justification and impact. As will be clear, the majority of evidence suggests that ATDs are effective and less harmful than detention. Yet, questions remain, as like detention, ATDs are also shaped by a series of contradictory goals and aspirations concerning care, control and community (Doering-White, 2018). Resolving such matters is beyond the scope of this literature review, yet important for considering in any analysis of border control.

Case studies: What works and why?

As has been already stated, the literature on alternatives to detention is both broad and narrow. While there are plenty of reports, and numerous documents advocating alternatives to detention, there has been limited academic qualitative or quantitative research on the nature or impact of these programs (although see EMN, 2014; Marouf, 2017). So, too, the literature spans a number of years, meaning that many programs that have been evaluated

are no longer operational. They may have been developed to respond to specific populations who are no longer considered a priority, or they have been superseded by changes in law and policy.

In those countries where immigration detention is mandatory (e.g. Australia), the goals of alternatives may be different from the UK where detention remains discretionary. The national framework is important to understand for other reasons too. Australia once again provides a signal example, as its immense financial investment in the 'regional processing centres', designed to prevent entry of a small number of refugees, reveals the threshold of what some governments are prepared to do with foreign nationals is not the same everywhere. We might be cautious at adopting policies developed under quite different circumstances.

Nonetheless a comprehensive account of national and international programs is helpful, as it identifies a set of common concerns and practices. From the government's perspective, matters of cost and compliance are high on the agenda. These are public policies that need to be justified as forms of expenditure. From the point of view of advocates and academics, however, access to rights, dignity and security are more salient. One perspective that is almost entirely missing from the literature is that of the individuals subject to these programs or who administer them on behalf of the state (although see Detention Action, 2016; Klein and Williams, 2012). Such absence of first-hand accounts is regrettable, and, should be addressed by greater research in this area.

United Kingdom

The United Kingdom uses an array of mechanisms to divert people from detention. The most common strategy has typically been to allow for temporary admission. This administrative measure can be handed out by an immigration officer in lieu of detention, or as a means of release from an Immigration Removal Centre (IRC). Temporary admission/release is usually accompanied by a series of restrictions on work, residence and reporting (Klein and Williams, 2012).

Bail offers another option to detainees for release. Granted in an immigration tribunal, like temporary admission, bail is accompanied by restrictions, including financial payments provided by financial supporters (previously known as sureties), residency requirements, reporting, and electronic monitoring (BID, 2018; Costello and Kayaz, 2013). Under the terms of the Immigration Act 2016 (Section 61 and Schedule 10), Temporary Admission and Bail are to be replaced by a single category of Immigration Bail. Those placed on this status will be diverted or released from detention, but will face extensive restrictions on housing, work, and education (ILPA, 2016). While some research has been conducted into the process of obtaining bail (see, for example, The Bail Observation Project Website), we know little about the outcomes for those placed on bail, other than a 2002 study published by South Bank University (Bruegel and Natamba, 2002). This study, cited in Alice Edwards' 2011 overview of ATDs for UNHCR, "traced the compliance rates for 98 asylum-seekers released on bail between July 2000 and October 2001 and found that 90 per cent satisfied the conditions of their bail, despite having been originally detained because of an allegedly high risk of absconding." (Edwards, 2011: 77)

Both bail and temporary admission come with reporting requirements. In a 2016 report Detention Action noted that the previous year then Immigration Minister James Brokenshire had referred to reporting as "the primary default alternative to detention" (Detention Action, 2016: 29). This strategy the report went on: "allows the Home Office to maintain regular contact with individuals, and is used on occasion to detain them. However, reporting is

generally not used to sustain a dialogue with individuals or seek to resolve their cases. Approximately 60,000 people report regularly; the compliance rate is 95%. The Government has estimated costs at £8.6 million." (Detention Action, 2016: 29).

As part of his review into the Welfare of Vulnerable People in Detention, [redacted] (2016) urged the government to extend the practice of electronic monitoring (tagging) as an alternative to detention. Tagging was initially introduced for asylum seekers following the Immigration and Asylum Act 2004. A small pilot, with 150 individuals in 2005 (House of Commons Home Affairs Committee, 2006), was assessed by the Home Office, yet the results were never published. The practice was widely condemned at the time by the voluntary sector at the time as a form of criminalisation (JCWI, 2006; Bonomi, 2006). The UK remains the only EU member state to use this practice in immigration matters.

Today, information remains hard to come by. In 2016, the government announced plans to tag all released foreign offenders facing deportation. This action, when paired with home curfew, however, was, ruled unlawful in *R (on the application of Abdiweli Gedi) v Secretary of State for the Home Department, [2016] EWCA Civ 409 (Admin)*, 17 May 2016.

According to the National Audit Office (NAO) (2017: 16), 3% of all people who were electronically monitored in 2016 were placed under this form of surveillance for immigration matters. Whereas qualitative literature on immigration detention (Bosworth 2014), has found that detainees sometimes claim they would prefer to be tagged than to be detained, the Jesuit Refugee Society (2011) and Bail for Immigration Detainees (Campbell et al, 2011) have both reported that clients who had been tagged had found the experience demeaning and upsetting (see also Bloomfield, 2016; Abraham, 2016; Camayd-Freixas, 2013).

Evidence from the criminal justice system about electronic tagging is quite clear. It expands the system of surveillance, drawing people in who would previously have been managed more informally. While the mechanism is effective in ensuring compliance with the legal restrictions with which it is associated, unless it is paired with additional caseworker based engagement it does not help with community reintegration or lowering recidivism (McNeill, 2017; Beyens, 2017). Moreover, although initially cheaper, due to its expansionist effect, electronic monitoring creates new costs for the overall system.

Casework management systems for immigration control in Britain are only relatively recent. In the first decade of the twenty-first century, in response to the outcry over child detention, the government piloted a small number of casework schemes for families facing removal, with limited success. Two in particular, the Millbank pilot in Dover, which ran from November 2007 to July 2008 and the Family Return Project in Glasgow, which ran from June 2009 to 2010, were found to be ineffective in ensuring the families left (The Children's Society et al, 2009; ODS Consulting, 2011; Edwards, 2011). Evaluations found that the schemes in question had not sufficiently carefully selected the families nor did they sufficiently support them in the process of navigating and understanding the immigration system. Their narrow focus on returns meant that other opportunities were missed (Edwards, 2011), while poor selection and review was also found to be crucial, with 68% of the 524 families referred to the Millbank project ineligible (The Children's Society et al, 2009).

Cedars, as a pre-departure accommodation unit, was not officially a form of detention, and so arguably falls within the broad, albeit contested, arena of 'alternative places of detention', like Australia's community detention. While Cedars had a high rate of compliance and succeeded in removing a number of families (Home Office, 2013), it was closed following the first Shaw Review (2016), in large part due to his recommendation about its cost and efficiency.

Cedars was run as a partnership between G4S, the Home Office and the Children's Charity Barnardos (Tyler et al, 2014). In this, too, it represented one of the characteristics of many 'alternatives to detention'; the involvement of the voluntary sector and NGOs either alongside the private sector or instead of the private sector. For a number of years, Refugee Action ran a casework pilot in Liverpool known as the 'Voluntary Sector Key Worker Pilot', on behalf of the Home Office for asylum seekers in the community (Edwards, 2011). Currently Detention Action, one of the government's fiercest critics, operates the Community Support Project, a casework management scheme with a small number of foreign ex-offenders (Detention Action, 2016).

Although not strictly speaking an 'alternative to detention', as the individuals in question were unlikely to be detained while their asylum case was underway, the Voluntary Sector Key Worker Pilot relied on a casework model to try to assist asylum seekers avoid detention in the future, by understanding their options. Key workers were assigned 35 – 40 individuals, whom they met at regular intervals. Participation was voluntary. Within the first seven months, five people returned voluntarily, three were removed by force and one was sent to detention. Among similarly situated individuals who were not in the Key Worker pilot program, one only voluntary removal occurred during the same period. Just under 5% of those in the pilot had absconded (Edwards, 2011: 80).

Detention Action's Community Support Project, which has been running since April 2014, is modelled on the International Detention Coalition's (2015) Community Assessment and Placement Model (CAP), for a group of male ex-offenders aged 18 – 30. These former prisoners face barriers to removal and have either already experienced long-term detention or are at risk of doing so. A recent report by Detention Action (2016: 51) states that participants in the programme "have a range of issues, including severe mental health problems, complex family situations, substantial offending histories, lack of confidence, precarious accommodation and subsistence situation and low self-esteem."

Men come to the programme via detention, where they are first assessed for suitability based on a set of criteria to establish "levels of risk of reo ending and absconding and willingness to engage actively." (Detention Action, 2016: 51). Risk levels are constantly reassessed via meetings and phone calls. After they are accepted into the programme the individual meets with the project coordinator and together they devise goals and actions. So far, the numbers on the project are small, but the results are positive; of 21 participants, there has been a compliance rate of at least 90%. One man returned voluntarily to his country of origin. The project saves the government between 83 – 95% of the cost of detention depending on whether or not the individual needs to be housed (Detention Action, 2016: 52; IARS, 2015).

Finally, the UK has operated an 'assisted voluntary returns' scheme since 1999. While the Home Office has administered the programme since 2015, previous incarnations, for foreign national prisoners as well as detainees and irregular migrants, have been run by a range of organisations including the International Organisation of Migration (IOM), Choices, Refugee Action, and Capita (Swan, 2017; Home Office, 2010; 2015; EMN, 2015; Black et al, 2011; Clery et al, 2006). According to a recent study for the Home Office by the European Migration Network (2015: 3), in 2014 the UK, enforced removal of 8,963 migrants. In addition, 25,815 more departed voluntarily including 2,403 cases of Assisted Voluntary Return (AVR).

According to the European Migration Network (2015: 23), AVRs offer a "dignified, cost-effective alternative to enforced removal for migrants illegally present who wish to depart the UK but need assistance to do so" (see also Swan, 2017; National Audit Office, 2009). Yet, AVRs in the UK as elsewhere are not without their critics. On the one hand, these schemes

are found to be ineffective (Black et al, 2011), on the other, they are accused of deepening social control via forms of 'penal humanitarianism' that occur largely outside public scrutiny (Bosworth, 2017; Walters, 2016).

In 2013, the British government piloted a 'go home or face arrest' scheme that included a small number of mobile vans, leaflets and advertisements in local newspapers, they sought to encourage voluntary return. Rapidly withdrawn in the face of strenuous criticism for its racialised targeting of neighbourhoods (Jones et al, 2017), this pilot was considered to have failed, despite resulting in a small number of departures. In the public outcry over the scheme, concerns were raised about the targeting of ethnic minority communities and the nature of the 'choice' being offered to those without immigration status. As such, responses to the programme reflected the European Migration Network's view of AVR programmes in general, that they should provide "access to information without threat of arrest", and that their success reflects the capacity of the government to build "relationships and trust" (European Migration Network, 2015).

Australia

Australia has, for some years now, operated one of the harshest legal regimes for irregular migrants and refugees in the world, particularly for those arriving without visas by boat. Nearly all detention and alternative to detention policies are designed to manage people arriving to seek asylum. A small number of former offenders are subject to mandatory deportation orders under section 501 of the Immigration Act (Powell and Segrave, 2018; Weber, 2017; Grewcock, 2010; 2011; 2014).

Anyone in Australia without a valid visa faces mandatory detention in Australia (Commonwealth of Australia, 2005). Under the terms of the 'Pacific Solution', then subsequently the 'No Advantage Policy' and 'Operation Sovereign Borders', asylum seekers arriving by boat without a visa have been processed in offshore sites. Since the passage of the *Migration and Maritime Powers Legislation Amendment (Resolving the Asylum Legacy Caseload) Act 2014,* those who arrived by boat and are living in the community are no longer eligible to apply for permanent protection. Instead they may only apply for a three-year temporary protection visa (TPV) or a five-year Safe Haven Enterprise Visa (SHEV).

At the time of writing, the most straightforward of these sites to describe is the Christmas Island Immigration Reception and Processing Centre (IRPC), which is run under contract by Serco. Additional processing centres exist on Manus Island, Papua New Guinea and on the island nation of Nauru, which, under the terms of the so-called Pacific Solution have been fully-funded by the Australian government, yet the legal definition of which is contested and somewhat outside the parameters of this review (Australian National Audit Office, 2017; Kneebone and Pickering, 2007). While, for instance, the Manus Island Regional Processing Centre officially closed on 31 October 2017, the residents of that institution most of whom have been recognised as refugees have been moved to new accommodation at East Lorengau Transit Centre and West Lorengau House under a complicated financial and geo-political agreement between the Australian and Papua New Guinea Government (REF).

In addition to the offshore detention sites, Australia operates a number of onshore detention centres, all of which, at the time of writing, are contracted out to Serco. Since 2010, the Australian government has also run a range of alternative forms of detention known under a range of appellations including 'Community Detention', 'Residence Determination' and 'Alternative Sites of Detention'. All are designed to house 'vulnerable detainees', particularly children in families and unaccompanied children (Katz et al, 2013) in the community with support from welfare agencies who, with funding from the government, source housing, 'provide payment of essential living expenses and ensure access to relevant health and

community services as well as social support networks' (AMES, 2018). Although contracted to offer welfare support, these agencies also play an important surveillance role, reporting to Department of Immigration and Border Protection (DIBP), any breaches of visa conditions, which can be very minor e.g. children not attending school.

According to a recent fact sheet produced by the Andrew & Renata Kaldor Centre for International Refugee Law at the University of New South Wales (2017), that summarises data released by the National Commission of Audit (2017), the costs of the various Australian options ranges from around $40,000 (AUD) for asylum seekers to live in the community on a bridging visa while their claim is processed to $400,000 (AUD) to be held in an offshore detention site. Detention within the mainland territory of Australia costs an estimated $239,000 (AUD) per person, whereas it is less than $100,000 (AUD) for someone to live in community detention. Figures produced by other organisations find the economic costs of detention on Nauru and Manus to be even higher. The social costs are likewise enormous (Amnesty International, 2016; UNICEF and Save the Children, 2016).

Before being allocated to an alternative to 'hold detention', individuals are risk assessed, for their likelihood of absconding. While in these houses, individuals are given temporary 'Bridging visas' (Nelson et al, 2017). They may volunteer and engage in activities arranged by the charitable organisations, which run the institutions. Individuals in community detention are supported by case managers who are meant to help them understand their immigration and asylum case and sign post them to welfare and social services. Children in community detention may attend local schools. Families are kept together (JSS, 2015).

Evidence suggests these programs are cheaper than closed detention and have high rates of compliance (Mitchell et al, 2004; Mitchell, 2009). In a 2009 report, for instance, the International Detention Coalition reported that "On average, there has been a 94% compliance rate, with only 6% those individuals who have exited the programs absconding and 67% of those not granted a visa to remain in the country voluntarily departing (Mitchell, 2009: 10; Edwards, 2011). Among families, the absconding rate was less than 1%.

Similarly, evidence suggests that programs were better for the mental and physical health of their inhabitants (Marshall et al, 2013; Mitchell, 2009; Katz, et al, 2013). In a 2013 evaluation of Community Detention, for example, the authors found that: "community detention appears to assist in improving the wellbeing of clients when compared with other forms of detention and does not exacerbate existing trauma for clients." (Katz et al, 2013: 23).

Questions remain, however, about the impact of the uncertainty and long duration of time in community detention. As with detention, the lack of clarity can be painful and corrosive on mental health and family cohesion (Nelson et al, 2017). Individuals in these forms of housing have little say over their location and can be moved at any time. Some find this level of uncertainty hard to bear (JRS, 2015; ASRC, 2010).

In 2014, Australia rebranded its somewhat piecemeal case management system the Status Resolution Support Services (SRSS), a single integrated programme designed to provide flexible support services to people seeking to resolve their immigration status. Funded by the DIBP, now part of Home Affairs, the SRSS has three main strands: case co-ordination, accommodation services and financial assistance. Through contractual arrangements with a range of social welfare agencies, asylum seekers can access carer and caseworker support, community accommodation and some financial assistance through Centrelink. Assistance is time limited and depends on the immigration status of the individuals. Those who are eligible for the programme are placed onto one of six bands (Jesuit Social services, 2015: 2-3):

- People on bands 1 to 3 (for unaccompanied minors or people assessed as having significant vulnerabilities in Community detention) are eligible for support services and limited income support.
- Band 4 transitional support is for asylum seekers released from an immigration detention facility and placed on a Bridging Visa. This involves six to 12 weeks support including temporary accommodation and income assistance. After this period they must make their own efforts to access the private rental market.
- Band 5 is for those assessed as having complex barriers to resolving their immigration status but able to live independently. They may receive a range of supports (including case management services) and income assistance.
- Band 6 is for those assessed as having low to medium level of need – they generally only receive income assistance.

Under this system, those subject to immigration controls receive partial access to aspects of the welfare state. While this allows for some benefits to their mental and physical health, organisations like the Jesuit Social Services point to the complex needs of the asylum-seeking population in Australia, many of whom have endured immense trauma (JSS, 2015).

Finally, Australia also operates an Assisted Voluntary Returns scheme (AVR). Dating to 2002, these range from travel assistance to in-country housing assistance. Delivered by the International Organization for Migration (IOM), there is little evidence that these programs alone affect removal rates (Koser, 2015; see also Black et al, 2011). Rather, a host of other factors, from gender, to pre-migration experiences, family ties and circumstances in the country of origin are better predictors of people's decision making. According to figures obtained from DIBP by the Australian Deportation Project, numbers of those who have left under AVR have remained stable over the past five years, around 400 per year, a sum that corresponds to 4% of the total population removed (The Australian Deportation Project, 2018). Over the same period, while monitored departure accounted for the vast majority, 'voluntary removals' from detention increased

In a recent Senate debate in the Legal and Constitutional Affairs Legislation Committee (23 October 2017), nearly all of which focussed on the closure of the Manus Island Regional Processing Centre, the government reported that Assisted Voluntary Return from these processing centres costs $25,000 (USD). At the time of the debate the government was expecting 52 people to have returned to their country of citizenship by the end of the calendar year.

Canada

Canada has very few sites of immigration detention and has, historically, been a country with a relatively liberal immigration control system (Pratt, 2005; Dauvergne, 2016). Over the last five years, the numbers in detention have declined by 27%. Although new sites of detention are currently under development, the numbers in them remain low. According to a recent report by the Canadian Border Security Agency (CBSA) on any one day, around 400 – 500 people are detained, a number that, in 2015- 16 corresponded to "a total of 6,596 individuals, approximately 0.02% of the near 32 million non-citizens who entered Canada" (CBSA, 2017). The average length of detention that year was 23 days (CBSA, 2017).

In 2014-15 the whole system of detention was reviewed in a process that identified a series of concerns over: the reliance on correctional facilities to house immigration detainees, the care and monitoring of detainees with mental health issues, the detention of children, conditions in some detention centres and the lack of nationally-available Alternatives to Detention (CBSA, 2017). In the New National Immigration Detention Framework, the

government committed itself to expanding ATDs nationally by expanding community programs and voice reporting and other forms of electronic supervision. In terms of the former, a 2017 report by the CBSA, notes that:

> "Community programming could be considered for eligible foreign nationals or permanent residents who are adequately supported by family/kin to ensure in-person reporting and/or a cash and/or performance bond. Alternatively, the person could be entrusted to a third-party community case management partner that would act as a guardian and assist clients to ensure their compliance with any and all terms and conditions, and provide them with social support that will enable them to comply with immigration requirements." (CBSA, 2017)

Electronic supervision, the same report sets out, would allow "for voice registration and recognition and as required, based on level of risk, the ability to track the person's location should there be a failure to comply with reporting conditions or an attempt to abscond" (CBSA, 2017).

While such developments are still in the process of being established, Canada hosts one of the few alternatives to detention programmes that has been evaluated. The Toronto Bail Project, which deals with individuals under immigration and criminal justice powers, has been in operation since 1996. The organisation identifies eligible detainees through a screening and assessment process before supporting their application for release on bail. Participants include a wide range of individuals from former prisoners, to refugee claimants, and others who have been detained for reasons of a perceived flight risk (Costello and Kaytaz, 2013; IDC, 2015).

Participants are supported through case management and regular reporting. Due to an agreement with the government, those who agree to the terms of the project, avoid the financial costs of bail that they would otherwise face, as the Bail project acts as their surety. According to the International Detention Coalition (IDC) (2015), "The programme costs CA$10-12 per person per day compared with CA$179 for detention. In the 2009-2010 financial year, it maintained a 96.35% retention rate; in the 2013-2014 year, it was 94.31%."

The Toronto Bail Programme is not without its critics, however. In particular, questions have been raised on the reliance on intensive supervision system that draws directly on a criminal justice model (CCR, 2015). The Canadian Council for Refugees also warn against extending enforcement measure against people who would otherwise be released (CCR, 2015). "There is a tendency," they write, "for a programme such as Toronto Bail Programme to become normative, rather than being seen as exception. Such a programme should be available as a last resort for people who have no other options for release." However unintentionally, the CCR claim, the Toronto Bail Project has become a standard against which other alternatives are measured and found wanting. Because it only exists in one region of Canada, it has also created an internal inconsistency. They likewise raise questions about its funding by CBSA (CCR, 2015).

Other, less coercive systems have been found to be as effective in Canada, with the IDC reporting that the FCJ Refugee Centre, which provides housing for women and children without the supervision, has a 99.9% compliance rate. Sojourn House, Hamilton House and Matthew House, all of which offer assistance to refugees and asylum seekers likewise have very high rates of compliance (Edwards, 2011: 83; Fields and Edwards, 2006).

– Between 2012-2015 Canadian Border Services Agency (CBSA) piloted an AVR scheme with the IOM to increase departures for failed asylum seekers with no legal right to remain (Citizenship and Immigration Canada, 2012; Swan, 2017). An in-house evaluation

for the 2013-14 period found that, while the overall programme had little impact on the speed of removing failed refugee claimants, overall the programme was popular and effective for those who volunteered rather than were referred by the CBSA. According to the final report, the "pilot programme processed departures for failed refugee claims with older Immigration and Refugee Board decision dates faster than low-risk, non-AVRR removals. However, failed refugee claims that were filed and decided after the refugee reform came into effect were processed slower." Likewise, take-up was better in the first year than in the second.

United States of America

As it has been with prison in the criminal justice system, the US is an enthusiastic proponent of immigration detention, in its immigration system (Kalhan, 2010; Legomsky, 2007). In 2016, more than 350,000 men, women and children were detained, while over 462,000 were removed or deported (Global Detention Project, 2018). Detainees are placed in purpose built facilities and in beds set aside in state, local and federal correctional institutions. The US detains unaccompanied children.

Alongside this system of detention, the US has a strong track record in developing and piloting alternatives to detention (Schuck, 1997). While funding for ATD programs "started small", Robert Khoulish (2015: 100) points out it "quickly grew into a significant financial commitment. In 2002, Congress appropriated $3 million for ATD. In FY 2005, Congress authorized $5 million. The following year its commitment to ATD jumped to $28.5 million." ATDs in the US take a number of forms, including reporting requirements (known as 'Orders of Supervision'), bail ('Order of Release on Recognizance'), community-based practices, that are often delivered by faith-based groups, tagging and intensive supervision (Legomsky, 2007; Marouf, 2017; Khoulish, 2015; Rutgers school of law and American Friends Service Committee, 2011).

Well before the current interest in ATDs, the Vera institute of Justice in New York City, pioneered a casework based community alternative (Stone, 2000). Over a three-year period, from 1997 – 2000, the Appearance Assistance Programme (AAP), allowed 165 irregular migrants to live in the community while their immigration case proceeded. While some were subject to an 'intensive' form of supervision, others were not. In all cases, migrants were assisted in accessing a range of welfare provision, including housing, food pantries, education and legal advice. They were also referred to English lessons, health clinics and other aspects of social services.

According to a 2000 evaluation, the programme was highly successful in ensuring clients attended court hearings, with 91% of AAP intensive participants appearing for all of their required hearings, "compared to 71% for the comparison groups that faced no risk of re-detention." (Stone, 2000: 681). The scheme was particularly successful with 'criminal aliens'; "Of the 111 criminal aliens who entered the regular supervision program, 102 (92%) appeared for all of their required hearings. Of the 62 participants who finished, 51 (82%) fully complied with their legal obligations. These data suggest, in short, that criminal aliens who do not pose a threat to public safety and who have a good history of compliance with prior legal proceedings are particularly amenable to supervision" (Stone, 2000: 682).

AAP staff wielded considerable coercive power. They could, and did, recommend re-detention, if participants failed to comply, likewise they escorted participants to the airport to confirm departure from the United States (Stone, 2000: 677-678). Overall, the evaluation concluded it was possible to "build and operate alternatives to detention with real teeth that improve integrity even while they relieve hardship. Implementing such alternatives will result in more deportations of those whom the law excludes, and less detention of those permitted

to remain in the United States" (Stone, 2000: 687). "Most people", the report found "want to comply" and" good supervision more than makes up for any deterrent impact that the possibility of immediate re-detention might have" (Stone, 2000: 686).

Other examples can be found with even higher rates of compliance for asylum seekers. Thus, the Lutheran Immigration and Refugee Services experimental project from the 1990s operated a case-management based system with a 99% compliance rate (Edwards, 2011: 83). A similar program, operated in 1998 by the Catholic Church in New Orleans, for asylum-seekers and other persons with over 90-day-old removal, had a 96% court appearance rate (Edwards, 2011: 84).

More recent examples of case management can be found. Throughout 2015 growing numbers of Central American women and children entered the USA from the Southern border with Mexico seeking refuge (Gomez Cervantez et al, 2017). After extensive legal action on behalf of these families, who had been subjected to mandatory detention in hastily constructed detention sites near the border, the US government looked into alternatives, one of which was the Family Case Management Programme (FCMP). In operation from September 2015 – June 2017, the program, run by Geo Care, reported high levels of compliance with the immigration and asylum system (GEO, 2017).

Working in partnership with community-based organisations in Maryland and the District of Columbia, Los Angeles, Chicago, Miami and New York, Geo offered essential support in housing, healthcare, trauma counselling and clothing. Children were registered in schools. Participants were subjected to intensive supervision, including a mix of office and home visits and telephone check-ins. They were instructed in the legal rights and obligations in Spanish and, were assisted in gathering relevant documentation such as passports prior to departure.

According to an internal report, published after the programme was terminated, the FCMP was broadly successful. Participants were highly compliant with check-in requirements (97.3% success rate) and in attending court (99.3% success rate) (Geo, 2017: 6). Absconding levels were low (2.5%) (Geo, 2017: 7).

Notwithstanding these success rates, current policy in the US favours electronic monitoring. Electronic Monitoring for immigration matters may take different forms depending on the technology of the tagging device and the reporting requirements. The Intensive Supervision Programme (ISAP), which was initiated in 2004 has become the most popular of the programmes. Currently delivered by GEO under a national contract, the ISAP are based on a criminal justice model. Immigrants are subject to a risk assessment (Noferi and Khoulish, 2014), developed by ICE, and then allocated to this programme.

People on ISAP are equipped with a GPS monitor and required to report. According to ICE's own statistics, the ISAP programme is both cheap and engenders high rates of compliance for all court hearings including the final removal hearing (Office of Inspector General, 2015). Thus, in a recent overview of US alternatives to immigration detention, Marouf (2017: 122) reported that:

> "Under the Technology-Only program, telephonic monitoring costs just $0.17 per participant per day, and GPS monitoring costs $4.41 per participant per day. The "Full-Service" option that includes case management costs $8.37 per participant per day. ICE estimated that the average cost per ISAP participant would be $5.16 in FY 2016, compared to $123.54 per day for detention."

On other parameters, however electronic monitoring is less successful. It does nothing to help people resolve their immigration case or navigate the legal system. Evidence suggests it makes it more difficult for participants to engage with community-based assistance. It is "more restrictive, more invasive of privacy and a greater affront to dignity" than any other alternatives (Marouf, 2017: 123). Along with other critics (AILA, 2008; Khoulish, 2015), Marouf raises concerns about the 'degrading and dehumanizing' nature of tagging, commenting on the physical discomfort of the GPS device and its stigmatizing effects. "The GPS device must be charged for several hours a day, which means that participants in the programme have to plug themselves into the wall, constraining their movement for hours at a time. This can be a degrading and dehumanizing experience," he notes, before observing that people often assume "that individuals wearing ankle bracelets are criminals" (Marouf, 2017: 123). Such matters, "can lead to discrimination and create problems at work or in school" (Martin, 2017: 123; see also Camayd-Freixas, 2013).

Perhaps more compellingly from the government's perspective, an internal review of ICE's own methodology draws at least some of their claims of efficacy into question (Office of Inspector General, 2015). Specifically, in a recent review of the programme by the Office of the Inspector General (2015), questions were raised about the efficacy of the programme in preventing absconding. The report also drew into question the utility of the risk assessment tool.

Estimates of the cost of ATDs in the US range widely from a purported 17 cents per day for telephonic monitoring (Marouf, 2017) to an average of $22 per day overall (Khoulish, 2015). All estimates are always considerably less than the daily rate cited of around $122 for detention (Rutgers School of Law and American Friends Service Committee, 2011). Nonetheless, the scale of cost-saving remains unclear, as there has been no evidence that the use of alternatives like electronic monitoring has reduced the reliance on detention (Acer and Magner, 2013).

European Union

Wherever they are implemented, alternatives to detention, like detention itself, exist within a legislative framework. Across the EU (other than the UK), alternatives are legal responses to the obligation in the 2008 Returns Directive, to examine 'less coercive measures' (Feldman, 2012; Ceccorulli and Labanca, 2012). ATDs have been further entrenched in law by the 2013 Reception Conditions Directive which "explicitly requires Member States to establish national rules concerning alternative schemes, and lists examples of ATDs" (Bloomfield, 2016: 32).

In response to such matters, according to a 2015 report by the European Commission (2015: 4), "The majority of (Member) States (24 in total) have developed alternatives to detention, which can include: reporting obligations; residence requirements; the obligation to surrender identity or a travel document; release on bail; electronic monitoring; provision of a guarantor; and release to care workers or under a care plan." In 2013, the same report found, the largest number of third-country nationals provided with an alternative to detention occurred in France (1,258), followed by Austria (771), Belgium (590) and Sweden (405).

Despite these figures, data about effectiveness or impact remains slight (European Commission, 2015: 5). In the sections below I will summarise examples from a selection of EU member states to draw out some of the variety of practice and effect (see also Bloomfield 2016, Bloomfield et al, 2015; Council of Europe, 2017; European Migration Network, 2015).

Belgium

Until recently, Belgium was a great proponent of alternatives to detention for families (Schockaert, 2013; European Migration Network, 2014; Cartuyvels et al, 2017). They had an emphasis on voluntary returns, which were administered through open family housing units. This strategy increased removals and was widely considered successful. However, in response to a growing number of families absconding from this programme, as well as hardening public opinion about irregular migration and asylum seekers, it is now being scaled back and more emphasis is being placed once again on closed detention (Global Detention Project, 2017a).

Open family units, also known as 'return houses' were initially introduced in Belgium in 2008, in response to concerns over the negative impact of detention on the wellbeing of children. They were created as an 'alternative to detention' for families with minor children who had been served with a detention order, although some families continued to be detained (Global Detention Project, 2017a). Asylum seekers were assigned a case manager to work with them throughout the status determination process. In practical terms, open family units include individual houses and apartments. Within them, adults are allowed a certain freedom of movement, and children attend local schools. Adults are not allowed to work, nor do they receive payments in cash. Instead they receive coupons to use at a local supermarket. Similarly, while they can access healthcare, appointments must be made on their behalf by their caseworker. In addition to legal advice, information is provided by the IOM about AVRs.

From October 2008 to December 2012 406 families had passed through the units. All had been given an immigration detention order, but were diverted to these houses due to the presence of minor children. Within the total number, 185 departed to their country of origin or to a third country; 33 of whom departed with IOM assistance. Some105 families absconded, usually within hours or days of arrival. And 115 families were released to live freely in the community, either due to being recognised as refugees or under other forms of protection. One family was disqualified from the programme (Schockaert, 2013: 54).

Since 2015, return houses have also been used for destitute irregular families who have applied for social welfare assistance, but have not been served an immigration detention order (Global Detention Project, 2017a: 10). As the numbers housed has grown over time, rates of absconding have increased as well. Without a corresponding growth in the numbers of 'coaches' to assist them, families have found it harder to access services. Their reduced contact seems to have diminished the program's effectiveness (van der Vennet, 2015: 95 – 96).

Sweden

Although numbers are currently dropping, Sweden remains a primary destination for and recipient of asylum seekers in Europe. As such, much of its immigration control system concerns managing asylum seekers while their legal case for sanctuary is under review and, for those facing removal if their case has been refused. Sweden has a very small immigration detention estate, although has recently been opening new facilities (Barker, 2017; EMN, 2016; 2013; Global Detention Project, 2016a). It uses a variety of strategies including community-based case-management, reception facilities, reporting and AVRs (Swedish Migration Board, 2014).

While much is made of Swedish case-management, this strategy is largely concerned with asylum seekers and so, strictly speaking, is not relevant for a comparison of ATDs in the UK, where few asylum seekers are detained while their case is underway. Instead, as the Global Detention Project observes (2016a), Chapter 10, Sections 6 – 8 of "the Aliens Act provides one non-custodial alternative measure to detention, "supervision" (*uppsikt*). Both adults and

children may be placed under "supervision," which entails an obligation to report to the police or to the Swedish Migration Agency regularly. A foreign national's passport may also be confiscated for the duration of the supervision period." Supervision orders are reviewed within six months, and cease immediately if grounds for detention are no longer valid.

Germany

Federal law in Germany does not include special provision for ATDs. Yet, section 62(1) of the Residence Act states that "pre-removal detention is not permissible if the purpose of custody can be achieved by other, less severe means" (Global Detention Project, 2017b). In response, some states have created alternatives to detention, particularly for unaccompanied minors who, in German law, may be detained. One such program, based in Brandenberg State, was evaluated by the Jesuit Refugee Service (JRS) in 2011.

Known as Alreju, this ATD was founded in 1993 as a pilot project. Run by a Protestant church-based social service agency, it offers housing, some education and social assistance to up to 40 unaccompanied minors in six housing units that are located within a former Red Army barracks. While young people are placed in education in the community as quickly as possible, they face a curfew in the evening and must reside in the facility. The programme, the JRS found, had had little discernible impact on the use of detention for unaccompanied minors, despite years of success in integrating them into the community (JRS, 2011).

The Netherlands

Despite fairly high levels of immigration and a growth in the number of asylum seekers, the Dutch immigration detention system is small and has recently been shrinking in size, with the numbers dropping from 6,104 in 2011 to 2,176 in 2015 (Global Detention Project, 2016b). Article 59 of the Aliens Act "Provides that detention can be ordered only if less coercive measures cannot be applied effectively" (Global Detention Project, 2016b: 8) and thus, like other EU member states, Holland runs a variety of alternatives to detention, which are inscribed in the law, and gathers statistics on their impact (EMN et al, 2014). Alternatives include reporting obligations and bail. Non-citizens whose application for a residence permit has been refused may be required to stay in a designated area or place, which could include a reception facility or family centre (Global Detention Project, 2016b: 8).

Numbers placed in alternatives are low. According to official statistics, between 1 January 2012 and 1 June 2013, for instance, 75 foreign nationals were required to report. Of these, 55 had left the Netherlands independently while ten continued to report. In less than five cases forced departure took place and in ten cases individuals left independently without supervision. An even smaller number were managed through a pilot financial caution system known as 'Borgsom.' Of the fifteen participants between 2012 and 2013, fewer than five had left independently. A number of pilot projects have been trialled with church-based and other voluntary sector organisations. In a 2013 government report, these were found to be largely successful; from a total of 180 participants, 75 had left the Netherlands independently, while 85 remained in the programs. Two programs in particular, Stichting Bridge to Better and Stichting Dalmar, which targeted Somali nationals were found to be most successful (Ministerie van Veiligheid en Justitie, 2013).

Outcomes of alternatives to immigration detention on mental and physical health

Evidence is clear that immigration detention is strongly correlated with poor mental and physical health outcomes (For an overview see Bosworth, 2016). In contrast, nearly all the material reviewed for this report found that alternatives to detention are less damaging to the mental and physical health of migrants (see in particular Bloomfield et al 2015; Detention Action, 2016; Katz et al, 2017). In particular, case-management based schemes the community, which facilitate contact with health care and mental health care, have better mental health outcomes (Katz et al, 2013).

In contrast, certain ATDs, such as reporting and intensive supervision may have negative effects on mental and physical health. In a 2011 report, for instance, the Rutgers School of Law and American Friends Service Committee (2011: 16) observed that: "Psychological effects of the check-in requirements include, but are not limited to, inability to sleep, loss of appetite, anxiety, stress, paranoia, and general lack of willpower to continue with one's immigration proceedings'." They likewise found that the distance people often had to travel for reporting requirements was not just costly but could be damaging for their physical health (p. 17). One way to mitigate such problems, the report suggested, was to ensure better consistency in check-ins, allowing people to report to the same officer each time to allow for rapport and trust to develop (p.22).

From Australia, some troubling evidence exists about the particular vulnerability of unaccompanied children placed in Community Detention (Commonwealth of Australia, 2017). Not only are these children particularly vulnerable to sexual assault, but their pre-existing mental health needs are complex and may not always be met. Research by the Jesuit Social Services (2015) in Australia has found, for example, that asylum seekers in the Australian community suffer a range of health problems including chronic diseases, and psychological illness at a significantly higher rate than other immigrants. Although under the terms of Community Detention they have access to healthcare, they are unable to make their own appointments and so may face barriers to seeking and receiving appropriate care. Furthermore, they may be unable to afford medication or access to secondary care.

In those countries like Australia (and Sweden) where ATDs are primarily used for asylum seekers, recipients exhibit high levels of PTSD, anxiety and depression (Jesuit Social Service, 2015). For these people, uncertain visa regimes under which many people may live for years pose significant challenges to mental health. Thus, while evidence is broadly supportive of ATD programs to assist with well-being (Katz et al, 2013), and self-esteem (Detention Action, 2016), attention needs to be paid to the wider immigration system in which these programs operate.

Conclusion

As the range of examples summarised in this review suggests, there is widespread support for Alternatives to Detention across many jurisdictions, groups and individuals. Yet, there is little consistency in the design, rationale or application of alternatives to detention. In this final section, I wish to set out some thoughts on how we might come to some agreement about such matters. In so doing, I seek to build on Alice Bloomfield's observation about the roots of support for ATDS, which, as she notes (2016: 32), "has emerged in response to more restrictive migration policies and tougher measures against irregular migration in a number of States around the world, of which detention is only one of the symptoms. In this sense, it was built as a reactive rather than a proactive advocacy campaign." I also take note of Michael Flynn's (2013; 2017) warnings about unintended consequences, with which the field of immigration control, like much public policy, is often marked. On this matter, the UNHCR is explicit: ATDs, they write, "must not become alternative forms of detention, nor imposed where no conditions on release or liberty are required. They should respect the principle of minimum intervention and pay close attention to the specific situation of particular vulnerable groups" (UNHCR, 2014: 5).

Part of the problem, is that, as the Rutgers School of Law-Newark Immigrant Rights Clinic in conjunction with the American Friends Service Committee (2011: iv) observed in 2011, "Despite their designation as "alternatives to detention," many ATD programs are used on individuals who have been released from detention or who were never detained in the first place, rather than individuals who would otherwise be detained in a detention facility and for whom the government's goals of ensuring compliance with removal orders and court appearances could be accomplished with alternative measures." The challenge then remains how to devise programmes that can assist without unnecessarily extending costly forms of state oversight and control.

In order to develop a robust, defensible, humane and effective system of ATDs, it is necessary to be clearer about their principles and goals and their basis in law. In this, three simple concepts are pertinent: liberty, proportionality and parsimony. When they work best, alternatives to detention restate our commitment to the right to liberty. In so doing, they remind us that detention is always the alternative.

In safeguarding liberty, ATDs have the potential to operationalise concerns about proportionality and parsimony. They allow us to consider not only what is the least intrusive action by the state possible, but also what might be the most useful, for the individual and the community?

As a matter of public policy, ATDs need to be cost effective. Yet what the appropriate elements should be in that calculation remains unclear. Evidence from around the world finds alternatives always to be cheaper than confinement, yet rarely do they reduce the reliance on detention, without an explicit commitment to ending detention, such as we saw in Britain with the end to child detention.

ATDs have the potential also to minimise harm. While case-management systems are not entirely un-coercive, in their roots in social work rather than criminal justice, they seek to safeguard the dignity of the individual and involve them as agents in their own decision making.

Like any form of coercive power, ATDs need to be subject to stringent oversight and monitoring. So, too, those subject to them need to have a clear pathway for lodging complaints, seeking redress, and challenging their treatment in the courts.

Certain schemes, like electronic monitoring may exacerbate problems already evident in the immigration control system, namely the withdrawal of face-to-face encounters, and the criminalisation of migration (Khoulish, 2015). Evidence from the criminal justice system raises urgent questions about the growing reliance on this form of technology, not only for individual rights and safeguards, but also for community cohesion and the erosion of civil liberties (McNeill, 2017; Beyens, 2017). The financial incentives for the private sector (or indeed the voluntary sector) in delivering mass-supervision are clear; the benefits to the rest of us are not.

As states around the world are faced with growing numbers on the move within an enduring era of fiscal restraint, alternatives to detention offer a potential way forward in managing migration. Extensive attention is now being paid to these schemes by the voluntary sector and by international agencies. As people are search for less coercive means than confinement, it is a good time to restate a commitment to liberty and to the ideal of a diverse community, as well as to the rule of law and the development of human rights based protections, checks and balances. In so doing, the UK government has the opportunity to build a new system of border control, based on best practice from around the world.

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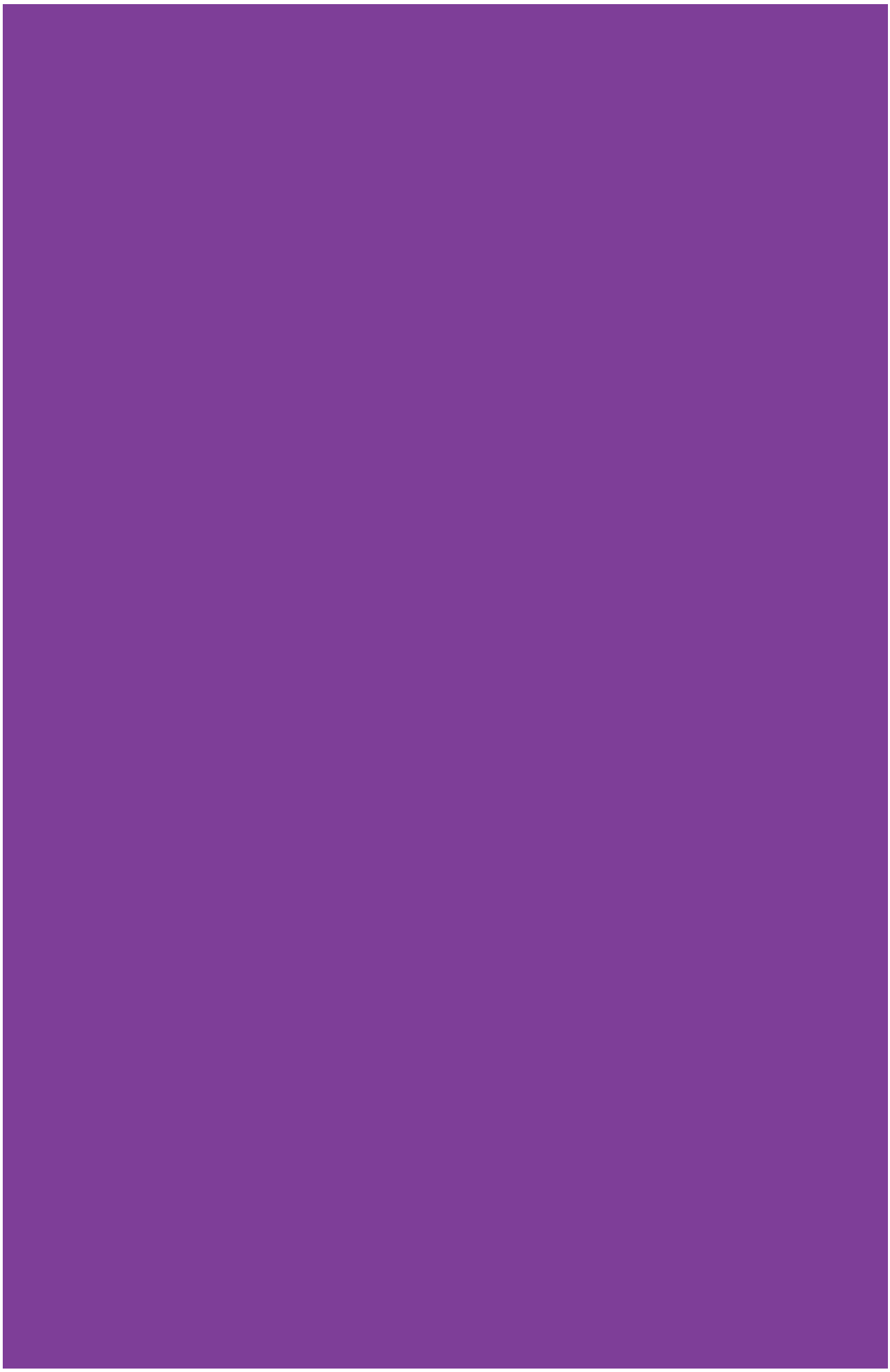
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Annex 12: Attendees at staff culture seminar, 24 January 2018

A12.1 I co-hosted a seminar on staff culture with Professor Mary Bosworth from Oxford University, at Friends House, Euston, London. The aim was to bring together academics and others to reflect on culture across the police, prisons, NHS, and IRCs, and to pull together some ideas of best practice.

A12.2 The organisations represented and the names of those who attended are set out below.

List of attendees	
Name	Organisation
[redacted]	College of Policing
	G4S
	GEO
	HM Inspectorate of Prisons
	HM Inspectorate of Prisons
	HMPPS
	HMPPS
	Home Office
	Home Office
	Home Office
	Home Office
	Home Office
	Independent Chief Inspector of Borders and Immigration
	Independent Chief Inspector of Borders and Immigration
	Independent Chief Inspector of Borders and Immigration
	Independent Chief Inspector of Borders and Immigration
	Independent Chief Inspector of Borders and Immigration
	Locala Community Partnerships
	Mitie Care and Custody
	NHS England
	Serco
	Shaw Review Team
	Shaw Review Team

List of attendees	
Name	**Organisation**
[redacted]	Shaw Review Team
	Shaw Review Team
	Shaw Review Team
	Shaw Review Team
	University of Cambridge
	University of Oxford

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