Report on an announced inspection of

Yarl's Wood Immigration Removal Centre

4 – 8 February 2008

by HM Chief Inspector of Prisons

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Introduction

Yarl's Wood, near Bedford, is the main immigration removal centre for women and families. This was the centre's first full announced inspection since it was taken over by Serco in April 2007. Despite the upheaval of this change of management and a significant reduction in staff, the centre was performing reasonably well in many areas. However, as with all immigration removal centres, there were insufficient activities for detainees. We were also particularly concerned by the length of detention of some children and the damaging effect this had on them.

Arrangements to ensure the safety of women at Yarl's Wood were generally sound: reception was well designed and managed, there was little evidence of bullying, rates of self-harm were low, use of force was proportionate and there was little use of separation. We particularly welcomed the much more reasonable approach to security now in place, with women allowed unsupervised access to more of the establishment than on our last visit. However, a lack of legal advice and inadequate information about immigration casework left many women anxious and afraid.

The plight of detained children remained of great concern. While child welfare services had improved, an immigration removal centre can never be a suitable place for children and we were dismayed to find cases of disabled children being detained and some children spending large amounts of time incarcerated. We were concerned about ineffective and inaccurate monitoring of length of detention in this extremely important area. Any period of detention can be detrimental to children and their families, but the impact of lengthy detention is particularly extreme.

The centre was brighter and better decorated than on our last visit. Staff and detainees generally got on well, although some staff appeared too busy to get to know the women in their care. Faith services were good, but it was disappointing that diversity policy and procedures were underdeveloped. Women complained about the food. Healthcare needed further improvement, particularly to address mental health and child health needs.

We were once again disappointed by the limited amount of activity available for detainees. The centre remained hamstrung by the Border and Immigration Agency (now the UK Border Agency) assumption that detainees would be quickly removed and, therefore, that purposeful activity was not a priority. Yet at the time of the inspection, over 40% of detainees had been at Yarl's Wood for more than a month. While there was a limited education programme, a small amount of paid work and good library and physical education opportunities, many detainees remained bored and insufficiently occupied. Many sat around watching television or films. The nursery was well resourced, but education and after-school activities for children were inadequate.

We welcomed the appointment of a new welfare officer, although his role was under-resourced. Visiting arrangements were good, but the visits area was not sufficiently supervised. Access to telephones was also good and internet access had recently been introduced.

Yarl's Wood is to be congratulated on sustaining reasonable performance in many areas, despite the upheavals of the change of management and reduction in staff numbers. However, significant concerns remain, particularly the lack of activity for detainees, which is a failure that we have identified across the immigration detainee estate. Even more worrying was the plight

of children detained for increasing periods of time and with insufficient provision to meet their needs. Yarl's Wood must seek to meet these concerns, but they are ultimately issues for the UK Border Agency, which must urgently address them.

Anne Owers May 2008
HM Chief Inspector of Prisons

Fact page

Task of the establishment

Immigration Removal Centre

Brief history

Yarl's Wood is a purpose-built immigration removal centre, originally opened in November 2001. The centre initially housed up to 900 detainees in two residential blocks. Following a disturbance and fire in February 2002, the B site block was demolished. After extensive rebuilding, the A site block re-opened in September 2003 with an initial capacity of 60. This was expanded to 120 by August 2004 and to full operational capacity by the end of 2005. Yarl's Wood has become the main removal centre for women and families. In December 2006, the contract for operating the Centre was awarded to Serco Ltd, who took over the management, operation and maintenance of Yarl's Wood in April 2007.

Number held

381 on 4 February 2008

Certified normal accommodation

405

Operational capacity

405

Last inspections

13 – 16 February 2006 (short follow-up)
28 February – 4 March 2005 (full)

Description of residential units

There are four main residential units and a dedicated healthcare centre with a small in-patient facility. Detainees in temporary confinement or removal from association rooms are accommodated on Kingfisher unit.

Bunting:	First night and induction unit. Single women. Forty-two beds, mostly in single rooms, with three double rooms.
Avocet and Dove:	Single women. Capacity of 130 and 112 respectively. All rooms are twin-bedded, apart from two single rooms on Avocet with some adaptations for people with disabilities. All rooms have en-suite toilet and shower facilities.
Crane:	Family unit. Capacity of 121 family members. All rooms are twin-bedded and are interconnected in pairs to allow families to be located together. Rooms have an integral screened shower and toilet. One room with a single bed is intended to be suitable for someone with disabilities. Each door has a picture to help guide children to their own room.

Healthy establishment summary

Introduction

HE.1 The concept of a healthy prison was introduced in our thematic review *Suicide is Everyone's Concern* (1999). The healthy prison criteria have been modified to fit the inspection of removal centres. The criteria for removal centres are:

Safety – detainees are held in safety and with due regard to the insecurity of their position
Respect – detainees are treated with respect for their human dignity and the circumstances of their detention
Purposeful activity – detainees are able to be purposefully occupied while they are in detention
Preparation for release – detainees are able to keep in contact with the outside world and are prepared for their release, transfer or removal.

HE.2 Although this was a custodial establishment, we were mindful that detainees were not held because they had been charged with a criminal offence and had not been detained through judicial processes. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of detention centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees:

- in a relaxed regime
- with as much freedom of movement and association as possible consistent with maintaining a safe and secure environment
- to encourage and assist detainees to make the most productive use of their time
- respecting in particular their dignity and the right to individual expression

HE.3 The statutory instrument also states that due recognition will be given at immigration removal centres to the need for awareness of:

- the particular anxieties to which detainees may be subject
- the sensitivity that this will require, especially when handling issues of cultural diversity

Safety

HE.4 Escort vehicles with caged compartments were inappropriately used to transport children. The reception area was well designed and managed. Room-sharing risk assessments were not always completed before detainees were allocated to double rooms. The lack of access to legal advice and information about immigration cases was a major concern for detainees. There had been significant improvements in child welfare procedures in the centre, but the average length of children's detention had increased and this had a detrimental effect on children and their families. There was little evidence of bullying and levels of self-harm were low. Physical security had been relaxed and helped to create a more positive atmosphere. Use of force was

proportionate and separation was used sparingly. Yarl's Wood was performing reasonably well against this healthy establishment test.

HE.5 The main escort contractors routinely telephoned the centre in advance. Escort vans with caged compartments were sometimes used to transport families with children. A number of people, including families, had been detained suddenly without adequate opportunity to gather essential possessions. This had generated insecurity and mistrust among many detainees. About a quarter of ex-prisoners were arriving without their prison records, which were not systematically pursued by centre staff.

HE.6 The reception area was spacious and well managed. We saw examples of a caring and measured reception process and a new 'express' reception process had helped to reduce waiting times. However, first night assessments were poorly completed, especially for non-English speakers. Some detainees were allocated to double rooms on the induction unit before completion of a room-sharing risk assessment, which was inappropriately done in groups rather than individually. Not enough attention was paid to the induction needs of detainees who were not fluent in English. The induction completed on the families unit was relatively superficial.

HE.7 Lack of legal representation was a major concern for detainees and, in our survey, fewer than half reported having a solicitor. Popular bail workshops had stopped and there was now a significant gap in provision. There was plentiful information about how to seek legal advice, but little supply. Twice-weekly Legal Services Commission-funded surgeries offered only a limited service.

HE.8 On-site immigration staff saw all new arrivals and reacted promptly to detainee requests. Immigration staff worked to help detainees, but the quality and timeliness of reviews by external case holders was sometimes poor. Monthly reviews rarely commented on detainees' changing circumstances, including the impact of lengthening detention. Immigration uncertainty was the main concern in our safety interviews.

HE.9 The physical environment in the children's unit was good and the centre had made significant improvements in how child care was handled. This was as a result mainly of a professional on-site social worker, regular telephone conferencing with Border and Immigration Agency (BIA) officials to determine whether further detention was necessary and weekly multidisciplinary welfare meetings. Cases were reviewed regularly and adequately. Child protection arrangements had improved and there was closer contact between the centre and the local authority. The appointment of a senior manager with sole responsibility for children also played an important role.

HE.10 However, we still had serious concerns about the welfare of children, for whom the average length of stay had, if the centre's figures were to be trusted, increased from eight days at the previous inspection to 15 days. The monitoring figures that were provided to the inspection team to show length of cumulative detentions were found to be wholly inaccurate. We found examples in the recent past of children with disabilities, who ought not to have been detained. The IS91 detention authority contained either no or insufficient information about their needs. Improvements in welfare assessment allowed cases such as this to be considered at an earlier stage. Despite the efforts of centre staff, prolonged detention was having a detrimental effect on the welfare and behaviour of children, whose fear and distress was strongly reflected in our children's interviews.

HE.11 We did not find evidence of a significant bullying problem and the few identified bullying cases were dealt with adequately. However, the lack of an internal bullying survey meant that it was hard to obtain a more accurate picture of levels of bullying. Patterns and trends were not examined at safer detention meetings.

HE.12 There were few self-harm incidents and few assessment, care in detention and teamwork (ACDT) monitoring forms were opened. The quality of initial assessments was generally good and care maps were usually appropriate. However, subsequent case reviews were not multidisciplinary and care maps were not updated. Daily ACDT booklet entries demonstrated relatively good engagement by staff. Overall, staff had made efforts to embrace the spirit of the ACDT process and detainees who had been on open ACDTs reported being well cared for. Management of food refusal was good. There were no peer supporters.

HE.13 The improved freedom of movement around the centre was a significant and sensible advance and much appreciated by detainees. The level of searching had also been reduced and the overall effect was a more relaxed atmosphere with no evident reduction in the level of order or control.

HE.14 Force was used mainly during planned removals. Completed documentation was generally good and planned removals were videoed, although not systematically reviewed by managers. The recordings provided some assurance that force was used as a last resort and was proportionate, although inappropriate techniques were used by some escort staff. Some planned removals took place with no healthcare official present and healthcare staff did not always write a report following an incident.

HE.15 The separation unit was rarely used and detainees who had experienced it said they had been treated fairly. A number of detainees had been moved from rule 40 (removal from association) and rule 42 (temporary confinement) at or near the 24-hour mark when further authorisation was required, which suggested they could have been moved earlier.

Respect

HE.16 There had been considerable improvements in the decoration and general environment of the centre. Staff-detainee relationships were reasonably good, although most staff appeared to have little time to get to know detainees. Diversity policy and procedures were underdeveloped. The faith team was effective and facilities for worship were good. Basic primary healthcare was adequate, but overall provision of health services was a concern. Complaints were dealt with adequately by Serco, but responses from the BIA were delayed and detainees had little confidence in the system. Food was an area of much complaint, despite efforts to improve standards. The centre was performing reasonably well against this healthy establishment test.

HE.17 The centre was clean and well lit, and the general environment had been improved through redecoration and the refurbishment of association rooms. Detainees had their own room keys and greater freedom of movement. There were few complaints about accommodation, sanitary or laundry facilities. New notices, pictures and signs were displayed, but there was insufficient translated material. Two monthly detainee

consultation forums were held, the main one chaired by the director, and action points were systematically followed up.

HE.18 Staff appeared to have little time to speak to detainees. We saw generally positive interactions and received some good reports on staff behaviour, but 68% of detainees in our survey, significantly below the comparator of 74%, said most staff treated them with respect. Not enough was done to communicate with detainees who spoke little English and history sheet entries were of generally poor quality.

HE.19 Detainees reported few negative outcomes in terms of diversity, but structures were weak. The diversity policy and impact assessments had not yet been completed and there was no systematic ethnic or nationality monitoring. There had been three racist incident reports in the year to date and those seen had been promptly investigated. The use of telephone interpreting had been encouraged by managers and had increased. However, interpreters were not systematically used to consult with detainee groups who were not fluent in English, particularly the large group of Chinese detainees, few of whom spoke English. Detainees were very positive about the support provided by the religious affairs team and had good access to attractive multi-faith facilities.

HE.20 The overall standard of healthcare was reasonable at the basic level of primary care, but gaps in provision, poor access and communication impacted negatively on detainees' wellbeing. Detainees did not have easy access to the health centre. Triage appointments were offered only in the late afternoon, which was an unnecessarily long period to wait for those who had been in discomfort overnight. We received reports of rude and unhelpful healthcare staff.

HE.21 Access to female GPs was limited. Detainees were not given information about planned hospital appointments in advance. In-patient services were limited. Mental health service provision for adults was limited to primary nurse assessment and any follow up by a consultant psychiatrist, although mental health beds could be accessed as needed. Adult detainees had access to counselling services, with urgent cases assessed promptly and routine assessments conducted within two weeks of application. Healthcare staff did not receive systematic feedback from the BIA when rule 35 letters were sent raising a query about fitness to detain.

HE.22 There were no specialist health services for children. There was no registered sick children's nurse, although the post was being advertised. Mental health services for children were not easily accessible and there was no pathway to access to mental health beds. There was no children's counsellor.

HE.23 There was little indication of drug use and the need for detoxification was rare.

HE.24 The rewards scheme was little understood, but nearly all detainees were on the enhanced level and expressed little concern about its operation. However, the behaviour of children in the family unit could lead to mothers being judged negatively under the scheme, which was inappropriate.

HE.25 There was little confidence in the complaints scheme, but replies from Serco were generally prompt, polite and thorough. Complaints made to the BIA were rarely resolved within an acceptable timeframe. There was little analysis of complaints.

HE.26 Menus had been translated into nine languages and a night café was provided. However, few detainees were positive about the food. We found the variety reasonable, but quality and presentation were sometimes below standard and detainees were not involved. Food surveys were done twice a year, but the questionnaire was in English and only two had been completed. The monthly food consultation meeting was poorly attended and detainees not fluent in English were not directly consulted. There was a reasonable shop list and a range of goods was available for detainees from different ethnic backgrounds.

Activities

HE.27 Detainees were offered little to fill their time, with limited resources committed to education or other activities. The strategic direction provided by the BIA focused on the provision of recreational activities for short-stay detainees, although over 40% had been at Yarl's Wood for over a month. There was some limited paid work. Children staying for more than a few days received an unsatisfactory educational experience and there were few activities outside school hours. Quality assurance and professional development for teachers was poor. The library provided a good service and physical education (PE) provision was satisfactory. The centre was not performing sufficiently well against this healthy establishment test.

HE.28 The new contract had seen the range of activity for adults significantly reduced, which had a particular impact on the many detainees in the centre for substantial periods. Over 40% were there for more than a month and 12% had been there for more than four months. Teaching staff were committed, but poorly resourced, and attendance was often low. There was little take-up of recreational activities, although the hairdressing salons were more attractive.

HE.29 Paid work had been introduced only in July 2007. Nine jobs had been created initially and this had increased to 20 just before the inspection. There were plans to expand the provision to 40 places, but this was still too limited for an adult population of some 300 people.

HE.30 On the family unit, teachers provided a reasonable quality of teaching. Staff knew the children and their families well and behaviour in the bright and welcoming classes was very good. However, educational provision was unsatisfactory overall. The curriculum was relatively narrow, there were no individual learning plans and inadequate formal targets were set or reviewed. There was no internal or external accreditation of learning. Apart from in the nursery, there was no systematic self-evaluation of teaching and learning.

HE.31 The problem of school refusers was not adequately tackled. The wide teaching age ranges (ages 5 to11 and 11 to16) hindered the teachers' ability to hold the interest of all children. Too little activity was offered outside school hours. A youth club had little take-up on weekdays, but this was better at weekends.

HE.32 The nursery was a bright and generally well resourced indoor environment, which made a good attempt at replicating facilities in the wider community. Staff were qualified and there was capacity for 20 children, although age-related staffing ratios limited sessions for some children.

HE.33 There was a well-qualified librarian and a large foreign language stock. There was also a good stock of books and videos. The sports hall was adequate and there was a popular, but cramped, fitness room and some outdoor space.

HE.34 PE was offered daily, but was largely recreational and did not offer children structured learning.

Preparation for release

HE.35 The welfare officer did some valuable work, but not enough resources had been put into the welfare role. Visits provided a good environment, although the area was not always properly supervised. Access to telephones was good and email had recently been made available. The centre was performing reasonably well against this healthy establishment test.

HE.36 The welfare officer had recently taken up his role, but also provided induction and had little time to commit to developing or extending its remit. Daily welfare surgeries were well publicised around the units, but only in English and awareness was limited. However, the welfare officer provided useful assistance to a significant number of detainees, mainly with property and banking issues, and was able to guide them to other resources. Records indicated that issues were usually dealt with promptly, often with positive outcomes.

HE.37 The visits hall had been understaffed and was sometimes left unattended for short periods. Daily visiting hours were reasonable and free transportation was provided between the centre and the train station. The visits hall was well decorated and provided a welcoming and relaxed environment with a range of notices and children's toys. Staff appeared to engage well with visitors and detainees. The visitors' centre was a contrastingly dull environment, with fixed furniture and minimal information on the walls. Staff were welcoming and reassured anxious visitors. The voluntary visitor scheme appeared effective.

HE.38 Many detainees had mobile telephones and could rent them for unlimited periods for a one-off charge of £2. There were enough incoming and outgoing lines on all units, but the switchboard was under-staffed and callers waited a long time to get through. Recent internet and email access was a step forward and there were no reported problems with the post.

HE.39 Removal directions were usually served with a few days' notice.

Main recommendations

HE.40 Reviews of detention should reflect consideration of all relevant information for and against detention, including the effect on detainees of lengthening detention.

HE.41 Children should be detained only in exceptional circumstances and then only for the shortest time necessary. Length of cumulative detention should be clearly and accurately recorded.

HE.42 Specialist general and mental health services should be available for children.

HE.43 Paid work for detainees should be significantly expanded.

HE.44 The range of learning and skills activity for adults should be increased and improved. This should include good quality tuition in English for speakers of other languages and ICT.

HE.45 The centre should improve the initial assessment of children's skills and abilities and use this information effectively to set and subsequently monitor progress towards short-term educational goals.

Section 1: Arrival in detention

Expected outcomes:
Escort staff ensure the well being and respectful treatment of detainees under escort. On arrival, detainees are treated with respect and care and are able to receive information about the centre in a language and format that they understand.

1.1 Relationships with escort contractors had improved, allowing reception staff to be better prepared for the arrival of detainees. Risk analysis documentation and information-sharing had also improved. Reception was a good environment and staff treated detainees with care and concern. First night documentation was poorly completed and detainees did not get enough help in their first 24 hours. Room-sharing risk assessments were completed late and inappropriately in groups. Induction for single women was fairly thorough, but less so for families.

Escort vehicles and transfers

1.2 The main escort contractor, Group 4 Securicor (G4S), escorted detainees to Yarl's Wood from other centres, short-term holding facilities and police stations. G4S and other contractors, including overseas escorters such as GEO and ITA, collected people leaving the centre. Relationships between reception and escort staff, particularly G4S, had improved. G4S staff usually telephoned in advance to give an estimated time of arrival, which allowed reception staff to prepare and prevented unnecessarily long waits in reception.

1.3 In our survey, 51% of detainees, significantly worse than the comparator of 57%, said they had been treated well or very well by escort staff. We did not observe any poor treatment by escort staff, but did witness some good interactions. The gender mix of escort staff was generally suitable to carry women and families. Escort vans were clean and some, but not all, had toys to keep children occupied. However, G4S regularly escorted families in vehicles with an unnecessary level of security and caged compartments in the larger vans were an inappropriate environment for children. Some families had not been given a comfort break on journeys of over 2.5 hours. One mother and four children transferred to Yarl's Wood from Dungavel in Scotland, a journey of over 350 miles, had been in the van for just under 7.5 hours with only one short break. The children said they had had to go to the toilet in the van.

1.4 We observed a family of two adults and three children being transferred to Heathrow airport. This was handled sensitively by GEO overseas escorts. The family had refused to be removed two weeks previously, but the available documents gave no indication why and there was no updated risk analysis in their movement sheets. We were told this was not unusual when overseas escorts brought failed removals back to the centre.

1.5 Most detainee records examined included some updated risk analysis that was shared with escort contractors. Yarl's Wood staff updated risk assessments and passed this information on to the Border and Immigration Agency's (BIA's) central Detainee Escorting and Population Management Unit (DEPMU). Information-sharing between overseas contractors, the centre and DEPMU was weak. About a quarter of women transferring to Yarl's Wood at the end of their custodial sentences arrived without their prison files and security information, but these were not systematically pursued by centre staff.

1.6 We looked at a number of IS91 detention authorities and movement records. Women and families were moved around less than men as only a few centres hold women and families. The status box was ticked in most, but not all, IS91s to indicate the basis for detention. Some families had been separated. In one case, this was due to the father's previous poor behaviour at the centre, which appeared harsh.

Reception and first night

1.7 The reception area was clean, bright and well decorated. Toilets included baby changing facilities and were well stocked with sanitary items and nappies. All new arrivals were offered use of the toilet, and hot or cold food and refreshments. The shower was rarely used, even though some detainees coming from short-term holding facilities and police stations had not showered for several days. All detainees were shown directly to one of four waiting rooms, all with access to the fresh air, although outside areas were a little stark with no play activities for children. The waiting rooms were easily supervised and well equipped with comfortable chairs, televisions, reading material and children's toys. A wide range of information was displayed on notice boards and through a welcome video, but this was mostly in English. We were told this was being translated in different languages and a welcome sheet was available in nine languages.

1.8 The reception process was caring, measured and unobtrusive. Searching was done considerately and 75% of detainees in our survey, significantly better than the comparator of 69%, said they had been searched sensitively. Some women detained at reporting centres were very distressed because they had not been allowed to gather essential possessions. One mother of a 12-month old son detained that morning at Loughborough reporting centre had just his pushchair with her. Reception staff treated her and her child with care and consideration and took her through the reception process at a pace she could understand.

1.9 Detainees were given a free telephone card allowing a five-minute call anywhere in the world. In our survey, 72% of women, significantly better than the comparator of 58%, said they had been able to make a free telephone call on the day of arrival. However, the two telephones available did not have privacy hoods.

1.10 The centre had recently introduced an express reception process, allowing detainees to move quickly to the residential units and reducing what were previously fairly long waiting times in reception. Property was usually searched and sorted the following morning when there was more time to do this carefully. All property and valuables were stored appropriately and property was recorded on computer. Detainees in our groups had complained about delays in accessing their property, but new receptions were brought down the following day and other property applications were usually addressed within 48 hours.

1.11 Reception interviews were considerate and empathetic. Staff completed a first night custodial sheet, recording observations, any concerns and general demeanour. However, most contained few, if any, worthwhile comment, the good work done was not recorded and useful information was not passed on. Induction and night staff made further notes on the sheets, but recording was poor on Crane unit and better, but still inadequate, on Bunting.

1.12 Single women usually went to Bunting unit, although they were sometimes allocated elsewhere if spaces were limited, and therefore had less support in their first few days. A brief reception summary was produced about the detainee, including any initial concerns, but room-sharing risk levels were recorded before women had actually been assessed. None of the women in the three double rooms on Bunting, including one smoker sharing with a non-smoker, had been assessed. The remaining rooms on the unit were singles. Single women not allocated to

Bunting were also put in double rooms before being assessed. Room-sharing risk assessments were usually completed at induction the day after reception, although some were not completed for a number of days. They were completed in groups, which was inappropriate as some of the information sought was sensitive. Reception staff concerned about any detainee could open a raised awareness support plan.

1.13 Bunting unit was clean, comfortable and friendly, and detainees were confident in approaching staff in the office. Relationships were positive and appropriate, but this was not well recorded in history files.

1.14 Detainees were not given enough support in their first 24 hours and only 42% in our survey, significantly less than the comparator of 56%, said they had felt safe on their first night. Eighty-one per cent, significantly more than the comparator of 75%, said they had had problems when they first arrived.

Induction

1.15 The welfare officer delivered induction, but he had a heavy workload and little support. Other staff on Bunting delivered it in his absence, but they were otherwise not routinely involved. Induction was comprehensive and delivered in a comfortable setting. The slides used were in English but we were told these were due to be translated, and written handouts about the centre were available in different languages. A telephone interpreting service was available and detainee interpreters were sometimes used, but not everyone was able to understand the full induction process. All families went to Crane unit where induction was adequate, but short and poorly recorded.

Recommendations

1.16 Overseas escort contractors should inform the centre of their estimated time of arrival in advance to allow staff time to prepare.

1.17 All escort vehicles carrying children should contain suitable toys or activities to keep them occupied.

1.18 Vans with caged compartments should not be used to transport children.

1.19 Overseas escorts should provide relevant information to receiving centres when a removal has failed.

1.20 Families should not be separated without a full assessment and Border and Immigration Agency senior manager authorisation. Reasons for separation should be recorded.

1.21 Escorts should provide comfort breaks at least every 2.5 hours, or in accordance with passenger needs, and record this accurately.

1.22 The outside areas in reception should contain activities for children.

1.23 The welcome arrival video should be available in different languages or formats.

1.24 Individuals detained at reporting centres should be given the opportunity to collect items, including medication, from their home.

1.25 Detainees should be offered a shower in reception.

1.26 The telephones in reception should have privacy hoods.

1.27 First night custodial sheets should be completed properly, detailing meaningful observations and interactions with detainees.

1.28 Room-sharing risk assessments should be completed individually on arrival and the practice of recording a room-sharing risk assessment risk level before the formal assessment has taken place should cease.

1.29 Staff on Bunting and Crane should be more involved in the induction process.

Section 2: Environment and relationships

Residential units

Expected outcomes:
Detainees are held in decent conditions in an environment that is safe and well maintained. Family accommodation is child friendly.

2.1 The accommodation was well ventilated, clean and brightly decorated, and association rooms were welcoming. Many doors were left open, allowing women to move about relatively freely. Detainees had good access to laundry facilities and replacement clothes. Effective monthly staff-detainee consultation meetings were chaired by the director.

Accommodation and facilities

2.2 Single women were housed on Bunting, Avocet and Dove units, while families were on the self-contained Crane unit (see fact page). Less than half the rooms were designated for smokers. Shared facilities included well-appointed association rooms, telephone rooms, laundries, hairdresser/beauty salons and outdoor recreation areas. Lighting, temperature and ventilation appeared adequate and women could open their windows a few inches. Rooms were adequately furnished and included a television and CD player. Beds and cupboards were in good condition.

2.3 Detainees were given room keys and could choose whether or not to lock their doors. They could go to the unit office, use the telephone and get a hot or cold drink any time of the day or night. Alarm bells connected with the unit office and control room, but were rarely used. Reaction times were monitored. Graphic fire instructions were displayed on the back of each room door and the centre was regularly visited by the local fire authority.

2.4 The accommodation was considerably improved since the last inspection. Many doors on Bunting, Avocet and Dove units were left open during the day, allowing women to move around without escorts. They could go to a central shop, the library or one of two cinema rooms. Colourful curtains covered some of the ugly bars and the long bleak corridors were now softened with decorations and displays, mostly created by the women and children. Association rooms had soft furnishings in warm colours. Women ate meals on their units, each of which had a servery and dining room. Staff referred to detainees as residents and were on first name terms with most.

2.5 Facilities on Crane unit included an adult association room intended to give the few men at the centre something to do. Women could visit other areas of the centre provided someone was looking after their children. Men did not have this option. Some detainees had complained that children played noisily in the corridors late at night.

2.6 There were regular consultation meetings with detainees on all units. A detainee information and activities committee (DIAC) met monthly, as did a separate food and shop meeting (see section on services). The DIAC was chaired by the director and attended by other staff members. Meetings were well advertised and open to all detainees. Matters arising from

previous meetings were systematically followed up and further discussion was wide ranging. Some suggestions from detainees were taken up.

Hygiene, clothing and possessions

2.7 The centre had recently been redecorated and was cleaned daily by contractors. Detainees could also get materials to clean their own rooms from the unit office and some were paid as cleaners. All rooms had an integral shower and toilet, with further toilets and bathrooms available for general use. Soap and other hygiene requisites were provided free. Bedding and towels were replaced weekly and a detainee who complained about her mattress during the inspection had it replaced the same day. Detainees had free access to laundry rooms with washers, driers and ironing boards. The laundry rooms also housed water boilers and coolers for hot and cold drinks, and complaints boxes. A hairdresser was regularly available in the beauty salons.

2.8 People who arrived without spare clothes were given a set of basic clothing and could apply for further items if they had not been able to arrange for a visitor to bring some. The centre stock included baby items and fleeces. There was no formal limit on how much people could have in their rooms, but large bags and valuables were stored centrally and could be accessed through application.

2.9 Detainees were discouraged from having more than £20 in cash as possessions were not secure in shared rooms. Money, including a daily allowance of 71 pence per person and 35 pence for children, was paid into their accounts.

Staff-detainee relationships

Expected outcomes:
Detainees are treated respectfully by all staff, with proper regard for the uncertainty of their situation, and their cultural and ethnic backgrounds. Positive relationships act as the basis for dynamic security and detainees are encouraged to take responsibility for their own actions and decisions.

2.10 Interactions between staff and detainees were generally positive, although detainees reported some poor staff behaviour. History sheets were poor quality and there was no care officer scheme. Not enough was done to communicate with detainees who spoke little or no English.

2.11 We observed a number of positive and respectful interactions between staff and detainees, and staff patiently trying to help people who were often frustrated and angry about their situation. Many detainees reported positively on staff behaviour, although in our interviews some said they did not trust staff to keep information confidential, or that staff were rude. In our survey, 68% of detainees, significantly lower than the comparator of 74%, said most staff treated them with respect, and only 56% said there was a member of staff they could turn to for help with a problem.

2.12 Since the change of contract, reduced staff numbers meant staff had less time to talk to detainees. Comments in history sheets were usually superficial, with little evidence of any real knowledge of detainees' circumstances and often gaps of many months between entries. There was no care or personal officer scheme. Some multi-lingual staff were able to build

relationships with detainees who spoke little English, but not enough was done to communicate with this group (see section on diversity).

Recommendations

2.13 Detainee history sheets should have regular, detailed and quality-checked entries.

2.14 All detainees should have an identified personal or care officer, who should make particular efforts to get to know those who are not fluent in English.

Section 3: Casework

Legal rights

Expected outcomes:
Detainees are able to obtain expert legal advice and representation from within the centre. They can receive visits and communications from their representatives without difficulty to progress their cases efficiently.

3.1 Possible sources of legal advice were well advertised, but few detainees had a solicitor and staff said they sent numerous requests for advice without response. Lack of understanding of legal processes particularly affected Chinese detainees, for whom acute language and literacy problems compounded lack of representation.

3.2 Detainees, staff and visitors repeatedly mentioned difficulties with getting legal advice. There was ample information about possible sources in the library and detainees were issued with a request letter on induction. Staff faxed these and other legal documents free of charge, but said the decreasing number of legal aid suppliers meant they could fax a dozen or more requests for advice without getting a response. In our survey, only 43% of detainees, significantly less than the comparator of 67%, said they had a solicitor and only 35% said they had been visited by their legal representative. This was surprising given that 30% of the women were fast track cases (see section on casework) and guaranteed a legal representative at least for the initial asylum interview. Some detainees assumed their fast track 'legal representative' was something to do with immigration.

3.3 Detainees said they could expect little from legal aid lawyers because of legal aid restrictions and that they usually had to find money to pay for representation. Seventy per cent of detainees had less than £50 in their accounts, including 43% with less than £5.

3.4 We tried to get through to the Community Legal Advice (CLA) free telephone line and searched the CLA site using one of the recently installed internet terminals. Other than solicitors in London, only the Luton law centre was identified as a potential source of advice in the area, but we were unable to get through despite several attempts. The Immigration Advisory Service and Refugee Legal Centre had small offices in Bedford and could take on a few cases. An advice surgery funded by the Legal Services Commission could potentially see up to 10 detainees a day for up to 30 minutes on Tuesdays, Thursdays and occasionally Fridays, notionally providing five hours of advice a day. However, providers usually arrived in the afternoon and rarely stayed five hours. They did not attend the centre on one of their allotted days during the inspection.

3.5 Many people had exhausted the status determination process, but prolonged detention raised a pressing need for independent specialist legal advice. Popular and regular Bail for Immigration Detainees (BID) workshops had previously been run but had been stopped, although the centre had recently approached BID about resuming them. The BID manual was the most popular item in the library, but was available only in a couple of languages.

3.6 Chinese detainees found it particularly difficult to understand their situation (see section on diversity). Many had been picked up in the community some months previously, but detention

had not been followed by speedy removal. Some had initially been detained in police stations and one had spent four nights in a London police station before transferring to Yarl's Wood. Of 12 detainees interviewed, only two had a legal representative and the others said they had no money to pay for one. They could not understand monthly detention reviews or decision and appeal papers, which were issued in English. Asked if they had been interviewed by Chinese embassy officials to progress travel documents for removal, they said they had been interviewed by a Chinese 'special customer' but were unsure where he came from (see section on casework).

3.7 Other legal issues arose when detainees were threatened with criminal prosecution for non-cooperation with removal, which carries a possible two-year sentence. Delays in acquiring travel documents for removal could be due to both the reluctance of detainees and the indifference of national authorities. A young Chinese woman had provided information for a travel document on the completion of fast track processing, but the Chinese authorities had raised a query and she had been formally notified of likely prosecution. The letter, in English, told her of her entitlement to seek legal advice, but that 'non-attendance by a legal representative or non-appearance of a legal representative will not be taken as a reason to postpone or cancel this [prosecution] interview. Failure to cooperate will be noted and the court informed.' The woman spoke no English and was reportedly illiterate. Her asylum interview had been conducted without a legal representative and she had not been given any advice on how she might set about finding a solicitor suitably qualified in criminal law.

3.8 Nine legal visits cubicles were available seven days a week from 9am to 9pm. The librarian had organised a range of legal reference materials, including legal texts and country reports, and had recently ordered a text book explaining immigration law and procedure in simple terms. Internet access, with some information and advice sites flagged up, was an asset.

Recommendations

3.9 The centre should consult with the Legal Services Commission with a view to improving access to legal advice for detainees.

3.10 Commensurate legal safeguards should be in place when detainees are threatened with criminal prosecution, including facilitated access to suitably qualified legal advice.

Immigration casework

Expected outcomes:
Decisions to detain are based on individual reasons that are clearly communicated and effectively reviewed. Detention is for the minimum period necessary and detainees are kept informed throughout about the progress of their cases.

3.11 Two immigration teams based at the centre saw all new arrivals and responded promptly to applications, but despite this few detainees said it was easy to see immigration staff. Reaction to concerns and the quality of information in detention reviews from external Border and Immigration Agency case-holders was often poor. The average stay at Yarl's Wood was less than a month, but some women had been detained cumulatively for more than a year. Reviews did not always turn up and were only in English.

3.12 In our safety interviews, detainees highlighted immigration uncertainty as a major concern. Two immigration teams based at Yarl's Wood, one for fast track and one for non-fast track cases, saw all new arrivals and responded promptly to applications. Nevertheless, only 9% of women in our survey, significantly less than the comparator of 26%, said it was easy to see immigration staff and detainees reported low levels of trust.

3.13 Up to 30% of single women were designated for the fast track asylum process. A Border and Immigration Agency (BIA) fast track case-working team based in a neighbouring building interviewed asylum applicants, made decisions and conducted appeals at the on-site hearing centre. The refusal rate was over 97% and a similar percentage of appeals were dismissed. Between October and December 2007, 70% of appellants were represented. Only four of the 45 bail applications made in the same period were granted. The determination process usually took no more than a few weeks, although people were often detained for months afterwards. The longest current fast track case had so far been detained for 218 days. The same team maintained responsibility, addressing any further queries, and the files seen indicated that casework was efficiently processed. Summary information about the fast track process was issued in various languages.

3.14 A second BIA team of a manager, deputy and seven administrative officers was responsible for all other detainees. It undertook no substantive casework, but liaised with BIA caseholders around the country, passed on or pursued information and queries, served papers issued by the case owner or completed paperwork such as biodata for travel document applications. A telephone interpreting service was used when required. The BIA's centralised family detention unit in Leeds had oversight of family cases, and its criminal casework directorate generally oversaw the 36% of single women who were former prisoners. The on-site team saw new arrivals within a day or two to clarify status and responded to inquiries. Responses were prompt and staff strove to engage with and assist detainees.

3.15 In the previous two months, healthcare had issued 18 notifications to the on-site immigration team under rule 35 of the detention centre rules[1]. These generally referred to allegations of torture. The fast track team had logged eight since the beginning of the year and these were considered within the determination process, with one case leading to release. The central folder on site confirmed that notifications were promptly sent to the BIA case-holder, but any responses were usually put with the individual file rather than attached to the original report so it was difficult to check the adequacy of reaction.

3.16 The average time spent at Yarl's Wood was 22 days, but some passed through briefly en route to Heathrow airport while others stayed more than a year. In our survey, 68%, significantly more than the comparator, said they had been at the centre more than a month. One woman had been detained for 21 months, granted release with reporting requirements for five months and then re-detained three months previously. Another had been at Yarl's Wood nearly 11 months, but detained elsewhere for five months before that. It was not easy to detect cumulative detention from the information recorded at Yarl's Wood.

3.17 Reviews of detention, which should have been issued at least monthly, were sometimes erratic, repetitive and poor quality. They were only in English. One detainee held for 13 months had written to complain about the lack of detention reviews and to request temporary release, but there was no sign of a response. When her detention reviews had resumed, they did not justify lengthening detention or comment on obstacles to removal to Somalia or Kenya, where she had previously lived. This was one of a few cases of women detained beyond a year, more

[1] Rule 35 requires a notification to be issued by the centre to the BIA if detention or conditions of detention are likely to be injurious to health, including suicidal intent or allegations of torture.

than twice the length of completed short custodial sentences, for being found with false documents.

Recommendations

3.18 Rule 35 processes should recognise the full scope of the rule, which is to raise a concern whenever detention or conditions of detention are likely to be injurious to health. Follow-up and case owner responses to rule 35 letters should be filed with the initial letter in the central log.

3.19 Border and Immigration Agency case owners should reply promptly to detainee correspondence.

3.20 Detention reviews and other significant decisions or events, such as removal directions or embassy interviews, should be issued and explained in a language the detainee can understand.

Section 4: Duty of care

Expected outcomes:
The centre exercises a duty of care to protect detainees from risk of harm. It provides safe accommodation and a safe physical environment.

Bullying and suicide and self-harm

4.1 Detainees raised some issues about bullying in our survey, but many women were reluctant to talk about it and it was difficult to determine what was actually happening. Suitable action was taken when bullying was identified. The centre had recently implemented the assessment, care in detention and teamwork (ACDT) model and initial progress had been good, although there were some weaknesses, notably with case reviews. Too few staff were dedicated to suicide prevention and peer supporters were not used. There were few open ACDT forms and detainees who had been on open forms said they had been well cared for.

Bullying

4.2 A published anti-bullying strategy accessible to all staff contained clear information about the procedures to be followed in the event of bullying. An anti-bullying manager and three coordinators had recently been appointed, but the team did not yet meet regularly. The intention was for bullying to be dealt with as a regular part of the monthly 'safe inside Yarl's Wood' meeting. Detainees were required to sign a statement at induction agreeing with the zero-tolerance approach to bullying and this message was reinforced through well-designed posters throughout the centre.

4.3 Detainees we talked to did not raise bullying as a significant problem, but some responses to our survey indicated potential concerns. Thirteen per cent said they had been victimised by other detainees because of their ethnic origin or nationality and 33%, significantly more than the comparator, that they had been victimised by staff.

4.4 A bullying incident log held on computer showed that the number of reported incidents was very low. The two current cases involved women who had made allegations about each other. The initial identifying information was adequate, but there was no record of any monitoring. During our night visit, we met staff who were unaware of individuals subject to bullying procedures.

4.5 The underlying patterns or trends of bullying had not been formally analysed and observations made by staff were based on anecdotal information. Staff dealing with this area of work believed that most problems related to personality clashes. Occasional queue jumping was also cited as a problem. Detainees appeared reticent to talk openly about bullying, making it difficult to determine what was actually happening.

Suicide and self-harm

4.6 The centre had launched ACDT in July 2007 and the associated policy was reasonable. The safer detention committee had only recently been re-established. It had met only a couple of

times since the implementation the new policy to set out its terms of reference and membership, but was not yet operating as an effective strategic body.

4.7 Staffing resources committed to suicide prevention work were limited and insufficient. An assistant director had overall responsibility for this area as well as safeguarding and activities. Other than a number of trained assessors and case managers, obligatory under the ACDT model, there were no dedicated staff and no suicide prevention liaison officer. Some detainee custody officers had been identified to do some work with anti-bullying and the aim was for them to pick up some suicide prevention issues as well, but this was not likely to come into effect in the near future. There were no peer supporters.

4.8 The number of open ACDT forms and incidents of self-harm was relatively low. Seventy-eight ACDT forms had been opened since July 2007 and only one was open during the inspection. The times of greatest vulnerability were when removal was imminent and immediately on arrival, despite this first night risk assessments were frequently poor quality (see section on first night).

4.9 Wing staff appeared to be identifying crises and opening ACDT forms appropriately. A parallel system of 'raised awareness' aimed to help a detainee get over a short-term crisis and any open longer than 48 hours were considered for conversion to an ACDT form. Three raised awareness forms were open during the inspection.

4.10 The quality of completed ACDT forms was mixed. Initial assessments were mostly good, but subsequent reviews were sometimes average and often unsatisfactory. Preparation for reviews was often inadequate, with no objectives or desired outcomes considered in advance. Reviews were frequently superficial and not multidisciplinary, with usually only a couple of wing staff and the detainee attending, although it was not always evident that the detainee had been present. There were several examples where staff identified at a previous review as needing to attend had not been invited. Individual care maps were largely ignored and were not updated. On one occasion, a decision taken by a specialist member of the healthcare team had been overturned by generalist staff two days later with no explanation. The write-up of case reviews was often illegible. Senior managers acknowledged these shortcomings and additional one-to-one training for case managers was ongoing.

4.11 The continuous update logs in ACDT forms maintained by unit staff were reasonable, although some entries were mechanistic, calling into question their validity. For example, entries such as 'appears asleep' were sometimes repeated at precisely every 15 minutes through the night. These were not always highlighted by management checks. However, many staff had clearly made a real effort to embrace the spirit of the ACDT process and many entries were good quality and provided a balanced picture of the individual.

4.12 The approach to managing detainees under ACDT procedures was slightly over-cautious, possibly because the system was still relatively new and staff may have lacked confidence in applying it. The frequency of required observations was often set at two, three or even four times an hour when the crisis did not appear to have been acute, which could have been invasive and possibly counter-productive. Reviews were often set to take place every couple of days, even when the form had been open for some time, with no explanation. This may have been the cause of some of the weaknesses we found in the quality of case reviews. However, despite the weaknesses, there was a good foundation on which to build further developments. Detainees who had been on open ACDT forms said they had felt cared for by staff when the forms were open and that the process had been helpful to them.

Recommendations

4.13 Records monitoring individuals subject to bullying procedures should be completed properly and quality-checked by managers.

4.14 All staff should be routinely briefed so that they are aware of who is subject to bullying procedures.

4.15 Annual surveys should be conducted to determine the extent and nature of bullying.

4.16 The management structure overseeing the governance of safer custody should be reviewed. In particular, someone should be identified and provided with sufficient time to oversee day-to-day operational issues relating to suicide and self-harm prevention.

4.17 Suitable detainees should be identified to act as peer supporters, particularly on the first night/induction unit, and provided with training and a job description.

4.18 The quality, structure and chairing of case reviews should urgently be improved.

4.19 Management checks should be more proactive in highlighting inadequate entries in continuous observation logs.

4.20 The safer detention committee should assure itself that the frequency of required observations and intervals between reviews are not set unduly frequently without explanation.

Childcare and child protection

Expected outcomes:
Children are detained only in exceptional circumstances and then only for a few days. Children are well cared for, properly protected in a safe environment and receive suitable education. All managers and staff safeguard and promote the welfare of children; as do any services provided by any other body.

4.21 The average length of stay of children had apparently increased from eight to 15 days, although in some cases the total time detained was much longer. There was no evidence that children's individual needs were systematically taken into account when decisions to detain were made. Our interviews with detained children illustrated the effect of sudden arrest and detention on their wellbeing and reflected how scared they were while held in detention. The review and monitoring of cases following detention had improved. Child protection arrangements were broadly sound.

Childcare

4.22 The centre's own figures indicated that the average length of children's detention had increased since the previous inspection from eight to 15 days. On the first day of the inspection, there were 56 children under the age of 16 at the centre (see population profile at appendix II). In the previous 10 months, the average age of detained children was between five and seven years and the total number held in any one month ranged from 122 to just two.

Of 450 children held at Yarl's Wood between May and October 2007, which included a period of chicken pox quarantine, 83 were held for more than 28 days. In the same period in 2005, more children passed through but the number spending more than 28 days at the centre was substantially lower at 27. The recent average length of stay for children was 15 days. A number of children had experienced longer cumulative periods of detention, which was worrying given the adverse effects that extended detention almost inevitably has on children and their families. However, the monitoring figures that were provided to the team to show length of cumulative detention were found to be wholly inaccurate. For example, children who we were confidentially told had been in detention for 275 days were later said to have been in detention for 14 and 17 days. At the end of their stay, most children were given removal directions or temporarily released, with very few transferred elsewhere.

4.23 Many parents believed their children had deteriorated quite quickly after arrival in detention. Children who otherwise had been described as coping well in the outside community were now reported to be having difficulty eating and sleeping, becoming withdrawn and showing other symptoms such as bed wetting. Nearly all the children we spoke to said they had felt scared, upset or worried on arrival, which was not surprising given the sometimes traumatic circumstances in which many had initially been detained. The children also indicated that these feelings remained or even worsened during their stay. Teachers working at the centre also reported cases of children withdrawing or appearing depressed and becoming rebellious and unreasonable following admission.

4.24 There had been some improvements to the management of individual cases. These were mainly as a result of new external and internal reviewing systems, along with the continuing presence and influence of an experienced social worker who was now able to produce independent welfare assessments.

4.25 Telephone conferencing arrangements introduced in early 2007 were a significant step forward. These allowed children's cases to be considered by a panel of representatives from external agencies chaired by a senior Border and Immigration Agency (BIA) official. The BIA case owners, two senior professional advisers from the children's champion's office within the BIA, the social worker, the healthcare manager, a member of the on-site BIA team and the assistant director for childcare in the centre also took part. The panel met weekly and discussed about 10 cases each time. The aim was to determine whether the length of time a family had been detained was proportionate and children's welfare needs were being met. The conference we observed was chaired skilfully and most contributions were constructive, although those made by case owners did not appear always to be centred on the best interests of the child. Of particular concern were some subjective, speculative and negative comments made about family members. We were told that the arrangements had resulted in about four families being discharged back into the community, but no clear record was maintained. Action points were not clearly attributed in the minutes, which were not detailed enough to allow monitoring to prevent cases drifting.

4.26 Another improvement was the introduction of the weekly welfare meetings, chaired by the assistant director responsible for children and family services. The social worker, one of the teachers, a nurse and the youth worker also attended. Meetings could last up to two hours and discussed the welfare needs of each child at the centre. Those attending had good knowledge of each child, identifying those not eating or sleeping properly or not attending school or nursery. One of the group usually arranged to interview the mother and, if appropriate, the child to try and resolve the situation. The deteriorating behaviour of children who remained at the centre for long periods was one the main themes of these meetings.

4.27 The centre social worker completed written welfare assessments on children. However, these applied only to those resident at the centre for more than three weeks, even though we found at least two cases where children with special needs should never have been taken in to detention and the IS91 detention authority contained little or no useful information about their needs. The welfare assessments were based on interviews with the child and parent as well as on medical and educational records. These useful documents provided a clear picture of how the child was coping, but it was not clear that full use was made of them and only a summary was actually passed on for ministerial consideration at 28 days. A meeting had been scheduled between centre staff and representatives from the children's champion's office to discuss this. The initial reports were reviewed every seven days, but only verbally.

4.28 When children needed to be admitted to outside hospital, there was no presumption that this should be done under temporary release arrangements. Standard practice was simply to organise a bed watch without a risk assessment.

4.29 The physical conditions and facilities for families and children were good. Some detainees complained to us that they could not look after their children by being able to cook and clean in the way they wanted to and which would help them maintain their independence and foster self respect. There was a youth club supervised by a youth worker in training where children could play pool and video games and listen to music. School hours included two outdoor playtimes and one hour of physical exercise. Children could use the playground before and after school until around 9pm and at weekends.

Child protection

4.30 A detailed local child protection policy, 'Keeping Children Safe', had been produced in collaboration with social work colleagues in the local authority and published in January 2008. The procedures specified that, following receipt of a child concern notification form or child protection referral, a decision would be taken internally about whether or not to make a referral. In order to maintain transparency, all such information should have been transferred, along with a recommendation about whether further action was necessary. The policy was on display in each unit office and a series of talks had been organised to inform staff of the contents.

4.31 Given the complex make up of the population and high levels of stress among family members, the number of child protection referrals was surprisingly low. Only about four had been made since September 2007, although the exact number was uncertain as a formal child protection log was not held at the centre so there was no historical record of all relevant cases allowing patterns and trends to be analysed.

4.32 The Keeping Children Safe document contained a useful description of the line of accountability in relation to child protection within the centre. This made explicit that the BIA held ultimate responsibility through a service level agreement with the contract director. The assistant director of children's services was the designated child protection coordinator in the centre and reported about these matters to the contract director. The assistant director was also responsible for convening the internal monthly child protection policy group (CPPG).

4.33 The purpose of the CPPG was to focus on any initiatives and developments in safeguarding practices at Yarl's Wood and to report on any cause for concern cases or child protection referrals. Records indicated that this meeting had been fairly recently constituted and had been functioning properly only for a few months. Attendance in the early stages had been poor, but was improving. Appropriate discussions were beginning to take place on all cause for concern referrals.

4.34 The centre-based social worker was experienced and had gained the trust and respect of colleagues and clients. She was therefore able to exert considerable professional influence over a wide range of child-related matters within the centre. Working in partnership with Bedfordshire County Council and the BIA, she carried out effectively the difficult role of delivering an independent social work service to children and families at Yarl's Wood. The level of social work input was shortly due to increase with the appointment of an agency worker to cover the vacant second social worker post.

4.35 The assistant director of social services for Bedfordshire County Council described working relationships between the local authority and the centre as transparent and open. The Yarl's Wood child protection coordinator represented the centre at the quarterly meetings of the Bedfordshire local safeguarding children board, but did not attend every meeting. She was undergoing training in her specialist role delivered by the local authority.

4.36 All centre staff had undergone very basic child protection awareness training as part of their initial induction. All had also received enhanced Criminal Records Bureau clearance. A general code of conduct for staff published on the intranet included general guidance on how staff should act if they believed colleagues were behaving inappropriately. These procedures had recently been followed and resulted in an external investigation after a member of staff was alleged to have smacked a child.

4.37 Age-dispute cases were rare at Yarl's Wood, but an unaccompanied young detainee had recently been located in the healthcare unit because staff doubted that she was an adult and contacted Bedfordshire social services for an age assessment. This had been done within 24 hours. The girl was assessed to be about 14 years old and transfer had been arranged. She told staff that her family had sold her and the purchaser had then sold her on. She had arrived from Heathrow with age 27 on her IS91 detention authority. There was nothing on the IS91 about age assessment, even though she had apparently spent two days in Heathrow short-term holding rooms. Given the difficulties in determining where trafficking was taking place, this area was worthy of closer scrutiny. The counselling available in the centre was designed for adults. There was no specialist support to help children following disclosure of past or current abuse.

Recommendations

4.38 The needs of individual children should always be taken into account when decisions to detain are made.

4.39 Initial welfare assessments should be completed within seven days of a child's arrival and subsequent assessments should be every seven days and in writing.

4.40 A clear central record should be maintained of all cases where discharge or transfer takes place as a result of decisions reached through the internal planning processes.

4.41 Clear minutes containing action points should be maintained of the telephone conferencing discussions.

4.42 Contributions made by Border and Immigration Agency caseworkers to the telephone conference should focus on the best interests of the child.

4.43 Where children need to be admitted to outside hospital, there should be a presumption that this will be done under temporary release unless a risk assessment indicates otherwise.

4.44 Parents should be given greater opportunity to carry out domestic tasks such as cooking and cleaning.

4.45 All information generated under the cause for concern procedures involving children should be referred out to the local authority social services department.

4.46 A log of all child protection referrals should be held securely in the centre and subject to an independent check by a senior social work manager representing the local authority.

4.47 The centre should always be represented at the local safeguarding children board.

4.48 Staff conducting reception procedures should receive specialist training on how to identify cases involving trafficked children.

4.49 Specialist counselling should be available for children.

4.50 Young people whose minority is in dispute should be subject to independent professional age assessment before being detained.

Diversity

Expected outcomes:
There is understanding of the diverse backgrounds of detainees and of different cultural norms. Detainees are not discriminated against on the basis of their race, nationality, gender, religion, disability or sexual orientation, and there is positive promotion and understanding of diversity.

4.51 Diversity was structurally undeveloped in terms of policy, staffing, training and evaluation, but there were recent signs of progress, including in the centre training plan. Staff could use a telephone interpreting service without managerial authorisation, but occasional interpreting was inadequate to break down the isolation and address the anxieties of the large group of Chinese detainees who spoke little English.

4.52 The diversity strategy was at an early stage of development. A cultural and religious affairs manager (CRAM) had recently been appointed, but how she was to divide her time between the substantial areas of diversity and faith had not been clarified and there was no detailed policy guidance on what she was expected to do. The acting race relations manager was also the activities manager and was temporarily managing the families' residential unit, again without clear definition of how his time was to be divided between these substantial tasks. Both received some support from other managers, including at the monthly race, faith and cultural affairs meetings. These were chaired by the director and attended by various other responsible staff. Detainees also attended, although their number and names were not always detailed in the minutes. The minutes recorded that some of the main gaps were recognised. An action plan had been drawn up following an independent race relations report.

4.53 Unit race relations officers had recently been designated, but it was unclear how successful this role would be as residential staff were not permanently based on a specific unit.

4.54 Staff including managers lacked adequate recent diversity training. Some had received recent training in diversity, race and cultural awareness and impact assessments. A series of training sessions was booked through to the summer to bring most staff up to date in cultural and race awareness. For key staff, an alternative to the inaccessible Prison Service race equality officer training was being sought.

4.55 Some information was gathered for monitoring purposes, including the names and nationalities of people using facilities. However, there was no systematic ethnic or nationality monitoring and no impact assessment of policies had yet been undertaken.

4.56 The diversity and equality policy statement was a summary, without detail of how it was to be implemented. It had been translated into several languages and the principles were drawn to the attention of detainees at induction. The Border and Immigration Agency race relations policy statement was also displayed in a range of languages.

4.57 General complaint and racist incident forms were translated into different languages and available on all units. Six racist incident forms had been submitted in 2007 and three to date in 2008. Those seen indicated prompt investigation and response. The process was being redeveloped to include computerised logging to allow better monitoring and supervision.

4.58 Photographs of relevant staff and news of forthcoming events celebrating diversity were displayed on notice boards around the centre. During the inspection, there were a number of activities to celebrate Chinese New Year. Detainee involvement was encouraged. Staff were exploring contact with some external organisations to increase community involvement.

4.59 An induction booklet containing summary information under most headings was issued in different languages and some translated material was on display. In our survey, 30% of detainees, significantly more than the comparator of 13%, said they had received induction information in translation. Sixty-two per cent said they understood spoken English and 59% written English.

4.60 Since the change of contractor, staff were authorised to use a telephone interpreting service without first seeking managerial approval. Relevant invoices, averaging close to £2,000 a month, showed a range of staff using the service. Detainees helped with interpreting general information, receiving some reward for this service, and a number of staff spoke various languages. Just over 25% of staff were from different ethnic minorities and more than 50% were women. However, occasional use of interpreters was not meeting all needs. Chinese detainees formed the second largest nationality group (14%). Most spoke little or no English and many had a poor level of literacy even in their own language. Combined with extreme anxiety about punitive consequences of forced return to China, this made them a particularly depressed and vulnerable group. Prolonged detention over several months and uncertainty about what would happen to them and when aggravated their anxiety. They felt isolated, misunderstood and ill-informed, although nearly £1,500 had been spent on Mandarin interpreters in a recent three-month period.

4.61 The centre had a lift and a number of sanitary facilities equipped for people with disabilities, although the accommodation and facilities did not generally appear to have been rigorously assessed and equipped for these detainees. One room on the families unit and two on Avocet had been modified, although the shower in the room we saw had a slight lip that would have made it challenging for a wheelchair user. Staff said the centre did not accept people with

severe disabilities who were not at least partially mobile. Staff collaborated effectively, if often informally, to deal with unusual needs.

4.62 The recently appointed CRAM had already engaged proactively with instances of anxiety arising from gender and sexual orientation. The circumstances of one detainee were particularly unusual and staff had consulted her regularly to alleviate her difficulties. More challenging was the reaction of other detainees, which required continuous persuasive effort by the CRAM.

Recommendations

4.63 Designated and trained diversity officers should have sufficient time and resources to meet their responsibilities.

4.64 All staff should receive regular training in diversity.

4.65 A detailed and comprehensive diversity policy should include recognition of equality obligations.

4.66 Relevant community groups should be involved in the promotion of diversity at the centre and invited to attend the race, faith and cultural awareness meetings.

4.67 Monitoring by nationality and ethnicity should be undertaken and the results shared with staff and detainees.

4.68 Diversity impact assessments should be undertaken.

4.69 Interpreting arrangements should meet the needs of all detainees and a Chinese speaker employed or contracted to ensure routine communication flow with, and pick up the anxieties of, this particularly isolated group.

Housekeeping point

4.70 Attendance of detainees at race, faith and cultural affairs meetings should be recorded.

Faith

Expected outcomes:
All detainees are able to practise their religion fully and in safety. The faith team plays a full part in the life of the centre and contributes to detainees' overall care, support and release plans.

4.71 The religious affairs team was small, but effective, and represented on key centre committees. Facilities for worship were attractive, well used and easily accessible. Detainees reported positively on faith provision, but there were no structured religious study classes.

4.72 The largest faith group was Christians (64%), followed by Muslims (15%) and Buddhists (5%). There was a large central Christian chapel and adequately sized, attractively decorated rooms

for Muslims, Buddhists, Hindus and Sikhs in the multi-faith area near Dove unit. There was another multi-faith room on Bunting and a Christian chapel and multi-faith room on the family unit. Facilities were easily accessible and well used. The main multi-faith area was the only part of the centre where we saw a significant amount of communal activity in the evenings.

4.73 A female Christian minister was the full-time CRAM. The assistant chaplain, a male Christian minister, was in the centre every afternoon. Two female Muslim visitors came once a week and a male Muslim minister led Friday prayers. A Chinese Christian minister also came once a week, as did male and female Roman Catholic faith representatives. Sikh, Hindu and Buddhist ministers attended regularly and a range of other ministers and faith visitors as required. In our survey, 71% of detainees, equal to the comparator, said their religious beliefs were respected and detainees spoke positively about faith provision throughout the inspection.

4.74 Members of the team were highly visible around the centre. The CRAM was part of the senior management team and involved in key centre committees, including the safer detention and diversity committees. She had been trained in assessment, care in detention and teamwork (ACDT) but was not routinely invited to ACDT reviews (see section on self-harm). Apart from weekly meetings held by the Chinese Christian and Muslim ministers, there were no religious study classes.

Recommendations

4.75 The multi-faith team should offer more structured classes for detainees.

4.76 The cultural and religious affairs manager (CRAM) should be routinely invited to assessment, care in detention and teamwork reviews.

Section 5: Health services

Expected outcomes:
Health services are provided at least to the standard of the National Health Service, include the promotion of well being as well as the prevention and treatment of illness, and recognise the specific needs of detainees as displaced persons who may have experienced trauma.

5.1 Healthcare was experiencing a lot of change due to new providers and there was work in progress relating to development of clinical governance and policies and procedures, and towards registration with the Healthcare Commission (HCC). The standard of care delivery was reasonable for basic primary care, but some serious gaps in provision, including poor access and communication, impacted negatively on detainee wellbeing. Services for children were under-developed.

General

5.2 Health services had been provided by Serco Health since April 2007 and a health needs assessment had been completed in December 2007. A draft 'heads of agreement' between Yarl's Wood and the Bedfordshire primary care trust (PCT) had not been fully agreed or signed. A steering group, which included representatives from the centre and local PCT, with sub-groups for adult health, children's health and mental health, was re-establishing following the transfer of healthcare to Serco Health. We saw minutes from only one meeting. The PCT was clear that it viewed its role as limited to supporting and advising Serco healthcare staff. There were memoranda of understanding between the local NHS Trust and Yarl's Wood relating to in-patient and out-patient care. The two documents dealt separately with the needs of adults and children. The centre was working towards registration with the HCC.

5.3 Detainees we spoke to disliked the attitude of some healthcare staff and did not find the service easy to access. Some viewed healthcare as part of the Immigration Service and did not believe it was confidential.

5.4 The healthcare centre was located at the end of the main corridor. One side of the waiting room was a large window that acted as the main interface between detainees and healthcare staff and was where detainees collected their medication. The main healthcare office was behind the window. There were separate offices for the head of healthcare and lead administrator. The door into the waiting room from the main corridor was kept locked. There were two consulting rooms, one of which was used by the GPs and the other by the counsellors, one treatment room and a dental surgery. There were additional consultation rooms on the family unit and in reception. All healthcare areas were clean and tidy but, apart from a play table for toddlers in the main waiting room, they were not child friendly. Notices and health promotion literature were displayed in the waiting room and reception room, but most, including information about service provision, was in English.

5.5 Medication was stored in locked cupboards in the main healthcare office. Medication that arrived at the centre with a detainee was stored in bags in unlocked filing drawers in the reception healthcare room. None of the healthcare rooms was on a separate suite key so this medication was unsecured, which was unacceptable.

5.6 The in-patient unit had six spaces, although only four of the rooms were available as one was used for storage and another as a multi-sensory room. All rooms had shower and toilet facilities and two were prepared for children, with bright fabrics and soft toys. There was a separate bathroom. None of the in-patient rooms had observation hatches in the doors so the only way to observe a patient was to have the door propped open. The primary care area was accessible to people using wheelchairs or with reduced mobility, but the in-patient unit was not suitable, with low beds, little space and raised edges at the entrance to showers.

5.7 There was a protocol for the clinical management of detainees refusing food and fluids and those who had ceased hunger strike and required re-feeding. A daily log with information on anyone not eating was kept in healthcare. We were told that the healthcare manager audited this regularly, but no record was kept.

5.8 A telephone interpreting service was used in consultations with non-English speaking detainees. All healthcare staff we asked knew when and how this was used. There was a protocol outlining the process, but it did not include provision for the use of face-to-face professional interpreters if required and staff said they did not use them. They said family and friends were used to interpret only as a last resort and both parties had to sign consent. The protocol clearly stated that family members and friends were considered as being with a patient as a support rather than as an interpreter.

5.9 There was information displayed in the healthcare centre advising detainees that they could request a second opinion regarding their care, although we saw this only in English.

5.10 The Border and Immigration Agency (BIA) was informed when a detainee was awaiting an external appointment for acute care. The intention was that the detainee would not be moved before completing any acute treatment. Handcuffs were not being used for external hospital appointments though they could be used in extreme cases, following risk assessment.

5.11 Following rule 35 of the detention centre rules, the BIA was also informed when a detainee disclosed information about previous mistreatment or torture, although healthcare staff were not told the outcome of these reports.

5.12 There was a palliative and end of life policy. This stated that, wherever possible, anyone requiring such care should be returned to the community.

Clinical governance

5.13 There did not appear to be a robust clinical governance infrastructure. There were monthly management meetings, but no formal clinical governance meeting. Clinical incidents and near misses were reported internally.

5.14 The head of healthcare was a registered general nurse (RGN), supported by a team leader who was also an RGN. There were three additional RGNs and three registered mental nurses (RMNs). Seven vacancies were being covered by two bank nurses (one RGN, one RMN and agency staff). There was no established induction for agency staff with on the job shadowing. Two more nurses were shortly due to start work at the centre, although one would be a bank nurse rather than a full-time member of staff.

5.15 There was no registered sick children's nurse, which was a real concern as there were more than 50 children in the centre on the first day of our inspection. Attempts were being made to recruit into this post. A part-time counsellor worked four days a week and a sessional counsellor came in once a week, but neither was a counsellor for children or adolescents,

although they did do some work with children. A nurse for older people was appropriately trained. There were two administrators, one of whom was part-time. When there were patients in the in-patient unit, a detainee custody officer was detailed to work there. The nurses' job title was 'practitioner nurse', which was misleading as none of the nurses was a nurse practitioner. Healthcare staff had job descriptions, but these were from the previous provider rather than Serco Health.

5.16 GPs attended the centre seven days a week. Two days were provided by GPs from a local practice and the remaining sessions by locum GPs. The two permanent GPs were both male and the centre requested female GPs from the locum agencies where possible. There were notices in the waiting area stating that detainees could request to see a female GP, but many women appeared unaware of this and only 21% in our survey, significantly less than the comparator of 47%, said they could see a doctor of their own gender. Out-of-hours arrangements were with Serco Health. Nurses contacted the on-call doctor, who gave telephone advice, but did not visit. We were told that the on-call doctor could arrange for a doctor to visit out of hours if necessary, but none of the healthcare staff we spoke to could remember this happening and they said it was either telephone advice or attendance at the local accident and emergency department.

5.17 Pharmacy services were provided by a local community pharmacy, and the pharmacist visited the centre monthly. A dentist and dental nurse attended one day a week, a midwife attended weekly and a health visitor came to the family unit once a fortnight. Other allied health professionals attended on request.

5.18 Staff said access to training had been difficult under the previous provider, but were optimistic that this would now improve. No staff had received resuscitation training in the previous 12 months. All permanent staff had attended a study day on post-traumatic stress syndrome and two had attended a training day on care of detainees with a history of torture. Arrangements for clinical supervision were informal. We were told that staff participated in reflective practice discussions at lunchtimes, but there was no formal documented clinical supervision. The healthcare manager took part in peer supervision with heads of healthcare from other centres. Records were maintained of nurses' clinical registration. None of the healthcare staff had received training in the correct usage of the moveable seat in the healthcare bath for those unable to bathe independently.

5.19 Emergency bags were located in the reception healthcare room and the primary care main office. Recorded checks were made daily by night staff. Portable oxygen was kept with the emergency bag in the healthcare centre. There was an automated external defibrillator in reception, one between Crane and Avocet units and another in the healthcare department. Those in reception and between Crane and Avocet included paediatric pads. There was no emergency delivery pack, although one was on order.

5.20 There were no formal arrangements with local health and social care agencies for the loan of occupational therapy equipment and no links with specialist nurses to offer advice on the use of mobility or health aids.

5.21 Clinical records were stored in locked filing drawers in the healthcare centre. They were filed by room number, which relied on staff refilling records as soon as a detainee moved room. We were able to locate all the records we looked for. There was no electronic system for clinical information, which made any form of audit difficult. In many cases, it was difficult to read entries in the handwritten records, including signatures, and few people included their designation or printed their names. All entries were dated. The only detainee in the in-patient unit had a care plan, but this was very basic and did not include a review date. We did not see

any evidence of primary care plans where there was a clear need, for example in the case of a child with sickle cell disease and an adult who had returned to the centre with a dressing following surgery. If a detainee returned to the centre, attempts were made to find their previous clinical notes, but this applied only to those who had left since April 2007 as records from before Serco took over were not available.

5.22 There was a system to obtain records from GPs in the community for those detainees who were registered, but this process started when detainees attended their GP appointment the day following their arrival at the centre and records were therefore not requested for those who did not keep this appointment.

Primary care

5.23 All detainees arriving at or returning to the centre were seen by a nurse in reception. New arrivals were given a healthcare screening and a telephone interpreting service was used when necessary. Self-completion screening questionnaires were available in a range of languages, with separate forms for adults and children. The interviews we observed were conducted sensitively and the nurse ensured that interviewees fully understood what was meant by torture before asking them about it. A pro forma letter was completed for anyone who reported having been a victim of torture. This was forwarded to the centre manager for transmission to the BIA, with copies in the patient's clinical record and a central healthcare file.

5.24 An information sheet was given to new arrivals outlining what they could expect from healthcare at the centre. This was in small print and in English. It included review and amendment dates. The sheet advised that detainees wanting to see a healthcare worker should complete a medical application, but staff said there was no such form. All new arrivals were offered an appointment with one of the GPs the following day. If detainees arrived needing an urgent prescription, the out-of-hours doctor had to be contacted. This was a particular problem for detainees who had not been allowed to return home to collect essential medication after being detained (see section on arrival in detention). Chlamydia testing was offered to adults under the age of 26.

5.25 Detainees could not access the healthcare centre independently, but had to make appointments through their wing office. Access to GPs was via nurse triage, which detainees seemed to regard as a barrier to seeing the doctor. Triage algorithms were in use. Triage appointments were available only in the afternoons so anyone feeling unwell overnight or in the morning had to wait to see a nurse. Single women attended the healthcare centre for all appointments, whereas a daily nurse triage clinic was run on the family unit. The wait to see a GP was short, with most people receiving appointments for the following day. Appointment slips were put under bedroom doors the night before.

5.26 A midwife provided routine care for pregnant women, who attended the local hospital for their scans. A health visitor held a drop-in clinic on the family unit once a fortnight. She did not contribute to the child's centre health record, although we were told that she did communicate any concerns to healthcare staff. Two staff were undertaking the necessary training to offer cervical screening to women. Barrier protection was freely available in toilet areas.

5.27 Detainees with life-long conditions were allocated to a nurse with an interest in that condition on arrival. The nurses maintained registers and saw detainees in clinics, although, apart from the nurse for older detainees, none held appropriate certification in specific life-long conditions. Some had attended study days in their area of interest.

5.28 Detainees leaving the centre were given a discharge summary to take to their GP and any medication currently prescribed. Any medication they had arrived with was returned to them, with a label alerting them to the fact that the medicines may be out of date and it was their responsibility to check this. The labels were available in seven languages.

5.29 A risk assessment relating to detainees holding medication in possession during transit was completed, but was printed on the reverse of the discharge letter and sealed in an envelope to which the escorting staff did not have access. We were told this was an administrative error and that the risk assessment was usually separate from the discharge letter.

Pharmacy

5.30 Prescription charts were clearly written and signed, with the patient's diagnosis included in all instances. There was a policy and risk assessment for issuing medication in possession. The risk assessment was reviewed with any review of a patient's prescription. There was no formal arrangement for detainees to have direct contact with the pharmacist, although we were told she would speak to them on request either in person or by telephone between her visits to the centre. Patient information leaflets were available only in English.

5.31 Detainees could obtain soluble paracetamol from unit offices at any time and were required to read an information sheet, available in a number of languages, beforehand. A log was kept of who was given paracetamol and when. This was checked daily by healthcare staff and stocks were replenished. Detainees who requested paracetamol on three consecutive days were invited to attend healthcare for a review. If they were then given medication containing paracetamol by healthcare, this was supposed to be entered in the log, but not all unit officers were aware of this. Parents of young children were given liquid paracetamol in possession for their children if required.

5.32 There was no medicines and therapeutics committee and no formulary was in use. This was a particular concern given the number of locums working in the centre. There was a policy for the management of medicines, controlled drugs and ordering and storage.

5.33 Patients taking medication not held in possession had to attend the healthcare centre to collect it. As the collection window was along one side of the waiting room, there was little privacy or confidentiality.

Dentistry

5.34 The dentist waiting list was not long and most detainees were seen within two weeks. Those in pain were prescribed analgesia and seen at the next clinic. Treatment available was for immediate needs only. Oral health promotion information was available and detainees were given information sheets, in English, following dental procedures. The dentist sometimes used the telephone interpreting service to explain what procedure he was about to carry out. The dentist's partner covered his leave and sickness so waiting lists did not build up.

In-patients

5.35 The in-patient beds did not form part of the certified normal accommodation of the centre. The layout of the unit meant only single adults or children could be accommodated at any one time. At the time of our visit, there was one adult male patient in the unit.

5.36 Officers were allocated to the in-patient area when it was occupied, but it was only possible to observe a patient if the door was kept open, and the need to leave a room door open to observe a patient gave the impression of a constant watch, which appeared intrusive. This duty was undertaken by different officers each hour throughout the day, which did not provide any continuity for the patients. Although the occupant had a care plan, it was brief and had not been reviewed. The officers, who were spending the majority of the time with the patient, were not aware of what was on the care plan and, although there was informal communication between them and healthcare staff, there was no formal process for this.

5.37 Meals for the in-patient were collected from one of the dining rooms and he could select what he wanted from the day's menu. The food was served in a disposable box rather than on a plate.

Secondary care

5.38 Detainees with outstanding medical appointments on arrival were told these had to be re-booked, although some appointments were kept. This approach was contrary to recent detention service order 1/2008 issued by the BIA, which stated that appointments should not routinely be cancelled, subject to risk assessment that gave specific intelligence relating to an escape.

5.39 Referrals were made to secondary services based on clinical need, but only acute referrals were notified to the BIA with a view to the patient being placed on a medical hold until they had received their treatment. The healthcare administrator booked appointments. Risk assessments were carried out by healthcare staff. If a child needed to attend an external appointment, a parent was able to accompany him or her with escorting staff. Detainees were not informed of their appointments in advance, which caused unnecessary anxiety.

5.40 If a detainee was removed from the centre, any outstanding hospital appointment was not cancelled for at least two days in case the removal was unsuccessful and the detainee returned.

Mental health

5.41 Mental health services were limited. The three RMNs on the primary care team carried out generic healthcare duties and mental health assessments. On some days, no RMNs were on duty. The primary care RMNs did not carry a case load, but conducted mental health assessments and referred anyone requiring treatment to the visiting consultant psychiatrist, who attended once a week. The psychiatrist was therefore seeing people with primary mental health needs and those with secondary mental health needs, which was inappropriate. The visiting consultant psychiatrist came from a local psychiatric unit and there were arrangements for patients to access mental health beds when clinically indicated.

5.42 There were no arrangements for the mental health assessment of children and no pathway to mental health beds for them. During our inspection, an adolescent requiring a mental health admission had to access this through the local accident and emergency department as this was the only pathway open to him, which was unacceptable. There were no links with the local community mental health team or child and adolescent mental health service. There was no provision for detainees who came into the centre already subject to care programme approach and no provision for this process to be commenced if it became necessary during their detention.

5.43 Two counsellors provided the equivalent of one full-time post. Anyone could refer to the service and the waiting time for assessment was about two weeks, although referrals indicated as urgent received an initial assessment the same or next working day. The counsellor we spoke to described most of the work undertaken as crisis intervention owing to the short and unpredictable length of stay of some detainees. They did not consider using telephone interpreting services or the introduction of a third person into the counselling environment as appropriate, which restricted what counselling was available to detainees with little or no English. The counsellor also offered some alternative therapies, including therapeutic massage, to all detainees. The multi-sensory room could be booked through the counsellor. There were no specialised counselling services for children and adolescents.

Recommendations

5.44 Detainees should be able to access the healthcare waiting room independently to attend clinics and triage.

5.45 Notices and other written literature should be available in a range of appropriate languages.

5.46 All healthcare rooms should be secured by a separate suite key.

5.47 Medications arriving at the centre with detainees and not retained in the detainee's possession should be securely stored.

5.48 The doors to rooms in the in-patient area should have observation panels.

5.49 Detainees not fluent in English should be interviewed in the presence of a professional interpreter, particularly for interviews that require confidentiality, such as disclosure of sexual assault and psychiatric interviews. A telephone interpreting service should be used only if clinically appropriate.

5.50 Clinical governance arrangements should be in place.

5.51 All healthcare staff should have at least annual resuscitation and defibrillation training.

5.52 All healthcare staff should receive training in the recognition and treatment of signs of trauma and torture.

5.53 An appropriate induction course should be introduced for agency nursing staff.

5.54 A registered sick children's nurse should be recruited as a priority.

5.55 Appropriate counselling services should be available for children.

5.56 Women should have access to a female GP when required.

5.57 Out-of-hours medical arrangements should include visits by a GP where appropriate.

5.58 All nurses should receive clinical supervision and records of this should be maintained.

5.59 Formal arrangements should be in place with local health and social care agencies for the loan of occupational therapy equipment.

5.60 Record-keeping should be in line with best practice guidelines for healthcare professionals.

5.61 A comprehensive, accurate healthcare information leaflet accessible to all detainees should be given to detainees in reception.

5.62 Nurse-led clinics should be run by nurses with appropriate post-registration training.

5.63 Detainees should have direct access to advice by appropriately trained pharmacy staff.

5.64 A medicines and therapeutics committee should be established.

5.65 There should be a local formulary.

5.66 A mental health needs assessment of adult detainees should be undertaken, and appropriate services provided.

5.67 There should be an appropriate mental health pathway for children.

5.68 Links should be developed between the centre and the local community mental health team and child and adolescent mental health service.

Housekeeping points

5.69 Appropriate toys should be available in treatment areas.

5.70 Records should be kept of management checks of the food refusal log.

5.71 The detainee medication risk assessment should be available to escorting staff.

5.72 Meals for in-patients should not be served in take-away containers.

5.73 Detainees should be informed of forthcoming medical appointments.

5.74 The bath hoist should be used only by staff trained in its use.

Section 6: Substance use

Expected outcomes:
Detainees with substance-related needs are identified at reception and receive effective treatment and support throughout their detention.

6.1 There was little evidence of substance use. There were few services and no protocols for substance-dependent detainees.

6.2 Staff said the need to tackle substance use was rare and there were few services for detainees who arrived requiring support in this area. There was no specific protocol for first night symptomatic relief for detainees experiencing withdrawal and no specialist substance use staff. There were links with the community drugs service, which appeared to be the only specialist support available to substance users.

Recommendation

6.3 Protocols should be put in place for the treatment of substance-dependent detainees.

Section 7: Activities

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

7.1 Activities did not offer detainees adequate mental stimulation or diversion to alleviate boredom and there was too little paid work. The range of learning and skills provision was narrow and poor quality. Education for school-age children was unsatisfactory, although teaching was satisfactory. There was too little for children to do outside school hours. Library provision was good. Physical education (PE) was adequate for most detainees.

Work and learning and skills

7.2 The centre had introduced paid work for detainees in July 2007, but its introduction had been slow and there were few work places. An initial nine work places had increased to 20 in the week before our inspection. Plans to extend the scheme to a modest 40 places were not due to take effect until summer 2008. The centre sensibly prioritised the small amount of work it offered to those who had already been detained for a significant period.

7.3 Since the implementation of the current contract in 2007, the range of structured learning and skills activity for adults had significantly reduced. Provision was narrow and poor quality.

7.4 The centre provided activity supervised by teachers in two adjacent rooms for single women on weekday mornings and afternoons. Each could accommodate around 15 detainees. In one, detainees participated in basic arts and crafts such as paper-folding and knitting and received appropriate instruction from a well-qualified teacher. The range of activity was severely limited by the narrow range of resources provided. In the other room, an experienced English language teacher supervised ICT and English language teaching. Some detainees worked independently on one of 10 computers. They received occasional help from the teacher, but were not offered tuition to develop their ICT skills systematically. In the same room, the teacher assisted a small group of detainees with practice in English for speakers of other languages (ESOL). Initial assessment of their language needs was superficial, planning to meet their varied language needs was poor and resources were inadequate, including a worksheet printed in monochrome used to practice the vocabulary of colours. In our survey, just under a third of detainees said they did not understand spoken English.

7.5 Attendance at sessions in both rooms was often low. The rooms were also open in the evenings and weekends supervised by activities' staff. The centre provided a much smaller programme of similar activity for adult family members in the Crane unit, but very few attended. Promotion of activity was weak, relying too heavily on cluttered wall displays in English. No accreditation was offered.

7.6 The centre had recently installed three computers in each of its two libraries as a pilot project offering detainees access to the internet. Those in the main library were used consistently by a small number of detainees, but the project was too recent to judge its success.

7.7 A varied range of English and foreign language films were shown in association rooms in both parts of the centre. Numbers watching were often low. Rooms equipped with board games and jigsaws were rarely used. A room with a pool table on the Crane unit attracted some family

members. Some detainees made good use of the centre's hairdressing salons. Occasional programmes of activity on specific themes were popular with some detainees, including a day of events marking the Chinese New Year. Detainees' rooms were equipped with televisions and video players.

7.8 Quality assurance was very weak. The centre had no arrangements to monitor teaching performance or provide professional support and development for activity staff. It did not carry out self-assessment of the quality of what it offered adults. It routinely collected information on the nationality of detainees attending structured activity, but did not analyse this to assess how well the profile of those participating matched the population as a whole or whether any nationalities or ethnic groups were excluded.

Child education

7.9 Education was provided on weekdays in two separate classes, one for children aged between 5 and 11 and one for children aged 11 to 16. The range of ages and abilities in the two classes was very wide and inevitably led to great variation in the standard of work produced.

7.10 Under the Border and Immigration Agency (BIA) contract, the school day was scheduled from 9am to 5pm, which was too long for children of primary age. Many children were still having breakfast when lessons were scheduled to begin and little purposeful learning took place until 9.30am. Attendance at education was voluntary and some school-aged children did not go. Teachers encouraged children to come to classes, including visiting families' rooms early in the morning to check that children were planning to attend.

7.11 Teachers had little knowledge of children's abilities or their learning needs on arrival. They said many families were not willing to allow staff to contact their child's previous school to establish their prior attainment. Teachers carried out a basic assessment of children's skills and abilities shortly after arrival, but the results were not used to establish suitable targets for children. There were no learning plans for individual children so it was difficult to track their progress. The centre did not offer short units of internally or externally accredited learning.

7.12 The curriculum offered was relatively narrow and dealt mainly with English and mathematics. PE was largely recreational and, although enjoyable, contained little educational focus or development of technical skills. Information and communication technology (ICT) use was mainly for research using the internet and for the presentation of work. History and geography were poorly resourced. Religious education was narrowly confined to topic work covering various religious festivals. The quality of this work was good, but it did not cover the essentials of the religious education curriculum. Science education contained far too little practical work and often relied on teachers supplying their own resources. Further resources were on order.

7.13 Classrooms were bright and airy and contained some outstanding examples of children's work. Teaching was satisfactory. Teachers knew children and their individual circumstances well and relationships between teachers and children were very good. Behaviour in lessons was very good and the small amount of inappropriate behaviour was managed skilfully and sensitively. Children were enthusiastic about their learning and were able to speak sensibly and articulately about their work. Progress in lessons was too variable, with some making very good progress while others struggled. Many tasks went on for too long and children sometimes lost concentration and did not make the progress they were capable of. The range of abilities in the class for 5 to 11 year olds was particularly wide and the teacher could not spend sufficient time with individual children to check on their learning and progress. There were no arrangements for learning support assistants.

7.14 As for adults, quality assurance arrangements for children's teaching were inadequate. Lessons were not observed routinely. Teachers' access to specialist professional development was too limited. A recent self-evaluation of the provision had been carried out by teachers, but with inadequate guidance or support. This was not evaluative or self-critical enough and was over-optimistic in its judgements. The centre acknowledged that it did not have managers with sufficient expertise to provide appropriate professional support and monitoring for staff responsible for children's education. It was developing plans to enable teachers to benefit from good practice elsewhere.

7.15 The centre did not provide enough activity to meet the needs and interests of children outside school hours. There was a youth club for two hours every evening for 11 to18 year olds and weekend afternoons for 5 to 11 year olds. A newly appointed youth worker was enthusiastic, but had only recently started to receive training for the role. Weekend provision was particularly popular, but there was little for younger children to do on weekday evenings apart from watch videos or DVDs and too little for either age-group at weekends. The centre had identified the need to improve out of school provision and planned to move activity to a better equipped room with outdoor access and secure additional support from volunteer youth workers.

7.16 There was a nursery for children under five in a bright, generally well resourced indoor environment that attempted to replicate facilities in the wider community. It offered morning and afternoon sessions on 363 days a year. It had capacity for 20 children, but the need to maintain appropriate ratios of staff to children of different ages meant some children could attend only part-time. The nursery was registered with Ofsted and carried out regular annual self-assessment. The centre had attracted external funding to support well advanced plans to provide an easily accessible and properly resourced outdoor space. The existing outdoor area was unsatisfactory.

Library

7.17 Library provision was good, with a main library for female detainees and another for those in family accommodation. Provision was managed well by a full-time chartered librarian. Officers involved in staffing the libraries received useful basic on-the-job training as library assistants. Access to the library was good, with morning, afternoon and evening sessions every day of the year. The stock of fiction and non-fiction books was extensive. The range of foreign languages catered for was particularly wide and included fiction, dictionaries and phrasebooks in more than 40 languages. A large number of videos in a good range of languages were available for detainees to watch in their rooms. The library in the family unit was timetabled during part of the week for use by children's education classes and stocked a good range of books for children. Few adults used it in the evenings. The main library was generally well used and about to be extended.

Physical education

7.18 PE facilities were satisfactory. The centre provided an adequately sized sports hall, a popular, but cramped, fitness room and outdoor space marked out for team games. Activities for adult detainees included team sports such as badminton and volleyball, cardio-vascular fitness routines and exercise to music. Activity for children was recreational rather than educational. Appropriate footwear and clothing were available. Detainees had good access to showers in their en-suite living accommodation. Arrangements to record and monitor accidents or incidents were appropriate.

7.19 Access to PE was satisfactory. A carefully planned rota provided separate sessions for men, women and children at least once a day. Take-up at some sessions was low. Officers supervising physical recreation were enthusiastic and had basic qualifications for the role. Staffing levels were sometimes too low and required an officer to oversee the sports hall and fitness room simultaneously.

7.20 Induction arrangements for PE were not sufficiently developed. Only the activity manager was qualified to carry out induction, which sometimes led to delays of a day or more before a detainee could use the fitness room. No formal induction was offered to detainees participating in sports hall activity or outdoor sport. Healthcare assessment of detainees' fitness was not readily accessible to activities staff supervising PE, or supplemented by any further physical checks.

7.21 Monitoring of participation in PE was poorly developed. The centre recorded the number and nationalities of detainees attending each session but did not collate or analyse the information to see how effectively PE met the needs of particular nationalities or ethnic groups.

Recommendations

7.22 The centre should improve its promotion, quality assurance and monitoring of participation in adult learning and skills activity.

7.23 The length of the school day should be reduced to reflect practice in the community, particularly for primary age children.

7.24 Greater efforts should be made to obtain details of children's prior educational attainment from schools.

7.25 The centre should introduce short units of accreditation for children.

7.26 The centre should improve the breadth of the curriculum and provide adequate resources to support this.

7.27 The centre should provide classroom assistants to help teachers better meet the wide range of children's needs within each class.

7.28 The centre should ensure that teachers receive appropriate professional support and development.

7.29 The centre should introduce appropriate arrangements for quality assurance of children's education, including self-evaluation and observation of teaching and learning.

7.30 The centre should improve the range and quality of out-of-school activity for children, especially at weekends, and this should include better-equipped activity rooms.

7.31 The centre should improve induction to physical education (PE) to ensure that it is more timely, comprehensive and includes adequate access to healthcare assessments of detainees' fitness.

7.32 The centre should collate and analyse information on participation in PE to ensure particular groups are not excluded.

Section 8: Rules and management of the centre

Expected outcomes:
Detainees feel secure in a predictable and ordered environment.

8.1 Reasonable steps were taken to help detainees understand how the centre operated. Physical security measures were proportionate. The rewards scheme was not prominent, although children's behaviour was inappropriately taken into account when assessing parents' status. Staff were encouraged to deal with conflict through negotiation and discussion. The evidence suggested that force was used legitimately and as a last resort, but governance arrangements were not sufficiently robust. The separation unit was sparingly, but guidelines on the use of the small section in Bunting unit were not sufficiently clear. Complaints were mostly dealt with appropriately and in good time, but those to the Border and Immigration Agency were delayed and detainees had little confidence in the complaints system. Complaints were not robustly analysed.

Rules of the centre

8.2 Clear written instructions about the rules of the centre were issued to detainees at induction and explained by staff. The written material was translated into different languages, although Spanish-speaking detainees said this had not been provided to them. Staff said they found it difficult to transmit information accurately to detainees who could not understand one of the more common languages. There were plans to introduce a scheme where detainees who spoke minority languages were paid to help new arrivals struggling with communication.

8.3 Material supplied included the centre's description of 'our commitment to you', with support services and facilities that 'cooperative' detainees could expect. This was useful, but the tone and content of some rules outlined in the document were slightly patronising and placed too much emphasis on presumed 'bad behaviour'.

Security

8.4 During the renegotiation of the contract, it had been recognised that the security department was over-resourced and it had subsequently been reduced dramatically from 33 to three and an appropriately light touch approach to security was now adopted. Much greater freedom of movement had been introduced and fewer locked doors meant detainees did not need to be escorted everywhere. The level of room searching had significantly reduced from monthly to three monthly, which had encouraged a more relaxed atmosphere that was clearly appreciated by detainees.

8.5 After a gap of some months during the transition phase, the monthly security meeting had recently been re-established. It was chaired by the security manager and well attended by relevant staff. Records indicated that there had been no evident deterioration in the level of control or order since the change in approach. A recent assault on a member of staff was regarded as unusual. Matters typically dealt with, such as detainees suspected of selling clothes, were not serious and were handled appropriately. Between 20 and 30 security information reports (SIRs) were received from staff each month and carefully considered at the

security meeting. This was around half the number received at the beginning of 2007 and the security manager believed there was a need to raise staff awareness about the SIR system. There were no obvious weaknesses in security and the environment was well ordered and calm.

Rewards scheme

8.6 New arrivals were told verbally and in writing at induction how the rewards scheme worked. A simple two level system operated. New arrivals were placed on the enhanced level and behaviour was monitored and recorded on unit files. Detainees tended to be cooperative and were relatively motivated so the rewards scheme did not play a particularly key role. However, despite the information provided, many detainees did not know how the scheme worked.

8.7 Poor behaviour resulted in an adverse report and particularly good behaviour in an exceptional report. These reports balanced each other so that, for example, an exceptional report eliminated one adverse report. Three adverse or three exceptional reports could result in promotion or demotion. These warnings lasted for seven days, after which they were spent. Residential managers usually interviewed anyone with two warnings in an attempt to avoid a third being issued. Few detainees were on standard level at any one time and only one during the inspection.

8.8 Children were not subject to the rewards scheme, but the behaviour of children was inappropriately included when their mothers' levels were assessed.

Discipline

8.9 There was no evidence of illegal or informal sanctions. Some detainees complained that they were not allowed to pray in each other's rooms early in the morning. Further investigation showed that the prayers were often loud and that staff were trying to persuade those involved not to disturb others or wake young children.

8.10 Staff were encouraged to deal with conflict through negotiation and discussion, which was proving effective. The centre's disciplinary procedures were not directly applied to children, but there were frequent difficulties with their behaviour that sometimes led to conflict between parents. Staff dealt with these situations sensitively.

Use of force and single separation

8.11 Force had been used about once a week over the previous year. Most related to a detainee's imminent removal, with the detainee restrained after having resisted removal. Nearly all of these cases involved adult women. When a detainee refused an order to leave the centre, Serco staff checked that escort staff were prepared to take the detainee under restraint and, if so, force was used.

8.12 Planned removals were recorded, but videos did not include the briefing sessions and negotiations with the detainee before an incident, which would have provided further assurances that all other avenues had been exhausted before force was deployed. Recording did not continue until after the detainee had been seen by healthcare staff. Videos and written documentation generally provided assurances that force was used only as a last resort and was proportionate. Many detainees being removed did not actively or violently resist staff, but refused to cooperate and sometimes stripped fully or partly. Staff had to carry them to

reception, often some distance away, and those who had stripped did not always stay covered by the blanket used.

8.13 We had some concerns about the control and restraint procedures adopted by escort staff once the detainee had been handed over to them. A couple of videos showed escort staff using inappropriate techniques when carrying detainees. The Serco manager supervising such incidents did not remain in overall charge, in a supervisory capacity, until the detainee has left the centre.

8.14 Completed use of force forms were of mixed quality. The main statement written by the person in charge of the incident was usually a good quality, detailed report. Duty managers were subsequently required to sign off all reports, but did not always do so. A healthcare report was also supposed to be written after every incident, but was not always included. Some planned removals took place with no healthcare official present. The quality of some reports was poor and pictorial body maps were not included. On a number of occasions, a detainee had clearly banged her head repeatedly, but no mention was made of this in the healthcare report.

8.15 Despite the fact that there was good video evidence in nearly all cases and the number of incidents was not high, overall governance and quality assurance were not robust. There was no use of force committee. No senior manager reviewed individual incidents to assure themselves as to the appropriateness of the intervention and for feedback and training purposes. No trend analysis took place.

8.16 Kingfisher unit was the recognised separation unit. Six cells were used for 'removal from association purposes' under rule 40 of the detention centre rules and four were designated as temporary confinement cells under rule 42. The condition of the unit was reasonable, although there was peeling paint in some cells. There was no broken furniture and lavatories were clean. Occupancy levels were relatively low and no detainees were located there during the inspection. Between 26 April 2007, when Serco took over the centre, and 31 Jan 2008, there were 91 incidents of removal from association involving 66 different detainees and 45 incidents of temporary confinement involving 37 different detainees.

8.17 The average length of stay on the unit was less than 24 hours, although some detainees stayed for several days, usually pending removal from the centre. Further authorisation was required if a detainee was to be kept in the unit for over 24 hours. A number of detainees were moved after 24 hours exactly, which raised the question of whether they could have been moved earlier.

8.18 There was no real opportunity to judge relationships between staff and detainees on the unit. We spoke to a small number of detainees who had spent time on Kingfisher. They reported being treated fairly, but little contact with staff. Only one member of staff was on duty when the unit was occupied, so detainees were usually let out one at a time.

8.19 One end of Bunting unit could be locked off as a contained unit to remove families from association. This could be for various reasons, but Kingfisher was not used to accommodate families with children. An unofficial, but among staff widely acknowledged, policy existed whereby single women detainees on Dove and Avocet units could be returned to Bunting main unit following disruptive behaviour on their main units. Theoretically, this move was for re-induction purposes, although no records were kept. This practice had not been evaluated and there was no evidence that detainees had actually been through the induction process again. Some occasions when women were ordered off their main unit ended up in a use of force incident following a refusal. Not all senior managers were aware of this practice, which had the

potential to be misused as an unofficial punishment without the paperwork safeguards that existed for Kingfisher.

Complaints

8.20 Complaint boxes were located in every laundry, the system was explained in a number of different languages, access was good and forms were plentiful. Detainees were encouraged to approach staff before making a formal complaint and staff offices were often busy with detainees asking questions and staff trying to resolve problems. However, in our survey, only 6% of detainees, significantly less than the comparator of 15%, said complaints were sorted out fairly and only 7%, significantly less than the comparator of 13%, said they were sorted out promptly.

8.21 Complaints could be made in confidence directly to the Border and Immigration Agency (BIA) and the Independent Monitoring Board. A member of BIA staff emptied all complaint boxes daily and ensured complaint forms were readily available. The on-site BIA manager recorded complaints received and allocated them to Serco or the BIA's operational support unit (OSU) in Harmondsworth for investigation.

8.22 Complaints referred to Serco were managed by the compliance and assurance manager. These were mostly responded to within an acceptable timescale and many managers gave comprehensive and appropriate answers, although a few could have been improved. Monthly statistics were kept and complaints were broken down by type, but not source, so it was difficult to identify any emerging patterns. It was not always clear when complaints were redirected to the diversity or safer custody manager. The BIA completed management checks on Serco, including the quality and timeliness of replies, but these were not recorded.

8.23 It was difficult to check on complaints referred to the OSU. Staff said they were aware that complaints were being dealt with because they had seen OSU staff visiting the centre and interviewing detainees, but this was not formally recorded at the centre. The OSU did not update the centre on any progress on complaints and there was a serious backlog, with some complaints over three months old.

Recommendations

8.24 All new detainees should be given information about the centre's rules in a form they can understand.

8.25 Staff awareness about the security intelligence system should be raised.

8.26 Awareness about the rewards scheme among detainees should be raised.

8.27 Children's behaviour should play no part in determining the level of the rewards scheme for adults.

8.28 A use of force committee should be set up to monitor trends and patterns and review every incident where force is used against detainees.

8.29 Video recordings of planned incidents should include staff briefings and negotiations with detainees before an incident, and incidents should be recorded until the detainee has been seen by a member of healthcare.

8.30 Detainees who have removed some or all of their clothing should be covered with a suitable garment before being taken to reception.

8.31 Detainees should only be restrained and carried, including by escorting staff, using approved techniques.

8.32 The supervising member of Serco staff should remain in overall charge of any incident until the detainee has left the premises.

8.33 Responsible managers and healthcare staff should always write a report after any incident involving force against a detainee.

8.34 Someone from healthcare should be present for all planned removals.

8.35 Healthcare reports relevant to use of force incidents should be quality assured.

8.36 The practice of returning single women to Bunting unit for re-induction as a disciplinary measure should cease.

8.37 Any decision to move a detainee from their normal wing to another wing for behavioural reasons should be confirmed in writing and authorised by a senior manager.

8.38 Detainees should spend the minimum possible time in temporary confinement or removal from association and should be returned to normal location at the earliest opportunity. Managers should review cases where detainees are moved after exactly 24 hours to assure themselves that the move could not have taken place earlier.

8.39 The centre should review why detainees have little confidence in the complaints system.

8.40 Any inappropriate replies to complaints should be sent back to the relevant manager to correct and advise staff on the importance of dealing with complaints appropriately.

8.41 Safer custody and diversity issues should be investigated separately, in line with the procedures applicable to those functions.

8.42 Analysis of complaints should be robust so that emerging patterns can be identified.

8.43 The Border and Immigration Agency should answer complaints in an acceptable timescale and update the centre and detainees regularly.

Section 9: Services

Expected outcomes:
Services available to detainees allow them to live in a decent environment in which their everyday needs are met freely and without discrimination.

9.1 Detainees were negative about the food. The menus attempted to meet cultural requirements, but the quality of some food was affected by being put on the hotplate too early. The shop list contained some 250 items, but few detainees said this met their needs. Profits from the shop were put into a general purpose fund. Recent monthly food and shop consultation meetings had been poorly attended.

Catering

9.2 In our survey and in group discussions, detainees were very negative about the quality of the food, with just 7%, significantly less than the comparator of 33%, saying it was good or very good. The menus operated on a four-week cycle and changed twice a year. Meals were not pre-selected and detainees could choose what to eat at the servery. Breakfast was served from 8am to 9am and offered a choice of cereal, preserves, toast, porridge and fresh fruit. Lunch was served from 12.30pm to 2pm and dinner from 5.30pm to 7.00pm. A night café serving hot and cold drinks and a light snack was open between 9pm and 9.45pm.

9.3 Each of the four units had its own servery and a clean dining room decorated with pictures. All detainees were expected to eat in the dining room and were marked off on a register when they entered. Each meal offered a healthy option and a vegetarian option. Meat and fish and five portions of fruit or vegetables were available daily. The menu choices were broadly representative of the population. The menus had been translated into nine languages and each servery had pictures and symbols of the food being served.

9.4 The meals we tasted were adequate, but some of the food, particularly potatoes and rice, was put on the hotplates about 40 minutes before serving and had deteriorated. The serveries were set up before noon and centre staff were able to have their lunch prior to the lunch time serving to detainees. Unit staff were informed of detainees who did not attend meal times and detainees who did not like the choices available were offered three pieces of fruit. Special or medical diets were catered for. Cultural events were marked and staff were preparing to celebrate Chinese New Year during the inspection.

9.5 There were four chefs, one trainee chef, a head chef who was also a qualified NVQ assessor and the catering manager. They were supported by 10 general assistants who helped with food preparation and cleaning. Another chef was due to start. All staff had received basic hygiene trained and wore appropriate clothing. The kitchen was large and food was stored appropriately. Frozen halal food was clearly marked and stored on one side of the freezer and there was a separate halal store room.

9.6 There was a food comments book in each dining room. Most comments were complimentary, but there were many complaints about food quality. All comments were in English, which indicated that non-English-speakers were not aware of the books or were not aware that they could write comments in their own language. Food surveys took place twice a year, but the questionnaires were in English and were simply left in the dining rooms. Only two had been completed.

9.7 A monthly food and shop consultation meeting was open to all detainees, but notices were only in English. It was chaired by the assistant director of residence and care, and residential managers, the catering manager and the manager of cultural and religious affairs also attended. No detainees had attended the meeting in December 2007 and only five in January 2008. Eighteen attended the meeting held during the inspection, but no non-English-speakers. The meeting was well run and detainees had the opportunity to express their concerns.

9.8 The catering manager had started to take steps to increase the involvement of detainees in food preparation, as recommended at our last inspection. Management, alongside the security department, was making catering and cleaning jobs available to detainees in the kitchen.

Shop

9.9 There were two shops, one of which was only for detainees on Crane unit. There were also vending machines around the centre selling hot and cold drinks and snacks. The shops were open from 9am to noon and from 2pm to 5pm.

9.10 The shop list contained some 250 items, including hair and skin care products for black and minority ethnic detainees and a range of hygiene products. However, in our survey, only 20% of detainees, significantly less than the comparator of 36%, said the shop sold a wide enough range of goods to meet their needs. Detainees could order approved items from mail order catalogues in the library. Apart from the monthly food and shop consultation meetings (see section on catering), the centre did not consult with detainees about the items sold in the shop.

9.11 Detainees could check their financial records at the shop and there were no limits on spending. The shop sold only one type of international telephone card at £3 or £5 and detainees complained that these were not good value. Detainees could also have discount telephone cards sent in.

9.12 Profits from the shop went into a general purpose fund. Some of the money had been used to buy a stock of mobile telephones for detainees, a pool table and a hammock for the garden.

Recommendations

9.13 Food, particularly vegetables and rice, should not remain on the hotplate for long periods before serving and the quality should be checked before serving.

9.14 Non-English-speakers should be encouraged to make comments in the food comments book in their own language. All comments should be analysed and issues discussed at the detainee food and shop consultation meetings.

9.15 Managers should encourage better attendance at the food and shop consultation meetings and assist non-English-speakers to make their views known.

9.16 Management should make job opportunities available for detainees in the preparation of meals.

9.17 Food surveys should be translated so that all detainees have the opportunity to influence the menu, and catering and residential managers should encourage detainees to complete the surveys.

9.18 A shop comments book should be available at the two shops and the catering manager should monitor the comments and address any issues at the food and shop consultation meetings.

9.19 Detainees should be consulted on what products they would like to see on the shop list at least twice yearly.

9.20 A range of best value discount international telephone cards should be available at the shop.

Section 10: Preparation for release

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

10.1 Detainees could attend the welfare officer's daily surgeries without appointment, but these were advertised in English only and the welfare officer did not have enough time to dedicate to developing services. Free internet/email access was available in the libraries. Some families with children had no opportunity to collect essential belongings within a few days of removal. Social visits were held every day. The visitors' centre was not a welcoming environment. The visits hall was well equipped and the atmosphere relaxed, but it was not always supervised. Less than a third of detainees in our survey said they were well treated by visits staff. Detainees had good access to telephones, but callers to the centre said the switchboard took a long time to answer. Removal directions were usually served with a few days' notice.

Welfare

10.2 The welfare officer had been in post only three weeks. His role included delivering the induction programme and he had little time to develop welfare services. He described his remit as offering support and advice on issues external to the centre and he largely dealt with helping detainees to access their property and with their financial affairs, for example closing bank accounts. The welfare officer held surgeries every weekday from 11am to noon in the main library and from 3.30pm to 4pm on Crane unit. Detainees did not need an appointment to attend. The surgeries were well advertised in the induction pack and around the centre, but only in English.

10.3 Records were kept of each detainee advised and the welfare officer had so far dealt with 48 welfare issues. The records were basic, giving the nature of the issue, action taken (mainly who was contacted and when) and outcome. They showed that the welfare officer had tried to resolve the issues raised. He did not address immigration issues, largely due to time constraints, but directed detainees to wing officers or resources in the library. Many detainees attending his surgeries wanted help with immigration matters. The welfare officer was expected to maintain links with the cultural and religious affairs manager and attend relevant meetings, but had not yet done so, seemingly because of time constraints.

Visits

10.4 Social visits took place every day from 2pm to 5pm and from 6pm to 9pm. Visitors who had travelled some distance were allowed to have a further visit in the afternoon if space permitted. Free transport to and from Bedford station was offered. A visitors' guide was available in the visitors' centre, but only in English. The visitors' centre was dimly lit and not a welcoming environment, with fixed furniture, limited information and muted decoration. Staff in the visitors' centre were welcoming and reassuring. They sensitively searched property and clearly explained what items were prohibited. Visitors walked from the visitors' centre to the centre, where they were searched and escorted to the visits hall. During the inspection, there was only

one member of staff in the visitors' centre and only two in the main hall to carry out searches and supervise visits. On more than one occasion, the visits hall was left unsupervised.

10.5 The visits hall was welcoming and relaxed, with a good range of notices and children's toys. Visitors could deliver up to six items and up to £20 in cash to detainees during a social visit. Snacks and drinks were available from vending machines and racist incident complaint forms and boxes were located in the hall. Appropriate physical contact was permitted. Voluntary visitors were available and used. Request forms were located in the visits hall.

10.6 We saw staff being respectful and engaging well with detainees and visitors, but only 31% of detainees in our survey, significantly less than the comparator of 38%, said they were treated well by visits staff. This may have been because of delays in getting into the visits hall when staffing levels were low, or because of the delays visitors experienced at the visitors' centre. Some detainees had made written complaints about not being notified of a visit.

Telephones

10.7 Detainees could keep their own mobile telephones as long as these did not have a camera or internet access. Otherwise, they could borrow one for a one-off £2 rental charge, but stocks were low and some did not work properly, if at all.

10.8 All units had several fixed incoming and outgoing telephones, most of which were in a separate room and had privacy hoods. Detainees were alerted of an incoming call by pager. They could use the telephone any time, but the incoming line was disconnected at night. The switchboard was busy, but staffed by only one or two staff who were also checking cameras, unlocking doors and collecting and sorting mail. Callers to the centre said it took a long time to get through to the switchboard. Detainees had free access to the Childline, Samaritans, Legal Services Commission and Asylum and Immigration Tribunal helplines.

10.9 Free internet and email equipment had recently been installed in the main and families unit libraries. Access to some sites was restricted, but some useful sites, such as Asylum Aid, were flagged up.

Mail

10.10 Detainees described no problems with sending and receiving mail. Incoming post was distributed around lunchtime and collected mail despatched the same afternoon. Detainees opened any incoming parcels in reception to allow the content to be checked.

Removal and release

10.11 Between 400 and 500 detainees left the centre each month. Nearly two-thirds were due to be removed, a quarter were granted temporary release subject to reporting requirements, a few were released on bail and a small number (2% in recent months) were transferred.

10.12 Removal directions were usually served a few days in advance, giving people time to prepare, although this was hampered if people were far from their home area as it was difficult for friends to visit and deliver property. Some families with young children were detained at a reporting centre shortly before planned removal and were given no opportunity to gather possessions from home. One couple with three young children had arrived at Yarl's Wood with only the contents of the mother's handbag. Documents in English given to them at the reporting centre included removal directions for a few days time, but they seemed unaware of

this and said the documents had not been explained. The declaration to indicate explanation of reasons for detention with an interpreter was not completed by the issuing immigration officer (see sections on casework and health services).

10.13 When necessary, centre staff could supply detainees leaving the centre with clean clothing, a fleece and a laundry bag to carry property. In appropriate cases, healthcare staff offered malaria prophylaxis for young children. The centre operated a free bus to Bedford station and people released were given a travel grant.

Recommendations

10.14 Welfare surgeries should be publicised in languages other than English to ensure that all detainees are aware that these are open to them.

10.15 The welfare officer should be given more time to develop welfare services.

10.16 The visitors' centre should be improved to create a welcoming environment and lockable lockers should be available to all visitors.

10.17 The visitors' centre, visits hall and search area should be appropriately staffed at all times to ensure constant supervision of detainees and visitors, and that visitors can progress through to the visits hall without delay.

10.18 Mobile telephone stocks should be kept at a level that meets need.

Section 11: Summary of recommendations, housekeeping points and good practice

The following is a listing of recommendations and good practice included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Main recommendations — To the director general of UKBA

11.1 Reviews of detention should reflect consideration of all relevant information for and against detention, including the effect on detainees of lengthening detention. (HE.40)

11.2 Children should be detained only in exceptional circumstances and then only for the shortest time necessary. Length of cumulative detention should be clearly and accurately recorded. (HE.41)

Main recommendations — To the centre manager

11.3 Specialist general and mental health services should be available for children. (HE.42)

11.4 Paid work for detainees should be significantly expanded. (HE.43)

11.5 The range of learning and skills activity for adults should be increased and improved. This should include good quality tuition in English for speakers of other languages and ICT. (HE.44)

11.6 The centre should improve the initial assessment of children's skills and abilities and use this information effectively to set and subsequently monitor progress towards short-term educational goals. (HE.45)

Recommendations — To the director general of UKBA

Arrival in detention

11.7 Families should not be separated without a full assessment and Border and Immigration Agency senior manager authorisation. Reasons for separation should be recorded. (1.20)

11.8 Individuals detained at reporting centres should be given the opportunity to collect items, including medication, from their home. (1.24)

Immigration casework

11.9 Rule 35 processes should recognise the full scope of the rule, which is to raise a concern whenever detention or conditions of detention are likely to be injurious to health. Follow-up and case owner responses to rule 35 letters should be filed with the initial letter in the central log. (3.18)

11.10 Border and Immigration Agency case owners should reply promptly to detainee correspondence. (3.19)

Childcare and child protection

11.11 The needs of individual children should always be taken into account when decisions to detain are made. (4.38)

11.12 Initial welfare assessments should be completed within seven days of a child's arrival and subsequent assessments should be every seven days and in writing. (4.39)

11.13 A clear central record should be maintained of all cases where discharge or transfer takes place as a result of decisions reached through the internal planning processes. (4.40)

11.14 Clear minutes containing action points should be maintained of the telephone conferencing discussions. (4.41)

11.15 Contributions made by Border and Immigration Agency caseworkers to the telephone conference should focus on the best interests of the child. (4.42)

11.16 Where children need to be admitted to outside hospital, there should be a presumption that this will be done under temporary release unless a risk assessment indicates otherwise. (4.43)

11.17 Young people whose minority is in dispute should be subject to independent professional age assessment before being detained. (4.50)

Rules and management of the centre

11.18 Detainees should only be restrained and carried, including by escorting staff, using approved techniques. (8.31)

11.19 The Border and Immigration Agency should answer complaints in an acceptable timescale and update the centre and detainees regularly. (8.43)

Recommendations — To UKBA and the Centre Manager

Legal rights

11.20 The centre should consult with the Legal Services Commission with a view to improving Commensurate legal safeguards should be in place when detainees are threatened with criminal prosecution, including facilitated access to suitably qualified legal advice. (3.10)

Recommendations — To the escort contractor or UKBA

Arrival in detention

11.21 Overseas escort contractors should inform the centre of their estimated time of arrival in advance to allow staff time to prepare. (1.16)

11.22 All escort vehicles carrying children should contain suitable toys or activities to keep them occupied. (1.17)

11.23 Vans with caged compartments should not be used to transport children. (1.18)

11.24 Overseas escorts should provide relevant information to receiving centres when a removal has failed. (1.19)

11.25 Escorts should provide comfort breaks at least every 2.5 hours, or in accordance with passenger needs, and record this accurately. (1.21)

Recommendations

To the centre manager

Arrival in detention

11.26 The outside areas in reception should contain activities for children. (1.22)

11.27 The welcome arrival video should be available in different languages or formats. (1.23)

11.28 Detainees should be offered a shower in reception. (1.25)

11.29 The telephones in reception should have privacy hoods. (1.26)

11.30 First night custodial sheets should be completed properly, detailing meaningful observations and interactions with detainees. (1.27)

11.31 Room-sharing risk assessments should be completed individually on arrival and the practice of recording a room-sharing risk assessment risk level before the formal assessment has taken place should cease. (1.28)

11.32 Staff on Bunting and Crane should be more involved in the induction process. (1.29)

Staff-detainee relationships

11.33 Detainee history sheets should have regular, detailed and quality-checked entries. (2.13)

11.34 All detainees should have an identified personal or care officer, who should make particular efforts to get to know those who are not fluent in English. (2.14)

Legal rights

11.35 The centre should consult with the Legal Services Commission with a view to improving access to legal advice for detainees. (3.9)

Immigration casework

11.36 Detention reviews and other significant decisions or events, such as removal directions or embassy interviews, should be issued and explained in a language the detainee can understand. (3.20)

Bullying and suicide and self-harm

11.37 Records monitoring individuals subject to bullying procedures should be completed properly and quality-checked by managers. (4.13)

11.38 All staff should be routinely briefed so that they are aware of who is subject to bullying procedures. (4.14)

11.39 Annual surveys should be conducted to determine the extent and nature of bullying. (4.15)

11.40 The management structure overseeing the governance of safer custody should be reviewed. In particular, someone should be identified and provided with sufficient time to oversee day-to-day operational issues relating to suicide and self-harm prevention. (4.16)

11.41 Suitable detainees should be identified to act as peer supporters, particularly on the first night/induction unit, and provided with training and a job description. (4.17)

11.42 The quality, structure and chairing of case reviews should urgently be improved. (4.18)

11.43 Management checks should be more proactive in highlighting inadequate entries in continuous observation logs. (4.19)

11.44 The safer detention committee should assure itself that the frequency of required observations and intervals between reviews are not set unduly frequently without explanation. (4.20)

Childcare and child protection

11.45 Parents should be given greater opportunity to carry out domestic tasks such as cooking and cleaning. (4.44)

11.46 All information generated under the cause for concern procedures involving children should be referred out to the local authority social services department. (4.45)

11.47 A log of all child protection referrals should be held securely in the centre and subject to an independent check by a senior social work manager representing the local authority. (4.46)

11.48 The centre should always be represented at the local safeguarding children board. (4.47)

11.49 Staff conducting reception procedures should receive specialist training on how to identify cases involving trafficked children. (4.48)

11.50 Specialist counselling should be available for children. (4.49)

Diversity

11.51 Designated and trained diversity officers should have sufficient time and resources to meet their responsibilities. (4.63)

11.52 All staff should receive regular training in diversity. (4.64)

11.53 A detailed and comprehensive diversity policy should include recognition of equality obligations. (4.65)

11.54 Relevant community groups should be involved in the promotion of diversity at the centre and invited to attend the race, faith and cultural awareness meetings. (4.66)

11.55 Monitoring by nationality and ethnicity should be undertaken and the results shared with staff and detainees. (4.67)

11.56 Diversity impact assessments should be undertaken. (4.68)

11.57 Interpreting arrangements should meet the needs of all detainees and a Chinese speaker employed or contracted to ensure routine communication flow with, and pick up the anxieties of, this particularly isolated group. (4.69)

Faith

11.58 The multi-faith team should offer more structured classes for detainees. (4.75)

11.59 The cultural and religious affairs manager (CRAM) should be routinely invited to assessment, care in detention and teamwork reviews. (4.76)

Health services

11.60 Detainees should be able to access the healthcare waiting room independently to attend clinics and triage. (5.44)

11.61 Notices and other written literature should be available in a range of appropriate languages. (5.45)

11.62 All healthcare rooms should be secured by a separate suite key. (5.46)

11.63 Medications arriving at the centre with detainees and not retained in the detainee's possession should be securely stored. (5.47)

11.64 The doors to rooms in the in-patient area should have observation panels. (5.48)

11.65 Detainees not fluent in English should be interviewed in the presence of a professional interpreter, particularly for interviews that require confidentiality, such as disclosure of sexual assault and psychiatric interviews. A telephone interpreting service should be used only if clinically appropriate. (5.49)

11.66 Clinical governance arrangements should be in place. (5.50)

11.67 All healthcare staff should have at least annual resuscitation and defibrillation training. (5.51)

11.68 All healthcare staff should receive training in the recognition and treatment of signs of trauma and torture. (5.52)

11.69 An appropriate induction course should be introduced for agency nursing staff. (5.53)

11.70 A registered sick children's nurse should be recruited as a priority. (5.54)

11.71 Appropriate counselling services should be available for children. (5.55)

11.72 Women should have access to a female GP when required. (5.56)

11.73 Out-of-hours medical arrangements should include visits by a GP where appropriate. (5.57)

11.74 All nurses should receive clinical supervision and records of this should be maintained. (5.58)

11.75 Formal arrangements should be in place with local health and social care agencies for the loan of occupational therapy equipment. (5.59)

11.76 Record-keeping should be in line with best practice guidelines for healthcare professionals. (5.60)

11.77 A comprehensive, accurate healthcare information leaflet accessible to all detainees should be given to detainees in reception. (5.61)

11.78 Nurse-led clinics should be run by nurses with appropriate post-registration training. (5.62)

11.79 Detainees should have direct access to advice by appropriately trained pharmacy staff. (5.63)

11.80 A medicines and therapeutics committee should be established. (5.64)

11.81 There should be a local formulary. (5.65)

11.82 A mental health needs assessment of adult detainees should be undertaken, and appropriate services provided. (5.66)

11.83 There should be an appropriate mental health pathway for children. (5.67)

11.84 Links should be developed between the centre and the local community mental health team and child and adolescent mental health service. (5.68)

Substance use

11.85 Protocols should be put in place for the treatment of substance-dependent detainees. (6.3)

Activities

11.86 The centre should improve its promotion, quality assurance and monitoring of participation in adult learning and skills activity. (7.22)

11.87 The length of the school day should be reduced to reflect practice in the community, particularly for primary age children. (7.23)

11.88 Greater efforts should be made to obtain details of children's prior educational attainment from schools. (7.24)

11.89 The centre should introduce short units of accreditation for children. (7.25)

11.90 The centre should improve the breadth of the curriculum and provide adequate resources to support this. (7.26)

11.91 The centre should provide classroom assistants to help teachers better meet the wide range of children's needs within each class. (7.27)

11.92 The centre should ensure that teachers receive appropriate professional support and development. (7.28)

11.93 The centre should introduce appropriate arrangements for quality assurance of children's education, including self-evaluation and observation of teaching and learning. (7.29)

11.94 The centre should improve the range and quality of out-of-school activity for children, especially at weekends, and this should include better-equipped activity rooms. (7.30)

11.95 The centre should improve induction to physical education (PE) to ensure that it is more timely, comprehensive and includes adequate access to healthcare assessments of detainees' fitness. (7.31)

11.96 The centre should collate and analyse information on participation in PE to ensure particular groups are not excluded. (7.32)

Rules and management of the centre

11.97 All new detainees should be given information about the centre's rules in a form they can understand. (8.24)

11.98 Staff awareness about the security intelligence system should be raised. (8.25)

11.99 Awareness about the rewards scheme among detainees should be raised. (8.26)

11.100 Children's behaviour should play no part in determining the level of the rewards scheme for adults. (8.27)

11.101 A use of force committee should be set up to monitor trends and patterns and review every incident where force is used against detainees. (8.28)

11.102 Video recordings of planned incidents should include staff briefings and negotiations with detainees before an incident, and incidents should be recorded until the detainee has been seen by a member of healthcare. (8.29)

11.103 Detainees who have removed some or all of their clothing should be covered with a suitable garment before being taken to reception. (8.30)

11.104 The supervising member of Serco staff should remain in overall charge of any incident until the detainee has left the premises. (8.32)

11.105 Responsible managers and healthcare staff should always write a report after any incident involving force against a detainee. (8.33)

11.106 Someone from healthcare should be present for all planned removals. (8.34)

11.107 Healthcare reports relevant to use of force incidents should be quality assured. (8.35)

11.108 The practice of returning single women to Bunting unit for re-induction as a disciplinary measure should cease. (8.36)

11.109 Any decision to move a detainee from their normal wing to another wing for behavioural reasons should be confirmed in writing and authorised by a senior manager. (8.37)

11.110 Detainees should spend the minimum possible time in temporary confinement or removal from association and should be returned to normal location at the earliest opportunity. Managers should review cases where detainees are moved after exactly 24 hours to assure themselves that the move could not have taken place earlier. (8.38)

11.111 The centre should review why detainees have little confidence in the complaints system. (8.39)

11.112 Any inappropriate replies to complaints should be sent back to the relevant manager to correct and advise staff on the importance of dealing with complaints appropriately. (8.40)

11.113 Safer custody and diversity issues should be investigated separately, in line with the procedures applicable to those functions. (8.41)

11.114 Analysis of complaints should be robust so that emerging patterns can be identified. (8.42)

Services

11.115 Food, particularly vegetables and rice, should not remain on the hotplate for long periods before serving and the quality should be checked before serving. (9.13)

11.116 Non-English-speakers should be encouraged to make comments in the food comments book in their own language. All comments should be analysed and issues discussed at the detainee food and shop consultation meetings. (9.14)

11.117 Managers should encourage better attendance at the food and shop consultation meetings and assist non-English-speakers to make their views known. (9.15)

11.118 Management should make job opportunities available for detainees in the preparation of meals. (9.16)

11.119 Food surveys should be translated so that all detainees have the opportunity to influence the menu, and catering and residential managers should encourage detainees to complete the surveys. (9.17)

11.120 A shop comments book should be available at the two shops and the catering manager should monitor the comments and address any issues at the food and shop consultation meetings. (9.18)

11.121 Detainees should be consulted on what products they would like to see on the shop list at least twice yearly. (9.19)

11.122 A range of best value discount international telephone cards should be available at the shop. (9.20)

Preparation for release

11.123 Welfare surgeries should be publicised in languages other than English to ensure that all detainees are aware that these are open to them. (10.14)

11.124 The welfare officer should be given more time to develop welfare services. (10.15)

11.125 The visitors' centre should be improved to create a welcoming environment and lockable lockers should be available to all visitors. (10.16)

11.126 The visitors' centre, visits hall and search area should be appropriately staffed at all times to ensure constant supervision of detainees and visitors, and that visitors can progress through to the visits hall without delay. (10.17)

11.127 Mobile telephone stocks should be kept at a level that meets need. (10.18)

Housekeeping points

Diversity

11.128 Attendance of detainees at race, faith and cultural affairs meetings should be recorded. (4.70)

Health services

11.129 Appropriate toys should be available in treatment areas. (5.69)

11.130 Records should be kept of management checks of the food refusal log. (5.70)

11.131 The detainee medication risk assessment should be available to escorting staff. (5.71)

11.132 Meals for in-patients should not be served in take-away containers. (5.72)

11.133 Detainees should be informed of forthcoming medical appointments. (5.73)

11.134 The bath hoist should be used only by staff trained in its use. (5.74)

Appendix 1: Inspection team

Nigel Newcomen	Deputy chief inspector of prisons
Hindpal Singh Bhui	Team leader
Gerry O'Donoghue	Inspector
Eileen Bye	Inspector
Ian Macfadyen	Inspector
Jonathan French	Inspector
Mandy Whittingham	Healthcare inspector
Laura Nettleingham	Researcher
Samantha Booth	Researcher
Helen Meckiffe	Researcher
Alastair Pearson	OFSTED
Martyn Rhowbotham	OFSTED
Justina Stewart	11 Million, office of the Children's Commissioner

Appendix 2: Centre population profile

Population breakdown by:

(i) Age	No. of men	No. of women	No. of children	%
Under 1 year			9	2.3
1 to 6 years			20	5.2
7 to 11 years			14	3.7
12 to 16 years			13	3.4
16 to 17 years				
18 years to 21 years	3	23		6.8
22 years to 29 years	4	107		29.1
30 years to 39 years	2	105		28.1
40 years to 49 years	4	60		16.8
50 years to 59 years	1	15		4.2
60 years to 69 years		1		0.3
70 or over				
Total	14	311	56	1085.3

(ii) Nationality	No. of men	No. of women	No. of children	%
Afghanistan				
Albania		2		0.5
Algeria				
Angola		3		0.8
Bangladesh		2		0.5
Belarus		2		0.5
Burundi		1	1	0.5
Brazil		2		0.5
Cameroon	1	28	2	8.1
China	1	52	1	14.1
Colombia		1		0.3
Congo (Brazzaville)		1		0.3
Congo Dem. Republic (Zaire)		3		0.8
Croatia		1		0.3
Eritrea	2	6	2	2.6
Ecuador	1	5	2	2.1
Estonia				
Georgia				
Ghana		10	1	2.9
Gambia		3		0.8
Guyana		1		0.3
India		9		2.4
Iraq				
Iran	2	1		0.8
Ivory Coast		2		0.5
Egypt		1		0.3
Jordan		1		0.3
Guinea		1		0.3
Lesotho		1	1	0.5

Jamaica		29	4	8.7
Kenya		15		3.9
Kosovo				
Latvia				
Lithuania				
Liberia		2		0.5
Malawi		6		1.6
Malaysia		3	3	1.6
Moldova		1		0.3
Nigeria		51	17	8.9
Namibia		1		0.3
Mongolia	1	1	2	1.1
Pakistan	2	11	4	4.5
Russia		2		0.5
Sierra Leone	1	4	2	1.8
Sri Lanka	1	4	2	1.8
Tanzania		1		0.3
Togo		1		0.3
Trinidad & Tobago				
Turkey	2	3	3	2.1
Ukraine		2		0.5
Vietnam		10		2.9
Yugoslavia (FRY)				
Uganda		7		1.8
Zambia		2	3	1.3
Zimbabwe		3		0.8
Other (please state what)				
Serbia		1	3	1.1
Somalia		6	2	2.1
St Lucia		1	1	0.5
St Vincent		1		0.3
South Africa		3		0.8
Venezuela		1		0.3
Total	14	311	56	100

(iv) Religion/belief	No. of men	No. of women	No. of children	%
Buddist		19		5.0
Roman Catholic	1	20	4	6.6
Orthodox		3		0.8
Other Christian religion	5	167	43	56.4
Hindu		5		1.3
Muslim	8	42	7	15.0
Sikh		5		1.3
Agnostic/atheist				
Unknown		33		8.7
Other (please state what)		13		3.4
Islamic		3	2	1.3
Jain		1		0.3
Total	14	311	56	100

(v) Length of time in detention in this centre	No. of men	No. of women	No. of children	%
Less than 1 week	4	58	17	20.8
1 to 2 weeks	3	56	13	18.9
2 to 4 weeks	4	56	12	18.9
1 to 2 months	3	50	7	15.7
2 to 4 months		45	7	13.6
4 to 6 months		27		7.1
6 to 8 months		14		3.7
8 to 10 months		2		0.5
More than 10 months (please note the longest length of time)		3		0.8
Total	14	311	56	100

(vi) Detainees last location before detention in this centre	No. of men	No. of women	No. of children	%
Community	4	52	17	19.2
Another detention centre	4	66	8	20.5
Prison		86	0	22.6
Police	3	47	15	17.1
Enforcement	0	10	10	5.2
Port	3	49	6	15.2
Total	14	311	56	100

Appendix 3: Summary of safety interviews

Eighteen detainees were interviewed regarding issues of safety at Yarl's Wood on 4 and 5 February 2008. This is a small sample (approx 5%) of the total population. Random individuals were approached on the units. Participation in the interview process was voluntary. Six detainees were interviewed on Avocet and Dove units, four on Crane unit and two on Bunting unit.

An interview schedule was used to maintain consistency, so all interviewees were asked the same questions.

Demographic information

- The average length of time in detention was approximately three months and ranged from two days to one year.
- Length of time at Yarl's Wood ranged from two days to one year. The average length of time spent at Yarl's Wood was approximately three months.
- For 15 interviewees, this was their first time in detention.
- Ages ranged from 22 to 54 years, the average being 35 years.
- Seven interviewees were Jamaican, two Nigerian, two Kenyan and one Brazilian, Cameroonian, Ethiopian, Sri Lankan, Gambian, South African, and Indian.
- All interviewees spoke English but only 12 spoke English as a first language.
- Fourteen interviewees identified their religion as Christian, two as Muslim, one as Sikh and one had no religion.
- Two interviewees stated they had a disability.

Safety

All interviewees were asked to identify areas of concern with regards to safety within Yarl's Wood, as well as rating how unsafe each issue they identified made them feel on a scale of 1 to 4 (1 = a little bit of a problem to 4 = very much a problem). A 'seriousness score' was then calculated, multiplying the number of individuals who thought the issue was a problem by the average rating score.

The top four issues were reported as safety concerns by at least half of the interviewees.

	2008		
	No. of interviewees who stated 'Yes, this is a problem'	Average safety rating	Seriousness score
Uncertainty/insecurity because of immigration case	14	4	56
Healthcare facilities	12	3.42	41
The way staff behave with detainees	13	2.73	35.5
Lack of trust in centre staff	12	2.92	35
Lack of confidence in staff	7	3.29	23
Access to legal advice	7	3.29	23

Number of staff on duty during the day	8	2.38	19
Information in translation	5	3.8	19
Number of staff on duty at night	5	3.6	18
Staff members giving favours in return for something	5	3.6	18
The way meals are served	5	3.4	17
Overcrowding	6	2.67	16
Aggressive body language of staff	5	3	15
Lack of communication with family/ friends	3	4	12
Response of staff to fights/bullying in the centre	4	3	12
Information about centre regime	3	4	12
Response of staff to self-harm incidents in the centre	3	4	12
Aggressive body language of detainees	4	2.75	11
Layout of the centre	3	3.33	10
Isolation (within the centre)	3	3	9
Procedures for discipline	2	4	8
Surveillance cameras elsewhere in the centre	2	3.5	7
Surveillance cameras on residential units	2	3	6
Discrimination by staff on the basis of culture or ethnicity	2	3	6
Discrimination by detainees on the basis of religion	2	3	6
Discrimination by detainees on the basis of sexual orientation	1	4	4
Existence of an illegal market	1	4	4
Discrimination by staff on the basis of disability	1	3	3
Discrimination by detainees on the basis of culture or ethnicity	1	3	3
Gang culture	1	2	2
Availability of drugs	0	0	0

Discrimination by staff on the basis of religion	0	0	0
Discrimination by staff on the basis of sexual orientation	0	0	0
Discrimination by detainees on the basis of disability	0	0	0
Discrimination by staff on the basis of age	0	0	0
Discrimination by detainees on the basis of age	0	0	0

Examples of comments for the top four issues

1. Uncertainty/insecurity because of immigration case

'Dealt with as second class citizens'
'Don't know your fate'
'Sometimes you think you are going and then you are not'
'No information from immigration'

2. Healthcare facilities

'Have to wait until triage to see a nurse'
'Healthcare are not independent, but part of immigration. They make sure people are 'fit to travel' even if ill''
'If you are five minutes late they don't take you and you have to wait another 24 hours. At 16:30 they have a cut off point and there is no doctor at the weekend. The staff down here are very rude. Paracetamol is the only thing they give you if you are ill.'

3. The way staff behave with detainees

'Some are very hostile and rude. Some do not knock on your door before entering'
'Some staff are rude and do not listen to you and are unhelpful. Some staff are good. G4 staff are the worst.'
'Staff have no manners'

4. Lack of trust in centre staff

'Don't trust staff to keep information confidential''
'Wouldn't tell them anything'

Overall safety rating:

Interviewees rated their feelings of safety at Yarl's Wood as 2.58 ('good') on a scale for 1 ('very bad') to 4 ('very good').

Appendix 4: Summary of children's interviews

Nine interviews were conducted with children detained at Yarl's Wood on 5 February 2008. One interview was not completed as the child had an appointment to attend.

Parents were spoken to before interviews were conducted with their children to explain the purpose of the interview and to request permission to interview their child. No parent refused. Parents raised some concerns about the effect detention was having on their children, in particular:

- One had been doing well at school outside, but had now become very withdrawn. Unlike his brother, he could remember what their country was like and was worried about returning.
- One child had been suffering from panic attacks since arriving at the centre.
- One child had become very withdrawn since entering the centre. They had loss interest in activities, were eating little and slept little as they were awake crying.
- Another child had also had problems sleeping as they were up crying at night and were missing their outside life.
- One child had begun bed wetting and their behaviour had deteriorated, with the child being rude to staff and having to be made to attend school.

Having spoken to their parent, children were then approached and asked if they would be happy to take part in an interview about their experience at the centre. No children refused. Children were interviewed within sight of a parent and it was made clear that they could end the interview at any time. Questions were asked under seven sections. Responses from the children are detailed below:

About you

How old are you?

10 years old = 2 children
11 years old = 2 children
12 years old = 1 child
13 years old = 2 children
14 years old = 1 child
15 years old = 1 child

How long have you been at this centre?

- The average length of time at the centre was a month, ranging from four days to two months and five days.
- Two had been held briefly in a different centre before coming to Yarl's Wood.

Who is here at the centre with you?

- All were in the centre with their mother.
- Two were with their father.
- Eight (89%) had a sibling/s in the centre with them.

Activities

Is there enough for you to do here in this centre?

- Three (33%) stated that there was enough for them to do in the centre.

- For those that did not feel there was enough to keep them busy, comments included:
  Don't want to go to school here as it's not proper studying
  Gaps between activities
  Quite boring here

What can you do with your time here?

Activities mentioned included:
- Five mentioned school. One 10 year-old commented that she was in a class with those aged five to 11 and found this hard.
- Four mentioned watching television.
- Three mentioned the youth club, where they could play on computer games.
- Three mentioned playing outside.
- Two mentioned the library.
- Two mentioned the cinema room, although one commented that this was only when staff were willing to put films on.
- Two mentioned the IT room, although one child was annoyed that you needed a parent present to be able to use the internet and the limited sites that could be accessed.
- Two mentioned the sports hall and the range of games they could play there, such as football and basketball.
- One mentioned praying.
- One child was unwell and so spent their days in bed watching television.

What do you do that you enjoy?

- Three children enjoyed the cinema.
- Two mentioned enjoying the youth club.
- Two enjoyed the sports/games offered.
- Two enjoyed school.
- One mentioned the library.
- One enjoyed the playground.
- One mentioned the IT room.
- One child enjoyed the 'girl's night' that takes place on Fridays where they can paint their nails and have facials.
- One stated that there was nothing they enjoyed.

What do you do that you don't enjoy?

- Three stated there was nothing they did that they did not enjoy.
- Two did not enjoy school.
- One found the outside playground claustrophobic as it is surrounded by walls.
- One did not enjoy time spent just sitting in their room.
- One child did not enjoy sports other than the trampoline.
- The child who was unwell did not enjoy going to healthcare.

Is there anything you would like to be able to do here?

- Three would like the chance to go swimming.
- Three wanted a chance to go outside the centre, one particularly to go back to her outside school, and one so that they could see their friends.
- One wanted the chance to play rugby.
- One child would like to have cooking lessons at school, particularly as they did not like the food at the centre.

- One child wanted more time to play the Playstation2.
- One child wanted to learn English.

Transfer/arrival

How did you get to this centre?

- Eight had been brought to the centre in a van and one in a bus.
- One child mentioned that she and her sister were gated apart from their mother and brother in the van. They had only one stop on the way from Dungavel IRC and her sister had had to go to the toilet in the van.

How did you feel when you first arrived at the centre?

- All children reported feeling scared, upset or worried when arriving at the centre.
- Three particularly mentioned not being able to sleep when they first arrived.
- One had felt lonely.

Do you feel happy at the moment?

- Only one child stated that they felt happy at the centre.
- Two particularly mentioned wanting to return home.

What makes you happy here in this centre?

- Having friends within the centre was mentioned by four children.
- Other things mentioned were: praying and having family with them; sports; staff being nice; visits with friends and family; the youth club; the cinema and library.
- Two children said nothing made them happy in the centre.

What makes you unhappy?

- Three stated that they wanted to go home and were missing family and friends.
- Two were unhappy with the food.
- Two were unhappy as they had been given flight dates that had then been cancelled. One of them stated that staff had given them a flight time at 2/3am.
- One, commenting on the staff, stated '*they're evil*" and that there were only two good members of staff.
- One was unhappy because they were ill.
- One was worried when thinking about going back to their country of origin and said *"I feel like I'm in prison, as if I've killed somebody.*"
- One was frustrated that they needed their mother to be able to do anything, i.e. dining hall and if they needed the toilet during visits.

Safety

Do you feel frightened/worried at this centre?

- Seven children stated that they felt frightened and worried.
- Two children did not feel frightened or worried.

What makes you feel frightened or worried?

- Three mentioned having to go back to their country of origin.
- One was upset as they had to see their mother cry when she was upset.
- One child did not like not having their own things and people asking too many questions.
- One did not like not being able to do proper education.
- One was worried about going to healthcare because it caused their mother some stress.
- One was worried because they did not know what was going to happen next. For example, they had been given a doctor's appointment when they had not requested one and worried what it was really about.

What helps you not feel frightened or worried?

- Three children mentioned keeping busy.
- One child was happy when their flight was cancelled, but was then upset when they had been given another one.
- One mentioned crying as helping them.

If you were unhappy, frightened or worried about something, who would you tell?

- Eight stated that they would tell their mother or parent.
- Two said they would also tell their sibling, with one stating that they would rather tell their brother as they did not want to worry their mother further.
- Two would also tell their friends within the centre.

Illness

Have you felt ill or been injured since being here?

- Five had felt ill since being at the centre.

If so, did you tell anyone?

- All those that had felt ill had told their mother and one had also told staff.

What did they do to help?

- One child had been sick in the playground and said staff did nothing and that their mother had been called to clean it up.
- One had been to see the nurse, but was only given paracetamol when having breathing difficulties and depression.
- Another had also been to healthcare

Staff (responses from eight children)

Do you like the staff here?

- Two liked the staff, three liked some of the staff and three stated that they did not like the staff.

What do you like about them?

- For the staff that were liked, this was due to them being friendly, kind and polite.

- Two mentioned that the staff they liked were helpful and listened to them.

What don't you like about them?

- Four mentioned not liking staff as they were unfriendly or rude.
- Two mentioned staff shouting at them.
- One mentioned that sometimes the office is closed and staff were not there when you need them.
- One mentioned staff not playing with them and that at night they sit down and talk about them in the office and they had heard them laughing about them.
- One child had been kicked by another child and when he told the shop staff was simply told to tell his mother.

Overall impressions (responses from eight children)

Overall, what do you think of it here?

- Four felt that the centre was all right.
- Three thought the centre was bad or scary, with one commenting that it should not have been built.

What do you like the most?

- Things that children mentioned liking the most included: the playground, sports available, the food (one child), school, the youth club and the 'girls' night' (one child).
- One stated that they liked nothing at the centre.

What do you like the least?

- Things that children liked the least included: school, lack of freedom and being in the centre, food (three children), the roll count, the way staff speak to you, staff swinging their keys at night, limited site access on the internet and having to be over 16 to go to the gym.
- One child said they disliked everything.

If you could change one thing at the centre what would it be?

- Three children would change the food.
- Two stated releasing everybody.
- Two wanted better school with better lessons.
- One would change the staff to have them being nicer and speaking more slowly.
- One would change the site access on the internet and the need to have your mother present.

Appendix 5: Summary of survey responses

Detainee survey methodology

A voluntary, confidential and anonymous survey of the detainee population was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

At the time of the survey on 22 January 2008, the detainee population at Yarl's Wood was 365. The questionnaire was given to 150 detainees. Overall, this represented 41% of the detainee population.

Selecting the sample

Questionnaires were offered to all adult detainees available at the time of the visit. A liaison officer, supplied to us by the IRC, organised nationality groups based on language to be convened throughout the course of the day.

Completion of the questionnaire was voluntary.

Interviews were offered to any respondents with literacy difficulties.

Questionnaires were offered in 24 different languages.

Methodology

Every attempt was made to distribute the questionnaires to each respondent either individually or in a language group. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- fill out the questionnaire immediately and hand it straight back to a member of the research team
- seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable
- seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire.

Response rates

In total, 92 respondents completed and returned their questionnaires. This represented 27% of the prison population. The response rate was 61%. In total, 58 questionnaires were not returned or returned blank. Forty-nine questionnaires (53%) were returned in English, 22

(24%) in Chinese, eight in Urdu (9%), four in French (4%), three in Punjabi (3%), two in Russian (2%), two in Vietnamese (2%) and one each in Portuguese and Tamil.

Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted, in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey are the comparator figures for all detainees surveyed in detention centres. This comparator is based on all responses from detainee surveys carried out in nine detention centres since September 2004.

In the above document, statistically significant differences are highlighted. Statistical significance merely indicates whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by grey shading, results that are significantly worse are indicated by a black background and where there is no significant difference, there is no shading.