Report on an unannounced short follow-up inspection of

Tinsley House Immigration Removal Centre

13–15 July 2009

by HM Chief Inspector of Prisons

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Introduction

Tinsley House immigration removal centre at Gatwick airport, run by G4S, holds men, women and children, most of whom are awaiting removal. When we last visited, we expressed serious concerns at the plight of the small number of children and women held in this largely male establishment. On our return for this unannounced follow-up inspection, conditions had generally deteriorated and the arrangements for children and single women were now wholly unacceptable.

Since our last visit, Tinsley House had effectively become a satellite of its newly opened neighbour, Brook House. This much larger and more secure removal centre, also run by G4S, provided a single management team for both sites. Managers at Brook House had faced a range of teething problems, which appeared to have been the focus of most of their attention. The consequence, pointed out to us by staff and detainees at Tinsley House, was that services and provision there had suffered, and a more restrictive approach had been introduced. Our previous suggestion that the opening of Brook House might allow Tinsley House to be refurbished to hold only families and single women had been ignored and, instead, already inadequate provision for these most vulnerable detainees had declined further.

Detainees continued to face disorienting moves around the immigration estate, and some vehicles were dirty. We also noted unprofessional conduct by some overseas escort contractors. Reception remained a poor quality facility and too little use was made of translation services here and on induction. There had been some improvement in suicide prevention work, although documentation remained variable. There was little evidence of bullying or use of drugs, but the small number of single women felt intimidated and rarely left their rooms.

While little use was made of separation and use of force, we were disturbed to find an incident where apparently unnecessary force had been used on children when removing a family. Children continued to be detained for more than 72 hours. There had been no progress in developing appropriate child protection arrangements, and parents reported being worried about their children's safety in a largely adult male environment. Childcare and education arrangements had deteriorated with the loss of trained and dedicated staff.

Accommodation remained clean, but stuffy and poorly ventilated. While staff-detainee relationships remained generally good, they had been affected by changed working patterns and more restrictive rules since the opening of Brook House. Staff talked openly about an increased prison culture encroaching on Tinsley House's previously relaxed atmosphere.

The race equality officer was now based in Brook House and had little time to address issues in Tinsley House. Work on diversity remained underdeveloped. The particular needs of single women were still ignored, leaving them feeling marginalised. Faith provision was good, although the multi-faith room remained inadequate. Healthcare remained reasonable, but was still housed in poor facilities.

Although some more paid work was now available, we disagreed with UKBA's insistence on linking access to it to compliance with immigration. This potentially compromised legitimate appeals against removal and bred discontent. The range of activities and education had shrunk. Education provision for children was now inadequate, and they had limited access to the fresh air. The library provision had also deteriorated.

There was limited preparation for release, with reliance on a small local charity rather than any in-house welfare provision. Access to visits was good, but there was neither food nor hot snacks for visitors. Access to phones and the internet was good, although there was a shortage of mobile phones to loan to those without one.

Overall, this is a deeply depressing report. Provision across a number of areas at Tinsley House had deteriorated since our last visit. In particular, the arrangements for children and single women were now wholly unacceptable and required urgent action by G4S and UKBA. It is also disappointing that the opening of the neighbouring Brook House had not led to a more thoughtful and rational approach to the use of Tinsley House. Instead, Tinsley House has become almost an afterthought, housing some poorly cared for children and a small number of scared and isolated single women. This is more than a missed opportunity; it is a wholly unacceptable state of affairs.

Anne Owers — October 2009
HM Chief Inspector of Prisons

Fact page

Task of the establishment
The detention, care and welfare of people subject to immigration control.

Location
Gatwick Airport

Contractor
G4S

Number held
120

Certified normal accommodation (CNA)
142

Operational capacity
154

Escort provider
G4S

Last inspection
Full announced inspection: 10-14 March 2008

Brief history
Tinsley House opened in May 1996 as the first purpose-built detention centre.

Description of residential units
Accommodation to hold men, women and families in separate areas.

Section 1: Healthy establishment assessment

Introduction

HE.1 All inspection reports include a summary of an establishment's performance against the model of a healthy establishment. The four criteria of a healthy establishment are:

Safety	detainees, even the most vulnerable, are held safely
Respect	detainees are treated with respect for their human dignity
Purposeful activity	detainees are able, and expected, to engage in activity that is likely to benefit them
Resettlement	detainees are prepared for their release into the community and helped to reduce the likelihood of reoffending.

HE.2 Under each test, we make an assessment of outcomes for detainees and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the UK Border Agency.

...performing well against this healthy establishment test.
There is no evidence that outcomes for detainees are being adversely affected in any significant areas.

...performing reasonably well against this healthy establishment test.
There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns.

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

...performing poorly against this healthy establishment test.
There is evidence that the outcomes for detainees are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for detainees. Immediate remedial action is required.

HE.3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy establishment summary setting out the progress of the establishment in the areas inspected. From the

evidence available they also concluded whether this progress confirmed or required amendment of the healthy establishment assessment held by the Inspectorate on all establishments but only published since early 2004.

Safety

HE.4 At the last inspection in 2007, we judged that Tinsley House was performing reasonably well against this healthy establishment test. Of the 56 recommendations in this area, 15 had been achieved, 16 partially achieved and 25 were not achieved.

HE.5 Some detainees had experienced successive disorienting moves within a short space of time. A vehicle used to transport families was dirty and strewn with used tissues and food debris. Most escort staff were polite and friendly and attempted to put detainees at ease. However, detainees collected by overseas escorts for removal to Afghanistan were poorly managed. There was no use of interpretation to explain what was going to happen to them, even though many could not speak English, and staff did not introduce themselves.

HE.6 The reception area remained cramped and needed redecoration. Staff were welcoming, but there was no evidence of interpretation to explain the reception process to detainees and to help complete the first night risk assessment. The lack of a dedicated reception staff group resulted in a generally less efficient management of the area, particularly disadvantaging those who did not speak English. Prison files were routinely received with former foreign national prisoners, but not always checked promptly. Induction was inadequate, particularly for those who did not speak English. The induction booklet was poorly written.

HE.7 Security information reports and incident reports were presented at security meetings, but management follow-up was uneven, and there was no written evidence of analysis of trends. Force was rarely used, and medical and duty manager assessments had improved. However, we were concerned to discover an incident where force had been used on children to effect the removal of a family. There was no suggestion that the children were at risk of harm to themselves or others, and no prior UK Border Agency (UKBA) authorisation was sought or given. Force had also been used on a detainee at risk of self-harm.

HE.8 Separation was not often used and there was evidence of generally good interaction with those held. However, recording was uneven and incomplete, and UKBA authorisation was not always obtained for separation of over 24 hours. Despite repeated recommendations, there was still no furniture other than the beds mounted on plinths in the rule 40 (removal from association in the interests of security or safety) rooms.

HE.9 There had been no progress in childcare and child protection, and significant deterioration in some areas, with an unfocused attitude to the needs of children. The facilities for children had deteriorated, with the loss of specialist childcare staff and the absence of a teacher qualified to teach them. During the inspection, there were no qualified childcare staff at all in the family unit. Parents were anxious about having their children in a facility with adult males, and were reluctant to let them play outside in close proximity to unrelated adults.

HE.10 We were especially concerned about the detention and welfare of children held for over 72 hours. In the previous six months, five families a month, on average, had been detained for over 72 hours, and some had been held for many weeks. Welfare assessments were not always promptly completed on children held beyond seven days, and staff who worked on the family unit were unfamiliar with the content of available assessments. It was still not possible to establish from the available figures the length of children's cumulative detention.

HE.11 A full-time safer detention coordinator had made some improvements to the overall management of safer detention. A more formal and appropriate 'raised awareness' support system for vulnerable detainees had superseded the previous 'discrete watch'. A care suite was now available, but access was inappropriately restricted. Management data on safer detention was gathered more systematically, but analysis of patterns and trends had not yet been carried out. Healthcare staff were not actively involved in the assessment, care in detention and teamwork (ACDT) self-harm monitoring procedures and did not attend reviews. The standard of monitoring documentation was variable, and there was too much focus on observation of rather than engagement with detainees at risk of self-harm.

HE.12 There was little evidence of bullying, but a comprehensive bullying survey had yet to be undertaken. The only substantial investigation had been thorough and efficient. The small number of women in the centre said they felt inhibited from going to activities such as the gym and library, or even queuing for lunch.

HE.13 Despite attempts to arrange a meeting, there had been no consultation with the Legal Services Commission (LSC) to seek ways of improving access to specialist legal advice and representation for detainees. In the absence of a librarian, there was no access to relevant information held on the library computer, such as country reports.

HE.14 Detainees had good access to UKBA staff. Some monthly reviews continued to be late, were repetitive and failed to identify any progress in cases. Five detainees had been at Tinsley House for over six months, with the longest detained for a year. There was no information on cumulative periods of detention across the estate, but case files showed that other detainees had been in detention for substantial periods. There was no procedure to ensure that bail summaries were served on detainees in a timely fashion before bail hearings. A sample of responses to rule 35 letters (notification of potential torture victims) contained substantial comments, which addressed fitness to detain.

HE.15 On the basis of this short follow-up inspection, we judged that Tinsley House was not performing sufficiently well against this healthy establishment test.

Respect

HE.16 At our last inspection, we assessed Tinsley House as not performing sufficiently well against this healthy establishment test. Of the 55 recommendations in this area, 13 had been achieved, seven partially achieved and 35 were not achieved.

HE.17 Ventilation in the centre remained poor, particularly in residential areas, parts of which were stuffy and smelly. The centre was clean, but some communal areas required redecoration and some information boards and displays required updating. Detainees still had restricted access to hot water for drinks.

HE.18 Detainees were generally very positive about their treatment by staff, and appreciated the humane and respectful approach taken by most. However, both detainees and staff felt that the previous good relationships had been affected by changed working patterns, lower staff morale and more restrictive rules that had followed the opening of nearby Brook House IRC a few months before the inspection. They described an encroaching prison culture and less focus on individual needs as a result of the preoccupation with the problems of Brook House IRC, where all but one of the senior managers were now based. The withdrawal of dedicated staff from several areas, including reception, the library and gym, had led to less well-organised provision and more frustration among detainees. There was still no care officer scheme. As there was also no welfare officer, a number of detainees were unsure about how to get help to retrieve property and deal with other practical problems.

HE.19 Detainees generally lived harmoniously with other nationalities in the centre, but there had been no progress in the management of diversity. The race equality officer was now based at Brook House and his assistant had little time to spend on diversity work. There was little attention to the wider diversity issues of disability, sexuality and gender. The small number of women in the centre remained particularly isolated and there were no specific policies or strategic initiatives to address their needs. There was little evidence of active promotion of diversity, such as regular advertised cultural events and celebrations. There was insufficient attention to the needs of detainees who spoke little English. Faith provision was good, but the multi-faith room was still in an unsuitable location between two noisy recreation areas.

HE.20 Nearly all detainees were on the enhanced level of the incentives and earned privileges scheme, although their only privilege was that they could apply for paid work. There was some confusion among managers about whether or not an incentives scheme was actually in operation.

HE.21 Many of the complaint form holders were empty during the inspection, and forms were not always available in different languages. There was no local analysis of topics or trends in complaints, and UKBA did not provide any statistics or analysis to local managers.

HE.22 Health services were reasonable but there had been little progress since the last inspection. There was a broad range of clinical services for detainees, including 24-hour nursing cover and good access to general practitioners. The nursing staff skill mix was good, and dedicated general and mental health nurses worked regularly at the centre. There was little ongoing professional training for nurses. Mental health support was adequate, but there was no regular input from community mental health teams and a lack of active nursing input for detainees with severe physical and mental health needs.

HE.23 We received many complaints about the quality and variety of food and portion sizes from both adult detainees and parents of children. The quality and variety of food was inadequate. There was no pictorial menu, and symbols on the menu to indicate food suitable for special diets were not always accurate. Small changes, such as the rationing of condiments, had had a considerable impact on the mood of detainees and the atmosphere in the dining hall. There was no food comments book. The range of items in the shop was limited, and there was no fresh fruit on sale.

HE.24 On the basis of this short follow-up inspection, we judged that Tinsley House was still not performing sufficiently well against this healthy establishment test.

Activities

HE.25 At our last inspection, we assessed Tinsley House as not performing sufficiently well against this healthy establishment test. Of the seven recommendations in this area, one had been achieved, one partially achieved and five were not achieved.

HE.26 Paid work had been available since the previous year and had expanded gradually to 25 roles. Promotion of work opportunities was insufficient. Fifteen detainees were in post at the time of the inspection and there was no waiting list. UKBA had explicitly linked access to work opportunities with compliance with immigration, and some detainees had been removed from their jobs as a result. This mixed the centre's operational and UKBA's removal objectives, which was inappropriate. It potentially punished detainees for exercising their right to contest removal, and made it harder to maintain a stable centre.

HE.27 The range of structured learning activities was narrow and had declined since the last inspection. Computer skills training was no longer offered, and arts and crafts teaching had been reduced pending recruitment of another teacher. Provision for the educational needs of school-age children was inadequate. It was unclear if any staff were suitably qualified to teach children rather than adults. Classes in English for speakers of other languages (ESOL) continued to be well planned and taught, but had been reduced from five to four sessions a week.

HE.28 Library provision had deteriorated since the last inspection, and there was no longer any librarian or other trained person in charge of it. The library was poorly used during the inspection, and there were no systems to administer loans, monitor or refresh stock.

HE.29 Access to the gym was reasonable and included evening and weekend sessions. There had been a slight extension in opening hours, but take-up was variable and it was not sufficiently promoted to women. Not all gym sessions were supervised by trained staff, which affected the quality of supervision and safety. There was poor monitoring of take-up.

HE.30 There had been no change in children's access to fresh air, and there was still no direct access to the play area from the family suite. The children's area was not screened from the adult detainee exercise area, and there was little planned physical exercise for children.

HE.31 On the basis of this short follow-up inspection, we assessed that Tinsley House was still not performing sufficiently well against this healthy establishment test.

Preparation for release

HE.32 At our last inspection, we assessed Tinsley House as not performing sufficiently well against this healthy establishment test. Of the 11 recommendations in this area, five had been achieved, one partially achieved and five were not achieved.

HE.33 Detainees' welfare needs were often poorly met. The Gatwick Detainees Welfare Group, a small local charity, gave detainees some useful assistance, but this was not a well-supported partnership and it had no formalised links with the centre. It could

not substitute for a comprehensive centre-based welfare service for detainees. There was no other structured assistance to help detainees prepare for removal or release.

HE.34 Access to visits was good, and booking was not required. A well-used free minibus service from Gatwick airport for visitors had been introduced. Vending machines in the visits area provided hot and cold drinks, and snacks, but visitors could not buy hot food or sandwiches.

HE.35 Access to phones was good. There were sufficient landline phones available and most detainees had their own mobile phones, although there were insufficient mobile phones for loan to detainees without one. Internet access was available and access was generally adequate.

HE.36 On the basis of this short follow-up inspection, we concluded that Tinsley House was still not performing sufficiently well against this healthy establishment test.

Section 2: Progress since the last report

The paragraph reference number at the end of each recommendation below refers to its location in the previous inspection report.

Main recommendations (from the previous report)

To the centre manager

2.1 If children are to remain at Tinsley House, their detention should be exceptional and only for a few days. (HE35)

Not achieved. The statistics that we were shown indicated that the detention of children was common and families were regularly detained for over 72 hours (see paragraph 2.116). This was of serious concern because the facilities for looking after children had deteriorated since the previous inspection.
We repeat the recommendation.

2.2 If single women are to remain at Tinsley House, their distinct needs should be systematically identified and met. (HE.36)

Not achieved. There had been no analysis to identify the needs of single women in detention at Tinsley House. The women we spoke with said they felt isolated, and particularly unsafe and uncomfortable in communal areas with large numbers of male detainees. Most avoided spending time in the communal areas, which restricted their access to the facilities. We were told that female staff had been asked to interact with the women to check on their wellbeing, but there was no formal key worker scheme, interactions were not recorded on detainee records, and we saw no evidence that women were given the support they needed.
We repeat the recommendation.

2.3 Medicines should not be administered without the informed consent of the patient. (HE.37)

Achieved. There was no recent evidence that medications had been administered without the informed consent of the patient. There were local guidelines on the administration of rapid tranquillisation. The principles were based on a comprehensive risk assessment of the detainee to minimise harm and ensure that all necessary care for the underlying condition was provided.

2.4 Detainees should be able to engage in voluntary or paid work. (HE.38)

Achieved. The centre had offered 25 work roles since June 2008, 15 of which were filled. The roles were part time; 10 were for three hours on Saturday and Sunday, and 15 for three hours each weekday. Pay was £1 an hour. Most work was mundane, such as cleaning, although a few roles involved assisting in areas such as the chapel and education classes.

Additional information

2.5 The process to recruit detainees to work was mainly appropriate. However, UKBA staff vetted applications and refused permission to work to detainees not complying with UKBA. This was

inappropriate as it mixed the centre's objectives to occupy detainees purposefully with UKBA's removal objectives. Since March 2009, six detainees had been subject to this ban.

Further recommendation

2.6 Detainees' cooperation or failure to cooperate with removal should not be considered as part of the recruitment to paid work roles.

2.7 If children are to remain at Tinsley House, a qualified teacher should be employed to provide structured and planned education to meet the needs of school-age children. (HE.39)

Not achieved. The arrangements to meet the needs of school-age children were very poor. The centre did not offer teaching or support from a teacher qualified and experienced in teaching the age ranges held, or otherwise make adequate provision to meet their educational needs. Parents had to request education for their children rather than it being provided as of right. If parents made a request, a teacher of adult classes employed by the centre set work for children to complete independently, rather than teaching them. It was not clear if these teachers had appropriate qualifications for teaching children or experience of the national curriculum. At the time of the inspection, two children of school age had been held at the centre with their family for two weeks. They spent their time watching DVDs or playing games, and occasionally in activity, such as painting and drawing, organised by a custody officer. We repeat the recommendation.

2.8 The centre should provide a welfare officer or team to help detainees prepare for their discharge. (HE.40)

Not achieved. The centre still had no formal provision to help detainees with welfare matters. We repeat the recommendation.

2.9 Subject to appropriate controls, detainees should be able to use the internet and email. (HE.41)

Achieved. Detainees had daily use of a suite of eight computers with internet access and email facilities, supervised by a detainee custody officer (DCO) for up to 12 and a quarter hours a day. There was an appropriate booking system, and suitable controls and monitoring of detainees' use of the internet. There was also a computer with internet access in the family facility for children to use under supervision, and for their parents. The centre did not offer detainees any training in using the internet or emailing.

Further recommendation

2.10 Detainees should be offered training in the use of the internet and email.

Other recommendations

To the director general, Border and Immigration Agency [now UK Border Agency (UKBA)]

Arrival in detention

2.11 Detainees should not be subjected to frequent, unexplained and disorienting transfers around the detention estate. (1.13)

Not achieved. We found examples where detainees had been transferred from different places of detention over a period of days. Transfers often took place at night or in the early hours of the morning. We were told that this was to make the best use of escort vehicles, but the practice showed little regard for the welfare of detainees who arrived exhausted and disoriented. Detainees were usually informed of transfers in advance, but often had only a few hours notice and were given little information about the reasons for transfer. Transfers from Tinsley House to other removal centres were often for the sole purpose of freeing space in the centre.
We repeat the recommendation.

2.12 Immigration detainees should not be held for long periods in police stations where facilities are designed for short periods of detention. (1.19)

Achieved. Although it was difficult to identify the number of detainees who had previously been detained in police stations and for how long, we did not see any examples in the case files we sampled where detainees had been held in police stations for more than 24 hours.

Casework

2.13 Reviews of detention should be issued in good time, in a language the detainee can understand, and should reflect balanced consideration of all factors relevant to continuing detention. (3.19)

Partially achieved. Most reviews of detention were received on time. There was a computer system to flag-up outstanding monthly reviews, but this did not work accurately. For example, it showed 27 monthly review letters outstanding on the first day of inspection but, after further enquiries, it appeared that only two were outstanding. There was no regular review of case files by on-site staff and they were usually accessed only when a monthly review letter was received. Some monthly reviews continued to list pro forma negative factors only and made general statements about lack of progress without identifying specific reasons. In the case of one detainee who had been in detention since July 2008, the two most recent review letters stated that UKBA was currently continuing 'to assess the outstanding issues' in his case. The reviews were issued in English but were explained to detainees using telephone interpreting, if requested.
We repeat the recommendation.

Further recommendation

2.14 On-site staff should regularly review case files and flag up concerns to case holders.

2.15 Border and Immigration Agency (BIA) case owners should consider and respond promptly and fully to detainee applications for temporary release. (3.20)

Not achieved. There continued to be delays in the UKBA caseworker response to detainee applications for temporary release. In one case, an application made on 12 June 2009 was still outstanding a month later. In another, there had been a five-week delay in a decision being made.
We repeat the recommendation.

2.16 Detainees should have sufficient time to confer with representatives before hearings that use the video link facility. (3.21)

Not achieved. The arrangements were unchanged since our last inspection, and detainees were still given only 10 minutes with their legal representatives before the hearing. This was usually inadequate, particularly if an interpreter was necessary.
We repeat the recommendation.

2.17 Bail summaries prepared by BIA case owners should be issued no later than the day before the hearing, with a copy faxed to the detainee as well as to the representative, if any. (3.22)

Not achieved. There was no procedure to monitor that bail summaries were received in time to serve on the detainee not later than 2pm the day before the bail hearing. There was no copy of the bail summary on several of the case files we reviewed, which suggested that it had not been received by the UKBA office before the bail hearing.

Further recommendation

2.18 In consultation with the centre, UKBA should ensure that all detainees receive a copy of the bail summary in due time before the hearing, and the on-site immigration team should monitor the receipt of bail summaries.

Health services

2.19 The BIA should revise its advice on use of the Mental Health Act to ensure the mental health needs of detainees are met. (5.31)

Achieved. We did not find any significant delays in the transfer of detainees to secure beds. The mental health needs of detainees were paramount in all cases, and if the patient's condition deteriorated while waiting for a bed to become available, he was transferred to an inpatient unit to facilitate closer observation.

Further information

2.20 The centre aimed to meet detainees' mental health needs, although this was not always the case. We found a lack of nursing input into the care of one detainee who had become agitated and distressed. Although she was subsequently seen and treated by a psychiatrist, a nurse who had been on duty since 7am told us at 2.15pm that he had not yet seen the detainee that day. There was also no documented care plan for this detainee, which was unacceptable practice.

Further recommendation

2.21 Detainees who clearly demonstrate a health need should have a care plan. The nurse on duty should see the patient each shift and, if necessary, update the care plan.

To BIA [UKBA] and centre manager

Duty of care

2.22 Records on individual children should state the cumulative period of detention. (4.49)

Not achieved. The UKBA case file contained a record of all transfers indicating their times, dates and place, from which it was possible, with some effort, to calculate the total length of detention. Records at the centre indicated that, for the previous six months, on average 23 children a month were held. However, there was no easily accessible data on their average or cumulative length of stay.

Further recommendation

2.23 Accurate records should be maintained of the average and cumulative length of stay of each child held at Tinsley House.

Casework

2.24 The central log of rule 35 notifications and BIA case owner responses (relevant to fitness to detain), to be maintained either by the healthcare department or the on-site BIA office, should include a copy of the notifications and responses. (3.23)

Partially achieved. There was a computer system to log the dates of rule 35 notifications (of detainees likely to have been tortured) and caseworker responses (relevant to fitness to detain). However, this was not as accessible as a paper record and did not include a copy of the documents, which could only be viewed on the individual case file. In the previous three months, 11 notifications and eight responses had been logged. A sample of these responses indicated that caseworkers largely addressed the issue of fitness to detain in response to a rule 35 notification.

Further recommendation

2.25 The central log of rule 35 notifications and caseworker responses should include a copy of the notifications and responses.

Rules and management of the centre

2.26 The reasons for use of separation and continued use should be clearly documented by centre managers and BIA. (8.33)

Partially achieved. The reasons for initial separation were clearly documented. However, in two of the three cases in the last six months where detainees had been held for more than 24 hours in single separation under rule 40, there was no formal authorisation by the UKBA's representative, as required.

Further recommendation

2.27 Use of separation for more than 24 hours should be authorised, with reasons recorded, by UKBA's representative.

2.28 The centre should be notified of the outcome of complaints dealt with by BIA for inclusion in its overall monitoring and analysis of complaints and issues of concern to detainees. (8.38)

Not achieved. The complaints clerk kept copies of replies received, but did not receive information about the outcomes of complaints, which were dealt with outside the establishment.
We repeat the recommendation.

Preparation for release

2.29 BIA and centre staff should discharge their responsibilities with regard to ex-prisoners released into the community on licence. (10.25)

Achieved. There was a system to identify ex-prisoners released on licence, and staff were aware of their responsibilities when releasing ex-prisoners into the community. We did not come across any examples of people released on licence during our review of case files.

To the escorting contractor

2.30 Escorts should use a professional interpreting service to respond to detainees' queries and concerns and to explain, in a language they understand, what is happening to them during transfer and removal. They should not provide false assurances to detainees being transferred or removed. (1.14)

Not achieved. We observed detainees being collected for removal under a 'Ravel' operation (the escorted removal of detainees to Afghanistan on a chartered aircraft). Although some of them could not understand English, there was no interpreter or use of telephone interpreting

service to explain what was going to happen.
We repeat the recommendation.

2.31 Families should not be split up when being transferred or removed unless guided by an up to date risk assessment, which takes into account all relevant information, especially the best interests of children. (1.15)

Achieved. We found no examples where families had been separated during transfer or removal. UKBA staff said that families would not be split up without a risk assessment.

2.32 Escort vehicles should be clean. (1.16)

Partially achieved. We inspected several vehicles. They were all clean except for two escort vehicles based at Gatwick airport. One of these had a caged seating area, and the second had an open seating area and was used to transport families with children. Both these vehicles were dirty. The family vehicle arrived at the centre to collect a woman and her six-year-old child. The vehicle contained soiled tissues and food debris. We were told by escorting staff that the vehicles based at Gatwick were only cleaned once a fortnight. These vehicles were only used for the short journey from the airport to Tinsley House (about 10 minutes) and did not carry supplies of water and refreshments. The other escort vehicles had supplies of water and snacks, as well as the escort contractor's detainee information booklet in 15 languages.
We repeat the recommendation.

2.33 In addition to regular training in control and restraint, escorts should receive training and supervision in de-escalation. They should understand the demarcation of responsibility between centres and escorts when collecting detainees from detention centres. (1.17)

Achieved. The escorting staff we spoke to had received training in control and restraint techniques and had been refreshed within the previous 12 months. They said that the training included instruction on how to de-escalate incidents to avoid using force. We did not observe any problems during the transfer of detainees from the care of centre staff to escorting staff.

2.34 Paramedics contracted by escorts should receive training and supervision to ensure they understand their role and duties as health professionals. (1.18)

Achieved. Paramedic services were provided to the escorting contractor by Aeromed. We spoke to one paramedic who was assisting on a Ravel operation (see below). The paramedic checked the medical information and medication supplied for each detainee, and was available in the event of a medical emergency or use of force. He had a clear understanding of his role and duties.

Additional information

2.35 During the inspection, we observed detainees who were collected from Tinsley House for an escorted removal to Afghanistan under a Ravel operation, on a flight chartered by UKBA. The centre received the list of detainees due to be removed only shortly before the transport arrived. Fourteen detainees had been identified on the list. They had been informed of the arrangements approximately one hour before the transport was due, and were waiting outside reception with their belongings for the arrival of the coach.

2.36 When the escorting staff arrived, there was considerable confusion about the number and names of the detainees to be removed. After some discussion, eight were identified and the

remaining six were told that they would not be removed that day. We were told that the Detainee Escorting and Population Management Unit (DEPMU) had indentified a greater number of detainees than the aircraft could accommodate to ensure that it was full. Additional 'reserve' detainees were collected and taken to the airport in case those on the list could not be removed as a result of last minute cancellation or illness or injury. The inevitable consequence was that some detainees were collected and taken to the airport, only to be returned to detention some hours later, which could cause extreme stress. The escorting staff involved in this operation were focused on getting the detainees on to the coach as quickly as possible and were abrupt and unapproachable. They did not introduce themselves, none wore name badges and some had no identification at all.

2.37 All the other escorting staff we met during the inspection were polite and professional with detainees. Most made a considerable effort to put detainees, particularly children, at ease, although not all wore name badges.

Further recommendations

2.38 The practice of taking additional detainees as reserves to the airport as part of charter flight removals should cease.

2.39 All escorting staff should wear name badges and introduce themselves to detainees.

To the centre manager

Reception and first night

2.40 There should be a formal room-sharing risk assessment of new arrivals, including consideration of prison security files that accompany former prisoners. (1.20)

Partially achieved. A formal first night risk assessment procedure involved the completion of a risk assessment form incorporating a section on the detainee's suitability for shared accommodation. The detainee was initially interviewed by reception staff who noted information on the detainee's mood and demeanour, and any cause for concern. After reception procedures were completed, the detainee was interviewed by healthcare staff who noted any concerns on the form. There was a section for completion by the DCO who conducted the detainee's induction tour and a final section for completion by the duty manager. Neither the first night risk assessment form nor the detainee reception and discharge operational instructions issued in February 2009 gave clear guidance to staff on how to conduct the interview or the questions to ask to obtain information about potential risk. Detainees transferred in from prison were accompanied by their prison records, including their security files. Reception staff said that they checked the files for information about the detainee's risk to themselves or others, and noted any relevant information, though this was not always prompt (see paragraph 2.201).

Further recommendation

2.41 The first night risk assessment form should be revised to include a more comprehensive list of questions and details of other sources – such as the escort record and prison file – to make an assessment of risk. It should be re-issued with guidelines for staff to ensure that it provides an adequate assessment of risk.

Additional information

2.42 All new arrivals were received at Tinsley House reception, although we were told there were future plans to use the reception at the nearby Brook House IRC for all single male detainees.

2.43 The reception area was cramped and needed redecoration. There were no interview rooms, and the first night risk assessment was conducted in a partially partitioned area within sight and hearing of other detainees.

2.44 A video about the centre was available in several languages, although we did not see it used during our inspection. An information booklet about the centre had been produced in 20 languages, but supplies in several languages had run out and had not been replaced. The booklet was misleadingly titled *Detainee house rules* and was not written in clear English. We were concerned that translations could have been as difficult to understand as the English version. We did not observe any use of telephone interpreting in reception, although some new arrivals had a very limited understanding of spoken or written English. One French-speaking detainee from Algeria, who had just arrived on a flight from Canada and repeatedly told staff that he did not understand English or what was happening to him, was booked into reception and risk assessed without using any interpretation. The French-language version of the information booklet had run out and he was offered no information in his own language.

2.45 There was no dedicated reception staff group, and incoming staff were not always briefed by staff going off shift or moving to another job in the centre. This resulted in a lack of continuity and responsibility for the area, such as the failure to replace translated copies of the information booklets and other documents.

2.46 After completion of the initial risk assessment, detainees' property was searched and logged. They could keep a small bag of property, and the remainder and any unauthorised items were stored in reception, and valuables were placed in the safe. Detainees were escorted to the healthcare clinic where a nurse completed the healthcare section of the risk assessment.

2.47 A DCO detailed to induction gave new arrivals a tour of the centre. During the tour, the officer was instructed to provide the detainee with induction information on all aspects of the centre, including the regime, activities, requests, complaints, telephones, and legal and immigration advice. At the end of the tour, the officer ticked the relevant section on the first night risk assessment form to indicate that the detainee had been give the information, and the detainee was asked to sign the form. Staff did not use telephone interpreting to convey this information to detainees who did not understand English. It was difficult to see how detainees could retain the extent of information even if they did understand English. Detainees we spoke to in focus groups said that the induction information was inadequate and they only learned of the centre's routines and systems by asking other detainees over a period of time.

Further recommendations

2.48 The reception area should be refurbished.

2.49 The first night risk assessment interview should take place in private.

2.50 A copy of the information booklet should be provided to every detainee in their own language, and the English and translated versions should be checked for comprehensibility.

2.51 Telephone interpreting should be used where necessary to complete the reception procedures, first night risk assessment and induction talk.

2.52 Induction should provide all detainees with the information they require to access all the centre's services.

2.53 Induction information should be explained to detainees who do not speak English fluently in their own language through telephone or face to face interpreting.

Environment and relationships

2.54 Residential units should be properly ventilated, and detainee living areas should receive priority for the installation of air conditioning units. (2.15)

Not achieved. There had been no change to the ventilation in the residential areas and it was very poor, particularly in the bedrooms, with unpleasantly stale and stuffy air. Most detainees wedged open the doors of their bedrooms day and night, which was not good fire safety practice. However, staff were understandably reluctant to enforce the closing of the doors when this hampered the already poor circulation of air.
We repeat the recommendation

2.55 The worn carpets and chairs in the association areas should be replaced. (2.16)

Not achieved. The carpets in some communal areas were dirty and worn, and a number of the chairs in the association areas were grubby and torn.
We repeat the recommendation.

2.56 Single women should have adequate accommodation, and access to their own dining and association facilities. (2.17)

Not achieved. Facilities for the few women held at Tinsley house were largely unchanged since our last inspection. At the time of our inspection, four women shared a room that could accommodate five (a fifth woman was held in separation due to concerns for her mental health). The room had a toilet and shower. A television was perched on top of the wardrobe, but there were no chairs in the room and it could only be viewed from two beds. Like the male accommodation, the room was poorly ventilated and was uncomfortably warm, smelly and stuffy. Women did not have separate association and dining facilities, and they told us that they felt unsafe and uncomfortable mixing in communal areas with male detainees. They spent much of their time in the bedroom or the corridor outside. Women said that they felt particularly uncomfortable eating in the dining room among large numbers of male detainees, which they found intimidating. One woman said she had requested to eat her meal separately from the men, either in a different area or by taking her meal before or after the men, but had been told

that this was not possible.
We repeat the recommendation.

2.57 Detainees should have access to hot water at night. (2.18)

Not achieved. Detainees could only obtain hot drinks from vending machines in the dining area and along the activities corridor. The machine in the dining area was free, and available from 9.30am to 10.30pm, but not accessible when the dining area was closed for cleaning between meals. The machine in the corridor charged 25p per drink and could not be accessed overnight. Neither machine dispensed hot water to enable detainees to make their own drinks.

Further recommendation

2.58 Detainees should have access to hot water to enable them to make a hot drink at any time.

2.59 Smokers should be restricted to a properly maintained discrete external area, which does not intrude on non-smokers and is not visible to children. (2.19)

Not achieved. The situation was unchanged since our last inspection. No smoking was allowed within the buildings, but detainees could smoke anywhere in the central courtyard area. This meant that there were no smoke-free outside areas, and smokers in this area were visible to children using the family exercise area.
We repeat the recommendation.

2.60 Discussions at the consultative committee should be more in depth, and issues raised should be followed up between meetings. (2.20)

Not achieved. Staff said that the safer detention meeting was the main means of consulting detainees, but the minutes showed that no detainees attended. The mis-named religious and cultural affairs committee meeting was, in fact, a detainee consultation meeting. It was scheduled to take place monthly, but had met only three times in the first six months of 2009. Several issues raised for action were not mentioned at subsequent meetings.
We repeat the recommendation.

2.61 Detainees should be able to obtain property from the reception store expeditiously. (2.21)

Achieved. Detainees could apply at the control room to obtain any property from reception. We observed that these requests were dealt with promptly the same day.

2.62 More use should be made of the professional interpreting services or, when appropriate, detainee or staff interpreters, to communicate with detainees who do not speak English. (2.25)

Not achieved. The telephone interpreting service invoices showed that nearly all usage was by healthcare staff. We noted other occasions when interpretation should have been used but was not, such as in reception.
We repeat the recommendation.

2.63 A care officer scheme should be implemented. (2.26)

Not achieved. There had been no attempt to implement a care officer scheme. In the absence

of care or welfare officers, detainees told us they found it difficult to know where to get help with practical issues, such as access to their property.
We repeat the recommendation.

2.64 History sheets should be used to record and develop knowledge and understanding of detainees. (2.27)

Not achieved. History sheets still contained scant information.
We repeat the recommendation.

Additional information

2.65 Detainees could wear their own clothes and use a laundry free of charge. There was a stock of basic clothing, such as underwear, jogging bottoms, T-shirts, sweatshirts and plimsolls, for those who did not have sufficient clothing.

2.66 Every detainee was given fresh bedding and free toiletries on arrival.

2.67 A public address system was used to inform detainees if they had an incoming call or a visit or if staff wished to speak to them. Speakers were in every room, including family sleeping areas, and were very intrusive and, at times, unintelligible. Families told us that it was sometimes difficult for children to sleep. During the inspection, we observed a three-month-old child who was woken by the public address system which made five announcements during a 20-minute period. This was detrimental for the child and upsetting for the mother. The pager system for contacting detainees was no longer used.

2.68 Most detainee custody officers were friendly and humane, and detainees were generally positive about relationships with staff. However, both staff and detainees expressed concerns about what they described as an encroaching 'prison culture'. Since the opening of the nearby higher security Brook House IRC, senior managers had been shared between the two centres. Staff morale was low and, until recently, none of the senior managers had been based on site as they were all located in Brook House. A single senior manager was now based at Tinsley House for most of the time. There was a perception among staff and some longer staying detainees that the near location and problematic nature of Brook House, which had experienced numerous incidents, had led to unnecessary changes in Tinsley House, including harsher rules and less focus on individual needs. For example, apparently small changes, such as making detainees ask for condiments in the dining room rather than having them freely available, had recently led to frustration among detainees. The removal of dedicated gym, reception and library staff was also cited as examples of deteriorating provision, which affected relationships between detainees and staff.

Further recommendations

2.69 The centre should use a system other than public address to contact individual detainees, such as contacting them by their mobile phone.

2.70 The public address speakers should be removed from family sleeping areas.

2.71 In consultation with custody and other staff, senior G4S and UKBA managers should address concerns about the deterioration of positive staff-detainee relationships.

Casework

2.72 In consultation with the Legal Services Commission, the centre should seek ways of improving access to specialist legal advice and representation for detainees. (3.7)

Not achieved. There had been attempts to arrange a meeting between the UKBA immigration office and the Legal Services Commission (LSC) to seek ways of improving access to specialist legal advice and representation for detainees. However, this had not taken place. The lack of access to suitably qualified legal advice and representation continued to be a concern for many detainees.
We repeat the recommendation.

2.73 The centre library should improve and update legal reference materials, which should be generally accessible. (3.8)

Not achieved. The information about possible sources of legal advice held in the library was not up to date. The lack of a librarian also meant that detainees could no longer access immigration materials on the computer in the library, which included copies of country reports.

Further recommendation

2.74 The legal and immigration reference materials in the library should be kept up to date, and those held on the computer should be accessible during library opening times.

Additional information

2.75 Uncertainty about immigration casework continued to be a source of anxiety revealed in the detainee group feedback. The on-site UKBA immigration office lacked its full staff complement at the time of the inspection, although detainees still had good access to staff. Five detainees had been at Tinsley House for over six months, the longest detained for a year. Although there was still no information on cumulative periods of detention across the estate, case files showed that other detainees had been in detention across the estate for periods of six months or more.

2.76 Refugee and Migrant Justice (RMJ – previously Refugee Legal Centre) continued to run twice-weekly legal advice surgeries in the library, which were accessible but not private. The librarian had run an appointment system for these sessions, but since his departure they had been on a first come, first serve basis, which was described as disorganised.

2.77 The two direct phone lines for detainees to obtain free legal advice from the RMJ and Immigration Advisory Service (IAS) respectively were not functioning sufficiently correctly to offer an effective service.

Further recommendations

2.78 Refugee and Migrant Justice legal advice sessions should be available to detainees on an appointments basis and in a private area.

2.79 The free legal advice phone lines should be properly maintained to ensure they offer an effective service at all times.

Bullying and suicide and self-harm

2.80 Regular surveys should take place to monitor detainees' perceptions of bullying and, in particular, establish the concerns of single women. (4.15)

Not achieved. There had been no bullying survey. Although there had been some general responses from detainees in a recent race equality survey, this did not provide the detail or range of information required. The detainees we spoke to in groups did not raise bullying as an issue, and there was no evidence that it was a serious problem. However, groups or individual detainees, such as single women, could have found it difficult to discuss these matters openly. Some single women made negative comments to us about their general treatment, which did not seem to have been picked up. Appropriate research was needed to provide objective data on the actual experience of bullying.
We repeat the recommendation.

2.81 The anti-bullying committee should include detainee representatives and take place regularly to enable sharing and discussion of information about all aspects of bullying. (4.16)

Partially achieved. Safer detention meetings took place monthly, and their date and location were displayed, but attendance was poor and there was only limited discussion on bullying. We were told that detainees were invited to attend, but records indicated that, in practice, they did not.

Further recommendation

2.82 Detainees should be actively encouraged to attend the safer detention meetings, which should always discuss bullying in the centre.

2.83 Staff should receive training to ensure that they can recognise and respond to potential bullying. (4.17)

Partially achieved. An initial training programme for all newly appointed staff provided them with a basic awareness of the subject and the steps to take if they encountered it. Refresher training on bullying had also been delivered since the previous inspection, but we were unable to establish the proportion of staff who had completed this.

Further recommendation

2.84 All staff should attend refresher training on potential bullying, and the establishment should maintain records on participation.

2.85 There should be effective multi-agency input into reviews and care plans for managing detainees at risk of self-harm, including BIA staff when appropriate. (4.18)

Not achieved. Although the introduction of management checks of relevant documentation had resulted in some improvement, the overall quality of recording was uneven (see further recommendation 2.101). Input to the reviews tended to be limited to two or three participants.
We repeat the recommendation.

2.86 There should be continuity of case management, and reviews should be scheduled to facilitate this. (4.19)

Achieved. The safer detention coordinator had responsibility for continuity. He managed some cases himself, and checked that in other cases, reviews involving the allocated case managers were scheduled and took place.

2.87 Care plans should be prepared with input from the detainee, using interpreters if required. Actions identified in care plans should be assigned to an individual to ensure accountability. (4.20)

Not achieved. We saw little evidence that detainees contributed to the completion of care plans, and found no evidence that interpreters had ever been used. Actions were assigned to individuals, but these were not reviewed or followed up.
We repeat the recommendation.

2.88 Records of observations should describe interaction between staff and the detainee, and observations should not be predictable. (4.21)

Partially achieved. The information in the records we examined was mostly observational rather than descriptive of engagement. The safer detention coordinator had identified this as an issue to be addressed, and had raised it with line managers to get staff to spend more time relating to detainees. The coordinator had also used the newly introduced quality assurance process to ensure that more of the observational checks were not predictable.
We repeat the recommendation.

2.89 There should be a care suite to enable peer support to detainees in crisis. (4.22)

Achieved. There was now a dedicated private room for this purpose. It had been open for three months and was comfortably furnished and well decorated. However, access to the room was restricted and the keys were held in a central office. This had contributed to it being little used as a care suite. There was little awareness of this facility or its purpose.

Further recommendation

2.90 Detainees should be able to access the care suite more easily, and its role should be advertised.

2.91 Peer interpreters should only be used in assessment, care in detention and teamwork (ACDT) reviews to support detainees, not to replace professional interpreters. (4.23)

Not achieved. We were told that detainees were permitted to choose another detainee to interpret for them instead of the formal interpretation service. We found no evidence that formal interpreting services had been used during ACDT reviews.
We repeat the recommendation.

2.92 Healthcare staff should be trained in ACDT procedures. (4.24)

Partially achieved. Not all healthcare staff had completed training for ACDT, and the training completed was only a shortened course of an hour's duration.

Further recommendation

2.93 All healthcare staff should complete the full training for ACDT, and a copy of the training record should be maintained.

2.94 Detainees should be encouraged to attend suicide prevention committee meetings. (4.25)

Not achieved. The suicide prevention committee had been replaced by the safer detention committee. See paragraph 2.81 and further recommendation 2.82.

2.95 There should be an ACDT coordinator to ensure the safe and efficient management of the ACDT process and that meetings of the suicide prevention committee take place regularly. (4.26)

Achieved. A full-time safer detention coordinator had been appointed in May 2009, and this had resulted in improvements in the management of this work. The safer detention group met monthly and reviews now took place on time. Regular quality assurance checks had led to an improvement in the quality of recording.

2.96 The ACDT coordinator should develop an effective database of incidents of self-harm so that patterns or trends are identified and preventative measures taken. (4.27)

Partially achieved. A database had been set up and information relating to self-harm was gathered systematically. However, this data was not yet being analysed.

Further recommendation

2.97 The data gathered in relation to self-harm should be analysed to identify any significant patterns and trends. The results of this analysis should be used to carry out any necessary preventative work.

2.98 Separation and strip conditions should not be used to manage the risk of self-harm. (4.28)

Partially achieved. We were told that separation and strip clothing were only used in exceptional situations, although we were unable to check this, as there was no documentation available for us to examine. During the inspection, we observed a case that supported what we had been told. A detainee who was subject to ACDT had been separated and located in the removal from association cell. Because of his threatening and aggressive behaviour, it was clear that staff were unable to deal with him in the mainstream accommodation, and had no realistic option but to place him in this cell.

Further recommendation

2.99 Whenever separation or strip clothing are used to manage the risk of self-harm, the reasons should be clearly recorded.

2.100 All ACDT files should be regularly quality assured by managers, with specific attention to the quality of care plans and observation records, and also the timeliness and

appropriate multidisciplinary input at reviews. (4.29)

Achieved. See paragraph 2.95. The newly introduced quality assurance arrangements had resulted in better scheduling of reviews and more comprehensive completion of the relevant forms. However, the standard of contributions was not consistent. They often had insufficient detail, and comments tended to focus on observation rather than engagement.

Further recommendation

2.101 The quality of written contributions to ACDT documentation should be consistently high.

Additional information

2.102 There had been only two formal complaints of bullying in 2009 to date. One was thought to be a mistake, resulting from a breakdown in communication. The other was substantiated, a thorough investigation was carried out, and the matter was dealt with efficiently.

2.103 The incidence of self-harm remained relatively constant, with four or five open ACDT cases at a time. There had been some important developments in suicide and self-harm prevention since the previous inspection, and there was evidence of gradual incremental change following the appointment of a full-time safer detention coordinator. The use of 'raised awareness' support plans had helped to ensure more accurate records, and was an improvement on the previous system of 'discrete watch'. All staff had been given ACDT information booklets, which had helped to reinforce the importance of maintaining a safe environment.

2.104 We were surprised at the lack of active involvement by healthcare staff in the ACDT procedures for a seriously mentally ill woman detainee resident during the inspection (see paragraph 2.20). This was a wider problem as nurses and doctors did not participate directly in the ACDT process at all.

Further recommendation

2.105 Healthcare staff should be actively involved in the ACDT process and attend reviews.

Childcare and child protection

2.106 All staff should be trained in child protection by specialist staff. (4.45)

Not achieved. We were told that some staff had completed child protection training delivered by specialist staff from the local authority, but we were unable to obtain precise figures about the proportion of staff involved.

Further recommendation

2.107 All staff should be trained in child protection by specialist staff, and accurate records maintained.

2.108 There should be 24-hour cover by trained childcare workers. (4.46)

Not achieved. There was no longer planned cover by trained childcare staff. Following contractual changes, the trained staff previously based in the family unit had been redeployed to generic duties.
We repeat the recommendation.

2.109 Social workers who have been involved in assessments or child protection referrals of individual children should attend the relevant weekly welfare telephone conferences and other meetings in the centre concerning any aspect of care planning. (4.47)

Not achieved. Social workers were not involved in the welfare telephone conferences. A representative from the Gatwick airport child asylum team attended the quarterly child protection welfare group meeting at the centre. This forum did not consider care planning of individual cases.
We repeat the recommendation.

2.110 Children held beyond seven days should have a care plan based on a comprehensive independent welfare assessment, which should be subject to weekly review and inform decisions about continued detention. (4.48)

Not achieved. We found evidence of welfare assessments in some cases, but these were sometimes late. Apart from these assessments, there was nothing that constituted care planning. There were no formal means of sharing this information appropriately or procedure for reviewing it.
We repeat the recommendation.

2.111 There should be minutes of the weekly welfare conferences to record relevant information and action points to inform individual care plans. (4.50)

Not achieved. We were told that the local UKBA manager participated in the welfare conferences when children resident at the centre were discussed. However, information from these conferences was only passed on verbally, and action points were not used to inform individual care plans.
We repeat the recommendation.

2.112 There should be a protocol or service level agreement with the Local Safeguarding Children Board setting out the arrangements for joint working on child protection and welfare assessments. (4.51)

Not achieved. There was no formal agreement between the centre and the local authority on the nature of joint working.
We repeat the recommendation.

2.113 The ACDT process should not replace a rigorous care plan drawn up and managed by qualified social workers. (4.52)

Partially achieved. The ACDT process was not used as a substitute for care planning, but there was no care planning for children (see paragraph and recommendation 2.110).

Additional information

2.114 There had been no progress in the arrangements for childcare or child protection. Given the very limited attempts to address the previous recommendations, we were concerned about the

centre's lack of focus on these key areas. There was clear evidence that the situation had got worse in certain respects.

2.115 Tinsley House remained an unsuitable environment for children. The living conditions for children were oppressive and claustrophobic. Families said they felt anxious about their children sharing a facility with adult males, and were inhibited from allowing them to play outside. The children's play area was in close proximity and clear sight of the adult detainees' exercise area.

2.116 We were particularly concerned about the detention and welfare of children held for over 72 hours. In the previous six months, on average five families a month had been detained for over 72 hours.

2.117 The completion of welfare assessments on children held beyond seven days seemed erratic. There was no central record of these assessments, and we were only able to obtain one to examine. We were told that an assessment had been carried out on an Egyptian family who had been resident at the centre for two weeks, but the report had not yet been produced. Where assessments were available, staff working on the family unit were not familiar with their content, and it appeared that they were not used to inform the way children were cared for in the centre.

2.118 The limited facilities previously available for children had deteriorated with the loss of specialist childcare staff in the family unit and the current absence of a classroom teacher. The absence of specialist childcare staff meant that children were no longer cared for by individuals with an expertise in this work. The lack of educational input meant that parents now had to structure activities for their children during the day. Both these deficits had a direct and negative effect on the experience of children in the centre.

2.119 We were very concerned to discover an incident where force had been used on two teenage children to effect the removal of a family. Force should only be used on a child where there is a serious risk of harm to themselves or others. Following this incident, some local guidance was issued to prevent this happening without prior approval of UKBA. UKBA's position on the use of force against children was not incorporated into the agency code of practice for keeping children safe.

Further recommendations

2.120 The facilities, conditions and specialist staffing arrangements for the treatment of children in the centre should be improved immediately, failing which children should not be held at the centre.

2.121 Force should only be used on children where there is a serious risk of harm to themselves or others. UKBA should communicate this through the estate urgently, and publish it in the relevant agency code of practice.

Diversity

2.122 A comprehensive diversity strategy should be produced, accompanied by an action plan and overseen by a diversity committee. (4.62)

Not achieved. The religious observance/race equality policy covered some wider aspects of

diversity, including a section on disability, but was mainly about race equality procedures. It made no mention of the needs of the women in the centre. There was no clear time-limited strategy with an accompanying action plan to show progress. There was no oversight from any management committee.
We repeat the recommendation.

2.123 All complaints relating to race and diversity should be fully investigated and results should be clearly recorded. (4.63)

Partially achieved. Seven racist incidents had been logged in the previous year. They had been thoroughly investigated and all parties had been interviewed, but no outcomes were recorded on the forms or the log. There were no copies of outcome letters to detainees. Final log entries simply stated that paperwork had been passed to the centre manager. The investigations were not always prompt. For example, one case took three months between the original complaint and the report to the manager, and an unknown time to completion.

Further recommendations

2.124 All racist incident complaints should be promptly investigated, and conclusions and outcomes should be clearly recorded on the racist incident log.

2.125 Outcome letters should be sent promptly to detainees and copies kept on file.

2.126 All staff should receive diversity training. (4.64)

Achieved. All staff received diversity training as part of their initial training course, and a refresher course was meant to take place annually. However, the centre could not supply figures on the number of staff who had completed the refresher training.

Further recommendation

2.127 All staff should receive annual diversity refresher training, and this should be recorded.

2.128 The race relations officer should have enough time to fulfil his duties and his role should be promoted in the centre. (4.65)

Not achieved. The race equality officer, who was also the coordinating chaplain, now spent most of his time at the neighbouring Brook House. The assistant chaplain was now the assistant race equality officer and was usually on site at Tinsley House. However, although he was visible around the centre, he said he spent little time on the race equality role. This lack of focus was reflected in a general lack of progress on diversity issues. A local race equality survey showed that most detainees did not know who the race equality officer was.
We repeat the recommendation.

2.129 Race relations meetings should provide strategic oversight and direction on race issues. They should consider racist incidents, nationality and ethnic monitoring in detail, and provide a means of monitoring and promoting race equality. (4.66)

Not achieved. The religious and cultural affairs meeting was the main forum for race equality discussion and was, in effect, a detainee consultation meeting. There was no systematic

consideration of strategic issues.
We repeat the recommendation.

2.130 Staff should be encouraged to use the telephone interpreting service, particularly to communicate with vulnerable detainees. (4.67)

Not achieved. The telephone interpreting service invoices showed that there was little use of the service outside of healthcare. We were told that a notice had been issued to staff encouraging use, but the message clearly needed reinforcement.
We repeat the recommendation.

2.131 There should be regular meetings with detainees who speak little English, using professional interpreters, to ensure good communication and identify unmet needs. (4.68)

Not achieved. There were no regular meetings facilitated by professional interpreters. We were told of some ad hoc meetings using detainee interpreters, but there was no record of them and no detainees could remember any taking place.
We repeat the recommendation.

2.132 Ethnic and nationality monitoring of detainees should be developed to examine and identify any problems. (4.69)

Not achieved. There had been no change to the monitoring arrangements since the previous inspection.
We repeat the recommendation.

2.133 There should be positive promotion of diversity throughout the centre. (4.70)

Not achieved. There was little evidence of positive promotion of diversity issues. For example, there were few cultural celebrations or events.
We repeat the recommendation.

Additional information

2.134 Detainees reported positive relations between different ethnic and nationality groups and there was little evidence of racism. The continuing isolation of the small number of women in the centre was a particular concern, and there were still no specific policies or strategic initiatives to meet their needs (see paragraph and recommendation 2.2).

Faith

2.135 The multi-faith facilities for detainees should be improved. (4.81)

Not achieved. The multi-faith room was unchanged, and still in a noisy location that provided little opportunity for quite contemplation.
We repeat the recommendation.

2.136 There should be greater use of professional interpretation services to cater for the religious needs of detainees who speak little or no English. (4.82)

Not achieved. As in other parts of the centre, there was little use of the telephone or other

professional interpreting service.
We repeat the recommendation.

Additional information

2.137 In our group interviews, detainees continued to report positively on faith provision in the centre. They had good access to the full-time assistant chaplain and chaplains from a range of religions.

Health services

2.138 The roles and responsibilities of health staff in incidents of control and restraint should be clarified and subject to review on each occasion. (5.29)

Achieved. Nurses were aware of their responsibilities in relation to a forced removal. The healthcare policy, which was renewed annually, detailed the responsibility of health professionals attending such incidents and the requirement to complete a comprehensive post-incident report. A member of the healthcare team attended all incidents where control and restraint was used, and made records in the detainee's clinical record of any injuries that resulted. Healthcare staff were also debriefed after instances of control and restraint.

2.139 The criteria for declaring an untoward incident should be broader and more accurately reflect the setting of a removal centre. The procedure should include prompt debriefing and multidisciplinary investigation. (5.30)

Achieved. There was a policy that referred to the management of an untoward incident. The policy included objectives, training and the necessary procedures to be carried out. Procedures included incident reporting and post-incident multidisciplinary reviews, to take place immediately following the incident.

2.140 Health services should establish formal links with the provider and commissioning sections of the primary care trust to promote quality assurance of services and ensure the health needs of detainees are met. (5.32)

Not achieved. Relationships with the West Sussex Primary Care Trust (PCT) were limited but said to be improving. There were no formal clinical or management meetings between the two organisations, and no quality assurance audits of health services.
We repeat the recommendation.

2.141 Health needs assessment work should include independent external input and review. (5.33)

Not achieved. There was no evidence that the PCT had participated in the health needs assessment of 2007. However, we were told that there was a memorandum of understanding with the PCT and that more collaborative work was due to commence. The lead GP was working with the PCT public health lead to update the health needs assessment.
We repeat the recommendation.

2.142 The health needs assessment should cover adult and child detainees' mental health needs. (5.34)

Partially achieved. The health needs assessment addressed only adult mental health needs, and did not cover mental health issues affecting children.

Further recommendation

2.143 The health needs assessment should be extended to cover child detainees' mental health needs.

2.144 A healthcare action plan based on up to date health needs assessment should be agreed and updated annually. (5.35)

Partially achieved. The 2007 health needs assessment had included an action plan, but work on updating this had not yet been completed.
We repeat the recommendation.

2.145 Healthcare representatives should contribute actively to the wider work of the establishment that directly affects the health and wellbeing of detainees, including child protection and ACDT reviews of detainees who have had health services treatment and care. (5.36)

Partially achieved. Healthcare staff attended multidisciplinary meetings or reviews with other departments, but not routinely. They were invited to several meetings, including child protection, safer custody and assessment, care in detention and teamwork (ACDT) reviews. They were not involved in the ACDT at all, apparently because of shortages of staff. The lead GP attended various external meetings, including the immigration healthcare steering group, clinical governance group and the detention user group (see also recommendation 2.105).

Further recommendation

2.146 Healthcare staff should make every effort to attend multidisciplinary meetings, especially those concerning child protection and ACDT. If necessary, cover from Brook House should be used to facilitate attendance.

2.147 Accommodation for the healthcare team should be expanded so that patient confidentiality can be preserved during consultations and administration of medicines, and to enable doctor- and nurse-led clinics to take place simultaneously. (5.37)

Not achieved. There had been no change or improvement in healthcare accommodation. It remained unsuitable for the delivery of a modern health service, and the lack of privacy for detainees was unacceptable. The treatment room led out directly to the waiting room and detainees continued to knock on the door during consultations. A toilet area leading from the room was used for urine testing as well as for staff use, and a small kitchen area was adjacent. The room was generally tidy but cluttered. There was an urgent need for additional accommodation to ensure patient confidentiality and clinical effectiveness.
We repeat the recommendation.

2.148 Infection control audits should be conducted annually, and recommended actions followed up. (5.38)

Not achieved. There had been no infection control audit, as the PCT did not have the

resources for this. The overall cleanliness of the healthcare room was only adequate and hand-washing facilities were poor. The room was due to be refurbished.

Further recommendation

2.149 The clinic should be refurbished as soon as possible, and it should include hand-washing facilities that meet infection control guidelines.

2.150 Health services and health promotion material should be more widely displayed around the centre, especially in the clinical waiting room and the library, be available in a range of languages, and include access to women health staff, second medical opinions and the health complaints system. (5.39)

Achieved. There was a range of health information and promotion in the clinic waiting room, much of which was in foreign languages. There were notices explaining that female detainees could see female staff, including doctors and nurses. Information on how to make a complaint about health services was displayed in the waiting room in English and other languages.

2.151 Children and young people should have access to primary care nursing and medical staff with appropriate expertise and qualifications in child health. (5.40)

Partially achieved. Primary care for children was provided by GPs who had the necessary qualifications and experience to care for young children. None of the nursing staff were qualified in childcare. Childcare officers were employed, but were frequently deployed to general duties, leaving the families area without appropriately qualified staff. The centre held too few children to recruit trained children's nurses, but regular visits by appropriate health professionals would ensure that children's health needs were met.

Further recommendation

2.152 The health provider should negotiate with the PCT to provide experienced health professionals, such as health visitors, to visit the centre regularly to ensure that the health and welfare needs of children are met.

2.153 A minuted meeting of the health team should take place regularly to promote communication, develop consistent policy and practice, and to improve quality of care for detainees. (5.41)

Not achieved. There had been no healthcare team meeting since Brook House had opened, and there were no minutes available from the last meeting. Nursing staff used a handover book to communicate issues that had occurred during their shift. The lack of team meetings appeared to have had a detrimental effect on staff morale.
We repeat the recommendation.

2.154 All health staff should receive in-depth training on recognition and treatment of patients who have experienced torture and violence. (5.42)

Partially achieved. Some, but not all staff had received training on how to deal with detainees who had experienced torture and violence. The lead GP told us that negotiations with the current provider of this specialist training had been unsuccessful, and that other avenues to

arrange appropriate training were being explored.
We repeat the recommendation.

2.155 An annual staff learning and development plan should be agreed that is based on the health needs of detainees, the aims and objectives of the service, and the personal professional development needs of staff. (5.43)

Not achieved. There was no current staff development plan. One member of staff who had been at Tinsley House for five years said he had not had any professional training in that time.
We repeat the recommendation.

2.156 Health staff should be offered external supervision. (5.44)

Not achieved. There was no structured clinical supervision policy, and any supervision was said to be informal. This consisted of nurses discussing any concerns with their colleagues or immediate supervisors. Access to external supervisors was not available.
We repeat the recommendation.

2.157 The healthcare department should introduce monitoring systems to ensure that detainees have equal access to services irrespective of age, gender, language, national origin etc. (5.45)

Not achieved. There was limited auditing of clinical activity to ensure that detainees had equal access to services. Detainees told us they could access services, although there were sometimes lengthy waiting lists for external appointments.
We repeat the recommendation.

2.158 Professional interpreting should be used consistently for patients who do not speak or understand enough English for a health consultation. (5.46)

Partially achieved. Invoices confirmed that health services regularly used professional interpretation, usually the telephone interpreting service. However, other detainees were also used to interpret if the detainee requested them, although they were not always able to interpret important medical information. A basic health questionnaire used during the reception screening process was printed in several languages. The GPs could also access a doctor-oriented web-based translation service specialising in health issues.

Further recommendation

2.159 Professional interpretation should be used routinely for interpreting patients' health needs. Family members or friends should only provide support and this should be noted in the detainee's clinical record.

2.160 All patients, including families with children, should be able to see a doctor or nurse in privacy. (5.47)

Achieved. Patients could have private consultations with healthcare staff with no custody officers present. A nurse accompanied the doctor where necessary to assist with examinations and to help the detainee understand instructions or advice.

2.161 There should be a consistent, multidisciplinary approach to assess and report on the extent to which a person's physical or mental health is or could be adversely affected

by detention. (5.48)

Not achieved. There was no evidence of multidisciplinary meetings to discuss whether continued detention could be detrimental to a detainee's health.
We repeat the recommendation.

2.162 Prescribing trends should be regularly reviewed to ensure appropriate evidence-based prescribing. (5.49)

Not achieved. Prescribing trends were monitored by the lead GP but there was no external audit by a professional pharmacist.
We repeat the recommendation.

2.163 Operating procedures and protocols for the safe storage and management of medicines should be developed and adhered to by all health staff. (5.50)

Achieved. The team leader (a registered general nurse) had responsibility for the management of medicines at the centre. She was undertaking a dispensing doctor's pharmacy course to give her greater skills in managing pharmacy issues. Medicine management was generally good. There was no evidence of excess stocks, and medicines we checked were appropriate and in date. Stocks were replenished from Brook House. Pharmacy policies were held in the clinic area.

2.164 Patients should have access to the advice of a pharmacist. (5.51)

Not achieved. The pharmacy was supply only, and there was no service level agreement to provide advice or support to detainees. Patients did not have direct access to advice by appropriately trained pharmacy staff, as they would do in the community.
We repeat the recommendation.

2.165 Prescribed medicines should not be issued from stock. (5.52)

Not achieved. Prescribed medicines continued to be dispensed from stock by the GP who completed a pharmacy label with the detainee's details.
We repeat the recommendation.

2.166 Detainees needing prescribed or non-prescribed medicines should normally hold them in possession, unless a multidisciplinary risk assessment based on agreed criteria suggests otherwise. (5.53)

Achieved. Detainees who arrived with prescribed medication were permitted to continue with it once it was verified as their medication. An in-possession policy had been introduced recently and included a comprehensive risk assessment tool. An in-possession risk assessment was completed at reception screening, and determined if the detainee were allowed to keep medication in possession. Detainees who met the criteria for having medication in possession were given this for up to seven days.

2.167 Detainees on medication for any condition should be provided with a reasonable supply for their onward journey. (5.54)

Achieved. All detainees who arrived with medication were given their own medication when they left the centre. Any additional medicines prescribed during their stay at Tinsley House were also given to them for up to seven days.

2.168 Detainees, including children, should have access to multidisciplinary primary and secondary specialist mental health treatment and care in line with their needs. (5.55)

Achieved. In addition to the medical GP service, there were three full-time and one part-time registered mental health nurses who provided primary care support to detainees where necessary. The GP service had links with the PCT and the mental health trust. The PCT provided a weekly psychologist session, and the mental health trust provided a weekly psychiatrist session when required. The PCT was reviewing mental health services to the centre to make improvements.

Additional information

2.169 There had been little improvement in health services since our last inspection. The majority of resources had been concentrated in Brook House when it opened, which had disadvantaged Tinsley House. Although most staff worked in both centres, Tinsley House was isolated from the main health team.

2.170 The GP service provided a good level of access and there was no appreciable waiting list. Nursing staff levels had been increased and overtime was used, supported by bank nurses. However, the opening of Brook House had made heavy demands on Tinsley House's staffing resources, and nurses often worked single handed there, apart from the GP's daily visits. Ongoing professional training for nursing staff was limited, and not all healthcare staff had undergone child protection training. There was no trained administrative support to Tinsley House, and nurses and the healthcare assistant carried out administrative duties. There was a lack of clear audit trails.

2.171 Our detainee groups were generally ambivalent about health services and expressed concerns about unhygienic practices in the administration of medicines. Contact with the PCT was said to be improving, but there appeared to be little overall support to improve health services for detainees.

Further recommendations

2.172 Administrative support should be provided at Tinsley House to release qualified nurses for professional duties in the care of detainees.

2.173 Clinical audit should be introduced and reviewed regularly.

Substance use

2.174 The need for a more explicit strategy for the management of illicit drugs and problem alcohol use should be considered at least annually. (6.5)

Not achieved. There was no drug strategy at Tinsley House. There was little evidence of substance misuse and there had been no finds of illegal drugs for some time. The only illegal drugs found at the centre were on visitors who attempted to bring in small quantities of cannabis. There were weekly routine searches, and targeted searches when intelligence suggested possible drug use. Preventative measures included examining detainees' post in front of them and the occasional use of drug dogs.
We repeat the recommendation.

2.175 There should be a comprehensive tobacco reduction strategy applying to both detainees and staff. (6.6)

Achieved. There was a tobacco reduction strategy, and staff and detainees were encouraged to stop smoking. The provider GP practice offered staff smoking cessation courses, and detainees and staff were offered nicotine replacement patches. There was literature encouraging staff and detainees to stop smoking throughout the centre, including the healthcare department.

Activities

2.176 Detainees should be able to complete accredited qualifications started at other establishments. (7.17)

Not achieved. Detainees were not able to complete accredited qualifications started at other establishments. The centre had ceased to offer structured information technology training, which might have allowed completion of computing qualifications started elsewhere. No learners in classes for English for speakers of other languages (ESOL) worked towards internal or external accreditation. The centre did not offer other learning that could lead to qualifications.
We repeat the recommendation.

2.177 There should be a wider range of structured purposeful activities and learning opportunities to suit the needs of longer stay and English-speaking detainees. (7.18)

Partially achieved. The introduction of paid work and internet access had improved the range of structured purposeful activity for all detainees. However, the range of learning opportunities had become narrower. Computer skills training had ceased. Arts and crafts had been reduced to one session a week, provided by the ESOL teacher, although this was due to restore to three sessions once a newly appointed teacher was in post. ESOL classes had reduced from five morning sessions to four to enable cover for the arts and craft class.

Further recommendation

2.178 The centre should provide a wider range of structured learning opportunities to suit the needs of longer stay and English-speaking detainees.

2.179 There should be improved promotion of sports and gym activities to make better use of available capacity. (7.19)

Not achieved. The centre had improved the sports and gym timetable, opening the gym half an hour earlier on some mornings to enable induction before regular activity commenced. Gym sessions were generally offered every morning and afternoon and on weekday evenings. Recorded attendance was generally good in the morning, but low in the afternoon. In the afternoons, other sporting activity was either scheduled or available by detainee request. However, attendance was very variable and some sessions did not run. Promotion remained weak. Information on notice boards about gym session times was often inaccurate, and only in English. The centre did not promote gym and sporting activity to women detainees effectively. Women detainees rarely used the gym, although an hour each morning was designated for their exclusive use. In their absence, men were usually allowed to use the gym.
We repeat the recommendation.

Further recommendation

2.180 The centre should identify and effectively promote appropriate gym and sporting activities to women detainees.

2.181 Access to fresh air and exercise for children should be improved, including direct access to the outside area from the family suite. (7.20)

Not achieved. Children's access to fresh air and activity had not improved. The centre planned an hour a day outdoors for children, but the time available was often shorter. Officers supervising children's activity in the sports hall were not trained to offer age-appropriate physical exercise, and children's visits there were infrequent. The centre still did not provide direct access to the outside area set aside for children from the family suite. The area was not screened from the adult exercise area, and parents said that children were intimidated by being watched by adult detainees.
We repeat the recommendation.

Further recommendation

2.182 The outdoor area set aside for children should be screened from the adult exercise areas.

2.183 There should be more books and activity materials for older children. (7.21)

Not achieved. The centre had not provided more books and activity materials for older children.
We repeat the recommendation.

Additional information

2.184 The range of activity for detainees at the centre for a short time remained satisfactory. There were common rooms with televisions, pool tables and table football. Bingo competitions held in the evenings were popular.

2.185 Arrangements to assure and improve the quality of activity at the centre were poorly developed. The manager responsible for activity had a similar role at Brook House and had little time or opportunity to develop and supervise the quality of activities at Tinsley House. Feedback from detainees on their experience of activities was no longer collected routinely, and the centre had no formal self-assessment process to support quality improvement. A manager responsible for education across G4S carried out occasional observations of teaching and learning, and provided useful feedback and suggestions for development to individual teachers, but findings did not contribute systematically to other quality improvement processes.

2.186 The centre continued to provide well-planned and taught ESOL classes, and detainees were assisted by a detainee classroom assistant. Promotion of ESOL and arts and crafts classes was poor, and information about them on notice boards was only in English, and usually inaccurate.

2.187 Library provision had deteriorated. The centre no longer employed a trained librarian and did not have an appropriately trained member of staff to oversee the library. Supervision of the

library was part of the routine patrolling of the centre by officers. The centre had no systems to administer loans of books or other materials, or on which to base decisions about stock replacement or replenishment. Attendance at the library was not routinely monitored to establish the extent to which it met the needs of different groups of detainees. Attendance was very low during the inspection. The provision of legal reference material was poor, texts were often out of date, and detainees no longer had access to the computer in the library that had this material.

2.188 The gym was well equipped with a range of fitness machines for up to 15 detainees at a time. A popular free weights facility had recently been removed. Team and other sports were played in a sports hall or on an outdoor sports area with a hard surface. Following recent changes to arrangements, around a quarter of gym sessions were overseen by officers as part of their regular duties rather than supervised by trained staff with specialised physical education experience. The centre had started to train all officers in supervising fitness and sporting activity. However, this training did not lead to a recognised qualification and it was not clear how effective it would be in ensuring detainees were safe when using equipment or taking part in sports.

2.189 Monitoring of the take-up of gym and sporting activity was ineffective. Staff reports of those attending only identified the number of attendances by nationality and did not identify patterns of attendance, such as the number and frequency of attendances by individuals, to help plan and improve provision.

2.190 There had been a reduction in the routine support from qualified care workers for families and children, which was now too low. At the previous inspection, two qualified care workers were generally available to provide support for up to 12 hours a day. Since then the number of trained care workers had reduced. During the three days of inspection, none were on site. Support and supervision increasingly depended on custody officers with no childcare training, some of whom were reluctant to engage with children. The centre planned to support one custody officer to follow a level three NVQ in childcare.

Further recommendations

2.191 There should be thorough and effective arrangements to assure and improve the quality of activities.

2.192 The promotion of classes in English for speakers of other languages (ESOL) and arts and crafts should be improved, especially to non-English speaking detainees.

2.193 The library should be managed by appropriately trained staff, and there should be systems for managing and renewing the stock of books and other materials.

2.194 Detainees should have ready access to up-to-date legal reference materials.

2.195 Patterns of attendance at the gym and take-up of sporting activity should be monitored and the outcomes used to improve provision.

2.196 Supervision of detainees participating in gym and sporting activities should ensure their health and safety.

2.197 There should be sufficient staff with specialist training and qualifications in childcare at all times.

Rules and management of the centre

2.198 Staff should be encouraged to complete security information reports (SIRs) when appropriate. (8.23)

Not achieved. An average of 1.27 SIRs a week had been submitted in the previous six months – slightly less than the equivalent figure at the previous inspection. Only five had been submitted in one five-week period in 2009, although 27 incident reports recorded a variety of events relevant to security management, with no cross-reference between the two types of document. As a result, any intelligence analysis based on SIRs could not be effective.
We repeat the recommendation.

2.199 A member of the senior management team should monitor all SIRs, and record appropriate actions. (8.24)

Not achieved. New SIR forms had recently been introduced, with a clearer requirement for senior management monitoring and recording of actions. However, in three of the previous six months, there had been no record of management monitoring of follow-up actions, and the records were incomplete for the remainder of the period.
We repeat the recommendation.

2.200 Information from SIRs should be analysed and trends or patterns identified. Objectives should be set from this analysis where necessary. (8.25)

Partially achieved. Intelligence objectives were set at the security meetings, and more frequently in response to specific intelligence, but they related to individual detainees rather than analysis across a range of SIRs. SIRs and incident reports were summarised in reports to the monthly security meetings, but there was no record of substantive analysis or any comment on patterns or trends.
We repeat the recommendation.

2.201 Prison records and security files should be sought from sending prisons, and analysed for relevant information. (8.26)

Partially achieved. Prison records were received from sending prisons. Reception staff consulted them briefly for any obvious risk information relevant to room sharing or suicide and self-harm, but there was rarely time to review them in detail to identify security concerns. Once the risk assessment was completed, they were supposed to be re-sealed and stored in the reception area. There were files lying sealed and unopened in the reception office (see also paragraph 2.40).

Further recommendation

2.202 All detainee security files should be analysed as soon as possible, and action taken promptly where evidence of specific risk is found.

2.203 Target searches should be recorded accurately. (8.27)

Achieved. All searching was accurately recorded.

2.204 The rewards scheme, and the need for it, should be reviewed. (8.28)

Not achieved. There was no evidence of a review or of an up-to-date written policy. Senior managers were not aware of the scheme at all. In principle, every detainee's incentive level was to be reviewed each week, and any with three warnings recorded that week were considered for reduction to the standard level. In practice, reviews did not happen every week. Detainees were routinely placed on the standard level on reception, and raised to the enhanced level if they complied with all that was expected of them in the first 24 hours. Typically, 97% of detainees were on the enhanced level. The only privilege at the enhanced level was the entitlement to apply for a paid work place. The scheme amounted, therefore, to a cumbersome means of excluding a very small number of detainees from paid work.

Further recommendation

2.205 The centre should reassess the rewards scheme and decide whether to continue it. If it is to continue, it should have an up-to-date written policy and be reviewed regularly.

2.206 Assessments by duty managers and medical practitioners should be completed thoroughly for every use of force incident. (8.29)

Achieved. There were assessments by duty managers and healthcare staff for all incidents where force had been used.

2.207 Medical assessments of detainees should always take place when handcuffs have been used on them. (8.30)

Achieved. Medical assessments were recorded for all uses of force.

2.208 Separation rooms should have furniture in them, which should only be removed or replaced by cardboard furniture following documented risk assessment. (8.31)

Not achieved. A detainee held in rule 40 (removal from association in the interests of security or safety) accommodation during the inspection had no furniture except for the mattress and bedding on one of the two plinths in the room. It was explained to us that the lack of furniture was normal, with no assessment of specific risk to justify it. No furniture was available for the rooms: the explanation given was that there was no convenient storage space.
We repeat the recommendation.

2.209 Rules 40 and 42 should be monitored by senior managers and any trends or patterns analysed. (8.32)

Partially achieved. The duty manager countersigned daily, and the operations manager reviewed uses. There was no evidence of analysis or reporting of trends and patterns in use of rules 40 and 42 (temporary confinement).

Further recommendation

2.210 Senior managers should commission and consider action in response to analysis of trends or patterns in use of rule 40 and 42.

2.211 Written reasons for separation should be given to detainees in a language they understand. (8.34)

Partially achieved. A copy of the front page of the authorisation document, with reasons for separation, was given to the detainee. Although there had been efforts to communicate the content orally where the detainee did not understand English, written reasons were not provided in translation.
We repeat the recommendation.

2.212 Detainees should be moved out of separation at the earliest opportunity, in line with detention centre rules. (8.35)

Achieved. Separation had been used 32 times in the previous 12 months. The average length of stay for 11 uses in the last six months was 20 hours, but eight of these were between five and 12 hours. Records showed that there had been priority to returning detainees to normal location as soon as possible.

2.213 Gym and education should be part of the separation regime. (8.36)

Achieved. Access to gym and education were incorporated into the separation regime displayed in the rule 40 unit and given to detainees.

2.214 Detainees should not be recorded as 'subjects' but by their names in records of separation. (8.37)

Achieved. All records referred to detainees by name.

Additional information

2.215 With the opening of Brook House, a single security department had been created for both centres, located at Brook House. This provided, for the first time, a dedicated security department with the potential for systematic analysis and objective-setting. However, as the volume of incidents and security information was likely to be substantially greater at Brook House, there was a risk that insufficient attention could be paid to Tinsley House matters.

2.216 Separation records and observation during the inspection showed a good level and quality of interaction by staff with detainees held in separation. Use of force had been recorded 17 times in the previous 12 months. Although this figure was relatively low, the use of force on children aged 10 and 14 was not acceptable (see paragraph 2.119 and recommendation 2.121), and force was used disproportionately to pin a detainee to the floor and cut off his clothing to check if he had concealed a blade to harm himself.

2.217 Complaint forms were freely available in racks in some languages, but forms in English usually had to be requested from one of two offices accessible only to staff. There was no evidence of monitoring or analysis of complaints. Since the opening of Brook House, complaints from both establishments were handled and filed together.

Further recommendations

2.218 Security information relating to Tinsley House should be collated, analysed and reported separately from Brook House.

2.219 Complaint forms in English and the most common languages should be available for detainees to collect freely and discreetly at all times.

2.220 Complaints should be monitored and analysed to identify and respond to patterns and trends.

2.221 Complaints from Tinsley House should be handled, recorded and monitored separately from those from Brook House.

Services

2.222 Pictorial menus and the menu cycle should be available to detainees before they reach the hotplate so that those with limited English are able to understand what is available. (9.10)

Not achieved. There was no pictorial menu to help detainees with limited English. There were symbols on the menu to indicate vegetarian, vegan and halal food, although these were sometimes inaccurate and too small to decipher. Menus were not available outside the dining hall to enable detainees to select their choices in advance. The only menu was just by the serving area, of A4 size and only available in English.
We repeat the recommendation.

2.223 Detainees should not be required to dispose of unopened food items that they have previously purchased unless there is good reason to do so. (9.11)

Achieved. Detainees could retain dried foods, which were stored with their property in reception, but had to dispose of perishable goods. They were not allowed to store any food in their rooms.

2.224 A pictorial version of the shop price list should be available. (9.12)

Not achieved. There was no pictorial version of the shop list for detainees who could not read English. The number and choice of items for purchase was limited, and did not contain any fresh fruit. The shop only stocked non-perishable items and was limited to cigarettes/tobacco, pop, sweets, chocolates, and a limited range of toiletries. The contractor G4S and Aramark made decisions about the number and choice of items available. There was no indication as to whether items were halal or not.

Further recommendation

2.225 A pictorial version of the shop price list should be available and it should indicate whether or not items on sale are halal.

2.226 The range of hair and skin products suitable for detainees from black and minority ethnic groups should be increased following consultation with them. (9.13)

Not achieved. There were only three or four skin and hair care products, and no evidence of any consultation with detainees about shop goods.
We repeat the recommendation.

Additional information

2.227 The catering contract had recently been taken over by Aramark. There were some complaints about the quality and quantity of food. Portion sizes were inadequate and the menu lacked variety. Detainees complained that the food was meagre and bland, and that there was no chilli sauce available to make it more palatable.

2.228 There was no food comments book in the dining area for detainees. There was just a plain white box with no indication as to its intended use, which was rarely checked.

Further recommendations

2.229 Detainees should be consulted on the menu.

2.230 The centre should supply condiments and seasoning in the dining area.

2.231 A food comments book should be available in the dining area, and its purpose should be advertised in a range of relevant languages.

Preparation for release

2.232 Managers should assist the Gatwick Detainees Welfare Group to set up a clinic in the centre as soon as possible. (10.17)

Not achieved. Despite efforts by Welfare Group staff to make contact with staff at the centre to extend the services they provided, no progress had been made.

Further recommendation

2.233 The centre manager should meet with representatives from the Gatwick Detainees Welfare Group to assess how they can help to improve welfare provision for detainees.

2.234 The centre should assist visitors with transport from local stations. (10.18)

Achieved. The centre provided a free minibus service during visiting hours, which operated twice an hour from 1.30pm to 9.30pm every day. It was well used and appreciated by visitors.

2.235 The children's play area in the visits room should be refurbished. (10.19)

Achieved. The children's play area was clean and well supplied with toys and books.

2.236 Visitors should be able to purchase or bring in more substantial food. (10.20)

Not achieved. Vending machines in the visiting area supplied hot drinks, cans of pop, chocolates and crisps, and detainees and their visitors had access to the centre shop during its opening hours. Visitors had no access to sandwiches or hot meals, and visitors were not allowed to bring in any food.
We repeat the recommendation.

2.237 Detainees should be able to rent mobile phones at a nominal rate. (10.21)

Not achieved. The centre had a stock of mobile phones to lend to detainees who did not have their own phone or who could not keep their phone if it had a camera. The number of phones was insufficient. At the time of our inspection, all the phones were in use and there were none available for new detainees.

Further recommendation

2.238 The centre should have a sufficient stock of mobile phones to loan to detainees.

2.239 Detainees transferred into further detention should be given written reasons for the decision and information about the centre to which they are being transferred. (10.22)

Not achieved. Detainees were not given written reasons for decisions to transfer them between places of detention. The movement orders gave reasons but these often gave little information, many simply stating, 'operational reasons'. Detainees were not given any information about the centre they were being transferred to, and we could find no information in the library.
We repeat the recommendation

2.240 Outdoor clothing should be available for detainees who need it on their removal. (10.23)

Partially achieved. The Gatwick Detainees Welfare Group provided second-hard clothing, including outdoor clothing, to detainees who applied.

Further recommendation

2.241 The centre should have a stock of outdoor clothing for detainees being released or removed.

2.242 Suitable bags should be available for detainees to carry their belongings on removal. (10.24)

Achieved. There was a stock of luggage bags in reception. The G4S staff on the Ravel operation also had a stock of plastic travel bags for detainees being removed.

Additional information

2.243 There was still no formal welfare provision for detainees. Detainees occasionally received assistance from an individual member of staff, but this was informal and officers did not regard it as part of their role. Some welfare support was available through the Gatwick Detainees Welfare Group, and this needed to be extended, but it was still no substitute for a properly funded, centre-based service.

2.244 The visits area was spacious and clean. Access to visits was good and they did not need to be booked in advance. Domestic visits started at 2pm and finished at 9.30pm with a break between 5.30 and 6.30pm for detainees to obtain their evening meal. Visitors could usually stay for the whole period. A notice in the visits area asked visitors to contact staff if they had any concerns about the welfare of a detainee, but this was only in English and did not give a contact number.

2.245 Most detainees had access to their own mobile phone and could buy top up phone credit at the shop. There were sufficient landline phones to satisfy demand, and detainees could receive incoming calls.

2.246 Mail was opened in front of detainees to ensure that it did not contain any unauthorised items, but was not routinely censored. Detainees were given one free letter a week to send to any destination in the world, and could buy additional stamps in the shop. Detainees could obtain stationery and post legal letters and faxes without charge. Internet and email facilities were available in the computer room (see paragraph 2.9).

2.247 As with welfare, there were no formal arrangements to assist detainees prepare for release or removal. Access to any assistance depended on the detainee requesting a member of staff for help and upon the skills, ability and willingness of the member of staff to assist.

2.248 Detainees who were released were offered a free phone call and a rail warrant in reception before departure. They could use the free minibus service from the centre to the train and bus station at Gatwick airport.

Further recommendations

2.249 The notice requesting visitors to contact staff if they have any concerns about detainees should be displayed in the languages used by detainees and should supply a phone number.

2.250 The centre should develop, publish and implement a policy on the needs and services available to detainees on removal or release, and this should be based on a needs analysis.

Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Main recommendations (from the previous report)

To the centre manager

3.1 If children are to remain at Tinsley House, their detention should be exceptional and only for a few days. (2.1)

3.2 If single women are to remain at Tinsley House, their distinct needs should be systematically identified and met. (2.2)

3.3 If children are to remain at Tinsley House, a qualified teacher should be employed to provide structured and planned education to meet the needs of school-age children. (2.7)

3.4 The centre should provide a welfare officer or team to help detainees prepare for their discharge. (2.8)

Recommendations

To the chief executive, UKBA

3.5 Detainees should not be subjected to frequent, unexplained and disorienting transfers around the detention estate. (2.11)

3.6 Reviews of detention should be issued in good time, in a language the detainee can understand, and should reflect balanced consideration of all factors relevant to continuing detention. (2.13)

3.7 On-site staff should regularly review case files and flag up concerns to case holders. (2.14)

3.8 UKBA case owners should consider and respond promptly and fully to detainee applications for temporary release. (2.15)

3.9 Detainees should have sufficient time to confer with representatives before hearings that use the video link facility. (2.16)

3.10 In consultation with the centre, UKBA should ensure that all detainees receive a copy of the bail summary in due time before the hearing, and the on-site immigration team should monitor the receipt of bail summaries. (2.18)

3.11 Detainees who clearly demonstrate a health need should have a care plan. The nurse on duty should see the patient each shift and, if necessary, update the care plan. (2.21)

3.12 The practice of taking additional detainees as reserves to the airport as part of charter flight removals should cease. (2.38)

Recommendations — To the chief executive, UKBA and centre manager

3.13 Records on individual children should state the cumulative period of detention. (2.22)

3.14 Accurate records should be maintained of the average and cumulative length of stay of each child held at Tinsley House. (2.23)

3.15 The central log of rule 35 notifications and caseworker responses should include a copy of the notifications and responses. (2.25)

3.16 Use of separation for more than 24 hours should be authorised, with reasons recorded, by UKBA's representative. (2.27)

3.17 The centre should be notified of the outcome of complaints dealt with by UKBA for inclusion in its overall monitoring and analysis of complaints and issues of concern to detainees. (2.28)

Recommendations — To the escorting contractor

3.18 Escorts should use a professional interpreting service to respond to detainees' queries and concerns and to explain, in a language they understand, what is happening to them during transfer and removal. They should not provide false assurances to detainees being transferred or removed. (2.30)

3.19 Escort vehicles should be clean. (2.32)

3.20 All escorting staff should wear name badges and introduce themselves to detainees.(2.39)

Recommendations — To the centre manager

Arrival in detention

3.21 The first night risk assessment form should be revised to include a more comprehensive list of questions and details of other sources – such as the escort record and prison file – to make an assessment of risk. It should be re-issued with guidelines for staff to ensure that it provides an adequate assessment of risk. (2.41)

3.22 The reception area should be refurbished. (2.48)

3.23 The first night risk assessment interview should take place in private. (2.49)

3.24 A copy of the information booklet should be provided to every detainee in their own language, and the English and translated versions should be checked for comprehensibility. (2.50)

3.25 Telephone interpreting should be used where necessary to complete the reception procedures, first night risk assessment and induction talk. (2.51)

3.26 Induction should provide all detainees with the information they require to access all the centre's services. (2.52)

3.27 Induction information should be explained to detainees who do not speak English fluently in their own language through telephone or face to face interpreting. (2.53)

Environment and relationships

3.28 Residential units should be properly ventilated, and detainee living areas should receive priority for the installation of air conditioning units. (2.54)

3.29 The worn carpets and chairs in the association areas should be replaced. (2.55)

3.30 Single women should have adequate accommodation, and access to their own dining and association facilities. (2.56)

3.31 Detainees should have access to hot water to enable them to make a hot drink at any time. (2.58)

3.32 Smokers should be restricted to a properly maintained discrete external area, which does not intrude on non-smokers and is not visible to children. (2.59)

3.33 Discussions at the consultative committee should be more in depth, and issues raised should be followed up between meetings. (2.60)

3.34 More use should be made of the professional interpreting services or, when appropriate, detainee or staff interpreters, to communicate with detainees who do not speak English. (2.62)

3.35 A care officer scheme should be implemented. (2.63)

3.36 History sheets should be used to record and develop knowledge and understanding of detainees. (2.64)

3.37 The centre should use a system other than public address to contact individual detainees, such as contacting them by their mobile phone. (2.69)

3.38 The public address speakers should be removed from family sleeping areas. (2.70)

3.39 In consultation with custody and other staff, senior G4S and UKBA managers should address concerns about the deterioration of positive staff-detainee relationships. (2.71)

Casework

3.40 In consultation with the Legal Services Commission, the centre should seek ways of improving access to specialist legal advice and representation for detainees. (2.72)

3.41 The legal and immigration reference materials in the library should be kept up to date, and those held on the computer should be accessible during library opening times. (2.74)

3.42 Refugee and Migrant Justice legal advice sessions should be available to detainees on an appointments basis and in a private area. (2.78)

3.43 The free legal advice phone lines should be properly maintained to ensure they offer an effective service at all times. (2.79)

Duty of care

3.44 Regular surveys should take place to monitor detainees' perceptions of bullying and, in particular, establish the concerns of single women. (2.80)

3.45 Detainees should be actively encouraged to attend the safer detention meetings, which should always discuss bullying in the centre. (2.82)

3.46 All staff should attend refresher training on potential bullying, and the establishment should maintain records on participation. (2.84)

3.47 There should be effective multi-agency input into reviews and care plans for managing detainees at risk of self-harm, including UKBA staff when appropriate. (2.85)

3.48 Care plans should be prepared with input from the detainee, using interpreters if required. Actions identified in care plans should be assigned to an individual to ensure accountability. (2.87)

3.49 Records of observations should describe interaction between staff and the detainee, and observations should not be predictable. (2.88)

3.50 Detainees should be able to access the care suite more easily, and its role should be advertised. (2.90)

3.51 Peer interpreters should only be used in assessment, care in detention and teamwork (ACDT) reviews to support detainees, not to replace professional interpreters. (2.91)

3.52 All healthcare staff should complete the full training for ACDT, and a copy of the training record should be maintained. (2.93)

3.53 The data gathered in relation to self-harm should be analysed to identify any significant patterns and trends. The results of this analysis should be used to carry out any necessary preventative work. (2.97)

3.54 Whenever separation or strip clothing are used to manage the risk of self-harm, the reasons should be clearly recorded. (2.99)

3.55 The quality of written contributions to ACDT documentation should be consistently high. (2.101)

3.56 Healthcare staff should be actively involved in the ACDT process and attend reviews. (2.105)

3.57 All staff should be trained in child protection by specialist staff, and accurate records maintained. (2.107)

3.58 There should be 24-hour cover by trained childcare workers. (2.108)

3.59 Social workers who have been involved in assessments or child protection referrals of individual children should attend the relevant weekly welfare telephone conferences and other meetings in the centre concerning any aspect of care planning. (2.109)

3.60 Children held beyond seven days should have a care plan based on a comprehensive independent welfare assessment, which should be subject to weekly review and inform decisions about continued detention. (2.110)

3.61 There should be minutes of the weekly welfare conferences to record relevant information and action points to inform individual care plans. (2.111)

3.62 There should be a protocol or service level agreement with the Local Safeguarding Children Board setting out the arrangements for joint working on child protection and welfare assessments. (2.112)

3.63 The facilities, conditions and specialist staffing arrangements for the treatment of children in the centre should be improved immediately, failing which children should not be held at the centre. (2.120)

3.64 Force should only be used on children where there is a serious risk of harm to themselves or others. UKBA should communicate this through the estate urgently, and publish it in the relevant agency code of practice. (2.121)

3.65 A comprehensive diversity strategy should be produced, accompanied by an action plan and overseen by a diversity committee. (2.122)

3.66 All racist incident complaints should be promptly investigated, and conclusions and outcomes should be clearly recorded on the racist incident log. (2.124)

3.67 Outcome letters should be sent promptly to detainees and copies kept on file. (2.125)

3.68 All staff should receive annual diversity refresher training, and this should be recorded. (2.127)

3.69 The race equality officer should have enough time to fulfil his duties and his role should be promoted in the centre. (2.128)

3.70 Race relations meetings should provide strategic oversight and direction on race issues. They should consider racist incidents, nationality and ethnic monitoring in detail, and provide a means of monitoring and promoting race equality. (2.129)

3.71 Staff should be encouraged to use the telephone interpreting service, particularly to communicate with vulnerable detainees. (2.130)

3.72 There should be regular meetings with detainees who speak little English, using professional interpreters, to ensure good communication and identify unmet needs. (2.131)

3.73 Ethnic and nationality monitoring of detainees should be developed to examine and identify any problems. (2.132)

3.74 There should be positive promotion of diversity throughout the centre. (2.133)

3.75 The multi-faith facilities for detainees should be improved. (2.135)

3.76 There should be greater use of professional interpretation services to cater for the religious needs of detainees who speak little or no English. (2.136)

Health services

3.77 Health services should establish formal links with the provider and commissioning sections of the primary care trust to promote quality assurance of services and ensure the health needs of detainees are met. (2.140)

3.78 Health needs assessment work should include independent external input and review. (2.141)

3.79 The health needs assessment should be extended to cover child detainees' mental health needs. (2.143)

3.80 A healthcare action plan based on up to date health needs assessment should be agreed and updated annually. (2.144)

3.81 Healthcare staff should make every effort to attend multidisciplinary meetings, especially those concerning child protection and ACDT. If necessary, cover from Brook House should be used to facilitate attendance. (2.146)

3.82 Accommodation for the healthcare team should be expanded so that patient confidentiality can be preserved during consultations and administration of medicines, and to enable doctor- and nurse-led clinics to take place simultaneously. (2.147)

3.83 The clinic should be refurbished as soon as possible, and it should include hand-washing facilities that meet infection control guidelines. (2.149)

3.84 The health provider should negotiate with the PCT to provide experienced health professionals, such as health visitors, to visit the centre regularly to ensure that the health and welfare needs of children are met. (2.152)

3.85 A minuted meeting of the health team should take place regularly to promote communication, develop consistent policy and practice, and to improve quality of care for detainees. (2.153)

3.86 All health staff should receive in-depth training on recognition and treatment of patients who have experienced torture and violence. (2.154)

3.87 An annual staff learning and development plan should be agreed that is based on the health needs of detainees, the aims and objectives of the service, and the personal professional development needs of staff. (2.155)

3.88 Health staff should be offered external supervision. (2.156)

3.89 The healthcare department should introduce monitoring systems to ensure that detainees have equal access to services irrespective of age, gender, language, national origin etc. (2.157)

3.90 Professional interpretation should be used routinely for interpreting patients' health needs. Family members or friends should only provide support and this should be noted in the detainee's clinical record. (2.159)

3.91 There should be a consistent, multidisciplinary approach to assess and report on the extent to which a person's physical or mental health is or could be adversely affected by detention. (2.161)

3.92 Prescribing trends should be regularly reviewed to ensure appropriate evidence-based prescribing. (2.162)

3.93 Patients should have access to the advice of a pharmacist. (2.164)

3.94 Prescribed medicines should not be issued from stock. (2.165)

3.95 Administrative support should be provided at Tinsley House to release qualified nurses for professional duties in the care of detainees. (2.172)

3.96 Clinical audit should be introduced and reviewed regularly. (2.173)

Substance use

3.97 The need for a more explicit strategy for the management of illicit drugs and problem alcohol use should be considered at least annually. (2.174)

Activities

3.98 Detainees' cooperation or failure to cooperate with removal should not be considered as part of the recruitment to paid work roles. (2.6)

3.99 Detainees should be able to complete accredited qualifications started at other establishments. (2.176)

3.100 The centre should provide a wider range of structured learning opportunities to suit the needs of longer stay and English-speaking detainees.(2.178)

3.101 There should be improved promotion of sports and gym activities to make better use of available capacity. (2.179)

3.102 The centre should identify and effectively promote appropriate gym and sporting activities to women detainees. (2.180)

3.103 Access to fresh air and exercise for children should be improved, including direct access to the outside area from the family suite. (2.181)

3.104 The outdoor area set aside for children should be screened from the adult exercise areas. (2.182)

3.105 There should be more books and activity materials for older children. (2.183)

3.106 There should be thorough and effective arrangements to assure and improve the quality of activities. (2.191)

3.107 The promotion of classes in English for speakers of other languages (ESOL) and arts and crafts should be improved, especially to non-English speaking detainees. (2.192)

3.108 The library should be managed by appropriately trained staff, and there should be systems for managing and renewing the stock of books and other materials. (2.193)

3.109 Detainees should have ready access to up-to-date legal reference materials. (2.194)

3.110 Patterns of attendance at the gym and take-up of sporting activity should be monitored and the outcomes used to improve provision. (2.195)

3.111 Supervision of detainees participating in gym and sporting activities should ensure their health and safety. (2.196)

3.112 There should be sufficient staff with specialist training and qualifications in childcare at all times. (2.197)

Rules and management of the centre

3.113 Staff should be encouraged to complete security information reports (SIRs) when appropriate. (2.198)

3.114 A member of the senior management team should monitor all SIRs, and record appropriate actions. (2.199)

3.115 Information from SIRs should be analysed and trends or patterns identified. Objectives should be set from this analysis where necessary. (2.200)

3.116 All detainee security files should be analysed as soon as possible, and action taken promptly where evidence of specific risk is found. (2.202)

3.117 The centre should reassess the rewards scheme and decide whether to continue it. If it is to continue, it should have an up-to-date written policy and be reviewed regularly. (2.205)

3.118 Separation rooms should have furniture in them, which should only be removed or replaced by cardboard furniture following documented risk assessment. (2.208)

3.119 Senior managers should commission and consider action in response to analysis of trends or patterns in use of rule 40 and 42. (2.210)

3.120 Written reasons for separation should be given to detainees in a language they understand. (2.211)

3.121 Security information relating to Tinsley House should be collated, analysed and reported separately from Brook House. (2.218)

3.122 Complaint forms in English and the most common languages should be available for detainees to collect freely and discreetly at all times. (2.219)

3.123 Complaints should be monitored and analysed to identify and respond to patterns and trends. (2.220)

3.124 Complaints from Tinsley House should be handled, recorded and monitored separately from those from Brook House. (2.221)

Services

3.125 Pictorial menus and the menu cycle should be available to detainees before they reach the hotplate so that those with limited English are able to understand what is available. (2.222)

3.126 A pictorial version of the shop price list should be available and it should indicate whether or not items on sale are halal. (2.225)

3.127 The range of hair and skin products suitable for detainees from black and minority ethnic groups should be increased following consultation with them. (2.226)

3.128 Detainees should be consulted on the menu. (2.229)

3.129 The centre should supply condiments and seasoning in the dining area. (2.230)

3.130 A food comments book should be available in the dining area, and its purpose should be advertised in a range of relevant languages. (2.231)

Preparation for release

3.131 Detainees should be offered training in the use of the internet and email. (2.10)

3.132 The centre manager should meet with representatives from the Gatwick Detainees Welfare Group to assess how they can help to improve welfare provision for detainees. (2.233)

3.133 Visitors should be able to purchase or bring in more substantial food. (2.236)

3.134 The centre should have a sufficient stock of mobile phones to loan to detainees. (2.238)

3.135 Detainees transferred into further detention should be given written reasons for the decision and information about the centre to which they are being transferred. (2.239)

3.136 The centre should have a stock of outdoor clothing for detainees being released or removed. (2.241)

3.137 The notice requesting visitors to contact staff if they have any concerns about detainees should be displayed in the languages used by detainees and should supply a phone number. (2.249)

3.138 The centre should develop, publish and implement a policy on the needs and services available to detainees on removal or release, and this should be based on a needs analysis. (2.250)

Appendix I: Inspection team

Hindpal Singh Bhui	Team leader
Martin Kettle	Inspector
Ian Macfadyen	Inspector
Anita Saigal	Inspector
Lucy Young	Inspector
Madeleine Colvin	Inspector
Bridget McEvilly	Health services inspector

Appendix II: Population profile*

Age	Men	Women	Children	%
Under 1 year			1	*0.83*
1 to 6 years			2	*1.67*
7 to 11 years			2	*1.67*
18 years to 21 years	11			*9.17*
22 years to 29 years	30			*25.00*
30 years to 39 years	51	3		*45.00*
40 years to 49 years	12			*10.00*
50 years to 59 years	7	1		*6.67*
Total	111	4	5	*100*

Nationality	Men	Women	Children	%
Afghanistan	21			*17.5*
Algeria	1			*0.83*
Angola	1			*0.83*
Azerbaijan	1			*0.83*
Bangladesh	2			*1.67*
Canada		1		*0.83*
China	7	1		*6.67*
Cote D'Ivoire	3			*2.5*
Congo (Brazzaville)	1			*0.83*
Dominican Republic	1			*0.83*
Egypt	1	1	5	*5.83*
Ecuador	3			*2.5*
Eritrea	1			*0.83*
Ethiopia	1			*0.83*
Gambia	1			*0.83*
Ghana	3			*2.5*
Grenada	1			*0.83*
India	1			*0.83*
Iraq	11			*9.17*
Iran	3			*2.5*
Jamaica	11			*9.17*
Liberia	1			*0.83*
Malaysia	1			*0.83*
Malawi	1			*0.83*
Nigeria	12	1		*10.83*
Pakistan	4			*3.33*
Portugal	1			*0.83*
Rwanda	1			*0.83*
Sierra Leone	3			*2.5*
Sri Lanka	1			*0.83*
Somalia	2			*1.67*
St Vincent and Grenadines	1			*0.83*
Trinidad and Tobago	1			*0.83*
Uganda	2			*1.67*
Ukraine	1			*0.83*
Uzbekistan	1			*0.83*
Vietnam	3			*2.5*
Total	111	4	5	*100*

* Percentages have been rounded up and may not always total 100%.

Religion/belief	Men	Women	Children	%
Buddhist	4			
Roman Catholic	8			
Other Christian religion	26	2	5	
Muslim	41	1		
Sikh	1			
Agnostic/atheist	3			
Unknown	17			
Other:	1			
Lutheran				
None	7	1		
Rastafarian	2			
Jehovah's Witness	1			
Total	111	4	5	*100*

Length of time in detention in this centre	Men	Women	Children	%
Less than 1 week	34	1		*29.16*
1 to 2 weeks	15	1		*13.33*
2 to 4 weeks	16	1	5	*18.33*
1 to 2 months	24			*20.00*
2 to 4 months	14	1		*12.50*
4 to 6 months	4			*3.33*
6 to 8 months	1			*0.83*
8 to 10 months	2			*1.67*
More than 10 months (longest=52 weeks)	1			*0.83*
Total	111	4	5	*100*

Detainee's last location before detention in this centre	Men	Women	Children	%
Community	2	1	5	*6.67*
IRC	64	1		*54.17*
A short-term holding facility (eg at a port or reporting centre)	30	1		*25.83*
Police station	13			*10.83*
Prison	2	1		*2.50*
Total	111	4	5	*100*

Outcome

Of detainees departing in last three months:

Removed: 481
Transferred: 201
Released on temporary admission/release: 124
Released on CIO bail: Records not retained
Released on AIT bail: Records not retained
Absconded: 0