Report on an unannounced short follow-up inspection of

Dover IRC

19 – 21 January 2009

by HM Chief Inspector of Prisons

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1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

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Introduction

Dover is one of the three immigration removal centres (IRCs) run by the Prison Service. It has previously had good inspection reports and we have commended the fact that it was swiftly able to change from a prison culture to one more suitable for detainees. This inspection, however, revealed some concerns about both the centre's approach and the outcomes for detainees.

Most detainees felt safe in the centre, but anti-bullying procedures were poorly understood and implemented. Use of force and separation had increased significantly and this needed to be monitored and carefully managed. Suicide and self-harm procedures were in general well managed, though the centre did not always receive risk information in advance, and the fact that detainees often arrived in the early hours of the morning increased their potential vulnerability.

There had been some improvements in casework, but monthly reviews continued to be largely uninformative and some detainees spent longer than necessary in detention. It was welcome that independent legal advice was now available, although not all detainees knew about it.

We were particularly concerned about the detention of those who claimed to be children, but whose ages were disputed. They were held in segregation, to keep them away from adults, in what amounted to solitary confinement and without care plans, while awaiting social service assessments. One such detainee, held for nine days, had not eaten for two days. Though the centre was not responsible for the delays in assessments, these were wholly unacceptable conditions in which to detain children.

Residential units were in reasonable condition, but showers were very poor in some areas and the environment was very prison-like. Relationships with staff were reasonably good and diversity was in general well managed. It was of concern that mental health needs were still not provided for, though they had been mapped. There were many complaints about the quality of food, and the planned new dining hall was much needed.

Dover was among the first IRCs to allow paid work and it was pleasing that this had increased slightly, with meaningful pay for detainees who engaged in it. Overall, there was more activity than is often the case in IRCs and detainees were particularly positive about PE and education.

Preparation for release was a less positive story. Unit staff, acting as care officers, were now supposed to deal with welfare issues, instead of the dedicated welfare team. This was not effective or consistent and in practice the volunteers in the Dover Detainee Visitors' Group dealt with many welfare issues. The visits room remained an austere environment. Detainees were able to contact family and friends by mobile telephone, but still lacked access to the internet or email, which significantly reduced their ability to use the simplest and cheapest means of communicating and obtaining information.

Like many IRCs, Dover is dealing with a more challenging and varied population, including a high proportion of ex-prisoners. It was nevertheless disappointing that there had been slippage in a number of areas and that the regime and approach was tending to revert to that of a prison, rather than an IRC. We had some concerns about the robustness of the procedures to

support safety and there had been a significant deterioration in welfare support for detainees about to leave the centre. These are matters that managers need to address if the centre is to retain its positive ethos and ensure a safe environment.

Anne Owers
HM Chief Inspector of Prisons

April 2009

Fact page

Task of the establishment
Immigration Removal Centre under service level agreement between HM Prison Service and UKBA

Operational area
Kent and Sussex

Number held
311 (19 January 2009)

Certified normal accommodation (CNA)
316

Last full inspection
March 2007

Brief history
Dover became a prison in 1952 when the Prison Service took it over from the army. In 1957, it became a borstal and continued to hold young offenders until 2002. From 29 April 2002, Dover was re-designated as an immigration removal centre operating under the 2001 detention centre rules.

Description of residential units
The centre is made up of five separate houses (Deal, Sandwich, Romney, Rye and Hastings). Over 40% of the accommodation comprises six-bed dormitories and all living accommodation has integral sanitation. Specifically:

- Romney: CNA 53, dormitories (6 persons), single rooms and one double
- Hastings: CNA 52, dormitories (6 persons), single rooms and one double
- Sandwich (induction unit): CNA 53, dormitories (6 persons), single rooms and one double
- Deal: CNA 58, all single rooms
- Rye: CNA 12, all single rooms, 2 are special rooms

Section 1: Healthy establishment summary

Introduction

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

Safety – that detainees are held in safety and with due regard to the insecurity of their position

Respect – that detainees are treated with respect for their human dignity and the circumstances of their detention

Activities – that detainees are able to be purposefully occupied while they are in detention

Preparation for release – that detainees are able to keep in contact with the outside world and are prepared for their release, transfer or removal.

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 prison 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 conclude 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, Dover was performing reasonably well in this healthy establishment test. At this inspection, 14 recommendations, including one main recommendation, were fully achieved, 10, including one main recommendation, were partially achieved and 18, including two main recommendations, were not achieved. One recommendation was no longer relevant. Thirty-six further recommendations were made.

HE.5 A large proportion of detainees, particularly from Colnbrook, arrived at Dover exhausted in the middle of the night. Some had been moved to Dover for short periods before being transferred out of the centre. Whatever the organisational justification, such moves were disorientating and distressing for detainees.

HE.6 Detainees generally stayed in reception for short periods, usually less than an hour, and the duty manager checked the length of reception stay on most days. Staff in reception did not use professional telephone interpreting services even though it would have been appropriate in at least some cases where sensitive information had to be obtained or imparted.

HE.7 The induction unit was well organised to assess and manage risk and provided care for new arrivals. However, apart from UK Border Agency (UKBA) staff and the chaplaincy, which saw all detainees on their first full day, no departments routinely provided an induction session. The induction information booklet, available in 21 languages, was in need of some updating.

HE.8 Use of force had increased significantly, as had the use of separation, suggesting a more volatile environment. Drug use among detainees was an emerging issue and a drug strategy was being developed.

HE.9 Removal from association was routinely used without individual assessment to separate detainees before transfer or removal. The two cells used to separate detainees under rule 42 were stark and had little natural light and no sanitation.

HE.10 There had been at least two recent age dispute cases. Potential minors spent too long waiting for social services assessments. Much of this time was spent in the separation unit, often locked in a rule 40 cell, which was inappropriate. We saw evidence of the deterioration in mental wellbeing of one such individual. Better liaison between social services and UKBA and a clearer understanding of each other's procedures could have significantly shortened his detention and ensured a lesser impact on his wellbeing.

HE.11 There was little evidence of bullying and detainees reported feeling generally safe. Violence reduction meetings provided good strategic oversight, but anti-bullying procedures were not sufficiently robust. There were few investigations and those that took place were generally of poor quality. Some unexplained injuries had not been properly investigated.

HE.12 The suicide and self-harm strategy was well managed. There was a comprehensive suicide and self-harm strategy document, and the safer detention committee was well attended. Detainees reported a good level of care for those at risk, but detainees at risk of self-harm still regularly arrived without warning or documentation. Strip clothing was used rarely and appropriately. Adequately documented risk assessments were now undertaken.

HE.13 Refugee Legal Centre staff regularly helped detainees with bail applications and contacted UKBA caseholders for information on cases. They identified ongoing difficulties in obtaining information on cases from UKBA. The noisy environment in legal visits was not suitable for legal interviews. The video link facility was well used, particularly for bail hearings, but some detainees were not given crucial bail summaries before hearings or sufficient time to speak to their solicitors.

HE.14 Monthly reviews of detention were received, usually on time. However, a significant minority arrived late and some were identical each month. One man detained for three years had received an identical update for the previous six months. There was no prospect of him being removed and his case was not being progressed. Other cases could have been progressed faster and therefore reduced the need for detention. Caseholders were not always giving full information on documentation about reasons for turning down release. The UKBA on-site team routinely met detainees the day after arrival and were diligent in obtaining information from caseholders. However, there was scope for more support from senior and more broadly experienced on-site immigration staff to promote the active progression of cases.

HE.15 On the basis of this short follow-up inspection, in spite of some deterioration, Dover was still performing reasonably well in this healthy establishment test.

Respect

HE.16 At the last inspection, Dover was performing reasonably well in this healthy establishment test. At this inspection, 10 recommendations were fully achieved, four were partially achieved and 11, including two main recommendations, were not achieved. Twelve further recommendations were made.

HE.17 A painting programme was under way, but the general decoration of the centre did not reflect the diversity of detainees and did little to soften the environment and make it less like a prison. Most accommodation was reasonable, but showers on some units were in very poor condition. On one unit, water boilers regularly ran out before detainees had a chance to collect water in the evenings. Material on display was not regularly updated and there was no systematic approach to displaying information in languages spoken by current detainees.

HE.18 Detainees described reasonably good relationships with staff and generally respectful treatment. There were no personal officers and the care officer scheme that had replaced both this and welfare support was inconsistently implemented. Many detainees were addressed politely, but some were addressed by surname alone and staff entered rooms without knocking. Many detainees said they saw little difference between Dover and a prison. Staff had less awareness than previously of the distinct role of an immigration removal centre (IRC) and less energy was devoted to creating a distinct IRC culture. Nearly all staff wore standard prison uniform and all continued to carry extendable batons.

HE.19 There were good frequent cultural events and diversity remained a well managed area. Telephone interpreting was used only occasionally. Nationality monitoring was undertaken and analysed at meetings. A disability protocol was in place. Detainees were very positive about access to faith facilities and the overall level of provision. Chaplains were appropriately involved in the life of the centre and ablution facilities for the substantial Muslim population had been upgraded.

HE.20 The primary care trust was not yet commissioning services and clinical governance was new and developing. The considerable mental health needs of detainees were not yet met. The mental health needs assessment was still in draft and a general health needs assessment had been undertaken. Mental health qualified staff were doing too much generic work. Detainees were allowed medication in possession following risk assessment. They had considerable problems in accessing a dentist in the community and arrangements were being made for an on-site dental surgery. Healthcare staff had not received training in recognising the signs of torture and trauma. Rule 35 letters were tracked, but a substantial number did not receive responses from UKBA caseholders.

HE.21 Detainees complained vociferously about the quality of food, which was still served in an unappetising way in plastic trays. Much of it was returned uneaten. A new dining hall had been approved and funding obtained. There had been some steep price rises in the shop and detainees felt that the prices were generally high.

HE.22 On the basis of this short follow-up inspection, Dover was still performing reasonably well in this healthy establishment test.

Activities

HE.23 At the last inspection, Dover was performing reasonably well in this healthy establishment test. At this inspection, one recommendation was fully achieved, three were partially achieved and five, including one main recommendation, were not achieved.

HE.24 The number of work places had slightly increased and employment was available for around a third of the population. Pay rates had improved significantly. There was little change in the range of opportunities for employment, which still involved mainly low level work such as cleaning, servery and kitchen work. The cycle workshop was a significant exception. It developed effective skills in cycle maintenance and renovation and was now available on five days a week for 12 detainees. The planned second cycle workshop had not yet opened.

HE.25 Some changes had been made to the education curriculum to respond to detainee needs, largely as a result of informal review by staff and quarterly user surveys. However, monitoring information was insufficiently well analysed and used by the education department to assess how effectively it was meeting the needs and interests of detainees overall. There was little effective routine promotion outside the education centre to those who were not attending.

HE.26 The internet was not easily accessible by staff in the library. Physical education and sports provision was very good. Detainees could move around all units bar one for at least 12 hours, but did not have 12 hours freedom of movement around the centre.

HE.27 On the basis of this short follow-up inspection, Dover was still performing reasonably well in this healthy establishment test.

Preparation for release

HE.28 At the last inspection, Dover was performing reasonably well in this healthy establishment test. At this inspection, one recommendation was fully achieved, one was partially achieved and four were not achieved. One recommendation was no longer relevant. Five further recommendations were made.

HE.29 A new unit care officer scheme had replaced the work of both personal and welfare officers, but was not working effectively in most areas. There was little awareness in some units among detainees and even staff about how the system should work, with the result that welfare and personal officer needs were not always met.

HE.30 There were no restrictions on the number of visits and there was an active and appreciated detainee visitors group. Visitors expressed concern mainly about the time taken to enter visits, which could take up to 45 minutes, and the fact that visitors had to leave the visits area and wait outside if they wanted to stay for more than a single session. New fixed tables and chairs had been installed, but were not particularly comfortable and the overall effect was to maintain an austere, prison-like environment out of keeping with the appropriate approach in immigration detention. There were no canteen or crèche facilities. Like prisoners, detainees had to wear bibs in visits, which was unnecessary and demeaning.

HE.31 There was good access to telephones. However, there were now no internet or email facilities, pending the completion of negotiations about security considerations with the Prison Service. This limited access to cheap international communication and to home country and other information that could help detainees prepare for their hearings.

HE.32 On the basis of this short follow-up inspection, Dover was not performing sufficiently well in 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 To the Chief Executive, UK Border Agency (UKBA)

2.1 The Border and Immigration Agency (now UKBA) should prevent unnecessary moves around the detainee estate, explain to detainees why they are being moved, and the reasons should be recorded. (HE.34)
Not achieved. Detainees were still transferred to Dover for short periods before being moved to another removal centre. It was not uncommon for a detainee to move to Dover pending removal on a particular flight and then to be transferred between centres again the following day. The reasons for such moves were not routinely explained to staff at Dover, so it was not normally possible to give any explanation to detainees.
We repeat the recommendation.

2.2 Staff training and supervision at the BIA's Criminal Casework Directorate should support efficient casework, timely reaction to detainees' queries, accurate assessment of the law and the facts, and a proper understanding of caseworkers' duty to the court. (HE.35)
Partially achieved. Under a case ownership system implemented at the end of 2006, one caseworker had oversight of each case and could, in theory, build up some knowledge of individual detainees' cases. All new case owners also completed a new training programme that focused on bail. Staffing levels at the Criminal Casework Directorate, which dealt with most of Dover's cases, had also been substantially increased. Despite this, legal representatives we spoke to reported regular difficulties in contacting case owners and obtaining relevant information on behalf of detainees, and we found some examples of poor casework. In one case, the delayed response from the case holder had led to the detainee, who wanted to return to his country of origin, spending longer than necessary in detention. Caseholders were not always sending full information on bail documentation. In one file, a chief immigration officer had simply noted 'I am not minded to grant temporary release' without further explanation. The officer's name was missing and the signature illegible. Another man detained under immigration powers for over three years had received an identical monthly case update for the previous six months. There was no foreseeable prospect of him being removed as his country of origin had declined to issue an emergency travel document despite being provided with biodata information, and his case was not being actively progressed.

Further recommendation

2.3 Immigration casework should be progressed promptly and reflect accurate assessment of the law and facts. Detainees' queries should be answered quickly and fully, and immigration bail documentation should provide explanations for the decisions reached and be clearly signed.

2.4 Detainees should have reasonably priced and easy access to the internet, including use of email (HE.36)
Not achieved. Detainees did not have access to the internet and were therefore at a disadvantage in maintaining contact with their families abroad and accessing information to prepare for hearings. Such access was not available at any Prison Service run immigration

removal centres (IRCs) pending a decision on security implications.
We repeat the recommendation.

Main recommendations

To the centre manager

2.5 A communal dining room should be provided and in the interim, each unit should have a servery. The quality and quantity of meals should be improved.
Not achieved. Funding had been approved for a new central dining room, but the system for serving food had not yet changed. The food was still delivered in often stained plastic boxes and condensation left it soggy. It was generally unappetising by the time it reached the units and a great deal was returned uneaten to the kitchen. Many detainees complained of blandness and inadequate portions, particularly at weekends; poor food was one of their most consistent criticisms of Dover. A wider choice of menu, including salads and sandwiches, had been introduced and specific nationality groups were involved in developing new menu items.
We repeat the recommendation.

2.6 All staff should be aware of the anti-bullying strategy, and the anti-bullying coordinator should be made aware of any allegations and incidents of bullying. Investigations into bullying should be rigorously pursued and all interviews and actions recorded. (HE.38)
Not achieved. The anti-bullying strategy was published on the intranet, but staff on the units had scant awareness of it. One member of staff gave us a copy of an obsolete bullying referral form. The anti-bullying coordinator received a summary of all incidents, security information reports relating to violence and all injury to detainee forms, averaging about 36 a month. These were discussed weekly at the 'inner cabinet' meeting chaired by the safer detention senior manager. However, the meeting did not routinely discuss action to be taken in response to potential bullying and many incidents such as assaults, fights and unexplained injuries were not investigated.

2.7 Information about potential bullying was not transferred onto a bullying incident referral form (BIRF), which was also the 'stage one monitoring' document. Minutes of recent inner cabinet meetings indicated that staff found the dual purpose confusing. The violence reduction strategy was underused. In the previous 15 months, only 18 BIRFs had been completed, 11 of which were victim support forms and seven were stage one monitoring. No detainees had been on stage two or three monitoring. Other than violence reduction staff, no staff had ever completed a BIRF. There was no information displayed describing who detainees should speak to if they had concerns about bullying. There was a bullying hotline, which was responded to within minutes, but it had been used only two or three times. Detainees at the November Helping Hands meeting said they were not aware of anti-bullying procedure and forms. They said raising issues with staff sometimes made situations worse as staff had to speak to the bully and it was obvious who had raised the concern.

2.8 The violence reduction coordinator had commissioned only three investigations. One had not involved interviews with the two detainees involved and another had concluded that bullying had not taken place when the evidence clearly indicated otherwise. The third had never been completed.

Further recommendations

2.9 Staff should be aware of the violence reduction strategy and how to submit a referral and should receive feedback on the outcome of referrals they submit.

2.10 All incidents of potential bullying should be recorded on a bullying incident referral form and properly and promptly investigated.

2.11 The commissioning arrangements for all health services for detainees (including contracts with allied health professionals) should be agreed expeditiously. (HE.39)
Not achieved. Progress towards commissioning arrangements with the local primary care trust (PCT) had remained slow. Health services were still not commissioned by the PCT, although we were told this would be in place from April 2009. The relationship with the PCT appeared to be developing and centre nurses had access to PCT training opportunities.
We repeat the recommendation.

2.12 Strip-searching of detainees and the use of strip clothing for detainees on open assessment, care in detention and teamwork (ACDT) plans should cease unless there are exceptional circumstances and a fully documented risk assessment has taken place. (HE.40)
Achieved. There was no routine strip-searching and detainees on open ACDT plans were strip-searched only with the authority of the duty manager. No detainees had been placed in strip clothing in the previous six months. The suicide prevention and self-harm management strategy set out clear guidelines on the use of strip clothing, which included that any decision to use it had to be made by the case review team in consultation with the duty manager. In addition, the register of use of the healthcare safer suite required managers to indicate if and why a detainee's clothing had been replaced with strip clothing (see also section on rules and management of the centre).

Recommendations

To the Chief Executive, UK Border Agency

Casework

2.13 Written reasons for detention should be provided in a language the detainee can understand. (4.9)
Not achieved. All written reasons for detention were still provided in English only.
We repeat the recommendation.

2.14 Detainees should be provided with written reviews of detention, justifying continued detention by reference to all known circumstances. Reviews should take place at least monthly or following a relevant change in circumstances. (4.10)
Not achieved. Monthly reviews of detention were usually received on time, although a significant minority arrived late. The on-site team's tracking figures showed that 59 reviews were outstanding, of which 47 were due from the Criminal Casework Directorate. Detainees complained that reviews were repetitive and some were uninformative. Reviews we looked at showed little evidence that caseworkers had considered relevant proposals for progressing cases and prospects of removal. They did not provide reassurance that caseworkers had considered whether continued detention was essential, as stipulated by the operational enforcement manual. One man detained for three years had received an identical update for the previous six months. We found no reviews issued as a result of a relevant change in circumstances.

Further recommendation

2.15 Written reviews of detention should justify continued detention by reference to all known circumstances. Reviews should take place at least monthly or following a relevant change in circumstances.

2.16 Detainees should be provided with contact details of those responsible for their casework. (4.11)
Partially achieved. UKBA relied on the on-site team to contact case owners for up to date information. The team had the relevant case owner telephone numbers, but these were not routinely provided to detainees. Monthly reviews had names of caseworkers and fax numbers only.

Further recommendation

2.17 Detainees should be provided with contact details, including telephone numbers, for all those responsible for their casework.

2.18 There should be sufficient suitably-experienced immigration staff on site to engage with all detainees, understand their status, respond to their queries and progress their casework. (4.12)
Partially achieved. The UKBA on-site administrative team routinely met detainees the day after arrival and was diligent in obtaining information from case owners. However, many detainees criticised the lack of useful or clear information from case owners. The on-site team was supported by assistant immigration officers from the local immigration enforcement office, but more senior and broadly experienced on-site immigration staff could have challenged some of the poor casework more effectively, thereby actively promoting case progression.
We repeat the recommendation.

Further information

2.19 Faxes could be sent from the units, but were limited to 20 pages, which was not always enough to send important legal documentation. Detainees who wanted to send longer faxes could do so through the immigration liaison officer, but this was not publicised and detainees and unit staff we spoke to were unaware of this facility. One member of staff said he advised detainees to post anything over 20 pages, which could result in critical delays.

2.20 Case owners sometimes faxed information directly to detainees and received information from them without the on-site team being made aware.

Further recommendations

2.21 There should be no limit to the length of fax detainees can send and detainees and staff should be made aware of arrangements for sending longer faxes.

2.22 The on-site team should be made aware of faxes to and from case owners.

Rules and management on the centre

2.23 Detainees should not be transferred without all of their property, property should be checked on transfer and detainees should be given their property record sheets. (8.33)
Partially achieved. Most detainees arriving at reception during the inspection had their property with them, but some indicated that they had not been able to check it before their transfer. Property remained the subject of most formal complaints made at Dover. Reception staff did not routinely supply detainees with a copy of their property record, but said these would be given on request.
We repeat the recommendation.

Recommendation — To the Director General of the Prison Service

Rules and management of the centre

2.24 Staff should not routinely carry staves or other defensive weapons. (8.26)
Not achieved. Staff routinely wore batons.

Further recommendation

2.25 Staff should not routinely carry defensive weapons such as extendable batons.

Recommendation — To the escort contractor

Arrival in detention

2.26 Discharging healthcare staff should conduct individual risk assessments to determine whether medication ought to be allowed in-possession and escort staff should be instructed accordingly. (1.14)
Not achieved. Detainees leaving the centre with medication in possession packed it with their other property. If detainees were taking medication that they were not assessed as able to hold in possession, at least seven days' worth was sealed in an envelope and put in the detainee's property. Healthcare staff made an entry on the detainee's escort record stating that there was medication in their property, but not what the medication was or if they should be allowed to have it in possession. Staff said that an entry was made on a detainee's escort record if they were asthmatic, diabetic or epileptic and medication was in their possession.
We repeat the recommendation.

Recommendations — To the centre manager

Arrival in detention

2.27 Reception interviews should be conducted in private and reception staff should make appropriate use of the telephone interpreting service. (1.15)
Not achieved. There was still no private interview room. Detainees were taken off the van one at a time and given a preliminary interview in the reception area. This was an open area with other activities and movements often in progress and the interviews were short due to the need to vacate the escort vehicle. The telephone interpreting service was not used in reception

and staff relied instead on other detainees to interpret. This did not guarantee confidentiality and openness in cases where sensitive personal issues might be important to the assessment of risk and wellbeing.
We repeat the recommendation.

2.28 The reception diary should be fully completed daily, and checked and signed by a manager. (1.16)
Achieved. The diary was fully completed and the duty manager usually completed a daily check sheet that included an entry for time in reception.

2.29 Managers should monitor how long detainees spend in reception to ensure that they arrive on Sandwich unit as quickly as possible. (1.17)
Achieved. Monitoring visits that included time spent in reception were recorded on a form that was signed on most days by the duty manager. The average time spent in reception for the 10 detainees received on 19 January 2009 was an hour.

Additional information

Escorts and transfers

2.30 Although there were now fewer moves out of Dover at night, about a third of arrivals occurred between 10pm and 6am. Such arrivals happened almost every night, almost always from other IRCs, with the majority coming from Colnbrook IRC. Many detainees said they were not given notice or explanation of these transfers and that they felt anxious and disorientated as a result, often having been woken up and told they were being transferred immediately. This was a particularly unacceptable way to treat those at risk of self-harm, given the negative impact that such stressful experiences could have on that risk.

2.31 Allegations of assault during escorts were noted in reception and, with their permission, detainees were examined by healthcare. This included taking photographs of injuries and detainees were asked if they wanted the police to be informed.

Further recommendation

2.32 Planned transfers between centres should not take place at night unless this is an exceptional and urgent operational necessity.

Reception and induction

2.33 The induction unit was well organised to assess and manage risk and care for new arrivals. Detainees were given a structured induction interview on their first night covering introductory information and the rules of the centre. They were offered a guided tour of the centre on their first full day and given a 16-page induction booklet available in 21 languages. This was comprehensive and helpful, but a year old and out of date. UKBA staff interviewed all new arrivals on their first full weekday and we were told that chaplaincy staff visited daily. No other departments visited the unit to provide induction.

Further recommendations

2.34 All detainees should receive an induction from key departments, especially education, as soon as possible after arrival.

2.35 The induction information booklet should be updated immediately and kept up to date in future.

Environment and relationships

Residential units

2.36 Detainees should be encouraged to keep their dormitories clean, and the cleaning orderlies should have an agreed job description. (2.12)
Partially achieved. Staff encouraged detainees to keep their rooms clean. One detainee in each dormitory was employed as a part-time cleaning orderly and most rooms were kept clean. Job descriptions and compacts were not in place on all units.

Further recommendation

2.37 All cleaning orderlies should have an agreed job description and compact.

2.38 Detainees should have access to hot water until later in the evening. (2.13)
Not achieved. Detainees could get hot water from boilers on each landing until evening lock-up, but the boilers on Rye House regularly ran out of hot water before all detainees had used them. Some flasks had been issued during Ramadan, but this was not routine and detainees were expected to buy flasks from the shop. A promise to issue flasks to all detainees had been made at the September 2008 consultative meeting.
We repeat the recommendation.

2.39 Information about the centre should be translated into the main languages used by detainees at Dover. (2.14)
Partially achieved. The induction booklet was available in 21 languages and the anti-bullying leaflet in eight. Some material was on display in various languages, but there was little evidence of a systematic approach to displaying information in the main languages spoken by detainees in Dover.

Further recommendation

2.40 Information notices and guides for detainees should be readily available to detainees in the most commonly spoken languages.

2.41 Action points from consultative meetings should be followed up at subsequent meetings and the results published to detainees. (2.15)
Not achieved. Each house held a bi-monthly consultative meeting and there was a centre-wide bi-monthly consultative meeting with senior managers. Action points were recorded in the minutes and sometimes referred to in subsequent minutes. Nine action points had been raised at the September 2008 centre-wide meeting, but any significant progress since then was

unclear. There were no obvious minutes on the residential units.
We repeat the recommendation.

2.42 All detainees should have lockable cupboards. (2.16)
Achieved. Keypad safes installed in every room had improved detainees' confidence in the safety of their possessions and made a significant contribution to good order on the residential units.

2.43 The showers on Hastings unit should be refurbished. (2.17)
Not achieved. The showers on Hastings remained in poor condition, with missing tiles, dirty conditions and shabby curtains.
We repeat the recommendation.

2.44 The décor of the centre should better reflect the diversity of its population. (2.18)
Not achieved. Several areas had been painted, but the decoration did not obviously reflect the diversity of the population and was bare and basic, with little attempt to soften the environment.

Additional information

2.45 The first floor showers on Romney House were particularly dirty, while those on the induction unit had been out of order for many months owing to a leak through the floor. Many room toilets, particularly on the induction unit, were unsanitary.

Further recommendation

2.46 All showers should be repaired and upgraded to provide hygienic and private conditions for detainees and there should be a regular programme of deep cleaning of the shower and toilet facilities.

Staff-detainee relationships

2.47 Staff should not address detainees by surname alone. (2.22)
Not achieved. While many staff addressed detainees politely and respectfully, a number used surnames alone.
We repeat the recommendation.

2.48 Personal officers should make regular and detailed entries in wing files. (2.23)
Not achieved. The personal officer scheme had been replaced by an inconsistently implemented care officer scheme (see section on preparation for release). A sample of unit history sheets showed that entries were generally made when a detainee came to staff attention. There were few positive comments and little evidence of consistent active engagement, with often long gaps between entries, particularly about detainees who spoke limited English. There was a six-month gap between the most recent entries in the file of one Vietnamese man who spoke 'little English' and a 4.5-month gap in the file of another man who spoke 'no English'.

Further recommendation

2.49 An effective personal or care officer scheme should be implemented and particular efforts made to communicate with detainees with little or no English. This engagement should be reflected in regular and detailed entries in history files.

Additional information

2.50 Most detainees described reasonably good relationships with staff and generally respectful treatment. However, some complained about rude and disrespectful staff and being 'treated like prisoners'. We saw staff enter rooms without knocking and prison procedures such as wearing coloured bibs during visits persisted (see section on preparation for release). There was limited staff or management awareness of, or commitment to, Dover's role as an IRC and not enough energy was devoted to creating a distinct IRC culture. It was particularly disappointing that nearly all staff wore standard prison uniform.

Further recommendations

2.51 Staff should not enter detainees' rooms without knocking.

2.52 There should be a renewed management focus on creating a distinct immigration removal centre rather than prison culture at Dover. The wearing of less formal uniforms should be encouraged.

Legal rights

2.53 The list of specialist immigration solicitors should be regularly updated. (3.5)
Achieved. A lengthy list of solicitors was kept in the library, with photocopies for detainees. The list was updated every month.

2.54 The centre should undertake an assessment of detainees' needs for legal information, advice and representation. (3.6)
Not achieved. There was no evidence of any such review.
We repeat the recommendation.

Additional information

2.55 Legal support was provided mainly by staff from the Refugee Legal Centre (RLC) who visited twice a week and Bail for Immigration Detainees workers who visited each month. The RLC saw detainees in the noisy and unsuitable legal visits area (see section on visits). The main focus of their work was on assisting detainees with bail applications. A number of detainees took advantage of this service, but others said they did not know about it.

2.56 The video link facility was used for all bail hearings. There had been 600 hearings in the previous six months, of which 24% had ended in bail being granted. However, some detainees were not given crucial bail summaries before the hearings and some complained that they did not have enough time to speak to their solicitors.

Further recommendations

2.57 The service provided by the Refugee Legal Centre should be advertised to all detainees.

2.58 The legal visits area should provide a quiet and confidential environment.

2.59 Detainees should always be provided with copies of bail summaries before hearings and have enough time to consult with solicitors.

Anti-bullying

2.60 The anti-bullying policy document should contain an action plan, including timescales for the completion of aims and naming the individuals responsible. An analysis of the population should be used to inform the policy. (5.27)
Partially achieved. The violence reduction policy action plan included timescales for the completion of action points, responsibility for which was clear. Outstanding actions were discussed at the safer detention meeting. However, no analysis of the population had been used to inform the policy, which was almost two years old, generic and not tailored to Dover's specific needs and issues.

Further recommendation

2.61 The anti-bullying policy should be tailored to the specific needs of detainees at Dover and its strategy should be informed by a bullying survey.

2.62 The responsibilities of the safer detention coordinator (SDC), safer detention manager and violence reduction manager should be clearly defined and job descriptions produced. (5.28)
Achieved. Job specifications for the safer detention manager and violence reduction coordinator were available.

2.63 All F213 forms reporting an unexplained injury to a detainee should be properly investigated and recorded. (5.29)
Not achieved. There had been no investigations into unexplained injuries, and we were told that this was because there were no unexplained injuries. However, we found a number of recent incidents that should have been investigated, including one detainee with a swollen eye where the F213 said another detainee had accidentally elbowed him; this explanation had been accepted and no further action taken.
We repeat the recommendation.

2.64 Staff should be trained in the anti-bullying procedures. (5.30)
Not achieved. Only 31 staff had completed violence reduction training (see also further recommendation 2.9).
We repeat the recommendation.

Additional information

2.65 There was little evidence of bullying, although detainees said they felt less safe on association, particularly on Rye Unit. Stealing of mobile telephones was also an issue, although managers felt that mobile telephones had also reduced bullying around the use of centre telephones.

There had been 16 recorded assaults on staff and 21 on detainees in the previous six months, although there was some doubt about the reliability of these figures (see also paragraph 2.63).

2.66 Anti-bullying was managed under the safer detention team leader. There was a safer detention senior manager, a violence reduction manager and a violence reduction/anti-bullying coordinator. The latter had 15 hours a week profiled to this role, which was low given that there was no administrative support. Each area working directly with detainees also had at least one violence reduction liaison officer, whose role was to ensure posters were up, go to consultation meetings and ensure staff and detainees were aware of the strategy.

2.67 Stage one of a three-stage anti-bullying strategy involved monitoring, stage two support and challenge and stage three segregation or a move. Staff said managers undertook mediation with detainees on stage two, but none had been trained in this type of intervention.

2.68 A monthly safer detention meeting discussed data analysis, but was not always well attended and did not include detainees.

2.69 There was a detailed anti-bullying survey and various means had been adopted to encourage detainees to complete it, but only six had to date.

2.70 Victim support plans did not demonstrate ongoing monitoring or support for detainees beyond initial actions such as asking if the detainee wanted protection, speaking to the perpetrator and offering to call the Samaritans.

Further recommendations

2.71 Some administrative support should be available to the anti-bullying coordinator.

2.72 Unit managers should be trained in mediation.

2.73 The monthly safer detention meeting should be properly attended and include detainee representatives for at least part of the meeting.

2.74 The anti-bullying survey should be completed and analysed.

2.75 Ongoing support and monitoring should be available to victims of bullying.

Suicide and self-harm

2.76 Dover staff should be told in advance of detainees due to arrive with open ACCT/ACDT plans. (5.31)
Not achieved. Detainees on open ACDT plans frequently arrived without prior notice and some arrived without the ACDT plan documents. In the previous six months, 28 such detainees had arrived, many from Colnbrook. Managers at Dover were closely monitoring the situation. All detainees on ACDTs arriving without prior notice were recorded, the sending establishment was contacted and details were sent to UKBA area managers. However, the situation had not improved despite their efforts.

Further recommendations

2.77 Detainees on open ACDT/ACCT plans should not be transferred without the receiving establishment being given advance notice of their arrival.

2.78 Detainees on open ACDT/ACCT plans should not be transferred without their plan documents.

2.79 The quality of comments made in ACDT night observation books should be improved. (5.32)
No longer relevant. Separate night observation books were no longer used and all night observations were now recorded in the main observations section of the plan. The quality of observations made during the day and at night was mixed, but generally reasonable. Some were excellent, showing good interaction with the detainee and well documented observations, and most were satisfactory, although a minority indicated little evidence of meaningful conversations with the detainee. The safer detention coordinator carried out regular audits of closed ACDTs and checks of open plans. Other members of the safer detention management team also completed quality checks of closed documents and managers conducted daily checks of open ACDTs. These checks helped identify staff who required additional guidance or training in working with detainees at risk of suicide and self-harm or in the ACDT process.

2.80 ACDT reviews should include the original case manager and should be multi-disciplinary. (5.33)
Partially achieved. Most ACDT reviews were conducted by the original case manager, but we noted examples where continuity was not maintained and the second or third case reviews were conducted by different case managers. The reviews were usually multidisciplinary. Healthcare staff provided a written report if unable to attend. Chaplains often attended, as did officers from the detainee's unit and sometimes staff from their work place, education or the gym. Immigration staff rarely attended. The safer detention coordinator said that attendance by immigration staff in the past had caused detainees to become agitated and that they therefore attended only if it was believed their presence would assist.
We repeat the recommendation.

2.81 The damaged 'safer suite' in healthcare should not be used until fully refurbished. (5.34)
Partially achieved. The water damage had been repaired, but the two safer rooms in healthcare were bare and remained a poor environment for detainees at risk of suicide or self-harm.

Further recommendation

2.82 The safer suites in healthcare should be refurbished and redecorated.

2.83 Any detainee on a constant watch should be watched at all times. (5.35)
Achieved. The suicide and self-harm management strategy document provided clear and comprehensive guidance on how constant supervision should be authorised, monitored and conducted. The one detainee under constant supervision in the healthcare centre during the inspection was observed continuously by a member of staff.

2.84 The aim of the 'helping hands' scheme should be clarified and evaluated and its use made clear to detainees and staff. (5.36)

Not achieved. The Helping Hands workers were managed by the diversity and race equality officer (DREO) and there was a joint diversity peer support/Helping Hands job specification document. This document indicated that the aim of Helping Hands was 'to provide a pool of specifically selected detainees who are willing to act as translator, guide and mentor to other detainees who are felt to be in need of such support'. No evaluation of the scheme had taken place and staff and detainees remained unclear about its role. Apart from a talk from the DREO, Helping Hands workers did not receive any training and saw their role mainly as attending meetings, providing some interpretation and acting as a link between staff and detainees. The workers were paid a £5 allowance for their work (see also section on diversity). We repeat the recommendation.

Additional information

2.85 The safer detention management team was multidisciplinary and the meeting we attended during the inspection was well attended, though this was not always the case. The safer detention coordinator produced a detailed report for the meeting, including full information on each ACDT plan open during the month.

Additional information

Childcare and protection

2.86 There had been several recent cases of those claiming to be children whose ages were disputed. The policy was to separate these detainees in Hythe Unit to ensure protection. A separation unit was an entirely unsuitable environment for children. There were few suitable alternatives in the centre and there had been delays in securing age assessments by social services. We were told by managers that this was because the busy local social services department did not give priority to Dover age dispute cases as they considered they were held safely. One detainee who said he was 15 had been in separation for nine days when we met him. During this time, he had become withdrawn and unengaged and had refused all food for the previous two days. He had no care plan, a limited regime and was locked behind his door in a separation cell for most of the time for no clear reason. When Kent social workers eventually visited him during the inspection, they declined to make an assessment because Oxfordshire Social Services had already started the process while the detainee was held at Campsfield House IRC. UKBA managers subsequently decided to release him into the care of his father rather than detain him any longer. Better liaison and a clearer understanding between social services and UKBA of each other's procedures would have significantly shortened his detention and therefore impacted less on his wellbeing.

Further recommendations

2.87 UKBA should ensure that its own policy commitments and procedures are followed to secure the earliest possible assessment of potential minors by Social Services.

2.88 A care plan should immediately be put in place when an age dispute case comes to staff attention and should include input from mental health services.

2.89 Detainees whose age is disputed should not be locked in rooms or held in the separation unit.

Additional information

Diversity

2.90 Diversity was generally well managed by a small but dedicated team of 1.5 full-time equivalent staff, line managed by the deputy centre manager. A part-time senior officer was the diversity adviser, a part-time officer was the race equality officer and there was a part-time administration officer.

2.91 There were seven detainee diversity/peer support workers in total. They received no formal training, only a job specification and a talk from one of the diversity team. Some diversity representatives saw their role as being to sort out disputes between detainees rather than to pass information on to staff and said their role involved race issues rather than other aspects of diversity (see also paragraph 2.84). There were no posters or other information reflecting the support available to detainees with issues relating to sexual orientation, age or disability related issues.

2.92 There were 12 diversity and race equality officers across the residential units. Their role was to promote diversity, keep notice boards up to date and attend meetings, but they had no specific training and received no facility time. Fifty-one per cent of staff had received some training in diversity. A 'challenge it, change it' diversity course had recently been introduced and 4.6% of staff had attended it. The aim was to train all staff within two years.

2.93 A monthly diversity data monitoring report included nationality monitoring of attendance at the gym, education and employment, the unit's population, use of force, complaints and those on ACDTs. The data, which included some discussion of trends, were discussed at bi-monthly diversity and race equality meetings chaired by the centre manager and attended by two detainees. Diversity issues were routinely raised at the consultation committee. A good range of diversity events had been held in the previous year.

2.94 The telephone interpreting service was used only infrequently, with costs averaging £153.68 a month plus £110 a month on translating documents. This was a significant reduction on previous years, which managers attributed to an increased use of Helping Hands detainees with multi-lingual skills and to the increased number of detainees who were ex-prisoners and more likely to speak English.

2.95 The race relations policy was displayed on the wings in a number of languages. Forty racist incident report forms had been submitted in the previous year. All had been investigated and nine had been upheld. Detainees found guilty were subject to the standard warning system. Racial complaints were treated in the same way as normal complaints. Race impact assessments were routinely completed and reviewed and an action plan monitored progress against issues raised in them.

2.96 A disability protocol was in place, but not dated. Five detainees were known to have a disability, three of whom had a care plan. No care plan was put in place if a detainee did not wish to discuss his disability. Where care plans highlighted that specific assistance was required, this was provided for by unnamed detainees. Two plans also stated that the detainee required assistance in an emergency, but did not state what assistance. However, we saw a thorough general fire evacuation assessment. A number of Disability Discrimination Act adjustments had been made, but no accommodation was suitable for detainees with mobility problems so wheelchair users were not brought to Dover.

Further recommendations

2.97 Posters and other information around the centre should reflect and promote a wider concept of diversity, including age, sexual orientation and disability, as well as the support available to detainees.

2.98 Detainee diversity/peer support workers and diversity and race equality officers should receive specific training in their role.

2.99 The disability protocol should be dated and all detainees who have a known disability should have a care plan. Where care plans rely on assistance from other detainees, this should be formally arranged and monitored, and care plans should specify what assistance is required in an emergency.

Faith

2.100 The ablutions area at the entrance to the mosque should be upgraded to meet the needs of the large Muslim population as soon as possible. (5.51)
Achieved. A new stainless steel ablutions facility allowed detainees easy access to clean water.

Additional information

2.101 Detainees reported easy access to the facilities for religious worship and appreciated the active religious affairs team. A wide range of chaplains was appropriately involved in the life of the centre, attending relevant meetings and routinely contributing to ACDT reviews.

Health services

2.102 A health needs assessment (including mental health needs) should be undertaken, to determine the types and levels of health services required. (6.28)
Partially achieved. A health needs assessment had been undertaken. A mental health assessment was in draft and was scheduled to be put before the partnership board in February 2009. The draft mental health needs assessment raised a concern that screening tools were not identifying detainees' mental health needs.

Further recommendation

2.103 The mental health needs assessment should be completed as soon as possible and appropriate actions taken to implement its recommendations.

2.104 Clinical governance policies and protocols should be put in place. (4.29)
Partially achieved. The first meeting of the clinical governance committee had been held in November 2008. Terms of reference including membership had been agreed and meetings were to be held monthly. Membership included representatives from the centre, the healthcare team, the primary care trust (PCT) and the pharmacy provider. The committee was to feed back to the partnership board. Local policies and procedures were in place.

Further recommendation

2.105 The clinical governance structure should continue to be developed.

2.106 All clinical records should be stored securely in accordance with data protection and Caldicott principles. (4.30)
Achieved. Clinical records were stored securely and were accessible only to healthcare staff. A separate healthcare archive had been set up from where records of previous detainees could be retrieved if they returned to the centre. This was also accessible only to healthcare staff.

2.107 An information-sharing policy should be developed. (4.31)
Achieved. There was an information-sharing policy. Confidentiality was discussed with new arrivals as part of the reception screening process and a confidentially agreement was completed. The agreement was available in a range of languages and detainees were invited to indicate with whom they did or did not want healthcare staff to share information.

2.108 A skill mix review of all staff should be undertaken to ensure that staff skills and competencies are used effectively. (4.32)
Not achieved. Although the health needs assessment described the current staffing arrangements, no skills needs analysis had been conducted. All primary care nurses carried out generic duties and took responsibility for specific clinics. The three registered mental health nurses (RMNs) spent most of their time carrying out the same duties as the registered general nurses (RGNs). They did not carry individual case loads.

2.109 All staff should have resuscitation training, including the use of an automated electronic defibrillator, at least annually. (4.33)
Achieved. Clinical staff received annual resuscitation training that included the use of automated electronic defibrillators.

2.110 The on-call arrangements for medical staff should be reviewed to ensure that they comply with current guidelines. (4.34)
Not achieved. On-call arrangements for medical staff had not changed and one of the visiting GPs provided most out-of-hours cover. Staff said this would change when the PCT started commissioning health services at the centre.
We repeat the recommendation.

2.111 Detainees should have direct access to a pharmacist. (4.35)
Achieved. New arrivals were told they could request to see the visiting pharmacist and this information was also included in the healthcare information handout given to all detainees. Posters in various languages also advertised the availability of a pharmacist.

2.112 All consultations between detainees and healthcare professionals should take place in private. (4.36)
Achieved. All consultations took place in private in consultation or treatment rooms. The hatch into the waiting area was now used only for detainees collecting medication, checking in for appointments or requesting to see healthcare staff.

2.113 Staff should use the agreed triage protocols to assess detainees presenting at the healthcare centre. (4.37)

Partially achieved. Nurses had been issued with copies of the triage protocols and a copy was also available in the room where triage clinics were held. However, the protocols were not specific to the centre population. For example, some included conditions appropriate only to female patients.

Further recommendation

2.114 Triage protocols should be appropriate to the centre population.

2.115 Life-long condition registers should be kept. (4.38)
Achieved. Details of new arrivals with a life-long condition were added to an electronic register. The nurses who took the lead for the different conditions also kept lists of their patients.

2.116 Detainees should be given detailed information in a range of languages about all the health services available. (4.39)
Achieved. The healthcare information handout outlined the health services available and how they could be accessed and was available in a range of languages.

2.117 All staff who come into contact with detainees should be aware of how to identify signs of torture and trauma, and the steps to be taken if a detainee alleges such abuse. (4.40)
Not achieved. The centre had not been able to identify appropriate training in the recognition of signs of torture and trauma and the steps to be taken if a detainee alleged such abuse. The importance of this training was recognised and attempts were being made to access it.
We repeat the recommendation.

2.118 The progress of rule 35 letters submitted by healthcare staff should be tracked. (4.41)
Achieved. A comprehensive tracking sheet maintained by the healthcare administrator recorded rule 35 letters submitted and any responses received by the healthcare department. Sixty-five rule 35 letters had been submitted by the healthcare department in 2008 and only 14 responses had been received. We were later told that the UKBA on-site team had received more responses, but these were clearly not routinely shared with healthcare staff.

Further recommendation

2.119 UKBA caseholders should respond to submitted rule 35 letters and such responses should be shared with healthcare staff.

2.120 Policies should be developed to ensure that any detainee requiring detoxification or symptom control is cared for in line with practice guidelines. (4.42)
Not achieved. A drug and alcohol strategy was being developed, but the centre did not cater for detainees requiring detoxification. If such a detainee arrived, staff contacted a GP for advice and to prescribe symptomatic relief if required. Staff said any detainee requiring detoxification was transferred to a centre offering substance use services as soon as possible.
We repeat the recommendation.

2.121 Detainees released from Dover should have support and assistance in accessing community health services as appropriate, and copies of health treatment should be given to detainees who leave the centre. (4.43)
Partially achieved. Discharge letters outlining treatment received and any prescribed medication were given as relevant to detainees leaving the centre. Detainees who were

remaining in the country were not told how to access community health services, but those who had been under the care of the community psychiatric nurse (CPN) were referred to local community teams by the CPN.
We repeat the recommendation.

2.122 Referral criteria for mental health services should be developed to ensure that detainees with primary mental health care needs and those with severe and enduring mental health issues are dealt with appropriately. (4.44)
Not achieved. Mental health services appeared underdeveloped and there were no regular meetings between the primary and secondary care mental health nurses. A very brief mental health policy document did not address how detainees with mental health needs would be identified or provide information on the care available other than referral to a GP or CPN. A CPN provided secondary care at two sessions a week. However, primary care RMNs did not carry individual case loads and it was unclear who provided day-to-day care for those detainees with mental health needs who did not meet the criteria for care from a CPN. One primary care RMN ran popular weekly talk clinics, but this appeared to be the only primary mental health care available.
We repeat the recommendation.

2.123 Formal arrangements for the provision of culturally-aware counsellors with skills in dealing with victims of torture and other sensitive issues should be put in place. (4.45)
Not achieved. No counselling services were available through healthcare.
We repeat the recommendation.

Additional information

2.124 Detainees we spoke to were unhappy with access to dental services. Healthcare staff confirmed this was a problem area. Detainees requiring dental care were escorted to an emergency dental clinic in the local community. Appointments were cancelled both by the dental service and also because escort staff were not available to accompany detainees. The PCT and centre were working together to introduce a dental service at the centre.

Further recommendation

2.125 Detainees requiring dental care should be able to access it without undue delay.

Activities

2.126 The opportunities for paid work should be further extended. (7.19)
Partially achieved. The number of work places had increased from 95 to 105. Regime monitoring statistics for week beginning 12 January showed 101 detainees in work. There was employment for around a third of detainees. Pay rates had improved significantly and now ranged from £5 to £60 a week. Most jobs were part time, but the number of full-time positions had increased. Employment still consisted mainly of low level work such as cleaning, servery and orderly work as well as cycle maintenance and renovation. Six detainees were employed in the kitchen and nine as Helping Hands to support other detainees as required. Plans for light assembly, packing and recycling work had not been developed.
We repeat the recommendation.

2.127 The cycle workshop should be available on 5 days a week. (7.20)
Achieved. The cycle workshop was now available on five days a week and the 12 places were well used. A planned second cycle workshop was not in place.

2.128 Internet access should be made available to library staff. (7.21)
Not achieved. Access to the internet was not available to library staff in a convenient location either in the library or adjacent to it. Internet access for staff was available in the education department, but could not be easily accessed by library staff as only one librarian was routinely on duty at any time. The county library service was used to provide resources in other languages not currently available in the library, but this did not enable staff to respond quickly to new detainees for whom there were no available resources in their language.
We repeat the recommendation.

2.129 The curriculum should be reviewed to cater more effectively for the needs and interests of a fluctuating population. (7.22)
Partially achieved. Some changes had been made to the curriculum to make better use of resources. These were mainly informed by informal reviews by staff and managers and by quarterly user surveys. A further study workshop provided literacy and numeracy support for detainees who arrived from prisons without completing their programmes. The education department carried out monitoring of participation, but the information was not well analysed or used to assess how effectively the department was meeting the needs and interests of the detainee population. Detainees who did not attend education classes were not surveyed to determine why.
We repeat the recommendation.

2.130 Education should be more effectively promoted to increase take up of provision. (7.23)
Partially achieved. Classes were well promoted within the education centre and therefore mainly to those who already attended. Information was well displayed on colourful and informative notice boards and education staff were helpful and effective in dealing with enquiries. However, there was little effective or regular promotion to those who did not attend classes. Induction sessions were held for detainees who visited the education department, but staff were not routinely involved in the main induction for new arrivals. A member of the education staff visited the residential units, particularly the induction unit, to update posters and give information to detainees, but this did not ensure effective promotion to all detainees.
We repeat the recommendation.

2.131 Good practice should be shared more effectively to improve the quality of provision. (7.24)
Not achieved. There has been little progress in identifying or sharing good practice. More teaching and learning sessions were observed, but mostly by curriculum team leaders who did not grade them or routinely identify good practice. Some good practice was informally identified and shared within individual curriculum areas, but there was no formal means of identifying or sharing general good practice across the department. Proposed changes in sub-contracting the education provision had meant that the annual graded observations had not been completed. There was no information on the quality of teaching and learning overall.
We repeat the recommendation.

2.132 Detainees should be able to use the physical education (PE) showering facilities in private. (7.25)
Not achieved. The showers adjacent to the sports hall could not be used in private and there were no plans to change this. There were well advanced plans to replace the gym with a new building that would not have showers, toilets or drinking water. Detainees had use of showers in their residential blocks. A programme of refurbishment and redecoration of these showers

was being carried out, but many were not of a suitable standard.
We repeat the recommendation.

2.133 Detainees should have 12 hours freedom of movement around the centre. (7.26)
Not achieved. The average freedom of movement was around 12 hours, but detainees were locked in their residential units for part of that time. The actual freedom of movement around the centre was estimated at 9 to 9.5 hours and less at weekends.
We repeat the recommendation.

Rules and management of the centre

2.134 Strip searches should take place only for specific properly documented reasons, all should be authorised by a senior manager and signatures should be legible. (8.23)
Partially achieved. Detainees were not routinely strip-searched and all strip searches were authorised by a duty manager. Some of the signatures on the authorisation form were difficult to decipher and the form did not require the authorising manager to print their name. In addition, the form did not record the time the authorisation was given or when the search was conducted. As a result, it took us some time to establish who had given authorisation for the search and it was not possible to establish that searches took place promptly after authorisation was given. On all the forms we examined, the reasons for the search had been properly documented and appeared to provide sufficient grounds to justify a strip search. In most cases, searches were authorised in response to information relating to drugs.

Further recommendations

2.135 The strip search authorisation form should be amended to include the authorising duty manager's name as well as their signature.

2.136 The strip search authorisation form should indicate the time authorisation is given and when the search is conducted.

2.137 The use of strip clothing should be exceptional and it should never be used without clearly documented authorisation. (8.24)
Achieved. See paragraph 2.12.

2.138 Detainees who do not fit reception criteria should not be brought to Dover. (8.28)
Not achieved. Detainees who did not fit the reception criteria, particularly those on level 3 multi-agency public protection arrangements, were still sent to Dover. They were identified in reception and held in the separation unit until their transfer could be organised.
We repeat the recommendation.

2.139 The rewards scheme should include details of possible sanctions and these should be well advertised to detainees. Sanctions should not include a reduction in weekly allowance. (8.27)
Achieved. The rewards scheme (known as the standard and privilege scheme) policy had been revised in September 2007 and the policy document specified the privileges available at each level of the scheme. A downgrade did not include a reduction in the weekly allowance. There were no detainees on the standard level of the scheme and staff said no one had been downgraded in the previous six months.

2.140 The separation unit should not form part of the rewards scheme. (8.28)
Not achieved. The standard and privilege scheme policy stated that a detainee could be removed to the separation unit if his behaviour or single action was considered a serious breach of compact.
We repeat the recommendation.

2.141 Use of force forms should be properly completed in all cases. (8.29)
Achieved. All 20 of a sample of use of force forms from the previous six months were properly completed and in all cases the detainee had been examined by healthcare immediately after the incident. We reviewed the recordings of four planned incidents and in each case, force had been used appropriately.

2.142 Use of the observation cell should be monitored. (8.30)
Achieved. The use of the observation cell on Hythe Unit was monitored by the safer detention management team. The room was fitted with standard cell furniture and had many ligature points. Hythe Unit staff said the room was used only for detainees on constant observations, but the register of use of the cells did not make clear that this was the case. The suicide prevention and self-harm management strategy document stated that the minimum level of supervision for detainees in the observation room was intermittent, defined as five observations an hour at irregular intervals.

Further recommendation

2.143 The observation room on Hythe Unit should be occupied only by detainees under constant observation and only when a risk assessment indicates that they cannot safely be located in healthcare.

2.144 Nationality should be recorded on the use of force forms. (8.31)
Achieved. The use of force forms recorded the nationality of the detainee involved. This information was monitored by UKBA.

2.145 Managers should continue to monitor and evaluate the use of special cells in order to identify any trends. (8.32)
Achieved. The use of the special cells or rule 42 temporary confinement rooms was monitored by managers. Full details were recorded in the security and operation manager's monthly report to the area manager and discussed at the monthly management team meeting. There were two identical rule 42 rooms, each fitted with a low concrete plinth bed area with a wooden top, a low fixed seat and a window covered with opaque material. Both were stark with little natural light and no sanitation facilities. Detainees held in these rooms were given cardboard urine bottles and bowls. The rooms had been used nine times in the previous six months and the average time spent on rule 42 was just over two hours. The paperwork for all incidents showed that temporary confinement had been correctly authorised and that the rooms had been used only as a last resort for violent or refractory detainees. In most cases, detainees were removed to a rule 40 room as soon as they ceased to be violent or refractory, although one detainee had been held under rule 42 for eight hours 45 minutes overnight when it appeared from the log that he had ceased to be violent and refractory some hours earlier.

Further recommendation

2.146 Detainees should not be held in temporary confinement under rule 42 after they have ceased to be violent or refractory.

2.147 Complaints should be monitored by nationality. (8.34)
Achieved. UKBA managers monitored complaints by nationality. Most complaints related to property issues and no obvious patterns had emerged related to nationality. A new complaints system was being piloted by which all complaints were sent to a central UKBA office, logged and returned to the centre or relevant department for investigation. Replies were sent back to the central office before being returned to the detainee. It was too early to establish whether this new system would improve the quality and timeliness of responses. A total of 122 complaints, including nine recorded as racist complaints, had been logged in the previous six months.

Additional information

2.148 Force appeared to be used more frequently, with an average of 6.6 incidents a month in 2008 compared to 4.5 a month in the six months before our previous inspection. Use of single separation also appeared to have increased, with an average of 30.7 uses a month in the six months leading up to this inspection compared to 11.75 a month at the time of our last inspection. The average time spent on rule 40 removal from association was 37 hours.

2.149 A significant number of detainees were held in the separation unit overnight if they were due to be transferred or removed overnight or early the following morning. The separation unit had been used for this purpose 13 times in the previous six months. The supporting paperwork showed that no individual risk assessments had been completed and detainees were apparently separated to avoid disruption to other detainees in shared accommodation and for the convenience of staff escorting the detainees to reception overnight. Detainees held on the unit for this reason were usually moved there between 8pm and 8.30pm so they had access to the normal regime until the usual lock up time. Despite these efforts, it was not appropriate for detainees to be placed in separation when there was no justification under rule 40 to remove them from association.

2.150 One detainee whose age was in dispute was being held on the unit in rule 40 accommodation. The logs showed that another detainee had been held in the separation unit under rule 40 from the afternoon of 8 December 2008 until 19 December 2008 to facilitate an age assessment (see section on childcare and protection).

Further recommendations

2.151 Managers should continue to monitor use of force and attempt to identify the reasons behind the increase in number of use of force incidents.

2.152 The separation unit should not be used routinely to accommodate detainees awaiting transfer or removal overnight.

Services

2.153 The weekend lunch should not be served before noon and breakfast packs should be provided on the morning they are eaten.
Not achieved. Lunch at weekends was still served at 11.30am and breakfast packs were given out with the evening meal on the previous day.
We repeat the recommendation.

2.154 Detainees should be provided with up-to-date information about the product range and prices of shop items, including tariffs for telephone cards.
Achieved. The range and prices were well publicised and kept updated on the computer drive from which staff printed off lists for detainees. Care had been taken in sourcing the best value telephone cards and better cards for calls to Africa were being sought. Detainees expressed concern about prices, some of which had recently increased sharply – these increases mirrored price rises in the wider market, but had a disproportionate impact on detainees, most of whom had little money. The planned move of the shop to a new room on the side of Deal House was causing anxiety, both about reduced space for stock and about detainees queuing in an unsheltered area.

Further recommendation

2.155 Managers should ensure that any relocation of the shop does not reduce the range of goods available or the suitability of queuing arrangements.

Preparation for release

2.156 The welfare team office should have its own fax. (10.18)
No longer relevant. There was no longer a separate welfare team office. Under a new care officer scheme, unit staff were now responsible for dealing with welfare issues. A number of detainees said the system was ineffective and that welfare issues were largely unaddressed. Records contained few entries by case officers and staff on some units were unaware of the scheme. Care officers dealt with faxes and photocopies, but only up to a maximum of 20 pages at a time. Many welfare issues were raised with the Dover Detainee Visitors Group, which was not resourced to deal with them.

Further recommendation

2.157 There should be an effective system for dealing with detainees' welfare issues.

2.158 All visitors should be provided with essential information on how to get to the centre and what to expect when they arrive. (10.19)
Partially achieved. The centre's website provided detailed information for visitors including visiting times, directions and how to book visits. However, information for visitors who did not have access to the internet was limited, as was the information given to detainees to pass on to their visitors.
We repeat the recommendation.

2.159 The range of information provided in the visitors' centre and the visits room should be improved. (10.20)
Achieved. The range of information in the visitors' centre and visits room had improved and now included information on race relations, bullying, Migrant Helpline, solicitors, bail and information about property/baggage, some of which was in different languages.

2.160 The visits room should provide an attractive and welcoming environment; facilities should be enhanced to include a canteen and supervised crèche. (10.21)
Not achieved. No improvements had been made to the visits room apart from new tables and chairs that were in fixed units of four, significantly less comfortable and more in keeping with a prison environment. One detainee said his five year old daughter had assumed he was still in

prison when she saw the room. There was still no canteen or crèche. There was a water machine, but no cups, and comments in the visitors' book indicated that this was a regular problem.
We repeat the recommendation.

2.161 Detainees should not have to wear bibs during visits. (10.22)
Not achieved. Detainees still had to wear coloured bibs during visits.
We repeat the recommendation.

2.162 Official visitors should be able to conduct their interviews in private. (10.23)
Not achieved. The official visits booths had not changed and official visitors still complained about noise and lack of privacy.
We repeat the recommendation.

2.163 The cost of internet access should be significantly reduced. (10.24)
Not achieved. Internet access was no longer available (see paragraph 2.4).

Additional information

2.164 There had been 136 removals/releases in the previous month, which was fairly typical, and on average a further 145 transfers in and out. The average stay was 88 days. However, there was inadequate support to help detainees prepare for release and the lack of welfare officers was having a significant impact in this area.

2.165 Visits took place every morning and afternoon lasting about 2.5 hours and on Monday and Wednesday evenings lasting 1.5 hours. There were no restrictions on how many visits detainees could have, but the timings were inconvenient for most visitors, who had usually travelled a long way and had to wait between morning, afternoon and evening visits. Visitors could leave comments and submit complaints through the visitors' centre. Common concerns included that disabled parking bays were frequently used by drivers without disabilities, inflexibility about bringing in property and staff being unhelpful and unfriendly, although the latter contradicted the view of detainees in our groups who said visitors were generally treated well. Visitors complained to us that it could take up to 45 minutes for them to be processed before getting in to the centre.

2.166 Detainees complained about the lack of family support. Many were far from their families and there was no family liaison officer to help maintain family links. However, they were positive about the Dover Detainee Visitors Group, which helped with telephone cards and mobile telephones, offered financial support and visited individual detainees. All new arrivals were given a £3 allowance for telephone calls. There was no system allowing those who did not receive visits in a given month to have additional telephone credit instead.

2.167 Bail for Immigration Detainees workers offered valued help in preparing for release on bail. They held a workshop once a month and gave individual assistance to those with special needs. They also worked with the National Asylum Support Service to assist detainees with finding accommodation.

2.168 Before receiving removal directions, consideration was given to whether a detainee was likely to self-harm or attempt suicide. There was a list of detainees, highlighted mainly by healthcare, considered to be at a higher risk. UKBA consulted managers before issuing directions and postponed them where risks were considered too high. Otherwise, staff monitored the detainee and, if necessary, put them on an ACDT booklet.

2.169 Reception staff were allowed to issue clothes and a holdall to detainees being removed who needed them. However, this rarely happened in practice and senior managers acknowledged that the facility was not well publicised.

Further recommendations

2.170 Visits should be open for a continuous and extended period.

2.171 Issues raised in the visitors' comments book should formally be taken to a managers' meeting for discussion and, where possible, resolved. Action should be communicated back through the comments book.

2.172 Detainees who do not receive domestic visits in the previous month should be given additional telephone credit.

2.173 When required, clothes and a holdall should be issued to detainees being released or removed.

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 — To the Chief Executive, UK Border Agency (UKBA)

3.1 The UK Border Agency should prevent unnecessary moves around the detainee estate, explain to detainees why they are being moved, and the reasons should be recorded. (2.1)

3.2 Immigration casework should be progressed promptly and reflect accurate assessment of the law and facts. Detainees' queries should be answered quickly and fully, and immigration bail documentation should provide explanations for the decisions reached and be clearly signed. (2.3)

3.3 Detainees should have reasonably priced and easy access to the internet, including use of email. (2.4)

Main recommendations — To the centre manager

3.4 A communal dining room should be provided and in the interim, each unit should have a servery. The quality and quantity of meals should be improved. (2.5)

3.5 Staff should be aware of the violence reduction strategy and how to submit a referral and should receive feedback on the outcome of referrals they submit. (2.9)

3.6 All incidents of potential bullying should be recorded on a bullying incident referral form and properly and promptly investigated. (2.10)

3.7 The commissioning arrangements for all health services for detainees (including contracts with allied health professionals) should be agreed expeditiously. (2.11)

Recommendations — To the Chief Executive, UK Border Agency and NOMS

Suicide and self-harm

3.8 Detainees on open ACDT/ACCT plans should not be transferred without the receiving establishment being given advance notice of their arrival. (2.77)

3.9 Detainees on open ACDT/ACCT plans should not be transferred without their plan documents. (2.78)

Recommendations — To the Chief Executive, UK Border Agency

Casework

3.10 Written reasons for detention should be provided in a language the detainee can understand. (2.13)

3.11 Written reviews of detention should justify continued detention by reference to all known circumstances. Reviews should take place at least monthly or following a relevant change in circumstances. (2.15)

3.12 Detainees should be provided with contact details, including telephone numbers, for all those responsible for their casework. (2.17)

3.13 There should be sufficient suitably-experienced immigration staff on site to engage with all detainees, understand their status, respond to their queries and progress their casework. (2.18)

3.14 There should be no limit to the length of fax detainees can send and detainees and staff should be made aware of arrangements for sending longer faxes. (2.21)

3.15 The on-site team should be made aware of faxes to and from case owners. (2.22)

Childcare and protection

3.16 UKBA should ensure that its own policy commitments and procedures are followed to secure the earliest possible assessment of potential minors by Social Services. (2.87)

Rules and management on the centre

3.17 Detainees should not be transferred without all of their property, property should be checked on transfer and detainees should be given their property record sheets. (2.23)

Recommendation

To the Director General of NOMS

Rules and management of the centre

3.18 Staff should not routinely carry defensive weapons such as extendable batons. (2.25)

Recommendation

To the escort contractor

Arrival in detention

3.19 Discharging healthcare staff should conduct individual risk assessments to determine whether medication ought to be allowed in-possession and escort staff should be instructed accordingly. (2.26)

Recommendations

To the centre manager

Arrival in detention

3.20 Reception interviews should be conducted in private and reception staff should make appropriate use of the telephone interpreting service. (2.27)

3.21 Planned transfers between centres should not take place at night unless this is an exceptional and urgent operational necessity. (2.32)

3.22 All detainees should receive an induction from key departments, especially education, as soon as possible after arrival. (2.34)

3.23 The induction information booklet should be updated immediately and kept up to date in future. (2.35)

Residential units

3.24 All cleaning orderlies should have an agreed job description and compact. (2.37)

3.25 Detainees should have access to hot water until later in the evening. (2.38)

3.26 Information notices and guides for detainees should be readily available to detainees in the most commonly spoken languages. (2.40)

3.27 Action points from consultative meetings should be followed up at subsequent meetings and the results published to detainees. (2.41)

3.28 The showers on Hastings unit should be refurbished. (2.43)

3.29 All showers should be repaired and upgraded to provide hygienic and private conditions for detainees and there should be a regular programme of deep cleaning of the shower and toilet facilities. (2.46)

Staff-detainee relationships

3.30 Staff should not address detainees by surname alone. (2.47)

3.31 An effective personal or care officer scheme should be implemented and particular efforts made to communicate with detainees with little or no English. This engagement should be reflected in regular and detailed entries in history files. (2.49)

3.32 Staff should not enter detainees' rooms without knocking. (2.51)

3.33 There should be a renewed management focus on creating a distinct immigration removal centre rather than prison culture at Dover. The wearing of less formal uniforms should be encouraged. (2.52)

Legal rights

3.34 The centre should undertake an assessment of detainees' needs for legal information, advice and representation. (2.54)

3.35 The service provided by the Refugee Legal Centre should be advertised to all detainees. (2.57)

3.36 The legal visits area should provide a quiet and confidential environment. (2.58)

3.37 Detainees should always be provided with copies of bail summaries before hearings and have enough time to consult with solicitors. (2.59)

Anti-bullying

3.38 The anti-bullying policy should be tailored to the specific needs of detainees at Dover and its strategy should be informed by a bullying survey. (2.61)

3.39 All F213 forms reporting an unexplained injury to a detainee should be properly investigated and recorded. (2.63)

3.40 Staff should be trained in the anti-bullying procedures. (2.64)

3.41 Some administrative support should be available to the anti-bullying coordinator. (2.71)

3.42 Unit managers should be trained in mediation. (2.72)

3.43 The monthly safer detention meeting should be properly attended and include detainee representatives for at least part of the meeting. (2.73)

3.44 The anti-bullying survey should be completed and analysed. (2.74)

3.45 Ongoing support and monitoring should be available to victims of bullying. (2.75)

Suicide and self-harm

3.46 ACDT reviews should include the original case manager and should be multidisciplinary. (2.80)

3.47 The safer suites in healthcare should be refurbished and redecorated. (2.82)

3.48 The aim of the 'helping hands' scheme should be clarified and evaluated and its use made clear to detainees and staff. (2.84)

Childcare and protection

3.49 A care plan should immediately be put in place when an age dispute case comes to staff attention and should include input from mental health services. (2.88)

3.50 Detainees whose age is disputed should not be locked in rooms or held in the separation unit. (2.89)

Diversity

3.51 Posters and other information around the centre should reflect and promote a wider concept of diversity, including age, sexual orientation and disability, as well as the support available to detainees. (2.97)

3.52 Detainee diversity/peer support workers and diversity and race equality officers should receive specific training in their role. (2.98)

3.53 The disability protocol should be dated and all detainees who have a known disability should have a care plan. Where care plans rely on assistance from other detainees, this should be

formally arranged and monitored, and care plans should specify what assistance is required in an emergency. (2.99)

Health services

3.54 The mental health needs assessment should be completed as soon as possible and appropriate actions taken to implement its recommendations. (2.103)

3.55 The clinical governance structure should continue to be developed. (2.105)

3.56 The on-call arrangements for medical staff should be reviewed to ensure that they comply with current guidelines. (2.110)

3.57 Triage protocols should be appropriate to the centre population. (2.114)

3.58 All staff who come into contact with detainees should be aware of how to identify signs of torture and trauma, and the steps to be taken if a detainee alleges such abuse. (2.117)

3.59 UKBA caseholders should respond to submitted rule 35 letters and such responses should be shared with healthcare staff. (2.119)

3.60 Policies should be developed to ensure that any detainee requiring detoxification or symptom control is cared for in line with practice guidelines. (2.120)

3.61 Detainees released from Dover should have support and assistance in accessing community health services as appropriate, and copies of health treatment should be given to detainees who leave the centre. (2.121)

3.62 Referral criteria for mental health services should be developed to ensure that detainees with primary mental health care needs and those with severe and enduring mental health issues are dealt with appropriately. (2.122)

3.63 Formal arrangements for the provision of culturally-aware counsellors with skills in dealing with victims of torture and other sensitive issues should be put in place. (2.123)

3.64 Detainees requiring dental care should be able to access it without undue delay. (2.125)

Activities

3.65 The opportunities for paid work should be further extended. (2.126)

3.66 Internet access should be made available to library staff. (2.128)

3.67 The curriculum should be reviewed to cater more effectively for the needs and interests of a fluctuating population. (2.129)

3.68 Education should be more effectively promoted to increase take up of provision. (2.130)

3.69 Good practice should be shared more effectively to improve the quality of provision. (2.131)

3.70 Detainees should be able to use the physical education (PE) showering facilities in private. (2.132)

3.71 Detainees should have 12 hours freedom of movement around the centre. (2.133)

Rules and management of the centre

3.72 The strip search authorisation form should be amended to include the authorising duty manager's name as well as their signature. (2.135)

3.73 The strip search authorisation form should indicate the time authorisation is given and when the search is conducted. (2.136)

3.74 Detainees who do not fit reception criteria should not be brought to Dover. (2.138)

3.75 The separation unit should not form part of the rewards scheme. (2.140)

3.76 The observation room on Hythe Unit should be occupied only by detainees under constant observation and only when a risk assessment indicates that they cannot safely be located in healthcare. (2.143)

3.77 Detainees should not be held in temporary confinement under rule 42 after they have ceased to be violent or refractory. (2.146)

3.78 Managers should continue to monitor use of force and attempt to identify the reasons behind the increase in number of use of force incidents. (2.151)

3.79 The separation unit should not be used routinely to accommodate detainees awaiting transfer or removal overnight. (2.152)

Services

3.80 The weekend lunch should not be served before noon and breakfast packs should be provided on the morning they are eaten. (2.153)

3.81 Managers should ensure that any relocation of the shop does not reduce the range of goods available or the suitability of queuing arrangements. (2.155)

Preparation for release

3.82 There should be an effective system for dealing with detainees' welfare issues. (2.157)

3.83 All visitors should be provided with essential information on how to get to the centre and what to expect when they arrive. (2.158)

3.84 The visits room should provide an attractive and welcoming environment; facilities should be enhanced to include a canteen and supervised crèche. (2.160)

3.85 Detainees should not have to wear bibs during visits. (2.161)

3.86 Official visitors should be able to conduct their interviews in private. (2.162)

3.87 Visits should be open for a continuous and extended period. (2.170)

3.88 Issues raised in the visitors' comments book should formally be taken to a managers' meeting for discussion and, where possible, resolved. Action should be communicated back through the comments book. (2.171)

3.89 Detainees who do not receive domestic visits in the previous month should be given additional telephone credit. (2.172)

3.90 When required, clothes and a holdall should be issued to detainees being released or removed. (2.173)

Appendix 1: Inspection team

Hindpal Singh Bhui	Team leader
Lucy Young	Inspector
Susan Fenwick	Inspector
Martin Kettle	Inspector
Mandy Whittingham	Healthcare inspector
Linda Truscott	Ofsted
John Cullinane	Guest inspector
Madeleine Colvin	Guest inspector

Appendix 2: Population profile

Population breakdown by:

(i) Age	No. of men	No. of women	No. of children	%
18 years to 21 years	14			4.5
22 years to 29 years	99			31.8
30 years to 39 years	141			45.3
40 years to 49 years	50			16.1
50 years to 59 years	7			2.3
60 years to 69 years	0			
70 or over	0			
Total	311			100

(ii) Nationality	No. of men	No. of women	No. of children	%
Afghanistan	10			3.22
Albania	2			0.64
Algeria	21			6.75
Angola	3			0.96
Bangladesh	6			1.93
Brazil	0			0
Cameroon	5			1.61
China	28			9.00
Cote Dinore	5			1.61
Congo (Brazzaville)	1			0.32
Ecuador	0			0
Eritrea	4			1.29
Ethiopia	1			0.32
Gambia	5			1.61
Guatalama	0			0
Ghana	12			3.86
India	7			2.25
Iraq	15			4.82
Iran	9			2.89
Jamaica	33			10.61
Kenya	0			0
Kosovo	3			0.96
Lebanon	1			0.32
Liberia	0			0
Mexico	0			0
Morocco	2			0.64
Nigeria	31			9.97
Namibia	0			0
Nepal	0			0
Pakistan	8			2.57
South Korea	0			0
Sierra Leone	7			2.25
Sri Lanka	14			4.50
Senegal	0			0
Somalia	16			5.14
Turkey	2			0.64
Uganda	0			0

Vietnam	1			0.32
Others				
Belgium	1			0.32
Benin	1			0.32
Columbia	2			0.64
Cuba	1			0.32
Cyprus	1			0.32
Democratic Republic of Congo	9			2.89
Georgia	1			0.32
Guinea	1			0.32
Kuwait	1			0.32
Libya	1			0.32
Malawi	3			0.96
Moldova	1			0.32
Palestine	1			0.32
Poland	3			0.96
Portugal	1			0.32
Romania	1			0.32
Rwanda	1			0.32
South Africa	4			1.29
Spain	1			0.32
St Lucia	1			0.32
St Vincent	1			0.32
Tunisia	2			0.64
Ukraine	1			0.32
USA	1			0.32
Yemen	1			0.32
Zimbabwe	4			1.29
Total	311			100

(iv) Religion/belief	No. of men	No. of women	No. of children	%
Buddhist	29			9.3
Roman Catholic	10			3.2
Orthodox	1			0.3
Other Christian religion	106			34.1
Hindu	16			5.1
Muslim	112			36.0
Sikh	4			1.3
Agnostic/atheist	1			0.3
Unknown	28			9.00
Other (please state what)				
Rastafarian	4			1.3
Total	311			99.97

(v) Length of time in Detention in this centre	No. of men	No. of women	No. of children	%
Less than 1 week	30			9.65
1 to 2 weeks	35			11.25
2 to 4 weeks	45			14.47
1 to 2 months	66			21.22
2 to 4 months	63			20.26
4 to 6 months	32			10.29

6 to 8 months	18			5.79
8 to 10 months	8			2.57
More than 10 months (please note the longest length of time)	14 (529 days)			4.50
Total	311			100

(vi) Detainees last location before detention in this centre	No. of men	No. of women	No. of children	%
Community	Not supplied			
Another IRC	Not supplied			
A short-term holding facility (eg at a port or reporting centre)	Not supplied			
Police station	Not supplied			
Prison	Not supplied			
Total				

(v) Outcome

Of detainees departing in last three months:

Removed:	268
Transferred:	255
Released on temporary admission/release:	62
Released on CIO bail:	3
Released on AIT bail:	98
Absconded:	0