Report on an unannounced inspection of

Dungavel Immigration Removal Centre

by HM Chief Inspector of Prisons

19–21 July and 2–5 August 2021

Contents

Introduction

Dungavel House is an immigration removal centre (IRC) in Lanarkshire, and the only such centre in Scotland. At the time of the inspection, the IRC operated under contract to the Home Office by GEO Group UK. Mitie Care and Custody assumed management of the centre from 25 September 2021. We were pleased to find that the imminent transfer of contract was being managed in a spirit of cooperation, which we have not always found when IRCs have changed hands in the past. There was currently no evidence that outcomes for detainees were being adversely affected by the transition.

Dungavel has tended to deliver some of the best outcomes in the detention estate and, in general, what we found at this inspection was no exception. Leaders had managed the demands of COVID-19 well and there had been only one positive detainee case, with evidence of effective cooperation between GEO, the Home Office and health agencies. As in the rest of the immigration detention estate, the number of detainees had been low throughout the pandemic, partly because detention ceases to be lawful if there is no reasonable prospect of removal. There was plenty of space in the centre, with only about 30 detainees resident at the start of the inspection, nearly all in single rooms; the maximum capacity of the centre had also been halved to 125.

One of our principal concerns at our last inspection was the deteriorating physical environment for detainees. There had subsequently been some much-needed investment in the centre, with substantial refurbishment and decoration of many areas, including a welcoming visits area.

The centre remained fundamentally safe, providing a relaxed and calm environment where levels of violence were very low. However, some detainees with a history of violence against women were held during the pandemic, which meant that detained women had to be escorted around the site. Detainees who pose risks to women should not be held in a centre with a mixed population.

Care for vulnerable detainees by centre staff was good, and a new supported living unit provided particularly good facilities. However, some detainees continued to be held for far too long, including those considered to be adults at risk and people whom the Home Office had itself accepted were victims of torture. Significant mental health needs continued to be met well by an impressive health care team.

Detainees had controlled access to a range of activities, but most employment had ceased during the pandemic. The rationale for removing some roles was unclear and more needed to be done to ensure that detainees had enough activity and time in the open air to support mental and physical well-being. Among staff generally, there remained a positive culture focused on detainee welfare, and this was reflected in many conversations we had with staff and in our observations of the way that staff and detainees related to each other around the centre. However, as at the last inspection, many detainee custody officers complained of low morale and understaffing. While we saw no evidence that this discontent had yet affected the treatment of detainees or safety in the

centre, it had the potential to become a more significant concern as the population increased and required sustained leadership attention. Currently, Dungavel remained a centre that was providing good care to detainees in challenging circumstances.

Charlie Taylor
HM Chief Inspector of Prisons
September 2021

About Dungavel

Task of the establishment
To detain pending removal men and women subject to immigration control.

Certified normal accommodation and operational capacity (see Appendix II Glossary of terms)
Detainees held at the time of inspection: 28 (27 men and one woman)
Baseline certified normal capacity: 125
In-use certified normal capacity: 125
Operational capacity:125

Population of the centre
- In the year before the inspection, 41% of detainees had been released, 16% were removed and the rest were transferred to another centre.
- 21 women had been held in the previous six months, and 44% of frontline operational staff were currently women.
- 8 detainees were regarded as adults at risk by the Home Office at the start of the inspection; 30 rule 35 reports (see Appendix II Glossary of terms) had been submitted in the previous year, leading to release in seven cases.

Name of contractor
GEO Group UK Ltd

Escort provider: Mitie Care and Custody
Search and patrol dog services provider: Specialist Dog Services Ltd
Health service providers: Med-Co Secure Healthcare Services Ltd
Learning and skills providers: GEO Group UK Ltd

Location
Strathaven, South Lanarkshire

Brief history
Dungavel House Immigration Removal Centre was formerly a hunting lodge. It was turned into a hospital during the two world wars, after which it became a training college for the Coal Board and then a Scottish Prison Service low-category prison. It became an immigration removal centre in 2001.

Short description of residential units
Three residential housing units comprised the main house and two annexes, Loudoun House and Hamilton House. Loudoun House had 12 rooms for men. A self-contained women's unit was located within Loudoun House.

Hamilton House was subdivided into four reverse cohort units (RCUs) (see Appendix II Glossary of terms) during the COVID-19 pandemic. All accommodation was sole occupancy with a restriction in place prohibiting detainees from sharing bathrooms. The five dormitory rooms in the main house were also being used as RCUs for newly arrived detainees – they had sole occupancy with bathrooms for individual use.

Name of centre manager and date in post
Sarah Lynch, July 2016

Leadership changes since the last inspection
None

Independent Monitoring Board chair
Bobby Mangto

Date of last inspection
July 2018

Section 1 Summary of key findings

1.1 We last inspected Dungavel in 2018 and made 34 recommendations, two of which were about areas of key concern. The immigration removal centre (IRC) fully accepted 26 of the recommendations and partially (or subject to resources) accepted six. It rejected two of the recommendations.

1.2 Section 7 contains a full list of recommendations made at the last full inspection and the progress against them.

Progress on key concerns and recommendations from the full inspection

1.3 Our last inspection of Dungavel took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for detainees at the time. Although we recognise that the challenges of keeping detainees safe during COVID-19 will have changed the focus for many IRC leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.

1.4 At our last full inspection, we made one recommendation about a key concern in the area of safety. At this inspection we found that this recommendation had not been achieved.

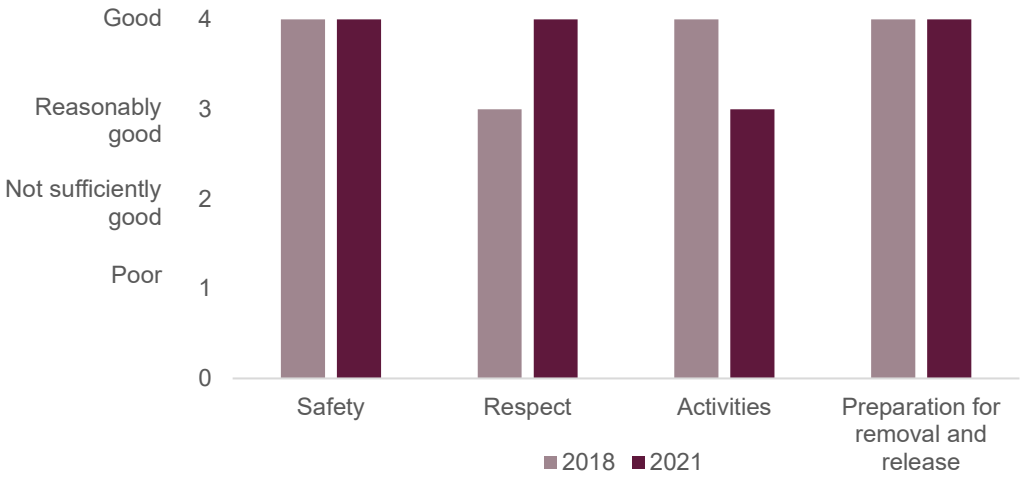
1.5 We made one recommendation about key concerns in the area of respect. At this inspection we found that this recommendation had been achieved.

Outcomes for detainees

1.6 We assess outcomes for detainees against four healthy establishment tests (see Appendix I About our inspections and reports, for more information about the tests). At this inspection of Dungavel, we found that outcomes for detainees had stayed the same in two healthy prison areas, improved in one and declined in one.

1.7 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the IRC's recovery from COVID-19.

Figure 1: Dungavel Immigration Removal Centre healthy establishment outcomes 2018 and 2021



Safety

At the last inspection of Dungavel in 2018 we found that outcomes for detainees were good against this healthy establishment test.

At this inspection we found that outcomes for detainees remained good.

1.8 Too many detainees continued to arrive at night, often following lengthy journeys. Reception risk assessments were thorough, and staff were polite and professional but did not always spend enough time reassuring detainees about what was happening. Cohorting arrangements to minimise the risk of COVID-19 transmission were managed well, and the induction was reasonably comprehensive.

1.9 Eight adults at risk were held in the centre at the start of the inspection, including some with serious mental health problems. Staff cared for them well, but, in two cases, detainees were held even though the Home Office accepted that detention was having a detrimental effect on their well-being. Monthly multidisciplinary adults at risk meetings were well attended, including by most Home Office case owners, and were effective forums for discussing detainees' case progression and well-being.

1.10 Rule 35 reports (see Appendix II Glossary of terms) were well managed, promptly submitted and thorough. Home Office responses were generally timely and about a quarter of the submissions had led to release. However, detention was often maintained, even when evidence of torture had been accepted.

1.11 Every detainee was placed on a vulnerable adult care plan (VACP) on arrival and plans that we reviewed documented good care. Neither the Home Office nor the centre had up-to-date records of the number of referrals made under the National Referral Mechanism (see Appendix II Glossary of terms) in the previous year. In our staff survey, most staff said they felt comfortable reporting concerns to managers. There was a

whistleblowing policy and a confidential reporting line, but no calls had been logged in the previous year.

1.12 There had been three incidents of self-harm in the past year, but none were serious. A new supported living unit for vulnerable detainees had a calm atmosphere and was well-equipped. The standard of assessment, care in detention and teamwork (ACDT) case management documentation for prisoners at risk of suicide or self-harm in IRCs had improved since our previous inspection and indicated that good support was provided, although care plans were mixed.

1.13 The centre was relaxed and calm, and levels of violence were very low. None of the detainees reported any concerns about their physical safety in the centre. Some detainees with a history of violence against women were held in the centre during the pandemic, which meant that female detainees had to be escorted around the site.

1.14 The security department was responsive to emerging risks and took appropriate remedial action when necessary. There were few security intelligence reports, but action required as a result was carried out promptly. Freedom of movement remained good for detainees who were not in isolation. Handcuffing during escorts was properly risk-assessed in each of the cases examined. Some action, such as routine room and detainee searches, including of all those placed on an ACDT, was disproportionate.

1.15 Force was not used frequently, and paperwork generally provided good justifications for its use. Most video footage we reviewed showed that incidents were managed reasonably well, but managers did not review all video footage and there was no evidence that action was taken in response to recommendations from reviews.

1.16 Separation was used infrequently, and the new separation unit was a reasonably good facility. Paperwork documented justifiable reasons for removing a detainee from association under detention centre rule 40. However, in one case a detainee was held without a mattress and most of his clothes in circumstances that were not clearly documented and without effective management oversight.

1.17 Detainees had good access to legal advice. Some were held for too long – the longest detained person had been held for almost a year with little prospect of him being removed in the near future. Many individuals who had received bail in principle also continued to be held because of a lack of suitable release addresses.

Respect

At the last inspection of Dungavel in 2018 we found that outcomes for detainees were reasonably good against this healthy establishment test.

At this inspection we found that outcomes for detainees were now good.

1.18 All detainees in our survey and all those to whom we spoke, said staff treated them with respect all or most of the time. Leaders continued to promote a culture that focused on detainee care. While many GEO staff reported poor morale and understaffing, we found no evidence that this had yet affected the treatment of detainees or safety in the centre.

1.19 The standard of accommodation had improved considerably since our previous inspection. All areas had been decorated, showers had been refurbished and rooms were suitably furnished, clean and in a good state of repair. Detainees had good access to clean clothing, cleaning materials and toiletries.

1.20 Consultation with detainees had continued throughout the pandemic. Complaint forms in a variety of languages were freely available and responses were polite and thorough, although not always timely.

1.21 The food was adequate, and detainees could eat in the main dining room or in their residential units. The cultural kitchen had been refurbished since the previous inspection and was a good but under-used facility.

1.22 There were still weaknesses in the oversight of work to promote equality, but there was little evidence of discrimination. Reception staff did not systematically identify all new detainees with protected characteristics and none of the detainees were identified as having a disability. Detainees struggling with their mental health received good support, especially from health care staff. Professional telephone interpretation was used reasonably well.

1.23 Faith provision remained reasonable. The chapel was good, but the multi-faith room was cramped and in need of redecoration.

1.24 Health services were responsive, and detainees continued to have good access to nurses and GPs throughout the pandemic. Strong clinical leadership was evident and supported by an experienced team who delivered a good standard of care. Effective contingencies were in place to manage COVID-19, and partnership working between the centre, the Home Office, the health care provider, NHS Lanarkshire and Public Health Scotland had been strengthened. Only one detainee had tested positive for COVID-19 since the beginning of the pandemic. Few health care complaints were made, but there was still no separate health care complaints system to preserve confidentiality. An electronic medical record had been introduced but was not fully functional at the time of the inspection. A process for alerting health care staff before

any bad news was delivered to detainees, enabled them to offer care and support to vulnerable detainees.

1.25 A good range of primary care services was available, and access was prompt. Mental health services were good. Demand for substance misuse services was low but the provision was good. Urgent dental treatment was also good.

Activities

At the last inspection of Dungavel in 2018 we found that outcomes for detainees were good against this healthy establishment test.

At this inspection we found that outcomes for detainees were now reasonably good.

1.26 Detainees could access a reasonable range of activities seven days a week, but participation was limited to take account of social distancing requirements.

1.27 The information learning centre had good facilities, including a library with a computer suite, an art room and a small classroom. There was a small range of classes and activities in arts and crafts, computer technology and English for speakers of other languages.

1.28 Although learning activities were promoted, attendance was low. Tutors had relevant qualifications and experience and worked well together to support detainees' learning needs. However, there was not enough focus on quality improvement planning.

1.29 Most employment had ceased during the pandemic, and not enough work opportunities had been created. The rationale for removing cleaning roles was unclear.

1.30 The library was bright and welcoming. It was used well and had long opening hours every day. The library book stock was narrow, but a number of electronic reading devices were available. Detainees could access legal textbooks and dictionaries in a range of languages, and there was a large stock of DVDs and games.

1.31 Detainees could use fitness facilities every day, including in the evenings. The gym was well equipped, and most equipment was well maintained. However, the all-weather pitch was not in use because of poor maintenance, which meant outdoor sports were restricted.

Preparation for removal and release

At the last inspection of Dungavel in 2018 we found that outcomes for detainees were good against this healthy establishment test.

At this inspection we found that outcomes for detainees remained good.

1.32 A welfare officer was on duty every day. Although no drop-in service was available, detainees' welfare needs were met through a one-to-one approach. Their needs were assessed on arrival and before detainees left the centre. Welfare requests recorded by the centre had all been resolved promptly. Detainee charity Scottish Detainee Visitors provided a valuable support service and had resumed in-person visits to the centre in June 2021.

1.33 Social visits had resumed in May 2021. The visits room was well decorated and welcoming, and legal visits and video calls could be facilitated in private.

1.34 All detainees were issued with a mobile phone on arrival and additional credit had been supplied throughout the pandemic. Detainees had reasonable access to the internet and email, but only legal attachments could be printed out and social media websites remained prohibited, which was a disproportionate restriction for a detainee population.

1.35 About 40% of detainees held in the previous year were subsequently released. Detainees who were bailed received some funds to help them on release, as well as a useful 'bail pack' containing personal protective equipment (see Appendix II Glossary of terms) and food. Detainees were informed in good time that they would be leaving the centre, apart from where there were assessed risks. Multidisciplinary meetings were held to discuss the risks for detainees who were subject to a complex removal to plan their safe exit from the centre.

Key concerns and recommendations

1.36 Key concerns and recommendations identify the issues of most importance to improving outcomes for detainees and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

1.37 During this inspection we identified some areas of key concern and have made a small number of recommendations for the IRC to address those concerns.

1.38 Key concern: Many detainees had been held for lengthy periods with little prospect of being removed within a reasonable time. One man had been held for almost a year, although he had no travel documents and flights to his home country were very restricted. Some long-held detainees had been assessed as level 3 adults at risk (the highest risk level), which meant that the Home Office accepted that ongoing detention was having a negative impact on their health and well-being.

Others were held despite the Home Office accepting that they were victims of torture.

Recommendation: **The Home Office should ensure that detention is not unnecessarily prolonged when there is little prospect of removal within a reasonable timeframe, especially for vulnerable detainees whose health and well-being is detrimentally affected by ongoing detention.**
(To the Home Office.)

1.39 Key concern: The centre held several men with a history of sexual violence against women. Before the pandemic, these men were held in a separate unit with controlled access to common parts of the centre. As a result of infection control arrangements, this was no longer considered practicable. This meant that for most of the previous six months, women had to be escorted when they moved around the site.

Recommendation: **Detainees who pose a risk to women should not be held in the centre when women are held.**
(To the Home Office.)

1.40 Key concern: Most employment had ceased during the pandemic, but the rationale for removing cleaning roles was unclear and there was not enough focus on creating new roles to help support detainees' mental and physical well-being.

Recommendation: **Leaders should substantially increase the range of paid work opportunities for detainees to help support their mental and physical well-being.**
(To the centre manager.)

Notable positive practice

1.41 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

1.42 Inspectors found nine examples of notable positive practice during this inspection.

1.43 Placing all detainees onto a VACP on arrival at the centre during the pandemic, and maintaining high-quality monitoring and engagement, had enabled centre staff to ensure that detainees' welfare was monitored, and that they received good support through their isolation period. (See paragraph 2.19.)

1.44 Since the previous inspection, the centre had opened a supported living unit, which provided a calm environment for vulnerable detainees. Detainees accommodated there could move around the centre, eat with their peers and use centre facilities. (See paragraph 2.24.)

1.45 Staff interviewed all detainees individually once a month, asking a range of questions about whether they felt safe in the centre. (See paragraph 2.36.)

1.46 Good efforts had been made to decorate and soften the environment of a very well-equipped room for detainees with mobility disabilities. The room offered, for example, an adjustable medical bed and a well-equipped wet room. (See paragraph 3.31.)

1.47 The adverse news alert process saw health care staff being notified in advance if a detainee was going to receive distressing news, so they could support them if they were particularly vulnerable. (See paragraph 3.50.)

1.48 The horticultural therapy group, run by the counsellor, provided a therapeutic activity, which detainees found beneficial for their mental health and well-being. Produce was used in the cultural kitchen. (See paragraph 3.69.)

1.49 The visits room had been refurbished to a high standard. It was well-maintained and thoughtfully set out to provide a welcoming and relaxed environment. (See paragraph 5.8.)

1.50 The centre continued to pay the local transport costs of family and friends visiting detainees. (See paragraph 5.10.)

Section 2 Safety

Detainees are held in safety and with due regard to the insecurity of their position.

Arrival and early days in detention

Expected outcomes: Detainees travelling to and arriving at the centre are treated with respect and care. Risks are identified and acted on. Detainees are supported on their first night. Induction is comprehensive.

2.1 There had been 383 arrivals at the centre in the 12 months leading up to the inspection, which was significantly fewer than in the year leading up to our previous visit. Most arrivals were from prisons and police stations. Thirty-eight women had arrived at the centre in the previous year.

2.2 Many detainees continued to arrive at the centre at night. Records of arrivals from June and July 2021 showed that 24 of the 51 newest detainees had arrived between 10pm and 8am. This was usually because they were collected late from nearby police stations.

2.3 The centre's remote location meant many detainees still faced long journeys, and some had been on board escort vehicles for more than four hours. Escort vehicles were clean, and detainees were provided with food and refreshments on board. The escorting crews we saw were friendly and reassured detainees. They also provided centre staff with an appropriate handover.

2.4 Since the previous inspection, the layout of the centre had changed so that escort vehicles could be brought into the secure area as soon as they arrived, reducing the amount of time detainees spent waiting in vehicles. The detainees we saw arriving waited on the escort vehicle for about 10 minutes, while centre staff checked their paperwork.

2.5 Detainees were searched promptly and in private after being brought into the reception area, before being taken to a holding room. The centre had two holding rooms, which meant that men and women could be held separately, when necessary. The holding rooms were comfortable and spacious. They had toilet facilities, and refreshments were available, but there was limited information about detention or the centre on display, most in English only.

2.6 Reception staff carried out a brief initial risk assessment on detainees' arrival. Detainees were then asked to take a COVID-19 lateral flow test. They received food and water in the holding room, while they waited for the test results. Once detainees had tested negative for COVID-19, a more detailed reception process took place. This included a more thorough risk assessment, which included questions about detainees'

welfare. Health care staff also undertook a confidential screening. We saw interpretation being used when it was needed, and important documents, such as the screening questionnaire and centre rules were available in a range of languages. Detainees received copies of important paperwork, including receipts for their stored property.

2.7 Reception staff were polite and friendly, and the process was prompt and efficient. However, some elements of the process were rushed, and staff did not always spend enough time reassuring detainees or explaining what was happening.

2.8 Hamilton House and some areas of the main house were being used as reverse cohort units (RCU) for new arrivals. Cohorting arrangements were well organised but, depending on when the last person entered their cohort, some detainees had to isolate for 21 days, which was too long. Although isolating detainees could go outside into a cordoned-off outdoor area, limited staff resources meant that some had their time outside restricted, and they therefore found isolation stressful and challenging.

2.9 Isolating detainees had access to a small fitness room and could order items from the shop and the library. They could also arrange Skype calls with their legal representatives and families. Women detainees could complete their isolation separately from men and were always supervised by a female officer.

2.10 Detainees were provided with written information about the centre and COVID-19 safety on arrival. All detainees received a visit from an officer the day after their arrival, to identify any unmet welfare needs. The Home Office detention engagement team also visited every new detainee in person within 48 hours of their arrival to provide them with information about their immigration case, including details about how to apply for bail. All the isolating detainees we spoke to told us that they felt staff supported them well, and that all their immediate welfare needs had been met.

2.11 Following their isolation period, detainees were provided with a comprehensive in-person induction, which included information about the facilities available, welfare services, visits, and their legal rights.

Recommendation

2.12 **Detainees should not be escorted during the night unless this is required for urgent operational reasons.** (Repeated recommendation 1.11.)

Safeguarding

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

Safeguarding of vulnerable adults

2.13 Since the previous inspection, the centre had introduced comprehensive local safer detention and adults at risk policies.

2.14 The centre and the Home Office now shared a regularly updated log of detainees who had been identified as adults at risk. Home Office case owners attended useful monthly adults at risk meetings alongside members of the Home Office detention engagement team, centre staff, and health care staff. Every detainee who was considered an adult at risk was discussed at these meetings, which covered any risk factors or areas of concern and any progress on their cases.

2.15 Centre staff provided vulnerable individuals with good care, but in several cases continuing detention was clearly detrimental to detainees' health and well-being (see key concern and recommendation 1.38). Eight detainees were recognised as adults at risk during our inspection. This included two detainees who were recognised as level 3 adults at risk (the highest level of risk). In one case, a man with a serious and chronic mental health condition had remained in detention for several months even though health care and Home Office staff recognised that detention was negatively affecting his health. The man had no immediate family or support network in his home country.

2.16 The centre had received 30 rule 35 reports in the year leading up to our inspection – two relating to health concerns and 28 regarding claims of torture. There was no waiting list to see a doctor for a rule 35 examination. Detainees were released in seven of these cases, but in 23 cases (77%) detention was maintained.

2.17 We reviewed a sample of 10 rule 35 reports from the previous 12 months. The reports were generally thorough and promptly submitted. While they did not contain body maps to illustrate injuries, they included adequately detailed descriptions and assessments of the ways that detention was affecting detainees' health. Eight of the 10 responses from the Home Office that we saw were on time, and all of them referred to the most up-to-date definition of torture.

2.18 Of the 10 reports we sampled, torture was accepted in nine cases. However, release was only recommended in one of these cases. In the other eight cases, detention was maintained. All eight of these detainees were subsequently released for other reasons. (See key concern and recommendation 1.38.)

2.19 During the COVID-19 pandemic, all detainees arriving at Dungavel had been placed on a vulnerable adults care plan (VACP). It was used to monitor and support detainees through their initial isolation period. Plans were reviewed once detainees had completed isolation, and only remained open if staff felt that an individual required additional support. The VACPs that we reviewed were of a high quality and suggested that staff were interacting well with detainees and promptly resolving any welfare needs. (See paragraph 1.43.)

2.20 Staff we spoke to had a good awareness of the National Referral Mechanism (NRM) and trafficking. However, neither the centre nor the Home Office kept an up-to-date record of the number of NRM referrals that had been made in the centre in the previous year.

2.21 GEO had a national whistleblowing scheme, which allowed staff to report any concerns anonymously. Staff were aware of it, and information about whistleblowing was included in staff training and in regular reminders circulated to all staff. In our staff survey, most respondents said they felt comfortable reporting concerns to managers. However, the whistleblowing scheme had not been used since the previous inspection. Immigration staff were aware of Home Office whistleblowing policies.

Recommendation

2.22 **The Home Office should maintain an up-to-date record of NRM referrals made at the centre.**

Self-harm and suicide prevention

2.23 There had been no deaths in detention since the previous inspection and only three incidents of self-harm in the 12 months up to the inspection. None of the incidents were serious.

2.24 Since the previous inspection, the centre had opened a supported living unit, which provided good facilities and a calm environment for vulnerable detainees. Detainees accommodated there could move around the centre, eat with other detainees and use centre facilities. (See paragraph 1.44.)

2.25 Fifty-five detainees had received support under assessment, care in detention and teamwork (ACDT) case management for detainees at risk of suicide or self-harm. Most detainees required ACDT support because of the impact of detention and removal on their well-being.

2.26 The quality of ACDT documentation had improved since the previous inspection and records outlined some good support for detainees. However, triggers for self-harm were not well defined, and although all documents had care plans, the standard of plans was mixed and not all of them were up to date. Health care staff attended case reviews, which supported good risk assessment, but onsite Home Office staff rarely did. Centre staff recorded interactions with detainees regularly, and most records documented reasonable support.

2.27 There was a useful process for alerting health care staff in advance of any bad news being delivered to vulnerable detainees (see paragraphs 1.47 and 3.50).

2.28 Staff had to deal with some particularly vulnerable detainees, and some did not feel that e-learning refresher training equipped them to deal with the complex issues they faced.

2.29 In the previous 12 months, four detainees had refused food and/or fluids. Documentation, including health care records, suggested they were supported well.

2.30 The safer detention meeting oversaw the management of self-harm and suicide prevention. Staff from key departments did not attend the meeting regularly. Although there was little discussion of individuals who had self-harmed or who were on an ACDT, those assessed to be an adult at risk had their cases discussed at a monthly adults at risk meeting, in most cases with Home Office case owner input (see paragraph 2.14). A range of quantitative data was produced, but low detainee numbers meant analysing the data for trends was of limited value.

Recommendation

2.31 **Home Office detention engagement staff should attend all case reviews where detention or the prospect of removal are factors in a detainee's risk of self-harm.**

Safeguarding children

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

2.32 Since the previous inspection, the centre had introduced a comprehensive child safeguarding policy, and guidance on handling age dispute cases. Training in child safeguarding had also been introduced, and all staff had completed it at the time of our inspection.

2.33 There had been one age dispute case at Dungavel in March 2019. Electronic Home Office records show that staff at the centre dealt with the case appropriately, accommodating the detainee in a private room and opening a care plan. The detainee was taken to Edinburgh Airport (where he had entered the country) for an age assessment, was found to be over 18 years old and was removed from the UK. However, from the electronic records we reviewed, it was unclear if the age assessment had been carried out by appropriately trained social services staff. No children had been held in Dungavel since then.

Personal safety

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

2.34 The centre remained safe, providing a relaxed and calm environment, where levels of violence were very low. Some detainees responding to our survey said they felt unsafe. Our discussions with detainees and ACDT documentation suggested that their uncertain immigration status was the main reason for this. We had no reports from detainees about concerns for their physical safety in the centre.

2.35 In our staff survey, three frontline operational staff said they had witnessed staff behaving inappropriately towards detainees. A staff comment in the survey response stated they had witnessed two occasions when a member of staff was verbally aggressive to a detainee. No further detail was provided and there was little other evidence of inappropriate behaviour.

2.36 Staff interviewed all detainees individually once a month and asked a range of questions about whether they felt safe in the centre. Their responses were collated for analysis, and it was rare for any concerns to be raised. (See paragraph 1.45.)

2.37 There had been four assaults on staff in the previous 12 months, and four detainee-on-detainee assaults. Over the same period, there had been one fight involving two detainees. Most incidents were minor, and nobody required hospital treatment.

2.38 Some of the few violent incidents were related to detainees' poor mental health. The cause of other incidents was unclear, and some had not been investigated sufficiently. The safer detention policy set out a three-stage process for managing perpetrators and supporting victims. However, the process had not been used in the previous year.

2.39 The centre had held 209 ex-prisoners in the six months up to the inspection. They were managed well, and their presence had not had any obvious impact on the stability of the centre.

2.40 The safer detention policy made better provision for the care of women than in 2018. However, we were concerned that the centre had held some detainees with a history of sexual violence against women. Before the pandemic, these men were held in a separate unit with controlled access to common parts of the centre. However, infection control arrangements meant this was no longer considered possible and women detainees had to be escorted around the site to make sure they were safe. (See key concern and recommendation 1.39.)

2.41 The safer detention policy stated that the safety of women should be a standing item at the security meeting. However, meeting minutes

suggested that the matter was not discussed substantively, other than stating that the centre was holding men who presented a risk to women.

2.42 The monthly safer detention meeting continued to take place, using video conferencing facilities, but was poorly attended (see paragraph 2.30).

Security and freedom of movement

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

2.43 Except for detainees in isolation, freedom of movement remained generally good, and detainees had access to all areas of the centre between 6.45am and 9.45pm. At night, while restricted to their units, detainees still had access to kitchen and recreational facilities (see paragraph 3.8).

2.44 There were few persistent or critical threats to the effective management of the centre. The amount of security information received was limited and only 33 security reports had been submitted in the previous 12 months. The small security department adopted a reactive response to emerging risks and took appropriate and prompt remedial action when necessary. Monthly security meetings continued to take place, but attendance was variable, with some key staff, such as those working in residential areas, regularly absent.

2.45 Some security arrangements remained disproportionate. Staff continued to carry out routine room and detainee searches owing to contractual requirements rather than assessed needs, including unjustified routine searches of those placed on an ACDT document. Considering the low levels of intelligence and lack of strategic security threats, the presence of patrol dogs remained disproportionate and was out of step with other IRCs and the generally otherwise relaxed atmosphere at Dungavel.

2.46 Strip-searches only took place when authorised by the centre manager herself. There had been four such searches in the previous year, all of which were adequately justified on the basis of risk.

2.47 Handcuffing of detainees on escort was subject to documented individual risk assessments and was appropriate in the sample of cases that we examined. In the previous 12 months, 39% of all detainees who had been escorted to a dentist or hospital had been handcuffed, which was similar to the previous inspection.

2.48 There was little evidence of drugs being available at the centre. However, a substance misuse policy was now in place, which established links between supply reduction and substance misuse treatment. In response to previous intelligence and finds, the centre

had also been able to procure a rapiscanner device from the Home Office enabling all mail to be scanned for illicit substances.

2.49 Corruption prevention measures were in place, but no specific intelligence had been received in the period before our inspection and there had been no significant finds resulting from regularly conducted staff searches.

Recommendation

2.50 **Room and detainee searches should only be carried out where intelligence or risks suggest they are necessary.**

Use of force and single separation

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

2.51 Force was not used frequently – it had been deployed 19 times in the previous year, mostly involving minimal force. Paperwork we examined was complete and generally documented the justification for its use. Many records described attempts to de-escalate incidents. Use of force data were scrutinised.

2.52 Most cases consisted of spontaneous incidents. Most incidents, including all planned use of force, were filmed using body-worn cameras. The quality of footage, particularly for planned incidents, was generally good, although there were occasions when cameras were not switched on quickly enough and therefore did not capture the whole incident.

2.53 Most footage we reviewed showed that incidents were managed reasonably well, force was used proportionately, and good attempts were made to de-escalate the situation. In one case, prompt intervention prevented a potentially life-threatening case of self-harm. In another case, intervention to prevent less serious self-harm was too slow and the detainee was held in a prone position for too long, which could have been dangerous.

2.54 We had some concerns about two cases involving Mitie Care and Control escort staff. We reviewed video footage in one of these cases in which escort staff had taken too long to gain control of a detainee, and only did so with the assistance of centre staff. Documentation for a second case also showed centre staff having to intervene to help escort staff to safely control a detainee. The Home Office professional standards unit investigated a complaint about this incident. The investigation was thorough and found that it had been handled reasonably well and that the force used was not excessive.

2.55 There were some weaknesses in the oversight of the use of force. Managers did not review all video footage, and there was no evidence that recommendations from reviews were acted on.

2.56 Separation was used infrequently, with only seven detainees being removed from association under rule 40 in the previous 12 months. No detainee had been held under rule 42 (for violent or refractory behaviour) during this period.

2.57 On average, detainees were held for almost 21 hours and the longest period had been for 47 hours. The new control and separation unit (CSU) was a much better facility than the previous provision and detainees there received a reasonable regime. Detainees were no longer held in separated conditions for excessive periods when there were delays in their transfer arrangements.

2.58 In the majority of cases, rule 40 paperwork was clear and detailed, and documented justifiable reasons for removing a detainee from association. Paperwork suggested staff in the CSU made good attempts to interact with detainees in their care, particularly those who were vulnerable. However, in one case, a detainee was left in his underpants and without a mattress for several hours in circumstances that were not clearly documented and without effective management oversight. Home Office staff had not been informed of this incident.

Recommendations

2.59 **All use of force incidents should be subject to a recorded review process and leaders should ensure that all recommendations are acted on.**

2.60 **All decisions concerning the separation of detainees should be clearly documented. Detainees should not be denied their clothing or bedding without express written authority from a senior member of staff and the Home Office compliance team.**

Legal rights

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

2.61 Access to independent legal advice was good. All the detainees who responded to our survey reported that it was easy for them to contact their legal representative.

2.62 The centre maintained a list of local legal representatives. The list was revised every month so that it remained up to date. Detainees could meet their legal representatives in private rooms in the visiting area. During the pandemic, the centre had introduced the use of Skype for legal visits, which had proven popular among detainees.

2.63 Detainees were provided with a telephone number and email address for the Home Office detention engagement team in the centre and could contact them at any time. They could also ask an officer to make a request for them to speak to a member of the team. Although the Home Office team had experienced staffing shortages, they continued to meet detainees in person to discuss their immigration cases during most of the pandemic.

2.64 In the sample of casework we examined, we saw immigration staff regularly reviewing detention in line with national policy, and evidence that detainees were informed of these reviews.

2.65 In our casework sample, several detainees were held for lengthy periods, despite there being significant barriers to their removal, or a case progression panel recommending release. In one case, a man had been held for almost a year, even though he had no emergency travel document, and flights to his home country were severely restricted due to the COVID-19 pandemic. (See key concern and recommendation 1.38.)

2.66 We also found cases where detainees who had been granted bail were held for lengthy periods because of a lack of suitable bail accommodation. The situation was especially challenging when detainees were former prisoners with licence conditions, which affected where they could live. We saw one case where a female detainee had been detained for an additional seven weeks after being granted bail owing to difficulties in securing appropriate accommodation.

2.67 A good range of legal resources was available in the centre library, including textbooks, country information reports and copies of the detention centre rules. Detainees could also use the internet to conduct research for their immigration cases, and print out, fax, or email related documents.

2.68 Detainees could apply for bail, and application forms were available in several areas of the centre. Detainees could appear at bail hearings via video link. The video link facility was in a private room and had been used 42 times in the three months leading up to our inspection.

2.69 Detainees were provided with information about upcoming transfers or removals in line with national policy, and electronic records showed that they were often given several days' notice of a move, unless staff felt detainees could be at risk of self-harm or pose a risk of refractory behaviour on receiving the news. In these cases, the adverse news process was employed (see paragraph 3.50). Detainees were informed about their release as soon as possible after the centre received a bail decision.

Section 3 Respect

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

Staff-detainee relationships

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

3.1 Leaders continued to promote a culture that focused on detainee care. Detainees in our survey and all those we spoke to, said staff treated them with respect. None had any complaints, and some told us how good some officers were. We saw friendly, professional and approachable staff who were focused on detainee welfare.

3.2 During our inspection and in the staff survey, some staff expressed concerns about staffing shortages, their own levels of stress, poor morale and, in some cases, poor managerial support. However, this negativity was not reflected in their interactions with detainees.

3.3 There were relatively few staff in residential units. Although we saw some staff remaining in their offices, there were a number who were interacting with detainees, supporting them and helping to resolve their concerns. In our survey, nearly all detainees said there was a member of staff they could turn to if they had a problem.

3.4 There was no personal officer scheme, but staff had to make daily history sheet entries on the detainee management system (an electronic system used to store detainee information). The entries we viewed were generally informative and adequately detailed. Regular quality assurance checks were also conducted.

Daily life

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

Living conditions

3.5 There were three main residential areas. All new arrivals completed their period of isolation at Hamilton House and some areas of the main

house (see paragraph 2.8). The low population and COVID-19 precautions meant that most detainees were in single occupancy rooms.

3.6 Communal areas were generally tidy and clean, and the standard of accommodation had improved considerably since 2018. All areas had been decorated and were suitably furnished, clean and in a good state of repair. All detainees were being paid a nominal amount to ensure they kept their areas clean. We saw no evidence of graffiti or significant damage to centre property.

3.7 Showers had been refurbished and most were now in good condition, with no evidence of damp or mould. All detainees we spoke to, and all survey respondents reported being able to have a shower every day.

3.8 Association areas were adequate. Recreational equipment, including some limited gym equipment, was available and there were basic cooking facilities in all areas, including at least one refrigerator, microwave oven, toaster, and tea and coffee making facilities. Detainees had equal access to the facilities and maintained them well.

3.9 Detainees had good access to clean clothing, cleaning materials and toiletries. Clean sheets were available on request and each unit had its own laundry, which detainees could use freely. The reception had a small stock of clothing that detainees could have if they were in need. Detainees could get cleaning materials every week and had enough suitable clean clothes for the week. They could ask staff for basic toiletries, which were free of charge.

3.10 Residential managers made sure sanitary products and other items, such as make up, were readily available for women detainees and replenished as needed.

3.11 Property was stored securely in reception when detainees arrived. They could ask an officer if they wanted access to it and most told us they could normally gain access to their property if they needed to.

3.12 Outside areas were well maintained and chairs and benches were available so detainees could sit together.

Detainee consultation, applications and redress

3.13 Regular weekly consultation with detainees had continued throughout the pandemic, although few issues were raised, and detainees' attendance was often limited to one to three individuals only. Meeting minutes indicated that questions or action were dealt with promptly. Minutes were displayed across the centre for other detainees to view.

3.14 Five general complaints had been submitted in the previous 12 months, four from the same detainee. No particular trends were identified in the type of complaint submitted (see also paragraph 3.48). Most detainees said they knew how to make a complaint.

3.15 Complaint forms in a variety of languages were freely available throughout the centre. Boxes were prominently located throughout residential units and emptied every day by staff from the Home Office compliance team.

3.16 Complaint responses were polite, indicated that there had been sufficient inquiry and addressed the issues raised. Staff were given a long time to respond to complaints – 28 days. While they were always returned within these timescales, replies could still have been timelier. Each response sent to a detainee also contained a leaflet about the work of the Prisons and Probation Ombudsman in case detainees wanted to pursue their complaints further.

Residential services

3.17 The food was adequate and plentiful, and it was served at appropriate times. A four-week menu cycle was operating, and specialist diets could be catered for, in conjunction with the health care department. In our survey, most detainees said the food provided was good or very good.

3.18 All mealtimes contained a hot option and, except for those in isolation, all detainees could collect their meals and eat in the central dining room, although many chose to eat in their rooms or communal areas.

3.19 Detainees in isolation could select a meal option, which staff delivered to their units. These arrangements appeared to work well and detainees we spoke to generally said meals were warm and portions ample.

3.20 The kitchen was clean and in good working order. Unlike at the previous inspection, there were no paid roles for detainees in the kitchen (see key concern and recommendation 1.40 and paragraphs 4.10 and 4.11).

3.21 The cultural kitchen (where detainees could prepare and cook meals independently for themselves and friends) had been refurbished since 2018 and remained available for detainees five days a week. COVID-19 arrangements meant that only two detainees could cook at any one time and only two more could be invited to participate in the meal (see paragraph 4.3).

3.22 The shop continued to provide a good service. In our survey, most respondents said the shop sold a wide enough range of goods to meet their needs. However, access was by appointment only to keep to social distancing measures. Detainees in isolation could place an order, which staff delivered to their rooms.

3.23 The charity-based shop, available at the previous inspection, where detainees could purchase clothing among other things, was no longer operating.

Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality and diversity, underpinned by processes to identify and address any inequality or discrimination. The distinct needs of detainees with protected and any other minority characteristics (see Appendix II Glossary of terms) are recognised and addressed. Detainees are able to practise their religion. The multi-faith team plays a full part in centre life and contributes to detainees' overall care and support.

Strategic management

3.24 There were still weaknesses in the oversight of equality work, although there was little evidence of any discrimination. There was now a monthly equality, diversity and inclusion (EDI) meeting, but attendance was poor. The small number of detainees and low levels of self-harm, violence, use of force and segregation meant that any analysis of equality data would not have been useful. No action was implemented as a result of any of the previous six EDI meetings, and there was no action plan.

3.25 The religious affairs manager led the centre's equality work and acted as the race equality liaison officer. There were also liaison officers for those with a disability, LGBT detainees, as well as for older and younger detainees, but not for women. In practice, the roles appeared quite limited, and most liaison officers did not attend EDI meetings.

3.26 The equality policy only referred to complaints of discrimination involving race, but not other protected characteristics (see recommendation 3.35). There had been only one complaint in the previous year relating to protected characteristics. The complaint was about tension between different nationality groups and was handled reasonably well.

3.27 Useful consultation meetings had been held with different nationality groups, but not with detainees from other protected groups.

Protected characteristics (see Appendix II Glossary of terms)

3.28 Reception staff did not systematically identify all new detainees who had a protected characteristic, although detainees were asked if they had a disability during their health care screening.

3.29 Incidents or tension between residents of different nationality groups were rare (see paragraph 3.26). No significant concerns had been raised in consultation meetings with detainees in different nationality groups in the previous six months.

3.30 Health care staff made good use of professional telephone interpretation. It was used less often in other parts of the centre, but we saw few examples where interpretation was not used when it was

needed. Staff also had access to hand-held interpretation devices and used them to communicate day to day.

3.31 The centre had no record of holding any detainee with a physical disability in the previous six months. There had been notable instances of detainees struggling with their mental health. They received good support from health care and other staff (see paragraphs 2.19, 2.25 and 3.50.) There was very well-equipped room for detainees with mobility disabilities, including an adjustable medical bed, and an appropriately equipped wet room (see paragraph 1.46).

Room for detainees with mobility disabilities, with adjustable medical bed

3.32 Twenty-one women had been held in the six months before the inspection, and 44% of frontline operational staff were women. The equality policy was underdeveloped and there was no female detainee liaison officer. The safer detention policy was better developed than at the previous inspection, although we were concerned that women were held in the centre at the same time as men with a history of violence against women (see key concern and recommendation 1.39 and paragraph 2.40).

3.33 Detainees aged 50 and over and under 21 were interviewed on arrival to identify their needs and determine if a care plan was required beyond their isolation period. Two detainees over 50 and four under 21 had been held in the previous six months. None were considered to require a support plan.

3.34 The centre was not aware of having held any LGBT detainees in the previous year, and no calls had been made to its confidential LGBT helpline for such detainees.

Recommendation

3.35 **Centre staff should systematically identify all detainees with a protected characteristic when they arrive in the centre and make sure their individual needs are assessed and met.**

Faith and religion

3.36 The religious and cultural affairs manager managed a small team of volunteer visiting chaplains. Until recently, COVID-19 restrictions had prevented volunteer chaplains from attending the centre. Staff continued to interview all new arrivals to identify any faith needs. Pastoral support had been arranged through Skype and telephone calls.

3.37 From the end of June 2021, Muslim and Christian chaplains visited the centre every week to hold Friday prayers and Christian services. Other chaplains attended when detainees requested a visit. As at the previous inspection, there was still no scheduled chaplaincy presence on three days of the week, although contact through Skype was still available.

3.38 The chapel was attractive and welcoming, but the multi-faith room was cramped and in need of redecoration. The continued closure of houseblock prayer rooms was no longer justified; managers assured us that they would be opened immediately after the inspection.

3.39 The cultural affairs manager was visible and accessible to detainees. If a detainee wished to see a chaplain of their faith in an emergency, the cultural affairs manager arranged it. In the event of a delay, the detainee was offered an immediate telephone or Skype consultation.

Health services

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

Governance arrangements

3.40 Med-Co Secure Healthcare Services Ltd (Med-Co), which had provided health care services since 2014, retained the health contract following a retendering process, with the new contract due to start in September 2021.

3.41 The contract was monitored through monthly data reports that were submitted to the centre, NHS Lanarkshire Health Board and to Med-Co. Contract review meetings and the partnership board had not taken

place during the pandemic but having to manage COVID-19 had strengthened working relationships between the partners.

3.42 There had been a cluster of positive COVID-19 staff cases in October 2020 and effective contingencies were put in place to contain it, including mass testing and robust contact tracing and isolation. Only one detainee had tested positive for COVID-19 since the beginning of the pandemic.

3.43 The health service at Dungavel had been registered with Healthcare Improvement Scotland in November 2019 and a recent inspection identified no major concerns.

3.44 NHS Lanarkshire ran a monthly outreach COVID-19 vaccination clinic and uptake was reasonable. The two visiting nurses used telephone interpretation services via a tablet to communicate with detainees about the vaccination.

3.45 The service provided 24-hour cover through a night-duty nurse and suitable clinical on-call arrangements. An experienced clinical manager led the service well and we observed conscientious and caring staff, who knew their patients, delivering a good standard of care. Staff had a good skills mix, were up to date with their mandatory training, and professional development was encouraged. The team had regular group clinical supervision sessions and team meetings, where any lessons learnt and service improvements were discussed. All health staff said they felt supported and received an annual appraisal. Managerial supervision was completed informally and was not recorded to demonstrate the ongoing support and development that staff required.

3.46 Patient satisfaction surveys informed service delivery and were mostly positive. The head of health care attended the monthly resident consultation committee to provide updates and answer any queries.

3.47 There had been very few adverse incidents or near misses during the previous year and they were reported through the Med-Co clinical incident reporting system and investigated by the head of health care.

3.48 Health complaints continued to be made through the centre's system, which compromised confidentiality. There had been five complaints about health care during the previous year. Responses were timely and respectful – they addressed the issues raised and told patients how to escalate their complaint if they were unhappy with the response.

3.49 An electronic medical record had been introduced in November 2020 but was not functioning fully at the time of the inspection. Several aspects had not been set up, such as the care plan templates, and staff had not received sufficient technical support or training. The team continued to complete paper records and had good administrative systems to manage them, but it created additional work and potential risks. Data collection continued to be carried out manually to make sure they were accurate.

3.50 All health care staff communicated well with GEO and the Home Office to optimise care for vulnerable detainees; for example, they held multidisciplinary meetings to plan detainees' release or removal from the centre. The adverse news alert, a process for notifying health care staff in advance of any potentially distressing news being delivered to vulnerable detainees, enabled health care staff to be present to offer care and support (see paragraph 1.47).

3.51 Rule 35 assessments were undertaken promptly. GPs had received relevant training; the standard of the reports was good. (See paragraphs 2.16, 2.17 and 2.18.)

3.52 The health care centre was bright and clean, and regular infection control audits demonstrated compliance with required standards. Health promotion, including COVID-19 information, was displayed in the health centre and at the gym. Information was available in a variety of languages and could be sourced in different formats and languages, when required. Support to help detainees give up smoking, including nicotine replacement therapy, was available.

3.53 The health team had provided some good examples of creative health promotion activities, such as sports activities and quizzes. They also included Schizophrenia Awareness Day. The team had good links with the kitchen and the gym, but there was no centre-wide approach to health promotion. The team's activities followed NHS health promotion campaigns.

3.54 The use of professional telephone interpreting services during health clinics was embedded in practice – health staff used them much more often than staff in other areas of the centre.

3.55 All equipment was calibrated and checked annually. Emergency resuscitation equipment and medication were in good order and checked regularly. Health staff had completed mandatory adult basic life support training.

3.56 Arrangements for identifying and managing communicable diseases, including COVID-19 and tuberculosis, were robust. Detainees who were refusing food and fluids were managed well in liaison with centre staff.

3.57 Detainees could access disease prevention and screening programmes, treatment for bloodborne viruses, as well as travel vaccinations, if required before removal. Access to barrier protection was freely available in the health centre waiting area and on release.

Recommendations

3.58 **Health staff should have access to a fully functioning electronic medical record system and receive training on the technology to enhance the efficiency of the service.**

3.59 **Detainees should be able to complain about health services through a well-advertised separate confidential health complaints system.** (Repeated recommendation 2.63.)

Primary care and inpatient services

3.60 Detainees were offered COVID-19 lateral flow tests on arrival and then every week. A PCR test was offered on detainees' second day at the centre. All tests had good uptake. A qualified nurse carried out a health screening within two hours of a detainee's arrival and information on health services in a wide range of languages was available. Nurses liaised appropriately with detention custody staff when additional support might have been needed. Patients' consent for sharing information was routinely sought and recorded. Their previous health records were requested promptly. All detainees were isolated for 14 to 21 days (see paragraph 2.8.)

3.61 The GP offered all detainees a comprehensive secondary assessment within 24 hours of their arrival. The medical records of those who declined an appointment were reviewed by the doctor in their absence and follow-up care scheduled if needed. Three regular doctors delivered GP clinics seven days a week in line with Home Office requirements. This continued throughout the pandemic.

3.62 There was a suitable range of primary care services and waiting times for routine GP appointments were short. Detainees had daily access to nurses who provided a responsive and caring service.

3.63 Information on vulnerable patients was shared with the wider centre team, and health staff knew what level of vulnerability would precipitate a review of a detainee's fitness to be detained. There were examples of detainees or individuals being moved to a more appropriate setting.

3.64 Detainees with long-term conditions were assessed promptly and reviewed by GPs, supported by nurse-led clinics and external specialists, when necessary. One of the nurses was a non-medical prescriber and most of the team was due to undertake further scheduled training.

3.65 Administrative and clinical oversight of external hospital appointments was effective, and more appointments were now being offered. The centre provided sufficient escort staff to take detainees to their appointments.

3.66 Detainees who were being released, transferred or removed were given a summary of their medical records and at least a week's supply of all necessary medication, and staff made concerted efforts to liaise with community services.

Mental health

3.67 Mental health nurses, a part-time counsellor/art therapist and a visiting consultant psychiatrist provided good mental health support. Approximately 44 referrals had been received from January to June

2021 through an open referral system, in which anyone could refer themselves or someone else. A routine assessment was conducted within 48 hours, and detainees with urgent needs were assessed within 24 hours. Staff were actively involved in all assessment, care in detention and teamwork (ACDT) case management reviews for prisoners at risk of suicide or self-harm.

3.68 A range of treatments was available for detainees with mild to moderate mental health needs or more serious and enduring mental health conditions, although few detainees had serious conditions. Treatments included self-help guidance in different languages, which staff would go through if the detainee wished, distraction packs and counselling sessions to help develop coping strategies. The team had produced individual stress packs, which included items such as stress balls, a lavender bag and camomile tea, which had been well received.

3.69 The horticultural therapy group continued with smaller numbers and individual sessions. It provided detainees with the opportunity to participate in the therapeutic benefits of growing flowers and vegetables, which were then used in the cultural kitchen. Feedback from detainees was positive – they felt it helped their mental health and well-being. (See paragraph 1.48.)

Polytunnel used by horticultural therapy group

3.70 Most detention custody staff had received ACDT and mental health training in the previous three years. The head of health care planned to reintroduce a mental health awareness training package.

3.71 Three patients had been transferred promptly under the Mental Health (Care and Treatment) (Scotland) Act 2003 to a secure mental health facility during the previous year. The team had good links with NHS

Lanarkshire's mental health services, including with a consultant psychiatrist who attended the centre on an ad hoc basis depending on needs.

Substance misuse treatment

3.72 There was now a substance misuse policy, which focused on supply reduction and referred to health care. Intelligence reports and finds indicated there was little use of illicit substances. The health team confirmed that, on a few occasions, the use of psychoactive substances was alleged pre-COVID-19, but they had not been prevalent during the previous year.

3.73 Some of the staff, including the GP, had undertaken specialist training in substance misuse treatment. Demand for clinical substance misuse services remained low.

3.74 All new arrivals received an assessment of their substance misuse needs, and those requiring clinical treatment were seen promptly. Psychosocial interventions, including information about addiction and illicit drug use, were available in different languages. The team could provide alcohol detoxification, with day and overnight monitoring in place, but this did not happen frequently.

3.75 Since the previous inspection, the range of opiate substitution treatment (OST) options had increased, and prescribing was now in line with best practice. Prescribing for opiate dependence usually focused on reduction. However, it was flexible, and patients were involved in treatment decisions. Regular reviews and care plans were in place. During the inspection, only one detainee was receiving OST and was on a maintenance dose.

Medicines optimisation and pharmacy services

3.76 A local pharmacy delivered medicines at least every week, while additional urgent medicines were delivered when needed. A stock of common medicines was kept on site to ensure supply continuity. The pharmacist visited every month and scrutinised the prescribing, use and storage of medicines. Detainees were offered access to medicine use reviews and advice from the pharmacist. The service was advertised but had not been used.

3.77 Medicine storage was well-organised, stock reconciliation was good, as were date checking and monitoring of the refrigerator temperature.

3.78 The pharmacy room was neat and tidy. Nurses administered medicines competently, and in a friendly and professional manner, three times a day at clinically appropriate times. Arrangements were made for medicines required at any other time to be administered. The prescribing and administration records we looked at were complete and non-attendance was followed up.

3.79 A detention custody officer was present during all medicine administration, and we observed the area being effectively managed to preserve patient confidentiality and prevent any diversion of medication.

3.80 Nurses could administer a suitable range of prescriptions and over-the-counter medication without a doctor's prescription, which gave detainees prompt access to treatment.

3.81 Staff made use of a suitable range of up-to-date protocols and procedures and had access to the current British National Formulary (a reference book for prescribing, dispensing and administering medicines). A local drug formulary highlighted medications not to be given in possession. Most medicines were in possession, following a risk assessment completed by the GP.

3.82 The medicines and therapeutics committee had not met recently due to the pandemic, but the head of health care had continued to send regular reports to update members on pertinent issues, including action following drug alerts.

Oral health

3.83 Dental services were no longer delivered on site and had been provided by a local community dental practice since October 2017. The dentist provided two slots per week, which sufficient escort staff facilitated, an improvement since the previous inspection. The dentist sent treatment plans to the health team outlining what had been delivered and when telephone interpreting services had been used.

3.84 Dental waiting times had also improved since 2018 from six weeks to a week. There was no one on the waiting list during the inspection. Detainees had access to pain relief and antibiotics, and the dentist provided urgent care, including tooth extraction and temporary fillings, as well as check-ups. If more complex oral surgery was required, patients were referred to the local hospital.

3.85 Although not required since the beginning of the pandemic, the dentist would not have been able to provide any routine treatment for detainees requiring aerosol generating procedures because detention custody officers did not have access to FFP3 masks. The dentist was planning to discuss the matter with the head of health care and the centre manager.

Recommendation

3.86 **Detainees should have access to the full range of NHS-equivalent treatment that can reasonably be delivered.**

Section 4 Activities

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

The inspection of Dungavel immigration removal centre in Scotland is conducted jointly with Education Scotland.

Access to activities

4.1 Detainees could participate in a range of activities, which were scheduled at the information learning centre (ILC) during the day and in the evening, seven days a week. However, social distancing measures due to COVID-19 had a considerable impact on detainees' access to activities. Group recreational activities, such as team sports, musical events and competitions, had been replaced with individual activities to comply with health and safety requirements.

4.2 Although detainees could move freely around the centre to take part in activities, they no longer had immediate drop-in access to the ILC or gym. While detainees could book an appointment easily, staff confirmed that this requirement, while necessary to promote COVID safety, had affected the number participating in activities.

4.3 Restrictions were starting to ease, and some valued activities were being made available to groups of detainees. The cultural kitchen, for example, allowed them to plan, cook and eat a meal together. Since the previous inspection, it had undergone a full refurbishment and provided detainees with a welcoming space, where they could socialise and relax together.

Education and work

4.4 Since the previous inspection, the ILC had been relocated to another part of the building. The new facility included a library with a computer suite, an arts and crafts room and a small classroom.

4.5 Detainees had access to a limited range of classes and activities. They were English for speakers of other languages (ESOL), information technology (IT) and art. None of the activities were externally certificated, because of the short period of time many detainees attended.

4.6 Staff produced an engaging weekly challenge booklet for detainees, containing facts, puzzles, competitions and other activities. The

booklets, which detainees appreciated, had changing themes, often reflecting current events such as Ramadan or the Olympics.

4.7 Learning activities were promoted during the induction process, through posters and informally through staff and detainees. However, attendance was low. In the calendar month before the inspection, only six detainees had attended an ESOL class and four attended an art class.

4.8 During their induction, all new detainees had their level of written English determined through a basic ESOL assessment tool. ESOL support was available at a range of levels to match the needs of detainees. Often the support was tailored to meet a particular requirement, such as producing a CV.

4.9 Tutors had relevant qualifications and experience and worked well together to support their learners. They routinely discussed plans and approaches to encourage detainees to participate more fully in activities. However, these informal arrangements were not sufficiently systematic – information was not recorded, which meant the arrangements were not subject to the quality improvement planning process.

4.10 There were insufficient paid work opportunities for detainees. During the inspection, only three paid work opportunities were available – in horticulture, ground maintenance and waste maintenance. Payment for this work was a standard rate of £1 per hour and detainees worked for a maximum of 15 hours per week.

4.11 Most work had been suspended owing to social distancing and isolation arrangements. However, the rationale for suspending cleaning roles for detainees across the establishment was unclear. (See key concern and recommendation 1.40.)

4.12 The centre had introduced appropriate arrangements to ensure detainees were not financially disadvantaged by being unable to work.

Library provision

4.13 The library was bright and welcoming, and detainees could borrow and use a range of reading, audio-visual, and online material. It was open every day, from 9am to 9pm and was popular with many detainees.

4.14 Detainees used the booking system to reserve a place in the library, as social distancing measures limited the number attending at any one time to six. About 10 detainees routinely used the library every day.

4.15 The library was stocked with a narrow range of fiction and non-fiction English language books and a more limited range of books in 36 other languages. Legal textbooks and dictionaries in a variety of languages were available for detainees to use in the library. Several English language newspapers and a Polish daily newspaper were also available. The library had a few electronic reading devices, which detainees could borrow.

4.16 A suite of internet-enabled computers was available in the library for detainees to use for email, browsing and research. They also used them regularly to read online newspapers in their own language. Detainees could make use of a fax machine to send material to legal representatives and the Home Office.

4.17 The library had built up a large stock of DVDs in a wide range of languages that detainees could borrow to watch in their rooms. In addition, game consoles and games were also available to borrow. Additional DVDs, game consoles and games had been purchased so those in isolation had a better selection.

Recommendation

4.18 **Leaders should work with the local authority library service to improve the range of stock and the provision for detainees.**

Fitness provision

4.19 Detainees could use fitness facilities every day, including in the evenings. The gym was open daily, between 9am and 9pm and contained a well-equipped weights room, a cardiovascular room, a games hall and an all-weather pitch. Detainees who were self-isolating could use a small gym in Hamilton House.

4.20 Detainee could reserve a gym session through a booking system, but only four or five routinely used the facilities every day. The gym had suitable showers for detainees to use after exercising, but most preferred to return to their residential areas to shower.

4.21 New detainees completed an induction with a gym instructor on their first visit, who made sure they knew how to use the equipment safely. Any user with a declared health issue was referred to the health centre for advice from a doctor before they could access the facilities.

4.22 Most equipment was in good condition and was maintained regularly. However, the all-weather pitch was not in use because of poor maintenance, which meant detainees could not play outdoor sports, such as football or cricket.

4.23 Gym staff were suitably qualified. The range of fitness activities available had been severely restricted because of COVID-19 and no team sports were currently on offer. Staff had been unable to organise recreational fun events and competitions, limiting the range of activities available.

Recommendation

4.24 **Leaders should repair the all-weather pitch to allow detainees access to outdoor sports facilities.**

Section 5 Preparation for removal and release

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

Welfare

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

5.1 Detainees' welfare needs were assessed shortly after their arrival. Officers used a comprehensive questionnaire, covering a range of issues, and any unmet needs were addressed at that point.

5.2 A welfare officer was on duty every day in the centre and was responsible for checking and managing welfare requests. While the 'hub' welfare office had recently been refurbished and provided a comfortable environment, there was no drop-in welfare service during the inspection because of the COVID-19 pandemic. However, given the small number of detainees held in the centre, a one-to-one approach to welfare currently met detainees' needs. Operational staff told us that staff shortages had meant that the welfare officer had often been redeployed during the pandemic, or that the role had been allocated to less experienced staff. This had caused some challenges, but we found no evidence that it had affected the quality of the provision.

5.3 There was no comprehensive record of the number of welfare requests submitted at the centre, as not all requests were recorded on the centre's system. However, the requests that we were able to view mostly related to detainees' property, to which staff responded promptly. We saw evidence of staff showing initiative and dedication in resolving some more complex welfare requests, such as in the case of a detainee whose property had been recovered in the lost property of a public transport service in an English city. Staff liaised with the Home Office and with the transport company to arrange for the man's property to be delivered to the centre.

5.4 The Scottish Detainee Visitors charity provided a valuable welfare service, including emotional support and befriending visits. The organisation's staff also directed detainees to agencies providing assistance with their immigration cases and to external support services, as well as providing small amounts of financial support. Staff had operated a drop-in service over Skype during much of the pandemic but had resumed their in-person drop-in services in June 2021.

Recommendation

5.5 **Centre staff should make sure all welfare requests are properly recorded.**

Visits and family contact

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

5.6 Face-to-face social visits had resumed in May, but only for detainees who had completed their period of initial isolation. Sessions could be booked for up to three hours, seven days a week, and extended, depending on available capacity.

5.7 Detainees in isolation could have a one-hour Skype call with their families and friends that took place in private in a side room in the main visits room. The facility was also available for all detainees as an alternative to face-to-face visits. Similar Skype arrangements were in place for legal consultations.

5.8 The visits room was well designed, welcoming and in good condition. It had natural lighting and soft seating (see paragraph 1.49). Families could buy refreshments from suitably stocked vending machines and some games and activities were available for children. Visitors could no longer order hot meals from the kitchens to eat with detainees as at the previous inspection. Centre managers told us they were keen to reintroduce this facility once pandemic arrangements allowed.

The visits room was welcoming and in good condition.

5.9 Scottish Detainee Visitors staff continued to provide a valuable support service. (See paragraph 5.4.)

5.10 There was no longer a free bus service for visitors, but the centre continued to pay travel expenses for detainees' visitors to and from a local train station. (See paragraph 1.50.)

Communications

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

5.11 Detainees were not allowed to keep their own mobile phones on arrival at the centre, but they were all issued with a phone from the centre instead. They could keep their own SIM cards if they wished, or alternatively the centre could supply one. All detainees received phone credit of £10 every week throughout the pandemic.

5.12 Detainees could send one free personal letter a week. There was a fax facility in the IT suite from which detainees could send and receive faxes if they related to their legal cases. Quality assurance processes were in place, which meant staff made sure incoming faxes were delivered to detainees promptly. Incoming and outgoing mail was not delayed, despite letters being scanned (see paragraph 2.48).

5.13 Six computers were available for detainees to use for 10 hours a day in the library. Current capacity meant detainees could use these facilities if they wanted to as long as no others were waiting.

5.14 The computers provided detainees with reasonable access to the internet and email, and they could also open PDF and Word documents, and arrange for staff to print out documents if they related to their legal cases. A wide range of important legal websites and foreign language news sites could be accessed. Social networking sites, which could have enhanced contact with family and friends, continued to be routinely blocked.

Recommendation

5.15 **Detainees should only be prevented from accessing social networking sites based on an individual risk assessment.**

Leaving the centre

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

5.16 In the 12 months before the inspection, 386 detainees had left the centre – 163 of them had been transferred to another immigration

removal centre and 60 had been removed from the UK. A total of 159 (41%) had been granted bail.

5.17 Detainees who were being discharged from the centre were held in a comfortable holding room in the reception area, with access to toilet facilities and refreshments.

5.18 A welfare officer saw all detainees before their departure and used a questionnaire to identify any unmet needs.

5.19 Detainees who were bailed were given £20, or cash which brought the total in their account to £20, ahead of their release. During the pandemic, they had also received 'bail packs' containing personal protective equipment and food. Detainees who were released were provided with transport to their destination. Those who were being removed received clothing that was appropriate for the climate in the country they were being removed to, if necessary.

5.20 Detainees were informed in good time that they would be leaving the centre, except where staff considered this to be a risk, when an adverse news alert process was used (see paragraph 3.50). In cases where a detainee might have been at risk or where their behaviour might have been refractory during a removal or transfer, multidisciplinary meetings to identify risks and plan a safe exit from the centre took place. Notes from the meetings we saw showed that staff considered detainees' vulnerabilities and potential triggers, as well as the potential risks they posed.

5.21 Home Office records showed evidence of positive interactions with probation services and offender managers in the cases of foreign national offenders. For example, they clarified licence conditions and the suitability of release addresses.

Section 6 Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

6.1 Key concern (1.38): Many detainees had been held for lengthy periods with little prospect of being removed within a reasonable time. One man had been held for almost a year, although he had no travel documents and flights to his home country were very restricted. Some long-held detainees had been assessed as level 3 adults at risk (the highest risk level), which meant that the Home Office accepted that ongoing detention was having a negative impact on their health and well-being. Others were held despite the Home Office accepting that they were victims of torture.

Recommendation: The Home Office should ensure that detention is not unnecessarily prolonged when there is little prospect of removal within a reasonable timeframe, especially for vulnerable detainees whose health and well-being is detrimentally affected by ongoing detention. (To the Home Office.)

6.2 Key concern (1.39): The centre held several men with a history of sexual violence against women. Before the pandemic, these men were held in a separate unit with controlled access to common parts of the centre. As a result of infection control arrangements, this was no longer considered practicable. This meant that for most of the previous six months, women had to be escorted when they moved around the site.

Recommendation: Detainees who pose a risk to women should not be held in the centre when women are held. (To the Home Office.)

6.3 Key concern (1.40): Most employment had ceased during the pandemic, but the rationale for removing cleaning roles was unclear and there was not enough focus on creating new roles to help support detainees' mental and physical well-being.

Recommendation: Leaders should substantially increase the range of paid work opportunities for detainees to help support their mental and physical well-being. (To the centre manager.)

Recommendations

6.4 Recommendation (2.12): Detainees should not be escorted during the night unless this is required for urgent operational reasons. (Repeated recommendation 1.11.) (To the Home Office and escort contractor.)

6.5 Recommendation (2.22): The Home Office should maintain an up-to-date record of NRM referrals made at the centre. (To the Home Office.)

6.6 Recommendation (2.31): Home Office detention engagement staff should attend all case reviews where detention or the prospect of removal are factors in a detainee's risk of self-harm. (To the Home Office.)

6.7 Recommendation (2.50): Room and detainee searches should only be carried out where intelligence or risks suggest they are necessary. (To the centre manager and the Home Office.)

6.8 Recommendation (2.59): All use of force incidents should be subject to a recorded review process and leaders should ensure that all recommendations are acted on. (To the centre manager.)

6.9 Recommendation (2.60): All decisions concerning the separation of detainees should be clearly documented. Detainees should not be denied their clothing or bedding without express written authority from a senior member of staff and the Home Office compliance team. (To the centre manager.)

6.10 Recommendation (3.35): Centre staff should systematically identify all detainees with a protected characteristic when they arrive in the centre and make sure their individual needs are assessed and met. (To the centre manager.)

6.11 Recommendation (3.58): Health staff should have access to a fully functioning electronic medical record system and receive training on the technology to enhance the efficiency of the service. (To the centre manager.)

6.12 Recommendation (3.59): Detainees should be able to complain about health services through a well-advertised separate confidential health complaints system. (Repeated recommendation 2.63.) (To the centre manager.)

6.13 Recommendation (3.86): Detainees should have access to the full range of NHS-equivalent treatment that can reasonably be delivered. (To the centre manager.)

6.14 Recommendation (4.18): Leaders should work with the local authority library service to improve the range of stock and the provision for detainees. (To the centre manager.)

6.15 Recommendation (4.24): Leaders should repair the all-weather pitch to allow detainees access to outdoor sports facilities. (To the centre manager.)

6.16 Recommendation (5.5): Centre staff should make sure all welfare requests are properly recorded. (To the centre manager.)

6.17 Recommendation (5.15): Detainees should only be prevented from accessing social networking sites based on an individual risk assessment. (To the Home Office.)

Section 7 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy establishment. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Safety

Detainees are held in safety and with due regard to the insecurity of their position.

At the last inspection, 2018, many detainees were still transferred to the centre overnight. Early days processes were reasonable but interpreting was underused. There was very little violence and detainees usually felt physically safe. Rule 35 reports were good and more than we usually see led to release. Self-harm was low and support was good. Staff were reasonably confident about raising concerns and there was a positive culture of care. Security was proportionate and freedom of movement was reasonable given the open nature of the centre. There was little use of force. Fewer detainees were placed in the separation unit than at the last inspection but some spent too long there awaiting transfer. Access to legal support was very good and fewer detainees were held for long periods. The on-site immigration team was understaffed and face-to-face support for detainees had reduced. Outcomes for detainees were good against this healthy establishment test.

Key recommendation

The risks associated with holding women and men should be routinely assessed and discussed at security meetings, and a specific safer custody and safeguarding policy should be developed for women. (S37)
Not achieved

Recommendations

Detainees should not be escorted during the night unless this is required for urgent operational reasons. (1.11)
Not achieved (recommendation repeated, 2.12)

The reception environment and procedures should be fit for purpose, ensuring that detainees' immediate vulnerabilities, needs and risks are assessed during a private interview with professional interpretation where required. (1.12)
Achieved

The Home Office should maintain a comprehensive and accurate record of adults at risk of harm. The record should be regularly updated and shared with the centre contractors and health care department. (1.19)
Achieved

There should be a joint local safeguarding policy on the care of adults at risk of harm. The policy should include all providers working in the centre and explain how risk information is shared with Home Office caseworkers. (1.20)
Achieved

A multidisciplinary committee, including health care staff, should meet frequently to consider the risks to and needs of adults at risk of harm. (1.21)
Achieved

Assessment, care in detention and teamwork (ACDT) documents should be completed in full and care plans should be tailored to the individual. Case reviews should include contribution or attendance by Home Office immigration enforcement staff. (1.30)
Partially achieved

The safer custody meeting should review all cases involving self-harm, violence or bullying, and discuss quality checks of safer custody documentation to learn lessons. (1.31)
Not achieved

There should be an up-to-date safeguarding children policy and all staff should have up-to-date safeguarding children training. (1.36)
Achieved

Allegations of bullying and violent incidents should be fully investigated, and actions should be followed up thoroughly. (1.43)
Not achieved

Detainees should not be subject to routine rub-down and room searches. (1.52)
Not achieved

Detainees should only be placed on closed visits on the basis of specific risks or intelligence. Their cases should be reviewed regularly, and the restriction should be removed when no longer supported by the evidence. (1.53)
Achieved

A centre-wide policy to manage substance misuse, including supply reduction action planning, should be developed. (1.54)
Achieved

All use of force incidents should be subject to a full recorded review process with lessons learned and disseminated to staff. (1.61)
Not achieved

Use of force data should be analysed thoroughly to ensure that trends are identified, and appropriate action taken. (1.62)
Achieved

Detainees should not be held in separated conditions for excessive periods because of delays in transfer arrangements. (1.63)
Achieved

Case workers should act with diligence and expedition. Deportation procedures for ex-prisoners should be concluded before the end of their custodial sentences. (1.71)
Not achieved

Respect

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

At the last inspection, in 2018, many residential areas had become run down and shabby, requiring significant refurbishment and redecoration. Staff-detainee relationships remained an exceptional strength. There was little evidence of discrimination, but equality and diversity structures were underdeveloped, and not enough attention had been given to the needs of women. Faith provision was adequate. Complaint responses were reasonable but some took too long to resolve. The food was reasonable and the cultural kitchen was a valued though underused resource. Health care provision was generally good. Outcomes for detainees were reasonably good against this healthy establishment test.

Key recommendations

Accommodation, including detainees' rooms, showers and shared areas, should be refurbished and maintained to a reasonable standard of decoration, furnishing and cleanliness. (S38)
Achieved

Recommendations

Detainee consultation should involve a wide cross-section of the population and individual updates should be provided for all generated actions. (2.20)
Not achieved

Responses to complaints should be timely. (2.21)
Not achieved

The cultural kitchen should be deep-cleaned and monitored regularly by the centre to ensure that acceptable standards of hygiene are maintained. (2.27)
Achieved

The cultural kitchen should have longer opening times and be effectively promoted, especially to women detainees. The reasons for the latter not using the facility should be investigated and action taken to encourage participation. (2.28)
Achieved

Equality policies, planning, monitoring, consultation and systems of redress should cover all protected groups. (2.32)
Not achieved

Professional telephone interpreting should be used for all interviews requiring accurate or confidential communication. (2.42)
Not achieved

Health staff should have access to an electronic medical record system to enable better use of data and technology and to enhance the quality and efficiency of the service. (2.62)
Partially achieved

Detainees should be able to complain about health services through a well-advertised separate confidential health complaints system. (2.63)
Not achieved

Nurses should have access to additional specialist training to support the delivery of best practice standards for the management of long-term conditions with evidence-based care plans. (2.70)
Partially achieved

Detainees on opiate substitution treatment should receive prescribing informed by a local policy, based on current best practice, a comprehensive specialist assessment, and regular documented reviews and documented harm reduction. (2.82)
Achieved

Detainees should have timely access to dental services based on clinical need and to the full range of NHS equivalent treatment that can reasonably be delivered. This should not be delayed by a lack of escort staff. (2.92)
Achieved

Activities

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

At the last inspection, in 2018, detainees had good access to a range of activities and recreational facilities. The information and learning centre (ILC) was popular and well-used. Delivery of education was good. All detainees could work and earn money, and there was a good range of jobs. There were no waiting lists. The library provided a good service. The gym and sports events were popular but gym equipment was worn and too many sessions had been cancelled because of staff shortages. Outcomes for detainees were good against this healthy establishment test.

Recommendations

Gymnasium staffing levels should ensure that detainees can access scheduled exercise activities throughout the week. (3.19)
Achieved

Broken exercise equipment should be repaired and maintained in good working order. (3.20)
Achieved

Preparation for removal and release

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

At the last inspection, in 2018, welfare support was good. Visits provision was good and the visiting group provided useful support. Detainees had good access to phones and faxes but could yet make video calls. Detainees could easily use the internet, but download speeds were slow. Needs were assessed before discharge. [insert HPS from last report]. Outcomes for detainees were good against this healthy establishment test.

Recommendations

The centre should identify and monitor detainees with friends and family living far from the centre, and take steps to address their potential sense of isolation. (4.12)
Achieved

Subject to a risk assessment, detainees should have access to video-calling and social networks. (4.19)
Partially achieved

Detainees should be informed of their transfer to another centre as soon as is reasonably practicable. (4.26)
Achieved

Appendix I About our inspections and reports

Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review Suicide is everyone's concern, published in 1999. For immigration removal centres the tests are:

Safety
Detainees are held in safety and with due regard to the insecurity of their position.

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

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

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

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

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

Outcomes for detainees are reasonably good.
There is evidence of adverse outcomes for detainees in only a

small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

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

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

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

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

Our assessments might result in one of the following:

Key concerns and recommendations: identify the issues of most importance to improving outcomes for detainees and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

Recommendations: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

Examples of notable positive practice: innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Five key sources of evidence are used by inspectors: observation; detainee and staff surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

We also offered every detainee a confidential interview with an inspector, using an interpreter where necessary. As only three detainees took up this offer, we have not produced a separate summary of findings from these interviews as in previous reports. We issued an invitation to recent ex-detainees to speak to us through various support groups, but none took up this offer. The interviews with detainees were semi-structured and took place from 19–21 July 2021.

Forty-one centre staff responded to our invitation to complete an electronic staff survey. All responses were anonymous. The staff survey responses are published alongside this report (see Appendix III Further resources). Comments made by staff have been reported on in the body of the report where relevant.

The main objective of this methodology is to give detainees and staff an opportunity to tell inspectors confidentially about concerns over safety and the treatment of detainees. We follow up serious allegations whenever there is sufficient information to do so, and report on relevant outcomes in the main body of the report. The results of these further interviews and survey are used as sources of evidence to inform the rounded judgements made by inspectors in the body of this report.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection. All inspections of immigration removal centres are conducted jointly with Ofsted or Education Scotland, the Care Quality Commission and the General Pharmaceutical Council (GPhC). This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report provides a summary of our inspection findings against the four healthy establishment tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees* (Version 4, 2018) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/immigration-detention-expectations/). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 6 lists all recommendations made in the report. Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of detainees and a detailed description of the survey methodology can be found on our website (see Appendix III Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant.

The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Hindpal Singh Bhui	Team leader
Deri Hughes-Roberts	Inspector
Rebecca Mavin	Inspector
Kam Sarai	Inspector
Amilcar Jones	Researcher
Shannon Sahni	Researcher
Maureen Jamieson	Lead health and social care inspector
John Bowditch	Education Scotland inspector
Kerry Love (Observer)	HMI Prisons Scotland

Appendix II Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

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

National Referral Mechanism
The National Referral Mechanism was put in place in the UK in April 2009 to identify, protect and support victims of trafficking.

Personal protective equipment (PPE)
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

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

Protection of adults at risk
Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Reverse cohort unit
Unit where newly arrived detainees are held in quarantine for between seven and 10 days.

Rule 35
Rule 35 of the detention centre rules requires a medical practitioner to report to the Home Office on the case of any detainee whose health is likely to be injuriously affected by continued detention, who may have suicidal intentions, or who may have been the victim of torture.

Appendix III Further resources

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

Detainee population profile

We request a population profile from each centre as part of the information we gather during our inspection. We have published this breakdown on our website.

Detainee survey methodology and results

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

Detention centre staff survey

Detention centre staff are invited to complete an electronic staff survey. The results are published alongside the report on our website.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England