Report on an unannounced full follow-up inspection of

Yarl's Wood Immigration Removal Centre

9 – 13 November 2009

by HM Chief Inspector of Prisons

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Introduction

Yarl's Wood is the only immigration removal centre that holds only women, children and families. The inherent vulnerability of the population has meant that it has been subject to particularly active scrutiny.

This inspection found that there had been some improvements in the centre since the last inspection, particularly in relation to conditions, services and support for children. There was a new school, professionally run, which attempted to provide a good curriculum for the wide range of transient children held. The youth club and youth worker provided much-needed support and activity and nursery provision was good. Social workers participated in weekly multi-disciplinary meetings to discuss the welfare of each individual child.

On the adult side, Yarl's Wood was a safer place than when last inspected, with little evidence of bullying or tensions between the different national and ethnic groups, and the environment was less institutional than previously. Healthcare provision had also improved, particularly for children, with specialist mental and physical health services.

In spite of these improvements, and the support which individual members of staff provided, we continued to have concerns about aspects of detention at the centre. The first related to the detention of children. In spite of the centre's considerable and commendable efforts, the fact of detention clearly and adversely affected children's welfare, as our interviews with and observations of detained children during the inspection made clear.

What was particularly troubling was that decisions to detain, and to maintain detention of, children and families did not appear to be fully informed by considerations of the welfare of children, nor could their detention be said to be either exceptional or necessary. Over the past six months, 420 children had been detained, of whom half had been released back into the community, calling into question the need for their detention and the disruption and distress this caused. Some children and babies had been detained for considerable periods – 68 for over a month and one, a baby, for 100 days – in some cases even after social workers had indicated concerns about their and their family's welfare. Detailed welfare discussions did not fully feed into submissions to Ministers on continued detention.

Secondly, the focus on improving the environment and activities for children appeared to have led to a lack of attention to the needs of the majority population of women. Provision of activities for them was among the poorest seen in any removal centre. It had been inadequate at the last inspection, and had declined even further. The absence of activity added to the depression and anxiety of women, many of whom were spending lengthy periods at Yarl's Wood. The average length of stay had increased by 50% since the last inspection, and one in ten women had been detained for more than six months. There was some paid work, but only about a dozen jobs offered more than 10 hours a week. The quality and quantity of education was poor, except for some good arts and crafts work.

Many women were extremely anxious about their future, and the quality of support procedures for those at risk of self-harm was not consistently good, though there was some caring individual work. There had been no assessment of adult mental health needs. Relationships with staff were reasonably good, but it was not clear that staff as a whole had sufficient time to provide positive help, and we were particularly concerned about levels of staffing at night.

Finally, we were concerned about the consistency and adequacy of preparations for release or removal. The assiduous welfare officer tried to assist detainees with practical issues, and was

a visible presence on the units. However, he was not routinely informed of all removals, and we came across some women and families who were extremely anxious about the arrangements, both overseas and in the UK. We found no evidence of multi-disciplinary pre-release strategy meetings in high risk cases, such as women at risk of self-harm. On some occasions, families were separated to effect removal, and on two occasions in the last year force had been used on children. Though we were assured that these events were exceptional, and were properly authorised and planned, better resourced pre-release work could reduce the need for such actions, which often resulted in failed removals. Moreover, there is no detailed national guidance to staff on the circumstances in which force can be used on children, at what age or with what methods.

Yarl's Wood was an improved and largely well-run centre. However, there were two main findings from this inspection. The first is that the conditions, activities and services for children, within the centre, had improved significantly, but this, while welcome, could not compensate for the adverse effect of detention itself on the welfare of children, half of whom were later released back into the community. The second main finding is that there had not been equal or sufficient attention to the needs of the majority population of single women, some of whom were held for long periods, and for whom there was little activity and sometimes not enough support. These are messages for the UK Border Agency, as well as for the centre and its managers.

Anne Owers February 2010
HM Chief Inspector of Prisons

Fact page

Task of the establishment
Immigration removal centre.

Location
Clapham, Bedfordshire

Contractor
Serco Ltd

Escort provider
G4S

Number held
306 (6 November 2009)

Certified normal accommodation
405

Operational capacity
405

Last inspection
4 – 8 February 2008 (full announced)

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

Description of residential units
The centre has four residential units. Residents in temporary confinement or removal from association rooms are accommodated on Kingfisher unit. Families identified as requiring additional support can be located in the Bunting family care suite.

- Bunting (single women): The first night and induction unit with 42 beds, mostly in single rooms and three double rooms. All rooms have en-suite toilet and shower facilities.
- Avocet and Dove (single women): Capacity of 130 and 112 respectively. All rooms are twin-bedded, apart from two single rooms on Avocet with some adaptations for people with disabilities. All have en-suite toilet and shower facilities.
- Crane (family unit): Capacity of 121 family members. All rooms except one are twin bedded and are interconnected in pairs to allow families to be located together. All rooms have en-suite toilet and shower facilities. One room with a single bed has some adaptation for people with disabilities. Sixteen bedrooms have been adapted to cater for families with babies.

Section 1: Healthy establishment assessment

Introduction

HE.1 The purpose of this inspection was to follow up the recommendations made in our last inspection of 2006 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy establishment. The four criteria of a healthy establishment are:

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

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

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

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

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

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

HE.3 Although this was a custodial establishment, we were mindful that detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention

Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees:

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

HE.4 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.

HE.5 At the last inspection in 2008, we found that Yarl's Wood was performing reasonably well against the healthy prison test of safety. We made 54 recommendations, of which 25 had been achieved, 12 had been partially achieved and 17 were not achieved. We have made 57 further recommendations.

HE.6 In 2008, we found that Yarl's Wood was performing reasonably well against the healthy prison test of respect. We made 55 recommendations, of which 25 had been achieved, 10 had been partially achieved, 19 were not achieved and one was no longer relevant. We have made 48 further recommendations.

HE.7 In 2008, we found that Yarl's Wood was not performing sufficiently well against the healthy prison test of purposeful activity. We made 14 recommendations, of which five had been achieved, three had been partially achieved, and six were not achieved. We have made 13 further recommendations.

HE.8 In 2008, we found that Yarl's Wood was performing reasonably well against the healthy prison test of resettlement. We made five recommendations, of which four had been achieved, none had been partially achieved and one was not achieved. We have made 10 further recommendations.

Safety

HE.9 Most detainees reported reasonable treatment by escorts, but many had spent periods in police custody. No police records arrived with detainees. Prison files were received, but not checked for risk information at an early stage. The reception area was well designed and comfortable, but the reception process was often slow. Security was generally proportionate. Use of force was infrequent, but had increased. Few detainees had experienced separation, but governance was not always adequate and some usage did not comply with detention centre rules. The care of children and the multidisciplinary support for them within the centre had improved. However, assessments made about their welfare while in the centre did not impact fully on detention decisions, and the fact of detention adversely affected their welfare and development. Many detained children were not subsequently removed. Detainees at risk of suicide and self-harm were engaged with well, but assessment,

care in detention and teamwork (ACDT) paperwork and strategic oversight were generally poor. There was little evidence of bullying and investigations were thorough. There was access to legal advice agencies in the centre, but not outside. Immigration uncertainty was a major concern for detainees. The centre was performing reasonably well against this healthy establishment test.

HE.10 Most detainees reported reasonable treatment by escorts, but some families said they had little time to prepare or to collect belongings and medication. The process of enforcement was likely to have been a frightening experience for children in particular. Families were transported in separate and well equipped vehicles. Many detainees did not know where they were going before they came to Yarl's Wood. Some detainees said they had not received comfort breaks or food on long journeys. Escort records were often poorly completed. There was no evidence of handcuffing on escorts. Some women had spent long periods in inadequate police custody, but no police custody records arrived with detainees.

HE.11 Reception was a clean and comfortable area, with separate waiting areas for families. Reception staff were friendly and helpful and usually very busy. There was often only one member of staff interviewing new arrivals. The reception process was slow and many detainees, including families, complained of long waits. There was limited translated information and the video was not used. Telephone interpretation was not used as frequently as necessary for the population.

HE.12 First night staff checked all new arrivals at least twice overnight and showed a caring approach. Prison files arrived with detainees but were sent direct to security instead of being checked for risk information at an early stage. Induction usually took place within 24 hours of arrival, but many detainees were not sure that they had received it. It appeared less effective for non-English speakers. Few detainees said they had seen the information booklet about the centre, which was available in 13 languages during induction. Family induction was delivered on a one-to-one basis by Crane unit staff, who delivered information from a script supported by a family induction booklet in 11 languages.

HE.13 Physical security was reasonable and the removal of razor wire from the area around Crane unit was a welcome development. Dynamic security based on positive relationships was good and the number of security information reports had increased substantially. There was insufficient analysis of patterns and trends from the information received.

HE.14 Force was used infrequently, but reported use had increased in 2009. This could have been attributed to better reporting, but this hypothesis was not yet supported by systematic analysis of data. Staff needed training in communication under pressure. Oversight by managers and monitoring by healthcare staff was generally good, but in some cases evidence of this was missing from the records.

HE.15 Few detainees had spent time in the Kingfisher separation unit, but one in six of those separated had spent over 24 hours there and authorisations for extension were not always given in time. There was an example of over-lengthy separation as an unofficial punishment, and separation was also used for those at risk of self-harm. The use of the 'family care suite' for isolation or imminent removal was potentially outside detention centre rules and again authorisation procedures were not always followed. During the inspection, staff in Kingfisher were unaware of the reasons for a detainee being placed in the unit and had no background information.

HE.16 Although the numbers had reduced slightly, over 400 children had been detained in the previous six months, in one case (a baby) for 100 consecutive days. The average length of stay was 16 days. Detention affected their welfare and development, despite the fact that the centre cared for them well. Our children's interviews illustrated the distress that children felt about their own and their families' detention, which increased over time, and all those we interviewed were temporarily released, as were half the children detained during the previous six months, calling into question the necessity of their detention. There were few opportunities in the detention environment for parents to look after their children in a setting that could mitigate the institutionalised experience.

HE.17 There was good multidisciplinary input to child welfare assessments, although relevant information was not properly disseminated to officers who had most contact with children. Weekly telephone conferencing was very effective in identifying the needs of children held for more than 28 days, but it was unclear to what extent this information was used to revisit the decision to detain. The weekly welfare meeting was also an in-depth and effective review of all children in the centre. Twenty-one day assessments by the independent social workers based at Yarl's Wood were thorough. There was no such assessment at the seven-day point to help plan for children's care. Submissions to ministers to authorise detention beyond 28 days did not fully reflect the social work assessments or the telephone conference discussions.

HE.18 Social workers screened relevant centre documentation to ensure that potential child protection referrals were picked up. Comprehensive and useful reports were prepared by the safeguarding coordinator to the relevant committee. The relationship between the centre and Bedford Borough Social Services worked well.

HE.19 Most detainees we spoke to who had been subject to assessment, care in detention and teamwork (ACDT) procedures said they felt well supported. Case reviews were sensitively chaired and multidisciplinary, and allowed the detainee every opportunity to participate. Initial assessments of detainees at risk and care maps were poor. Staff observations were detailed and demonstrated engagement with detainees. Strategic oversight of suicide and self-harm procedures was weak and there was insufficient discussion of these or bullying issues in the poorly attended monthly safer detention committee meetings.

HE.20 There was very little evidence of bullying from our group interviews, survey or in-depth safety interviews, and fewer detainees than at the time of the last inspection said they had felt unsafe. There had been eight anti-bullying investigations over the previous six months, all of which were thorough and detailed appropriate action. There were some posters about tackling bullying on the units, but these were in English only. There was a good anti-bullying display on Crane unit with useful helpline numbers, including Childline.

HE.21 In our survey, three-quarters of detainees said they had legal advice, significantly more than the comparator[1]. The centre facilitated weekly surgeries with the Immigration Advisory Service, and a Legal Services Commission-funded surgery also took place each week. Workers from Refugee and Migrant Justice also saw detainees by appointment and Bail for Immigration Detainees held a fortnightly

[1] The comparator figure is calculated by aggregating all survey responses together and so is not an average across establishments.

surgery. However, outside legal advice and representation remained a significant problem. The library had one legal reference book, which was only available on request. The librarian spent much time assisting individuals to complete legal forms, but had no training and little time for this.

HE.22 No statistics were readily available for the cumulative length of detention. More than 10% of detainees had been held at the centre for over six months, several with no imminent prospect of removal. The average stay for single women had increased from 22 to 34 days since the last inspection. Monthly progress review letters were sometimes late and frequently repetitive, failing to identify progress or reasons for no progress. Late reviews were pursued by on-site staff. There was no system for monitoring and ensuring that detainees received bail summaries before hearings.

HE.23 Responses to Rule 35 letters were often late and some were inadequate or did not revisit decisions in light of present clinical evidence. In some cases, in spite of the fact that detainees had been seen by healthcare, there did not appear to be accompanying medical evidence. The details of some detainees' visitors were held on file after requests from caseworkers, raising issues of data protection and privacy. Staff from some embassies had recently started visiting the centre to speed up the documentation process, and Criminal Casework Directorate caseworkers had recently attended to progress individual cases.

Respect

HE.24 Residential areas were generally comfortable and attractive. Staff-detainee relationships were in general positive, although staff appeared to lack the time for engagement. There was no personal officer scheme, and history sheets were little used. Diverse groups of detainees lived together with little conflict and there was generally appropriate use of interpretation. Faith provision was very good. The rewards scheme had been used inappropriately in some cases and the complaints system, though better used, was confusing. The management and provision of health services had improved significantly, but there had been no assessment of adult mental health needs. Food lacked variety, could be of poor quality and was much criticised by detainees. The shop provided a good service. The centre was performing reasonably well against this healthy establishment test.

HE.25 Rooms and communal areas were well equipped. Some detainees complained of cold rooms, particularly in the early hours when the heating went off automatically. The water supply had been turned off more than once with no warning. The mattresses were thin and did not provide adequate support for most detainees. There was a lack of clear signage to help detainees find their way around the centre. Some protruding metal door fixtures presented a safety hazard, particularly to children. On Crane unit, children could too easily access the laundry and therefore hazards such as hot water and irons. It could take some days for detainees to obtain requested property from reception.

HE.26 Staff-detainee relationships were generally positive, but significantly fewer women than the comparator in our survey reported respectful treatment. On the whole, staff dealt well with detainees when they came to their attention, but most were very busy and unable to spend significant time speaking with detainees. Staffing numbers for units appeared low in the evenings and at night, often with only one officer on units

overnight. History sheets were little used, with gaps of up to three months between some entries. Most entries were functional or negative. There was no personal officer scheme. New more informal uniforms had been purchased and were about to be phased in.

HE.27 There was no diversity policy covering issues such as sexuality, gender and religion, but there was an appropriate disability policy, with some limited discussion of this issue in the safer detention meetings. Support plans were produced for all those identified as having a disability. Detainees appeared to live in harmony with each other and did not report significant conflicts between groups. Wide-ranging ethnic and nationality monitoring was carried out, but it was unsophisticated and did not provide an accurate picture of trends and patterns. The introduction of focus groups by nationality was a positive development, but inconsistent use was made of professional interpretation for the groups. Issues raised were not always followed up and the smaller nationality groups were not adequately covered. There was good use of telephone interpreting overall and a number of officers spoke languages other than English. There was limited translated information around the centre.

HE.28 Detainees reported very positively on faith provision and had good access to well maintained and attractive places of worship. There was access to a wide range of chaplains. Religious festivals were celebrated and this was appreciated by detainees.

HE.29 A full set of rules was issued on induction and available in translation. It was clear, simple and fit for purpose. The standard level of the rewards scheme was rarely used, but detainees could be unjustifiably downgraded for single, minor breaches. The restriction of internet access to 30 minutes a week on standard level was an inappropriate restriction for a detainee population.

HE.30 Centre managers' responses to complaints were generally thorough and courteous, although often defensive in tone. The parallel system of minor complaints was likely, in view of the guidance published to detainees, to discourage detainees from formal complaints. The complaints boxes were not secure and we were able to take some complaints out of the locked boxes. There was a new and well managed complaints system specifically for children.

HE.31 Clinical governance and management of health services had significantly improved. A female GP attended once a week. Detainees had good access to primary care services. Many detainees complained about delays in seeing healthcare staff and there could be some long waits for additional clinics when detainees attended at the same time. GP clinics were available every weekday and on Saturday mornings. In contrast to clinics, there were no significant waiting times for routine appointments and detainees were seen on the same or following day following nurse triage.

HE.32 Child and adolescent mental heath services had improved significantly, but there had been no assessment of adult mental health needs.. There was no programme for mental health awareness training for custody officers. Two counsellors provided a service throughout the week, including a specialised service for children. A registered children's nurse assessed new families and children and attended the child welfare meeting. There was also a visiting midwife and a health visitor who provided support to nursing mothers. Dental services were good, with minimal waiting times and a good range of treatment options. There was little information about healthcare services in languages other than English and healthcare staff did not attend induction.

HE.33 The quality of food was inconsistent and some we sampled was poor. Detainees also complained about the lack of variety and over half in our survey described the food as poor or very poor. Detainees did not work in the kitchen and were unable to contribute to the preparation of national dishes. There were shortfalls in standards of hygiene, with uncooked perishable food left out overnight. There had been low attendance at recent consultation meetings on catering and surveys were not issued in any language but English.

HE.34 The shop layout had improved and allowed almost a normal shopping experience. Local sourcing of goods in response to detainee requests was also providing a better service, along with a good catalogue ordering service.

Activities

HE.35 There was insufficient activity for most detainees. There was more paid work, but not enough for the population. The quantity and quality of education for adults was inadequate. Children's education had significantly improved and the school provided an improved learning environment. The library provided a reasonable service. The gym was adequate, but not always properly supervised. Freedom of movement around the centre was curtailed by detainees having to wait for staff to unlock unit doors. The centre was not performing sufficiently well against this healthy establishment test.

HE.36 In our survey, only a third of detainees, similar to the previous inspection, said there was enough to do to fill their time. The hair salon was popular and there were plans to introduce beauty therapy. A cinema was used intermittently and common rooms were generally comfortable. There was a calendar of events and monthly visits from Music in Detention. Access to outdoor sports facilities for older children and adults was inadequate. One of the outdoor sports facilities for older children had been used to build the new school and the other was no longer used. A wider age range of children could attend the youth club, which was in a better location and had access to outside space. Promotion of activities generally was weak.

HE.37 Paid work had expanded to 49 paid work roles, but this was still inadequate for the population. Only a quarter of roles offered work for more than 10 hours a week and there was a two to three week waiting list for jobs. The application process was unclear and work agreements that detainees were required to sign were not translated. Access to work could be vetoed for non-compliance with UKBA, which inappropriately mixed custodial and immigration functions.

HE.38 Education for adults had been poor at the previous inspection and had declined since then. English for speakers of other languages (ESOL) was offered for only six hours a week and the tutor was expected to supervise the library simultaneously. Information and computer technology (ICT) was similarly poor and again that tutor had to supervise internet use simultaneously. Arts and craft sessions were appreciated. They were offered every morning and afternoon in both Crane and the main centre, but sessions in Crane were poorly attended. It was inappropriate that detainees had to pay for some materials such as paper and t-shirts for t-shirt printing. Quality assurance of education for adults was weak.

HE.39 Children's education had improved considerably. There was a good new purpose-built school building. A qualified primary teacher had significantly improved the curriculum for all ages and this was now linked appropriately to the national curriculum, though there was a wide range of abilities and ages. The structure of the school day had improved, but was still too long. There were no classroom assistants. Quality assurance had improved, but was still in its early stages. Nursery provision for younger children remained good.

HE.40 The main library had improved. It was managed by a qualified librarian, but she was often diverted by giving advice to detainees. Detainees had good access, seven days a week and in the evenings. There was an extensive and improved stock of books in languages other than English. There was a good range of newspapers and periodicals in English and other languages. There was a wide range of videos, but all in English. The smaller library in Crane also provided an appropriate service.

HE.41 Gym facilities were reasonable. There was good timetabled access for all groups daily and in the evenings, but the gym was sometimes closed and the sports hall opened late. In our survey, significantly fewer detainees than the comparator said it was easy to go to the gym. Outdoor facilities were limited. Staff were not appropriately trained or qualified, although some were starting national vocational qualifications. Sports hall activity was not sufficiently supervised. There had been no gym induction for the three weeks before the inspection. Children had physical education (PE) every day and there was a good balance between recreational and structured PE.

HE.42 Detainees could move around the centre for nine hours a day, but had to wait for staff to let them through unit doors. There seemed little reason for locking unit doors, as it restricted movement and took up staff time unnecessarily. Some officers were unclear about the circumstances in which women were allowed to leave Crane unit.

Preparation for release

HE.43 The welfare officer provided a helpful and well advertised service, but this needed to be further expanded. Visits provision was adequate. Detainees had good access to telephones, although receipt of incoming calls was sometimes problematic. Access to the internet and email was reasonable. The welfare officer undertook some pre-release work, but this was not systematic and did not support some of the most vulnerable. There were no strategy meetings to support removal in high risk cases of women subject to ACDT procedures and there was evidence of family separation and force being used on rare occasions on or in the presence of children during attempted removals. The centre was not performing sufficiently well against this healthy establishment test.

HE.44 There was a full-time welfare officer who had cover from another officer experienced in welfare work. He held daily surgeries with a caseload of between 50 and 70 each month, as well as around 100 'corridor' or 'office' consultations. Demand was steadily rising. The welfare officer had a reasonably high profile around the centre and information was displayed around the centre. Obtaining property and money for detainees, and to a lesser extent assisting with legal referrals, formed the largest part of his work. Outcomes were not always clearly recorded, but the paperwork showed that he had determinedly dealt with some long-term welfare problems. He was able to

assist some people with pre-release concerns before they left the centre, but was not systematically informed of removals or releases. Without further resources, it was unlikely that he could carry out this work on the necessary scale.

HE.45 The visitors' centre was comfortably furnished and equipped with vending machines providing snacks and hot and cold drinks. It contained a small play area with a selection of children's toys. The visitors' centre, searching area and visits hall were adequately staffed by a dedicated visits team, and visitors were treated helpfully and sensitively by staff. Searches we observed were undertaken sensitively. Evening visits sometimes began late as detainees were unable to get through locked doors on units while unit staff were supervising evening meals.

HE.46 Detainees appreciated the provision of mobile telephones on arrival in return for a £2 deposit, but some had to wait for a day or more to receive them. The stock was being replenished and expanded. The system for ensuring that detainees were alerted to incoming calls did not work effectively.

HE.47 Detainees described no problems in sending and receiving mail and this was supported by our survey. They had improved access to internet and email, which helped them stay in touch with families and advisers. However, the machines were slow and the 30-minute internet slots were consequently too short. A fax machine was available on all units and detainees said these were easy to access.

HE.48 Detainees had some support with retrieving their property, contacting relations in their receiving country and making links with appropriate external agencies before release. However, this was not systematic. In view of the vulnerable population of women and children held at Yarl's Wood this was a serious failing. Many left the centre without effective pre-release support and planning. There were concerning incidents of force being used to split or keep families apart before removal, and on rare occasions of the use of force on pregnant women and children in order to seek to effect removals. There were a number of failed removals each month, including of families and children. There was no specific UKBA guidance on the use of force on, or in front of, children. There was no evidence of strategy meetings to support removal in high risk cases or of links between ACDT procedures and removals.

Main recommendations

HE.49 Reviews of detention should reflect consideration of all relevant information for and against detention, including the effect on detainees of lengthening detention.

HE.50 Children should be detained only in exceptional circumstances, where a clear necessity can be evidenced, and only immediately before removal.

HE.51 The UK Border Agency should ensure that reports are produced and sent to the Children's Champion, to explain the necessity and circumstances of detention in cases where children have been detained, but subsequently temporarily admitted or released.

HE.52 Length of cumulative detention should be clearly and accurately recorded.

HE.53 The UK Border Agency should develop and issue specific guidelines on the circumstances in which force can be used on or in front of children, and the methods that can be employed.

HE.54 Force should be used on children only in exceptional circumstances, where there is a serious and imminent risk of harm to the child or others.

HE.55 Staffing levels on the adult units should be reviewed to ensure that staff are able to engage with detainees, perform personal officer work and complete history sheets. All units should have at least two staff on duty at night.

HE.56 The range of learning and skills activity for adults should be increased and improved. This should include good quality tuition in English for speakers of other languages and ICT.

HE.57 The centre should extend the number and hours of paid work roles, improve the promotion of the scheme and ensure procedures for recruitment are appropriate and fair.

HE.58 The welfare officer should be notified at the earliest possible time of all detainees issued with removal directions, due to be released into the community or transferred.

HE.59 There should be a system of properly resourced pre-release planning to ensure that detainees are properly prepared for release, transfer or removal, to deal with any outstanding concerns, with the aim of providing necessary support and minimising forcible or failed removals.

Progress on main recommendations since the previous report

(The paragraph numbers at the end of each main recommendation refer to its location in the previous inspection report)

Main recommendations

To the Chief Executive of UKBA

MR.1 Reviews of detention should reflect consideration of all relevant information for and against detention, including the effect on detainees of lengthening detention. (HE.40)
Not achieved. On-site UK Border Agency (UKBA) staff examined each case file at the beginning of the month to ensure receipt of the monthly detention review letter (form 151F) from UKBA caseworkers. Some of these letters continued to be late. They were frequently repetitive and some failed to identify any progress in the case or give reasons where there was no progress. Although the UKBA on-site team pursued late reviews, inadequate reviews were not consistently challenged as this was not seen as part of their remit.
See main recommendation HE.49.

MR.2 Children should be detained only in exceptional circumstances and then for only the shortest time necessary. Length of cumulative detention should be clearly and accurately recorded. (HE.41)
Not achieved. Records held at the centre did not detail exceptional circumstances as justification for the detention of children. Although there had been a slight reduction in the number of children held between May and October 2009 compared to the same period in 2007 (420 compared to 450), large numbers of children were still detained. Between 50 and 92 had been received each month over the previous six months and 66 had been held beyond 28 days (the longest stay was a baby held for 100 days). This was fewer than in the same period in 2007, when 83 children had been held beyond 28 days, although this had included a period of chicken pox quarantine. Half the children detained in the previous six months had been temporarily released or bailed from Yarl's Wood. None of the five families who had been held for 28 days or more and who were discussed during a conference call held during the inspection were removed and all were eventually released. These figures called into question the justification for detaining children, sometimes for a significant period, with the inevitable distress and disruption to their lives that this entailed.

It was not possible to determine how many children had previously been detained and released, although minutes of the weekly telephone conferences referred to children who had been in detention several times. Details of cumulative detention were held on individual electronic records, but the data collected on the total number of days children had been in detention did not include cumulative detention. The monthly data recorded the average number of days children were held at Yarl's Wood and this had varied between 12 and 27 days since the beginning of 2009.
See main recommendation HE.50.

Main recommendations

To the centre manager

MR.3 Specialist general and mental health services should be available for children. (HE.42)

Achieved. A full range of mental health services was provided, following a memorandum of agreement with the community mental health teams and the child and adolescent mental health service.

MR.4 Paid work for detainees should be significantly expanded. (HE.43)
Not achieved. The centre had more than doubled to 48 the number of paid work roles available to detainees, but these were sufficient for less than a fifth of the adults detained and much of the work was for very limited periods. The wait between application and starting work was long, at up to three weeks (see section on work and learning and skills).
See main recommendation HE.57.

MR.5 The range of learning and skills activity for adults should be increased and improved. This should include good quality tuition in English for speakers of other languages and ICT. (HE.44)
Not achieved. Learning and skills activity for adult detainees had diminished and quality had not improved. In our survey, only 19% of detainees, significantly lower than the comparator, said they attended education. English language tuition was poor and offered for only three two-hour sessions a week. This was a reduction since the previous inspection when it had been offered on weekdays in the mornings and afternoons. The member of staff responsible was required to combine teaching English for speakers of other languages (ESOL) to the few students who attended along with the role of supervising the library in adjoining room. She could not give her full attention to either and this had led to a deterioration in the quality of what she could provide. No formal arrangements existed to assess the English language level and needs of detainees and there was no structured planning to meet their individual needs. Learning relied too heavily on learners completing unsuitable photocopied worksheets. Classes were regularly cancelled because the room was booked for other uses. Up to a quarter of detainees responding to our survey did not understand spoken English and a third did not understand written English. Tuition in using information and communications technology (ICT) was very limited. This was now only offered on weekday afternoons, a reduction since the previous inspection. The centre had recently started to offer appropriate short externally accredited units of ICT learning. Since their introduction, only 10 detainees had achieved any certification. Limited availability of suitable ICT equipment and a requirement for the tutor to supervise other detainees using the internet in the computer room at the same time had led to the virtual abandonment of the scheme. In practice, no ESOL or ICT classes took place in the family unit.
See main recommendation HE.56.

MR.6 The centre should improve the initial assessment of children's skills and abilities and use this information effectively to set and subsequently monitor progress towards short-term educational goals. (HE.45)
Achieved. The centre had developed formal systems to obtain information on each child's previous educational attainment whenever possible and used this to establish meaningful targets for children (see section on child education).

Progress on recommendations since the last report

Section 1: Arrival in detention

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

Escort vans and transfers

1.1 Families should not be separated without a full assessment and Border and Immigration Agency senior manager authorisation. Reasons for separation should be recorded. (1.20)
Achieved. A small number of families had been separated during transport, but the reasons for this had been assessed in each case and the separation had been properly authorised by a senior manager in the UK Border Agency (UKBA).

1.2 Individuals detained at reporting centres should be given the opportunity to collect items, including medication, from their home. (1.24)
Not achieved. Detainees detained at reporting centres said they had not been allowed to return home to collect personal belongings and medication. Instead, they had been told they would be provided with medication on arrival at the centre.
We repeat the recommendation.

1.3 Overseas escort contractors should inform the centre of their estimated time of arrival in advance to allow staff time to prepare. (1.16)
Achieved. Reception staff said inland and overseas escort contractors contacted them in advance to say when they were due to arrive.

1.4 All escort vehicles carrying children should contain suitable toys or activities to keep them occupied. (1.17)
Achieved. The vehicles we inspected contained toys for young children, puzzle and colouring books, crayons and a portable DVD player with children's DVDs. They also carried a stock of nappies, baby food, snacks and drinks.

1.5 Vans with caged compartments should not be used to transport children. (1.18)
Achieved. During the inspection, no families travelled to Yarl's Wood in vehicles with caged compartments. UKBA staff said such vehicles were no longer used for families and reception staff confirmed that they had not seen families escorted in one for at least six months.

1.6 Overseas escorts should provide relevant information to receiving centres when a removal has failed. (1.19)
Achieved. Detainee records included a number of cases where there had been a failed removal. In each case, there was a full record of the circumstances.

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

Not achieved. Detainees complained about long journeys without comfort breaks. In our survey, 35% of detainees, against a comparator of 29%, said their journey had taken over four hours. Some detainees transferred from Dungavel immigration removal centre (IRC) complained of journeys of 10 hours with only one stop. Escort records varied in quality, with some very detailed and others simply noting times of departure and arrival. Even when records were kept, there were numerous examples of detainees travelling for more than 2.5 hours without a break and some with journeys of four or five hours without a break.
We repeat the recommendation.

Further recommendation

1.8 Escort records should record times of departure and arrival, details of refreshments offered and accepted and information on comfort breaks requested and given.

Additional information

1.9 Some vehicles that arrived to collect detainees were dirty and strewn with rubbish. All carried supplies of water and snacks, but not all had sandwiches. In our survey, 57% of detainees, similar to the comparator, said they had been treated well or very well by escort staff. Many of those we spoke to had not been told where they were being taken and no one had been given written information about the centre. Movements of detainees often took place late at night or in the early hours of the morning, adding to their discomfort and disorientation. Escort staff contacted the centre in advance to notify staff whom they were bringing and give an estimated time of arrival. Of the detainees held in the centre on the first day of the inspection, including families, about 19% had transferred from a police station, 22% from prison, 32% from a short-term holding facility (STHF) or reporting centre, 16% from another IRC and 11% directly from the community.

1.10 One young woman had spent five days in police custody before being collected at 10.35pm and arriving at the Port of Dover STHF at 12.30am. She was subsequently transferred to Yarl's Wood, arriving at 3.50pm. At 5.30pm, she was told she was to be temporarily admitted, but was too exhausted to make the journey to London and asked to stay at Yarl's Wood overnight to recover. She appeared distressed and exhausted and said she had not been able to shower or exercise in the fresh air throughout her time at the police station nor had she been given anything to read. Records showed that single women were often held in police custody for two to four days and several said they had not been able to shower. None of the women held in police custody, including one who had self-harmed there, arrived at Yarl's Wood with copies of their police custody records.

1.11 Most families had been taken into detention from their homes and transferred to the care of the escorting contractor at STHFs, although a small number had arrived from airport terminals. Some families complained that they had not been allowed to bring medication with them and had not been able to prepare for the journey by changing clothes or collecting the belongings they needed. In one case, a child reported having been woken up by a member of the enforcement team, rather than a family member.

1.12 Given the small number of centres holding women and families, only a small percentage of detainees leaving Yarl's Wood were transferred to other centres. Between August and October 2009, 69 detainees (4.6% of discharges) had been transferred to other centres. Detainees being transferred were not given written information about their destination (see also section on removal and release).

1.13 There was no evidence that detainees were handcuffed to attend outside medical appointments. Managers said a risk assessment was completed in each case and that any decision to handcuff a detainee required the authority of a senior manager, which was given only in exceptional circumstances.

Further recommendations

1.14 Escort vehicles should be cleaned and restocked before each journey.

1.15 Detainees should be told where they are being taken and provided with written information about the centre.

1.16 Copies of police custody records should accompany all detainees on transfer from police custody.

1.17 Families detained in their homes should be allowed to bring medication and necessary belongings with them. Parents should always be able to rouse children and explain what is happening.

Reception, first night and induction

1.18 The outside areas in reception should contain activities for children. (1.22)
Not achieved. Neither of the small courtyards outside the two family waiting rooms contained any children's toys or activities.
We repeat the recommendation.

1.19 The welcome arrival video should be available in different languages or formats. (1.23)
Not achieved. Detainees arriving during the inspection were not shown an information video in reception and staff said no such video was available in different languages.
We repeat the recommendation.

1.20 Detainees should be offered a shower in reception. (1.25)
Achieved. All detainees were offered a shower in reception and this was recorded on the reception checklist. The one shower in the reception area was clean and well stocked with toiletries and fresh towels. Some detainees used the showers, but most preferred to wait until they were taken to the residential units, where there were en suite facilities.

1.21 The telephones in reception should have privacy hoods. (1.26)
Achieved. Privacy hoods had been installed on the telephones in the main arrivals area of reception. The two pay telephones in the departure area did not have privacy hoods, but were rarely used. Detainees also had access to mobile telephones.

1.22 First night custodial sheets should be completed properly, detailing meaningful observations and interactions with detainees. (1.27)
Achieved. All first night custody forms we looked at contained an assessment by reception staff and the nurse in reception together with details of interactions with detainees during their first 24 hours, including two checks overnight. Entries were generally appropriate and meaningful, recording the apparent mood of the detainee and any concerns. Concerns were raised with the duty manager.

1.23 Room-sharing risk assessments should be completed individually on arrival and the practice of recording a room-sharing risk assessment risk level before the formal assessment has taken place should cease. (1.28)
Achieved. Reception staff completed an initial risk assessment during the booking in procedure covering the detainee's risk to themselves and others and including questions on their suitability to share a room. This information was given to staff on the Bunting (first night and induction) unit. Staff on Bunting completed a second room-sharing risk assessment before detainees were located in a shared room or moved to Dove or Avocet, where most rooms were twin rooms. This included some of the questions asked at reception and covered the detainee's preferences, such as sharing with a smoker or non-smoker or with someone of their own nationality or religion.

1.24 Staff on Bunting and Crane should be more involved in the induction process. (1.29)
Achieved. A regular team of staff worked on Bunting and Crane units. One of the officers on duty in each unit carried out the induction.

Additional information

1.25 The spacious reception area contained a number of waiting rooms, which were well decorated, clean and equipped with soft furnishings, low tables, and a television. Some designated as family rooms also had children's furniture, toys and books. All contained a rack of magazines, some in languages other than English, but little information about the centre. Only one waiting room had a folder giving basic information about the centre in several languages. Detainees were given a UKBA leaflet about detention available in most relevant languages. There were several toilets, which were supplied with sanitary products and disposal facilities. Two baby change facilities contained stocks of nappies in a range of sizes. Detainees were offered food and drinks on arrival and at mealtimes. There was a selection of sandwiches, microwave meals and fruit. A vending machine supplied hot drinks and cold drinking water and squash were also available.

1.26 All detainees arrived with an IS91 authority to detain. Those transferred from prison arrived with their prison and medical records, but reception staff said they did not have time to examine these and were not sure where to look for information about risk. The records were therefore not used to inform the initial risk assessment, but were passed unopened to the security department.

1.27 Staff were polite and helpful, but with an average of 916 movements in and out a month over the previous three months, reception was busy and the process was slow. Staff often had to book in new arrivals and discharge detainees at the same time, so only one member of staff was available to interview new arrivals. Detainees in focus groups complained of long waits and from what we saw, waits of over two hours were not unusual. Families were prioritised, but one family that arrived at about 12.30pm was not taken to the family unit until 4.30pm, by which time the mother was exhausted. She had repeatedly asked staff to take her to the family unit so she could get her children settled. Reception staff were not trained to identify detainees who had been victims of trafficking.

1.28 Adults were given a rub down search, but children were not searched. Staff also searched all the detainees' property. This process appeared lengthy and over-zealous, with staff examining every piece of paper and checking every seam of clothing. The procedures appeared identical regardless of the risk presented by each detainee. New arrivals were not routinely fingerprinted, but the centre had been told by UKBA of plans to introduce this shortly.

1.29 Reception staff had access to a telephone interpreting service and some reception staff spoke other languages. We saw staff using telephone interpreting, but some detainees said the service had not been used to interview them and invoices indicated that it was not used as often as necessary.

1.30 In our survey, 43% of detainees, against a comparator of 53%, said they had felt safe on their first night. All new single women spent their first night on Bunting, where they were given a tour of the unit and shown to their room. The rooms prepared for new arrivals were clean and contained fresh bed linen, a pack of toiletries and sanitary items. New arrivals were identified to night staff and their location listed on the unit roll board. They were checked by staff at least twice during the night (see also paragraph 1.22).

1.31 Induction usually took place the day after arrival. On Crane, it was delivered separately to each family. Unit staff gave families information about the centre from a detailed script supported by a detailed induction booklet available in 11 languages. Women on Bunting were seen individually or in groups if they spoke the same language. Staff delivered the information using a script that was also available as a DVD power point presentation. The DVD was in English only, but a detailed induction booklet was available in 13 languages. A number of the staff on the unit could speak languages other than English, and other detainees were sometimes used to translate the induction information. Nevertheless, some detainees, particularly those who spoke little or no English, could not recall being given induction information or booklets and those who had received such information said it was too short and did not tell them everything they needed to know.

Further recommendations

1.32 Prison records should be checked in reception and any relevant risk information used to inform the initial risk assessment and room-sharing assessment.

1.33 Detainees should not spend long periods in reception.

1.34 The level of searching of property in reception should be proportionate to the risk presented by detainees.

1.35 Telephone interpreting should be used to interview all detainees who are not fluent in English or do not speak a language also spoken by staff.

1.36 All detainees should be given information about the reception process and the centre in a language they can understand.

1.37 Reception staff should be trained to identify victims of trafficking and given guidelines on what action to take.

1.38 All detainees should receive a full induction that they can understand.

Section 2: Environment and relationships

Residential units

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

No recommendations were made under this heading at the previous inspection.

Additional information

2.1 The accommodation and communal areas were clean and bright. The corridors and central activity areas were pleasantly decorated with murals and artwork, mostly done by the detainees.

2.2 Single women were located on Bunting, Dove and Avocet and families were held on Crane (see fact page). Staff checked all bedrooms daily for any defects. All rooms were adequately equipped with lockable wardrobes, a desk, chairs, a television and a CD radio player, and all had emergency call bells, but these were rarely used. Detainees had keys to their rooms. Some complained that staff did not knock before entering or knocked and entered without waiting for an answer. Detainees were not locked in their rooms at any time. Women could open bedroom windows, but could not regulate the heating and many complained that rooms were too hot during the day and cold at night. They complained, and staff agreed, that sleeping areas were sometimes noisy at night. Staff said they spoke to detainees who were disturbing others.

2.3 Fire evacuation instructions were displayed on the inside of bedroom doors and the centre was regularly inspected by the local fire service. Detainees with disabilities had personal emergency evacuation plans and the location of anyone needing assistance in an evacuation was marked on the unit roll board. A room on Dove unit had been adapted and equipped for use by women with disabilities, specifically wheelchair users. Lifts enabled detainees with mobility problems to access all areas of the centre.

2.4 Some fire doors in the main corridors had protruding metal parts and a number of detainees and staff had sustained cuts and grazes from these. Some protuberances had been covered in hazard tape, but remained sharp and were a potential hazard, particularly to children. Children on Crane had easy access to the laundry area, where there were hazards such as a hot water boiler, irons, washers and dryers.

2.5 Each residential unit had a laundry, dining room, telephone room and sitting room with a television and comfortable sofas. A touchscreen information point was being trialled on Dove, but the only information provided was some photographs of key staff and a function, welcomed by detainees, allowing them to access their account details at the centre. Outside spaces were well maintained and had seating. Women could use the central communal areas and outside spaces for nine hours a day, but had to be let on and off their residential units and were not allowed on other residential units. Men and children were restricted to Crane unless accompanied by a member of staff. Women were not allowed to leave Crane unit unless

attending religious services or the gym. There was some confusion among staff about the circumstances under which they could leave the unit unaccompanied.

2.6 The layout of the centre could be confusing and signage was poor. Most of the few signs were in English and made little use of symbols or colour coding. Some areas were identified using prison-related language such as 'association room' and 'wing office'.

2.7 Managers held monthly consultation meetings with detainees. The agenda covered all aspects of the facilities and routines of the centre. Focus groups were also held with detainees of different nationalities (see section on diversity).

Clothing and possessions

2.8 Detainees could wear their own clothes and those without enough were given one or two sets of clothing in reception. This was inappropriately referred to as 'destitute' clothing. Detainees could have additional clothing and possessions posted or brought in on a visit. Laundry facilities were available on all residential units. Laundry rooms were equipped with washing machines, dryers, an iron and ironing board, and detainees could have a daily supply of washing powder tablets. Only two machines were out of order and there were no queues.

2.9 All property sent in and applications for access to stored property were dealt with by reception. At busy times, detainees could wait up to three days for their property.

Hygiene

2.10 In our survey, 97% of detainees said they could shower every day. Rooms had en-suite facilities and each residential floor also had a small bathroom and toilets, some of which were of the squat toilet design. Detainees were given a pack of basic toiletries on arrival and replacement supplies of these and sanitary products were available from unit offices. In our focus groups, women complained that the water supply to the units had been shut off for several hours without notice. This happened during the inspection when workmen cut off the water supply to one unit to carry out maintenance without notifying the women.

2.11 Unless healthcare confirmed the need for more, detainees were allowed only one pillow and they complained that these were flat and uncomfortable. There was no system to check the condition of mattresses, which happened only if detainees complained. Replacement mattresses were ordered as necessary, but the centre had recently started to replace sprung mattresses with thin foam versions, which were very thin and unsupportive. There was no system of bedding exchange and the centre had found that most detainees preferred to retain and launder their own bedding in the unit laundries.

2.12 Communal areas were cleaned daily by the contract cleaning company that also cleaned detainees' rooms once a week. In between, detainees were expected to keep their rooms clean and tidy. Detainees complained that there were insufficient cleaning materials. They could borrow a mop and bucket, but there were no separate mops for toilet areas and some units had no cleaning fluid.

Further recommendations

2.13 The centre should ensure that the temperature in bedrooms is kept at a comfortable level at all times.

2.14 Staff should wait for an answer after knocking before entering detainees' rooms.

2.15 The hazard created by the protruding metal part on fire doors should be removed.

2.16 Signs should be improved and symbols or colour coding used to help detainees locate key areas and facilities.

2.17 The centre should eliminate the use of prison-related language wherever possible.

2.18 Detainees should be supplied with pillows that provide adequate support.

2.19 The thin foam mattresses should be replaced with mattresses that provide adequate support and comfort.

2.20 The centre should supply enough cleaning equipment and materials to enable detainees to keep their rooms clean.

Housekeeping points

2.21 All staff should be reminded that women on Crane have free unescorted access to the main centre.

2.22 Detainees should be given notice of any planned disruption to services such as the water supply.

2.23 Clothing provided by the centre should not be referred to as destitute clothing.

Staff-detainee relationships

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

2.24 Detainee history sheets should have regular, detailed and quality-checked entries. (2.13)
Not achieved. Detainee history sheets were little used. Some had gaps of up to four months between entries, and gaps of six to eight weeks were common. Most entries were negative or functional, indicated minimal interaction and did little to build a picture of the detainees.
We repeat the recommendation.

2.25 All detainees should have an identified personal or care officer, who should make particular efforts to get to know those who are not fluent in English. (2.14)
Not achieved. There was no personal officer scheme, though we were told one was planned.
We repeat the recommendation.

Additional information

2.26 Only 64% of women in our survey, significantly fewer than the comparator of 71%, said most staff treated them with respect. However, 65% of detainees, significantly more than the comparator of 56%, also said they could turn to a member of staff if they had a problem, and in our detainee group meetings, staff attitudes and behaviour were mentioned as one of the main

positive aspects of the centre. Our in-depth interviews with 20 randomly selected detainees were also generally positive.

2.27 We saw most staff interacting well with detainees when they came to their attention, but most were very busy and unable to spend significant time talking to detainees. This was particularly true on Avocet and Dove, where staff constantly had to unlock doors to let women in and out while simultaneously managing the staff office. Staffing numbers appeared low in the evenings and at night. On one night of the inspection, there was only one officer stationed on most units, including the family unit.

2.28 Unit staff made little use of the telephone interpreting service, but a number of multilingual staff used their skills to communicate with detainees. We saw one member of staff speaking at length and reassuringly with a distressed woman in the separation unit in her own language.

2.29 Black trousers and blue or pink open-neck shirts for staff were about to be phased in and staff we spoke to were receptive to wearing more informal uniforms. No staff carried defensive weapons. Detainees said staff addressed them politely, usually by the first name. A number of staff and detainees were on first name terms. There were some positive attempts to use non-institutional language and detainees were referred to as residents.

Further recommendation

2.30 Staff should use professional telephone interpretation whenever needed to communicate with detainees in their care.

Section 3: Casework

Legal rights

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

3.1 Commensurate legal safeguards should be in place when detainees are threatened with criminal prosecution, including facilitated access to suitably qualified legal advice. (3.10)
Achieved. Twenty per cent of detainees were fast track cases and therefore guaranteed a free legal representative at least for the initial asylum interview. Twice-weekly legal surgeries funded by the Legal Services Commission were run by the Immigration Advisory Service (IAS) and one of four firms of solicitors on a rota for detainees who arrived without a legal representative.

3.2 The centre should consult with the Legal Services Commission with a view to improving access to legal advice for detainees. (3.11)
Partially achieved. In our survey, 74% of detainees said they had access to legal advice. The legal surgeries saw 16 to 18 people each week and there was no waiting list, but the IAS believed more legal advice time was needed and intended to offer a hotline for appointments outside these surgeries. Bail for immigration Detainees also held a fortnightly bail surgery and a monthly workshop. Refugee and Migrant Justice attended by appointment.

3.3 However, detainees' ability to obtain legal advice and particularly legal representation from local solicitors in addition to, or as an alternative to, these legal surgeries remained a significant problem. The list available in the library identified up to five local legal aid firms and detainees were advised to contact them by fax, although staff acknowledged that this produced a poor response and created a false expectation on the part of detainees. One local solicitor said the problem was both the number of faxes received and the lack of information for assessing the request to justify further expenditure of public funds in responding. This frequently meant that no reply was sent.

Further recommendation

3.4 The centre should consult with local legal aid solicitors' firms undertaking immigration work with a view to providing a more effective procedure for facilitating access to legal advice and representation by detainees.

Additional information

3.5 The library was well stocked with country reports and simple guidance publications in different languages. However, there was only one legal reference book and this was available only on request due to the loss of similar books in the past. There were no legal materials on the computers in either the library or the IT room and no guidance on legal research on the internet. Detainees clearly saw the librarian as an important resource and she was spending significant time assisting them with immigration matters, particularly completing legal forms.

Several staff, including the UKBA on-site immigration team, the welfare officer and the librarian, agreed that it would be advantageous to have a dedicated person trained to assist with completing the forms.

Further recommendations

3.6 There should be guidance and support to enable detainees to use the internet for researching the law and their cases.

3.7 There should be a trained person available daily to assist detainees with completing legal forms.

Immigration casework

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

3.8 Rule 35 processes should recognise the full scope of the rule, which is to raise a concern whenever detention or conditions of detention are likely to be injurious to health. Follow-up and case owner responses to rule 35 letters should be filed with the initial letter in the central log. (3.18)
Partially achieved. Copies of responses by case workers to rule 35 letters were now kept on the central file with the initial letter. The UKBA team had also set up a central file to monitor receipt of responses received from UKBA case workers so that late responses could be followed up. The files also contained detailed notifications from healthcare, including a body map showing a detainee's scars or other injuries. However, responses from case workers were frequently beyond the required two working days and some were inadequate, such as 'Information contained within the report has been considered and the decision to detain you has been reviewed. Detention will be maintained.' Even in detailed responses, the case worker often relied solely on the fact that the torture claim had been considered in the asylum appeal without an evaluation of the fitness to detain in light of present clinical evidence.

3.9 In several responses, the case worker referred to the fact that there was no supporting clinical evidence, despite the practice in healthcare for every detainee making a report to be seen by a doctor. This suggested that procedures were not always providing the case worker with the available medical evidence for a proper assessment. There were also examples of women reporting a claim of torture, but not wishing to disclose further details. These matters, together with the lack of statistical or research evidence on the impact of rule 35 procedures, highlighted the need for a comprehensive audit of the workings of the provision to ensure that it was achieving its intended purpose.

Further recommendations

3.10 Rule 35 processes should recognise the full scope of the rule, which is to raise a concern whenever detention or conditions of detention are likely to be injurious to health.

3.11 UKBA should undertake a comprehensive research audit of the workings of rule 35 with particular attention to whether it is providing the intended important safeguard.

3.12 Border and Immigration Agency (now UKBA) case owners should reply promptly to detainee correspondence. (3.19)
Not achieved. There were still examples of delays in case owners responding to detainee correspondence.
We repeat the recommendation.

3.13 Detention reviews and other significant decisions or events, such as removal directions or embassy interviews, should be issued and explained in a language the detainee can understand. (3.20)
Partially achieved. Important documents, such as monthly detention reviews and removal directions, were delivered in person to detainees by members of the UKBA on-site team, who used a professional telephone interpreting service to explain them when necessary, but the documents were still written in English only.

Further recommendation

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

Additional information

3.15 More than 10% of detainees had been held at Yarl's Wood for more than six months. Of these, 13 had been held for six to eight months, eight for eight to 10 months and 11 for more than 10 months. Three detainees had been detained for two years and more. The average length of detention at the centre was 34 days for single female detainees (compared to 22 days in 2008) and 16 days for families. There were no statistics for length of detention across the estate and even those for length of detention at Yarl's Wood were not easily accessible. The cumulative length of detention was highly relevant to the management of cases, including by the UKBA's on-site office, so this lack of accurate statistics could adversely impact on detainees.

3.16 The centre's UKBA team inducted detainees within 72 hours of arrival and families on the day of arrival. While this included how to obtain legal advice, no written information on this was provided. The induction sheet did not record the date of the detainee's first immigration detention when this was different from the arrival date at the centre. Detainees were seen each month when the monthly review of detention letter (form 151F) was served and requests from detainees were responded to within 48 hours or, if urgent, within 24 hours. However, only 14% of detainees in our survey said they could see immigration staff when they wanted. There were a few examples of staff members proactively raising a matter with the case worker. These were largely limited to cases of lengthy detention. On-site staff did not generally see it as their remit to challenge caseworkers on the content of reviews.

3.17 The in-depth surveys showed that casework remained the most significant issue for detainees. Several case files of detainees held longer than six months indicated no imminent prospect of removal. One Zimbabwean woman detained for nearly two years was awaiting a Court of Appeal hearing, but the monthly review letters failed to mention that there had been no forced removals to Zimbabwe throughout this period. In the case of another woman held for 13 months, it had taken a year to confirm her claim of having Nigerian nationality and the monthly

review letters failed to identify the reason for lack of progress. There was no evidence in the case file that the detainee was not cooperating. In other cases, the reason for continued detention was highly questionable. One Nigerian woman who had been at the centre for 16 months was told that her continued detention was because she had been 'assessed as posing a serious risk of harm to the public' for committing the offence of possession of a false identity document for which she had served nine months in prison.

3.18 Case files showed that prolonged detention was often due to the time it took for embassies to issue travel documents. UKBA had therefore set up several useful documentation operations where staff from the Chinese, Vietnamese and Jamaican embassies visited the centre to interview detainees. Criminal Casework Directorate caseworkers also attended an open forum with detainees in an attempt to progress individual cases.

3.19 Two case files showed that a record held at the centre of a detainee's visitors and their details had been requested by the UKBA case worker and a copy put on the file. In one case, this covered a period of a year, detailing over 40 visitors including legal representatives. This raised an issue of data protection as personal information collected for one purpose was being used for another without consent and in circumstances where it was not specifically legally justified. The centre had a central file with broad guidance on data protection legislation, but there was no detailed guidance for staff responsible for holding personal information on individuals, including visitors.

3.20 Use of the IS91 authority to detain form did not reflect the different considerations when detaining minors (see section on childcare and child protection). Even though the form requested that risk factors, including whether the detainee was a minor, be identified, case files showed this was routinely not completed.

3.21 The format for reviews of detention was insufficiently clear to ensure that the author covered all relevant information for and against detention, including the effect on detainees of lengthening detention. The review letter did not include reference to 'progress since last report' to ensure that the issue was addressed and particularly that reasons were given for any lack of progress.

3.22 There was no system to monitor and ensure that detainees received the bail summary before bail hearings. Most relevant case files examined did not include a copy of the bail summary, indicating that none had been received through the UKBA office. Staff said some bail summaries were faxed directly to the detainee on the residential unit either by the UKBA caseworker or the Presenting Officers Unit. The arrangement was that bail summaries were sent only to those who were unrepresented, with legal representatives responsible for sending them to their clients. The evidence was that some detainees were either not receiving the bail summary or received it later than the required time of 2pm the day before the hearing. In contrast, the practice of the UKBA fast-track case team at the centre was to send the bail summary to all detainees irrespective of whether they were legally represented.

3.23 Case files included some examples of detainees being referred to inappropriately as 'prisoner' or 'subject', although we were assured that this was not by on-site staff.

Further recommendations

3.24 Statistics for the length of detention across the estate as a whole should be completed routinely every month for all detainees.

3.25 The UKBA on-site office should ensure that the date of the first immigration detention is recorded on the induction sheet attached to the case file.

3.26 Where there is no prospect of a detainee being removed either because removals to the country of origin have been suspended or because that country declines or unreasonably delays issuing travel documents, the UKBA case worker should specifically address continued detention in these circumstances as a matter of law and fact.

3.27 The lawfulness of disclosing the record of a detainee's visitors to UKBA case workers should be determined urgently and detailed guidance on data protection requirements provided to all staff responsible for handling personal data on computers.

3.28 All relevant risk factors, including whether the detainee is a minor, should be entered on the IS91 form.

3.29 The monthly review letters should include a subheading that refers to 'progress since last report' and reasons should always be given when there is a lack of progress.

3.30 UKBA should adopt a national policy that bail summaries are issued by case workers to all detainees, regardless of whether they are legally represented, at least one day before the hearing through the on-site immigration team of each immigration removal centre.

3.31 The centre's UKBA office should implement a system to monitor that bail summaries are received and in time.

3.32 Detainees should be referred to in all documents by name or as 'detainee' or 'resident'.

Section 4: Duty of care

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

Bullying

4.1 Records monitoring individuals subject to bullying procedures should be completed properly and quality-checked by managers. (4.13)
Achieved. There had been eight investigations into suspected bullying in the previous six months. These involved 22 detainees, nine of whom were identified as victims. Following investigation, only two detainees had been formally monitored under the anti-bullying procedures. Both had been monitored appropriately by staff and the records quality checked by residential managers.

4.2 All staff should be routinely briefed so that they are aware of who is subject to bullying procedures. (4.14)
Achieved. A daily briefing document listed all detainees subject to anti-bullying procedures and all staff had access to the bullying log on the centre's computer system.

4.3 Annual surveys should be conducted to determine the extent and nature of bullying. (4.15)
Not achieved. A survey had been completed in March 2009, but the results had not been analysed. The survey indicated that 28% of detainees believed bullying was a problem.

Further recommendation

4.4 An annual bullying survey should be undertaken and the results analysed.

Additional information

4.5 There was little evidence that bullying was a significant problem. In our survey, in focus groups and during the inspection, detainees generally reported positively on safety. In our survey, 25%, similar to the comparator and significantly better than the 33% at the last inspection, said they had been victimised by a detainee or group of detainees. In safety interviews, 75% of interviewees said staff would take it seriously if detainees were victimised or bullied, 19% said it depended on the member of staff approached and only one said staff would not take it seriously. This was despite the fact that staffing levels on residential units were low and staff had little opportunity to patrol and supervise communal areas and residential units. The anti-bullying policy was understood by staff, but was not well publicised. Posters displayed on notice boards in residential areas were in English only.

4.6 Bullying issues were discussed at the safer detention meeting, which considered a monthly anti-bullying report. The meeting was not well attended, with notable absences from security and healthcare. No detainee representatives were invited. The anti-bullying report prepared by the anti-bullying coordinator was based entirely on reported incidents of bullying and the meeting did not discuss any bullying-related intelligence or review unexplained injuries.

4.7 Teachers had worked with children on Crane to produce an excellent display about bullying. The Childline number was detailed on the display, but it was not widely advertised on the family unit.

Further recommendations

4.8 Posters highlighting the issue of bullying and promoting the anti-bullying policy should be available in a range of relevant languages.

4.9 The safer detention meeting should be multidisciplinary and include representatives from security and healthcare as well as detainee representatives. It should discuss all relevant data related to bullying.

4.10 The Childline freephone number should be prominently advertised on the Crane unit, particularly by the telephones.

Suicide and self-harm

4.11 The management structure overseeing the governance of safer custody should be reviewed. In particular, someone should be identified and provided with sufficient time to oversee day-to-day operational issues relating to suicide and self-harm prevention. (4.16)
Partially achieved. The 'management of residents at risk of self-harm' policy, first issued in September 2007, had been due to be reviewed in September 2009, but no updated document had been produced. The senior manager and coordinator responsible for the development and implementation of the suicide and self-harm prevention policy had been in post since September 2009 and said they were reviewing existing arrangements to assess what changes needed to be made. The suicide and self-harm prevention coordinator was an operational manager. She was also responsible for the management of one of the residential units, but spent about 40% of her time undertaking the coordinator role. This was clearly defined and included the collection and presentation of assessment, care in detention and teamwork (ACDT) data and daily management checks of the 'raised awareness' system and cases requiring a constant watch. Although relatively new to the role, she demonstrated an excellent understanding of the issues and highlighted areas such as data collection and the ACDT assessment and review process that she had already identified for improvement.

4.12 Suitable detainees should be identified to act as peer supporters, particularly on the first night/induction unit, and provided with training and a job description. (4.17)
Not achieved. The centre had accepted this recommendation, but no peer supporter scheme had yet been introduced.
We repeat the recommendation.

4.13 The quality, structure and chairing of case reviews should urgently be improved. (4.18)
Partially achieved. Case reviews were timely and generally well attended by a multidisciplinary group of staff. The chairing of reviews was shared between the six detention and care managers (DCMs), who had been given additional training to improve the quality of this role. All three ACDT reviews we observed were sensitively and effectively chaired by the DCM. They allowed detainees to express their concerns and feelings and attending staff could also contribute. The meetings were held in a relaxed and respectful environment. However, the same case managers did not necessarily chair a detainee's review and chairing was not therefore consistent. In one of the reviews we attended, the chair had not previously met the

detainee and frequent changes in case manager had resulted in inconsistent planning, which meant that the right people were not always at the most appropriate review meeting.

Further recommendation

4.14 A case manager should be appointed at the start of each open assessment, care in detention and teamwork (ACDT) form and manage all aspects of the process until its conclusion. When case managers are not chairing a review, they should take responsibility for ensuring that the right people are represented.

4.15 Management checks should be more proactive in highlighting inadequate entries in continuous observation logs. (4.19)
Achieved. The observation logs were detailed and demonstrated good engagement with detainees. Some of the frequent manager comments simply noted that the file had been checked, but others appropriately added additional observations that added value to the text. Some night observations were too predictable and managers occasionally commented on this, resulting in immediate improvements.

4.16 The safer detention committee should assure itself that the frequency of required observations and intervals between reviews are not set unduly frequently without explanation. (4.20)
Partially achieved. The monthly safer detention committee did not routinely discuss this to satisfy itself that the level of observations was appropriate. However, ACDT paperwork and the reviews we observed showed that decisions on frequency of observations were carefully thought through.

Additional information

4.17 In the previous six months, 58 ACDTs had been opened and 28 detainees had spent some time on a constant watch. The data did not indicate the reasons for detainees' vulnerability, but staff said it was mainly due to their concerns about their future safety should they have to return to their home country. Most detainees we spoke to who had been subject to ACDT procedures said they had been well cared for. The centre also operated a 'raised awareness' procedure if staff had concerns about a detainee. Detainees subject to these procedures were risk assessed daily by managers and transferred to more formal ACDT procedures if they were still giving cause for concern after two assessments. In the previous six months, 135 detainees had been subject to this process.

4.18 The quality of ACDT forms was mixed. Most initial assessments lacked a meaningful assessment of relevant personal and external factors and many assessors simply repeated what the detainee said without attempting to analyse the material. In a number of cases, the final box indicating future action agreed with detainee was either not completed or gave very little detail. We saw one very good initial assessment, which suggested that the required standard could be achieved with further training, supervision and ongoing quality assurance.

4.19 Care maps did not appear to be discussed at every case review and the link between the initial assessment and subsequent care maps was not always clear. Care maps were rarely updated after each review meeting, so the review process was not delivered as intended. The goals prescribed in the care maps were rarely specific to the detainee's immediate care and often focused on future actions outside their control. One detainee who did not want to leave this country was given the goal of remaining in the UK and the action to talk to her solicitor, both of

which were unhelpful. In a number of cases, the detainee was inappropriately named as the person responsible for delivering the actions required, with no reference to how staff would support them in meeting their goals. Concern about removal was clearly a major factor in many detainees' distress, but there was no effective connection between ACDT procedures and removal or release planning (see section on removal and release).

4.20 The management of residents at risk of self-harm policy did not describe how essential information gathered during the ACDT process was passed to those responsible for caring for vulnerable detainees when they were released or removed (see section on removal and release).

4.21 Strategic oversight of suicide and self-harm prevention took place at the monthly safer custody committee meeting, but specific cases of concern were not discussed so lessons could not be learned. There was no consistent format for collecting ACDT data and all the recent monthly reports differed in style and content. Data were presented to the meetings, but issues arising, including identification of emerging patterns and trends, were not discussed. The data did not include information on why detainees self-harmed or when they were at their most vulnerable.

Further recommendations

4.22 Initial assessments should be completed fully and reviewed at the initial review meeting.

4.23 Care maps should be reviewed and updated at all review meetings.

4.24 The self-harm policy should include a section on how this links to preparation for removal and how information is shared with agencies responsible for the removal of detainees after they have left the centre.

4.25 The safer detention committee meeting should discuss individual detainees subject to the ACDT process and develop a system where lessons learned can be used to improve practice.

4.26 The safer detention meeting should identify the patterns and trends relating to suicide and self-harm prevention.

4.27 The centre should collect consistent monthly data, which should include why detainees are considered vulnerable or self-harm and when they are most at risk.

Childcare and child protection

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

4.28 The needs of individual children should always be taken into account when decisions to detain are made. (4.38)
Not achieved. The decision to detain children was taken by case owners and was based on a family booking form completed by case holders in the case-owning office. The forms had been redesigned to take account of checks that needed to be carried out, some of which had been suggested by the independent social worker. Records held in the centre did not include

specific reasons why children and their families had been detained, other than to effect removal and that they were likely to abscond if given temporary admission or release. The assessment of likelihood of absconding was not supported by evidence. The same notice to detainees (reasons for detention and bail rights form) was completed for children and frequently stated that the decision to detain the child had been based on having previously failed or refused to leave the UK when required to do so. This indicated that the initial decision to detain children did not take account of their needs, but was solely based on the perceived over-riding need to detain the parents. There seemed to be no change in practice following the removal of the reservation to Article 22 of the Convention on the Rights of the Child and no consideration of whether detention was essential or in the best interests of the child.

4.29 UKBA told us that a decision to detain children and families would be made only when all rights had been exhausted, removal directions were in place, the family had been offered voluntary departure and packages of assistance had been offered. Caseholders were required to sign a checklist to say that all the requirements were in place. They were also required to carry out checks with local social services and education authorities and confirm that no child was about to sit GCSEs, A levels or their equivalent and that no child was awaiting a mental health assessment. This did not amount to a systematic assessment of the interests, needs and welfare of a child (see also paragraph MR.2).

4.30 There had been some improvements in the centre's gate-keeping mechanisms. There was a daily 'referral' meeting attended by a representative from healthcare, the social workers and the assistant director of children and families services in the centre. All UKBA referrals were considered by these centre staff to ensure that the caseworker had signed off the checklist. We were told that some referrals had been rejected when the checklist had not been completed. There was no indication that UKBA had waited to consider the responses to the enquiries before making a decision to detain the child.
We repeat the recommendation.

4.31 Initial welfare assessments should be completed within seven days of a child's arrival and subsequent assessments should be every seven days and in writing. (4.39)
Partially achieved. A child welfare form based on the Every Child Matters outcomes had recently been introduced. It was described as 'key information and initial assessment'. It included a written instruction 'to be completed by relevant staff within 7 days of arrival'. It had been introduced to unit staff with very limited guidance and no training. 'Relevant staff' referred to in the document were not defined and some of the detainee custody officers we spoke to on Crane were unsure who they were, although managers said custody officers were expected to contribute. A small number of custody officers had made very limited contributions to the document, but we examined all 22 forms and none could be considered to provide key information or could be described as an assessment.

4.32 Weekly welfare meetings were held, involving the social worker, the associate director responsible for children and families, and the youth worker. Unit staff and UKBA staff did not attend. The meetings discussed all detained children individually. They continued to be well attended and provided a very good multidisciplinary forum in which detailed discussions about all children on the unit took place. We observed a good level of information exchange and decision making about the care of individual children. Minutes of the meetings were produced and provided a record of the main points of discussion as well as action points and the person responsible for ensuring that the action was taken. A record was made when the action was completed. However, this information was not transferred to individual files or translated to a welfare monitoring action plan to provide an ongoing weekly update of the initial assessment as intended. This meant unit staff did not have a record of the information shared and decisions made at the meetings and it was not surprising that they did not engage in the

process by contributing to the child welfare forms. Nor was information from this meeting shared with UKBA caseworkers.

4.33 The on-site social workers began separate assessments on the fourteenth day of detention so that they were completed by day 21. These were used to provide annexed material to requests for ministerial authorisation for continued detention. There were also weekly telephone conferences to review the cases of children and families who had been, or were about to be, detained for 28 days or more. These involved the same centre staff as the weekly welfare meetings, but also UKBA caseworkers and the UKBA children's champion. In the great majority of cases where family or child welfare concerns were noted, the social work assessment, or the recommendations following review went no further than to say 'detention should be kept to the absolute minimum'. Moreover, the annexes we examined did not adequately reflect the comprehensive social work assessments or telephone conferences. In addition, it did not appear that new information, available through these mechanisms, was ever used to review the initial decision to detain itself.

4.34 Individual care plans were not completed for all children held in detention, even those held for long periods. However, decisions were sometimes made at the weekly welfare meetings to develop individual behaviour plans or family support plans for children who were causing concerns or whose behaviour was problematic. Those we examined were simple, but clearly addressed the issues and actions were time bounded. The weakness in the plans was the lack of accountability for the action points required, which were usually assigned to an unnamed member of unit staff.

Further recommendations

4.35 The child welfare form should be developed so that it provides a suitably detailed initial assessment.

4.36 All staff who work with children and families should be trained to contribute to the initial assessment and there should be comprehensive staff guidance for their reference.

4.37 The initial assessment should be completed by an independent social worker and used to develop a care plan for each child, to be reviewed and updated at the weekly welfare meeting throughout their period in detention.

4.38 Comprehensive information from assessments and conferences should be set out in an annex to ministerial submissions to review detention after 28 days. Cumulative detention should always be taken into account.

4.39 A clear central record should be maintained of all cases where discharge or transfer takes place as a result of decisions reached through the internal planning processes. (4.40)
Achieved. The centre produced monthly reports setting out the number of children admitted that month who had been transferred, temporarily admitted, bailed or transferred.

4.40 Clear minutes containing action points should be maintained of the telephone conferencing discussions. (4.41)
Achieved. Minutes of the weekly telephone conferences were produced by the family detention unit (FDU). They set out the main points raised during the meetings, the decision regarding detention and included action points where relevant. However, they did not report

follow up to the action points agreed at previous meetings and did not always make clear whether the agreed action had been taken.

Further recommendation

4.41 Action points agreed during the telephone conferences should always be included in the following meeting and the minutes should include a progress report.

4.42 Contributions made by Border and Immigration Agency (now UKBA) caseworkers to the telephone conference should focus on the best interests of the child. (4.42)
Partially achieved. Caseworkers contributed to telephone conferences, but issues relating to the welfare of the children were mainly covered by centre staff and social workers and caseworkers confined their contributions to issues relating to progress with the removal. We observed a telephone conference, during which the children's champion raised concerns about release plans for a mother and her two children relating to previous problems that the family had experienced in a hostel. The caseworker was not aware of the issues, which were directly relevant to the welfare of the children.
We repeat the recommendation.

4.43 Where children need to be admitted to outside hospital, there should be a presumption that this will be done under temporary release unless a risk assessment indicates otherwise. (4.43)
Not achieved. This recommendation had been rejected. There had been no hospital admissions since the previous inspection, but managers were not prepared to accept that temporary release should be the presumption.
We repeat the recommendation.

4.44 Parents should be given greater opportunity to carry out domestic tasks such as cooking and cleaning. (4.44)
Not achieved. There were plans to develop a 'home corner' or family room where parents could prepare and take meals with their children, and cleaning materials were available on request, but there remained few opportunities for parents to look after their children in a setting that mitigated the institutionalised existence.

Further recommendation

4.45 Centre staff should provide as many opportunities as possible for parents to provide and care for their children, such as taking meals together as a family unit rather than communally.

4.46 All information generated under the cause for concern procedures involving children should be referred out to the local authority social services department. (4.45)
Achieved. The cause for concern procedures had been replaced by Keeping Children Safe from Harm procedures. The procedures were modelled on the ACDT procedures to monitor children when staff had any concerns about their welfare. All child concern notifications were passed to the independent on-site social workers and the UKBA child protection coordinator. They were appropriately screened for child protection concerns and relevant cases were referred to Bedford Borough Social Services (intake and assessment team) in accordance with procedures agreed and described in the centre's Keeping Children Safe policy. An internal strategy meeting was held in almost all cases to consider the concerns raised, regardless of child protection implications. The minutes of the strategy meetings demonstrated good multidisciplinary involvement and appropriate decision making. One of the independent social

workers always attended. In the previous 10 months, there had been six child protection referrals to the local authority. There had been no allegations against members of staff and referrals mainly related to concerns about parenting. All referrals had been independently investigated in accordance with agreed procedures with Bedford Borough Social Services.

4.47 A log of all child protection referrals should be held securely in the centre and subject to an independent check by a senior social work manager representing the local authority. (4.46)
Partially achieved. A log was securely held and overseen by attendees of the safeguarding governance group meetings, which included a senior manager from the local authority. However, the meeting arrangements had undergone considerable restructuring and there had been no external attendance since January 2009 (see also additional information on child protection).
We repeat the recommendation.

4.48 The centre should always be represented at the local safeguarding children board. (4.47)
Not achieved. The centre had been represented at three of the last five meetings of the local safeguarding children board (LSCB). Only one meeting had included an agenda item directly related to the centre and its business. The assistant director of children and families services assured us that a number of safeguarding issues discussed at the meetings were relevant to Yarl's Wood and that contributions about Yarl's Wood were made during discussions, but this was not reflected in the minutes and there was no regular update about safeguarding concerns at the centre. Comprehensive and useful safeguarding reports were prepared by the assistant director of children and families services for the centre's safeguarding governance group meetings. These reports, or a modified version of them, would have been a useful way of apprising the LSCB of safeguarding issues at Yarl's Wood.
We repeat the recommendation.

Further recommendation

4.49 The centre should provide a regular report to the local safeguarding children board (LSCB) outlining safeguarding concerns and developments at Yarl's Wood to ensure that safeguarding issues relevant to Yarl's Wood are considered at LSCB meetings.

4.50 Staff conducting reception procedures should receive specialist training on how to identify cases involving trafficked children. (4.48)
Not achieved. The previous assistant director of children and families services had delivered some training to staff based on the specialist training she had received. However, there was no accompanying basic guidance for staff to explain its relevance to Yarl's Wood or describe how staff should care for children who had been trafficked. An annex to the Keeping Children Safe policy related to child trafficking was simply the government guidance, with no local interpretation or explanation of its application. Recent rotation of staff to different positions in the centre meant none of the staff recently allocated to reception duties had completed training on how to identify children who had been trafficked.
We repeat the recommendation.

Further recommendation

4.51 The safeguarding policy should include local guidance based on the national guidance regarding the identification and care of children who have been trafficked.

4.52 Specialist counselling should be available for children. (4.49)
Achieved. (See paragraph 5.14.)

4.53 Young people whose minority is in dispute should be subject to independent professional age assessment before being detained. (4.50)
Not achieved. There had been one age dispute case in the previous four months. This involved a young woman from Sierra Leone who had said she was 17 when in court during the fast track procedure. She was placed in Bunting unit while a Merton assessment was made, which put her age at 23. It took 10 days for the assessment to be carried out.
We repeat the recommendation.

Additional information

Child welfare

4.54 The weekly telephone conferences continued to be an effective way of sharing information about individual children who had been held longer than 28 days and monitoring the effect of detention on their welfare.

4.55 We observed a telephone conference chaired by a senior manager from the family detention unit (FDU). Representation from the centre included the assistant director of children and families services, UKBA managers, the family unit manager, healthcare and the independent senior social worker employed in the centre by a grant agreement with the local authority. The education department did not attend, although a brief educational report was delivered by the social worker as part of the welfare report. Other participants included two representatives from the office of the children's champion (OCC), two representatives from the FDU and the caseworkers from the relevant offices of UKBA with case management responsibility for the children and families under discussion. There were detailed discussions about the children being reviewed and their families. The centre representatives were well informed and gave considered views. The representatives from the OCC asked pertinent questions related to the children's welfare. The meeting served its function to discuss any identified concerns and to expedite removal.

4.56 Cumulative detention was referred to in one case in the conference we observed, but was not routinely mentioned as relevant or not in the other cases under discussion. Minutes of the previous six meetings outlined the discussions and decisions made in all cases, but made few references to cumulative detention. We found only one case where it was recorded that the family had been released on welfare grounds, which were the deterioration of the mother's well being and that of her 17 year old daughter, who had taken on an onerous role caring for her mother. (See also paragraph MR.2.)

4.57 The minutes contained two examples of decisions to release the family because of expected delays in effecting removal. However, there were several other examples of decisions to maintain detention 'for effective removal' even when concerns had been raised about the continued length of detention, predicted in some cases to be several more weeks. In one case, concerns were expressed about the length of detention for four consecutive weeks. The family

had been at Yarl's Wood for 56 days and the length of cumulative detention had been 93 days. There had been a number of failed removals. The decision was recorded as 'cautiously maintain detention'.

4.58 The minutes recorded concerns about the predicted disruptive behaviour of parents, most frequently the mother, and it was clear that previous failed removals, in some cases several, and the impact on the children were of concern. The proposed remedies were equally concerning (see section on removal and release).

4.59 The impact of detention on the welfare of children was evident from the structured interviews we conducted with the three children aged over eight who were in the centre in the early part of the inspection (see appendix IV). The children described feelings of depression and shock at detention. They were worried about, and sometimes protective of, their parents, and distressed at the loss of contact with friends and about being removed from school. One child said he was unhappy because his father had been moved to another centre. Another boy said that he had missed his mock GSCEs and became visibly less interested in schoolwork and more depressed during the inspection. He said 'Felt it was unfair because I had not done anything wrong and it was like being sent to prison. Felt I am being denied my education and that it is going to ruin my life. [I am] worried about my education and future life, worried that mum is unwell, worried for sister who will not have an education'. The children nevertheless appreciated the help and support they received from centre staff, and the youth worker in particular. All the children interviewed were subsequently granted temporary release with their families, which called into question the need to detain them, and to subject them to the inevitable distress and disruption to their lives.

Child protection

4.60 The previous child protection policy had been recently revised and was now the Keeping Children Safe policy, which reflected a broader approach to safeguarding incorporating more than child protection. The policy was comprehensive and described the procedural arrangements with Bedford Borough Social Services. We did not see any examples of these procedures operating in practice, nor were we able to gauge the response of social services to any concerns raised.

4.61 The strategic oversight of safeguarding policy and practice had also very recently changed and there were now two groups with different responsibilities. The safeguarding operations group had an internal membership and met eight times a year to monitor practice and policy issues, particularly those arising from social work interventions. The safeguarding governance group met quarterly and had external members as well as key internal managers. The group had met only once and was still refining its terms of reference. A self audit was due to be completed to report on the centre's compliance with section 11 of the 2004 Children Act. It was anticipated that a large part of the governance group's remit would be to monitor section 11 responsibilities. It was too soon to assess how effective the new arrangements were. However, minutes of the meetings of the previous child protection policy group showed that the meetings had taken place regularly, with wide ranging discussion and reasonable attendance.

4.62 All centre staff were subject to enhanced Criminal Records Bureau clearance. A small number of staff awaiting clearance were identified and not permitted to go on to Crane or have any contact with the children.

4.63 All detainee custody offers had received basic child protection training delivered by the assistant director of children and families services. There was a programme of refresher training and eight staff who had not completed refresher training were scheduled to do so.

Neither the local authority nor the independent social workers were involved in the delivery of child protection training, so participants did not benefit from their expertise and experience.

Further recommendation

4.64 The centre should agree its programme of child protection training with the local safeguarding children board. It should seek the assistance of the local authority in delivering the programme with the help of specialist child protection practitioners.

Diversity

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

4.65 Designated and trained diversity officers should have sufficient time and resources to meet their responsibilities. (4.63)
Partially achieved. Four custody officers had been selected to act as designated diversity officers. All had received one day's training for the role. A job description had been drawn up, which specifically mentioned race relations responsibilities, including to ensure that racist incidents were dealt with and victims of racist incidents supported. However, in the absence of a diversity policy, it did not cover responsibilities relating to any other aspects of diversity, such as disability and sexuality.

Further recommendation

4.66 The responsibilities of diversity officers in their job description should include all aspects of diversity.

4.67 All staff should receive regular training in diversity. (4.64)
Not achieved. Until recently refresher training had been delivered annually. All new staff undertook a diversity and race relations module as part of their initial training course, but no other diversity training had been delivered in the previous six months following the withdrawal of the previous training package. Consequently, only 65% of staff had been trained in diversity and 49% required refresher training. A new training package had just started. Cultural away days for staff had recently been organised and one was delivered during the inspection.
We repeat the recommendation.

4.68 A detailed and comprehensive diversity policy should include recognition of equality obligations. (4.65)
Not achieved. There was still a diversity and equality policy statement, but no diversity policy. We were told one was being developed.
We repeat the recommendation.

4.69 Relevant community groups should be involved in the promotion of diversity at the centre and invited to attend the race, faith and cultural awareness meetings. (4.66)
Not achieved. There were still no external members of the race equality action team (REAT) meetings, which had replaced the race, faith and cultural awareness meetings. Invitations had

been sent to Bedfordshire's Race Equality Council, but without success.
We repeat the recommendation.

4.70 Monitoring by nationality and ethnicity should be undertaken and the results shared with staff and detainees. (4.67)
Achieved. Monthly religious and cultural affairs reports were prepared and submitted to the REAT meeting. Statistics provided each month broke down the population by ethnicity, nationality and religion. Monitoring by ethnicity and nationality was carried out in areas such as complaints, the incentives and earned privileges scheme, detainees accessing the welfare service, detainees subject to rules 40, 41 and 42, access to employment, children's access to education and activities, detainees refusing food and those subject to ACDT procedures. Only the ACDT data were also monitored by religion. The data were presented in a range of formats and included a written analysis highlighting any inconsistencies. An annual report produced in April 2009 showed that all areas monitored were generally proportionate to the make-up of the population. Minor anomalies had been explored and action taken, including reasonably successful efforts to encourage Chinese detainees to apply for work. The data collection and analysis were available to staff on an electronic database and the monthly reports were published in the library for residents, although only in English. There was no comparison of the data month by month to highlight patterns or trends.

Further recommendations

4.71 All data collected for the race equality action team meetings should be monitored by religion.

4.72 Monthly religious and cultural affairs reports should be published in a range of languages.

4.73 Ethnic and nationality monitoring should be routinely analysed to identify patterns or trends.

4.74 Diversity impact assessments should be undertaken. (4.68)
Not achieved. Six months before the inspection, the contract manager and the centre's assistant director of diversity and regimes had considered whether there was a contractual requirement to carry out impact assessments, which are in fact a legal duty on all public bodies and those carrying out duties on their behalf. A decision was made that Serco did not have the resources to carry out impact assessments and UKBA was content with the centre's compliance with the contract. We were told that a scoping exercise was now under way to measure the additional resource required to conduct impact assessments.
We repeat the recommendation.

4.75 Interpreting arrangements should meet the needs of all detainees and a Chinese speaker employed or contracted to ensure routine communication flow with, and pick up the anxieties of, this particularly isolated group. (4.69)
Partially achieved. A Chinese speaker had not been employed, but regular focus groups had been introduced in an effort to improve communication with Chinese and other detainees. Two members of the chaplaincy team acted as Chinese interpreters and minutes of the focus group meetings showed a reasonably wide range of discussion, with between 11 and 22 detainees attending.

4.76 Attendance of detainees at race, faith and cultural affairs meetings should be recorded. (4.70)
Not achieved. REAT meetings took place monthly. There were no nominated detainee representatives as the meetings were an open forum. Staff said there was regularly wide representation by detainees, but this could not be verified as their attendance was still not

recorded.
We repeat the recommendation.

Additional information

4.77 The senior librarian was also the diversity manager. She regularly downloaded from the internet international news items and magazine articles to help detainees keep in touch with events in their country. The library also held a good range of newspapers and magazines in languages other than English. Few notices on display around the centre had been translated into other languages, which did not help alleviate the isolation of detainees who could not speak English. We were told that the high cost of translation services meant the centre prioritised making essential information, most of which was given on induction, accessible to all detainees, but some detainees said they could not remember receiving it (see section on reception, first night and induction).

4.78 There was a comprehensive disability policy, but no identified disability liaison officer. We were told of plans to recruit one. Data on disability were not collected and there was no central list of detainees with disabilities or their locations. Staff said there were fewer than 10 detainees with disabilities at the centre. In our survey, 15 detainees said they had a disability and their responses to questions about safety were significantly worse than those of detainees without a disability. We were shown two simple support plans for two previous detainees with mobility difficulties, one of whom was a wheelchair user. No impact assessments had been carried out, but we were told that the female wheelchair user had made a number of complaints about inaccessibility and her experience had been used to identify physical adaptations required to ensure the centre was fully accessible to detainees with mobility problems.

4.79 There was some evidence of efforts to promote diversity among staff and detainees, including a diversity day organised the week before the inspection. Organisations such as Stonewall, the Royal National Institute for the Blind and the Royal National Institute for the Deaf, various mental health organisations and the Metropolitan Police had been contacted and all had responded positively and provided material for the event. Special demonstrations had been prepared for children. About 30 detainees, (including 10 children) and 26 staff had attended. It was intended to organise diversity events quarterly. A cultural and religious events action plan showed an average of between four and nine events planned a month. Most were religious celebrations, but there had also been several cultural days.

4.80 The minutes of the REAT meetings demonstrated discussion of the ethnic, religious and cultural monitoring reports, racist incidents, promotion of diversity, race and cultural affairs and religious affairs. Disability, sexuality and gender issues were not covered, although there was some discussion of disability at the safer detention meetings. Attendance at REAT meetings was sporadic. Most residential units were usually represented, except for Crane, and healthcare and education had not attended over the previous three months.

4.81 Only two racist incidents had been reported in the previous six months, both of which had been properly investigated and dealt with. One woman had complained about feeling isolated because of her sexual orientation and staff had made a basic plan to monitor her.

Further recommendations

4.82 Notices on display around the centre should be available in a range of languages.

4.83 A disability liaison officer should be appointed.

4.84 Initial assessments should be sufficiently comprehensive to identify all detainees with a disability.

4.85 Information on detainees who declare a disability or are assessed as having a disability should be maintained centrally and essential information passed to residential staff to enable them to meet detainees' specific needs.

4.86 The race equality action team should consider issues relating to sexual orientation, gender and disability.

Faith and religious activity

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

4.87 The multi-faith team should offer more structured classes for detainees. (4.75)
Partially achieved. There had been a slight increase in religious teaching, but there were still few formal classes. The Muslim chaplain held a Qur'an study class on Mondays, but bible studies classes were not timetabled and were held when there was time after services or on request.
We repeat the recommendation.

4.88 The cultural and religious affairs manager (CRAM) should be routinely invited to assessment, care in detention and teamwork reviews. (4.76)
Achieved. The coordinating chaplain was routinely invited to ACDT reviews and attended whenever he could (see also additional information).

Additional information

4.89 In group interviews, faith provision was named as one of the most positive aspects of the centre. About 70% of detainees said they were Christian, 19% were Muslim and 7% Buddhist. In our survey, 76% of detainees said their religious beliefs were respected and 10% did not feel this question applied.

4.90 The full-time Christian coordinating chaplain had good links to external faith groups and managed an adequately sized team. This comprised a Muslim chaplain who normally attended for 10 hours a week and every day during Ramadan, Hindu and Sikh chaplains who attended for three to five hours a week and an Anglican chaplain for a couple of hours a week. A Chinese Christian chaplain attended for five hours a week and was particularly appreciated by the large number of Chinese detainees who spoke little English. There was also a wide range of regular and occasional ministers of different faiths and nationalities, including Buddhist, Eritrean Christian Orthodox, Jehovah's Witness, Jewish, Russian Orthodox and Baptist.

4.91 The coordinating chaplain focused on front-line provision of services, while a diversity and regimes manager was responsible for cultural and religious affairs and for attending relevant management meetings. He and the coordinating chaplain were in regular contact and appeared to work together effectively. The coordinating chaplain had an open door policy and detainees could see him in his office near the central hub. He had a high profile and was known to nearly all detainees we spoke to, regardless of religion. Other ministers walked

around the centre regularly, attended the weekly focus group meetings and sometimes acted as interpreters.

4.92 The centre was advertising for female Muslim women visitors and a Catholic group that attended each week included two female volunteers. The coordinating chaplain had links with an outside group that provided suitcases for detainees leaving the centre.

4.93 There was an attractive central Christian chapel in the multi-faith area next to Dove unit . A nearby mosque, multi-faith room for use by Sikhs and Hindus and a Buddhist prayer room were similarly attractive and welcoming. A separate Christian chapel and multi-faith room was provided on the Crane family unit and another chapel on Bunting unit. All facilities were easy to access and well used, particularly in the evenings. Religious dates and festivals, such as Ramadan, Chinese New Year and the Chinese Moon Festival were celebrated and appreciated by detainees.

Section 5: Health services

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

5.1 Detainees should be able to access the healthcare waiting room independently to attend clinics and triage. (5.44)
Achieved. The healthcare waiting room was open and accessible to detainees throughout the day so they could attend clinics as required.

5.2 Notices and other written literature should be available in a range of appropriate languages. (5.45)
Partially achieved. A limited range of notices and health promotion literature was available in appropriate languages. Efforts were being made to translate further literature.

Further recommendation

5.3 A wide range of health promotion literature should be available in relevant languages.

5.4 All healthcare rooms should be secured by a separate suite key. (5.46)
Not achieved. The main healthcare treatment facility, the archives and the new pharmacy on Crane unit had an additional lock available only to healthcare staff. All other healthcare areas were accessible by any key holder in the centre.
We repeat the recommendation.

5.5 Medications arriving at the centre with detainees and not retained in the detainee's possession should be securely stored. (5.47)
Achieved. All medications arriving at the centre with detainees were either held in possession following risk assessment or securely stored in locked cabinets in the healthcare room in reception.

5.6 The doors to rooms in the in-patient area should have observation panels. (5.48)
Not achieved. Observation panels had not been installed on doors to in-patient rooms and close observation of patients was carried out with the doors open.
We repeat the recommendation.

5.7 Detainees not fluent in English should be interviewed in the presence of a professional interpreter, particularly for interviews that require confidentiality, such as disclosure of sexual assault and psychiatric interviews. A telephone interpreting service should be used only if clinically appropriate. (5.49)
Achieved. Family members and/or other detainees were not longer used to act as interpreters. Professional interpreters were employed as required and healthcare staff made the most use of telephone interpreting services.

5.8 Clinical governance arrangements should be in place. (5.50)
Achieved. Formal clinical governance arrangements had been established, with local and regional meetings that were also attended by representatives from the primary care trust.

5.9 All healthcare staff should have at least annual resuscitation and defibrillation training. (5.51)
Achieved. Mandatory training for all healthcare staff had been established. A rolling programme of courses included annual training in resuscitation and the use of defibrillators.

5.10 All healthcare staff should receive training in the recognition and treatment of signs of trauma and torture. (5.52)
Not achieved. Efforts had been made to obtain appropriate training in the recognition of signs of trauma and torture, but no suitable course had yet been made available to healthcare staff.
We repeat the recommendation.

5.11 An appropriate induction course should be introduced for agency nursing staff. (5.53)
No longer applicable. No agency staff were employed in healthcare. A bank of nursing staff was used and they received the same induction programme as all healthcare staff.

5.12 A registered sick children's nurse should be recruited as a priority. (5.54)
Achieved. A registered sick children's nurse had been employed full time for almost a year. However, she was employed on the nursing roster, which restricted her time to three long days a week with occasional night shifts.

Further recommendation

5.13 The service for nursing children should be available throughout the week.

5.14 Appropriate counselling services should be available for children. (5.55)
Achieved. Appropriate counselling services were available to children and formed a major part of the counselling team's caseload.

5.15 Women should have access to a female GP when required. (5.56)
Partially achieved. Detainees could request to see a female GP if required, but routine provision did not reflect the needs of the mainly female population. Although a female GP had been employed, she provided a clinic for only one day a week, which was insufficient. The other six GPs were male.
We repeat the recommendation.

5.16 Out-of-hours medical arrangements should include visits by a GP where appropriate. (5.57)
Partially achieved. Out-of-hours medical arrangements were provided by the employed GPs, who provided a telephone service and attended on occasions, but not routinely.

Further recommendation

5.17 Out-of-hours cover should include on-site visits by the GP as a matter of routine.

5.18 All nurses should receive clinical supervision and records of this should be maintained. (5.58)
Achieved. Clinical supervision was made available to all nursing staff, mainly in the form of group supervision, and records of meetings were made. One-to-one clinical supervision was available and used more rarely.

5.19 Formal arrangements should be in place with local health and social care agencies for the loan of occupational therapy equipment. (5.59)
Achieved. Formal arrangements had been made with the local health and social care agencies for the loan of occupational therapy equipment. The healthcare centre also had a good supply of its own equipment.

5.20 Record-keeping should be in line with best practice guidelines for healthcare professionals. (5.60)
Achieved. Clinical records were well organised, clear and accurate. All records were on paper, with some electronic support for data collation. Contributions were generally clear and legible.

5.21 A comprehensive, accurate healthcare information leaflet accessible to all detainees should be given to detainees in reception. (5.61)
Achieved. A healthcare leaflet had been produced and was issued to detainees in reception. The leaflet was available only in English, but was being translated into a range of other languages. Details of the leaflet were read to detainees using interpreting services when required.

5.22 Nurse-led clinics should be run by nurses with appropriate post-registration training. (5.62)
Not achieved. An appropriate range of nurse-led clinics was delivered, supervised by the senior nurses of the team. However, specialist post-registration training had not yet been carried out.
We repeat the recommendation.

5.23 Detainees should have direct access to advice by appropriately trained pharmacy staff. (5.63)
Achieved. The pharmacist visited twice a month and additionally as required. She was available to detainees for advice.

5.24 A medicines and therapeutics committee should be established. (5.64)
Achieved. A medicines and therapeutics committee had been established and met quarterly. The pharmacist, medical and nursing staff and the primary care trust (PCT) were represented.

5.25 There should be a local formulary. (5.65)
Achieved. The local PCT formulary had been adopted and was available.

5.26 A mental health needs assessment of adult detainees should be undertaken, and appropriate services provided. (5.66)
Not achieved. A mental health needs assessment of adult detainees was being developed, but no draft was available.
We repeat the recommendation.

5.27 There should be an appropriate mental health pathway for children. (5.67)
Achieved. An appropriate mental health pathway for children had been developed in conjunction with the community mental health team and the child and adolescent mental health service.

5.28 Links should be developed between the centre and the local community mental health team and child and adolescent mental health service. (5.68)
Achieved. Links with the local community mental health team and child and adolescent mental health service had been developed and more formal arrangements were due to commence in January 2010.

Additional information

5.29 Healthcare services were provided by a private healthcare company that had gained the contract about two years previously. There had been significant development of the clinical governance and management arrangements. Healthcare was fully staffed but needed further professional development of the nursing staff. The service was in the final stage of an application to be registered with the Care Quality Commission. The last health needs assessment had been completed in 2007 and the healthcare manager was finding it difficult to get support for a new assessment. The health protection agency had plans to carry out an assessment, but appeared to have competing priorities. There were formal links with Bedfordshire primary care trust (PCT), which contributed to clinical governance meetings and the partnership board.

5.30 A senior nurse was the healthcare contract manager. She was supported by another senior nurse as the deputy healthcare manager, whose primary responsibility was managing the delivery of primary care services. A further 13 full-time nurses (seven general nurses, five mental health nurses and one children's nurse) provided 24-hour healthcare cover. A bank of nine nurses was also available when necessary. Counselling services for adults and children were provided by two counsellors who shared a full-time post. The healthcare manager kept records of professional registrations and clinical supervision sessions when completed. Training plans were well managed.

5.31 Contracts had been agreed for the delivery of dental and pharmacy services. Memoranda of understanding were being developed with Bedfordshire PCT for children's services, accident and emergency care, sexual health, adult mental health and child and adolescent mental health.

5.32 Resuscitation equipment was regularly checked, but the recording of checks was not well organised until the week of our inspection, when a new protocol was established.

5.33 Patients were informed about healthcare services, the opportunity for a second medical opinion and how to complain, but notices were all in English. Detainees did not have the opportunity to discuss healthcare matters in a confidential environment with a dedicated healthcare forum. Their main concern was the long waiting times (see paragraph 5.36). Only a third of detainees, similar to the comparator and to the last inspection, said health services were good or very good.

5.34 Nursing staff had access to a good range of appropriate policies and nursing protocols that had been developed and followed NICE guidelines, but it was not clear that national service frameworks were used to inform practice.

5.35 Healthcare services were provided from the healthcare centre and a separate treatment facility on Crane unit. Fresh case clinics were provided throughout the week and specialist clinics on weekdays. Detainees on Crane unit were escorted to the healthcare centre if they needed to attend any of the specialist services. A separate healthcare consultation room in reception was adequately equipped. A good range of age-related screening tools was available and age-related screening was routine. All detainees were given the opportunity to see a GP and receive secondary screening within 24 hours following initial screening. Staff were sensitive to the needs of detainees and asked appropriate questions about any maltreatment or torture.

5.36 Visiting specialists provided appropriate additional clinics, including weekly visits by a midwife and health visitor. There was limited waiting time for routine appointments, but detainees

complained about longer waits when they were grouped together for some of the specialist clinics. There was an open appointment system and detainees were seen initially by a triage nurse who would then refer to the GP clinic by the following morning at the latest if required.

5.37 Seven GPs were employed from local practices. Contact was made with the individual detainee's previous GP when possible and detainees being released or removed were given a discharge letter outlining any treatment and care provided. A supply of prescribed medication was also given if required.

5.38 A limited list of medication was available to supply on special sick. Other general sales list medicines were available from the pharmacy room, but there was no list of these and most medication was supplied as monthly in-possession, with few patients requiring supervised administration. In-possession risk assessments were made in reception and regularly reviewed by nursing staff. Risk assessments were stored with the medical notes and not attached to the prescription and administration charts. There was no special sick policy. There were no patient group directions, so only medication available from general stores could be supplied without a prescription. Two nurse prescribers could prescribe more potent medication if appropriate.

5.39 The key to the controlled drugs cabinet was held in a digital key-safe and all nurses had access to the combination. There was a limited audit trail to show who had used the key. Thermolabile products could not be proved to have been stored in appropriate conditions. No records could be found for the fridges in the pharmacy room for the previous month and the fridge used to store medicines was outside the acceptable range, with a block of ice forming inside. Methadone was measured using plastic measuring cups rather than stamped glass measures.

5.40 Patients could access medication out of hours on the authority of the local out-of-hours doctors' service, which would fax a prescription that was posted to the centre the following day. Pre-packs were not dual-labelled to reduce the risk of selection errors out of hours.

5.41 Waste medication was de-blistered into waste bins in contravention of the waste regulations. This exposed staff to unnecessary risk.

5.42 Detainees had access to excellent dental services. The facilities were well equipped and in very good order. There was a very short waiting list and detainees were offered a good range of treatments, although the priority was for immediate needs. Emergency and out-of-hours cover was provided by the GPs and the local dental access centre.

5.43 The in-patients facility contained five single rooms and one multisensory room used mainly by the counsellors. The rooms were very clean and well equipped. The facility was rarely used and primarily for detainees requiring isolation. There were no in-patients during the inspection.

5.44 The full-time mental health nurses each saw about 10 patients with mental health problems a month. There was an open referral system and a visiting psychiatrist saw about two patients month. There was no programme for mental health awareness training for custody officers.

Further recommendations

5.45 A health needs assessment should be completed as soon as possible to identify the healthcare requirements of the population. It should take into account general and mental health needs, including those of children.

5.46 Detainees should have access to a dedicated healthcare patients' forum.

5.47 National service frameworks should be used to develop policy as appropriate and should be easily available to all healthcare staff.

5.48 All healthcare appointments should be timed and group attendance avoided to reduce any undue waiting time for detainees.

5.49 A copy of the in-possession risk assessment should be attached to the prescription and administration chart.

5.50 A special sick policy should be developed and reviewed regularly by the medicines and therapeutics committee to ensure that all appropriate medicines can be supplied. Patient group directions should be produced to allow supply of more potent medicines by nursing staff where appropriate.

5.51 The security of the controlled drugs cabinet key should be reviewed and there should be a clear audit trail for each use.

5.52 Methadone mixture should be measured using appropriate glass measures.

5.53 All pre-packs should be dual labelled. When the pre-pack is dispensed against a prescription, one label should be removed from the pack and attached to the prescription chart, which should then be faxed to the pharmacy provider to allow the pharmacist to satisfy him/herself that the prescription is appropriate and that the correct item has been supplied.

5.54 Pharmaceutical waste disposal should be reviewed to comply with the waste regulations that came into force in July 2005.

5.55 Mental health awareness training should be provided on a rolling programme for all staff.

Housekeeping point

5.56 Maximum/minimum temperatures for the drug refrigerators in treatment rooms and the pharmacy should be recorded daily to ensure that thermolabile items are stored within the 2-8°C range. Corrective action should be taken where necessary and monitored by pharmacy staff.

Section 6: Substance use

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

6.1 Protocols should be put in place for the treatment of substance-dependent detainees. (6.3)
Achieved. Protocols were now in place for the treatment of substance-dependent detainees.

Additional information

6.2 There was very little evidence of substance misuse and no specialist services for the management of users. A detoxification procedure was available for detainees with mild use, but such detainees were unlikely to be allocated to Yarl's Wood.

Section 7: Activities

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

Work and learning and skills

7.1 The centre should improve its promotion, quality assurance and monitoring of participation in adult learning and skills activity. (7.22)
Not achieved. Promotion of adult learning and skills activity remained weak and relied largely on notices displayed around the centre. These were often lost among the many other notices and were rarely written simply or clearly. All, including those advertising English for speakers of other languages (ESOL), were in English. Large video screens displayed some information on activities, but no distinction was made between the display in the family unit and other units, although the information did not apply to the family unit. Information given at induction was brief and unmemorable. Quality assurance was very weak. The centre did not self-assess the quality of its learning and skills, work or other activity. There were no observations of learning and skills activity by managers or others to monitor quality or identify areas for development. Monitoring of participation was ineffective. The names and nationalities of those attending sessions were routinely recorded, but not the length of time they attended. Collation and analysis of this data were rudimentary and did not clearly indicate whether provision was suitably inclusive of different nationalities or individuals. Professional development for staff was weak. The arts and crafts officer was not adequately trained and, despite requesting it, had not been offered appropriate training.
We repeat the recommendation.

Additional information

7.2 The centre did not provide enough activity for women to provide mental stimulation or alleviate boredom, particularly for the significant numbers remaining for extended periods. Only a third of respondents to our survey said there was enough to do. The contractual requirements of UKBA for purposeful activity were very limited and largely ignored detainees' needs, particularly for learning and skills activity. The range of activity generally available to adult family members was even more limited, especially for the small number of men detained.

7.3 The centre had more than doubled the number of paid work roles, but this was still insufficient (see section on progress on main recommendations and main recommendation HE.57) and the number of hours attached to most roles was low. Only a quarter were for more than 10 hours a week. The centre had extended the responsibilities of some existing roles, but much of the work was basic, such as serving food. Occasional short-term paid projects offered more interesting tasks, such as sewing curtains. The centre planned to extend paid roles to kitchen work when security issues had been resolved.

7.4 Promotion of paid work was limited. Publicity was mainly through poorly presented posters in English. The application and selection process was not sufficiently formal and included an undocumented promotion system. Before starting work, detainees were required to sign an agreement covering terms and conditions, which was not translated. UKBA staff vetted applications and could refuse permission to work to detainees not cooperating with them, which was inappropriate, as it mixed the centre's objectives to occupy detainees purposefully

with UKBA's removal objectives. Detainees received no formal training before starting work. Planned computer-based training in food hygiene for those working in food service was inoperative.

7.5 Recreational facilities and activity were adequate for those at the centre for short periods. They included two rooms showing culturally and linguistically appropriate films that catered well for some national groups such as Chinese and Indian detainees. All bedrooms had televisions with video playback. There was a well planned calendar of cultural events, including the celebration of religious festivals. Music in Detention visited monthly, offering well attended musical activity days. Some facilities in the main hairdressing salon were available for detainees to use in the evenings and at other times, attracting up to 20 detainees at a time. Monthly discos and weekly bingo games with prizes payable through the shop were popular. There were enough association rooms, some with activities such as pool and a room for board games. The centre had an imaginative plan to provide kitchens for national groups to prepare and cook their own food at certain times, but this had yet to be implemented.

7.6 An enthusiastic member of activity staff offered recreational craft sessions on weekday mornings and afternoons in both the main area and the family unit. Those in the main area were popular, but attendance in the family unit was poor. Detainees learned new skills and practised existing ones, such as paper folding and sewing. However, the centre did not supply basic materials, such as paper or the t-shirts needed for printing and dyeing, which detainees were inappropriately required to buy from the shop.

7.7 There were 11 computers in the main area for internet use and email, available nine hours a day throughout the week. Supervision and arrangements to block unsuitable content and access to inappropriate websites were in place. Detainees could book sessions daily and facilities were well used in the afternoons and evenings. However, the internet connection was slow, making the 30-minute sessions too short. Three computers in the family unit library provided supervised access to the internet and dedicated times catered to the needs of older teenagers and adults.

7.8 Detainees did not have sufficient freedom of movement around the centre. Detainees from the three units where single women were resident were allowed on to the main area for only nine hours a day, significantly below the expectation of at least 12 hours, and freedom of movement between the three units was inappropriately restricted.

Further recommendations

7.9 Detainees' cooperation or failure to cooperate with UKBA should not be part of the process for allocating paid work roles.

7.10 The centre should provide necessary materials for craft sessions free of charge.

7.11 Single women detainees should have at least 12 hours daily freedom of movement within the main communal area and between the three units in which they are resident.

Child education

7.12 The length of the school day should be reduced to reflect practice in the community, particularly for primary age children. (7.23)
Partially achieved. A curriculum review, together with good timetabling and planning, had led

to a formal school day that was more appropriate to, and manageable by, children of primary school age. Providing recreational physical education at the end of the classroom-based lessons worked well, allowing children to work off excess energy at the end of a long and busy school day. However, the length of the school day was still longer than was practice in the community. This was to comply with the requirements in the UKBA contract, rather than on educational grounds.

Further recommendation

7.13 UKBA should revise the contractual requirements concerning the length of the school day to reflect more closely the experiences of children in the community.

7.14 Greater efforts should be made to obtain details of children's prior educational attainment from schools. (7.24)
Achieved. The centre had developed formal systems to obtain information on each child's previous educational attainment. Around 50% of parents refused permission for the centre to contact their child's school, so it was difficult to gain information for a significant proportion. Information that was obtained was used well to help establish meaningful targets for children. The centre had developed some assessments of its own to provide an indication of children's abilities where information from the previous school was not available. Children's targets were based appropriately on the national strategies for literacy and numeracy. Targets and progress were routinely recorded and monitored through individual learning plans, but children were not always aware of their targets or what they needed to do in order to achieve them.

Further recommendation

7.15 Education staff should ensure that children understand their learning targets and what they need to do to achieve them.

7.16 The centre should introduce short units of accreditation for children. (7.25)
Achieved. The Yarl's Wood school had introduced internal accreditation based on the successful achievement of short units of study. Given the very short length of stay of most children, this was appropriate and worked well. Since September 2009, children had achieved 56 units of internal accreditation, based on the subjects covered within the short units. However, children who stayed less than two weeks could not achieve this accreditation and their often considerable achievements were not formally recognised.

Further recommendation

7.17 The centre should establish arrangements to recognise formally the achievements of children who stay for less than two weeks.

7.18 The centre should improve the breadth of the curriculum and provide adequate resources to support this. (7.26)
Achieved. The curriculum and its delivery had been completely revised and there was now an innovative curriculum that successfully met the needs of children, though their ages, abilities and prior attainment were extremely broad. It was much more structured and delivered through a range of themes, such as the lives of famous people, rivers and mountains and habitats. The centre taught national curriculum foundation subjects through these themes, as well as in literacy and numeracy lessons. Daily physical education consisted of a good balance of skill

development and recreational activity. Early indications were that this revised approach to the curriculum worked well as it offered a much broader range of subjects.

7.19 The centre should provide classroom assistants to help teachers better meet the wide range of children's needs within each class. (7.27)
Not achieved. No classroom assistants had been appointed. Progress had been made in developing teaching and learning strategies that catered for the wide range of ages and abilities within lessons. Tasks based around a common theme were set at different levels that generally matched children's individual abilities. However, these good strategies had not reached their full potential as teachers' time was spread too thinly working with children who, despite the range of task levels, found the work too easy or too hard. We observed lessons that, although effective, suffered from the lack of an appropriately qualified classroom assistant to help support the teacher and children with their tasks.
We repeat the recommendation.

7.20 The centre should ensure that teachers receive appropriate professional support and development. (7.28)
Partially achieved. Both teachers were taking professional development courses in personal, social and health education. This was appropriate given their working environment. Links with other local schools were at an early stage of development.

Further recommendation

7.21 The centre should develop effective links with local schools to improve professional support and development for teachers.

7.22 The centre should introduce appropriate arrangements for quality assurance of children's education, including self-evaluation and observation of teaching and learning. (7.29)
Partially achieved. Some lesson observations had taken place and outcomes were recorded in some detail, but some aspects of the lesson judged as strengths were no more than standard practice. The outcomes of lesson observations had yet to be linked formally to appraisal or professional development. The team responsible for children's education at Yarl's Wood had adopted an appropriate and effective self-critical ethos and had made significant progress in improving provision, but the centre had still not produced a formal self-evaluation.

Further recommendation

7.23 The centre should improve the accuracy and use of observations of teaching and learning and establish a formal self-evaluation process.

7.24 The centre should improve the range and quality of out-of-school activity for children, especially at weekends, and this should include better-equipped activity rooms. (7.30)
Achieved. The well managed youth club was very popular with children aged from seven upwards. It had relocated to a more spacious and better equipped ground floor room. Opening hours were between 7pm and 9pm every evening and also between 2pm and 5pm at weekends. All children could use the youth club at these times, rather than different age groups having allocated slots, but this was possible only when the number of children detained was low. The club now opened directly on to an external courtyard, allowing children to use skateboards, scooters and swing ball during the summer. Additional recreational PE in the evenings was popular, but some staff involved were not qualified or adequately trained to lead

and supervise PE sessions for young people. The centre did not provide suitable facilities for outdoor team games.

Further recommendation

7.25 The centre should ensure that officers supervising recreational PE for young people are appropriately trained and qualified.

Additional information

7.26 Education was provided on weekdays in two separate classes; one for children of primary school age (5 to 11) and one for children of secondary school age (11 to 16). There was no formal provision for the small number of children aged 16 or over, although individual programmes were arranged as necessary. The Yarl's Wood school now consisted of purpose-built classrooms, including a good sized computer room, in an attractive new building detached from the residential units. Classrooms were bright and airy and contained displays of children's work. The new school building was respected by children and there was no sign of damage or graffiti. Resources had improved in quality and quantity, with much less reliance on the use of printed worksheets.

7.27 Children's behaviour was good and they enjoyed their learning. They were proud of their achievements and were keen to do their best. One pupil had produced a PowerPoint presentation to a very high standard and spoke about it articulately and with great enthusiasm. Children produced good work when producing bar charts from tally charts. In the lessons observed, learning was active and teachers had prepared interesting and challenging activities. As a result, children's progress and achievement was usually good.

7.28 Attendance at education had improved and was now satisfactory. Progress had been made in monitoring non-attendance and following up the reasons. Punctuality had improved significantly and was now good.

7.29 There was now a clear vision for the school, within the necessary limitations of the range of children it dealt with. Much had been achieved and managers were clear of the need to continue with the improvements.

The nursery

7.30 The centre's nursery continued to cater well for children under five. Its bright, generally well-resourced indoor environment successfully replicated facilities in the wider community. It offered morning and afternoon sessions on 363 days a year. It had capacity for 20 children, but the need to maintain appropriate ratios of staff to children of different ages meant sometimes children could attend only part-time. The centre had used external funding to provide an easily accessible and well-resourced outdoor space for children's play. It had also developed imaginative strategies to get feedback from children on the activities they liked.

7.31 The nursery was registered with Ofsted and had been judged good at its inspection by Ofsted in April 2008.

Library

7.32 The library was situated in the main communal area, with a smaller facility in the family unit. The main library had been extended to include a spacious quiet area in an adjoining room, used also for ESOL classes and meetings. A full-time chartered librarian was responsible for the library, assisted by a detainee who worked for 1.5 hours a day. The librarian divided her time between the two libraries. Activities staff who had received very basic training as library assistants provided supervision during the day in one or other of the libraries and in both in the evenings and at weekends. Access to the libraries was good, with both open for nine hours a day throughout the week and with sessions in the morning, afternoon and evening.

7.33 The extensive book stock included a wide range of fiction and non-fiction books in English and more than 60 other languages, catering for the diversity of the detainees at the centre. Regular replenishment of stock and interchange of books between the two libraries reflected changes to the detainee population. Newspapers and periodicals were available in a wide range of languages. Other newspapers were available on the intranet, accessible from a computer room located close to the main library. The stock of dictionaries and phrase books was adequate. A large number of videos were available for detainees to watch in their rooms, but these were all in English. An appropriate range of easy reader books was available for adults. There were no music CDs or talking books.

7.34 In the family unit library, the range of newspapers and periodicals mirrored closely those of the main library. It had a comfortable cushioned area for young children to sit and read. It stocked an appropriate range of books for children and teenagers.

7.35 Management of the library was generally effective. An appropriate computer-based system facilitated effective management of loans and stock. However, much of the librarian's time was diverted to responding to detainees' requests for advice and assistance with immigration matters. Recording of detainees' visits to the library was rudimentary and did not identify who visited or why. It was not clear how effectively the library reached individuals or groups, or to what extent visits were for advice and assistance rather than to use library facilities and services.

Further recommendations

7.36 The library should provide for loan a range of videos in languages appropriate to the detainee population as well as music CDs and talking books.

7.37 The centre should establish effective arrangements to monitor library use to ensure it meets the needs of individuals and national groups.

Physical education

7.38 The centre should improve induction to physical education (PE) to ensure that it is more timely, comprehensive and includes adequate access to healthcare assessments of detainees' fitness. (7.31)
Not achieved. Induction to the gym was not timely. Some detainees reported a six week wait before induction and no inductions had taken place for more than three weeks due to a shortage of sufficiently qualified staff. Although all detainees routinely received a healthcare

assessment on arrival, this was not readily accessible to staff carrying out inductions. Detainees attending induction were required to return to the health centre to obtain verification of their fitness and return a signed form to this effect to staff running induction. This was unnecessarily complex and time consuming. The centre did not provide an induction or confirm the fitness of detainees participating in activities in the sports hall, such as aerobic sessions. We repeat the recommendation.

7.39 The centre should collate and analyse information on participation in PE to ensure particular groups are not excluded. (7.32)
Not achieved. There was a system to record the names and nationalities of those who used the gym or sports hall, but it did not record the length of time they spent there. Since some sports activities were not supervised, records of those who attended were incomplete. Collation of attendance data was rudimentary and did not allow analysis to determine whether PE sessions were suitably inclusive of different nationalities or individuals.
We repeat the recommendation.

Additional information

7.40 Indoor PE facilities were satisfactory. An adequately sized sports hall was used for activities such as team games, badminton, table tennis, step and aerobic group sessions. The gym was small, but well equipped with modern fitness equipment. Outside facilities had reduced. One of the two enclosed sports areas had been built on and the other was no longer used. Each residential unit had an open air courtyard with space for small team games, but equipment for these was extremely limited. The centre supplied suitable footwear for gym and sports activities and clothing to those who needed it. Visual images were used to promote some sports activities, but some depicted activities not available at Yarl's Wood.

7.41 A well-established rota provided access to the gym and sports hall, with at least four separate timetabled sessions for men and children each week, and more for women. The gym and sports hall were advertised as open seven days a week including evenings, but this schedule was not always followed. On three days of the inspection, the gym was closed for half a day and the sports hall sometimes opened late. In our survey, only 47% of detainees, significantly lower than the comparator, said it was easy to use the gym.

7.42 Too few trained staff were available to supervise the gym or activity in the sports hall. Of 10 staff, four had just started working towards appropriate national vocational qualifications at level 2, and another was working towards a higher level qualification. Others had not received specialist training. Detainees ran popular aerobic classes, but these were strenuous and sessions were long. Supervision by trained staff was needed to ensure the safety of participants, which the centre did not provide.

7.43 The centre recorded and monitored accidents, injuries, assaults and self-harm. However, it did not display information in the gym or sports hall for detainees on what to do if incidents or accidents occurred.

Further recommendations

7.44 The centre should offer regular outdoor activity, including team games, with sufficient suitable equipment for detainees to participate effectively.

7.45	The centre should ensure sufficient appropriately qualified staff to supervise the gym and sports hall whenever it is scheduled to be open, including when activities are led by detainees.

Section 8: Rules and management of the centre

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

Rules of the centre

8.1 All new detainees should be given information about the centre's rules in a form they can understand. (8.24)
Achieved. The induction information booklet contained a set of rules and expectations. It was simple, clear and practical and had been translated into the main languages other than English spoken by detainees.

Additional information

8.2 A copy of the rules and behaviour compact was given to each detainee at induction, but this was when many detainees were disorientated and unlikely to retain the information. The rules and compact were not displayed on residential units in a range of relevant languages and were not available in audio format for those with low levels of literacy in their own language.

Further recommendation

8.3 The rules and behaviour compact should be displayed on all residential units in a range of relevant languages and a recorded audio version made available.

Security

8.4 Staff awareness about the security intelligence system should be raised. (8.25)
Achieved. A new system of security intelligence report forms, based on the prison system, had been introduced, supported by a training programme. The number of reports submitted had approximately doubled in the previous six months.

Additional information

8.5 Physical security was at a reasonable level. The doors of residential units were locked during the day, apparently for reasons of security and safety, so that detainees had to wait until a member of staff could let them out. This did not appear to be justified, restricted free movement and took up staff time. The razor wire had been removed from around the family unit and was being almost entirely removed from the centre.

8.6 Information received was not sufficiently analysed for patterns and trends either within the security department or at the security committee meetings. Reporting at these meetings consisted largely of quantitative analysis by subject. Managers emphasised the importance to security of relationships between staff and residents, and duty directors spent more time than previously talking to detainees in residential areas. There were very few finds of drugs or

alcohol. A number of security information reports submitted by staff in fact referred to health and safety issues.

8.7 There was no routine strip searching. It was occasionally undertaken on the authority of the contract director, such as when a detainee being admitted to separation was suspected of carrying a concealed weapon. The level of personal searching was limited and proportionate. Room searches were carried out quarterly and little was found other than excess or cooked food presenting a potential health hazard. Staff did not carry defensive weapons.

Further recommendations

8.8 The doors of residential units should not be kept locked during the day.

8.9 The security department should provide monthly analysis of patterns and trends arising from information received and this should be discussed at the security meetings as a basis for action planning.

8.10 Staff should be encouraged to submit information about health and safety issues to the health and safety officer rather than the security department.

Rewards scheme

8.11 Awareness about the rewards scheme among detainees should be raised. (8.26)
Partially achieved. Notices in English had been widely displayed, but described only the privileges available at the respective levels of the scheme, not how they could be won or lost. Many detainees we spoke to, particularly those who did not speak English, were unaware of the scheme.

Further recommendation

8.12 Information about the working of the rewards scheme should be given to detainees in a language they understand and reinforced through notices displayed in relevant languages.

8.13 Children's behaviour should play no part in determining the level of the rewards scheme for adults. (8.27)
Achieved. There was no evidence that children's behaviour was taken into account when their parents' rewards scheme status was reviewed. Written instructions to staff had been amended to ensure this did not happen.

Additional information

8.14 The standard level was used sparingly, which was appropriate, and a maximum of five residents were on this level during the inspection. However, detainees were sometimes unjustifiably downgraded for single minor breaches. One woman had been downgraded after rotten food and a needle and thread that should have been returned to the office were found in her room. Another had been found with nail clippers and tweezers. Both women were Vietnamese with a very limited grasp of English. Both had been due for a review after one week, but no review had taken place for five weeks.

8.15 The privileges of enhanced status were access to the clothing bazaar, 30 minutes a day internet access and the ability to apply for paid work, subject to UKBA approval (see section on work and learning and skills). Standard level detainees were restricted to 30 minutes a week of internet access, which inappropriately reduced the amount of their contact with the outside world.

Further recommendations

8.16 Detainees should only be downgraded to the standard level for a pattern of behaviour rather than a single incident, unless that incident is very serious.

8.17 Reviews should be regular and take place on time.

8.18 Reduced access to the internet should not be a penalty within the rewards scheme.

The use of force

8.19 A use of force committee should be set up to monitor trends and patterns and review every incident where force is used against detainees. (8.28)
Not achieved. The monthly security committee received and discussed summary reports on use of force. However, the minutes of only one meeting between January and September 2009 recorded detailed review of individual incidents. The meeting held during the inspection included such a detailed review and viewing of a tape of one incident of use of force. However, the security committee's agenda was very long and it would have been preferable for a use of force committee to be established to review all use of force in full, watch all filmed records, identify patterns and trends and initiate actions accordingly.
We repeat the recommendation.

8.20 Video recordings of planned incidents should include staff briefings and negotiations with detainees before an incident, and incidents should be recorded until the detainee has been seen by a member of healthcare. (8.29)
Achieved. Incidents were now recorded from the staff briefing to the healthcare assessment following the incident. Clear instructions to this effect had been issued to all managers.

8.21 Detainees who have removed some or all of their clothing should be covered with a suitable garment before being taken to reception. (8.30)
Achieved. Modesty blankets with elasticated tops were used to cover up detainees who had removed some or all of their clothes.

8.22 Detainees should only be restrained and carried, including by escorting staff, using approved techniques. (8.31)
Partially achieved. Filmed and written records indicated that approved physical techniques were used. However, several centre staff lacked confidence in live situations and were not equipped with the necessary skills in calm communication under pressure. They sometimes addressed the detainee loudly, repetitiously and all at once when attempting to direct or control their movements, which served only to increase tension and anxiety on all sides.

Further recommendation

8.23 Training in use of force should cover all aspects of communication and teamwork as well as physical techniques.

8.24 The supervising member of Serco staff should remain in overall charge of any incident until the detainee has left the premises. (8.32)
Not achieved. This was not always the case. Instructions to staff allowed formal discharge into the care of escort staff to occur in the separation suite or the rear stair well from the Bunting family care suite. This had occurred on occasions, so that the overseas escort staff took control from there to the departure point.
We repeat the recommendation.

8.25 Responsible managers and healthcare staff should always write a report after any incident involving force against a detainee. (8.33)
Partially achieved. Oversight by managers and monitoring by healthcare staff was generally good, but in some cases evidence of this was missing from the record.
We repeat the recommendation.

8.26 Someone from healthcare should be present for all planned removals. (8.34)
Achieved. Healthcare staff were present at all planned removals and a senior member of the clinical staff attended more complex and difficult removals.

8.27 Healthcare reports relevant to use of force incidents should be quality assured. (8.35)
Achieved. Healthcare reports seen were thorough and of good quality.

Additional information

8.28 Force had been used 33 times from January to September 2009, compared to 20 times in the same period in 2008. Seventeen incidents in 2009 were to prevent self-harm. Managers partially attributed the overall increase in incidents to better recording of such cases. Handcuffs had not been used in any incident in the first nine months of 2009.

8.29 On escorts, handcuffs were used only if justified by risk assessment. Most hospital visits took place without use of handcuffs. A protest in the family unit in June 2009 had resulted in detainees occupying the corridor and a large-scale intervention involving the use of force on a number of men and women in sight of children (see section on removal and release).

Discipline

8.30 The practice of returning single women to Bunting unit for re-induction as a disciplinary measure should cease. (8.36)
Achieved. Detainees who had been separated were always now returned to their original residential unit. Any allocations to Bunting unit other than for induction were made on the basis of specific need for a single room.

8.31 Any decision to move a detainee from their normal wing to another wing for behavioural reasons should be confirmed in writing and authorised by a senior manager. (8.37)
Achieved. Wing files showed that moves for behavioural reasons were authorised by a senior manager.

Single separation

8.32 Detainees should spend the minimum possible time in temporary confinement or removal from association and should be returned to normal location at the earliest opportunity. Managers should review cases where detainees are moved after exactly 24 hours to assure themselves that the move could not have taken place earlier. (8.38) Partially achieved. Of 60 stays in the separation unit between January and September 2009, 11 had been for over 24 hours and a very few close to 24 hours. During the inspection, a detainee was placed in the separation unit after an uncharacteristic outburst (involving lunging at an officer) following the receipt of bad news. She was held in the unit long after she had calmed down, which was said to be intended to underline to staff and detainees that such behaviour was not acceptable. It was therefore in practice a form of unofficial punishment. Supervising staff in the separation unit had no knowledge of why the woman was there, and had no written background information.
We repeat the recommendation.

Further recommendations

8.33 Detainees should never be kept in separation any longer than is justified as a means of managing evidenced and documented risk.

8.34 Detainees should not be placed in separation without supervising staff having written reasons and background information on the circumstances of their separation.

Additional information

8.35 Use of temporary confinement under Rule 42 had increased from seven in the first nine months of 2008 to 13 in the same period in 2009.

8.36 Although managers said separation was not used for monitoring those at risk of self-harm, this was recorded as the primary reason in a number of cases. Some staff felt that separation was the most effective way of monitoring individuals at risk of self-harm, although this was likely to take them away from the active support of peers and compatriots.

8.37 Records made available to inspectors did not show that UKBA always authorised continued separation within the required 24-hour period. On 27 January 2009, a woman had gone into the separation unit at 10.15pm. UKBA authorisation for continuance was recorded as on 29 January, but with no time. The first UKBA visit recorded in the running log was at 5pm on 29 January.

8.38 Use of the 'family care suite' on Bunting unit was recorded in the monthly security reports as 'Bunting RFA' (removal from association). A daily record similar to that for Rule 40 was maintained in the family care suite. A family was kept there for 4.5 days because the child had an infectious disease. None of the checklist of daily tasks had been completed until the fourth day, which was the first day of the inspection.

8.39 Rule 40 paperwork had been used for this suite until the beginning of 2009, when new forms had been produced in consultation with UKBA for 'resettlement' (usually meaning removal) or 'isolation' for up to 48 hours, renewable on the authority of a UKBA senior manager. This did

not appear to be under any detention centre rule. The forms specified initial authorisation by a UKBA senior manager, but this was sometimes completed by a SERCO senior manager.

8.40 If there was an assessed risk of resistance, single women were sometimes located in the Bunting care suite for a few hours before removal. This amounted to separation. They could in this case have access to activities, but only when other detainees were not in the relevant place (such as the gym or IT room). A member of staff was present whenever the care suite was in use. Children in the care suite could attend school and a family care plan was included whenever a family was located there, usually incorporating some element of access to centre facilities, but often at times when no other detainees would be there.

Further recommendations

8.41 Separation should not be used solely to keep safe a detainee at risk of self-harm.

8.42 Managers should investigate the reasons for the increase in the use of temporary confinement under Rule 42 and act on any conclusions with a view to reducing its use.

8.43 All separation, including separation of individuals or families in the Bunting care suite, should be governed by a local policy and should comply with explicit provisions in the Detention Centre Rules.

8.44 Authorisation for separation should be given at the correct times. Where authorisation for separation is required to be given by a UKBA manager, this should never be devolved to a member of the contractor's staff.

Complaints

8.45 The centre should review why detainees have little confidence in the complaints system. (8.39)
Achieved. The complaints system had been reviewed and some changes had been made. It was more widely used, with 37% of detainees in our survey saying they had made a complaint, significantly more than the 27% at the previous inspection. There was a minor complaints system, which was being renamed 'manager requests', to deal with issues that could easily be dealt with at local level. Managers believed staff could clearly distinguish between such issues and matters that required a formal complaint, but instructions by complaint boxes were confusing and indicated that formal complaints were restricted to legal and immigration issues. This was likely to deter detainees from complaining formally about other matters. The range of different complaint routes and methods of handling (UKBA, centre managers, minor complaints) risked causing confusion.

Further recommendations

8.46 UKBA, with centre managers, should review the complaints system to ensure a simple, consistent and unified process.

8.47 Any system for applications or requests should be properly defined and launched, and it should be made clear that this does not prevent detainees complaining about any aspect of their care or treatment.

8.48 Any inappropriate replies to complaints should be sent back to the relevant manager to correct and advise staff on the importance of dealing with complaints appropriately. (8.40)
Partially achieved. The local complaints manager checked responses and returned any deemed inadequate to the respondent. However, while responses to complaints were generally thorough and courteous, they were often defensive in tone. Replies from healthcare, the commonest recipient of complaints, were sometimes abrupt.
We repeat the recommendation.

8.49 Safer custody and diversity issues should be investigated separately, in line with the procedures applicable to those functions. (8.41)
Partially achieved. Racist incident report forms and bullying allegations were normally pursued separately through the relevant managers. However, security intelligence reports relating to possible bullying did not routinely record referral to the anti-bullying manager.

Further recommendation

8.50 Security staff should always refer evidence of bullying to the manager responsible for the anti-bullying strategy and record this on the original security information report.

8.51 Analysis of complaints should be robust so that emerging patterns can be identified. (8.42)
Not achieved. Although complaints were broadly analysed by topic, there was no evidence that patterns or trends were identified. The substance of complaints had not been discussed at senior management team meetings in the previous six months.
We repeat the recommendation.

8.52 The Border and Immigration Agency (now UKBA) should answer complaints in an acceptable timescale and update the centre and detainees regularly. (8.43)
Not achieved. It was still difficult to track performance as UKBA did not feed back to the centre about complaints requiring response from elsewhere. A complaint made by a detainee on 4 November was returned to the centre by UKBA with a request for reply by 30 November, which was too long. The target time for reply within 12 weeks in 95% of cases for complaints referred to the UKBA Professional Standards Unit was also too long for most detainees who spent short periods in the centre.
We repeat the recommendation.

Further recommendation

8.53 All formal complaints should be responded to within three days, or 10 days in exceptional circumstances, with either a resolution or a comprehensive explanation of future action.

Additional information

8.54 In the first nine months of 2009, 56 complaints had been submitted and 16% had been upheld. Medical issues were the most common cause of complaint (32%), with 'poor communication' second (16%). Only three had been answered outside the required timescale. No racist incident reports had been received in this period.

8.55 Complaint forms in 8-10 languages were available on all units, including the separation unit, but not in the Bunting family care suite. There were no complaint forms in English on the separation unit. The complaints boxes were not secure and we were able easily to remove complaint forms from two boxes.

8.56 Members of the Independent Monitoring Board (IMB) were in the centre daily and residents had free access to them. There were IMB post boxes by each of the unit dining rooms and in the library.

Further recommendations

8.57 Complaints boxes should be secure.

8.58 Complaint forms in English and the other main languages used by detainees should be available in all residential areas.

Section 9: Services

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

Catering

9.1 Food, particularly vegetables and rice, should not remain on the hotplate for long periods before serving and the quality should be checked before serving. (9.13)
Not achieved. Temperature checks were made at the point of service, but we saw food uncovered on the hotplate 25 minutes before the start of service.
We repeat the recommendation.

9.2 Non-English-speakers should be encouraged to make comments in the food comments book in their own language. All comments should be analysed and issues discussed at the detainee food and shop consultation meetings. (9.14)
Not achieved. There was no evidence that comments in languages other than English were encouraged or responded to. During the inspection, one such comment was translated, but all other previous comments written in languages other than English had received no response apart from one where the response had been 'no comment'.
We repeat the recommendation.

9.3 Managers should encourage better attendance at the food and shop consultation meetings and assist non-English-speakers to make their views known. (9.15)
Not achieved. Attendance at the monthly food and shop consultation meetings was still low, with only two detainees at the last meeting. Food and shop matters were also raised at the focus groups held by nationality and at the unit drop-in sessions, although no detainees had attended a recent unit drop-in group.

Further recommendation

9.4 Managers should encourage better attendance at the food and shop consultation meetings and bring to that meeting all suggestions made at the focus groups.

9.5 Management should make job opportunities available for detainees in the preparation of meals. (9.16)
Not achieved. No residents worked in the kitchen, although we were told that the systems for storing and accounting for kitchen utensils were due to change in preparation for employing detainees.
We repeat the recommendation.

9.6 Food surveys should be translated so that all detainees have the opportunity to influence the menu, and catering and residential managers should encourage detainees to complete the surveys. (9.17)
Not achieved. A food survey had been distributed in English only shortly before the inspection and no replies had been received.
We repeat the recommendation.

Additional information

9.7 In our survey, only 17% of detainees, significantly worse than the comparator of 27% but better than the 7% at the previous inspection, said the food was good or very good. Methods and standards of cooking were inconsistent. Managers had recently introduced a roster that provided a head chef for every shift and intended to issue standardised recipe instructions. There was a current hygiene certificate from the local environmental health department. Standards of hygiene were generally good, but we found large containers of flour and rice uncovered overnight in the kitchen.

9.8 There were two cooked three-course meals daily and a substantial breakfast. Snacks and drinks were freely available at 9pm and there were also vending machines for snacks and hot and cold drinks. The 28-day menu cycle did not include a wide enough range of healthy options and did not fully reflect the range of cultures in the population. Provision for vegetarians was poor and worse for vegans. A pre-select system had been introduced, but this meant the previously offered culturally themed menus could not be accommodated and were now restricted to evening buffets outside normal meals. Menus did not make enough use of pictures to help non-English speakers to make their selections.

9.9 There were food comments books in each unit dining room, but one book contained no replies to comments made in the previous seven weeks. Responses to critical comments in other books were limited to 'thank you for your thoughts', 'thank you for your comments', 'all the food is prepared to a high standard'.

9.10 All detainees could eat in the unit dining rooms. Detainees not taking meals were reported to the duty operational manager, who compiled a daily list and checked whether they had bought any food items from the shop that day.

Further recommendations

9.11 Managers should revise catering procedures to ensure compliance with the expected standards of food hygiene.

9.12 The 28-day menu cycle should be revised to include a healthier range of options and a better reflection of the cultures and diets in the population.

9.13 More pictorial aids should be used on menus and dining room displays.

9.14 The catering manager should check and respond to entries in the food comments books each week and written responses should be polite and address the issue raised.

Centre shop

9.15 A shop comments book should be available at the two shops and the catering manager should monitor the comments and address any issues at the food and shop consultation meetings. (9.18)
Achieved. Shop comments books had been introduced and issues raised were addressed both immediately by the shop manager and in due course at the consultation meetings.

9.16 Detainees should be consulted on what products they would like to see on the shop list at least twice yearly. (9.19)
Partially achieved. Detainees were consulted only informally by shop staff and at the monthly consultation meetings.
We repeat the recommendation.

9.17 A range of best value discount international telephone cards should be available at the shop. (9.20)
Achieved. The shop now sold international SIM cards, which were regarded by detainees as much better value than the available range of telephone cards.

Additional information

9.18 A new shop facility had recently opened, giving a much better experience close to normal shopping. Prices were reasonable and all goods were sourced locally. Fresh fruit was available and a range of food items was available for different cultural groups. Some over-the-counter remedies were stored. Orders were accepted for the Argos catalogue and processed efficiently, with delivery normally within a week. Detainees could use cash or credit from their centre account. Detainees could withdraw £20 a day of their own money. Managers monitored this and reported any apparent accumulation of unspent money in case of bullying issues.

Section 10: Preparation for release

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

Welfare

10.1 Welfare surgeries should be publicised in languages other than English to ensure that all detainees are aware that these are open to them. (10.14)
Achieved. There were notices in seven languages around the centre about daily welfare surgeries held in the main and Crane libraries. The welfare officer's picture was also on separate posters about the service, alongside that of a second experienced welfare officer who provided cover in his absence. The role was publicised at induction, where detainees were also shown pictures of the welfare officers. There was also a new fax referral form that staff could be used to refer detainees. The number of cases dealt with had risen substantially since the last inspection.

10.2 The welfare officer should be given more time to develop welfare services. (10.15)
Achieved. The welfare officer was no longer required to deliver induction and spent most of his time following up welfare issues. However, the demand was greater than he could satisfy.

Additional information

10.3 There had been a steady rise in demand for welfare provision. The welfare officer was dealing with up to 70 requests a month, averaging 55 over the previous six months, substantially more than at the last inspection. He also recorded around 100 'corridor' or 'office' consultations each month, which did not necessarily result in the start of a new formal record, but might have been related to open cases. He occasionally used a professional telephone interpreting service and at the surgery we observed detainees brought friends along to help interpret.

10.4 Obtaining property left behind at previous accommodation, prisons and particularly police stations formed the largest proportion of referrals. A frequently recorded problem with the last was the difficulty in tracking down responsible police officers, which required persistence and time. The second most common issue was retrieving money for detainees from bank accounts before removal or helping detainees to open accounts. The welfare officer also assisted detainees with a range of other issues, including contact with immigration caseworkers, obtaining solicitors and writing letters, such as to the Prisons and Probation Ombudsman or the Independent Police Complaints Commission. He was often asked for help with legal forms, but was concerned about his lack of training to help with this. He had received no other specific training in advice or guidance and had little time to visit outside agencies to build his knowledge and experience for the benefit of detainees. He had been fully in post for two months, although he had been covering the previous welfare officer's position before then.

10.5 Detailed hand-written records were kept of the substantial cases. Many showed that the welfare officer had determinedly dealt with some difficult issues on behalf of detainees and had continued to work on some cases after detainees had been removed. However, actions were sometimes wrongly recorded as outcomes and it was not always clear what the conclusion of the case had been. The fact that records were handwritten sometimes made them difficult to

decipher. A basic analysis was done of the types of enquiry and the nationalities of those approaching the welfare officer. Nigerian, Chinese and Jamaican women, who formed a large proportion of the centre's population, predominated, although a wide range of nationalities was represented in the figures. No analysis was done to determine if there was any under-representation of nationalities using the service. Some of the work done by the welfare officer assisted people with pre-release concerns, but he was not systematically informed of removals or releases and therefore did not see all detainees who might have needed help (see also section on removal and release). Without further resources, he could not in any event carry out this work on the necessary scale (see main recommendation HE.58).

Further recommendations

10.6 A programme of ongoing welfare training should be developed, which includes visits to relevant outside agencies.

10.7 Welfare records should clearly show outcomes and be computerised.

10.8 There should be an analysis of welfare records to show if there is under-representation of nationalities and action should be taken to reach any groups identified.

Visits

10.9 The visitors' centre should be improved to create a welcoming environment and lockable lockers should be available to all visitors. (10.16)
Achieved. The visitors' centre had been refurbished in May 2009. It was welcoming, comfortably furnished and provided lockable lockers for visitors. There were vending machines for snacks and hot and cold drinks, a DVD screen and a small play area with children's toys. A complaints book was also provided.

10.10 The visitors' centre, visits hall and search area should be appropriately staffed at all times to ensure constant supervision of detainees and visitors, and that visitors can progress through to the visits hall without delay. (10.17)
Achieved. The visitors' centre, visits hall and search area were adequately staffed by a dedicated visits team. Two staff on duty in the visitors' centre welcomed visitors, answered queries and searched property thoroughly and sensitively. Visitors we spoke to said they felt welcomed, had not experienced any delays and had no complaints about the facilities. In our survey, 71% of detainees, significantly more than at the last inspection, said they had been treated well by visits staff. The search area was staffed by one person, with provision for two at busy times. Visitors could be searched by either a woman or a man. Searches were conducted sensitively. Two staff were on duty in the visits hall and the rota ensured that there was always a male and female member of staff. Visits staff said detainees sometimes did not arrive at the visits hall promptly at 6pm as unit staff were still supervising meals and were unavailable to unlock unit doors. One detainee who arrived 30 minutes late said staff had not been available to let her out of her unit.

Further recommendation

10.11 Detainees should be able to be in the visits hall as soon as visiting time commences.

Additional information

10.12 Social visits took place every day from 2pm to 5pm and from 6pm to 9pm. Visitors were allowed to attend both sessions if space permitted. The free transport service to and from Bedford was prominently advertised in the visitors' centre and visits hall. The visits hall was welcoming and relaxed, with a good range of notices and children's toys. Visitors could deliver up to six items and up to £20 in cash to detainees. Snacks and drinks were available from vending machines and racist incident complaint forms and boxes were located in the hall. Appropriate physical contact was permitted. Voluntary visitors were available and used.

Telephones and mail

10.13 Mobile telephone stocks should be kept at a level that meets need. (10.18)
Not achieved. Some detainees still had to wait for a mobile telephone and we saw one distressed woman who had been waiting several days for one. Unit staff said such delays caused tension between them and detainees, but that they had no control over the situation. We were told that more mobile telephones had been ordered.
We repeat the recommendation.

Additional information

10.14 All detainees were given a telephone card to make a free five-minute international telephone call and could keep their mobile telephone so long as it did not have a camera or internet access. Those without a suitable mobile telephone could hire one from the centre for a one off payment of £2 subject to availability (see above).

10.15 All units had several fixed incoming and outgoing telephones, most of which were in a separate room, and all had privacy hoods. Detainees could use the telephone any time, but the incoming line was disconnected at 9pm. Detainees were alerted to an incoming call by pager or over the unit tannoy, although the tannoy was difficult to hear in detainees' rooms or the gym. Switchboard staff said delays connecting incoming calls were caused by detainees not responding to pagers or the tannoy. Callers to the centre said it took a long time to get through to the switchboard. In our survey, only 47% of detainees, significantly worse than the comparator of 59% but better than the 29% at our last inspection, said it was easy or very easy to receive an incoming call. Detainees had free access to the Childline, Samaritans, Legal Services Commission and Asylum and Immigration Tribunal helplines and these numbers were advertised by each telephone and on unit notice boards.

10.16 Detainees did not raise any problems with sending and receiving mail. Postage was free whether for an official letter to legal representatives or to families and friends overseas. Incoming post was distributed around lunchtime and collected mail sent the same afternoon. Detainees opened any incoming parcels in reception to allow the content to be checked.

10.17 Free internet and email equipment had been installed in the main and families unit libraries. A separate internet room was well used by detainees and we saw a member of staff helping them with the facility. However, detainees were restricted to 30-minute sessions, which were not enough, as the machines were slow. There was a fax machine on each unit and detainees said they had easy access to them.

Removal and release

10.18 Between August and October 2009, 512 detainees had been temporarily admitted or given bail. All were offered a rail warrant and were either taken to the station or caught the visitors' free bus. Those who had been transferred to other centres, but were given no written information about their destination. During the same period, 845 detainees had left following issue of removal directions: 554 had been escorted by G4S inland and 143 of these removals (26%) had failed; 291 had been escorted by overseas escorts and 74 (25%) had failed.

10.19 There was no strategy for the removal and release of detainees or any guidance for staff setting out how to advise and support detainees who were leaving Yarl's Wood. No data were collected on the scale or nature of problems detainees faced when leaving the centre. Removal and release was not a functional responsibility allocated to any senior manager at the centre.

10.20 Detention custody managers said officers helped detainees leaving the centre whenever possible. This usually involved referral to the welfare officer (see section on welfare) or advising detainees of the agencies and organisations available to assist them, such as the Red Cross, the International Organisation for Migration and Bail for Immigration Detainees. All these services were advertised on notice boards around the units, although only in English, and details of when the Red Cross was available to detainees were prominently displayed in unit offices for detainees to see.

10.21 None of a sample of 15 unit files of detainees who had recently left the centre mentioned any assistance given by staff with removal and release and we found no further evidence of such assistance in case files. One woman who did not speak English had been at the centre for 36 days, but there were no entries at all in her file. While unit staff actively engaged with detainees, they did not proactively check whether detainees needed help and had little time to help with pre-release concerns (see also section on staff-detainee relationships). It was also clear that unit staff were told of detainees due to leave only 24 hours in advance, so had limited opportunity to offer timely support.

10.22 The welfare officer was not automatically informed of the timings of all removals and releases and therefore was only able to assist detainees who approached him for help or were referred by other staff. Welfare and custody staff generally provided practical support, such as enabling detainees to make free telephone calls to family or friends in their receiving country to help them make plans for their return. Fax machines on each unit facilitated this type of contact. Helping detainees retrieve property before removal was the focus of much of the welfare officer's efforts, particularly when property had been left in police stations (see section on welfare).

10.23 The chaplaincy team had organised bags to be provided for detainees to carry their property on leaving. Suitable bags were not always available and laundry bags were used instead. Staff said black plastic bags were never used. There was no specific provision for detainees who needed more suitable clothing when they returned to their receiving country.

10.24 One single woman whose visa had expired before her accountancy course had finished was due to be removed to Namibia the following day. She had not been able to contact family or friends at home and was very concerned that she would have to find a way to travel hundreds of miles through Namibia without the help of a good internal transport system. Another single woman due to be removed to Jamaica was in a similar position and very concerned about

travel arrangements from the airport to her destination. Neither knew what time they were due to leave the centre or arrive in their respective country. Both said they had not spoken to unit staff and were unaware of any help available from the welfare officers. We also met an anxious woman with children who was being temporarily released but did not know whether she would be able to get keys to her flat. In fact, arrangements were made by the centre and UKBA for the housing authority to meet her at the flat with the keys.

10.25 Some pre-release work was taking place with families as part of the discussions that took place during the telephone conferences, which reviewed the detention of children after 28 days (see section on child welfare). However, we were concerned by some of the instances of family separation or use of force to effect removals, particularly where children were concerned.

10.26 There were several examples of arrangements made to split the family for effective removal. This usually meant separating the family from the father, but in one case the proposal was to separate a five year old child from his mother on their journey to the airport. In another case, separating the father was described as 'leverage over the mother' and in another, separating the mother from her 18 year old son was described as 'leverage to decrease the mother's obstructive behaviour'.

10.27 In January 2009, force had been used to split a family of six so that the father and two children could be removed. The youngest child had been removed by force from his father's grip and a 10 year old child was taken by force into the departure area after refusing to leave his mother. In the same month, force was used on a pregnant woman. Her three year old son had been kept in the family care suite while she was taken to the legal offices to be given removal directions. On leaving the offices, she had refused to move further and called repeatedly for her son. She had been forcibly placed in, and held in, a wheelchair and taken to the family care suite where she was reunited with her son. She became calm and was subsequently removed. The records did not indicate that her son's needs had been considered, although her pregnant condition was taken into account in the preparatory briefing and in the presence of a senior nurse. A month earlier, she had been found screaming in her room, with her son having been sick in front of her, and she had then attempted to strangle herself with a telephone charger cable wrapped twice around her neck. These incidents were rare, and we were assured that they were exceptional, and had been properly authorised and planned in different cases. However, they raised questions about the protection of vulnerable family members from the harm associated with separation from each other for the purposes of removal, a time of great stress. There was no specialist and detailed UKBA guidance on use of force on children.

10.28 Large numbers of escorts were booked to control parents assessed as likely to be disruptive. In one case, it was recorded that eight escorts would be booked because it had taken five escorts to control the father in a previous failed removal. The record of the behaviour of another father, who had removed all his clothes and bitten and scratched several escorts despite being handcuffed, illustrated vividly the distressing experience for children. There were examples of submissions for approval to use force to carry out the removal. These included one submission to use force on a pregnant woman, which did take place (a different case to that mentioned in the paragraph above), and one to use force on an 11 year old and a 15 year old in the same family. In the event, the children did not resist and the application of force was not necessary.

10.29 There were several references in the minutes to the need to 'shield' children when it was anticipated that their parents would be unlikely to cooperate with their removal. During the telephone conference we observed, there was discussion about the need to shield the five year old child from his mother and the suggestion was that he should be provided with a video

and headphones so that he would be distracted from seeing and hearing his mother's distressing behaviour (see section on child welfare).

10.30 During the inspection, a boy aged 10 and girl aged 17 left the centre with their respective mothers. The boy and his mother were notified of their removal to India a week in advance, but the last entry in their unit file, made on the day they were notified, made no reference to it. Neither file contained much evidence of engagement with the family or any pre-release plan. One file referred to issues of contact with the father in another IRC, but there was no removal plan or reference to a removal plan, despite the fact that the difficult relationship between the mother and father would impact on their child. The 17 year old girl was subject to assessment, care in detention and teamwork (ACDT) procedures as there had been significant concerns about her low moods and failure to eat properly. Her final ACDT review identified an appropriate care plan while she remained at the centre, but her unit file, which we looked at the day after she had left, contained no record of the decisions made at the review or reference to a broader pre-release plan.

10.31 We met some women being monitored through the ACDT process whose anxiety was clearly linked to their imminent removal, but who had been offered little help to prepare for their release and alleviate their distress. There was no evidence that strategy meetings took place to develop multidisciplinary care plans and risk assessments to support removal in high risk cases. This was particularly evident in two of the ACDT reviews we attended, where two women threatened suicide or self-harm because they were unable to manage their considerable anxieties about returning to their home country. At one review, the detainee said she intended to commit suicide either at the centre or at the airport rather than return to her home country. She clearly needed coordinated multidisciplinary input to develop a care and risk management plan to ensure her safe removal, but there were no actions in her care map to help alleviate her distress or help her prepare properly for removal.

Further recommendations

10.32 There should be an agreed procedure and routine checks should be made to ensure that suitable bags and clothing are provided for all detainees leaving the centre.

10.33 Detainees being transferred to other places of detention should be given written information about their destination.

10.34 Details of removal and release plans should be maintained in unit files.

10.35 Unit files should demonstrate that meaningful engagement has taken place with detainees as soon their removal or release date is set.

10.36 In planning and managing family removals, priority should be given wherever possible to enabling the family to stay together throughout.

10.37 Strategy meetings should take place to develop multidisciplinary care plans and risk assessments to support removal for detainees considered to be at high risk.

Section 11: Summary of recommendations

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

Main recommendations to the Chief Executive of UKBA

11.1 Reviews of detention should reflect consideration of all relevant information for and against detention, including the effect on detainees of lengthening detention. (HE.49)

11.2 Children should be detained only in exceptional circumstances, where a clear necessity can be evidenced, and only immediately before removal. (HE.50)

11.3 The UK Border Agency should ensure that reports are produced and sent to the Children's Champion, to explain the necessity and circumstances of detention in cases where children have been detained, but subsequently temporarily admitted or released. (HE.51)

11.4 Length of cumulative detention should be clearly and accurately recorded. (HE.52)

11.5 The UK Border Agency should develop and issue specific guidelines on the circumstances in which force can be used on or in front of children, and the methods that can be employed. (HE.53)

Main recommendations to UKBA and centre manager

11.6 Force should be used on children only in exceptional circumstances, where there is a serious and imminent risk of harm to the child or others. (HE.54)

11.7 The range of learning and skills activity for adults should be increased and improved. This should include good quality tuition in English for speakers of other languages and ICT. (HE.56)

Main recommendations to the centre manager

11.8 Staffing levels on the adult units should be reviewed to ensure that staff are able to engage with detainees, perform personal officer work and complete history sheets. All units should have at least two staff on duty at night. (HE.55)

11.9 The centre should extend the number and hours of paid work roles, improve the promotion of the scheme and ensure procedures for recruitment are appropriate and fair. (HE.57)

11.10 The welfare officer should be notified at the earliest possible time of all detainees issued with removal directions, due to be released into the community or transferred. (HE.58)

11.11 There should be a system of properly resourced pre-release planning to ensure that detainees are properly prepared for release, transfer or removal, to deal with any outstanding concerns, with the aim of providing necessary support and minimising forcible or failed removals. (HE.59)

Escort vans and transfers

11.12 Copies of police custody records should accompany all detainees on transfer from police custody. (1.16)

11.13 Families detained in their homes should be allowed to bring medication and necessary belongings with them. Parents should always be able to rouse children and explain what is happening. (1.17)

Immigration casework

11.14 Rule 35 processes should recognise the full scope of the rule, which is to raise a concern whenever detention or conditions of detention are likely to be injurious to health. (3.10)

11.15 UKBA should undertake a comprehensive research audit of the workings of rule 35 with particular attention to whether it is providing the intended important safeguard. (3.11)

11.16 UKBA case owners should reply promptly to detainee correspondence. (3.12)

11.17 Detention reviews and other significant decisions or events, such as removal directions or embassy interviews, should be issued and explained in a language the detainee can understand. (3.14)

11.18 Statistics for the length of detention across the estate as a whole should be completed routinely every month for all detainees. (3.24)

11.19 The UKBA on-site office should ensure that the date of the first immigration detention is recorded on the induction sheet attached to the case file. (3.25)

11.20 Where there is no prospect of a detainee being removed either because removals to the country of origin have been suspended or because that country declines or unreasonably delays issuing travel documents, the UKBA case worker should specifically address continued detention in these circumstances as a matter of law and fact. (3.26)

11.21 The lawfulness of disclosing the record of a detainee's visitors to UKBA case workers should be determined urgently and detailed guidance on data protection requirements provided to all staff responsible for handling personal data on computers. (3.27)

11.22 All relevant risk factors, including whether the detainee is a minor, should be entered on the IS91 form. (3.28)

11.23 The monthly review letters should include a subheading that refers to 'progress since last report' and reasons should always be given when there is a lack of progress. (3.29)

11.24 UKBA should adopt a national policy that bail summaries are issued by case workers to all detainees, regardless of whether they are legally represented, at least one day before the hearing through the on-site immigration team of each immigration removal centre. (3.30)

11.25 The centre's UKBA office should implement a system to monitor that bail summaries are received and in time. (3.31)

11.26 Detainees should be referred to in all documents by name or as 'detainee' or 'resident'. (3.32)

Childcare and child protection

11.27 Contributions made by UKBA caseworkers to the telephone conference should focus on the best interests of the child. (4.42)

Child education

11.28 UKBA should revise the contractual requirements concerning the length of the school day to reflect more closely the experiences of children in the community. (7.13)

Complaints

11.29 UKBA, with centre managers, should review the complaints system to ensure a simple, consistent and unified process. (8.46)

11.30 UKBA should answer complaints in an acceptable timescale and update the centre and detainees regularly. (8.52)

Recommendations to UKBA and escort contractors

Escort vans and transfers

11.31 Individuals detained at reporting centres should be given the opportunity to collect items, including medication, from their home. (1.2)

11.32 Escorts should provide comfort breaks at least every 2.5 hours, or in accordance with passenger needs, and record this accurately. (1.7)

11.33 Escort records should record times of departure and arrival, details of refreshments offered and accepted and information on comfort breaks requested and given. (1.8)

11.34 Escort vehicles should be cleaned and restocked before each journey. (1.14)

11.35 Detainees should be told where they are being taken and provided with written information about the centre. (1.15)

Recommendations to the centre manager

Reception, first night and induction

11.36 The outside areas in reception should contain activities for children. (1.18)

11.37 The welcome arrival video should be available in different languages or formats. (1.19)

11.38 Prison records should be checked in reception and any relevant risk information used to inform the initial risk assessment and room-sharing assessment. (1.32)

11.39 Detainees should not spend long periods in reception. (1.33)

11.40 The level of searching of property in reception should be proportionate to the risk presented by detainees. (1.34)

11.41 Telephone interpreting should be used to interview all detainees who are not fluent in English or do not speak a language also spoken by staff. (1.35)

11.42 All detainees should be given information about the reception process and the centre in a language they can understand. (1.36)

11.43 Reception staff should be trained to identify victims of trafficking and given guidelines on what action to take. (1.37)

11.44 All detainees should receive a full induction that they can understand. (1.38)

Residential units

11.45 The centre should ensure that the temperature in bedrooms is kept at a comfortable level at all times. (2.13)

11.46 Staff should wait for an answer after knocking before entering detainees' rooms. (2.14)

11.47 The hazard created by the protruding metal part on fire doors should be removed. (2.15)

11.48 Signs should be improved and symbols or colour coding used to help detainees locate key areas and facilities. (2.16)

11.49 The centre should eliminate the use of prison-related language wherever possible. (2.17)

11.50 Detainees should be supplied with pillows that provide adequate support. (2.18)

11.51 The thin foam mattresses should be replaced with mattresses that provide adequate support and comfort. (2.19)

11.52 The centre should supply enough cleaning equipment and materials to enable detainees to keep their rooms clean. (2.20)

Staff-detainee relationships

11.53 Detainee history sheets should have regular, detailed and quality-checked entries. (2.24)

11.54 All detainees should have an identified personal or care officer, who should make particular efforts to get to know those who are not fluent in English. (2.25)

11.55 Staff should use professional telephone interpretation whenever needed to communicate with detainees in their care. (2.30)

Legal rights

11.56 The centre should consult with local legal aid solicitors' firms undertaking immigration work with a view to providing a more effective procedure for facilitating access to legal advice and representation by detainees. (3.4)

11.57 There should be guidance and support to enable detainees to use the internet for researching the law and their cases. (3.6)

11.58 There should be a trained person available daily to assist detainees with completing legal forms. (3.7)

Bullying

11.59 An annual bullying survey should be undertaken and the results analysed. (4.4)

11.60 Posters highlighting the issue of bullying and promoting the anti-bullying policy should be available in a range of relevant languages. (4.8)

11.61 The safer detention meeting should be multidisciplinary and include representatives from security and healthcare as well as detainee representatives. It should discuss all relevant data related to bullying. (4.9)

11.62 The Childline freephone number should be prominently advertised on the Crane unit, particularly by the telephones. (4.10)

Suicide and self-harm

11.63 Suitable detainees should be identified to act as peer supporters, particularly on the first night/induction unit, and provided with training and a job description. (4.12)

11.64 A case manager should be appointed at the start of each open assessment, care in detention and teamwork (ACDT) form and manage all aspects of the process until its conclusion. When case managers are not chairing a review, they should take responsibility for ensuring that the right people are represented. (4.14)

11.65 Initial assessments should be completed fully and reviewed at the initial review meeting. (4.22)

11.66 Care maps should be reviewed and updated at all review meetings. (4.23)

11.67 The self-harm policy should include a section on how this links to preparation for removal and how information is shared with agencies responsible for the removal of detainees after they have left the centre. (4.24)

11.68 The safer detention committee meeting should discuss individual detainees subject to the ACDT process and develop a system where lessons learned can be used to improve practice. (4.25)

11.69 The safer detention meeting should identify the patterns and trends relating to suicide and self-harm prevention. (4.26)

11.70 The centre should collect consistent monthly data, which should include why detainees are considered vulnerable or self-harm and when they are most at risk. (4.27)

Childcare and child protection

11.71 The needs of individual children should always be taken into account when decisions to detain are made. (4.28)

11.72 The child welfare form should be developed so that it provides a suitably detailed initial assessment. (4.35)

11.73 All staff who work with children and families should be trained to contribute to the initial assessment and there should be comprehensive staff guidance for their reference. (4.36)

11.74 The initial assessment should be completed by an independent social worker and used to develop a care plan for each child, to be reviewed and updated at the weekly welfare meeting throughout their period in detention. (4.37)

11.75 Comprehensive information from assessments and conferences should be set out in an annex to ministerial submissions to review detention after 28 days. Cumulative detention should always be taken into account. (4.38)

11.76 Action points agreed during the telephone conferences should always be included in the following meeting and the minutes should include a progress report. (4.41)

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

11.78 Centre staff should provide as many opportunities as possible for parents to provide and care for their children, such as taking meals together as a family unit rather than communally. (4.45)

11.79 A log of all child protection referrals should be held securely in the centre and subject to an independent check by a senior social work manager representing the local authority. (4.47)

11.80 The centre should always be represented at the local safeguarding children board. (4.48)

11.81 The centre should provide a regular report to the local safeguarding children board (LSCB) outlining safeguarding concerns and developments at Yarl's Wood to ensure that safeguarding issues relevant to Yarl's Wood are considered at LSCB meetings. (4.49)

11.82 Staff conducting reception procedures should receive specialist training on how to identify cases involving trafficked children. (4.50)

11.83 The safeguarding policy should include local guidance based on the national guidance regarding the identification and care of children who have been trafficked. (4.51)

11.84 Young people whose minority is in dispute should be subject to independent professional age assessment before being detained. (4.53)

11.85 The centre should agree its programme of child protection training with the local safeguarding children board. It should seek the assistance of the local authority in delivering the programme with the help of specialist child protection practitioners. (4.64)

Diversity

11.86 The responsibilities of diversity officers in their job description should include all aspects of diversity. (4.66)

11.87 All staff should receive regular training in diversity. (4.67)

11.88 A detailed and comprehensive diversity policy should include recognition of equality obligations. (4.68)

11.89 Relevant community groups should be involved in the promotion of diversity at the centre and invited to attend the race, faith and cultural awareness meetings. (4.69)

11.90 All data collected for the race equality action team meetings should be monitored by religion. (4.71)

11.91 Monthly religious and cultural affairs reports should be published in a range of languages. (4.72)

11.92 Ethnic and nationality monitoring should be routinely analysed to identify patterns or trends. (4.73)

11.93 Diversity impact assessments should be undertaken. (4.74)

11.94 Attendance of detainees at race, faith and cultural affairs meetings should be recorded. (4.76)

11.95 Notices on display around the centre should be available in a range of languages. (4.82)

11.96 A disability liaison officer should be appointed. (4.83)

11.97 Initial assessments should be sufficiently comprehensive to identify all detainees with a disability. (4.84)

11.98 Information on detainees who declare a disability or are assessed as having a disability should be maintained centrally and essential information passed to residential staff to enable them to meet detainees' specific needs. (4.85)

11.99 The race equality action team should consider issues relating to sexual orientation, gender and disability. (4.86)

Faith and religious activity

11.100 The multi-faith team should offer more structured classes for detainees. (4.87)

Health services

11.101 A wide range of health promotion literature should be available in relevant languages. (5.3)

11.102 All healthcare rooms should be secured by a separate suite key. (5.4)

11.103 The doors to rooms in the in-patient area should have observation panels. (5.6)

11.104 All healthcare staff should receive training in the recognition and treatment of signs of trauma and torture. (5.10)

11.105 The service for nursing children should be available throughout the week. (5.13)

11.106 Women should have access to a female GP when required. (5.15)

11.107 Out-of-hours cover should include on-site visits by the GP as a matter of routine. (5.17)

11.108 Nurse-led clinics should be run by nurses with appropriate post-registration training. (5.22)

11.109 A mental health needs assessment of adult detainees should be undertaken, and appropriate services provided. (5.26)

11.110 A health needs assessment should be completed as soon as possible to identify the healthcare requirements of the population. It should take into account general and mental health needs, including those of children. (5.45)

11.111 Detainees should have access to a dedicated healthcare patients' forum. (5.46)

11.112 National service frameworks should be used to develop policy as appropriate and should be easily available to all healthcare staff. (5.47)

11.113 All healthcare appointments should be timed and group attendance avoided to reduce any undue waiting time for detainees. (5.48)

11.114 A copy of the in-possession risk assessment should be attached to the prescription and administration chart. (5.49)

11.115 A special sick policy should be developed and reviewed regularly by the medicines and therapeutics committee to ensure that all appropriate medicines can be supplied. Patient group directions should be produced to allow supply of more potent medicines by nursing staff where appropriate. (5.50)

11.116 The security of the controlled drugs cabinet key should be reviewed and there should be a clear audit trail for each use. (5.51)

11.117 Methadone mixture should be measured using appropriate glass measures. (5.52)

11.118 All pre-packs should be dual labelled. When the pre-pack is dispensed against a prescription, one label should be removed from the pack and attached to the prescription chart, which should then be faxed to the pharmacy provider to allow the pharmacist to satisfy him/herself that the prescription is appropriate and that the correct item has been supplied. (5.53)

11.119 Pharmaceutical waste disposal should be reviewed to comply with the waste regulations that came into force in July 2005. (5.54)

11.120 Mental health awareness training should be provided on a rolling programme for all staff. (5.55)

Work and learning and skills

11.121 The centre should improve its promotion, quality assurance and monitoring of participation in adult learning and skills activity. (7.1)

11.122 Detainees' cooperation or failure to cooperate with UKBA should not be part of the process for allocating paid work roles. (7.9)

11.123 The centre should provide necessary materials for craft sessions free of charge. (7.10)

11.124 Single women detainees should have at least 12 hours daily freedom of movement within the main communal area and between the three units in which they are resident. (7.11)

Child education

11.125 Education staff should ensure that children understand their learning targets and what they need to do to achieve them. (7.15)

11.126 The centre should establish arrangements to recognise formally the achievements of children who stay for less than two weeks. (7.17)

11.127 The centre should provide classroom assistants to help teachers better meet the wide range of children's needs within each class. (7.19)

11.128 The centre should develop effective links with local schools to improve professional support and development for teachers. (7.21)

11.129 The centre should improve the accuracy and use of observations of teaching and learning and establish a formal self-evaluation process. (7.23)

11.130 The centre should ensure that officers supervising recreational PE for young people are appropriately trained and qualified. (7.25)

11.131 The library should provide for loan a range of videos in languages appropriate to the detainee population as well as music CDs and talking books. (7.36)

11.132 The centre should establish effective arrangements to monitor library use to ensure it meets the needs of individuals and national groups. (7.37)

Physical education

11.133 The centre should improve induction to physical education (PE) to ensure that it is more timely, comprehensive and includes adequate access to healthcare assessments of detainees' fitness. (7.38)

11.134 The centre should collate and analyse information on participation in PE to ensure particular groups are not excluded. (7.39)

11.135 The centre should offer regular outdoor activity, including team games, with sufficient suitable equipment for detainees to participate effectively. (7.44)

11.136 The centre should ensure sufficient appropriately qualified staff to supervise the gym and sports hall whenever it is scheduled to be open, including when activities are led by detainees. (7.45)

Rules of the centre

11.137 The rules and behaviour compact should be displayed on all residential units in a range of relevant languages and a recorded audio version made available. (8.3)

Security

11.138 The doors of residential units should not be kept locked during the day. (8.8)

11.139 The security department should provide monthly analysis of patterns and trends arising from information received and this should be discussed at the security meetings as a basis for action planning. (8.9)

11.140 Staff should be encouraged to submit information about health and safety issues to the health and safety officer rather than the security department. (8.10)

Rewards scheme

11.141 Information about the working of the rewards scheme should be given to detainees a language they understand and reinforced through notices displayed in relevant languages. (8.12)

11.142 Detainees should only be downgraded to the standard level for a pattern of behaviour rather than a single incident, unless that incident is very serious. (8.16)

11.143 Reviews should be regular and take place on time. (8.17)

11.144 Reduced access to the internet should not be a penalty within the rewards scheme. (8.18)

The use of force

11.145 A use of force committee should be set up to monitor trends and patterns and review every incident where force is used against detainees. (8.19)

11.146 Training in use of force should cover all aspects of communication and teamwork as well as physical techniques. (8.23)

11.147 The supervising member of Serco staff should remain in overall charge of any incident until the detainee has left the premises. (8.24)

11.148 Responsible managers and healthcare staff should always write a report after any incident involving force against a detainee. (8.25)

Single separation

11.149 Detainees should spend the minimum possible time in temporary confinement or removal from association and should be returned to normal location at the earliest opportunity. Managers

should review cases where detainees are moved after exactly 24 hours to assure themselves that the move could not have taken place earlier. (8.32)

11.150 Detainees should never be kept in separation any longer than is justified as a means of managing evidenced and documented risk. (8.33)

11.151 Detainees should not be placed in separation without supervising staff having written reasons and background information on the circumstances of their separation. (8.34)

11.152 Separation should not be used solely to keep safe a detainee at risk of self-harm. (8.41)

11.153 Managers should investigate the reasons for the increase in the use of temporary confinement under Rule 42 and act on any conclusions with a view to reducing its use. (8.42)

11.154 All separation, including separation of individuals or families in the Bunting care suite, should be governed by a local policy and should comply with explicit provisions in the Detention Centre Rules. (8.43)

11.155 Authorisation for separation should be given at the correct times. Where authorisation for separation is required to be given by a UKBA manager, this should never be devolved to a member of the contractor's staff. (8.44)

Complaints

11.156 Any system for applications or requests should be properly defined and launched, and it should be made clear that this does not prevent detainees complaining about any aspect of their care or treatment. (8.47)

11.157 Any inappropriate replies to complaints should be sent back to the relevant manager to correct and advise staff on the importance of dealing with complaints appropriately. (8.48)

11.158 Security staff should always refer evidence of bullying to the manager responsible for the anti-bullying strategy and record this on the original security information report. (8.50)

11.159 Analysis of complaints should be robust so that emerging patterns can be identified. (8.51)

11.160 All formal complaints should be responded to within three days, or 10 days in exceptional circumstances, with either a resolution or a comprehensive explanation of future action. (8.53)

11.161 Complaints boxes should be secure. (8.57)

11.162 Complaint forms in English and the other main languages used by detainees should be available in all residential areas. (8.58)

Catering

11.163 Food, particularly vegetables and rice, should not remain on the hotplate for long periods before serving and the quality should be checked before serving. (9.1)

11.164 Non-English-speakers should be encouraged to make comments in the food comments book in their own language. All comments should be analysed and issues discussed at the detainee food and shop consultation meetings. (9.2)

11.165 Managers should encourage better attendance at the food and shop consultation meetings and bring to that meeting all suggestions made at the focus groups. (9.4)

11.166 Management should make job opportunities available for detainees in the preparation of meals. (9.5)

11.167 Food surveys should be translated so that all detainees have the opportunity to influence the menu, and catering and residential managers should encourage detainees to complete the surveys. (9.6)

11.168 Managers should revise catering procedures to ensure compliance with the expected standards of food hygiene. (9.11)

11.169 The 28-day menu cycle should be revised to include a healthier range of options and a better reflection of the cultures and diets in the population. (9.12)

11.170 More pictorial aids should be used on menus and dining room displays. (9.13)

11.171 The catering manager should check and respond to entries in the food comments books each week and written responses should be polite and address the issue raised. (9.14)

Centre shop

11.172 Detainees should be consulted on what products they would like to see on the shop list at least twice yearly. (9.16)

Welfare

11.173 A programme of ongoing welfare training should be developed, which includes visits to relevant outside agencies. (10.6)

11.174 Welfare records should clearly show outcomes and be computerised. (10.7)

11.175 There should be an analysis of welfare records to show if there is under-representation of nationalities and action should be taken to reach any groups identified. (10.8)

Visits

11.176 Detainees should be able to be in the visits hall as soon as visiting time commences. (10.11)

Telephones and mail

11.177 Mobile telephone stocks should be kept at a level that meets need. (10.13)

Removal and release

11.178 There should be an agreed procedure and routine checks should be made to ensure that suitable bags and clothing are provided for all detainees leaving the centre. (10.32)

11.179 Detainees being transferred to other places of detention should be given written information about their destination. (10.33)

11.180 Details of removal and release plans should be maintained in unit files. (10.34)

11.181 Unit files should demonstrate that meaningful engagement has taken place with detainees as soon their removal or release date is set. (10.35)

11.182 In planning and managing family removals, priority should be given wherever possible to enabling the family to stay together throughout. (10.36)

11.183 Strategy meetings should take place to develop multidisciplinary care plans and risk assessments to support removal for detainees considered to be at high risk. (10.37)

Housekeeping points

Residential units

11.184 All staff should be reminded that women on Crane have free unescorted access to the main centre. (2.21)

11.185 Detainees should be given notice of any planned disruption to services such as the water supply. (2.22)

11.186 Clothing provided by the centre should not be referred to as destitute clothing. (2.23)

Health services

11.187 Maximum/minimum temperatures for the drug refrigerators in treatment rooms and the pharmacy should be recorded daily to ensure that thermolabile items are stored within the 2-8°C range. Corrective action should be taken where necessary and monitored by pharmacy staff. (5.56)

Appendix I: Inspection team

Anne Owers	Chief Inspector of Prisons
Hindpal Singh Bhui	Team leader
Fay Deadman	Inspector
Lucy Young	Inspector
Martin Kettle	Inspector
Ian Thomson	Inspector
Madeleine Colvin	Guest inspector
Michael Bowen	Healthcare Inspector
Michael Skidmore	Researcher
Hayley Cripps	Researcher
Catherine Nichols	Researcher
Alastair Pearson	Ofsted inspector
Martin Rhowbotham	Ofsted inspector
Sheila Willis	Ofsted inspector

Appendix II: Population profile

Population breakdown by:

(i) Age	No. of men	No. of women	No. of children	%
Under 1 year			2	0.64
1 to 6 years			13	4.18
7 to 11 years			5	1.6
12 to 16 years			2	0.64
16 to 17 years			2	0.64
18 years to 21 years	1	20		6.72
22 years to 29 years	3	70		22.5
30 years to 39 years	2	102		33.4
40 years to 49 years	2	63		20.9
50 years to 59 years		20		6.4
60 years to 69 years		4		1.2
70 or over				
Total				100

(ii) Nationality	No. of men	No. of women	No. of children	%
Algeria		1		0.32
Angola		2		0.64
Bangladesh		5		1.6
Cameroon	1	2	1	1.28
China		51		16.39
Congo (Brazzaville)		5	1	1.92
Congo Democratic Republic (Zaire)		13	1	4.5
Georgia		3		0.96
Ghana		7		2.25
India	1	11	1	4.9
Iran	1	7	2	3.26
Iraq	1			
Ivory Coast		1		0.32
Jamaica		24		7.71
Kenya		5	1	1.92
Latvia		1		0.32
Liberia		1		0.32
Malaysia		2		0.64
Moldova		1		0.32
Nigeria	1	30	10	13.50
Pakistan	1	10		3.53
Russia		2		0.64
Sierra Leone		3		0.96
Sri Lanka		3		0.96
Trinidad and Tobago		3		0.96
Turkey	1	1	3	1.29
Ukraine		7		2.25

Vietnam		7		2.25
Yugoslavia (FRY)		1		0.32
Zimbabwe		2		0.64
Other	2	69	2	23.47
Total				100

(iv) Religion/belief	No. of men	No. of women	No. of children	%
Buddhist		22		7.07
Roman Catholic		26		8.36
Orthodox		3		0.96
Other Christian religion	3	172	17	61.73
Hindu	1	7	1	2.89
Muslim	3	51	6	19.29
Sikh	1	7		2.57
Agnostic/atheist		9		2.89
Unknown		1		0.32
Other		13		4.18
Total				100

(v) Length of time in detention in this centre	No. of men	No. of women	No. of children	%
Less than 1 week	3	47	12	19.93
1 to 2 weeks	4	38	5	15.11
2 to 4 weeks		44	4	15.43
1 to 2 months	1	60	3	20.57
2 to 4 months		39		12.54
4 to 6 months		19		6.11
6 to 8 months		13		4.18
8 to 10 months		8		2.57
More than 10 months		11		3.53
Total				100

(vi) Detainees' last location before detention in this centre	No. of men	No. of women	No. of children	%
Community	1	28	5	10.93
Another IRC	5	32	13	16.07
A short-term holding facility (e.g. at a port or reporting centre)	2	96	1	31.83
Police station		55	5	19.3
Prison		68		21.9
Total				100

Appendix III: Summary of safety and staff-detainee relationship interviews

Twenty detainees were approached by the research team to undertake structured interviews regarding issues of safety and staff-detainee relationships at Yarl's Wood IRC. Individuals were randomly selected.

Location of interviews

Interviews were undertaken in a private interview room and participation was voluntary. An interview schedule was used to maintain consistency, so all interviewees were asked the same questions. The interview schedule had two distinct sections, the first covering safety and the second staff-detainee relationships.

The demographic information of interviewees is detailed below followed by the results from each section.

Demographic information

- The average length of time in detention was approximately 3.5 months and ranged from five days to 20 months.
- Length of time at Yarl's Wood ranged from five days to 20 months. The average length of time spent at Yarl's Wood was approximately 3.5 months.
- For nine interviewees, this was their first time in detention.
- Ages ranged from 24 to 50 years, the average being 34 years of age.
- Five interviewees were Jamaican, four Nigerian, two Pakistani, two Iranian, two Congolese and one each from the Maldives, China, Trinidad, Uganda and St Lucia.
- All interviewees spoke some English, but only 10 spoke English as a first language.
- Fifteen interviewees identified their religion as Christian, four as Muslim and one interviewee as none.
- Five interviewees stated they had a disability.

Safety

All interviewees were asked to identify areas of concern with regards to safety within Yarl's Wood IRC, as well as rating the problem on a scale of 1-4 (1 = a little unsafe, to 4 = extremely unsafe). A 'seriousness score' was then calculated, by multiplying the number of individuals who thought the issue was a problem by the average rating score.

Scores highlighted in red indicate areas in which over 50% of respondents mentioned the area to be of concern.

	Yes, this is a problem (number of respondents)	Average rate (1 = a little unsafe, to 4 = extremely unsafe)	Seriousness score
Uncertainty/insecurity because of immigration case	14	3.79	53

Staff behaviour with detainees	9	3.22	29
Lack of trust in staff	9	2.89	26
Access to legal advice	7	3.57	25
Lack of confidence in staff	7	3.29	23
Healthcare facilities	8	2.63	21
Lack of communication with family/friends	6	3.5	21
Aggressive body language of staff	8	2.4	19
Lack of information about centre regime	7	2.43	17
Aggressive body language of detainees	5	3.2	16
The way meals are served	4	4	16
Lack of information in translation	4	3.5	14
Isolation (within the centre)	5	2.6	13
Overcrowding	3	3.67	11
Response of staff with regards to fights/bullying in the centre	3	2.67	8
Response of staff to self harm incidents in the centre	2	4	8
Number of staff on duty during the day	2	2.5	5
Surveillance cameras	2	2	4
Layout of the centre	1	4	4
Existence of an illegal market	1	4	4
Availability of drugs	1	3	3
Staff members giving favours in return for something	0	0	0
Gang culture	0	0	0

The top five issues were:

- Uncertainty/insecurity because of immigration case
- Staff behaviour with detainees
- Lack of trust in staff
- Access to legal advice
- Lack of confidence in staff

Overall rating

Interviewees were asked to give an overall rating for safety, with 1 being very bad and 4 being very good. The average rating was 2.5.

A breakdown of the scores given is shown in the table below:

1	2	3	4
5 (25%)	4 (20%)	7 (35%)	4 (20%)

Staff-detainee relationships

All interviewees were asked to rate their relationship with staff for the following questions. For each question, a breakdown of responses is provided, as well as an average rating, where applicable. Missing data have been excluded.

Do you feel that staff are respectful towards you?

1 Completely	2	3	4 Not at all
5 (25%)	10 (50%)	4 (20%)	1 (5%)

The average rating was 2.05

How often are staff appropriate in their comments and attitudes to you?

1 Always	2	3	4 Never
7 (39%)	6 (33%)	2 (11%)	3 (17%)

The average rating was 2.06

How often do wing staff address you by your first name or by Ms?

1 Always	2	3	4 Never
16 (80%)	2 (10%)	2 (10%)	0 (0%)

The average rating was 1.3

How often do wing staff knock before entering your room?

1 Always	2	3	4 Never
11 (55%)	4 (20%)	4 (20%)	1 (5%)

The average rating was 1.8

How helpful are staff generally with questions and day to day issues?

1 Very helpful	2	3	4 Not at all helpful
9 (47%)	4 (21%)	3 (16%)	3 (16%)

The average rating was 2

How often are staff appropriate in their behaviour?

1 Always	2	3	4 Never
7 (39%)	7 (39%)	1 (6%)	3 (17%)

The average rating was 2

Do staff treat detainees fairly?

1 Completely	2	3	4 Not at all
7 (37%)	6 (32%)	3 (16%)	3 (16%)

The average rating was 2.1

Would staff take it seriously if you were being victimised or bullied?

Yes	No	Depends who you approach
12 (75%)	1 (6%)	3 (19%)

How often do staff interact with you?

1 Always	2	3	4 Never
7 (35%)	3 (15%)	3 (15%)	7 (35%)

The average rating was 2.5

Do you have a member of staff to turn to if you have a problem?

Five (25%) stated they did not. Of the 15 (75%) who said they did, they gave the following rating of how many staff they felt they could approach:

1 Many	2	3	4 One
7 (50%)	0 (0%)	4 (29%)	3 (21%)

The average rating was 2.2

Do staff challenge inappropriate behaviour?

1 Always	2	3	4 Never
5 (33%)	7 (47%)	1 (7%)	2 (13%)

The average rating was 2

Do staff actively encourage you to take part in activities within the centre?

1 Always	2	3	4 Never
6 (33%)	1 (6%)	1 (6%)	10 (56%)

The average rating was 2.8

Have you ever been discriminated against by staff because of:

Your culture or ethnicity

Yes	No
4 (20%)	16 (80%)

Your nationality

Yes	No
4 (20%)	16 (80%)

Your religion

Yes	No
1 (5%)	19 (95%)

Your age

Yes	No
0 (0%)	20 (100%)

You have a disability

Yes	No
0 (0%)	19 (100%)

Your sexual orientation

Yes	No
0 (0%)	20 (100%)

Overall rating

Interviewees were asked to give an overall rating for staff-detainee relationships at Yarl's Wood IRC, with 1 being excellent and 4 being poor. The average rating was 2.25.

A breakdown of the scores given is shown in the table below:

1	2	3	4
4 (20%)	10 (50%)	3 (15%)	3 (15%)

Appendix IV: Children's interviews

At the time of inspection, there were three children over eight years in the centre. All were interviewed using a children's interview schedule. Parents were spoken to before interviews were conducted with their children to explain the purpose of the interview and to request permission to interview their child. No parent refused. The responses are summarised from children's replies and are not exact quotes.

Child 1: A 10 year old Indian boy who had been at the centre for 19 days and had previously spent 27 days at another centre. He was at the centre with his mother and they were due to be removed to India on 12 November. His father had been held at Yarl's Wood too, but was moved, apparently as a result of poor behaviour in the centre.

Child 2: A 17 year old Turkish girl who was at the centre with her parents and young brothers, aged 16 and 7 years. The family had been at the centre for four days and had previously been at Tinsley House IRC for five days. Her mother was ill (back pains) could not speak English and Child two interpreted for her.

Child 3: A 16 year Turkish boy, brother of Child 2 and the eldest of the two boys in the family. He was also seen interpreting for his mother. He said the family were from south London and his father had worked in restaurants for 10 years. The family had been 'signing on at the police station for years'. The boy was at school and was due to take GCSEs in 2010. He said his sister was at college and younger brother was also at school. He was very worried about his mother's health. The family had a bail application on 13 November and he was desperate for it to be successful. His mood was very low.

General comments

All the children said that they came to the centre by minibus or car. Child 3 said that it was very hot in the vehicle they came in from Tinsley House. He was worried for his sister and mother, both of whom suffer from asthma. Both Turkish children said there was not enough to do. The boy said that he had started school at the centre, but it was boring so he stopped. Child 1 said there was enough to do, but he sometimes became bored at lunch time and when there was no school or youth club. The Turkish children said they spent a lot of time in their room watching television. They and Child 1 all went to the youth club and all said it was the best thing about the centre.

Replies to questions

Question: How did you feel when you first arrived at the centre?
Child 1: Scared.
Child 2: Depressed and shocked.
Child 3: Felt very bad – was angry and sad at the same time. Felt it was unfair because I had not done anything wrong and it was like being sent to prison. Feel I am being denied my education and that it is going to ruin my life.

Question: Do you feel happy at the moment?
Child 1: I'm OK.
Child 2: No, I feel depressed.
Child 3: No, I miss school and my friends.

Question: What things make you happy here at the centre?
Child 1: Having mum with me.
Child 2: Youth club.
Child 3: Nothing – but happier because the workers at the centre are nice to him. They are all nice and help my family a lot.

Question: What things make you unhappy?
Child 1: That my dad was moved to another centre.
Child 2: Food and unclean showers and beds.
Child 3: All things.

Safety

Question: Do you feel frightened/worried at this centre?
Child 1: No.
Child 2: No – feel safe but after 11 at night there are people shouting. Makes me frightened.
Child 3: Yes – worried about my education and future life; worried that mum is unwell; worried for sister who will not have an education.

Question: What helps you not feel frightened and worried?
Child 2: Officers checking the corridors at night.
Child 3: The thought of going home.

Question: If you were unhappy, frightened or worried about something, who would you tell?
Child 1: Mum.
Child 2: Officers who are friendly, they are so good (also told my family).
Child 3: The youth worker, she is my friend (also family). Know about Childline from the TV, but not told about it.

Illness

Question: Have you felt ill or been injured since being here?
Child 1: Yes – dizziness and stomach ache.
Child 2: Yes – asthma. I now have leg and back pain.
Child 3: Yes – I have felt ill. I had a temperature at Tinsley House.

Question: If so did you tell anyone?
Child 1: Yes – mum.
Child 2: Yes – nurse and then the doctor.
Child 3: Yes – just told mum and dad [did not tell doctor].

Question: What did they do to help?
Child 1: Took me to see the nurse and then the doctor.
Child 2: Nothing, I have an inhaler already.
Child 3: I didn't feel that I needed any help. Mum was more ill so I was more worried about her.

Staff

Various comments – they all said they liked the staff.

Child 1: Officers are good – the doctor and nurse are nice. They have time to listen.

Child 2: Staff are friendly and I am able to talk to them anytime. We have fun with them. However, I felt pressurised and bullied in the reception area; we were told to sign documents.
Child 3: Staff were very nice to the whole family – all staff were fine and no complaints.

Overall impressions

Question: Overall, what do you think of it here?
Child 1: It's all right.
Child 2: No comment.
Child 3: It's all right, but it's not a place I want to be in.

Question: What do you like most?
Child 1: I like the play area, but it's not big enough.
Child 2: Nothing said.
Child 3: Youth club and the youth leader.

Question: What do like least?
All said the food and Child 2 said dirty showers and dirty bed clothes.

Question: if you could change one thing about the centre what would it be?
Child 1: The food is nearly the same every day.
Child 2: Food – different foods, more careful preparation of food and allowing us to cook our own food.
Child 3: Food.

Appendix V: Summary of detainee survey responses

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

Choosing the sample size

At the time of the survey on 4 – 6 November 2009, the detainee population at Yarl's Wood was 326. The questionnaire was offered to all detainees.

Selecting the sample

Questionnaires were offered to all adult detainees available at the time of the visit. Detainees were approached at meal times and also on the units. This ensured that all detainees were approached by the Inspectorate.

Completion of the questionnaire was voluntary. Questionnaires were offered in 23 different languages.

Interviews were carried out with any respondents with literacy difficulties. In total, one respondent was interviewed.

Methodology

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

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

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

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

Response rates

In total, 101 respondents completed and returned their questionnaires. This represented 31% of the detainee population. Sixty-nine questionnaires (68%) were returned in English, 12 (12%) in Chinese, four (4%) in French and Urdu, two (2%) in Bengali, Farsi, Punjabi, Spanish and Russian and one each (1%) in Portuguese and Vietnamese.

Comparisons

The following details the results from the survey. Data from each centre has been weighted in order to mimic a consistent percentage sampled in each centre.

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses are excluded from the analysis.

Presented alongside the results from this survey are the comparator figures for all detainees surveyed in detention centres. This comparator is based on all responses from detainee surveys carried out in nine detention centres since April 2006. This document also shows statistically significant differences between the responses of detainees at Yarl's Wood IRC in 2008 and those from detainees in 2009.

In addition, further comparative documents are attached. These detail statistically significant differences between the responses of non-English speaking detainees and English speaking detainees and between the responses of detainees who consider themselves to have a disability and those who do not.

In all the above documents, statistical significance is used to indicate whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading and where there is no significant difference, there is no shading. Orange shading has been used to show a significant difference in detainees' background details.

It should be noted that, in order for statistical comparisons to be made between the most recent survey data and that of the previous survey, both sets of data have been coded in the same way. This may result in percentages from previous surveys looking higher or lower. However, both percentages are true of the populations they were taken from and the statistical significance is correct.

Summary

In addition, a summary of the survey results is attached. This shows a breakdown of responses for each question. Percentages have been rounded and therefore may not add up to 100%.

No questions have been filtered within the summary so all percentages refer to responses from the entire sample. The percentages to certain responses within the summary, for example 'Not made a complaint' options across questions, may differ slightly. This is due to different response rates across questions, meaning that the percentages have been calculated out of different totals (all missing data is excluded). The actual numbers will match up as the data are cleaned to be consistent.

Percentages shown in the summary may differ by 1% or 2% from that shown in the comparison data as the comparator data have been weighted for comparison purposes.

Section One: About You

Q1 Are you male or female?

Male	5%
Female	95%

Q2 What is your age?

Under 18	2%
18-21	6%
22-29	28%
30-39	35%
40-49	18%
50-59	9%
60-69	1%
70 or over	0%

Q3 What region are you from? (Please tick only one.)

Africa	40%
North America	0%
South America	4%
Indian subcontinent (India, Pakistan, Bangladesh, Sri Lanka)	14%
China	12%
Other Asia	8%
Caribbean	12%
Europe	6%
Middle East	2%

Q5 Is English your first language?

Yes	24%
No	76%

Q6 Do you understand spoken English?

Yes	75%
No	25%

Q7 Do you understand written English?

Yes	64%
No	36%

Q8 What would you classify, if any, as your religious group?

None	4%
Church of England	4%
Catholic	17%
Protestant	7%
Other Christian denomination	36%
Buddhist	7%
Hindu	7%
Jewish	0%
Muslim	18%
Sikh	1%

Q9 **Do you consider yourself to have a disability?**

Yes 16%

No 84%

Q10 **Do you have any children under the age of 18?**

Yes 42%

No 58%

Section Two: Immigration Detention

Q11 **When being detained, were you told the reasons why in a language you could understand?**

Yes 75%

No 25%

Q12 **Following detention, were you given written reasons why you were being detained in a language you could understand?**

Yes 70%

No 30%

Q13 **Were you first detained in a police station?**

Yes 54%

No 46%

Q14 **Including this centre, how many places have you been held in as an immigration detainee since being detained (i*ncluding police stations, airport detention rooms, removal centres, and prison following end of sentence*)?**

One to two 74%

Three to five 24%

Six or more 2%

Q15 **How long have you been in detention here?**

Less than 1 week 15%

More than 1 week less than 1 month 27%

More than 1 month less than 3 months 29%

More than 3 months less than 6 months 16%

More than 6 months less than 9 months 4%

More than 9 months less than 12 months 4%

More than 12 months 5%

Section Three: Transfers and escorts

Q16 **Did you know where you were going when you left the last place where you were detained?**

Yes 38%

No 57%

Do not remember 4%

Q17 **Before you arrived here did you receive any written information about what would happen to you in a language you could understand?**

Yes 36%

No 59%

Do not remember 4%

Q18 How long did you spend in the escort vehicle to get to this centre on your most recent journey?

Less than one hour	2%
One to two hours	18%
Two to four hours	38%
More than four hours	35%
Do not remember	6%

Q19 How did you feel you were treated by the escort staff?

Very Well	15%
Well	41%
Neither	24%
Badly	10%
Very Badly	6%
Do not remember	3%

Section Four: Reception and first night

Q21 Were you seen by a member of healthcare staff in reception?

Yes	94%
No	6%
Do not remember	0%

Q22 When you were searched in reception, was this carried out in a sensitive way?

Yes	75%
No	15%
Do not remember/not applicable	9%

Q23 Overall, how well did you feel you were treated by staff in reception?

Very well	21%
Well	43%
Neither	26%
Badly	5%
Very badly	5%
Do not remember	0%

Q24 On your day of arrival, did you receive any of the following? (Please tick all that apply to you.)

Information about what was going to happen to you	30%
Information about what support was available to people feeling depressed or suicidal	15%
Information about how to make applications	18%
Information about healthcare services at this Centre	51%
Information about the religious team	45%
Information on how to make a bail application	22%
Information about how people can visit you	54%
Did not receive anything	27%

Q25 Was any of this information given to you in a translated form?

Do not need translated material	27%
Yes	17%
No	57%

Q26 On your day of arrival were you given any of the following? (Please tick all that apply to you.)

Something to eat	85%
The opportunity to make a free telephone call	81%
The opportunity to have a shower	70%
The opportunity to change into clean clothing	54%
Did not receive anything	4%

Q27 Did you feel safe on your first night here?

Yes	43%
No	55%
Do not remember	2%

Q28 Did you have any of the following problems when you first arrived here? (Please tick all that apply to you.)

Not had any problems	24%
Loss of property	24%
Housing/accommodation	10%
Contacting employers	7%
Contacting family	21%
Ensuring dependants were being looked after	7%
Access to phone numbers	16%
Access to legal advice	27%
Access to your immigration case papers	20%
Money/debt problems	10%
Feeling depressed or suicidal	40%
Drug problems	5%
Alcohol problems	1%
Health problems	36%
Needing protection from other detainees	7%

Q29 Did you receive any help/support from any member of staff in dealing with these problems within the first 24 hours?

Not had any problems	28%
Yes	23%
No	48%

Section Five: Legal rights and immigration

Q31 Do you have a solicitor/legal representative?

Do not need one	4%
Yes	73%
No	23%

Q32 Do you get legal aid (*free advice under the legal aid scheme)?*

Do not need legal advice	4%
Yes	38%
No	57%

Q33 How easy or difficult is it to communicate with your solicitor or legal representative?

Very easy	1%
Easy	24%
Neither	13%
Difficult	20%
Very difficult	14%
Not applicable	28%

Q34 Are you able to send a fax to your legal representative free of charge?

Yes	69%
No	2%
Do not know/not applicable	29%

Q35 Are you able to send letters to your legal representative free of charge?

Yes	40%
No	7%
Do not know/not applicable	53%

Q36 Have you had a visit from your solicitor/legal representative?

Do not have one	28%
Yes	41%
No	31%

Q37 Can you get hold of books about your legal rights?

Yes	27%
No	31%
Do not know/not applicable	42%

Q38 How easy or difficult is it for you to obtain bail information?

Very easy	6%
Easy	21%
Neither	16%
Difficult	22%
Very difficult	24%
Not applicable	10%

Q39 Can you get access to official information reports on your country?

Yes	10%
No	55%
Do not know/not applicable	34%

Q40 How easy or difficult is it to see immigration staff when you want?

Do not know/have not tried	28%
Very easy	1%
Easy	12%
Neither	17%
Difficult	15%
Very difficult	27%

Q41 **Have you had a review of your detention every month?**
(You should have had a review if you have been in detention anywhere for over one month.)

Not been in detention for over a month	29%
Yes	43%
No	11%
Don't know	16%

Q42 **If yes, was the review written in a language you could understand?**

Have not had a review	47%
Yes	41%
No	12%

Section Six: Respectful detention

Q44 **Are you normally offered enough clean, suitable clothes for the week?**

Yes	41%
No	59%

Q45 **Are you normally able to have a shower every day?**

Yes	97%
No	3%

Q46 **Is it normally quiet enough for you to be able to relax or sleep in your room at night time?**

Yes	49%
No	51%

Q47 **Can you normally get access to your property held by staff at the centre, if you need to?**

Yes	47%
No	39%
Do not know	14%

Q48 **What is the food like here?**

Very good	3%
Good	14%
Neither	31%
Bad	24%
Very bad	28%

Q49 **Does the shop sell a wide enough range of goods to meet your needs?**

Have not bought anything yet	6%
Yes	30%
No	63%

Q50 **Do you feel that your religious beliefs are respected?**

Yes	76%
No	15%
Not applicable	10%

Q51 **Are you able to speak to a religious leader of your faith in private if you want to?**

Yes	55%
No	11%
Do not know/not applicable	34%

Q52 **How easy or difficult is it for you to contact the Independent Monitoring Board?**

Do not know who they are	64%
Very easy	0%
Easy	7%
Neither	15%
Difficult	6%
Very difficult	8%

Q53 **How easy or difficult is it to get a complaint form?**

Very easy	21%
Easy	33%
Neither	3%
Difficult	3%
Very difficult	5%
Do not know	35%

Q54 **Have you made a complaint since you have been at this centre?**

Yes	37%
No	48%
Do not know how to	15%

Q55 **If yes, please answer the following questions about complaints:**

	Yes	*No*	***Not made a complaint***
Do you feel complaints are sorted out fairly?	11%	24%	65%
Do you feel complaints are sorted out promptly?	7%	21%	72%

Section Seven: Staff

Q57 **Do you have a member of staff at the Centre that you can turn to for help if you have a problem?**

Yes	64%
No	36%

Q58 **Do most staff at the Centre treat you with respect?**

Yes	64%
No	36%

Q59 **How often do staff normally speak to you?**

Never	8%
Rarely	24%
Some of the time	38%
Most of the time	19%
All of the time	11%

Q60 **Have any members of staff physically restrained you (C&R) in the last six months?**

Yes	6%
No	94%

Q61 **Have you spent a night in the separation/isolation unit in the last six months?**

Yes 8%

No 92%

Section Eight: Safety

Q63 **Have you ever felt unsafe in this centre?**

Yes 46%

No 54%

Q64 **Do you feel unsafe in this centre at the moment?**

Yes 40%

No 60%

Q65 **Has another detainee or group of detainees victimised (insulted or assaulted) you here?**

Yes 24%

No ..... 76% **If No, go to question 67**

Q66 **If you have felt victimised by a detainee/group of detainees, what did the incident(s) involve? (Please tick all that apply to you.)**

Insulting remarks (about you or your family or friends) 8%

Physical abuse (being hit, kicked or assaulted) 5%

Unwanted sexual attention 0%

Your cultural or ethnic origin 3%

Because of your nationality 8%

Having your property taken 2%

Because you were new here 5%

Drugs 0%

Because of your sexuality 0%

Because you have a disability 0%

Because of your religion/religious beliefs 0%

Q67 **Has a member of staff or group of staff victimised (insulted or assaulted) you here?**

Yes 23%

No ..... 78% **If No, go to question 69**

Q68 **If you have felt victimised by a member of staff/group of staff, what did the incident(s) involve? (Please tick all that apply to you.)**

Insulting remarks (about you or your family or friends) 10%

Physical abuse (being hit, kicked or assaulted) 1%

Unwanted sexual attention 4%

Your cultural or ethnic origin 5%

Because of your nationality 5%

Because you were new here 4%

Drugs 1%

Because of your sexuality 0%

Because you have a disability 0%

Because of your religion/religious beliefs 0%

Q69 If you have been victimised by detainees or staff, did you report it?

Yes	12%
No	22%
Not been victimised	66%

Q70 Have you ever felt threatened or intimidated by another detainee/group of detainees in here?

Yes	9%
No	91%

Q71 Have you ever felt threatened or intimidated by a member of staff in here?

Yes	18%
No	83%

Section Nine: Healthcare

Q73 Is health information available in your own language?

Yes	34%
No	41%
Do not know	24%

Q74 Do you know whether counselling is available at this centre?

Yes	44%
No	56%

Q75 Are you able to see a doctor of your own gender?

Yes	36%
No	28%
Do not know	36%

Q76 Is a qualified interpreter available if you need one during healthcare assessments?

Do not need an interpreter/do not know	50%
Yes	18%
No	32%

Q77 Are you currently taking medication?

Yes	64%
No	36%

Q78 If you are taking medication, are you allowed to keep possession of your medication in your own room?

Not taking medication	36%
Yes	34%
No	30%

Q79 What do you think of the overall quality of the healthcare here?

Have not been to healthcare	6%
Very good	5%
Good	26%
Neither	30%
Bad	14%
Very bad	20%

Section Ten: Activities

Q81 Do you have unrestricted access to the centre facilities for at least 12 hours each day?

Yes	50%
No	50%

Q82 Are you doing any education here?

Yes	14%
No	86%

Q83 Is the education helpful?

Not doing any education	87%
Yes	10%
No	2%

Q84 Can you work here if you want to?

Do not want to work	27%
Yes	56%
No	17%

Q85 Is there enough to do here to fill your time?

Yes	34%
No	66%

Q86 How easy or difficult is it to go to the library?

Do not know/do not want to go	7%
Very easy	40%
Easy	38%
Neither	11%
Difficult	2%
Very difficult	2%

Q87 How easy or difficult is it to go to the gym?

Do not know/do not want to go	22%
Very easy	17%
Easy	30%
Neither	19%
Difficult	8%
Very difficult	4%

Section Eleven: Keeping in touch with family and friends

Q89 How easy or difficult is it to receive incoming calls?

Do not know/have not tried	16%
Very easy	20%
Easy	27%
Neither	12%
Difficult	18%
Very difficult	7%

Q90 How easy or difficult is it to make outgoing calls?

Do not know/have not tried	13%
Very easy	19%
Easy	29%
Neither	14%
Difficult	17%
Very difficult	8%

Q91 Have you had any problems with sending or receiving mail?

Yes	25%
No	36%
Do not know	39%

Q92 Have you had a visit since you have been here from your family or friends?

Yes	67%
No	33%

Q93 Have you had a visit since you have been here from volunteer visitors?

Do not know who they are	19%
Yes	32%
No	49%

Q94 How do you feel you are treated by visits staff?

Not had any visits	34%
Very well	8%
Well	39%
Neither	14%
Badly	2%
Very Badly	2%

Yarl's Wood detainee survey responses 2009

Detainee survey responses (missing data has been excluded for each question). Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

	Any numbers highlighted in green are significantly better.
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	Any percent highlighted in orange shows a significant difference in detainees' background details.
	Numbers which are not highlighted show there is no significant difference.

		Yar'ls Wood 2009	IRC comparator		Yar'ls Wood 2009	Yarl's Wood 2008
SECTION 1: General information						
Number of completed questionnaires returned		101	926		101	92
1	Are you male?	5%	99%		5%	4%
2	Are you aged under 21 years?	8%	15%		8%	7%
5	Is English your first language?	24%	27%		24%	31%
6	Do you understand spoken English?	75%	76%		75%	62%
7	Do you understand written English?	64%	71%		64%	59%
8	Are you Muslim?	18%	44%		18%	13%
9	Do you consider yourself to have a disability?	16%	21%		16%	12%
10	Do you have any children under the age of 18?	42%	39%		42%	48%
SECTION 2: Immigration detention						
11	When being detained, were you told the reasons why in a language you could understand?	75%	70%		75%	65%
12	Following detention, were you given written reasons why you were being detained in a language you could understand?	70%	61%		70%	52%
13	Were you first detained in a police station?	54%	63%		54%	62%
14	Including this centre, have you been held in six or more places as an immigration detainee since being detained?	2%	10%		2%	7%
15	Have you been here for more than one month?	58%	67%		58%	68%
SECTION 3: Transfers and escorts						
16	Did you know where you were going when you left the last place where you were detained?	38%	44%		38%	40%
17	Before you arrived here did you receive any written information about what would happen to you in a language you could understand?	37%	32%		37%	26%
18	Did you spend more than four hours in the escort van to get to this centre?	35%	29%		35%	23%
19	Were you treated well/very well by the escort staff?	57%	52%		57%	51%

Key to tables

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	Numbers which are not highlighted show there is no significant difference.					
SECTION 4: Reception and first night						
21	Were you seen by a member of healthcare staff in reception?	**94%**	**87%**		**94%**	**93%**
22	When you were searched in reception was this carried out in a sensitive way?	**75%**	**63%**		**75%**	**75%**
23	Were you treated well/very well by staff in reception?	**64%**	**60%**		**64%**	**59%**
24a	Did you receive information about what was going to happen to you on your day of arrival?	**30%**	**33%**		**30%**	**28%**
24b	Did you receive information about what support was available to people feeling depressed or suicidal on your day of arrival?	**15%**	**28%**		**15%**	**16%**
24c	Did you receive information about how to make applications on your day of arrival?	**18%**	**29%**		**18%**	**17%**
24d	Did you receive information about healthcare services at the centre on your day of arrival?	**51%**	**43%**		**51%**	**30%**
24e	Did you receive information about the religious team on your day of arrival?	**45%**	**36%**		**45%**	**28%**
24f	Did you receive information on how to make a bail application on your day of arrival?	**22%**	**25%**		**22%**	**20%**
24g	Did you receive information about how people can visit you on your day of arrival?	**54%**	**40%**		**54%**	**49%**
For those who required information in a translated form:						
25	Was any of this information provided in a translated form?	**23%**	**29%**		**23%**	**38%**
26a	Did you receive something to eat on your day of arrival?	**85%**	**71%**		**85%**	**78%**
26b	Did you get the opportunity to make a free telephone call on your day of arrival?	**81%**	**61%**		**81%**	**72%**
26c	Did you get the opportunity to have a shower on your day of arrival?	**70%**	**61%**		**70%**	**55%**
26d	Did you get the opportunity to change into clean clothing on your day of arrival?	**54%**	**53%**		**54%**	**49%**
27	Did you feel safe on your first night here?	**43%**	**53%**		**43%**	**42%**
28a	Did you have any problems when you first arrived?	**76%**	**74%**		**76%**	**81%**
28b	Did you have any problems with loss of transferred property when you first arrived?	**24%**	**23%**		**24%**	**17%**
28c	Did you have any housing problems when you first arrived?	**10%**	**13%**		**10%**	**8%**
28d	Did you have any problems contacting employers when you first arrived?	**7%**	**7%**		**7%**	**7%**
28e	Did you have any problems contacting family when you first arrived?	**21%**	**19%**		**21%**	**17%**
28f	Did you have any problems ensuring dependants were being looked after when you first arrived?	**7%**	**11%**		**7%**	**5%**
28g	Did you have any problems accessing your phone numbers when you first arrived?	**16%**	**16%**		**16%**	**11%**

Key to tables

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SECTION 4: Reception and first night continued						
28h	Did you have any problems accessing legal advice when you first arrived?	**27%**	**19%**		**27%**	**24%**
28i	Did you have any problems getting access to your immigration case papers when you first arrived?	**20%**	**21%**		**20%**	**24%**
28j	Did you have any money/debt worries when you first arrived?	**10%**	**14%**		**10%**	**5%**
28k	Did you have any problems with feeling depressed or suicidal when you first arrived?	**40%**	**29%**		**40%**	**33%**
28l	Did you have any drug problems when you first arrived?	**5%**	**5%**		**5%**	**0%**
28m	Did you have any alcohol problems when you first arrived?	**1%**	**3%**		**1%**	**3%**
28n	Did you have any health problems when you first arrived?	**37%**	**27%**		**37%**	**40%**
28o	Did you have any problems with needing protection from other detainees when you first arrived?	**7%**	**8%**		**7%**	**7%**
For those who had problems on arrival:						
29	Did you receive any help/support from any member of staff in dealing with these problems within the first 24 hours?	**33%**	**32%**		**33%**	**27%**
SECTION 5: Legal rights and immigration						
31	Do you have a solicitor or legal representative?	**74%**	**65%**		**73%**	**43%**
For those who have a solicitor or legal representative:						
33	Is it easy/very easy to communicate with your solicitor or legal representative?	**35%**	**47%**		**35%**	**31%**
34	Are you able to send a fax to your legal representative free of charge?	**97%**	**95%**		**97%**	**97%**
35	Are you able to send letters to your legal representative free of charge?	**84%**	**79%**		**84%**	**83%**
36	Have you had a visit from your solicitor/legal representative?	**57%**	**53%**		**57%**	**69%**
32	Do you get legal aid (free advice under the legal aid scheme)?	**38%**	**46%**		**38%**	**52%**
37	Can you get access to books about your legal rights?	**27%**	**30%**		**27%**	**40%**
38	Is it easy/very easy for you to obtain bail information?	**27%**	**29%**		**27%**	**23%**
39	Can you get access to official information reports on your country?	**10%**	**20%**		**10%**	**16%**
40	Is it easy/very easy to see immigration staff when you want?	**14%**	**25%**		**14%**	**9%**
41	Have you had a review of your detention every month?	**43%**	**40%**		**43%**	**39%**
For those who have had a written review:						
42	Was the review written in a language you could understand?	**78%**	**63%**		**78%**	**65%**

Key to tables

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SECTION 6: Respectful detention						
44	Are you normally offered enough clean, suitable clothes for the week?	**41%**	**55%**		**41%**	**37%**
45	Are you normally able to have a shower every day?	**97%**	**93%**		**97%**	**93%**
46	Is it normally quiet enough for you to be able to sleep in your room at night?	**49%**	**57%**		**49%**	**45%**
47	Can you normally get access to your property held by staff at the centre, if you need to?	**47%**	**53%**		**47%**	**41%**
48	Is the food good/very good?	**17%**	**27%**		**17%**	**7%**
49	Does the shop sell a wide enough range of goods to meet your needs?	**30%**	**32%**		**30%**	**20%**
50	Do you feel that your religious beliefs are respected?	**76%**	**71%**		**76%**	**71%**
51	Are you able to speak to a religious leader of your own faith if you want to?	**55%**	**57%**		**55%**	**56%**
52	Is it easy/very easy to contact the Independent Monitoring Board?	**7%**	**19%**		**7%**	**9%**
53	Is it easy/very easy to get a complaint form?	**53%**	**52%**		**53%**	**51%**
54	Have you made a complaint since you have been at this centre?	**37%**	**33%**		**37%**	**27%**
For those who have made a complaint:						
55a	Do you feel complaints are sorted out fairly?	**32%**	**27%**		**32%**	**25%**
55b	Do you feel complaints are sorted out promptly?	**26%**	**23%**		**26%**	**31%**
SECTION 7: Staff						
57	Do you have a member of staff you can turn to for help if you have a problem?	**65%**	**56%**		**65%**	**56%**
58	Do most staff treat you with respect?	**64%**	**71%**		**64%**	**68%**
59	Do staff speak to you most of the time/all of the time?	**30%**	**24%**		**30%**	**14%**
60	Have any members of staff physically restrained you in the last six months?	**6%**	**14%**		**6%**	**16%**
61	Have you spent a night in the segregation unit in the last six months?	**8%**	**15%**		**8%**	**12%**
SECTION 8: Safety						
63	Have you ever felt unsafe in this centre?	**46%**	**42%**		**46%**	**61%**
64	Do you feel unsafe in this centre at the moment?	**40%**	**39%**		**40%**	**51%**

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SECTION 8: Safety continued						
65	Has another detainee or group of detainees victimised (insulted or assaulted) you here?	**25%**	**30%**		**25%**	**33%**
66a	Have you had insulting remarks made about you, your family or friends since you have been here? (By detainees)	**8%**	**11%**		**8%**	**13%**
66b	Have you been hit, kicked or assaulted since you have been here? (By detainees)	**5%**	**6%**		**5%**	**5%**
66c	Have you experienced unwanted sexual attention here from another detainee?	**0%**	**3%**		**0%**	**1%**
66d	Have you been victimised because of your cultural or ethnic origin since you have been here? (By detainees)	**4%**	**5%**		**4%**	**13%**
66e	Have you been victimised because of your nationality since you have been here? (By detainees)	**8%**	**5%**		**8%**	**13%**
66f	Have you ever had your property taken since you have been here? (By detainees)	**2%**	**7%**		**2%**	**3%**
66g	Have you ever been victimised because you were new here? (By detainees)	**5%**	**4%**		**5%**	**9%**
66h	Have you been victimised because of drugs since you have been here? (By detainees)	**0%**	**1%**		**0%**	**0%**
66i	Have you been victimised here because of your sexuality? (By detainees)	**0%**	**2%**		**0%**	**3%**
66j	Have you ever been victimised here because you have a disability? (By detainees)	**0%**	**1%**		**0%**	**1%**
66k	Have you ever been victimised here because of your religion/religious beliefs? (By detainees)	**0%**	**4%**		**0%**	**10%**
67	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	**23%**	**23%**		**23%**	**33%**
68a	Have you had insulting remarks made about you, your family or friends since you have been here? (By staff)	**10%**	**7%**		**10%**	**9%**
68b	Have you been hit, kicked or assaulted since you have been here? (By staff)	**1%**	**4%**		**1%**	**1%**
68c	Have you experienced unwanted sexual attention here from staff?	**4%**	**2%**		**4%**	**4%**
68d	Have you been victimised because of your cultural or ethnic origin since you have been here? (By staff)	**5%**	**5%**		**5%**	**7%**
68e	Have you been victimised because of your nationality since you have been here? (By staff)	**5%**	**6%**		**5%**	**8%**
68f	Have you ever been victimised because you were new here? (By staff)	**4%**	**4%**		**4%**	**7%**
68g	Have you been victimised because of drugs since you have been here? (By staff)	**1%**	**1%**		**1%**	**0%**
68h	Have you been victimised here because of your sexuality? (By staff)	**0%**	**1%**		**0%**	**4%**
68i	Have you ever been victimised here because you have a disability? (By staff)	**0%**	**1%**		**0%**	**4%**
68j	Have you ever been victimised here because of your religion/religious beliefs? (By staff)	**0%**	**3%**		**0%**	**11%**

Main comparator and comparator to last time (if applicable)

Key to tables

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	Any numbers highlighted in blue are significantly worse.					
	Any percent highlighted in orange shows a significant difference in detainees' background details.					
	Numbers which are not highlighted show there is no significant difference.					
SECTION 8: Safety continued						
For those who have been victimised by detainees or staff:						
69	Did you report it?	**35%**	**43%**		**35%**	**50%**
70	Have you ever felt threatened or intimidated by another detainee/group of detainees in here?	**9%**	**19%**		**9%**	**23%**
71	Have you ever felt threatened or intimidated by a member of staff in here?	**17%**	**22%**		**17%**	**16%**
SECTION 9: Healthcare						
73	Is health information available in your own language?	**34%**	**32%**		**34%**	**33%**
74	Do you know whether counselling is available at this centre?	**44%**	**26%**		**44%**	**22%**
75	Are you able to see a doctor of your own gender?	**36%**	**42%**		**36%**	**21%**
76	Is a qualified interpreter available if you need one during healthcare assessments?	**18%**	**14%**		**18%**	**18%**
77	Are you currently taking medication?	**64%**	**43%**		**64%**	**46%**
For those who are currently taking medication:						
78	Are you allowed to keep possession of your medication in your own room?	**54%**	**54%**		**54%**	**70%**
For those who have been to healthcare:						
79	Do you think the overall quality of health care in this Centre good/very good?	**33%**	**37%**		**33%**	**33%**
SECTION 10: Activities						
81	Do you have unrestricted access to the centre facilities for at least 12 hours each day?	**50%**	**44%**		**50%**	**37%**
82	Are you doing any education here?	**14%**	**36%**		**14%**	**14%**
For those doing education here:						
83	Is the education helpful?	**83%**	**85%**		**83%**	**75%**
84	Can you work here if you want to?	**56%**	**48%**		**56%**	**38%**
85	Is there enough to do here to fill your time?	**34%**	**39%**		**34%**	**29%**
86	Is it easy/very easy to go to the library?	**77%**	**67%**		**77%**	**77%**
87	Is it easy/very easy to go to the gym?	**47%**	**64%**		**47%**	**45%**
SECTION 11: Keeping in touch with family and friends						
89	Is it easy/very easy to receive incoming calls?	**47%**	**59%**		**47%**	**29%**
90	Is it easy/very easy to make outgoing calls?	**48%**	**53%**		**48%**	**42%**
91	Have you had any problems with sending or receiving mail?	**25%**	**24%**		**25%**	**23%**
92	Have you had a visit since you have been in here from your family or friends?	**67%**	**45%**		**67%**	**47%**
93	Have you had a visit since you have been here from volunteer visitors?	**32%**	**19%**		**32%**	**22%**
For those who have had visits:						
94	Do you feel you are treated well/very well by visits staff?	**71%**	**64%**		**71%**	**59%**

Key questions (disability analysis) Yarl's Wood 2009

Detainee survey responses (missing data has been excluded for each question). Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

		Consider themselves to have a disability	Do not consider themselves to have a disability
	Any percent highlighted in green is significantly better.		
	Any percent highlighted in blue is significantly worse.		
	Any percent highlighted in orange shows a significant difference in detainees' background details.		
	Percentages which are not highlighted show there is no significant difference.		
Number of completed questionnaires returned		15	76
5	Is English your first language?	29%	25%
6	Do you understand spoken English?	64%	80%
13	Were you first detained in a police station?	64%	52%
14	Including this centre, have you been held in six or more places as an immigration detainee since being detained?	6%	1%
15	Have you been here for more than one month?	53%	63%
19	Were you treated well/very well by the escort staff?	47%	59%
21	Were you seen by a member of healthcare staff in reception?	94%	94%
22	When you were searched in reception was this carried out in a sensitive way?	74%	73%
23	Were you treated well/very well by staff in reception?	60%	68%
24b	Did you receive information about what support was available to people feeling depressed or suicidal on your day of arrival?	22%	12%
24d	Did you receive information about healthcare services at the centre on your day of arrival?	64%	49%
27	Did you feel safe on your first night here?	29%	47%
28a	Did you have any problems when you first arrived?	80%	75%
28k	Did you have any problems with feeling depressed or suicidal when you first arrived?	33%	42%
28n	Did you have any health problems when you first arrived?	40%	38%
28o	Did you have any problems with needing protection from other detainees when you first arrived?	6%	8%
31	Do you have a solicitor or legal representative?	80%	72%
40	Is it easy/very easy to see immigration staff when you want?	7%	15%
41	Have you had a review of your detention every month?	33%	51%
44	Are you normally offered enough clean, suitable clothes for the week?	33%	45%

Key to tables

		Consider themselves to have a disability	Do not consider themselves to have a disability
	Any percent highlighted in green is significantly better.		
	Any percent highlighted in blue is significantly worse.		
	Any percent highlighted in orange shows a significant difference in detainees' background details.		
	Percentages which are not highlighted show there is no significant difference.		
45	Are you normally able to have a shower every day?	**100%**	**97%**
53	Is it easy/very easy to get a complaint form?	**42%**	**57%**
54	Have you made a complaint since you have been at this centre?	**29%**	**43%**
57	Do you have a member of staff you can turn to for help if you have a problem?	**55%**	**67%**
58	Do most staff treat you with respect?	**62%**	**63%**
60	Have any members of staff physically restrained you in the last six months?	**8%**	**3%**
61	Have you spent a night in the segregation unit in the last six months?	**8%**	**8%**
63	Have you ever felt unsafe in this centre?	**58%**	**44%**
64	Do you feel unsafe in this centre at the moment?	**58%**	**35%**
65	Has another detainee or group of detainees victimised (insulted or assaulted) you here?	**38%**	**22%**
67	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	**24%**	**23%**
70	Have you ever felt threatened or intimidated by another detainee/group of detainees in here?	**26%**	**7%**
71	Have you ever felt threatened or intimidated by a member of staff in here?	**28%**	**18%**
74	Do you know whether counselling is available at this centre?	**84%**	**40%**
76	Is a qualified interpreter available if you need one during healthcare assessments?	**8%**	**18%**
77	Are you currently taking medication?	**84%**	**62%**
81	Do you have unrestricted access to the centre facilities for at least 12 hours each day?	**54%**	**49%**
82	Are you doing any education here?	**16%**	**13%**
85	Is there enough to do here to fill your time?	**41%**	**29%**
86	Is it easy/very easy to go to the library?	**74%**	**81%**
87	Is it easy/very easy to go to the gym?	**45%**	**51%**
89	Is it easy/very easy to receive incoming calls?	**46%**	**53%**
90	Is it easy/very easy to make outgoing calls?	**54%**	**48%**
91	Have you had any problems with sending or receiving mail?	**17%**	**29%**
92	Have you had a visit since you have been in here from your family or friends?	**72%**	**68%**

Key questions (non-English speakers) Yarl's Wood 2009

Detainee survey responses (missing data has been excluded for each question). Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

		Non-English speakers	English speakers
	Any percent highlighted in green is significantly better.		
	Any percent highlighted in blue is significantly worse.		
	Any percent highlighted in orange shows a significant difference in detainees' background details.		
	Percentages which are not highlighted show there is no significant difference.		
Number of completed questionnaires returned		25	74
11	When being detained, were you told the reasons why in a language you could understand?	73%	75%
12	Following detention, were you given written reasons why you were being detained in a language you could understand?	40%	77%
14	Including this centre, have you been held in six or more places as an immigration detainee since being detained?	8%	0%
15	Have you been here for more than one month?	48%	61%
16	Did you know where you were going when you left the last place where you were detained?	30%	41%
17	Before you arrived here did you receive any written information about what would happen to you in a language you could understand?	39%	36%
19	Were you treated well/very well by the escort staff?	52%	59%
23	Were you treated well/very well by staff in reception?	48%	70%
24a	Did you receive information about what was going to happen to you on your day of arrival?	42%	26%
24b	Did you receive information about what support was available to people feeling depressed or suicidal on your day of arrival?	8%	18%
24c	Did you receive information about how to make applications on your day of arrival?	13%	20%
24d	Did you receive information about healthcare services at the centre on your day of arrival?	38%	56%
24e	Did you receive information about the religious team on your day of arrival?	33%	50%
24f	Did you receive information on how to make a bail application on your day of arrival?	21%	23%
24g	Did you receive information about how people can visit you on your day of arrival?	25%	65%
27	Did you feel safe on your first night here?	57%	39%
28a	Did you have any problems when you first arrived?	68%	79%
31	Do you have a solicitor or legal representative?	75%	73%
40	Is it easy/very easy to see immigration staff when you want?	9%	15%

Key to tables

		Non-English speakers	English speakers
	Any percent highlighted in green is significantly better.		
	Any percent highlighted in blue is significantly worse.		
	Any percent highlighted in orange shows a significant difference in detainees' background details.		
	Percentages which are not highlighted show there is no significant difference.		
41	Have you had a review of your detention every month?	**23%**	**49%**
44	Are you normally offered enough clean, suitable clothes for the week?	**27%**	**46%**
45	Are you normally able to have a shower every day?	**92%**	**99%**
53	Is it easy/very easy to get a complaint form?	**50%**	**54%**
54	Have you made a complaint since you have been at this centre?	**27%**	**39%**
57	Do you have a member of staff you can turn to for help if you have a problem?	**57%**	**66%**
58	Do most staff treat you with respect?	**81%**	**58%**
59	Do staff speak to you most of the time/all of the time?	**15%**	**34%**
63	Have you ever felt unsafe in this centre?	**25%**	**51%**
64	Do you feel unsafe in this centre at the moment?	**20%**	**45%**
65	Has another detainee or group of detainees victimised (insulted or assaulted) you here?	**21%**	**24%**
67	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	**5%**	**27%**
70	Have you ever felt threatened or intimidated by another detainee/group of detainees in here?	**0%**	**10%**
71	Have you ever felt threatened or intimidated by a member of staff in here?	**0%**	**22%**
73	Is health information available in your own language?	**28%**	**36%**
76	Is a qualified interpreter available if you need one during healthcare assessments?	**27%**	**15%**
82	Are you doing any education here?	**9%**	**15%**
84	Can you work here if you want to?	**55%**	**56%**
85	Is there enough to do here to fill your time?	**40%**	**31%**
86	Is it easy/very easy to go to the library?	**77%**	**78%**
87	Is it easy/very easy to go to the gym?	**28%**	**53%**
89	Is it easy/very easy to receive incoming calls?	**43%**	**48%**
90	Is it easy/very easy to make outgoing calls?	**47%**	**47%**
91	Have you had any problems with sending or receiving mail?	**9%**	**30%**
92	Have you had a visit since you have been in here from your family or friends?	**34%**	**76%**