Report on an unannounced short follow-up inspection of

Tinsley House Immigration Removal Centre

13–15 July 2009

by HM Chief Inspector of Prisons

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Introduction

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

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

Detainees continued to face disorienting moves around the immigration estate, and some vehicles were dirty. We also noted unprofessional conduct by some overseas escort contractors. Reception remained a poor quality facility and too little use was made of translation services here and on induction. There had been some improvement in suicide prevention work, although documentation remained variable. There was little evidence of

There was limited preparation for release, with reliance on a small local charity rather than any in-house welfare provision. Access to visits was good, but there was neither food nor hot snacks for visitors. Access to phones and the internet was good,[e int)TCthoughthwas

Fact page

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

Location
Gatwick Airport

Contractor
G4S

Number held
120

Certified normal accommodation (CNA)
142

Operational capacity
154

Escort provider
G4S

Last inspection
Full announced inspection: 10-14 March 2008

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

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

Section 1: Healthy establishment assessment

Introduction

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

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

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

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

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

...not performing sufficiently well against this healthy establishment test.
There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of

evidence available they also concluded whether this progress confirmed or required

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

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

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

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

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

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

Activities

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

HE.26 Paid work had been available since the previous year and had expanded gradually to 25 roles. Promotion of work opportunities was insufficient. Fifteen detainees were in post at the time of the inspection and there was no waiting list. UKBA had explicitly

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

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

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

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

Section 2: Progress since the last report

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

Further recommendation

Other recommendations

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

Arrival in detention

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

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

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

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

Casework

2.13 Reviews of detention should be issued inl

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Further recommendation
2.14

Further recommendation

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

Rules and management of the centre

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

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

Further recommendation

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

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

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

Preparation for release

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

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

To the escorting contractor

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

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

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

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

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

2.32 Escort vehicles should be clean. (1.16)

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

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

Achieved. The escorting staff we spoke to had received training in control and restraint techniques and had been refreshed within the previous 12 months. They said that the training included instruction on how to de-escalate incidents to avoid using force. We did not observe any problems during the transf(all0y1.6(w0the trancl)-4.3epl5.2(ad 001 Tc.5021 Tw[t[.2(e en cen 9(es-6.f ar)-6f8(e 1(

Further recommendation

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

Additional information

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

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

2.44 A video about the centre was available in several languages, although we did not see it used during our inspection. An information booklet about the centre had been produced in 20 languages, but supplies in several languages had run out and had not been replaced. The booklet was misleadingly titled *Detainee house rules* and was not written in clear English. We were concerned that translations could have been as difficult to understand as the English

Further recommendations

2.48 The reception area should be refurbished.

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

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

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

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

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

Environment and relationships

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

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

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

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

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

Not achieved. Facilities for the few women held at Tinsley house were largely unchanged since our last inspection. At the time of our inspection, four women shared a room that could accommodate five (a fifth woman was held in separation due to concerns for her mental health). The room had a toilet and shower. A television was perched on top of the wardrobe, but there were no chairs in the room and it could only be viewed from two beds. Like the male accommodation, the room was poorly ventilated and was uncomfortably warm, sme uectind w-1.1803 TD-.0014 Tc.00

that this was not possible.
We repeat the recommendation.

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

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

Further recommendation

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

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

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

2.60 Discussions at the consultative committee should be more in depth, and issues raised

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

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

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

Additional information

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

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

2.67

Casework

2.72

Bullying and suicide and self-harm

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

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

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

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

Further recommendation

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

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

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

Further recommendation

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

2.85 There should be effective0.04 reAll staff sho

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

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

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

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

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

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

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

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

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Further recommendation

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

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

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

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

appropriate multidisciplinary input at reviews. (4.29)

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

Further recommendation

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

Additional information

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

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

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

Further recommendation

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

Childcare and child protection

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

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

Further recommendation

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

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

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

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

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

2.110 Children held beyond seven days should have a care plan based on a comprehensive independent welfare as

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

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

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

Further recommendations

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

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

2.126 All staff should receive diversity training. (4.64)

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

consideration of strategic issues.
We repeat the recommendation.

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

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

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

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

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

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

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

Not achieved. There was little evidence of positive promotion of diversity issues. For example,

professional interpreting service.
We repeat the recommendation.

Additional information

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

Health services

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

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

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

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

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

Not achieved. Relationships with the West Sussex Primary Care Trust (PCT) were limited but said to be improving. There were no formal clinical or management meetings between the two organisations, and no qu4 Tw[Tinslev8 Tw( )Tj4]TJT(Not3.8(l TD.0001 .1(r)-7-)4(a)2to the mm)-5.1)-3.tto ds ,e(s)-.2(es
the recommendant.

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

Further recommendation

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

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

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

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

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

Further recommendation

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

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

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

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

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

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

Further recommendation

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

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

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

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

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

Further recommendation

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

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

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

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

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

by detention. (5.48)

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

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

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

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

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

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

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

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

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

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

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

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

Achieved. In addition to the medical GP service, there were three full-time and one part-time registered mental health nurses who provided primary care support to detainees where

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

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

Activities

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

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

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

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

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

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

Further recommendations

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

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

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

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

2.195 Patterns of attendance at the gym and take-up of sporting activnclally t.0012 -5.4(atte (e)5.ub3.9(d/TT8 1 Tf3gb1lh.8(

Rules and management of the centre

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

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

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

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

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

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

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

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

Further recommendation

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

2.203 Target searches should be recorded accurately. (8.27)

Achieved. All searching was accurately recorded.

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

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

Further recommendation

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

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

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

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

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

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

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

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

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

Further recommendation

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

2.211

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

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

2.221

Additional information

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

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

Further recommendations

2.229 Detainees should be consulted on the menu.

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

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

Preparation for release

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

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

Further recommendation

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

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

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

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

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

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

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

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

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

Further recommendation

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

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

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

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

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

Further recommendation

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

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

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

Additional information

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

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

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

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

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

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

Further recommendations

Section 3: Summary of recommendations

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

Main recommendations (from the previous report)

To the centre manager

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

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

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

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

Recommendations

To the chief executive, UKBA

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

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

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

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

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

3.10 In consultation with the c4.3(04 Tc.0019 Tw[In cf4.6(so4.3(04 1(s)-ld c)-5.56(so.4(ns.5(tateera-.000T2 6(The)Tj-3un)-

Recommendations — To the chief executive, UKBA and centre manager

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

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

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

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

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

Recommendations — To the escorting contractor

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

3.19 Escort vehicles should be clean. (2.32)

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

Recommendations — To the centre manager

Arrival in detention

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

3.22 The reception area should be refurbished. (2.48)

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

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

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

3.26 Induction should provide all detainees with the information they require to access all the

Environment and relationships

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

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

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

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

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

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

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

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

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

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

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

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

Casework

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

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

3.42

Duty of care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health services

3.77 Health services should establish formal links with the provider and commissioning sections of the primary care trust to promote quality assurance of services and ensure the health needs of

3.92 Prescribing trends should be regularly reviewed to ensure appropriate evidence-based

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

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

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

Rules and management of the centre

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

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

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

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

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

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

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

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

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

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

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

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

Services

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

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

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

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

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

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

Preparation for release

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

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

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

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

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

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

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

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

Appendix I: Inspection team

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

Religion/belief	