

Report on an announced inspection of

# **Haslar Immigration**

# **Removal Centre**

9 –14 May 2005

by HM Chief Inspector of Prisons

Crown copyright 2005  
ISBN 1-84473-719-5  
Printed and published by:  
Her Majesty's Inspectorate of Prisons  
1st Floor, Ashley House  
Monck Street  
London SW1P 2BQ  
England

# Contents

<b>Introduction</b>	<b>5</b>
<b>Fact page</b>	<b>7</b>
<b>Healthy establishment summary</b>	<b>9</b>
<b>1 Arrival in detention</b>	
<hr/>	
Escort vans and transfers	13
Reception	14
First night	15
<b>2 Environment and relationships</b>	
<hr/>	
Residential units	19
Clothing and possessions	20
Hygiene	20
Staff–detainee relationships	21
<b>3 Legal rights</b>	
<hr/>	
	23
<b>4 Casework</b>	
<hr/>	
	25
<b>5 Duty of care</b>	
<hr/>	
Anti-bullying	29
Self-harm and suicide	30
Health and safety	31
Diversity	33
Faith	34
<b>6 Healthcare</b>	
<hr/>	
	35
<b>7 Activities</b>	
<hr/>	
	41

## **8 Rules and management of the centre**

---

Rules of the centre	45
Security	45
Rewards scheme	46
Discipline	46
Use of force and single separation	46
Complaints	47

## **9 Services**

---

49

## **10 Preparation for release**

---

Visits	51
Telephones	52
Mail	52
Welfare, removal and release	53

## **11 Recommendations, housekeeping points and good practice**

---

55

## **Appendices**

---

I Inspection team	i
II Detainee population profile	ii
III Summary of survey responses	v

# Introduction

Haslar immigration removal centre is one of three run by the Prison Service on behalf of the Immigration and Nationality Directorate (IND). We last inspected the centre in March 2004 and recorded some improvements. This report records further improvements, although the poor fabric of this aging facility means that without major investment it will never offer the standard of accommodation that is appropriate to house immigration detainees.

On our last visit we identified some significant concerns about health and safety, specifically inadequate fire prevention arrangements. These matters had been addressed. Procedural arrangements to protect detainees were generally adequate, although first night processes were not always adhered to for late arrivals and anti-bullying arrangements were hindered by the inadequate and hard-to-supervise accommodation. In our survey a significant number of detainees reported feeling unsafe at some point and this required management investigation. We were also concerned to find that some custody staff routinely carried staves (and one had been drawn on a recent occasion). There may be exceptional circumstances that demand the issue of weaponry, but their routine deployment in a centre holding those not convicted of any criminal offence is intimidating and, significantly, is not regarded as necessary in private sector removal centres.

Staff-detainee relations at Haslar were mutually respectful and the general environment was cleaner and brighter than on our last visit. However, the accommodation remained poor. Privacy and sleep were inhibited by three-quarter height partition walls and a lack of doors which led to excessive light and noise. Matters were not helped by the use of a booming and intrusive tannoy system.

While outside Haslar's control, the new vehicles used by escort contractors were not fit for purpose. The seating was cramped and made it difficult for staff to maintain order and safety if there was an incident. The clear windows allowed onlookers to see in and there had been recorded incidents of abuse from passers-by. IND needs to require contractors to review these matters urgently.

There was a reasonable amount of purposeful activity for detainees: education was basic but very popular and had excellent pass rates for qualifications. Physical education was very good and the enthusiastic staff ensured excellent take-up of facilities. As in other removal centres, there was no paid work available, but it was pleasing to see that an innovative voluntary work scheme was under way to offer some meaningful occupation to detainees.

Support with maintaining family ties was inhibited by a lack of flexibility in visiting times with no evening visits, although visits facilities themselves were good. Access to phones was adequate, but there was no pager system which would avoid the need for the intrusive tannoy and better ensure that detainees received incoming calls and arrived at interviews promptly. As in other centres there was little welfare support to prepare detainees for release or deportation. However, it was pleasing to learn that IND were responding to our previous recommendations on this point, by setting up a pilot welfare officer post. We will follow this innovation with interest.

Overall, Haslar is delivering a largely safe and respectful service to detainees. Various improvements are clearly visible and this is to be commended, but continued use of Haslar as an immigration centre should be contingent on IND investing in a major rebuilding and

refurbishment programme without which Haslar is not a decent environment in which to hold detainees.

Anne Owers  
HM Chief Inspector of Prisons

July 2005

# Fact page

## **Task of the establishment**

To hold those detained by the Immigration and Nationality Directorate (IND) as overstayers, illegal entrants or failed asylum seekers prior to their removal from the country. Haslar also holds a proportion of detainees whose cases have not yet been determined but who are considered to be at risk of absconding.

## **Location**

2 Dolphin Way, Gosport, Hampshire, PO12 2AW

## **Contractor**

HM Prison Service

## **Number held**

103

## **Operational capacity**

160

## **Escort provider**

GSL UK Limited

## **Last inspection**

Short unannounced inspection: 29-31 March 2004

## **Brief history**

The centre originally operated as an army facility, then as a young offender detention centre before being used as an immigration removal centre.

## **Description of residential units**

The residential accommodation provided spaces for 160 male detainees in six dormitories. Three of these were divided into separate rooms with their own doors but three were partitioned into cubicles with walls that did not extend to the ceiling, and with open doorways.



# Healthy establishment summary

## Introduction

---

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

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

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

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

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

HE.2 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 detention 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.3 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.

## Safety

---

HE.4 There had been improvement in the areas of health and safety and fire protection since the last inspection. Detainees were unhappy with the escort provision and the new escort vans were not suitable for purpose. Initial reception did not always include a first night risk assessment. A good quality first night information leaflet was

available in 18 different languages. A significant number of detainees reported feeling unsafe at some point and this required further investigation by staff and a more rigorous approach taken to anti-bullying. Nevertheless, Haslar was performing reasonably well against this healthy establishment test.

- HE.5** Our previous, short unannounced, inspection raised significant concerns about health and safety and fire management at Haslar. This inspection found that considerable improvements had been made to the management and implementation of health and safety and fire safety in particular. There was a comprehensive health and safety policy and risk assessments were in place, together with a growing number of safe systems of work. The risks identified in an independent fire report had been addressed and a new fire detection and alarm system had been fitted throughout.
- HE.6** Only 28% of detainees surveyed reported positive treatment by escort staff which was significantly lower than the national benchmark of 65%. Several detainees had missed meals during transit and escort staff confirmed that refreshments and comfort breaks were not generally provided. The new escort vans were uncomfortable, poorly heated and had windows that allowed people outside to see in. This had resulted in detainees being verbally abused.
- HE.7** In our survey, 34% of detainees said they were treated well in reception, which was significantly worse than the benchmark of 62%. This perception could have been influenced by a lack of interaction by staff, as detainees were treated courteously, but staff spent little time engaging with them.
- HE.8** There were difficulties in completing first night assessments when large numbers of detainees arrived near closing time. Some staff said that the risk assessment was then deferred until the following day or that reception staff were not required to complete first night assessments. A useful leaflet containing essential first night information was available in 18 languages and all new arrivals were provided with a first night pack which contained confectionery and basic toiletries. In our survey, 66% of detainees said that they could make a free telephone call on their day of arrival which was significantly better than the benchmark of 43%.
- HE.9** A high proportion of detainees in our survey said they had felt unsafe at some point (74%) and a large percentage (around 40%) said they felt victimised by staff and other detainees. During the inspection we found that a complex range of factors had contributed to these findings, including the open and inadequate design of the accommodation and a history of conflicts between different nationalities. Between the time of the survey and the inspection the makeup of the population had changed significantly. A better balance of nationalities appeared to have lessened conflict. There was a need for further investigation of detainee concerns by managers and far more rigorous anti-bullying procedures. There were good suicide and self-harm prevention procedures and a safer room had been installed.
- HE.10** The use of force had been low; however, a staff had been drawn, though not used, on one of those occasions. This equipment is only carried by Prison Service-employed custody officers and not by those employed by the private sector who do not carry weaponry as a matter of routine.
- HE.11** As in most immigration removal centres (IRCs) there was no on-site independent legal advice. Many detainees did not have legal representation and the standard of

advice available was sometimes inadequate. Volunteers who visited detainees reported high levels of uncertainty about status and legal rights.

HE.12 Casework documentation did not always show the total period of detention and detainees were often moved from one detention centre to another for no obvious reason. There was evidence that detained cases were not always investigated and progressed with appropriate priority. There was a good system for serving removal directions.

## Respect

---

HE.13 Staff-detainee relationships were reasonably good. The general cleanliness of the centre had improved since the last inspection. However, the open dormitory cubicles were disrespectful and caused tension because of excess noise and light. The tannoy system was intrusive. Healthcare provision was acceptable. Race relations and the new reward scheme needed more work. Haslar was not performing sufficiently well against this healthy establishment test.

HE.14 Staff-detainee relationships were reasonably good and inspectors observed some positive and constructive interactions.

HE.15 Improvements had been made to the general cleanliness and decoration of the residential areas. Despite this, the dormitories remained unsuitable because of a lack of privacy, due to inadequate panelling and a lack of doors for many rooms. As a result, detainees suffered excess noise and light at night, which impeded sleep and led to unnecessary tension and friction. In addition, an extremely loud tannoy system was intrusive and caused considerable irritation.

HE.16 The information booklet about Haslar and its rules was exceptionally good. A reward scheme had been developed since the last inspection but work was needed to firmly establish this very recent initiative across the centre.

HE.17 Race relations management had improved and the recently appointed race relations liaison officer was effective, but more work remained to be done in this vital area.

HE.18 Healthcare was satisfactory with some good systems and policies.

## Activities

---

HE.19 Education was basic, but sound. Attendance was good and there were good pass rates for accredited qualifications. The library was good and physical education (PE) was very good. There was no paid work but voluntary work was available for a minority of the population. Haslar was performing reasonably well against this healthy establishment test.

HE.20 Education was well resourced and the education staff worked hard to ensure the environment was comfortable and inviting. A large proportion of detainees attended education at some stage during their stay at Haslar and education was, for the most

part, delivered effectively to a transient and diverse population. Tutors were generally successful in developing a positive culture in difficult circumstances. The pass rates for detainees taking externally accredited qualifications in English for speakers of other languages (ESOL) and IT were high. The library was providing a good quality service. The PE provision was very good, with good facilities and enthusiastic staff, which was appreciated by detainees. As in other IRCs there was no paid work available but a voluntary work scheme had begun recently.

## Preparation for release

---

**HE.21** Visiting facilities were good but evening visits were not available. Access to telephones was good but there was still no pager system. Detainees were well informed about planned removals but there was no welfare support available. A welfare officer had been selected but not appointed. Haslar was not performing sufficiently well against this healthy establishment test.

**HE.22** The visits room facilities were good and visitors were provided with lunch during a full day visit, available once each week. However, they could only be accommodated during the day which did not meet visitors' and detainees' needs. Access to phones was adequate but there was still no pager system as recommended in previous inspections. There was a good procedure to inform detainees of planned removal from the country but there was no internal welfare support for detainees, and no practical assistance to prepare them for release, transfer or removal. An Immigration and Nationality Directorate (IND) pilot welfare officer project was planned and a member of staff had been appointed to take on this vital role, though it was not clear when he would be taking up this position.

## Main recommendations

---

**HE.23** There should be an urgent review of the adequacy of the new escort vehicles and steps taken to ensure the safety, control and respectful transportation of detainees.

**HE.24** Staff working in immigration removal centres should not carry offensive or defensive weapons as a matter of routine.

**HE.25** Anti-bullying issues should be discussed in depth in a multi-agency meeting, and remedial action should be taken.

**HE.26** A major rebuilding and refurbishment programme is required, in particular the dormitories should be rebuilt to allow detainees some privacy and to minimise noise and light intrusion.

**HE.27** There should be a review of the prohibition on detainees engaging in paid work, and in the meantime, the voluntary work scheme should be expanded.

**HE.28** Visiting times should be more flexible to meet visitors' needs.

# Section 1: Arrival in detention

## Expected outcomes:

On arrival, detainees are treated with respect and care and are able to receive information about the centre in a language that they understand.

1.1 Detainees were not provided with refreshments or comfort breaks during escorts. The new fleet of escort vehicles did not offer the same comfort or safety as the previous vehicles. Medicines were not provided to detainees under escort, even on overnight journeys. Reception staff dealt with new arrivals efficiently and courteously but telephone translation was rarely used. Searching procedures were considerate. Not all detainees were offered something to eat and drink when they arrived. There was confusion about responsibility for completing first night assessments and some were not completed until the following day. There was a good system to alert residential staff to new arrivals. A comprehensive induction booklet had been translated into six languages and was a valuable source of information about the centre, as not all detainees understood the information delivered in induction sessions.

## Escort vans and transfers

---

- 1.2 Escort services were provided by GSL UK Limited (GSL). The escort team generally telephoned the centre to update reception staff with a clear estimated time of arrival and to confirm details of the number of detainees they were transporting.
- 1.3 In our survey, only 28% of detainees said that they had been treated well or very well by the escort staff, which was significantly lower than the benchmark of 65%. During the inspection we observed procedures for new arrivals over three days and spoke to detainees who had just arrived. There was good rapport between escort officers and detainees. None of the detainees we spoke to complained about the escort staff directly but some told us that they had not been given any refreshments. We spoke to several detainees who had missed meals during their period in transit. One detainee, who arrived late in the afternoon, having been held at a police station overnight, said he had not eaten for 24 hours. A revised format of escort records no longer required the escort providers to enter details of comfort breaks or refreshments offered. The escort staff we spoke to said that refreshments were not generally provided and neither were comfort breaks.
- 1.4 We had concerns about the new fleet of escort vehicles. The new vans had clear windows which not only allowed detainees to see out but also allowed them to be seen. Escort staff told us that detainees had been verbally abused and intimidated by people shouting at them through the windows. Escort staff also complained about poor heating in the new vehicles and told us that the seating arrangements made it more difficult to intervene in disturbances between passengers.
- 1.5 Escort staff passed on information about vulnerable detainees and risk of harm to reception staff by the escort staff as soon as they arrived, but often they did not have the necessary information themselves. We saw a cellular escort vehicle arrive from Harmondsworth. The escorts said the tactical vehicle had been requested but no information had been offered about why it was needed, or whether the detainee to be moved was violent or vulnerable. The detainee was not violent but he was very distressed and had to be carried to the vehicle. En route he tried to choke himself using some of his clothing and was refusing to disembark. It

transpired that he had been in detention for more than three months, during which time removal directions had been fixed and cancelled twice because of escort problems. He had been moved seven times and, the previous day, he had refused to do so again. As he spoke no English escort staff could not tell him where he was going or why. When later interviewed via a telephone translation service the detainee said that he was fed up with being moved for no reason. His third removal directions had just been fixed, although he was now further away from the airport and would have to be moved again. The detainee told us that if the third set of removal directions were cancelled he would go mad.

- 1.6 There was no protocol in place for the administration of medication to detainees during escort and staff told us that they were prohibited from administering any medication, including during overnight trips.
- 1.7 In our survey, only 15% of detainees said that they had received any written information about what would happen next, which was significantly lower than the benchmark of 26%. Copies of the "Welcome to Haslar" information leaflet (see paragraph 1.14) had been distributed to all nine centres transferring detainees to Haslar on a regular basis. However, none of the detainees we spoke to had been given this leaflet prior to their arrival.

## Reception

---

- 1.8 Reception was open from 8am to 8pm on weekdays and until 4pm at weekends. The area was usually staffed by two officers from a dedicated team of six reception officers. On average there were approximately 10-12 new receptions each day and about the same number going out, mainly on transfer or removal.
- 1.9 When large numbers of detainees arrived near closing time, there were difficulties in completing all procedures properly, particularly first night risk assessments. Some reception staff told us that the assessment was then deferred until the following day. More significantly, some reception staff told us that in their opinion they were not required to complete first night assessments; and that it was the nurse's responsibility.
- 1.10 The Immigration and Nationality Directorate's (IND) detainee escorting and management unit faxed over advance details of new arrivals. The fax included a checklist of positive risk indicators and offered the centre the opportunity to refuse unsuitable transfers or new receptions before arrangements were finalised. On occasion, risk indicators had been incomplete or inaccurate. For example, a complete record of previous convictions was not provided. We were told that detainees had arrived only to be immediately transferred out again when relevant information had come to light. All detainees arrived with an IS91 (authority to detain form) which was checked by reception staff.
- 1.11 Reception staff took detainees through the procedures as quickly as possible, and relied on residential staff to check on detainees' immediate needs once in the first night unit. Detainees were treated courteously throughout the process, but little time was spent engaging with them on an individual basis or enquiring about any immediate problems at this stage.
- 1.12 We observed that all new arrivals and those leaving the centre were pat-down searched in a considerate manner. Staff always ascertained what language the detainee spoke before undertaking the search. Detainees we spoke to had no complaints about searching procedures in reception. Strip-searching was very rare and carried out only on the basis of specific intelligence.

- 1.13 Reception staff did not make much use of the telephone translation service (less than once a week), although records showed that the nurse who carried out the reception interview used the service more frequently.
- 1.14 Detainees were held in reception until they were seen by the nurse for an initial health assessment. The holding rooms were clean and there was adequate bench seating with a small table. Each holding room contained a toilet fitted with a stable door which did not afford adequate privacy. The majority of the notices on display in the holding rooms were in English but a helpful "Welcome to Haslar" information leaflet was available in 18 different languages. The leaflet contained essential first night information and the majority of detainees we spoke to said that they found it helpful.
- 1.15 In our survey, 34% of detainees said that they had been treated well or very well in reception which was significantly worse than the benchmark of 62%. From our observations, this perception of less than favourable treatment by reception staff was more likely to have been influenced by a lack of interaction with staff at this time of uncertainty and anxiety for many detainees. This was clearly a particular problem for those who spoke very little English.
- 1.16 We were not satisfied that new arrivals were always given a drink and a meal. In our survey, 54% of detainees said that they received something to eat on the day of their arrival. Reception staff told us that a meal would be provided on the residential unit for detainees who arrived after meal times. However, staff on the residential units said that they were unable to keep meals for late arrivals and in any event microwave meals could be offered in reception. The only microwave meal on offer was a ready-made chicken dinner.
- 1.17 All new arrivals were provided with a first night pack which contained confectionery and basic toiletries. Smokers were provided with less confectionery and given the equivalent in tobacco and papers. Detainees were not given the opportunity to make a telephone call or offered a shower in reception but they were able to do so following their location on the residential unit. In our survey, 66% of detainees said that they could make a free telephone call on their day of arrival which was significantly better than the benchmark of 43%.

## First night

---

- 1.18 The recently introduced first night and induction policy was a more thorough risk-assessed approach to first night care, but it was clear that not all staff were familiar with it and it was not being fully implemented. For example, there was confusion about whether reception, first night or nursing staff were responsible for completing the first night risk assessments and confusion about their purpose. The aim of the risk assessment, as set out in the policy, was to assimilate all relevant information, from the movement documentation and the detainee himself, to determine whether the detainee was low, medium or high risk. This required reception officers to ask sensitive and personal questions in an area which afforded detainees no privacy.
- 1.19 The detailed assessment could not be completed in the limited time available to reception staff and was seen by reception officers as an administrative function rather than as part of procedures to keep detainees safe.
- 1.20 Completed first night assessment forms were sent to the main administration office to be filed centrally. Consequently, officers on the units, who were looking after new arrivals on their first night in detention, did not have access to this important information.

- 1.21 There was a card system displayed on the office wall showing photographs and details of all new arrivals for all staff, and particularly night staff, to be aware of. Night staff checked all detainees four times during the evening. Our night visit revealed that staff had knowledge of the new arrivals and did use the card system. Although this was innovative practice, it was not an adequate substitute for the detailed information that was contained within the first night risk assessment.
- 1.22 In addition to the first night risk assessment, a first night immediate needs assessment was completed by the officer responsible for locating the detainee. In our survey, 82% said that they had problems when they first arrived which was significantly higher than the benchmark of 69%. However, 39% of respondents said that they received help with these problems, which was significantly better than the benchmark of 18%.
- 1.23 The whole of E unit was designated as the first night unit as it was opposite the main office and easier for staff to observe. New arrivals were invited to select any empty bed within E unit and could choose to share or have a room on their own. In our survey, 38% of detainees said that they felt safe on their first night which was significantly worse than the benchmark of 56%. New arrivals we spoke to did not complain specifically about first night arrangements or say they felt unsafe, but complained more generally about the state of the accommodation throughout the residential areas.

## Induction

---

- 1.24 There was a dedicated group of immigration liaison officers (ILOs) who delivered the induction session to all detainees the day after their arrival.
- 1.25 The comprehensive induction session contained the essential components to enable detainees to settle in and to understand the rules and routines of the centre. A "Welcome to the Centre Induction and Information Booklet" supplemented the induction session and was available in six languages. There was some confusion about how the English version was issued (reception staff believed that it was issued on induction and induction staff that it was issued on reception). We spoke to several English speakers who had not been given a copy. The detainees who had received a copy in other languages said it was useful.
- 1.26 Our observation of one induction session highlighted the difficulties involved in delivering detailed information to a disparate group of new arrivals with varying degrees of English. Insufficient attention was paid to making sure the information was properly understood.
- 1.27 The induction session also explained the role of the ILOs. Detainees were informed that ILOs were on duty to help with enquiries every day between 9am and 4pm. Good use was made of this facility throughout the inspection.

## Recommendations

---

- 1.28 Detainees under escort should be provided with refreshments and comfort breaks and escort providers should maintain records of refreshments and breaks offered.
- 1.29 Information about risk of harm, vulnerability and other special needs should accompany detainees.
- 1.30 There should be a protocol in place for the administration of medication during escort.

- 1.31 Movement notifications should contain a complete list of positive indicators of risk.
- 1.32 Detainees should always be offered a meal following their reception.
- 1.33 First night risk assessments should be completed in private by residential staff with the necessary skills and sufficient time to carry out the task properly. Each assessment should be retained on the detainee's file on the residential unit.
- 1.34 Staff delivering induction sessions should ensure that the information is understood by all.
- 1.35 Detainees who are being moved should be provided with information about their destination and the reason for the move.

### Housekeeping points

---

- 1.36 The choice of microwave meals available in reception should be improved and include options for special diets.
- 1.37 Checks should be made to ensure that all detainees receive a copy of the "Welcome to the Centre Induction and Information Booklet".



# Section 2: Environment and relationships

## Residential units

---

### Expected outcomes:

Detainees are held in decent conditions in an environment that is safe, well maintained and respectful of cultural norms.

- 2.1 The refurbished residential units were a considerable improvement on what was found during the previous inspection. However, the dormitories remained unsuitable for purpose owing to a lack of privacy and to the intrusion of noise and light. Shower facilities required redecoration. An extremely loud tannoy system was particularly intrusive. There was a need for unit-based washing machines. The standard of hygiene was variable and deep-cleaning was required in some areas. Access to essential hygiene items was good.
- 2.2 There was space for 160 male detainees in six units located off a main central corridor. Three units contained open dormitories and three had enclosed rooms. Most detainees were in 3-bed rooms, a small number in 4-bed rooms and some in 2-bed and single rooms in the enhanced units (A for smokers and H for non smokers, both of which had an in-room television). Bars had recently been fitted on the outside of the dormitory windows in response to concerns about potential absconds, but it was still relatively easy to open windows to let in fresh air. Communal areas contained television, chairs and tables, which were in a reasonable state of repair. There was a recently opened games room which contained snooker tables, table football and game machines.
- 2.3 The residential units had been refurbished and redecorated the previous year, and their appearance had markedly improved since the previous inspection in 2004. Shower rooms were generally tidy but the peeling paintwork in some of them meant they were already in need of redecoration.
- 2.4 The centre's bid to rebuild the units was still pending, and despite the decorative improvements, most of the serious accommodation problems identified in the previous report remained. There were still no upper walls or doors in three of the dormitories, leading to severe light and noise pollution, lack of privacy and a fundamentally disrespectful living environment. The shared rooms were small and crowded and not all detainees had lockable cabinets. In our survey, 35% of respondents said that it was not quiet enough for them to sleep at night against a benchmark of 65% in all immigration removal centres. The lack of doors undoubtedly contributed to the fact that 74% of detainees felt unsafe at some point compared to a benchmark of 35%. Some detainees stayed up until the early hours of the morning watching television, talking or playing games which inevitably disturbed those trying to sleep.
- 2.5 The walls were bare in most of the residential areas and added to the bleak institutional feel of the dormitories. However, there were a large number of translated notices in the communal areas although when they were checked it was found that the translations were of variable quality and some made no sense. There was a loud and intrusive tannoy system which caused much irritation to detainees and some staff. It was used frequently, and made it difficult to continue conversations either face to face or on the phone. Detainees using the phones were particularly frustrated at the amount of conversation time that could be wasted waiting for

tannoy messages to end. Telephones were located in the communal areas on the units, and privacy hoods were not effective in screening out the noise from either the tannoy or the television.

- 2.6 The heating system had been improved the previous year and appeared to work reasonably well as there were few complaints about extremes of temperature. The mattresses had recently been replaced and were in good condition. All detainees were issued with three cotton blankets and could request an extra one if required, although some still complained that the thin blankets did not retain enough heat. The centre's action plan showed that duvets were due to be provided.

## Clothing and possessions

---

- 2.7 There was a large, well-run central laundry, which was open in the mornings. Clothes handed in for washing were generally returned the next day. Detainees were able to do 'personal laundry', which entailed tags being placed on their clothes before they were washed in a communal load. However, many detainees did not consider this to be hygienic and preferred to wash their underwear and some other clothes in the shower rooms. Previous recommendations for unit-based washing machines had been rejected on the grounds of cost, but there was clearly a need for them. Blankets were laundered monthly, and sheets and pillowcases were laundered weekly.
- 2.8 Detainees could wear their own clothes or the tracksuits provided by the centre, and could exchange clothing on a daily basis. Toiletries, such as soap and razors, could also be collected from the laundry. Detainees were given four pairs of underwear and socks on arrival.

## Hygiene

---

- 2.9 A specialist company carried out cleaning duties, and although improved since the previous inspection, the standard of cleanliness was variable. Some deep cleaning had taken place but a lot of ingrained dirt was still visible in some living areas. Detainees expressed particular concern that the same mops were being used to clean toilet areas and bedrooms, and a colour-coded system was required. Managers had accepted that the cleaning was not up to standard. As a result, cleaners were subject to closer scrutiny and disciplinary measures. A new contract was to be renegotiated in February 2006. Detainees could also borrow brooms and mops from the centre office to clean their own living areas.

## Recommendations

---

- 2.10 Shower rooms should be regularly redecorated.
- 2.11 All detainees should have lockable cabinets in their rooms.
- 2.12 Pictures, displays and other notices which reflect the cultural diversity of the centre should be put up in the residential areas.
- 2.13 All translated notices should be checked by professional translators and no new notices should be put up unless they are accurate and easily understood.

- 2.14 The tannoy system should be used as little as possible and pagers should be provided to detainees.
- 2.15 Telephone privacy hoods should be effective in screening out the noise from the television in communal areas.
- 2.16 Detainees should be provided with duvets.
- 2.17 All units should have washing machines to allow detainees to do their own washing.

### Housekeeping points

---

- 2.18 A colour-coding system should be introduced to ensure that the same mops are not used to clean toilet areas and bedrooms.
- 2.19 The cleaning contract should be reviewed as planned.

## 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.

2.20 Staff–detainee relationships were reasonable. Managers were keen to promote understanding and interaction between staff and detainees and communication and understanding had improved with increased use of the telephone translation service. However, the survey response with regard to perceptions of respectful treatment was significantly lower than the benchmark, no doubt affected by the poor quality of accommodation.

2.21 More than half the respondents in our survey said that staff treated them respectfully and detainees could turn to them for help. However, the overall response for respectful treatment (51%) was significantly below the benchmark (78%) and this was a cause for concern. The regime and living environment undoubtedly contributed to anxiety and distrust among detainees, most of whom had never before been in a custodial environment, associated it with criminality and shame, and did not believe anything they had done warranted incarceration.

2.22 Detainees who had settled in said they were treated with respect and knew at least some officers they could approach if they had problems. We observed good staff–detainee interaction in relation to a detainee who had just arrived from Harmondsworth IRC, and refused to leave the escort van. He had to be carried to the van at the point of departure and attempted self-harm in transit. He had been in Haslar before but did not seem to know this was where he had arrived. He spoke no English. A Haslar officer whom he recognised from a previous stay entered the vehicle and he immediately changed his mind, got out of the vehicle and indicated he wanted to stay as a result of his previous good experience of the officer. Managers encouraged respectful and helpful exchanges between staff and detainees. Recent training in the use of the telephone translation service and consequent increased use assisted

communication. The new dormitory officer scheme which was being developed was a promising initiative and should help to improve engagement and understanding.

## Section 3: 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 There was no on-site independent legal advice. Half of the detainees at Haslar had no legal representative and the standard of advice available to those who did have representation was sometimes questionable. Voluntary bodies who regularly visited detainees reported high levels of uncertainty about status and legal rights.
- 3.2 Only half of the detainees who responded to our pre-inspection survey said that they had a legal representative, and less than a quarter had had a visit from their representative. Half the detainees who responded had been detained at Haslar for more than a month, and were likely to have been detained elsewhere prior to their arrival. Legal visits remained limited to two hours on six afternoons per week, plus mornings on Thursdays. There were no evening visits. During the preceding three months the number of legal visits averaged less than one a day. The booking clerk reported a steady decrease compared with the previous year. A legal representative booking to see more than one detainee was rare. The legal bookings clerk told us that following checks two firms had been banned for touting or unprofessional conduct.
- 3.3 Some detainees said that a friend or relative outside had located a representative for them and was paying their bill. However, not only had they never had a visit but there was no correspondence from which either status or competence of representatives could be deduced. One man, detained for four months, said representatives found by his cousin had lodged a High Court application for judicial review two or three months ago and this was confirmed in an Immigration and Nationality Directorate (IND) document. However, he had no copy statement or grounds, and no explanation of the nature or timescale of the court application. He told us he had never received, and the bundle of documents he showed us did not reveal, a single letter from his representatives.
- 3.4 Those without legal advice had little chance of getting any in Haslar, particularly if they had no money. The Haslar Visitors Group said they spent a lot of time trying to find competent legal advice for those they visited. They knew of only one firm of solicitors undertaking immigration advice in the area. Those they contacted elsewhere, usually in London, were no longer taking on legal aid cases, had no spare capacity or were disinclined to make the journey to Haslar. Immigration staff said that many detainees were 'at end of process' and there was little scope for representatives to help them. However, independent advice was still needed to clarify status and options, as well as issues raised by prolonged detention without time limit, and without automatic court review. Both the visitors group and Gosport Citizens Advice Bureau, which visited every other week, but which was not itself qualified to give specialist immigration advice, agreed that the fact that people did not understand their own legal status was a primary concern. The Citizens Advice Bureau spent a lot of time contacting other bodies to try to find out where a detainee stood in the determination or appeal process. It did not help that people were often detained unexpectedly, without any of their documents, other than the IS91R (summary reasons for detention form).
- 3.5 Haslar helped detainees to send free faxes and letters to legal representatives and included addresses of some voluntary advice agencies in the induction booklet. The centre also

provided copies of Office of the Immigration Services Commissioner (OISC) booklets published in 20 languages, which suggested how to find and assess specialist legal advice. There was a reasonable stock of legal reference materials and information about home countries in the library. Informally, some staff provided pens, paper and photocopies to detainees who were trying to represent themselves. Detainees had no access to the internet or email.

## Recommendations

---

- 3.6 Detainees should have access to on-site independent, suitably qualified legal advisers.
- 3.7 The centre should review legal visits arrangements and consult a range of legal service providers in the private, legal aid and not-for-profit sectors, with a view to enlarging legal visits for the benefit of detainees.
- 3.8 Detainees who are representing themselves should be provided with sufficient materials to conduct their case.
- 3.9 Detainees should have access to the internet and email, with suitable restrictions, to enable them to cheaply and instantly contact legal representatives and trace up-to-date information relevant to their case.

## Section 4: Casework

Expected outcomes:

Detention is carried out on the basis of individual reasons that are clearly communicated.

Detention is for the minimum period necessary.

- 4.1 Documentation did not reveal the total period of detention at successive places. Detainees were inadequately informed and commonly confused about their status and what options were open to them. Confusion was compounded because they were often moved from one detention centre to another for no clear reason. Many detainees had no legal representative to advise them. There was evidence that detained cases were not investigated and progressed with appropriate priority. There was a good system for serving removal directions.
- 4.2 Two-thirds of Haslar's detained population of 109 were recorded as having spent no more than four weeks there. Seven people had arrived at Haslar during 2004, including one man who had arrived nearly 10 months ago. Rarely, if ever, was Haslar the first place of detention and many detainees had spent time at several centres. However, documentation available to us on site did not always reveal the total period of detention at successive places. We examined two-thirds of the reception files and noted that more than 50% of detainees had initially been detained in police stations, in one case for four days, in seven other cases for three days. We spoke to several detainees: some had been allowed to use the telephone but all said that they had no shower, no change of clothing, and no exercise in the police station. None had encountered a duty solicitor able to give immigration advice.
- 4.3 Haslar had agreed allocation criteria with the Immigration and Nationality Directorate (IND) which stated that their dormitory accommodation was unsuitable for high risk cases, including those young people claiming to be minors but who are detained because their age is in dispute. However, we met a young man in the centre with a 1988 birth date. He had supplied some supporting documents which had yet to be translated and verified. He had been picked up leaving a lorry the previous month and the police had referred him to social services as a minor. Social services treated him as a minor and accompanied him to the IND asylum screening unit. It was noted on IND's casework information database (CID) that, "It has to be said that he carried/conducted himself in the manner of a minor" and the young man remained in the care of social services. An IND officer then decided that he was not to be treated as a minor and he was detained. No reason was given for this difference of opinion. Haslar was at least his third place of detention and during the inspection he was moved on to Dover immigration removal centre. His solicitor in the north-west had no idea where he was because the young man spoke no English and had no idea how to contact her. Until we suggested it he had not been given copies of his supporting documents to pass to his solicitor. He told us he did not feel safe, not because staff at Haslar were unkind but because he did not understand anything that was happening to him. Using an interpreter he told us "I feel like a blank person".
- 4.4 As we find at other removal centres, the on-site immigration team acted as an important quality check on the case-holding offices around the country with primary responsibility for detainees' cases. On-site immigration staff complained that remote caseworkers did not always comprehend and prioritise detained cases. On-site staff saw all new arrivals within 24 hours, at which stage they had little information beyond the IS91 (authority to detain form), supplemented by patchy information on CID. They could not correct or update the information on CID as they had read only access. Although, essentially, on-site staff's role was to liaise between responsible IND offices and detainees, they monitored cases with some rigour in an effort to

minimise delay and error. However, delays were not uncommon, for example, in relation to obtaining travel documentation. In one case, a Chinese detainee, in custody since arriving in the country eight months ago, had served four months of an eight-month sentence in prison on a charge of arriving without a passport. His case was with IND's criminal casework team. Since his transfer to immigration detention three months previously there did not appear to have been any progress on his case, despite reminders by the on-site immigration team. There was no evidence that he had even been interviewed about his asylum claim.

- 4.5 Request for fingerprints, photos or basic information, which were either not taken at the time of detention, or had been lost, were an everyday occurrence. When detainees were asked for basic or repeated information again at a later stage, they suspected that they had been unjustifiably detained at a time when no progress was being made on their case and were likely to become more anxious and uncooperative. One officer thought that some enforcement staff detained people with minimal investigation as to whether it was appropriate, possibly because targets related to the number detained rather than the quality of decisions.
- 4.6 One of the open F2052SHs (suicide and self-harm monitoring forms) we looked at was for a man who had been detained at Becket House reporting centre a week previously, even though he had a medical appointment to attend. He had been in the country for five years, was reporting to the IND office, and there was no sign that removal was imminent. There was a copy on file of a letter his MP had sent to IND two months previously, which reported his mental health problems and requested that no action be taken until inquiries were completed. There was no evidence of a response. Haslar healthcare staff were concerned that the risk of suicide had increased and a response from Becket House was awaited. Staff told us that, in the last six months, eight standard letters reporting allegations of torture had been passed to case-holding ports. Rule 35 of the Detention Centre Rules, requires healthcare staff to report any detained person whose health is likely to be injuriously affected by continued detention or conditions of detention, suicidal intentions, or allegations of torture. Immigration staff said they did not normally get a written response.
- 4.7 There had been some improvement in monthly reviews of detention. Most were the responsibility of IND's Management of Detained Cases Unit (MODCU) in Leeds, which took over the majority of detained cases after 28 days. Fewer reviews arrived significantly late, and there was improvement in the detail given, although successive monthly reviews were often repetitive and failed either to provide evidence that consideration had been given to all relevant factors, including those favouring release; or to show that a proper balancing exercise had been conducted; or to address what progress had been made in the last month to justify lengthening detention. Original reasons for detention and monthly reviews were seen in English only. On-site immigration officers used a telephone interpreter to serve documents or deal with enquiries where appropriate.
- 4.8 On-site immigration staff had a good working relationship with other staff and were aware of all potential self-harm cases. When an individual's removal directions arrived a 'removal directions warning form' was inserted in every new file opened, for distribution within Haslar. Removal directions were generally served promptly, subject to risk assessment in identified vulnerable cases.
- 4.9 Of the 393 movements from Haslar in the preceding three months, 13% had been removals, 52% had been transfers (the majority en route to imminent removal), 25% had been released, generally on temporary admission subject to reporting requirements but in three cases unconditionally, and 9% had been released on bail. One detainee had been released following a court order that he was to be treated as a minor.

## Recommendations

---

- 4.10 Documentation accompanying detainees should record the cumulative history of their period of detention. This should be completed at all places of detention, including police stations, and should document the detainee's access to telephones, legal advice, showers, change of clothing, exercise, medical checks and visitors, as well as noting incidents and reviews.
- 4.11 The Immigration and Nationality Directorate (IND) travel documentation unit should prioritise detained cases.
- 4.12 Age dispute cases should be subject to independent medical assessment.
- 4.13 Written reasons for detention and reviews should relate to the individual's circumstances and reflect balanced consideration of all relevant factors, for and against detention, including any progress in the case. They should be issued in a language the detainee can understand.
- 4.14 IND should investigate and consider any conditions affecting a detainee raised under Rule 35 of the Detention Centre Rules. This process should be documented and the detainee notified of the outcome.
- 4.15 There should be clear demarcation of responsibility within IND for all aspects of detainees' cases and detainees should be notified of the office to which they should address queries about their detention or case progression.
- 4.16 Detainees who supply original documents to IND while in detention should be given copies of their documents.



## Section 5: 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.

5.1 Detainees' perceptions of bullying were complex, and the lack of systems to examine and tackle any potential victimisation was a serious weakness. Anti-bullying was given little attention; staff training focused on staff issues only and there was no confidential system for detainees to report bullying. There were good systems for managing risk of self-harm and positive attempts to involve detainees, but other detainees were used as interpreters during reviews involving risk assessment. Considerable improvements had been made to the management and implementation of health and safety and fire safety in particular.

### Anti-bullying

---

5.2 Staff made regular patrols of the residential areas throughout the day and night and detainees told us that they were able to contact staff easily if required.

5.3 In our survey, 74% of detainees said they had felt unsafe at some point; 40% said they had been verbally or physically victimised by staff and 42% said they had been verbally or physically victimised by other detainees. However, few concerns were raised when inspectors spoke to detainees about these issues individually and in groups during the inspection. Further investigation suggested that perceptions of bullying among detainees may have been due to conflict between the hitherto large population of Chinese people and people from African countries and Jamaica. Detainees from both groups said they felt bullied by the other as a result of disagreements over the amount of noise made at different times of the day and night. The open dormitory accommodation greatly exacerbated and, to an extent, had created this problem, and was also a strong factor in feelings of not being safe. At the time of the inspection, there were dramatically reduced populations of both Chinese and Jamaican nationals, and little sign of the tension that we were told had existed when the survey was carried out a few weeks earlier.

5.4 It remained unclear what lay at the root of perceptions of staff bullying, and this required further investigation by the centre. However, many detainees, while generally positive about staff, told us a few officers did not treat them with respect. One detainee stated that staff tended to treat detainees who spoke English with more respect and made less effort with others. The picture was complicated further by a high population turnover which meant that the dynamic between staff and detainees could change from week to week. This population turnover, together with language difficulties, limited the opportunity for detainees to complain about possible staff abuse, and meant that there was a need for rigorous anti-bullying procedures to minimise the risk of abuse.

5.5 However, anti-bullying was given little attention in the establishment despite the fact that a senior officer was identified as the anti-bullying coordinator. Although anti-bullying was part of the remit of the safer custody meeting, there had been little or no discussion of this issue in the minutes for the previous three meetings, none of which had been attended by the anti-bullying coordinator. A meeting took place during the week of inspection during which detainees were encouraged to offer their views on bullying. They raised the issue of cultural misunderstanding

about what the term means among different nationalities, which they felt reduced the likelihood of detainees reporting it. Regular and clear information exchange and consultation were also mentioned as important ways of enhancing understanding of the centre's policies.

- 5.6 The monthly detainee consultative meetings appeared to be effective in attaining detainee views on a range of subjects, but bullying was not included among them. Given such rapid turnover, meetings should have taken place on at least on a weekly basis, to increase staff detainee communication, inform staff of emerging detainee concerns, and inform detainees of centre policies and procedures.
- 5.7 There was a clear, step-by-step anti-bullying procedure which culminated in the bully being placed in the special accommodation unit (SAU). However, only three anti-bullying books had been opened since the start of the year and all had been quickly closed as the identified detainees were not thought to have a case to answer.
- 5.8 The only anti-bullying training on offer focused on staff issues and did not cover bullying among or of detainees. The anti-bullying report box in the main corridor was intended for confidential reports of bullying, but did not seem to be in use, which was unsurprising given that it was unlocked and therefore accessible to all for the duration of the inspection. There were translated notices around the centre encouraging detainees to report bullying behaviour. However, when checked, some of these notices, apparently those that had been translated by computer, made no sense at all, while others were difficult to understand.

## Suicide and self-harm

---

- 5.9 Haslar used the Prison Service's F2052SH monitoring system to manage detainees at risk of self-harm and suicide. There were four open F2052SHs (self-harm monitoring forms) during the week of inspection, and a total of nine had been opened between January and the end of April 2005. Staff in all departments were informed of newly opened F2052SHs by a form which contained a picture of the detainee and brief details of the reasons for the risk. The orderly officer was responsible for distributing the forms, which were present in appropriate areas, though not up to date in one area. When removal directions were received, these were also recorded in a book kept in the centre office to alert staff to periods of increased risk.
- 5.10 There was reasonably good monitoring, and regular reviews of, those identified at risk. Vulnerable detainees we spoke to praised the level of care they received from some staff. In one case, a detainee who had refused food for some days told us that the consistent care and concern shown by an officer had been a major factor in his decision not to harm himself and to begin eating again. However, many entries in the F2052SHs indicated observation rather than the kind of positive interaction demonstrated by this officer.
- 5.11 Although there was some use of the telephone translation service, detainees were often asked to interpret for other detainees during sensitive and confidential discussions involving an element of risk assessment, including F2052SH reviews. This was an inappropriate and potentially dangerous practice.
- 5.12 Safer custody meetings were held every six to eight weeks and normally included chaplaincy, healthcare, immigration and residential staff, as well as a Samaritans representative and some detainee representatives. There was also useful casework input from the immigration staff. The chairing of the meetings was not consistent and this had a negative impact on their focus and effectiveness. The person who chaired the meeting during the inspection had not attended any previous meetings. Action points from previous meetings were not always followed up, and

progress was not consistently discussed at subsequent meetings. While there was some useful discussion of salient issues, the minutes indicated often cursory consideration of F2052SH cases.

- 5.13 Efforts were made to obtain the views of a detainee representative on safer custody issues. However, detainees were generally asked to give their views and then leave, at which point the main meeting continued. Detainees were not told in advance that they would be asked to leave and this deprived them of the ability to comment on specific areas of practice and to participate fully in the safer custody strategy. At the meeting observed during the inspection, the detainee representatives were allowed to remain for the whole meeting apart from the discussion of immigration cases and individuals on the F2052SH register. This was more appropriate and useful for them and for the centre, as they were able to contribute valuable perspective and information.
- 5.14 The local visitors group provided befriending support to detainees. The high population turnover made a Listener scheme impractical. There was scope for a 'buddying' scheme supported by the Samaritans, but this had not previously been considered. There was a dedicated Samaritans phone which could be used by detainees who could speak English.
- 5.15 Sixty-three per cent of staff had been trained in suicide and self-harm during the previous three years. Taking all staff, including volunteers and externally employed staff, into account, the figure was just over 52%. Some of this shortfall was due to new staff who had not been trained in previous establishments, but there were clearly some established Haslar staff who had not been trained.
- 5.16 The first aid kit in the centre office did not contain a signed monitoring form indicating that it had been checked and kept up to date.
- 5.17 There was a safer room in the SAU where detainees at imminent risk of self-harm could be monitored. However, in the absence of 24-hour healthcare at the centre we were told those at risk of imminent self-harm would normally be transferred to Harmondsworth.

## Health and safety

---

- 5.18 Haslar had a comprehensive site-specific health and safety policy document. Formal risk assessments had been completed for the majority of areas in the centre. Good progress had also been made in establishing safe systems of work throughout. Documentation was of a high quality and management and administration of health and safety procedures were of a very good standard.
- 5.19 Our last short unannounced inspection of Haslar had raised serious concerns about the management of fire safety. Since that inspection, most of the fire inspection action plan had been achieved. A modern electronic fire alarm system had been installed in all areas, which included both smoke and heat detectors. The part-time fire officer was arranging fire evacuation exercises, including simulated night time evacuation but these were sporadic. Not all false alarms and consequent evacuations were being recorded if the fire officer was off duty. Fire training for staff was ongoing and 75% of staff had received training since the last short inspection. There were notices in four languages and pictorial displays of the action detainees should take in the event of discovering a fire.

## Recommendations

---

- 5.20 The centre should hold weekly meetings to increase staff–detainee communication, inform staff of emerging detainee concerns, and inform detainees of centre policies and procedures, including the anti-bullying policy.
- 5.21 Staff should be trained in recognising and responding to bullying in relation to detainees.
- 5.22 The anti-bullying report box should be locked. It should be emptied regularly by the anti-bullying coordinator.
- 5.23 During regular checks, staff should make an effort to interact positively with detainees at risk of self-harm, rather than simply observing them from a distance.
- 5.24 Detainees should not be asked to interpret for other detainees during discussions involving an element of risk assessment, especially F2052SH (self-harm monitoring) reviews.
- 5.25 Safer custody meetings should have a consistent chair and clear action points should be systematically followed up at subsequent meetings.
- 5.26 Detainees should be allowed to participate in all aspects of the safer custody meeting that do not involve discussions of confidential or sensitive matters.
- 5.27 A ‘buddying’ scheme should be introduced.
- 5.28 All staff should be trained in suicide and self-harm policy and procedures.
- 5.29 The first aid kits should be routinely monitored and kept up to date.
- 5.30 Fire exercises should take place monthly and all official and unofficial exercises should be recorded.

## Good practice

---

- 5.31 *Staff in all departments were informed of those at risk of self-harm by a form containing a picture of the detainee and brief details of the reasons for the risk and the means by which he had indicated he might harm himself. This was an effective way of encouraging good observation of at-risk detainees, and a whole-centre approach to the care of those at risk of self-harm.*
- 5.32 *Removal directions were recorded in a book kept in the centre office, thereby alerting staff to periods of increased risk.*
- 5.33 *Fire safety had been improved by fire safety notices displayed in the main languages and in pictorial displays of the actions detainees should take in the event of a fire.*

# 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 or religion and there is positive promotion and understanding of diversity.

5.34 The race relations liaison officer (RRLO) had only been in post for four weeks at the time of our inspection, but key processes for the management of race relations were in place. Diversity training for staff was well established and regularly updated, although it did not focus sufficiently on the changing cultural mix reflected in the centre. The standard Prison Service ethnic monitoring programme was not appropriate to Haslar and an alternative needed to be developed.

5.35 The RRLO had arrived only four weeks before the inspection but had held the post of RRLO at another Prison Service establishment. Key processes were in place to ensure that the race relations management team (RRMT) operated effectively. There were detainee representatives at the RRMT, which was chaired by the centre manager, and there were plans to display the photos of the representatives to prompt detainee comments and suggestions for improvements.

5.36 There were very few staff from visible ethnic minorities (less than 2%). Racist incident reporting forms (RIRFs) were available and their purpose and the definition of a racist incident were advertised in a number of languages. Only two RIRFs had been submitted in the previous four months; both were adequately responded to.

5.37 Ethnic monitoring and range setting were undertaken and the standard Prison Service "SMART" programme was applied. However, the programme was not satisfactory, as it relied on comparing the access minorities enjoyed with that of the host white community, which was irrelevant to Haslar. This weakness needed to be addressed to ensure that each of the minority groups represented in the centre had equal access to the facilities.

5.38 Staff training in diversity was up to date; over 80% of basic grade officers had received refresher training in the last 12 months. All nursing staff, all middle managers, 75% of operational support grades and all but one of the catering staff had also received training. The training package in use did not focus on understanding the differing needs of the constantly changing cultural mix reflected in the centre and it would have been worthwhile exploring alternative training options.

## Recommendations

---

5.39 An alternative ethnic monitoring and range setting programme should be developed for use in IRCs.

5.40 Alternative training packages should be identified and developed to help staff better understand and manage the different ethnic and cultural groups the centre has to accommodate.

# Faith

---

## Expected outcomes:

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

- |      |  |
|------|--|
| 5.41 | Faith matters were well managed and the manager had been in post for five years. All key faiths were represented in the establishment. |
|------|--|
- 5.42 At the time of the inspection there were 109 detainees; 44 of whom described themselves as Christian and 43 as Muslim. The remainder described themselves either as Hindu (5) Buddhist (1) or as being of no faith.
- 5.43 The manager of religious affairs was an Anglican chaplain who had been in post for five years. She had developed effective relationships with other faith leaders who visited the establishment when required. An imam visited weekly, although he was unable to lead Friday prayers.
- 5.44 There were large areas for Christian and Muslim worship in the centre and one smaller room shared by Sikhs and Buddhists.

## Section 6: Healthcare

### Expected outcomes:

Healthcare is provided at least to the standard of the National Health Service, includes the promotion of well being as well as the prevention and treatment of illness, and recognises the specific needs of detainees as displaced persons who may have experienced trauma.

- 6.1 The healthcare team was respectful and caring towards detainees. Detainees were actively encouraged to maintain a healthy lifestyle. Some of the dental equipment and processes required attention. The centre's communicable disease policy worked well. There was no formal medicines and therapeutics committee to develop medicines policy until the primary care trust (PCT) took over formal responsibility for the centre. There were anomalies in risk assessments requiring detainees to be handcuffed for outside healthcare appointments.

### Environment

---

- 6.2 The healthcare centre was next to the detainee information office, off the main corridor of the centre. A variety of health promotion information including information about anxiety, sleep, stress and sports injuries, was displayed in English only.
- 6.3 Outside the healthcare centre there was a small room, with a stable door from where detainees collected their medication. It was clean and tidy but there was no running water either for drinking or for hand washing. There was no privacy for confidential discussions. The room was secure and only healthcare staff had access. If required, a key to the pharmacy was held in a sealed pouch for emergency access out of hours by the medical officer. Medicines were stored in locked metal drug cabinets. Stock levels seemed reasonable and all medicines were labelled in accordance with Medicines Act requirements. No controlled drugs were kept at the establishment at the time of the inspection. Thermolabile (heat sensitive) medicines were stored in a pharmacy fridge, which was equipped with a minimum/maximum thermometer and a temperature record was kept of the daily minimum and maximum temperatures. In addition, the temperature of the room itself was monitored to prevent extremes affecting the stability of medicines.
- 6.4 A small single room, with safer custody furniture but no toilet or washing facilities, was used for detainees who needed to be observed for a few hours. There was a small GP room and a treatment room, where resuscitation equipment, including an automated external defibrillator, were kept. Emergency resuscitation drugs were available and were checked by the pharmacist and replaced when necessary.
- 6.5 The dental surgery had been re-equipped within the last six years. The protocols and procedures which were necessary for satisfactory cross-infection control in the dental surgery, including sterilisation of instruments, the use of disposables, disposal of sharps, were available and followed according to guidelines. However, the storage of instruments between the dentist's monthly visits was problematic. Under current cross-infection guidelines, pre-sterilized instruments should be stored within sealed pouches. This issue had been under review for some time. Some of the dental equipment, such as the compressor had not been regularly serviced and other equipment needed attention.

- 6.6 There was a staff office and a large room that was used as a waiting room and to see groups of detainees, for example, during induction. All the notice boards within the healthcare centre displayed relevant, current health promotion information, some of which was in languages other than English. The room was clean but the flooring did not meet current infection control guidelines.
- 6.7 There was a small healthcare interview room in reception, but the photocopier was also kept in this room.

## Records

---

- 6.8 At the time of the inspection an electronic records system had been in place for a week. New detainees had electronic records, but those who had been at the centre for more than a week had paper records. The paper records were stored in filing cabinets. Entries were clear, concise and contemporaneous. The staff undertook a peer review audit of medical notes every month, by looking at five random sets of medical records. The results were presented at the monthly staff meeting. Old paper records were stored in the healthcare centre for three months before being archived elsewhere.
- 6.9 The electronic system was password protected and staff had been involved in its design. The reception screening information was available in a variety of languages on the computer screen, so detainees could read the questions and enter their responses in the presence of a nurse.
- 6.10 Prescriptions were written on standard prescription and administration charts. Active prescription forms were stored in ring binders and locked in the pharmacy room when not in use. All of the prescriptions inspected appeared to be correctly written and appropriately reviewed by the doctor. A computer patient medication record system was kept for items dispensed for individual patients by Lloyds pharmacy. Items supplied from stock were also recorded, but medicines supplied as special sick were only recorded in the patient record and not for stock monitoring purposes.
- 6.11 Dental records were appropriately held and annotated.
- 6.12 Staff had access to a wide range of policies including food refusal and management of substance misuse. There was also a system for reporting adverse incidents.

## Staffing

---

- 6.13 A managing medical officer, who was also a GP in a local practice, headed the staff team. There was a G grade healthcare manager and three F grade nurses. All were registered general nurses (RGNs), but one also had a mental health qualification. All staff had training plans. GPs from a local practice provided a primary care service. They undertook a daily GP clinic and were on call during the working day. At other times, Solent Forensic Medical Services provided medical cover. None of the staff had undertaken training specifically for working with detainees. Staff meetings took place regularly.
- 6.14 A dentist and qualified dental nurse attended the centre once a month. The pharmacist employed by Lloyds Pharmacy visited the centre every six weeks. There was an informal medicines and therapeutics committee but the medical staff rarely attended.

## Primary care

---

- 6.15 A nurse saw detainees on arrival and carried out a reception-screening interview. If detainees had been transferred from another centre, a short interview was carried out. A more in-depth interview was undertaken if they had arrived from elsewhere. The detainee's height, weight and blood pressure were recorded and they were asked if they had previously had a vaccination against tuberculosis (TB). If the detainee could not speak English nurses either used the electronic version of the reception-screening tool or a telephone translation service. Healthcare staff made the most use of this service within the centre. Staff gave detainees a patient information leaflet, but this was available in English only. Our survey indicated that 37% of detainees had access to health information in their own language, compared to a benchmark of 31%.
- 6.16 Staff were sensitive to the possibility that a detainee may have been the victim of torture as defined by the Medical Foundation for Victims of Torture. They highlighted any concerns to the GP who then informed immigration officers by letter. Records kept by healthcare staff indicated that in a six-month period 18 letters had been sent to the immigration officer, following 34 detainees reporting torture. Our survey indicated that 40% of detainees claimed to have health problems caused by mistreatment, compared to a benchmark of 23%. The staff told us that they also encouraged the detainee to contact the Medical Foundation for Victims of Torture.
- 6.17 Detainees were invited to see the GP the day following their arrival, as part of the induction programme. Nursing staff took part in the induction programme and reiterated information about the healthcare services on offer. They also actively promoted the use of the gym and education facilities as a way of maintaining well being.
- 6.18 The healthcare centre was open from 8am until 9pm during the week and from 8am to 5pm at weekends. However, detainees did not have access to the department unless they had an appointment or they were attending at 8am when they could see a nurse if they had a problem.
- 6.19 Nurses were able to administer a variety of non-prescription remedies and appropriate records of items supplied were maintained on their medical records. Nursing staff could refer the detainee to a GP, but did not use triage algorithms. Detainees could obtain condoms from nursing staff at this time.
- 6.20 There were four appointments available per GP clinic and the average wait to see a GP was two days. One of the GPs was female, but staff always offered detainees the option of seeing a male GP if they preferred. Detainees could obtain a second opinion at their own expense if they wanted to.
- 6.21 All medicines were issued to detainees in-possession as either daily or 7-day treatment. Medicines were issued on occasion for 28 days following a risk assessment. There was a drug formulary in place. An in-possession policy was in use and this had been translated into most of the languages represented in the centre. Dosage instructions, although printed in English, were provided in other languages wherever possible and/or the use of picture dosage aids and the translator service were also available if needed.
- 6.22 Patient information leaflets were provided where available and notices were displayed at the healthcare centre informing detainees of the availability of leaflets in various languages. The pharmacist was available to speak with detainees about their medicines.

- 6.23 A nurse transcribed prescriptions on to a sheet, which was countersigned by the medical officer and acted as a prescription for the pharmacy to retain. The sheet was faxed through to the pharmacy after the morning surgery and the original prescription sheets were sent later, where they were retained for legal purposes. Medicines were delivered to the centre each afternoon. Stock items were also available for supply in urgent cases. Any items urgently required which were not available via this method could be obtained from the pharmacy during normal opening hours.
- 6.24 When the healthcare department was closed, detainees could not obtain basic over the counter remedies, although we were told that a policy permitting this was in the final stages of development.
- 6.25 The centre had recently had an outbreak of chickenpox, which had tested the communicable diseases policy. The systems had apparently worked well and the healthcare staff had a good working relationship with the local consultant in communicable diseases.
- 6.26 Meningitis C vaccinations were offered at a weekly clinic for those eligible, but other vaccinations were not offered, on the advice of a consultant from the London School of Health and Tropical Medicine. Detainees were screened for tuberculosis if they had a productive cough or other clinical signs and symptoms.
- 6.27 Each nurse had responsibility for specific chronic disease management, for example, respiratory conditions or diabetes and arranged to see detainees on an individual basis.
- 6.28 Smoking cessation services were offered. Detainees were expected to arrive at the allotted time. If they were late, for any reason, they had to make another appointment, even if there was no one else waiting to see a member of the healthcare team.
- 6.29 A dentist provided treatment under the regulations of the General Dental Services of the NHS. Because of the short-term stay, care was generally restricted to the simpler symptom relief treatments such as fillings, extractions and gum treatment. Emergency care was available, by arrangement with the practitioner, the local emergency service and the dental department of the local hospital. Waiting times for treatment were apparently short, but the monthly pattern of attendance meant that occasional delays occurred in individual cases. However, all patients on the list awaiting treatment were seen at each treatment session.
- 6.30 The standard of oral hygiene and the levels of gum disease among the detainees gave healthcare staff cause for concern. A range of toothbrushes and toothpastes were available. It was appreciated that the one to one oral hygiene instruction provided in the dental surgery only helped the actual patients seen, a relatively small proportion of the population.
- 6.31 If necessary, the GP referred a detainee to a local psychiatrist. Records showed that in the previous two years, two detainees had been transferred informally to local NHS mental health beds and one had been transferred under the Mental Health Act 1983. On average, at any one time at Haslar, five detainees (4% of the population) had identified primary mental health problems. The GP and the registered mental health nurse (RMN) cared for these detainees and the RMN provided one to one anxiety management. There were no trained counsellors available. A member of the healthcare team attended most suicide and self-harm reviews.
- 6.32 At meal times, discipline staff made a record of any detainee who did not attend the canteen. Healthcare staff examined this record on a daily basis and saw anyone who had not eaten (without a reasonable explanation, such as fasting) for three days or more.

- 6.33 Detainees could be referred for healthcare appointments outside the centre. A risk assessment was carried out prior to each appointment. There were anomalies in the outcome of the assessment depending on how the detainee travelled to the appointment. If, as in the majority of cases, they were taken by the contracted escort service they were not handcuffed. However, if prison staff took them, using a local taxi service, they were handcuffed. We were also told that hospital appointments often had to be cancelled because of the escort service's failure to meet the appointment times, but we could not find recorded evidence to support these claims.
- 6.34 When detainees left the centre, they took a record of their healthcare treatment only if it was deemed necessary by healthcare staff. If detainees were taking prescribed medications at least one week's supply was given to them.

## Recommendations

---

- 6.35 All healthcare information, such as the healthcare information booklet, in-possession policy and health promotion material should be available in a wide variety of languages.
- 6.36 A secure hatchway should be installed in the small cell adjacent to the pharmacy so that detainees can be spoken to confidentially at the time of handing out medication.
- 6.37 There should be a sink with hand washing facilities and drinking water in the pharmacy room.
- 6.38 Detainees should be able to obtain mild analgesia when healthcare staff are not on duty. Any policy or consent form should be available in a range of languages so that detainees understand that they are being provided with medication by staff without a medical qualification.
- 6.39 A formal medicines and therapeutics committee should be set up involving the healthcare staff at the centre, the medical staff and the pharmacist to develop and formally approve medicines policies. Until the primary care trust's (PCT) formal responsibility for the centre has been established, the PCT pharmaceutical prescribing adviser should be approached informally with an invitation to attend such meetings.
- 6.40 The medicines and therapeutics committee should review all medication-related policies and procedures annually and ratify all patient group directives.
- 6.41 Until the necessary IT software is available, every detainee's transcribed prescription must be signed by the medical officer. When the software is installed, there should be electronic prescribing and transmission of prescriptions.
- 6.42 Triage algorithms should be used to ensure consistency of assessment and advice.
- 6.43 When the PCT's formal responsibility for the centre has been established, links with the PCT and the Portsmouth School for Professionals Complementary to Dentistry should be explored.
- 6.44 All the dental equipment, including the compressor should be subject to planned preventative maintenance checks.

- 6.45 The arrangements for storing dental instruments should be reviewed to ensure that it meets both cross infection and security guidelines.
- 6.46 Detainees should be able to obtain condoms without asking a member of staff.
- 6.47 There should be a presumption against the use of handcuffs during visits to outside healthcare facilities.

### Housekeeping points

---

- 6.48 The photocopier in the reception healthcare room should be moved, to allow uninterrupted confidential medical interviews.
- 6.49 Medicines supplied as stock by Lloyds pharmacy should be in the form of manufacturers' patient packs wherever possible.
- 6.50 The floor in the dental suite should have sealant applied to the floor/skirting board edges to improve cleanliness.

### Good practice

---

- 6.51 *Patient information leaflets and notices, in various languages, helped detainees to become more knowledgeable about their medications.*
- 6.52 *The system of peer review and audit of clinical records and the adverse incident reporting schemes promoted a supportive culture within the working environment of openness and honesty.*

# Section 7: Activities

## Expected outcomes:

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

7.1 Education provision was good. Many detainees attended educational sessions and pass rates for accredited subjects were relatively high. The facilities were good and the education team was generally enthusiastic and resourceful, though some attention was needed to improve the teaching methods in a few classes. The library was providing a high quality service and an enthusiastic PE staff delivered a much appreciated PE programme. There was no paid work available but a voluntary work scheme involving a few detainees was under development.

## Education

---

- 7.2 A large proportion of the population attended education at some stage during their stay. Detainees were consistently engaged by the learning sessions and were treated with dignity and respect. Pass rates for external qualifications were high and achievement was celebrated, although more short courses were needed. Learning resources were good. Management of education was good although feedback on teaching observation was insufficiently focused. Some sessions in English for speakers of other languages (ESOL) and information and communications technology (ICT) were over dependent on workbooks and had not adapted to detainees' needs.
- 7.3 There was a good rapport between tutors and detainees. Relationships were quickly established with new detainees who routinely arrived at different points in learning sessions. Good individual support and encouragement was offered to detainees during classes.
- 7.4 Detainees rapidly developed skills in music and art. Despite the relatively short stay, art tutors were particularly effective in helping detainees develop high levels of ability and skills suitable for employment or for further study.
- 7.5 The pass rates for externally accredited qualifications in IT were high. Around 30% of detainees starting IT programmes remained at the centre long enough to complete the nationally recognised qualification and all passed. Of the few detainees who took ESOL qualifications the pass rate was high at 87%. Many detainees achieved certificates validated by the college which held the education contract. The centre held a weekly awards ceremony where detainees publicly received their certificates.
- 7.6 The learning environment was well resourced and welcoming. The education staff worked hard to ensure it was comfortable and inviting. Classrooms were well furnished and there were educationally relevant displays on the walls. IT equipment was up-to-date and sufficiently powerful to run industry standard software on the learning network. Detainees taking ESOL courses made good use of modern laptop computers running specialist language learning programmes. Resources for art and music were good.
- 7.7 There was a wide range of art activities including beading, ceramics, tie dye, craft, computer art, drawing and painting. An art tutor had produced a very helpful set of workbooks related to skills such as painting at three different levels for detainees to use. Detainees were

encouraged to use their imagination and creativity, but in painting and drawing there was an overemphasis on copying from photographic or printed images. A college certificate was awarded on completion of each workbook to mark achievement.

- 7.8 Achievement in art was celebrated throughout the education department and some other areas by prominent displays of detainees' work. The displays were rich in colour, design, texture and perspective and vividly reflected the diversity of detainees' beliefs, faith, experiences, travels and national customs.
- 7.9 In ESOL sessions detainees did not receive sufficient structured practice to develop their oral communication skills. ESOL learning was over-dependent on completion of exercises in workbooks which ensured detainees could work on their English outside the class sessions, but placed too much emphasis on learning formal language structure. Some of the content was culturally inappropriate. Lessons did not always adequately cater for the wide span of detainees' language levels.
- 7.10 ICT sessions were also heavily dependent on detainees following instructions in workbooks. While these were closely aligned to the accreditation, many detainees understood little of the text they copied, or data they entered when using computers.
- 7.11 Given the short stay, curriculum planning did not sufficiently prioritise the development of short courses. Insufficient attention was given to adapting provision, such as ICT, for detainees whose proficiency in English was limited.
- 7.12 The amount of time detainees could study effectively was restricted. Detainees could only use the education facilities for study during day and evening opening hours, and no access was possible at weekends. Facilities for independent study elsewhere in the centre were poor. The centre planned to train some officers and detainees to supervise the use of education facilities outside education opening hours.
- 7.13 The education provision was well managed. The commitment to improvement across the curriculum was good and hampered only by local and national constraints. Data on detainees' progress, achievement attendance and ethnicity was readily available and was used effectively to identify curriculum performance, profile the detainee population and in some areas to track detainee progress. The centre management team were proactive in their support for education. The education manager effectively managed learning and teaching and education staff formed a very strong and cohesive team. Team meetings were regular and administrative support was exemplary. Communication between education and the centre staff was good as were links with the main college site.
- 7.14 The education department did not act sufficiently to raise detainees' awareness of their rights and responsibilities towards each other.
- 7.15 Some teachers benefited from continuing professional development to alert them to new initiatives in their areas. Feedback on observations of teaching and learning by managers and other staff was too general and lacked focus on the specific areas which needed improvement.

## Employment

---

- 7.16 Detainees were not offered paid work at the centre. However, a recently introduced scheme allowed up to 18 detainees to volunteer for specific roles in areas of the centre such as education, the canteen and PE. An initial eight detainees had taken up this opportunity.

Detainees were offered incentives which included enhanced accommodation. All detainees received a weekly allowance of £5.

## Library

---

- 7.17 The library was located in the education department. It was open for 18 hours each week over five mornings and four afternoons. Detainees had free access to the library during opening hours. There was no access during the evenings or weekends. It was staffed by a part-time librarian and a part-time assistant librarian. The county council held the contract. The centre recently contributed substantial funds to maintain and improve the stock. Although small, the library was very well organised and welcoming. Wall displays were attractive. An extensive and wide ranging stock of fiction, non-fiction and reference books was available in 32 languages, and there was material on different faiths. Six English newspapers and a good range of foreign newspapers in 14 languages were available. Detainees had access to music CDs in nine languages. A quiet room next to the library where detainees played music through headphones and read the newspapers was popular. A stock of videos and DVDs, in English and five foreign languages, was in regular use. The library stock was increased and updated on a well-planned rota basis. There was an effective system for managing and monitoring loans and returns.

## Physical education

---

- 7.18 The range of PE activities was good and was well promoted across the establishment. Detainees knew what activities were available, and were able to choose freely between them. They made regular use of an appropriate full-sized outdoor football pitch. They were provided with suitable clothing and equipment. Shower facilities were satisfactory. The gym was well resourced and the range of equipment available was good, including running machines, cross trainer, weights, rowing machines and static bikes. These were generally well positioned and maintained. All instructors were appropriately qualified. A limited range of accredited courses was offered periodically in manual handling, first aid and the STAR awards through BAWLA (British amateur weight lifting association). The senior officer had made a concerted effort to identify detainees' needs and preferences and develop a suitable programme of activities.

## Recommendations

---

- 7.19 There should be more practice in developing oral communication skills in English for speakers of other languages (ESOL) sessions.
- 7.20 ESOL lessons should cater adequately for the learners' different needs.
- 7.21 ESOL materials should be culturally appropriate.
- 7.22 More short courses should be developed.
- 7.23 Provision such as information and communications technology (ICT) should be adapted to meet the needs of detainees with limited English.
- 7.24 Action should be taken to improve detainees' understanding of their rights and responsibilities.
- 7.25 Library opening hours should be extended to include evenings and weekends.

## Housekeeping points

---

- 7.26 Information and communications technology (ICT) and English for speakers of other languages (ESOL) workbooks should be improved.
- 7.27 Opportunities for independent study using education facilities should be extended.
- 7.28 Feedback after teaching observations should be specific about areas requiring improvement.

## Good practice

---

- 7.29 *A large picture was displayed in the entrance lobby to the education department, and was about two-thirds complete. The picture, based on a small scale original work, was created by arranging individual square panels together in a grid. Each square was painted by a different person. While styles were different each had to fit with the adjacent panels to help form the whole. Both detainees and staff contributed panels. The picture vividly celebrated the centre community as an entity and reflected a belief that the whole was bigger than the constituent parts. It formed a dynamic public display, growing over time.*

# Section 8: Rules and management of the centre

## Expected outcomes:

Detainees are able to feel secure in a predictable and ordered environment.

8.1 The rules of the centre were well understood by detainees. Security had been upgraded since the last inspection but CCTV had not been installed in corridors and dormitories. Access to the roof needed attention. Searching was carried out respectfully. A new rewards scheme had been implemented but needed time to bed in. Positive staff–detainee relationships had helped establish a good degree of control. Force was rarely used and was well documented. Records for use of the separation unit were good. There was a little-used combined requests and complaints system in place.

## Rules of the centre

---

- 8.2 A comprehensive set of centre rules had been recently published and was given to detainees on or very soon after arrival. The rules were available in 22 languages other than English and described the centre's role, the reward scheme, the compact and acceptable behaviour. The rules were also on display in English in the main corridor, and were displayed in a range of languages in the dormitories. Most detainees we spoke to had their own copy and said they understood them. In our survey, 36% said that they understood how to make routine requests compared to a benchmark of 26%.
- 8.3 Managers visited all parts of the centre regularly and recorded their visits. The quality of entries in the observation book was checked. If rules were breached, staff explained the nature of the breach to the detainee concerned using a detainee interpreter or telephone translation as required.

## Security

---

- 8.4 There had been a general upgrade to physical security since our last inspection. CCTV cameras had been installed around the perimeter fence and high tensile steel bars were fixed outside each dormitory window. However, CCTV had not been installed in corridors or dormitory association rooms. Observation of these areas was dependent on the number and location of the staff team. Staff were not regularly deployed to observe CCTV monitors and the monitors were located in two different parts of the centre this had serious implications as for safety and control and needed to be rectified.
- 8.5 There were no electronic movement detectors around the perimeter fence to trigger an alarm and make up for the lack of continual observation. There were some points of easy access to roofs from the exercise area which needed attention. No detainee had absconded from the centre since May 2004.
- 8.6 Detainees who had served prison sentences were accepted at Haslar but information about their custodial history was not provided by the Prison Service or the Immigration and Nationality Directorate (IND). The security team at Haslar put considerable effort into establishing links with sending prisons to gain intelligence about new arrivals.

- 8.7 Searching of individual detainees was carried out respectfully and always by two officers. Strip-searching was only carried out following a formal risk assessment.

## Rewards scheme

---

- 8.8 At the time of the last inspection there was no documented reward scheme at Haslar. Some weeks prior to this inspection a full reward scheme had been published. There were signs around the centre describing the scheme and detainees were told about the reward scheme during induction. An outline of the scheme was also contained in the centre rules in a range of languages. Detainees who fully participated in the regime and were of good behaviour were eligible to advance from standard to enhanced level. Poor behaviour meant a demotion to basic level and removal from association, though no detainees had been reduced to basic prior to the inspection. Detainees were expected to propose themselves for advancement though staff could initiate the process for them. Applications to progress to enhanced level went to the head of residence and appeals against rejection were heard by the head of operations.
- 8.9 Those detainees on enhanced level could choose A (smoking) or H (non smoking) dormitories which had in-room televisions. They could also order goods from an Argos catalogue, take part in bingo sessions paying higher prize money and use the games room at weekends.
- 8.10 Demotions from enhanced to standard level were based around a card system similar to that used by referees in football matches. The yellow card was used as a first warning and the red card as a final warning. Two detainees were given a red card for fighting during the inspection which was the first time the system had been used since the reward scheme had been developed.
- 8.11 Though detainees and staff told us that they understood or had heard about the scheme, residential staff were not always using the relevant documentation in accordance with policy. The scheme needed more time and management attention to be properly implemented. Managers were unable to give inspectors a breakdown of detainees on standard and enhanced levels.

## Discipline

---

- 8.12 A good degree of control had been achieved through positive staff-detainee interaction. Managers had dealt with recent minor incidents in dormitories involving different nationalities through discussion with the relevant detainees using detainee interpreters when necessary. We were told that group sanctions were not used to manage situations involving more than one person. Detainees confirmed this in individual discussions.

## Use of force and single separation

---

- 8.13 Records showed that force had been used on five occasions in the previous six months and we did not consider this to be excessive. However, this included one incident of a member of staff drawing his staff (but not having used it). Private sector custody officers do not routinely carry staves but many prison service staff do carry them. Routine deployment of offensive/defensive weaponry is not appropriate in a removal centre context. Training records showed that the majority of uniformed staff (over 90%) were up to date with control and restraint training.

- 8.14 The special accommodation unit (SAU) consisted of two cells in a side spur off the main corridor. This was the only cellular facility in the centre, and was used to hold detainees under both Rule 40 (removal from association) and Rule 42 (temporary confinement). Managers understood the separate considerations governing the use of each rule. Detainees were not routinely strip-searched on arrival in the SAU. Good case records were kept about each detainee's stay, although what happened to the detainee to bring the period of temporary confinement or removal from association to an end was not always recorded.

## Complaints

---

- 8.15 Detainees could readily access combined request and complaint forms. There was little information in other languages and all the complaints submitted from January to May 2005 were in English. It was not clear why the establishment continued to combine both requests and complaints systems rather than follow the Prison Service example of separating them.
- 8.16 Seven complaints had been submitted in 2005. Of the seven, four referred to problems with property outside Haslar. These were clearly requests for assistance rather than complaints about institutional treatment. One complaint was about immigration status. Of the two that were more properly complaints, one was about medical issues and the other alleged abusive behaviour by staff.
- 8.17 One of the complaints did not appear to have been answered and the answer to another referred to the complainant in the third person and was not respectfully written.
- 8.18 The establishment was not held accountable for timely responses and long delays could go unnoticed. This was especially unacceptable for detainees who are unlikely to spend long in the centre.

## Recommendations

---

- 8.19 CCTV monitors should be routinely and consistently observed by staff.
- 8.20 CCTV should be installed in the corridors and dormitory association rooms.
- 8.21 Electronic movement detectors and alarms should be installed.
- 8.22 All roof areas around the exercise area should be made secure.
- 8.23 The Immigration and Nationality Directorate (IND) and/or the Prison Service should provide relevant security information about ex-prisoner detainees to Haslar's security department.
- 8.24 Staff should take responsibility for proposing detainees for advancement on the reward scheme.
- 8.25 Management attention should ensure that the administration of the scheme by residential staff is in accordance with the policy.
- 8.26 Accurate records should be kept of each detainee's level within the reward scheme.

- 8.27 The special accommodation unit (SAU) case records should always clearly state what brought a detainee's stay in temporary confinement or removal from association to an end.
- 8.28 The establishment should develop separate requests and complaints systems.
- 8.29 Complaints should be answered promptly, using respectful language, and the timeliness of replies should be monitored.

## Section 9: Services

### Expected outcomes:

Services available to detainees allow them to live in a decent non-punitive environment in which their normal everyday needs are met freely and without discrimination.

- 9.1 Access to the shop was limited during the week and there was no access at weekends. The two telephone cards on sale offered poor value. Menus and meals seen in the communal canteen were varied and healthy and the kitchen was clean.
- 9.2 The centre shop was supplied by a wholesaler and sold products at the manufacturer's recommended retail price. Telephones were card-operated and telephone cards were sold at a discount: the centre purchased cards at 25% less than face value and passed this saving on. However, the poor value of the two telephone cards sold in the shop was one of detainees' main complaints. Forty per cent of detainees had less than £10 in their account. Managers recognised the poor value offered by the telephone cards and were investigating alternatives.
- 9.3 The shop opening hours were limited: four mornings and four afternoons over five weekdays. It closed no later than 3.30pm and was not open at all at weekends. Detainees were only allowed to visit once a day. The restrictions were partly caused by the centre's cashless system. The shop officer checked detainees' account balances on a computer, but he could not alter these at the time of purchase. On each occasion he and the detainee completed a transaction form which was passed to administrative staff for processing the same day and the shop hours were therefore linked to administrative staff hours. Detainees would have preferred later opening hours, not least because the last meal of the day finished by 6pm and breakfast was not until 8am. Daily tea/coffee packs and a few biscuits were supplied as an evening snack, but these were supplied in the morning and often already eaten by the evening. Detainees could purchase other snacks including fish in tins without ring pulls, but no tin opener was available during our night visit. Profits from the shop were applied for detainees' benefit. An Argos catalogue was available to detainees on enhanced level.
- 9.4 In our pre-inspection survey detainees were negative about the food, but we encountered less criticism during the inspection. We observed a range of meals, of good quantity, variety, quality and presentation. The centre restaurant was used by detainees and staff. There was a four-week menu cycle, refreshed with new or seasonal variations. Menus were displayed pictorially with signs indicating halal, vegetarian and healthy options. As not all meat was halal, this option was signalled both by a sign on the menu and by use of green utensils at the servery.
- 9.5 The catering manager had consulted widely, internally and externally, to provide a diverse and healthy menu cycle suitable for the population. Fresh fruit and yoghurt, rather than desserts, were available every day. Detainee representatives were able to report complaints or suggestions to the monthly consultative committee meetings. There was a complaints book at the servery which had a number of comments and responses in recent months. The catering manager also conducted twice yearly surveys. To improve response rates he asked detainees to distribute them. Some menu changes had been made as a result of the survey findings.
- 9.6 The kitchen was clean and had achieved a gold mark from the local authority. Detainees ate all three daily meals in the communal canteen, on a dormitory rota basis. During the half-hour meal time, staff toured the dormitories to see who was not eating and why. Names of non-

attendees were entered with comments in a book in the centre office and detainees were referred to healthcare staff if non-attendance was repeated.

## **Recommendations**

---

- 9.7 Detainees should be able to use telephones at a cost similar to that in the community.
- 9.8 Shop opening hours should be extended.

## **Housekeeping point**

---

- 9.9 Tin openers should be available to detainees during the evening if snack items cannot be provided in easily opened containers.

# 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.

10.1 Visiting arrangements were efficient and facilities were reasonable, although there were no evening visits. Access to incoming and outgoing telephone calls was good, although some detainees said that high costs of calls were prohibitive. Arrangements for incoming and outgoing mail were good. There were few formal arrangements to help detainees to prepare for transfer, removal or release. The relationship between the centre and the Haslar Visitors Group needed to be formalised.

## Visits

- 10.2 Visiting hours were from 2pm to 4pm every day except Thursdays when the times were extended from 9.30am to 4pm. There were no evening visits. A very useful information leaflet, "Visiting IRC Haslar – A Guide for Visitors" had been produced, although it was available in English only. The leaflet contained information that visitors needed to know in advance of their visit, such as travel directions, property they were allowed to take in and a suggestion to telephone the day before their visit to check that the detainee had not been transferred or removed. However, during the inspection, the leaflet had not been given to visitors prior to their visit and neither was it available to them when they arrived. Visitors told us that they found out about visiting arrangements from detainees.
- 10.3 Visitors were processed quickly from the point of arrival. We were told that there were rarely queues but there was no visitors' centre or shelter from the elements for those arriving early. Property brought in by visitors was processed efficiently.
- 10.4 No bookings were needed and visitors were asked to turn up at the gate with photographic ID and the name of the detainee they wished to visit. They were asked to give their name and address and also to sign a declaration to say that they had read and understood the centre regulations. The declaration was available in English only and we met a group of visitors who told us that they had no idea what they had signed.
- 10.5 After signing the declaration, male visitors were given a rub-down search. We were told that female visitors were rarely searched because visits staff were usually male, although a female member of staff could be brought to the gate if an intelligence-led search was required. We observed courteous treatment of visitors and good cultural awareness. However, one member of staff ran his fingers through visitors' hair during searches which was inappropriate and disrespectful. This was immediately remedied during the inspection.
- 10.6 Visitors could store personal property in a locker in the waiting room. The waiting room was small but few visitors waited there for long before being escorted across to the visits room. There was a range of notices on boards in the waiting room but all were in English apart from the word "Welcome".

- 10.7 After visitors were checked in at the gate, detainees were summoned via the tannoy and there was no delay in bringing them across. Detainees were given a rub down search prior to entering the visits room. Strip-searching of detainees prior to visits rarely took place and only on the basis of risk assessment.
- 10.8 The visits area was reasonably comfortable and clean with informal seating, although it was not particularly welcoming in design or decoration. There was a well-stocked vending machine. On Thursdays visitors could buy lunch supplied by the kitchen. The visitors' toilets were very clean and there was a separate disabled toilet and nappy changing facility. There was a good supply of toys but no supervised crèche. Visits staff maintained discreet observation.

## Telephones

---

- 10.9 In our survey, 27% of detainees said that it was easy or very easy to make outgoing telephone calls which was significantly worse than the benchmark of 45%. This was surprising since 24-hour access to the phones was very reasonable and we did not observe any queues. We did not receive similar complaints during the inspection, although detainees did complain about high costs which may have influenced their perception of ease of access.
- 10.10 A range of telephone cards was available from the centre shop and they were sold at a discount of 25% off face value (see also paragraph 9.2). Regular meetings had been held with BT with a view to improving the system to offer best value for money. Detainees without means were given £1 per day to cover all expenditure – including telephone calls, toiletries and tobacco. They could also acquire extra telephone credit through the recently introduced incentive scheme. Detainees did not have access to email or the internet.

## Mail

---

- 10.11 Systems for collecting outgoing mail and distributing incoming mail were efficient. Incoming mail arrived daily for distribution on the unit around 10.30am and outgoing post was collected at 3pm and posted the same day. One air mail and one standard letter each week was offered at public expense to detainees without funds and there were no restrictions on mail sent or received.
- 10.12 Faxes and letters to legal advisors and the Immigration Service were despatched twice a day at public expense.

## Welfare, removal and release

---

- 10.13 There was no formal welfare policy or provision to assist detainees being removed from the country. Agreement to appoint a welfare officer had been made over 12 months ago but it was unclear when the successful (internal) candidate would take up post. In the meantime, arrangements to provide practical assistance to prepare detainees for release, transfer or removal were minimal and not systematic. The chaplain collected voluntary donations of clothing and distributed them to those she thought needed them but there was no formal process by which detainees' needs were assessed and met prior to release, transfer or removal.
- 10.14 There were no formal arrangements in place to allow detainees to settle their affairs before they were removed. There was, however, a good system in place to inform detainees of

planned removal. Observation books on the units demonstrated staff involvement in checking detainees' reaction to news of imminent transfer or removal. Those detainees who reacted badly to the news of removal were put under closer observation by residential staff or healthcare, or referred to immigration staff for advice.

- 10.15 Efforts had been made to obtain information from other IRCs, so that detainees could be informed about where they were being transferred to. However, so far, these efforts had been unsuccessful.
- 10.16 In the case of the minority who were released, there were similarly no integration or reintegration arrangements, other than provision of a travel warrant and subsistence for those faced with journeys longer than five hours.
- 10.17 The Citizen's Advice Bureau offered fortnightly surgeries. The Haslar Visitors Group visited frequently and detainees spoke well of the support they received from them. In our survey, 28% of detainees said that they had been visited by a community group or volunteer visitor which was significantly better than the benchmark of 16%. The relationship between the Haslar Visitors Group and the centre had not been formalised. There were no regular meetings and communication needed to be improved so that detainees gained maximum benefit from their support. This was particularly important considering the recommendations made in a previous death in custody report that any welfare support available to detainees should be utilised.

## Recommendations

---

- 10.18 **A visitors' centre with appropriate facilities should be available for visitors arriving early.**
- 10.19 **The welfare officer post should be activated without delay.**
- 10.20 **The centre manager and relevant staff representatives should meet representatives of the Haslar Visitors Group on a regular basis to share information and discuss concerns.**

## Housekeeping points

---

- 10.21 The visitors' declaration should be available in a range of languages.
- 10.22 The "Visiting at IRC Haslar – A Guide for Visitors" leaflet should be available in a range of different languages. A system should be introduced to send the leaflet to visitors in advance of their visit whenever possible. It should also be prominently displayed in the waiting area and proactively promoted by staff.
- 10.23 Notices in the waiting room should be available in a range of different languages.



# Section 11: Recommendations, housekeeping points and good practice

The following is a listing of recommendations, housekeeping points and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

## Main recommendations

To the director general, Immigration and Nationality Directorate (IND)

---

- 11.1 There should be an urgent review of the adequacy of the new escort vehicles and steps taken to ensure the safety, control and respectful transportation of Detainees. (HE.23)
- 11.2 Staff working in immigration removal centres should not carry offensive or defensive weapons as a matter of routine. (HE.24)
- 11.3 Anti-bullying issues should be discussed in depth in a multi-agency meeting, and remedial action should be taken. (HE.25)
- 11.4 A major rebuilding and refurbishment programme is required, in particular the dormitories should be rebuilt to allow detainees some privacy and to minimise noise and light intrusion. (HE.26)
- 11.5 There should be a review of the prohibition on detainees engaging in paid work, and in the meantime, the voluntary work scheme should be expanded. (HE.27)

## Main recommendation

To the centre manager

---

- 11.6 Visiting times should be more flexible to meet visitors' needs. (HE.28)

## Other recommendations:

To the director general, Immigration and Nationality Directorate (IND)

---

### **Courts and escorts**

---

- 11.7 Detainees under escort should be provided with refreshments and comfort breaks and escort providers should maintain records of refreshments and breaks offered. (1.28)
- 11.8 Information about risk of harm, vulnerability and other special needs should accompany detainees. (1.29)
- 11.9 There should be a protocol in place for the administration of medication during escort. (1.30)
- 11.10 Movement notifications should contain a complete list of positive indicators of risk. (1.31)

## **Legal rights**

---

- 11.11 Detainees should have access to on-site independent, suitably qualified legal advisers. (3.6)
- 11.12 Detainees should have access to the internet and email, with suitable restrictions, to enable them to cheaply and instantly contact legal representatives and trace up-to-date information relevant to their case. (3.9)

## **Casework**

---

- 11.13 Documentation accompanying detainees should record the cumulative history of their period of detention. This should be completed at all places of detention, including police stations, and should document the detainee's access to telephones, legal advice, showers, change of clothing, exercise, medical checks and visitors, as well as noting incidents and reviews. (4.10)
- 11.14 The Immigration and Nationality Directorate (IND) travel documentation unit should prioritise detained cases. (4.11)
- 11.15 Age dispute cases should be subject to independent medical assessment. (4.12)
- 11.16 Written reasons for detention and reviews should relate to the individual's circumstances and reflect balanced consideration of all relevant factors, for and against detention, including any progress in the case. They should be issued in a language the detainee can understand. (4.13)
- 11.17 IND should investigate and consider any conditions affecting a detainee raised under Rule 35 of the Detention Centre Rules. This process should be documented and the detainee notified of the outcome. (4.14)
- 11.18 There should be clear demarcation of responsibility within IND for all aspects of detainees' cases and detainees should be notified of the office to which they should address queries about their detention or case progression. (4.15)
- 11.19 Detainees who supply original documents to IND while in detention should be given copies of their documents. (4.16)

## **Diversity**

---

- 11.20 An alternative ethnic monitoring and range setting programme should be developed for use in IRCs. (5.39)

## **Rules and management of the centre**

---

- 11.21 The Immigration and Nationality Directorate (IND) and/or the Prison Service should provide relevant security information about ex-prisoner detainees to Haslar's security department. (8.23)

## Other recommendations:

to the Centre Manager

---

### **Escort vans and transfers**

---

- 11.22 Detainees should always be offered a meal following their reception. (1.32)
- 11.23 First night risk assessments should be completed in private by residential staff with the necessary skills and sufficient time to carry out the task properly. Each assessment should be retained on the detainee's file on the residential unit. (1.33)
- 11.24 Staff delivering induction sessions should ensure that the information is understood by all. (1.34)
- 11.25 Detainees who are being moved should be provided with information about their destination and the reason for the movement. (1.35)

### **Residential units**

---

- 11.26 Shower rooms should be regularly redecorated. (2.10)
- 11.27 All detainees should have lockable cabinets in their rooms. (2.11)
- 11.28 Pictures, displays and other notices which reflect the cultural diversity of the centre should be put up in the residential areas. (2.12)
- 11.29 All translated notices should be checked by professional translators and no new notices should be put up unless they are accurate and easily understood. (2.13)
- 11.30 The tannoy system should be used as little as possible and pagers should be provided to detainees. (2.14)
- 11.31 Telephone privacy hoods should be effective in screening out the noise from the television in communal areas. (2.15)
- 11.32 Detainees should be provided with duvets. (2.16)
- 11.33 All units should have washing machines to allow detainees to do their own washing. (2.17)

### **Legal rights**

---

- 11.34 The centre should review legal visits arrangements and consult a range of legal service providers in the private, legal aid and not-for-profit sectors, with a view to enlarging legal visits for the benefit of detainees. (3.7)
- 11.35 Detainees who are representing themselves should be provided with sufficient materials to conduct their case. (3.8)

## **Duty of care**

---

- 11.36 The centre should hold weekly meetings to increase staff–detainee communication, inform staff of emerging detainee concerns, and inform detainees of centre policies and procedures, including the anti-bullying policy. (5.20)
- 11.37 Staff should be trained in recognising and responding to bullying in relation to detainees. (5.21)
- 11.38 The anti-bullying report box should be locked. It should be emptied regularly by the anti-bullying coordinator. (5.22)
- 11.39 During regular checks, staff should make an effort to interact positively with detainees at risk of self-harm, rather than simply observing them from a distance. (5.23)
- 11.40 Detainees should not be asked to interpret for other detainees during discussions involving an element of risk assessment, especially F2052SH (self-harm monitoring) reviews. (5.24)
- 11.41 Safer custody meetings should have a consistent chair and clear action points should be systematically followed up at subsequent meetings. (5.25)
- 11.42 Detainees should be allowed to participate in all aspects of the safer custody meeting that do not involve discussions of confidential or sensitive matters. (5.26)
- 11.43 a ‘buddying’ scheme should be introduced. (5.27)
- 11.44 All staff should be trained in suicide and self-harm policy and procedures. (5.28)
- 11.45 The first aid kits should be routinely monitored and kept up to date. (5.29)
- 11.46 Fire exercises should take place monthly and all official and unofficial exercises should be recorded. (5.30)

## **Diversity**

---

- 11.47 Alternative training packages should be identified and developed to help staff better understand and manage the different ethnic and cultural groups the centre has to accommodate. (5.40)

## **Healthcare**

---

- 11.48 All healthcare information, such as the healthcare information booklet, in-possession policy and health promotion material should be available in a wide variety of languages. (6.35)
- 11.49 A secure hatchway should be installed in the small cell adjacent to the pharmacy so that detainees can be spoken to confidentially at the time of handing out medication. (6.36)
- 11.50 There should be a sink with hand washing facilities and drinking water in the pharmacy room. (6.37)

- 11.51 Detainees should be able to obtain mild analgesia when healthcare staff are not on duty. Any policy or consent form should be available in a range of languages so that detainees understand that they are being provided with medication by staff without a medical qualification. (6.38)
- 11.52 A formal medicines and therapeutics committee should be set up involving the healthcare staff at the centre, the medical staff and the pharmacist to develop and formally approve medicines policies. Until the primary care trust's (PCT) formal responsibility for the centre has been established, the PCT pharmaceutical prescribing adviser should be approached informally with an invitation to attend such meetings. (6.39)
- 11.53 The medicines and therapeutics committee should review all medication-related policies and procedures annually and ratify all patient group directives. (6.40)
- 11.54 Until the necessary IT software is available, every detainee's transcribed prescription must be signed by the medical officer. When the software is installed, there should be electronic prescribing and transmission of prescriptions. (6.41)
- 11.55 Triage algorithms should be used to ensure consistency of assessment and advice. (6.42)
- 11.56 When the PCT's formal responsibility for the centre has been established, links with the PCT and the Portsmouth School for Professionals Complementary to Dentistry should be explored. (6.43)
- 11.57 All the dental equipment, including the compressor should be subject to planned preventative maintenance checks. (6.44)
- 11.58 The arrangements for storing dental instruments should be reviewed to ensure that it meets both cross infection and security guidelines. (6.45)
- 11.59 Detainees should be able to obtain condoms without asking a member of staff. (6.46)
- 11.60 There should be a presumption against the use of handcuffs during visits to outside healthcare facilities. (6.47)

### **Activities**

---

- 11.61 There should be more practice in developing oral communication skills in English for speakers of other languages (ESOL) sessions. (7.19)
- 11.62 ESOL lessons should cater adequately for the learners' different needs. (7.20)
- 11.63 ESOL materials should be culturally appropriate. (7.21)
- 11.64 More short courses should be developed. (7.22)
- 11.65 Provision such as information and communications technology (ICT) should be adapted to meet the needs of detainees with limited English. (7.23)
- 11.66 Action should be taken to improve detainees' understanding of their rights and responsibilities. (7.24)

11.67 Library opening hours should be extended to include evenings and weekends. (7.25)

### **Rules and management of the centre**

---

- 11.68 CCTV monitors should be routinely and consistently observed by staff. (8.19)
- 11.69 CCTV should be installed in the corridors and dormitory association rooms. (8.20)
- 11.70 Electronic movement detectors and alarms should be installed. (8.21)
- 11.71 All roof areas around the exercise area should be made secure. (8.22)
- 11.72 Staff should take responsibility for proposing detainees for advancement on the reward scheme. (8.24)
- 11.73 Management attention should ensure that the administration of the scheme by residential staff is in accordance with the policy. (8.25)
- 11.74 Accurate records should be kept of each detainee's level within the reward scheme. (8.26)
- 11.75 The special accommodation unit (SAU) case records should always clearly state what brought a detainee's stay in temporary confinement or removal from association to an end. (8.27)
- 11.76 The establishment should develop separate requests and complaints systems. (8.28)
- 11.77 Complaints should be answered promptly, using respectful language, and the timeliness of replies should be monitored. (8.29)

### **Services**

---

- 11.78 Detainees should be able to use telephones at a cost similar to that in the community. (9.7)
- 11.79 Shop opening hours should be extended. (9.8)

### **Preparation for release**

---

- 11.80 A visitors' centre with appropriate facilities should be available for visitors arriving early. (10.18)
- 11.81 The welfare officer post should be activated without delay. (10.19)
- 11.82 The centre manager and relevant staff representatives should meet representatives of the Haslar Visitors Group on a regular basis to share information and discuss concerns. (10.20)

## **Housekeeping points**

---

### **Escort vans and transfers**

---

- 11.83 The choice of microwave meals available in reception should be improved and include options for special diets. (1.36)

- 11.84 Checks should be made to ensure that all detainees receive a copy of the "Welcome to the Centre Induction and Information Booklet". (1.37)

### **Residential units**

---

- 11.85 A colour-coding system should be introduced to ensure that the same mops are not used to clean toilet areas and bedrooms. (2.18)
- 11.86 The cleaning contract should be reviewed as planned. (2.19)

### **Healthcare**

---

- 11.87 The photocopier in the reception healthcare room should be moved, to allow uninterrupted confidential medical interviews. (6.48)
- 11.88 Medicines supplied as stock by Lloyds pharmacy should be in the form of manufacturers' patient packs wherever possible. (6.49)
- 11.89 The floor in the dental suite should have sealant applied to the floor/skirting board edges to improve cleanliness. (6.50)

### **Activities**

---

- 11.90 Information and communications technology (ICT) and English for speakers of other languages (ESOL) workbooks should be improved. (7.26)
- 11.91 Opportunities for independent study using education facilities should be extended.(7.27)
- 11.92 Feedback after teaching observations should be specific about areas requiring improvement. (7.28)

### **Services**

---

- 11.93 Tin openers should be available to detainees during the evening if snack items cannot be provided in easily opened containers. (9.9)

### **Preparation for release**

---

- 11.94 The visitors' declaration should be available in a range of languages.(10.21)
- 11.95 The "Visiting at IRC Haslar – A Guide for Visitors" leaflet should be available in a range of different languages. A system should be introduced to send the leaflet to visitors in advance of their visit whenever possible. It should also be prominently displayed in the waiting area and proactively promoted by staff. (10.22)
- 11.96 Notices in the waiting room should be available in a range of different languages. (10.23)

# Good practice

---

## Duty of care

---

- 11.97 Staff in all departments were informed of those at risk of self-harm by a form containing a picture of the detainee and brief details of the reasons for the risk and the means by which he had indicated he might harm himself. This was an effective way of encouraging good observation of at-risk detainees, and a whole-centre approach to the care of those at risk of self-harm. (5.31)
- 11.98 Removal directions were recorded in a book kept in the centre office, thereby alerting staff to periods of increased risk. (5.32)
- 11.99 Fire safety had been improved by fire safety notices displayed in the main languages and pictorial displays of the actions detainees should take in the event of a fire. (5.33)

## Healthcare

---

- 11.100 Patient information leaflets and notices, in various languages, helped detainees to become more knowledgeable about their medications. (6.51)
- 11.101 The system of peer review and audit of clinical records and the adverse incident reporting schemes promoted a supportive culture within the working environment of openness and honesty. (6.52)

## Activities

---

- 11.102 A large picture was displayed in the entrance lobby to the education department, and was about two-thirds complete. The picture, based on a small scale original work, was created by arranging individual square panels together in a grid. Each square was painted by a different person. While styles were different each had to fit with the adjacent panels to help form the whole. Both detainees and staff contributed panels. The picture vividly celebrated the centre community as an entity and reflected a belief that the whole was bigger than the constituent parts. It formed a dynamic public display, growing over time. (7.29)

## Appendix I: Inspection team

---

Nigel Newcomen	Deputy Chief Inspector of prisons
Jim Gomersall	Team Leader
Hindpal Singh Bhui	Inspector
Eileen Bye	Inspector
Fay Deadman	Inspector
Elizabeth Tysoe	Healthcare inspector
Alastair Pearson	Inspector, Adult Learning Inspectorate
Penny Allen	Inspector, Adult Learning Inspectorate
Kate Eves	Researcher
Mark Challen	Researcher
Charlotte Owiredu-Oppong	Student
Clare Kumahor	Observer

## Appendix II: Detainee population profile

---

### Population breakdown by:

(i) Age	No of men	No. of women	No. of children	
Under 18	0	N/A	N/A	0
18 years to 21 years	21	N/A	N/A	19
22 years to 29 years	39	N/A	N/A	36
30 years to 39 years	37	N/A	N/A	34
40 years to 49 years	10	N/A	N/A	9
50 years to 59 years	2	N/A	N/A	2
60 years to 69 years	N/A	N/A	N/A	0
70 or over	N/A	N/A	N/A	0
<b>Total</b>	<b>109</b>			

(ii) Nationality	No. of men	No. of women	No. of children	
Afghanistan	3	N/A	N/A	3
Albania	1	N/A	N/A	1
Algeria	1	N/A	N/A	1
Bangladesh	2	N/A	N/A	2
Belarus	0	N/A	N/A	0
Cameroon	1	N/A	N/A	1
China	10	N/A	N/A	9
Colombia	0	N/A	N/A	0
Congo Dem Republic (Zaire)	5	N/A	N/A	4
Czech Republic	0	N/A	N/A	0
Ecuador	0	N/A	N/A	0
Estonia	0	N/A	N/A	0
Former Republic of Yugoslavia	0	N/A	N/A	0
India	1	N/A	N/A	1
Jamaica	1	N/A	N/A	1
Kenya	4	N/A	N/A	4
Kosovo	0	N/A	N/A	0
Latvia	0	N/A	N/A	0
Lithuania	0	N/A	N/A	0
Moldavia	0	N/A	N/A	0
Nigeria	12	N/A	N/A	11
Russia	0	N/A	N/A	0
Singapore	0	N/A	N/A	0
Sri Lanka	6	N/A	N/A	5
Trinidad & Tobago	0	N/A	N/A	0
Turkey	12	N/A	N/A	11
Ukraine	0	N/A	N/A	0
Yugoslavia	0	N/A	N/A	0
Zimbabwe	6	N/A	N/A	5
Sudan	2	N/A	N/A	2
Liberia	7	N/A	N/A	6
Palestine	0	N/A	N/A	0

Yemen	0	N/A	N/A	0
Libya	1	N/A	N/A	1
Iraq	4	N/A	N/A	4
Burma	1	N/A	N/A	1
Jordan	1	N/A	N/A	1
Ghana	4	N/A	N/A	3
Sierra Leone	2	N/A	N/A	2
Guinea	1	N/A	N/A	1
Nepal	2	N/A	N/A	2
Pakistan	3	N/A	N/A	2
Malawi	1	N/A	N/A	1
Egypt	0	N/A	N/A	0
Angola	1	N/A	N/A	1
Iran	2	N/A	N/A	2
South Africa	0	N/A	N/A	0
Rwanda	1	N/A	N/A	1
Kazakhstan	1	N/A	N/A	1
Ethiopia	0	N/A	N/A	0
Somalia	0	N/A	N/A	0
Stateless	1	N/A	N/A	1
Eritrea	1	N/A	N/A	1
Georgia	2	N/A	N/A	2
Macedonia	1	N/A	N/A	1
Congo	2	N/A	N/A	2
Botswana	1	N/A	N/A	1
Romania	1	N/A	N/A	1
Uganda	1	N/A	N/A	1
Other (please state what)				
<b>Total</b>	<b>109</b>			

(iii) Religion/belief	N/A	No. of women	No. of children	%
No religion	16	N/A	N/A	15
Buddhist	1	N/A	N/A	1
Roman Catholic	4	N/A	N/A	4
Orthodox	N/A	N/A	N/A	0
Pentecostal	0	N/A	N/A	0
Seventh Day Adventist	0	N/A	N/A	0
Other Christian religion	40	N/A	N/A	37
Hindu	5	N/A	N/A	4
Muslim	43	N/A	N/A	39
Sikh	0	N/A	N/A	0
Agnostic/atheist	N/A	N/A	N/A	0
Unknown	N/A	N/A	N/A	0
Other (please state what)				
<b>Total</b>	<b>100</b>			<b>100</b>

(iv) Length of time in Detention in this centre	No. of men	No. of women	No. of children	%
Less than one week	35	N/A	N/A	32
More than one week up to four weeks	36	N/A	N/A	33
More than one month up to two months	14	N/A	N/A	13
More than two months up to four months	17	N/A	N/A	15
More than four months up to six months	4	N/A	N/A	4
More than six months up to eight months	1	N/A	N/A	1
More than eight months up to ten months	2 (Longest 92 days)	N/A	N/A	2
More than ten months (please note the longest length of time)	0	N/A	N/A	
<b>Total</b>	<b>100</b>			<b>100</b>

(v) Ethnic Group	No of Men	No. of women	No. of children	%
Asian				
Indian	0	N/A	N/A	0
Sri Lankan	In Other Asian	N/A	N/A	0
Bangladeshi	1	N/A	N/A	1
Pakistan	3	N/A	N/A	3
Other	15	N/A	N/A	14
Black				
North African	See below	N/A	N/A	
Sub Saharan Africa (below Morocco)	57 Africans - total	N/A	N/A	52
Caribbean	1	N/A	N/A	1
Other	1	N/A	N/A	1
White				
White European	See Below	N/A	N/A	0
Dark European	See Below	N/A	N/A	0
Other	19 total white	N/A	N/A	17
Other				
Chinese	10	N/A	N/A	9
South American	Not recorded	N/A	N/A	
Mixed background	0	N/A	N/A	1
Other (please state what)				
Stateless	1	N/A	N/A	1
<b>Total</b>	<b>100</b>			<b>100</b>

## Appendix III: Summary of survey responses

---

### Detainee survey methodology

---

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 from the 30<sup>th</sup> to 31<sup>st</sup> March 2005, the detainee population at Haslar IRC was 139. The questionnaire was offered to all 139 detainees. Overall, this represented 100% of the detainee population.

#### Selecting the sample

---

On this occasion questionnaires were offered to all detainees.

Completion of the questionnaire was voluntary.

Interviews were carried out with any respondents with literacy difficulties. Questionnaires were offered in 26 different languages. In total, one respondent was interviewed.

### Methodology

---

Every attempt was made to distribute the questionnaires to each respondent on an individual basis. 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:

- to have their questionnaire ready to hand back to a member of the research team at a specified time;
- to seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable; or
- to 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, 69 respondents completed and returned their questionnaires. This represented 50% of the prison population. The response rate was 50%. In total 70 questionnaires were not returned.

## Comparisons

---

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted, in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey, are the benchmark figures for all detainees surveyed in detention centres. This benchmark is based on all responses from detainee surveys carried out in four detention centres since April 2003.

In all the above documents, statistically significant differences are highlighted. Statistical significance merely indicates 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 grey shading, results that are significantly worse are indicated by a black background and where there is no significant difference, there is no shading.