Report on an unannounced inspection of

Campsfield House Immigration Removal Centre

3 - 5 August 2004

by HM Chief Inspector of Prisons

ISBN 1-84473-473-0
Printed and published by:
Her Majesty's Inspectorate of Prisons
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Introduction

This unannounced follow-up inspection records some improvements at Campsfield removal centre since our last inspection two years ago. Many of our recommendations had been implemented. Staff–detainee relationships remained good, and staff supervision of detainees within the centre, a major safety concern in 2002, had improved. Campsfield had also made progress in providing support for vulnerable and anxious detainees: there was a dedicated group of reception staff, and a 16-strong welfare support team, trained by Samaritans. On-site immigration officers were more ready to discuss cases with detainees.

However, there were various factors that risked undermining these developments. Some were outside the centre's control. We reviewed the escort records of a fifth of detainees, and discovered that five had had journeys of over 18 hours before reaching the centre, with overnight stops at airports: one, indeed, had been in transit for nearly 36 hours. Others had had lengthy periods in transit. Many had been in over four different places of detention. These movements around the detention estate, and the wholly unacceptable lengths of time spent in transit, inevitably increase detainees' vulnerability; and action should be taken to monitor and significantly reduce them.

Some practices within the centre itself required attention. Care plans for those on suicide watch needed to be developed. And, in spite of the care shown by reception staff, detainees faced long waits in inadequate facilities. There were two places where detainees could be held in isolation from others: the isolation and segregation units. Procedures for monitoring the isolation unit were inadequate, and, in the case of those removed there for reasons of discipline or fear of abscond, should comply with detention centre rules on segregation. We were particularly concerned that detainees at risk of self-harm could not be observed through the doors in the isolation unit where they were held; this had already resulted in a near-fatality.

As in all removal centres, we note the inadequacy of legal advice available to detainees; and the difficulty on-site staff had in communicating with, and stimulating timely action from, external caseworkers making decisions on detention and asylum. And, as elsewhere, there was insufficient activity to occupy detainees. A voluntary work scheme was greatly appreciated, but very limited in scope. Finally, we repeat the need for formal, properly resourced welfare officers to assist with detainees' practical problems and prepare them for what comes next.

Many of the problems experienced at Campsfield require action by agencies outside the centre. It is encouraging that centre staff and managers have made some progress since the last inspection; though there are further measures they can take to enhance the safety of those in their care.

Anne Owers September 2004

HM Chief Inspector of Prisons

Fact page

Task of the establishment
Campsfield House holds people detained by the Immigration and Nationality Directorate under immigration laws.

Contractor
Global Solutions Ltd

Number held
163 on 3 August 2004

Operational capacity
184

Last inspection
18–20 March 2002

Brief history
The site, which had been a young offenders institution, became an immigration removal centre in 1993. At one time it held up to 199 residents including 36 female places. Since 1997 it has held only male detainees, with a slightly reduced capacity of 184 following the conversion of some rooms into a healthcare centre.

Description of residential units
The centre had three residential units: pink, yellow and blue blocks. Pink block, with 26 beds, was the induction unit. Yellow block had 48 beds and included a small isolation unit. Blue block had 110 beds. Rooms were single, double or multiple occupancy. A prefabricated unit beside reception housed two small segregation cells.

Section 1: Healthy establishment summary

Introduction

HE.1 This inspection was a short follow up to our full inspection of Campsfield House immigration removal centre in March 2002. The principal focus of the inspection was to examine progress against the recommendations arising out of the 2002 inspection. We also considered how well the four criteria of a healthy custodial environment were being met. The criteria are:

Safety – that detainees are held in safety, with due regard for the insecurity of their position
Respect – that detainees are treated with respect for their human dignity and the circumstances of their detention
Activity – that detainees are able to be purposefully occupied during the day
Preparation for release – that detainees are able to keep in contact with the outside world and are prepared for their release, transfer or removal.

HE.2 Inspectors kept fully in mind that although this was a custodial establishment run by Global Solutions Ltd (GSL), detainees had not been charged with a criminal offence and had not been detained through normal judicial processes. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees:

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

HE.3 The rule also states that due recognition will be given at immigration removal centres to the need for awareness of:

- the particular anxieties to which detainees may be subject and
- the sensitivity that this will require, especially when handling issues of cultural diversity.

HE.4 Campsfield House had been selected for closure but, in October 2003, ministers announced that the centre would remain open and would be expanded to hold up to 290 detainees (an increase in capacity of 106 places) by adding a new residential unit and some other facilities. Anxieties about closure had resulted in some staff resignations but, at the time of inspection, most of the shortfall was being made good through active recruitment.

Safety

HE.5 Escort arrangements were unsatisfactory, and some detainees spent well over 12 hours in transit before reaching the centre. A dedicated staff group dealt well with them at reception, though there were long waits in unsuitable facilities. Staff supervision in the centre had improved, and all areas were actively managed. Access to legal advice, and the management of casework, remained unsatisfactory. There had been no independent fire safety risk assessment and there was no health and safety policy. Vulnerable detainees held in single separation in the isolation unit could not be observed through the doors.

HE.6 The report of our last inspection concluded that Campsfield House was not a safe establishment due, primarily, to insufficient supervision by centre staff. Residential unit staff were now providing good levels of supervision in all the residential areas and interacted well with detainees.

HE.7 Examination of 20% of escort records revealed that on average detainees had been held in four different places of detention, many in police cells. Thirteen had been in transit overnight. Five had spent over 18 hours in transit, in one case nearly 36 hours. Detainees were given insufficient information while on escort.

HE.8 Our last inspection had noted long delays in reception into the centre. That remained the case in this inspection and we observed some detainees being held in the small, inadequate holding room for over four hours. A dedicated staff group dealt well with detainees. No improvements had been made to the reception accommodation and the area remained too cramped. There was still a lack of written information in different languages to guide new arrivals through the reception process and detainees were not routinely offered telephone calls in reception.

HE.9 Induction unit staff interacted well with detainees and relationships were good, but the induction programme was short, did not include a tour of the establishment and the induction facilities were inadequate. Detainees were not always given a guide to the rules of the establishment, although a video about Campsfield House was made available in several languages.

HE.10 There were regular suicide prevention meetings and the strategy was generally well managed. The isolation unit held those at serious risk of self-harm, abscond or who had been disruptive. It was clean and well supervised but there were no observation panels which, when the doors were closed, made monitoring vulnerable people impossible. This was unacceptable.

HE.11 The segregation unit comprised two rooms in an adapted portakabin in the reception yard and was used to hold detainees who had been violent. The unit had clearly not been cleaned properly for some time, but this was attended to during the inspection. The unit was cramped and its outdoor exercise area was totally inadequate.

HE.12 A greater emphasis had been placed on health and safety since the last inspection. Internal risk assessments had been properly completed but there was no documented, independent, fire safety risk assessment as we recommended in our full inspection in 2002. There was no formal health and safety policy document in place. The smoking policy was not enforced and a redrafted policy required implementation.

HE.13 Several detainees had no legal representation; for those who did, the quality of advice and assistance sometimes appeared inadequate. Two voluntary groups came in each month and tried to arrange legal representation, but there was a general lack of qualified legal assistance available.

HE.14 Casework management and contact with detainees on-site had improved, but relationships between on-site staff and external caseworkers remained poor. The role of on-site staff remained unclear, and in many cases limited to passing on messages between detainees and external colleagues, who provided insufficient and often delayed information.

Respect

HE.15 The centre was generally clean and tidy, with sufficient telephones and an effective pager system. Staff–detainee relationships were positive and helpful, and there was a positive emphasis on diversity. Primary healthcare was good, though preventive care needed improvement, and patients were still routinely handcuffed for hospital appointments.

HE.16 Residential areas were clean and tidy, with the exception of the segregation unit (see para HE.10). The paintwork was shabby in some areas but, since the decision had been made to keep the centre open, these areas were being attended to.

HE.17 There was good access to telephones but only one type of telephone card was available. An effective pager system was in use but detainees did not have access to email.

HE.18 In our previous report we said that staff–detainee relationships were good at Campsfield House; that remained the case in this inspection. There was good interaction and staff were generally respectful and helpful.

HE.19 There was much evidence of attention to race and diversity around the centre, such as notices outlining the race relations policy and clear statements to both detainees and staff about unacceptable behaviour and language. Ethnic monitoring was, however, still unsatisfactory, and Muslim detainees had insufficient access to the Imam. The race relations liaison officer had good community links. There were very few racial complaints, but no evidence that detainees were encouraged to make complaints in their own language.

HE.20 There was no formal reward scheme in operation at the centre.

HE.21 The healthcare centre was clean, well ordered and accessible to detainees. There were good links with local NHS secondary healthcare providers. No hepatitis B screening or vaccination programme was in operation. There was no specialist training in the healthcare needs of detainees. Despite risk assessments being completed, it appeared that detainees were routinely handcuffed when going through public areas to hospital appointments.

Activities

HE.22 The education centre was closed for holidays during the week of the inspection. There were in total insufficient activities for the population. A small voluntary work initiative had begun but needed to expand to include all detainees who wanted to work. Unqualified staff supervised some of the sports provision.

HE.23 No paid work was available but a voluntary work initiative for a very small number of detainees was operation. Detainees welcomed the initiative.

HE.24 Our previous inspection found that there was a lack of trained staff to supervise physical activity. This time there were enough trained staff in post to provide regular supervision of both the fitness room and the sports hall, but while the staff supervising the fitness room were British Weightlifting Association (BWLA) qualified, the staff supervising the sports hall were not qualified to the standard expected in a public facility, which was a deficiency.

Preparation for release

HE.25 Other than occasional input from the relatively new welfare team, there was no provision to help detainees prepare for release, removal or transfer.

HE.26 As in all immigration removal centres, there was a clear need for welfare support. The newly formed voluntary staff welfare team was attempting to meet those needs at Campsfield House. The team comprised volunteer custody officers who were able to address some urgent concerns, for example, about external property, contacting friends and relations and other issues. However they did not have enough time to prepare all detainees for removal, transfer or release.

HE.27 Detainees without means had inadequate access to telephones and all detainees remained unable to access cheaper means of contact, by controlled use of email and the internet.

Main recommendations

To the Director General IND

HE.28 **Detainees should be able to engage in paid work, or be rewarded for voluntary work undertaken in the centre.**

HE.29 **There should be dedicated welfare support staff to provide practical assistance to detainees during detention and assistance with release, transfer or removal.**

HE.30 **Detainees should have access to email and controlled access to the internet.**

HE.31 **The Immigration & Nationality Directorate should monitor detainees' time in transit and the provision of breaks, in order to ensure direct and swift journeys to removal centres.**

To the Centre Manager

HE.32 **A new reception facility should be built.**

HE.33 **The segregation unit should be rebuilt to an acceptable standard and located in a more appropriate area with proper exercise facilities.**

HE.34 **All rooms used to accommodate those at risk of self-harm or suicide should have observation panels.**

HE.35 **A documented risk assessment should be undertaken by independent specialists on fire safety.**

Section 2: Progress since the last report

2.1 We have used the recommendations from our last inspection of March 2002 as a framework to examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress had been made and work remained to be done. The paragraph reference numbers below refer to each recommendation's location in the previous inspection report.

Escorts and transfers

2.2 During the inspection a sample of 20% (30) of detainees' escort records were reviewed. This sample revealed a pattern of lengthy journeys, night time movements and frequent transfers between places of detention.

2.3 The majority of detainees' records began in police custody, although 10 of the sample (33%) only recorded the time of leaving police custody rather than the time and date of entering custody; consequently the period spent in the police station was not recorded. The average time spent in detention was 45 days; three of the sample had spent over 100 days in detention and four less than 10 days in detention. Detainees had been to an average of four places of detention, ranging from two to 21 changes of location. Four detainees had spent a period of detention in a prison.

2.4 The time spent in transit for each detainee in the sample was reviewed and the following examples of extended journeys were found, in some cases involving overnight stops at an airport facility.

2.5 There were 13 examples of detainees being in transit overnight. There were also a number of cases of detainees being picked up from police stations in the early hours of the morning. There were six examples of detainees spending over 10 hours in transit. The maximum time was just under 36 hours.

Ten hours or more

Time and place of journey start	Time and place of arrival	Length of time in transit	Locations visited en route
7.45pm police station	9.55pm (next day) Oakington	26 hours 10 mins NIGHT TIME	Airport terminal three
8.00am Tinsley House	5.01am Campsfield House	21 hours 1 min NIGHT TIME	Airport Queens Building
8.00am police station	6pm Campsfield House	10 hours	
11.30am Haslar	23.25pm (next day) Campsfield House	35 hours 55 mins NIGHT TIME	Queens Building
1.55pm Campsfield House	8.45am Campsfield House	18 hours 50 mins NIGHT TIME	Airport Queens Building

7.45am Campsfield House	3.45am Campsfield House	20 hours NIGHT TIME	Airport Queens Building

Night-time journeys

Time and place of journey start	Time and place of arrival	Length of time in transit	Locations visited en route
3.45am police station	5.01am Campsfield House	1 hour 16 mins	
10.00pm police station	1.29am Campsfield House	3 hours 29 mins	
Midnight police station	1.30am Campsfield House	1 hour 30 mins	
7.20pm police station	2.30am Harmondsworth	7 hours 10 mins	
10.55pm Tinsley House	2.41am Campsfield House	3 hours 46 mins	
9.20pm police station	4.00am Campsfield House	6 hours 40 mins	
10.30pm police station	5am Harmondsworth	6 hours 30 mins	
3.35am Oakington	5.35am Harmondsworth	2 hours	

2.6 Detainees spoken to during the inspection confirmed that they were not given written or verbal information about the escort contractor, provision of breaks, what to do in an emergency or how to complain. Reception staff reported that they occasionally received complaints from detainees about escort staff, but there was no system to pass complaints on and they were usually not dealt with.

2.7 *The contract monitor for the escort service should ensure that comfort breaks are provided in transit. (13.5)*
No longer applicable. The contract monitor at Campsfield House did not monitor escort journeys or waiting time in vans outside the establishment, as this was the task of the IND detainee escort monitor.

Further recommendations

2.8 IND should issue records of custody (Form 91) that log the date and time of detainees' reception into custody.

2.9 IND should provide detainees with written information about the escort contractor, provision of breaks, what to do in an emergency and how to complain.

Reception, first night and induction

2.10 *A larger room should be allocated as the reception holding room and this should contain sufficient chairs for all detainees to be able to sit down. (5.1)*
Not achieved. There had been no alteration to the physical layout of the reception holding room, which had six fixed chairs, a television and access to a toilet. However, the number of people held in the room at any one time had been reduced to six in order to improve safety and comfort. This arrangement meant that detainees were kept waiting on vans if they arrived when the area was occupied. The reception holding room was dirty, too small, provided no privacy to talk to detainees and had very poor access and egress. Managers were aware of the extreme difficulty experienced by detainees and staff using this area. A proposal to build a new facility with additional rooms and space had been in place for at least a year. **(See main recommendation HE.32)**

2.11 *The use of the video player to impart information in translation to new arrivals should be re-instated. (5.2)*
Achieved. The induction video was used on a daily basis as part of the first day induction procedure. The video was useful and informative and was available in 17 languages. Although the video did cover in detail the practicalities of the reception process it was not shown on the television in the reception holding room. **(See further recommendation 2.23 below.)**

2.12 *A telephone with acoustic hood should be installed in reception and a telephone card provided for the use of arriving and departing detainees. (5.3)*
Not achieved. A telephone had not been installed for detainees in reception. Staff who regularly worked in reception said that they were authorised to offer the use of the office telephone to new arrivals or those being transferred if they believed that the detainee had a credible reason for requiring this. For example, detainees were allowed to inform people at home of their planned arrival date and time. The office reception telephone was not private. **We repeat the recommendation.**

2.13 *A water machine and facilities to make tea and coffee should be installed. (5.4)*
Not achieved. There were no refreshment facilities for detainees in the holding room. The reception process was designed to keep newly arrived detainees within the area for a very short time only and to provide refreshments and other welfare services in the induction unit. However, the volume of movements through reception had increased significantly and serving new arrivals meals in the holding room was a routine event. During the inspection, five detainees were located in the holding room between 10.30am and 3.30pm while detainees who were leaving were being processed. They were served drinks and meals in the room, but it was not a suitable environment for this purpose, especially as some detainees had arrived after lengthy journeys. **We repeat the recommendation.**

2.14 *Legal papers should not be removed unless this is the detainee's wish. (5.5)*
Achieved. Detainees were offered the opportunity to place money and valuables in the safe in reception, and allowed to decide which personal items they took into the centre and what to leave in sealed bags in the property store. Legal papers were not taken from detainees.

2.15 *Dedicated staff should be allocated to reception and trained in reception duties. (5.6)*
Achieved. Reception staff were assessed individually for this task and underwent a four-shift training period when they worked alongside experienced colleagues. They were required to pass a competency assessment prior to being allocated reception duties. The benefit of this selection and training was evident in the high level of technical knowledge that the reception

staff displayed, their confidence in prioritising work and managing stressed detainees with care and sensitivity, despite the unacceptable layout of the accommodation.

2.16 *Detainees should be given written information about the centre and what will happen to them in the first 24 hours in a language they can understand. (5.7)*
Not achieved. There were no information leaflets that specifically addressed detainees' immediate needs or the key issues relating to the first 24 hours of detention. There was a comprehensive booklet – 'House rules and information for detainees (revised July 2001)'– which was detailed, relevant and produced in 22 different languages. But this booklet was not given to detainees during the induction process and a number of detainees who had arrived in recent days had not seen it. The contract monitor's survey of the induction process identified that this information was given out only intermittently, and that a number of detainees missed out. Detainees were also not provided with copies of the Office of the Immigration Services Commissioner (OISC) leaflet, concerning access to legal advice, which was available in 17 languages in the induction unit. **We repeat the recommendation.**

2.17 *The policy on the allocation and replenishment of essential items to those without means should be clarified and communicated to all staff and detainees, in line with best practice in other centres. (5.8)*
Achieved. Toiletries were freely available to all detainees in the induction unit, and were readily available from the information centre. There was no restriction on entitlement to these items. Some items, such as toothbrushes and razors, were replaced on a new for old basis.

2.18 *'Destitute' packs should be re-named reception packs. (5.9)*
Achieved. The term 'destitute' was not used during this inspection and toiletries were not provided in complete packs, but individually as required.

2.19 *Clarification should be given to staff in reception and those on the induction unit about their respective roles and responsibilities. (6.4)*
Achieved. There was a clear demarcation between reception and induction staff and a good understanding of what would be expected at each stage. Positive working relationships were observed between the teams. The system had been set up to deal with new arrivals immediately and to keep them in reception for the minimum time. However, this strategy had been introduced when the average number of movements in and out was a quarter of the usual number. It did not provide an appropriate level of care to detainees in the almost daily event of longer stays in reception. Detainees required information, access to telephones, drinks, food and smoking breaks, which reception staff were not resourced to provide.

2.20 *A system should be in place for providing help with the legitimate welfare concerns of detainees on first arrival. (5.10)*
Partially achieved. There was no vulnerability or risk assessment included in the reception process and insufficient welfare support in general in the centre. However, induction staff were able to make some judgements about immediate needs or concerns. This was reinforced by a medical assessment, which could provide additional information. Induction staff had access to a wide range of information and were aware that the welfare team could, in some cases, provide ad hoc practical support. Although the absence of a separate office for induction staff made it more difficult for them to speak to detainees in private, their ready availability at all times was a very positive aspect of their supervision and care. **(See main recommendation HE.29)**

Additional information

2.21 There was a daily induction session for detainees who had arrived in the previous 24 hours. The session included the showing of a clear and useful video, which provided information

about the centre. The session was delivered in the induction unit lounge, which had insufficient chairs, some of which faced away from staff. The session observed used a lot of colloquial language and jargon and was delivered with few attempts to clarify detainees' understanding.

2.22 Staff working in the induction unit appeared to interact well with detainees and knew who was staying for one night or for longer. The induction unit was staffed throughout the day and night and relationships between staff and detainees were relaxed and positive.

Further recommendations

2.23 The reception/induction information video should be shown to new detainees waiting in the reception holding room.

2.24 Systems should be put in place to ensure that detainees are dealt with quickly in the reception area and to monitor delays experienced.

2.25 The location, content and style of the induction process should be reviewed to ensure that it meets the needs of detainees.

Accommodation

2.26 *Each detainee should have a chair and access to a table in his room. (6.1)*
Partially achieved. Each residential room was provided with a chair but there was insufficient space for a conventional writing table. There was, however, space to provide a folding writing surface.

Further recommendation

2.27 A folding writing surface should be fitted in every residential room.

2.28 *Greater effort was needed to explain the reasons for allocation decisions to new detainees. (6.2)*
Achieved. Detainees did not express concern about room allocation. The process was explained in the 'House rules and information for detainees' booklet produced in 22 different languages.

2.29 *The incentive scheme should be based on the behaviour of individuals rather than rooms and the details communicated in the languages of detainees. (6.3)*
Not achieved. There was no formal incentive scheme at Campsfield House but some detainees had the opportunity to do voluntary work. There was a clean room scheme, by which detainees who kept their rooms tidy were paid a weekly allowance of £5 centre shop vouchers. Failure to comply resulted in no allowance being paid.

Further recommendation

2.30 A formal reward scheme should be implemented as a matter of urgency.

2.31 *Information packs should be made available to detainees in their own languages. (6.5)*
Not achieved. (See recommendation 2.16)

Access to legal advice and representation

2.32 *Arrangements should be made to ensure that detainees have access to advice and representation from qualified independent legal representatives. (7.1)*
Not achieved. There was no on-site qualified, independent provider of legal advice and representation. We met a number of detainees who said they had no representative and that finding one was difficult. A directory entitled 'OISC approved advisors and solicitors', which was available in the information centre and the library, listed one entry in Oxford, one in Reading, two in Swindon and five in Slough. The entries included no information about what the organisations could offer and were undated. The Refugee Legal Centre (RLC) and Immigration Advisory Service (IAS) were able to provide free telephone advice but rarely visited the site. An RLC adviser told us that calls from friends or relatives were more common than calls from detainees because of the lack of confidential telephone access at Campsfield House.

2.33 Two voluntary advice organisations visited the centre regularly – Bail for Immigration Detainees (BID) Oxford and Asylum Welcome. Both had limited registration with OISC, which did not include undertaking general casework. BID Oxford, which had no paid staff, visited for a two-hour period, once a month, and saw no more than a few people. Asylum Welcome visited twice a month for a couple of hours on each occasion. Staff, including immigration officers, referred detainees to both organisations. Both organisations told us that they were inundated with requests for help that they could not meet and that they spent a lot of time trying to find competent legal representatives. The current gap in provision was being met by advisers whom BID and Asylum Welcome regarded as predatory and unscrupulous.

2.34 Some detainees had been dropped by representatives who had told them that new legal aid rules meant they were unable to help with bail applications or appeals. Many who said they had a representative had never received a legal visit in detention. The documents we saw reflected a very poor quality of advice.

Further recommendation

2.35 IND, in cooperation with the Legal Services Commission and the OISC, should ensure that all detainees have access to on-site independent, qualified legal advice and representation.

Additional information

2.36 At the time of the inspection the population included 38 people subject to 'fast track' procedures who had been moved from Harmondsworth IRC following a disturbance there in July. Under special arrangements they had access to duty solicitors available solely to fast track cases. Their stay at Campsfield House was temporary and most of the process was carried out at Harmondsworth, where they returned for interview. Their access to legal advice and representation was not inspected.

2.37 *Detainees should be told, in a language that they understand, of their rights to bail, appeals and legal aid within 24 hours of arrival at the centre. (7.2)*
Partially achieved. Detainees generally arrived with an IS91R form indicating brief pro forma reasons for detention and brief mention of bail and appeal rights. This document was in English only. Immigration staff saw detainees by appointment, but usually without an interpreter. OISC leaflets (in 17 languages) explained how to obtain legal advice and what to expect of a competent adviser, but did not explain detainees' legal rights. **We repeat the recommendation.**

2.38 *The Office of the Immigration Services Commissioner (OISC) should devise a way of regularly checking the competence of those providing legal advice to detainees, who are in an exceptionally vulnerable situation. (7.3)*
Partially achieved. Immigration legal services providers are obliged to register with the OISC unless they are members of a designated professional body with its own regulatory scheme. The OISC had made some progress in improving standards by its pre-registration audit and its complaints investigation processes. It had collaborated with others in producing, translating and distributing a free leaflet to advise people how to obtain legal advice and what standards to look for. Further enforcement powers were included in the Asylum and Immigration (Treatment of Claimants, etc.) Act, July 2004. Nonetheless, documentation we observed, and the reports of OISC-registered volunteer advisers regularly visiting the site, indicated that detainees were commonly receiving poor and incomplete advice from their representatives. **We repeat the recommendation.**

2.39 *Detainees should have information in their own languages about the service they should expect to receive from legal representatives, how to complain if they do not receive it, and how to check whether a representative is properly regulated by OISC or a professional body. (7.4).*
Achieved. OISC leaflets containing this information in a number of languages were freely available in reception, in the information centre and in the library.

2.40 *Detainees should be able to contact their legal representatives by phone, fax or email without impediment. (7.5)*
Partially achieved. Detainees were able to send free legal correspondence and legal faxes were free. In cases of need they were able to make free telephone calls to representatives. Otherwise their £5 weekly allowance was expected to cover telephone calls and other needs. There was no controlled email access for detainees. **We repeat the recommendation.**

2.41 *Detainees should have access to up to date legal text books on immigration law. (7.6)*
Partially achieved. Library reference material included some legislative material, in English, copies of the Detention Centre Rules in various languages, and BID guidance on how to make a bail application. We did not see a copy of the standard JCWI Handbook, which explains immigration and asylum law and procedure in plain English. There was no librarian in post during the inspection. A number of detainees had no legal representation and as a result of the extensive changes in immigration and asylum law there was a pressing need for more legal resources in the library. **We repeat the recommendation.**

2.42 *Any information or decisions regarding the individual's detention, movements, immigration status, or removal should be communicated to the detainee and his or her representative without delay. (7.7)*
Partially achieved. The on-site immigration team generally served removal directions and other decisions on the detainee soon after receipt. However, they could only relay information if and when they had received it from the primary caseworking port or office, or from the Detainee Escorting and Population Management Unit (DEPMU). The information they received was patchy and notice varied. Many detainees were moved from one removal centre to another but the reasons for this were rarely recorded. The external caseworking office was also responsible for notifying representatives. Legal representatives told us that movements were often arranged without any prior notice being given and spoke of their frustration at turning up at the centre only to discover that detainees had been abruptly moved. **We repeat the recommendation.**

2.43 *Detainees should be able to attend their bail and appeal hearings and should be produced on time. (7.8)*
Partially achieved. Detainees came from all over the country and could have hearings listed in any part of the country. The port or office progressing their case and DEPMU were responsible for court production arrangements. We observed on-site immigration staff going to

some lengths to remind a port to comply with requirements for a bail hearing listed the following day. We met a detainee who had recently wasted a day travelling to and from Cardiff for a bail application, which was denied because he arrived too late. **We repeat the recommendation.**

Additional information

2.44 Some detainees said they were escorted to their embassies or consulates in London to progress travel documents for removal. This involved walking along a busy London street in handcuffs with escorts who released them to the consular official once inside the building. Foreign embassies are not listed on the Immigration (Places of Detention) Direction 2004, issued under the 1971 Immigration Act, schedule 2, paragraph 18. Rule 8 of the Detention Centre Rules requires that, outside places of detention, detainees should remain in the custody of an appointed officer.

Further recommendation

2.45 IND should not take detainees to foreign diplomatic offices within which their care and protection cannot be guaranteed.

2.46 Detainees should not routinely be handcuffed in public places.

Casework

2.47 *It should be a priority to progress the casework of those held in detention. (8.1)*
Partially achieved. As the casework files belonging to detainees at Campsfield House were held at 27 different ports or IND offices it was difficult to evaluate the progress of casework. Information in on-site files was very limited, patchy and concerned processes rather than substance. For example, entries showed officers' diligence in reminding caseworkers to issue monthly reviews of detention but they generally contained little evidence that careful consideration had been given to maintaining detention. Detainees to whom we spoke appeared uncertain about the on-site officer role. We met detainees who had not passed on relevant changes of circumstances to immigration staff, because they perceived them to be conveyors of removal directions only.

Additional information

2.48 The average stay at Campsfield House was eight days during July 2004 compared with 11 days in July 2003. Behind this average were a number who spent only a night at the centre (because it had 24-hour reception) and, at the other end of the scale, a detainee who had spent nearly 14 months there. The cumulative time detainees had spent in detention was not always easy to calculate from documentation held at the centre. The reception sample questioned at the start of the inspection indicated an average time in detention of 45 days, which did not include time spent in police cells. Total movements had risen and in the previous three months 1,024 had been removed (61%), 545 had been transferred to further detention (32%), 96 had been released on temporary admission or release (5%), and 24 had been released on bail (1%).

2.49 *Detainees should be told the individual reasons for their detention in a language they understand. (8.2)*
Not achieved. Detainees had the pro forma IS91R checklist in which standard reasons for

detention were ticked, usually without further explanation. These were issued in English only. Detainees could make an application to see an immigration officer but as on-site officers could only relay the information they had from the caseworking office, they often had no more information than the detainee did. On-site officers rarely used interpreters or Language Line. **We repeat the recommendation.**

2.50 *Detainees should receive monthly reviews on time and in a language they understand, explaining fully any progress in their cases and the reason for continued detention. (8.3)*
Partially achieved. The monthly review form, IS151F, was generally written in summary and often repetitive form, which showed little evidence that cases had been progressed or that all factors relevant to continued detention had been considered since the last review. The ones we saw were in English only. The Management of Detained Cases Unit (MODCU) takes responsibility for most detained cases after 28 days. Some reviews issued by MODCU contained more information and addressed the individual's history, although we saw no evidence that these were translated into the detainee's language. **We repeat the recommendation.**

2.51 *On-site immigration officers should have access to the Asylum Casework Information Database (ACID). (8.4)*
Achieved. The centre immigration team had read-only access to the casework information database (CID), although it was not always up to date and the quality of input varied. A full training programme had yet to be implemented to enable staff better to use CID.

Further recommendation

2.52 IND should ensure that immigration officers who are required to access the Casework Information Database have appropriate training.

2.53 *The role of on-site immigration officers should be reviewed and clarified and their casework responsibilities clearly defined. (8.5)*
Partially achieved. There were plans to review and possibly expand the role of on-site officers. They spent a lot of time prompting primary casework offices to undertake practical tasks which they could do themselves, such as arranging travel documentation and removal directions in the final stages of casework. Officers who saw the detainees on-site were in a position to note changes of circumstances, including any relevant to risk assessment. **We repeat the recommendation**.

2.54 *All cases should be regularly reviewed, minuted and signed by on-site immigration officers, with a further monthly review by a chief immigration officer. (8.6)*
Partially achieved. An experienced on-site immigration team reviewed cases efficiently, and the chief immigration officer reviewed outstanding matters to see what further steps could be taken to reduce delay. However, the information or reaction from the primary caseworking office limited what they could achieve.

2.55 *Interpreters or Language Line should always be used for interviews where detainees are being informed of important decisions or of their rights. (8.7)*
Partially achieved. Immigration officers at caseworking ports arranged interpreters if they wanted to interview a detainee. On-site officers rarely conducted substantive interviews and generally only saw detainees to update their cases or serve various documents. Interpreters or Language Line were not systematically used, but on-site officers were trying to set up arrangements with Language Line and were investigating the installation of telephone points in interview rooms. Mobile telephone reception was poor in all but two of the interview rooms. **We repeat the recommendation.**

2.56 *Immigration staff should work with other centre staff to ensure that detainees are prepared for their removal and given adequate time and facilities to consult their legal representatives. (8.8)*
Partially achieved. The notice given by caseworking offices was often short and, if received in the evening or at weekends, did not permit contact with legal representatives. On-site staff policy was to serve removal directions as soon as they were received, not least because staff on-site recognised that they were likely to be better able to deal with anxious reaction. However, in some cases where we would have expected to see advice from other staff, such as healthcare, included on the immigration file there was none. For example, we saw no evidence of any consultation between immigration officers and healthcare staff about a detainee who had attempted suicide shortly before the inspection, and who was being referred for psychiatric assessment, but following his return from hospital had been given removal directions for a few days later.

2.57 The centre was willing to accept delivery of property up to airline limits. We were told that there had been occasions when centre staff escorted a detainee to a bank to enable him to access savings, but there was no systematic policy to enable detainees to recover all reasonably accessible property prior to removal. Sudden movements sometimes thwarted arrangements to reunite detainees with their property. **We repeat the recommendation.**

Further recommendation

2.58 Detainees at risk of self-harm or thought likely to resist removal should be subject to a multi-disciplinary care plan and risk assessment.

2.59 *The opinion of medical experts should be sought in age dispute cases. (8.9)*
Not achieved. The Immigration and Nationality Directorate has no policy of seeking independent medical opinion in age dispute cases. In some cases, local social services or healthcare opinion had been sought and on-site immigration officers had asked caseworking offices to reconsider detention. **We repeat the recommendation.**

2.60 *Detainees should have controlled access to the internet. (8.10)*
Not achieved. Detainees had no internet access. The printed legal resource material and country background material in the library was inadequate to meet the needs of detainees. The only collection of country-specific human rights information seen was that issued by the Home Office, the respondent in detainees' proceedings, and it did not cover all countries. **(see main recommendation HE.30)**

Duty of care

2.61 *Further specialist advice should be sought on the arrangements for fire safety and the merits of installing a sprinkler system. (9.1)*
Not achieved. The last Fire Service inspection of Campsfield House was in October 2003. We were told that there had not been a recommendation for sprinklers but managers had no knowledge of ever having received a written report to that effect. Managers told us that there would be a further fire risk assessment during the planning stages of the residential area expansion. **(See main recommendation HE.35)**

2.62 *Health and safety risk assessments of the risks to detainees should be carried out and appropriate action taken, particularly of the risk from fire and from the increased use of the centre for short stay detainees. (9.2)*
Achieved. A senior manager was responsible for health and safety at the centre. All risk

assessments examined were up to date and the risks to detainees had been taken into account. Risk assessments were regularly revised.

Additional information

2.63 No health and safety policy document had been published at Campsfield House. A company policy document was awaited from Global Solutions Ltd headquarters.

2.64 There was a local policy on smoking but we observed some detainees in communal areas ignoring this, with no staff intervention. Non-smoking detainees told us that this was distressing to them. There was a redeveloped policy available and urgent implementation was needed.

Further recommendation

2.65 A health and safety policy document should be published in Campsfield House without delay.

Housekeeping point

2.66 The no-smoking policy should be enforced in residential and communal areas.

2.67 *Both escorting staff and immigration officers should be trained in suicide awareness and be able to raise F2052SH forms as necessary. (9.3)*
Partially achieved. Escorting staff sampled told inspectors that they had received suicide awareness training and had raised self-harm notification forms (F2052SHs). On-site immigration officers had not been trained in suicide awareness.

Further recommendation

2.68 IND should ensure that all immigration personnel working in holding facilities receive suicide awareness training as a matter of priority.

2.69 *Consideration should be given to introducing a buddy scheme. (9.4)*
Not achieved. Although there was no written evidence available to confirm that a buddy scheme had been considered, staff remembered discussing this issue after the full inspection in 2002. It had apparently been decided that implementing a buddy scheme was too difficult because of the high turnover of detainees. However, staff told us that detainees were often called upon to support vulnerable people in the establishment. A buddy scheme, albeit an informal and ad hoc version, was therefore already in operation. The problem of high population turnover was therefore clearly surmountable, and there seemed no reason to delay implementation of a more formal scheme.

Further recommendation

2.70 A formal buddy scheme should be implemented.

2.71 *A suicide prevention management committee should meet monthly to oversee the operation of suicide prevention procedures and to monitor trends. (9.5)*
Achieved. An active suicide prevention committee met every month and the minutes showed

wide representation, including the IMB, chaplaincy, Samaritans and the race relations liaison officer. There were indications in the minutes that positive action had been taken in relation to issues that are particularly relevant to detainees. For example, the food refusal policy had been revised to ensure greater healthcare involvement, reflecting the fact that it is a form of self-harm.

2.72 *Staff should receive training to help them understand the backgrounds of the people in their care and the impact of detention in a foreign country so that they can provide individual support to detainees. (9.6)*
Partially achieved. The staff training had been updated to include a substantial amount of cultural awareness training and was positively regarded, but it did not include material specific to the impact of detention.

Further recommendation

2.73 Staff should be trained in understanding the impact of detention in a foreign country.

2.74 *Exit interviews should be conducted to glean more information about race relations and victimisation within the centre. (9.7)*
Not achieved. Exit interviews had not been conducted, but a comprehensive detainee survey had been carried out by the race relations liaison officer (RRLO), and included questions on race relations and victimisation. The results had helped to inform the RRLO's work in the centre, but there was little evidence that the wider race relations committee had used them to inform policy and practice development. The results had not been collated systematically – for example, in some cases the answers to different questions were conflated into the same statistic, reducing the usefulness of the data.

Further recommendation

2.75 The detainee surveys should be systematically collated, and the results should be discussed by the race relations committee and used to inform policy and practice development.

2.76 *There should be an overall vulnerability committee, which addresses bullying, harassment and self-harm issues. (9.8)*
Achieved. Anti-bullying was a separate agenda item for the suicide prevention committee, and all issues relating to individual vulnerability were considered during this meeting.

Additional information

2.77 Some people considered to be at risk of self-harm were managed on the units with enhanced support from staff. Those considered to be at greater risk of self-harm were managed in the isolation unit, as they could be monitored for 24 hours a day by having staff sit opposite the detainee's open door. The unit was also used for people thought to be at risk of absconding or whose behaviour in the main unit had been disorderly. Unless a detainee was violent, all room doors were open throughout the day, and there was free movement between rooms, as well as good interaction with unit staff.

2.78 There were no viewing panels in any of the doors on the unit. Unless a detainee was on 24-hour watch, there was no easy way to check on him during the night without opening his door. A recent suicide attempt by a man originally brought to the unit for disruptive behaviour had only been prevented because a member of staff from outside the unit had happened to look up

at his room window and raised the alarm. The inability to see into rooms was clearly a major concern for the staff on the unit, both because of the risk to detainees and the possible risk to staff. **(See main recommendation HE.34)**

2.79 There was no occurrence log kept to record visits by management, the IMB, healthcare staff or the contract monitor. All visits were recorded on detainees' individual files, which made checks of past visits very difficult.

2.80 We were concerned about the poor standard of entries on some F2052SH (at risk) forms. The form relating to the attempted suicide (above) showed no evidence of a review meeting or care plan, and as a result the duty unit staff did not feel they had sufficient information about the detainee. It was also a concern that cross-referencing of the F2052SH log and the isolation wing log showed that at least two people on the isolation unit who were considered to be at risk of self-harm did not have open F2052SHs.

2.81 There was a well-regarded welfare support team, consisting of 16 officers, who were able to provide emotional and some practical support to detainees, many of whom were distressed and vulnerable. The officers all underwent two days of welfare training from Prison Service trainers, and one day of training from the Samaritans.

Further recommendations

2.82 Entries in F2052SH books should be kept up to date and this should be closely monitored by senior managers.

2.83 The suicide prevention committee should take steps to ensure that F2052SH books are opened in all suitable cases.

2.84 A care plan should be developed for each detainee at risk of suicide or self-harm, and regular reviews carried out.

Housekeeping point

2.85 A central occurrence log, recording all official visits and incidents should be maintained in the isolation unit.

Good practice

2.86 The trained welfare support team provided support to vulnerable detainees, and is an initiative that should be replicated in other establishments.

2.87 *There should be a forum for the manager of religious affairs to meet with detainees with interpreters present to discuss the arrangements for the use of space in the centre for worship and spiritual contemplation. (9.9)*
Not achieved. This recommendation was rejected, on the basis that there was no scope for altering existing arrangements on an equitable basis. There was widespread discontent among Muslim detainees, who formed 30–40% of the centre's population, about inadequate access to the Imam. The Imam worked at the centre for only four hours a week.

Further recommendation

2.88 Centre managers should ensure that detainees have greater access to an Imam, to meet the needs of the large Muslim population.

2.89 *Ethnic monitoring data should be interpreted by means of 'range setting' tables. (9.10)*
Not achieved. This recommendation was originally rejected and deemed irrelevant to removal centres where detainees have open access to all facilities. However, other IRCs make use of such tables, which help to identify disproportionate patterns in the appropriation of facilities by certain nationalities or ethnic groups. **We repeat the recommendation.**

Further recommendation

2.90 IND should issue guidance on monitoring to individual establishments so that a consistent approach is achieved across the detention estate.

2.91 *There should be a race and diversity committee with detainee representation and/or representation from relevant outside groups. (9.11)*
Partially achieved. There were regular race relations committee meetings, which included members of Oxfordshire Race Equality Council. The race relations liaison officer had developed links with the outside community and had invited a range of cultural and religious groups to the centre. This had made a positive difference to the culture of the establishment. However there was still no representation from detainees themselves. **We repeat the recommendation.**

2.92 *It should be the responsibility of a senior manager to chase up the progress of logged complaints and to ensure that they are satisfactorily and promptly resolved. (9.12)*
Achieved. A member of the senior management team monitored written complaints, ensuring replies were timely and helpful and the contract monitor oversaw the process. The replies we examined were both respectful and helpful.

2.93 *Detainees should have access to an independent ombudsman once avenues of complaint open to them are exhausted. (9.13)*
Not achieved. As in other immigration removal centres, there was no provision for access to an independent ombudsman. **We repeat the recommendation**.

Use of force and single separation

Additional information

2.94 During our previous full inspection, we noted (9.1) that there were two rooms in a prefabricated building within the centre that had been constructed to provide a segregation facility. Those behaving in an aggressive or disruptive manner could be segregated there under Detention Centre Rule 42. The segregation unit was revisited during this short follow-up inspection. The unit had been used an average of four-and-a-half times each month and detainees had been held there for between two-and-a-half and 66 hours.

2.95 Only one of the two rooms was in use as the other had been badly damaged by a previous occupant. The lobby between the two rooms was very dirty, cluttered and cramped. The area

was cleaned during the inspection. The size and fabric of the temporary building meant the segregation unit was not fit for purpose. The unit was located in the small reception yard, which was the main point of entry and exit; it was also used inappropriately as an exercise area for those held in segregation.

2.96 A single custody officer was present in the lobby area and observed the occupant of the room and made regular observations in his file. There was no central occurrence log of visits by management, the IMB, healthcare staff or the contract monitor. Instead all visits were recorded on detainees' individual files, which made checks of past visits very difficult. The room in use was relatively clean and tidy and the detainee held there expressed no concerns. He knew why he had been detained in the segregation unit and he knew that he was being transferred on the day of inspection. **(See main recommendation HE.33)**

Housekeeping point

2.97 A central occurrence log to record all official visits and incidents should be maintained in the segregation unit.

Healthcare

2.98 *The new doctor should receive specialist training in the health needs of asylum seekers. (10.1)*
Partially achieved. Since the last inspection a local GP practice had taken on responsibility for providing medical services for detainees. There was no formal induction and GPs admitted to learning on the job, with guidance from the healthcare manager. Primecare provided out of hours cover although they were seldom required as there was a nurse on call.

Further recommendation

2.99 A formal induction programme should be devised for new medical staff and it should include specialist training in the health needs of detainees.

2.100 *Administrative help should be provided to the nursing staff. (10.2)*
Achieved. There was an administrative officer who worked 20 hours per week in the healthcare centre.

2.101 *A system should be introduced for the transfer of medical records between detention centres and the Health Service on transfer or release. (10.3)*
Partially achieved. The system for the transfer of healthcare records had apparently improved in recent months, with greater co-operation between IRCs. However, there were still problems when the healthcare centre was not informed of transfers in good time for the records to be sent. When a detainee was released into the community, a discharge letter was written by nursing staff for the detainee to take to his GP. He was also given a two-week supply of any medication that he required.

2.102 *The system for providing simple remedies out of hours should be reviewed. (10.4)*
Partially achieved. There was a system in place for Global Solutions Ltd (GSL) staff to administer simple remedies (soluble Paracetamol and Magnesium Triscilicate) when nursing staff were not on duty. However, IRC staff did not establish that detainees understood the consequences of taking the medication. When GSL staff administered simple remedies out of hours they recorded the action in a log. But the information was not transcribed into detainees'

medical records, so there was the potential for detainees to be given more than the recommended daily dose.

Further recommendations

2.103 There should be a protocol for providing access to medication by non-healthcare staff.

2.104 The system for recording medications administered should be reviewed to ensure that all doses are recorded in detainees' medical records.

2.105 *Notices in translation should be displayed in the treatment room informing detainees that information leaflets about their medication would be translated if required. (10.5)*
Not achieved. While it is not a legal requirement that patient information leaflets are provided in a variety of languages, healthcare staff have a responsibility to ensure that patients understand how and when to take their medications. We were told that the reason the recommendation had not been achieved was because of the cost of translating the leaflets, but detainees could ask staff if they needed any information. **We repeat the recommendation.**

2.106 *Both the maximum and minimum temperatures of the drugs fridge should be recorded daily and the thermometer reset after each reading. (10.6)*
Not achieved. The maximum and minimum temperatures of the drugs fridge were being recorded. However, the temperatures were not within acceptable limits and no action was being taken.

Further recommendation

2.107 The drugs fridge should be serviced or replaced to ensure that thermolabile medications are stored within 2-8 degrees centigrade at all times.

2.108 *The number of drugs cabinets and their security should be reviewed and consideration given to replacing them with additional secure drug cabinets. (10.7)*
Achieved. New drugs cabinets were in place following the last inspection. A large variety of medications were held in stock in recognition of the fact that detainees could arrive at the centre at any time.

2.109 *The pharmacist should monitor the usage of benzodiazepines and take steps to develop a formulary with the new medical officer. (10.8)*
Achieved. The healthcare centre staff adhered to Primecare Forensic Services medications formulary. We were told that benzodiazepines were only used in cases of extreme agitation. Detainees on medication were reviewed every 28 days.

2.110 *Testing and treatment should be offered for hepatitis B and HIV, depending on the anticipated length of stay at the centre. (10.9)*
Partially achieved. HIV testing (with pre- and post-test counselling) was offered by staff within the healthcare centre. If a detainee was moved to another centre before he received the results, the healthcare manager ensured that the results were sent on. Similarly, if he was granted admission to the country attempts were made to ensure he received the test results. We were pleased to note that the healthcare centre staff continued to maintain good links with the Terrence Higgins Trust. Condoms were available free of charge and without detainees having to request them from a member of staff. Hepatitis B vaccinations were not offered. We were told that this decision had been made following advice from Oxfordshire public health authority, and because of the short duration of stay of the majority of detainees. We

considered this to be poor practice. **We repeat the recommendation that hepatitis B vaccinations should be offered to all detainees at Campsfield House.**

2.111 *Arrangements for the delivery of secondary healthcare should be formally agreed with the local area health authority. (10.10)*
Partially achieved. There were currently no formal arrangements with secondary healthcare providers in the locality. However, there were good links with local healthcare services, including the consultant in infectious diseases and local radiography department. The medical staff told us that they had no difficulty in referring patients to a local hospital service. A clinical psychiatrist from Oxfordshire Mental Health Trust would also attend the centre to see detainees with severe and enduring mental health needs.

2.112 *There should be a presumption against the use of restraints for detainees attending outside hospitals. (10.11)*
Not achieved. Handcuffs were routinely used for detainees attending hospital. In addition it was normal practice for a detainee to be accompanied by three members of staff. **We repeat the recommendation**.

2.113 *Consent forms should be available for the disclosure of health information relevant to asylum claims to the authorities and to legal representatives. (10.12)*
Achieved. There were two separate consent forms in use. One was for access to medical records by the patient or a third party, the other was for a detainee to give permission for healthcare staff to divulge medical details to the Immigration Service.

2.114 *There should be a clear protocol governing the disclosure of information of mistreatment and fitness for detention to the relevant authorities and what action should follow. (10.13)*
Partially achieved. While there was no formal policy in place it was customary for the healthcare manager to send a memorandum to the centre manager if a detainee alleged previous torture or victimisation or if it was felt that he was unfit for detention. **We repeat the recommendation.**

2.115 *There should be a forum for regular consultation between managers and detainees which could be used to discuss health matters, among other things. (10.14)*
Not achieved. There was no forum for regular consultation between managers and detainees. Healthcare issues were discussed on an individual basis and the healthcare manager operated an 'open door' policy. **We repeat the recommendation.**

Additional information

2.116 Due to the rapid turnover of detainees at Campsfield House the healthcare manager had devised a shortened version of the health assessment questionnaire. Nearly all detainees were seen by healthcare staff as part of the induction process. Detainees were unable to use the gym or sports facilities without a healthcare assessment. Detainees who were only lodging at the centre overnight were not assessed because of the short duration and the lack of nurses on-site at night. However, the short assessment form was in English only whereas the previous, longer form had been translated into 18 different languages.

Further recommendation

2.117 All healthcare paperwork should be available in a variety of different languages.

Activities

2.118 *The education centre should implement its plan to provide one-to-one tutorials where appropriate. (11.1)*
Recommendation no longer relevant. The education department was closed during the inspection but centre staff confirmed that one-to-one tutorials were not provided. Given the average length of stay at Campsfield House, we considered the recommendation to be no longer applicable**.**

2.119 *The take up of activities should be monitored by nationality and ethnicity. (11.2)*
Partially achieved. The race relations liaison officer (RRLO) said he did a snapshot survey of the take-up of activities every month by going to each activity area, literally counting the number of people and surmising nationality and ethnicity from appearance and his own knowledge of the population. He collated the information and kept it for his own use. This was not a reliable or sustainable way to monitor activities and placed too great a responsibility on the RRLO.

Further recommendation

2.120 Systematic monitoring of the take-up of activities should be developed, and the results should be used to inform discussions of policy and practice in the race relations committee. (See also recommendation 2.74)

2.121 *Paid work should be available for detainees who choose to undertake it. (11.3)*
Not achieved. As is the case in other immigration removal centres, there was no formal paid work available to detainees. **(See main recommendation HE.28)**

2.122 *Until such time as paid work is provided incentives should be available to all who participate in the regime or help to provide a service in the centre. (11.4)*
Partially achieved. There was no rewards scheme in effect at Campsfield House but some detainees had the opportunity to do voluntary work such as garden tidying. Their efforts were rewarded with vouchers for use in the centre shop. During the inspection the initiative had been limited to nine people only, but there was sufficient voluntary work available, particularly in the grounds, for many more. **(See main recommendation HE.28)**

2.123 *Videos in different languages should be available. (11.5)*
Partially achieved. Few of the videos in the detainee video cabinet were in languages other than English. In fact we were told that most foreign language videos were provided by the detainees themselves. **We repeat the recommendation**.

2.124 *The induction completion forms should be available in a range of languages. (11.6)*
No longer relevant. This form had been superseded by an alternative system, the 'green form' which recorded the initial assessments and actions taken by first night staff. These were not used by detainees and were required in English only for staff.

2.125 *Sufficient trainers should be provided for all those who wished to take part in gym activities. (11.7)*
Achieved. There were enough trainers to ensure that the sports hall and the fitness room opened as scheduled. A records check established that there had been no closures of facilities due to staff shortages in the previous two months. The staff supervising the fitness room were British Weightlifting Association (BWLA) qualified but the staff supervising the sports hall were not qualified to the standard that would be expected in the community. Detainees did not have access to supervised games in the grounds of the centre.

Further recommendations

2.126 Supervisory staff should have the minimum qualifications that would apply in a public facility.

2.127 Supervised outside sporting activities should be made available to detainees.

2.128 *The book stock in the library should be increased to provide suitable books in the full range of appropriate languages. (11.8)*
Not achieved. Most detainees using the library were dissatisfied with the range of foreign language books available. There was no librarian in post at the time of the inspection, so it was difficult to establish the extent to which this problem was being addressed. **We repeat the recommendation**.

2.129 *Detainees should have controlled access to the internet and email. (11.9)*
Not achieved. Detainees did not have any access to the internet or to email. **(See main recommendation HE.30)**

Services

2.130 *The kitchen and reception staff should ensure that packed meals provided for detainees who are being discharged actually reach them, and this should be monitored by the contract monitor and visiting committee (now Independent Monitoring Board). (12.1)*
Achieved. Meals were made available to detainees leaving the centre when required. Staff also made arrangements to provide meals for detainees who had spent long periods in escort vans, even if they were passing through rather than being received into Campsfield House.

2.131 *The shop should stock inexpensive national and international telephone cards for use by detainees. (12.2)*
Not achieved. Only one type of telephone card was available from the centre shop. Detainees, in groups and individually, complained that national and international telephone calls were expensive. A meeting between centre managers and telephone service providers had been arranged to take place after the inspection, with the view to increasing the range of cards available. **We repeat the recommendation.**

2.132 *A needs assessment should urgently be carried out by Aramark to establish which products should be stocked to meet the cultural and ethnic needs of detainees. (12.3)*
Achieved. Aramark conducted a survey of detainees' needs every six months. The results of the surveys were used to adjust the items that were stocked in the shop.

2.133 *The policy for providing essential items to those arriving without money should be clarified to staff, and should include the provision of free toiletries and £5 per week phone cards. (12.4)*
Achieved. The position had been clarified and there was no means testing prior to issuing toiletries to detainees. These items were on display and freely available in the induction unit and information room. No detainees complained to us about access to toiletries or cleaning materials. A system was in place to provide a £5 voucher to all detainees who kept their own bed and living area tidy. Detainees could exchange vouchers for telephone cards.

Preparation for release, transfer or removal

2.134 *There should be a common standard across the detention estate for the provision of domestic and legal visits and it should follow current best practice at centres such as Tinsley House. (13.1)*
Partially achieved. Arrangements across the detention estate vary. At Campsfield House good legal visits arrangements were available nine hours a day, seven days a week. Social visits were available during afternoons and evenings, six hours a day, seven days a week.

2.135 *There should be a common standard across the detention estate for the provision of free phone cards to those without means, consistent with current best practice, which is the issue of £5 cards each week. (13.2)*
Not achieved. Detainees were able to earn a £5 voucher if they kept their property and residential area clean and tidy. This could be used to purchase telephone cards, although no specific assessment was made of the detainees' ability to support contact with their family by telephone. Staff told us that if they recognised a detainee's need to speak to his family they were authorised to offer the centre telephone, and each detainee could apply once a week, via the information centre, for a free national or international call. Detainees described variable access to telephones and inconsistencies in tariffs in different IRCs.

Further recommendations

2.136 Detainees who have no available funds on reception should be issued with a £5 telephone card.

2.137 The provision of access to telephones, means testing and tariffs for calls should be consistent across the IRC estate and in line with current best practice.

2.138 *Detainees should be able to purchase international telephone cards and have access to email. (13.3)*
Partially achieved. Detainees were able to purchase international telephone cards in the centre shop but they did not have access to email. **(See main recommendation HE.30)**

2.139 *Detainees should be able to obtain objective information about the political situation in their home countries through controlled access to the internet and specialist foreign journals. (13.4)*
Not achieved. Detainees had no access to the internet. The library had a number of foreign newspapers but the only collection of country specific information was a selection of country reports issued by the Home Office. The reports were dated 2004 but did not include all countries. **We repeat the recommendation.**

2.140 *Visitors should be allowed to restore property to detainees by delivering it to reception. (13.6)*
Achieved. Visitors were able to deliver property, which was processed through reception. Detainees were also able to exchange items and arrange for some of their property to be handed out to visitors.

2.141 *Centre staff and immigration officers on-site should provide advance notice and support for those being released, transferred into detention elsewhere or removed. (13.7)*
Partially achieved. On-site immigration officers served decisions soon after they were received from the caseworking port or office, but the time between issue and implementation varied and there was often no notice of transfer. No formalised assistance was given to those being released; there was no liaison with the Home Office National Asylum Support Service

(NASS) which supports eligible asylum seekers who are not detained. The centre allowed deposit of property for those being removed, if detainees knew someone prepared to do this for them. We were told that occasionally centre staff had accompanied someone to a bank to recover savings, when they had imminent removal directions and no money, but there was no system to reunite people with their property. **We repeat the recommendation.**

2.142 *Those being transferred into further detention should be given written reasons for this decision and information about the centre to which they are being transferred. (13.8)*
Not achieved. In the three months prior to the inspection a third of detainees leaving the centre were transferred to other places of detention. Some were moved a number of times (see para 2.3) and said that they were not always told where they were going. Written information about transfer was not generally issued. Representatives told us that they and their clients often received no prior warning of movements to other places of detention, which sometimes happened at night. When clients were moved some distance it became difficult for representatives to maintain good contact. **We repeat the recommendation.**

2.143 *There should be a system which assists detainees with their release or removal through orientation courses for those being admitted into the country for the first time, assistance with resettlement for those returning to their communities in the UK, and assistance for those being removed which enables them to close their affairs in this country and provides them with the means to reach a safe onward destination. (13.9)*
Not achieved. Detainees were occasionally able to recover property and were likely to be allowed a free telephone call to their home country, but there was no pre-release system in place. **(See main recommendation HE.29)**

Section 3: Summary of recommendations

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

Main recommendations

To the Director General, Immigration & Nationality Directorate

3.1 **Detainees should be able to engage in paid work, or be rewarded for voluntary work undertaken in the centre. (HE.28)**

3.2 **There should be dedicated welfare support staff to provide practical assistance to detainees during detention and assistance with release, transfer or removal. (HE.29)**

3.3 **Detainees should have access to email and controlled access to the internet. (HE.30)**

3.4 **The Immigration & Nationality Directorate should monitor detainees' time in transit and the provision of breaks, in order to ensure direct and swift journeys to removal centres. (HE.31)**

To the Centre Manager

3.5 **A new reception facility should be built. (HE.32)**

3.6 **The segregation unit should be rebuilt to an acceptable standard and located in a more appropriate area with proper exercise facilities. (HE.33)**

3.7 **All rooms used to accommodate those at risk of self-harm or suicide, should have observation panels. (HE.34)**

3.8 **A documented risk assessment should be undertaken by independent specialists on fire safety. (HE.35)**

Other recommendations

To the Director General, Immigration and Nationality Directorate

3.9 IND should issue records of custody (Form 91) that log the date and time of detainees' reception into custody. (2.8)

3.10 IND should provide detainees with written information about the escort contractor, provision of breaks, what to do in an emergency and how to complain. (2.9)

3.11 IND, in cooperation with the Legal Services Commission and the OISC, should ensure that all detainees have access to on-site independent, qualified legal advice and representation. (2.35)

3.12 The Office of the Immigration Services Commissioner (OISC) should devise a way of regularly checking the competence of those providing legal advice to detainees, who are in an exceptionally vulnerable situation. (2.38)

3.13 IND should not take detainees to foreign diplomatic offices within which their care and protection cannot be guaranteed. (2.45)

3.14 IND should ensure that immigration officers who are required to access the Casework Information Database have appropriate training. (2.52)

3.15 IND should ensure that all immigration personnel working in holding facilities receive suicide awareness training as a matter of priority. (2.68)

3.16 IND should issue guidance on monitoring to individual establishments so that a consistent approach is achieved across the detention estate. (2.90)

3.17 The provision of access to telephones, means testing and tariffs for calls should be consistent across the IRC estate and in line with current best practice. (2.137)

3.18 Detainees should be able to obtain objective information about the political situation in their home countries through controlled access to the internet and specialist foreign journals. (2.139)

To the Centre Manager

Reception, first night and induction

3.19 A telephone with acoustic hood should be installed in reception and a telephone card provided for the use of arriving and departing detainees. (2.12)

3.20 A water machine and facilities to make tea and coffee should be installed. (2.13)

3.21 Detainees should be given written information about the centre and what will happen to them in the first 24 hours in a language they can understand. (2.16)

3.22 The reception/induction information video should be shown to new detainees waiting in the reception holding room. (2.23)

3.23 Systems should be put in place to ensure that detainees are dealt with quickly in the reception area and to monitor delays experienced. (2.24)

3.24 The location, content and style of the induction process should be reviewed to ensure that it meets the needs of detainees. (2.25)

Accommodation

3.25 A folding writing surface should be fitted in every residential room. (2.27)

3.26 A formal reward scheme should be implemented as a matter of urgency. (2.30)

Access to legal advice and representation

3.27 Detainees should be told, in a language that they understand, of their rights to bail, appeals and legal aid within 24 hours of arrival at the centre. (2.37)

3.28 Detainees should be able to contact their legal representatives by phone, fax or email without impediment. (2.40)

3.29 Detainees should have access to up to date legal text books on immigration law. (2.41)

3.30 Any information or decisions regarding the individual's detention, movements, immigration status, or removal should be communicated to the detainee and his or her representative without delay. (2.42)

3.31 Detainees should be able to attend their bail and appeal hearings and should be produced on time. (2.43)

3.32 Detainees should not routinely be handcuffed in public places. (2.46)

Casework

3.33 Detainees should be told the individual reasons for their detention in a language they understand. (2.49)

3.34 Detainees should receive monthly reviews on time and in a language they understand, explaining fully any progress in their cases and the reason for continued detention. (2.50)

3.35 The role of on-site immigration officers should be reviewed and clarified and their casework responsibilities clearly defined. (2.53)

3.36 Interpreters or Language Line should always be used for interviews where detainees are being informed of important decisions or of their rights. (2.55)

3.37 Immigration staff should work with other centre staff to ensure that detainees are prepared for their removal and given adequate time and facilities to consult their legal representatives. (2.56)

3.38 Detainees at risk of self-harm or thought likely to resist removal should be subject to a multi-disciplinary care plan and risk assessment. (2.58)

3.39 The opinion of medical experts should be sought in age dispute cases. (2.59)

Duty of care

3.40 A health and safety policy document should be published in Campsfield House without delay. (2.65)

3.41 A formal buddy scheme should be implemented. (2.70)

3.42 Staff should be trained in understanding the impact of detention in a foreign country. (2.73)

3.43 The detainee surveys should be systematically collated, and the results should be discussed by the race relations committee and used to inform policy and practice development. (2.75)

3.44 Entries in F2052SH books should be kept up to date and this should be closely monitored by senior managers. (2.82)

3.45 The suicide prevention committee should take steps to ensure that F2052SH books are opened in all suitable cases. (2.83)

3.46 A care plan should be developed for each detainee at risk of suicide or self-harm, and regular reviews carried out. (2.84)

3.47 Centre managers should ensure that detainees have greater access to an Imam, to meet the needs of the large Muslim population. (2.88)

3.48 Ethnic monitoring data should be interpreted by means of 'range setting' tables. (2.89)

3.49 There should be a race and diversity committee with detainee representation and/or representation from relevant outside groups. (2.91)

3.50 Detainees should have access to an independent ombudsman once avenues of complaint open to them are exhausted. (2.93)

Healthcare

3.51 A formal induction programme should be devised for new medical staff and it should include specialist training in the health needs of detainees. (2.99)

3.52 There should be a protocol for providing access to medication by non-healthcare staff. (2.103)

3.53 The system for recording medications administered should be reviewed to ensure that all doses are recorded in the detainees' medical records. (2.104)

3.54 Notices in translation should be displayed in the treatment room informing detainees that information leaflets about their medication would be translated if required. (2.105)

3.55 The drugs fridge should be serviced or replaced to ensure that thermolabile medications are stored within 2-8 degrees centigrade at all times. (2.107)

3.56 Testing and treatment should be offered for hepatitis B to all detainees at Campsfield House. (2.110)

3.57 There should be a presumption against the use of restraints for detainees attending outside hospitals. (2.112)

3.58 There should be a clear protocol governing the disclosure of information of mistreatment and fitness for detention to the relevant authorities and what action should follow. (2.114)

3.59 There should be a forum for regular consultation between managers and detainees which could be used to discuss health matters, among other things. (2.115)

3.60 All healthcare paperwork should be available in a variety of different languages. (2.117)

Activities

3.61 Systematic monitoring of the take-up of activities should be developed, and the results should be used to inform discussions of policy and practice in the race relations committee. (2.120)

3.62 Videos in different languages should be available. (2.123)

3.63 Supervisory staff should have the minimum qualifications that would apply in a public facility. (2.126)

3.64 Supervised outside sporting activities should be made available to detainees. (2.127)

3.65 The book stock in the library should be increased to provide suitable books in the full range of appropriate languages. (2.128)

Services

3.66 The shop should stock inexpensive national and international telephone cards for use by detainees. (2.131)

Preparation for release, transfer and removal

3.67 Detainees who have no available funds on reception should be issued with a £5 telephone card. (2.136)

3.68 Centre staff and immigration officers on site should provide advance notice and support for those being released, transferred into detention elsewhere or removed. (2.141)

3.69 Those being transferred into further detention should be given written reasons for this decision and information about the centre to which they are being transferred. (2.142)

Housekeeping points

3.70 The no-smoking policy should be enforced in residential and communal areas. (2.66)

3.71 A central occurrence log, recording all official visits and incidents should be maintained in the isolation unit. (2.85)

3.72 A central occurrence log to record all official visits and incidents should be maintained in the segregation unit. (2.97)

Good practice

3.73 The trained welfare support team provided an essential service to detainees, and is an initiative that should be replicated in other establishments. (2.86)

Appendix I: List of inspectors

Jim Gomersall	Team leader
Hindpal Singh Bhui	Inspector
Eileen Bye	Inspector
Gabrielle Lee	Inspector
Elizabeth Tysoe	Healthcare inspector

Appendix II: Population Profile

POPULATION PROFILE AT CAMPSFIELD HOUSE
On 3rd August 2004-09-28

Population breakdown by:

(i) Status	Number of detainees	%
Detainees (single power status) Of which: Non-asylum seekers Asylum seekers	163 (NB capacity 184)	100
Total		

(ii) Length of stay	Number of detainees	%
Less than one week	64	39
Less than one month	65	40
1 month to 3 months	31	19
3 months to 6 months	0	0
6 months to 1 year	3	2
1 year to 2 years	0	0
2 years to 4 years	0	0
4 years or more	0	0
Total	163	100

(iii) Age	Number of detainees	%
18 years to 20 years	12	7
21 years to 29 years	72	44
30 years to 39 years	58	36
40 years to 49 years	17	11
50 years to 59 years	4	2
60 years to 69 years	0	0
70 plus years	0	0
Please state maximum age	59	-
Total	**163**	**100**

(iv) Nationality	Number of detainees	%
Afghanistan	2	1
Albania	2	1
Algeria	5	3
Angola	3	1.5
Armenia	0	0
Bangladesh	4	2.5
Belarus	1	0.5
Bissau	0	0
Brazil	1	0.5
Cameroon	1	0.5
Chad	2	1
China	3	1.5

Congo	5	3
Croatia	1	0.5
Czechoslovakia	0	0
Dominican Republic	1	0.5
Ecuador	2	1
Eritrea	1	0.5
Egypt	0	0
Ethiopia	0	0
Georgia	0	0
Gambia	1	0.5
Ghana	11	7
Guinea	0	0
India	2	1
Indonesia	0	0
Iran	7	4
Iraq	1	0.5
Ivory Coast	2	1
Jamaica	15	9
Jordan	1	0.5
Kazakhstan	1	0.5
Kenya	2	1
Kosovan	5	3
Kuwait	1	0.5
Latvia	0	0
Lebanon	0	0
Liberia	6	3.5
Libya	2	1
Madagascar	0	0
Malawi	3	1.5
Malaysia	2	1
Mali	0	0
Mauritania	1	0.5
Mauritius	1	0.5
Moldova	1	0.5
Mongolia	0	0
Mozambique	0	0
Nepal	0	0
Nigeria	13	8
Not known/stateless	0	0
Pakistan	4	2.5
Poland	0	0
Romania	10	6.5
Russia	0	0
Rwanda	0	0
Senegal	1	0.5
Sierra Leone	2	1
Somalia	2	1
South Africa	0	0
Sri Lanka	6	3.5
Sudan	3	1.5
Syria	2	1
Tanzania	0	0
Togo	3	1.5

Turkey	8	5
Uganda	6	3.5
Ukraine	1	0.5
United States of America	0	0
Usbekistan	1	0.5
Vietnam	1	0.5
Yugoslavia	0	0
Zaire	1	0.5
Zimbabwe	0	0
Total	**163**	**93**

(v) Ethnicity	**Number of detainees**	**%**
White		
British	0	0
Irish	0	0
Other white	29	18
Mixed		
White & black Caribbean	0	0
White & black African	0	0
White & Asian	0	0
Other mixed	34	21
Asian or Asian British		
Indian	2	1
Pakistani	4	2
Bangladeshi	4	2
Other Asian	2	1
Black or black British		
Caribbean	21	13
African	55	34
Other Black	0	0
Chinese or other ethnic group		
Chinese	3	2
Other ethnic group	9	6
Total	**163**	**100**

(vi) Religion	**Number of detainees**	**%**
Baptist	0	0
Church of England	0	0
Roman Catholic	7	4
Other Christian denominations	62	38
Muslim	55	34
Sikh	2	1
Hindu	3	1.5
Buddhist	1	0.5
Jewish	0	0
Other	6	3
No religion	27	18
Total	**163**	**100**