Report on an announced inspection of

Cedars Pre-Departure Accommodation

30 April – 25 May 2012
by HM Chief Inspector of Prisons
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Introduction

This is our first inspection of the Cedars pre-departure accommodation, where families are detained for up to a week immediately before removal. It has largely replaced the detention of children in Yarl’s Wood immigration removal centre. Given the uniqueness of this unit, inspectors spent four weeks speaking to detained families, accompanying them during in-country escort journeys, examining documentation and speaking to Cedars staff and other involved agencies in the community.

Apparent inconsistencies in the application of detention criteria were highlighted by the fact that most families arrived from the north of the country. Most of the work we saw from Reliance escort staff was commendable and families were, in general, complimentary about their treatment during escort, even during the stressful removal stage. However, as at some previous inspections, we also observed unprofessional behaviour, not by one of the family escort team, but by an officer on a different escort in the hearing of children.

Most of what we saw from the point of arrival at the centre was good and it was clear that it had been designed around the needs of children and families. Families were welcomed and their immediate needs were met. Children were well occupied and told us they enjoyed the care and stimulation they received at the centre. The physical environment was clean, well maintained and attractive, and the level of care provided by the enthusiastic staff group was exceptional. Health care staff were accessible, though specialist provision for those with mental health problems was limited. Families told us they felt safe in the centre and had confidence in staff. Barnardo’s staff played an important role in the centre and their involvement was a major factor in securing the safety and wellbeing of children while they were held.

The initial arrest, the point of removal and the use of force to effect removal were the main causes for concern. These were times of stress and upset for all family members and the behaviour of arrest teams was criticised. Although considerable efforts were made to avoid force at the point of removal, it had been used against six of the 39 families going through Cedars. We were very concerned to find that force had been used to effect the removal of a pregnant woman, using non-approved techniques. There is no safe way to do this while protecting the unborn child and it is simply not acceptable to initiate force for such purposes.

The circumstances of detention and removal were clearly traumatic for parents and their children but, unlike our consistent finding at Yarl’s Wood, the conditions and length of detention at Cedars could not be said to cause distress to children and parents. In fact, parents told us that if they were to be removed forcibly, they would rather be held in Cedars for a short time, both to provide time for applications for judicial review, and to help them settle and prepare their children.

The attractive environment and caring ethos of Cedars contrast with the inevitable fear and uncertainty among families undergoing the removal process to create a sense of dissonance for visitors. It is an exceptional facility and has many practices that should be replicated in other places of detention. However, it is also, when said and done, a place that precedes a

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1 Another new family unit at the nearby Tinsley House immigration removal centre also holds families with children for short periods. These families have been refused access and detained at the border, and are awaiting return flights. We have yet to inspect that facility.
traumatic dislocation for children who have, in many cases, been born in this country or been here for much of their lives. It is to the considerable credit of staff at Cedars that children held in these circumstances were, in general, happily occupied, and that parents were able to concentrate on communication with solicitors, family and friends. This inspection found conditions and treatment that exceed by some distance what families have previously experienced before removal. For that reason, staff at Cedars deserve great credit for what has been achieved in circumstances that are never less than sad.

Nick Hardwick
HM Chief Inspector of Prisons
July 2012
Fact page

Task of the establishment
Cedars holds families before their removal from the UK. The facility is used after advice has been sought from the independent family returns panel, which is made up of people with expertise in child welfare. Families should normally be held there for no more than 72 hours. With ministerial authority this can be extended to one week.

Location
Pease Pottage, Crawley

Name of contractor
G4S

Number held
Between 2 and 10 detainees during the inspection

Certified normal accommodation
44

Operational capacity
44

Date of last full inspection
N/A

Brief history
In December 2010, the Government published details of its new approach to removing families from the UK. The final stage of the new process may include detention in ‘pre-departure accommodation’, which is intended to be a last resort if options such as assisted voluntary return have failed. Cedars was opened in August 2011 as a secure facility to hold such families. The children’s charity Barnardo’s works alongside G4S custodial staff at the facility.

Short description of residential units
There are nine self-contained apartments of varying sizes that can hold a total of 44 people. One apartment is compliant with the Disability Discrimination Act (Snowdrop). Two apartments, Lavender and Orchid, are designed to accommodate families presenting particular concerns. Cedars also has a library, a family lounge, a children’s activity area, a youth lounge for older children, a multi-sensory room and a gym. There is a chapel and multi-faith room, two medical rooms, laundry, shop and cafe, and additional bathrooms for families whose apartments only have showers. There is also a ‘cool down’ separation room.

Centre managers
Sarah Newland - G4S
Jennifer Carnegie - Barnardo’s
Rosy Meek - UKBA

Escort contractor
Reliance

Health service commissioner and providers
G4S Integrated Services
Learning and skills providers
Barnardo's

Independent Monitoring Board chair
Robert Young
Healthy establishment summary

Introduction

HE.1 Her Majesty’s Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, immigration detention facilities and police custody.

HE.2 All inspections carried out by HM Inspectorate of Prisons contribute to the UK’s response to its international obligations under the UN Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

HE.3 The concept of a healthy prison was introduced in this inspectorate’s thematic review Suicide is Everyone’s Concern (1999). The healthy prison criteria, upon which inspections base the four tests of a healthy establishment, have been modified to fit the inspection of removal centres. The criteria for removal centres are:

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

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

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

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

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

- outcomes for detainees are reasonably good against this healthy establishment test. There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.
HE.5  - outcomes for detainees are not sufficiently good against this healthy establishment test.
There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.

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

HE.6  Although this was a custodial establishment, we were mindful that detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes. In addition to our own independent Expectations, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees:

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

HE.7  The statutory instrument also states that due recognition will be given at immigration removal centres to the need for awareness of:

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

Safety

HE.8  Detainees reported positively on escorts overall, but families complained about their treatment at the point of arrest. There was good preparation for families arriving at the centre and detailed advance information was communicated to appropriate staff. The arrivals area was welcoming and the arrivals process was well managed. Detainees said they felt safe. Those at risk of self-harm were well managed. A strong child-centred culture had been developed in the centre. Safeguarding and child protection procedures were well understood by all staff. Where force had been used it was usually minimal. However, it had been used to effect the removal of a pregnant woman, posing an unacceptable risk to the unborn child. Force had also been used against children. Detainees were given good access to legal assistance. On-site immigration staff were accessible. There were apparent inconsistencies in the decision to detain families. Outcomes for detainees against this healthy establishment test were reasonably good.
HE.9  We inspected four escort journeys involving families, all of which were managed well. Spacious and appropriate coaches were usually used but on occasion smaller vehicles that were much less suitable for children had been used. Reliance family escort staff were sensitive to the needs of children, and care was taken to ensure that families understood what was happening. All the parents brought to the centre reported positively on the treatment they and their children received from escorts.

HE.10  Despite efforts to reduce night-time moves, about half the families who had been in Cedars were subject to them, which was particularly tiring for children. Records indicated that families often had only one hour between arrest and handover to Reliance escorts. This did not give them enough time to have breakfast, dress, pack up belongings and prepare their children. This was the main complaint from parents about the initial arrest, but one parent also described intimidating behaviour by the arrest team, and her children told us they were also upset by the way the team behaved. We observed a handover from an arrest team to Reliance escorts that was inappropriately undertaken in full public view outside a police station. We also observed casual use of offensive language and gestures by a member of Reliance staff in the hearing of a family including two children.

HE.11  Centre staff had a large amount of detailed information about families in advance of their arrival, and preparation for them was very good. There were well established working relationships between G4S, the UK Border Agency (UKBA) and Barnardo’s. A family welfare form was shared with senior staff in each organisation and was well communicated to relevant centre staff. The arrivals area was attractive and welcoming, and toys, books and games were selected in advance of an arrival in line with the anticipated needs of individual children. Reception staff engaged with children well and were responsive to their individual needs. However, paperwork took too long to complete, further exhausting families arriving after long journeys. The support given by Barnardo’s staff and the G4S family care officer to help families settle in was very good. A good quality Barnardo’s family support plan was developed in advance of arrival.

HE.12  It was rare for more than one family to be held at the same time and we saw no evidence of bullying. There was good staff interaction with families, reducing the risk of such incidents. Children were accompanied by care workers and there was ongoing and generally unobtrusive staff supervision of all families when they were in communal areas. Anti-bullying procedures had not been needed, and the intention was, appropriately, to manage any tensions that arose between children without resorting to formal procedures.

HE.13  There had been two self-harm incidents since the centre opened. Paperwork indicated that both were well managed. A detainee at risk of self-harm and subject to an open ACRT (assessment, care for residents and teamwork) booklet told us she was well cared for by centre staff. Fifteen ACRTs had been opened since the centre opened and the quality of documentation was generally good. Case reviews were usually well attended, but did not always include UKBA. A well designed safer suite had been used on three occasions and was an appropriate environment for detainees in crisis. If parents were considered at risk of self-harm, children received good support and care.

HE.14  There were detailed safeguarding guidance and procedures for adults at risk. Arrangements had been made with West Sussex Adult Social Services to refer at-risk adults, but it was unlikely that they would get better care elsewhere.
HE.15 A strong child-centred culture had been developed in the centre. Staff with training and qualifications in social work and child care were always available. All staff had received basic training in safeguarding children, and Barnardo’s training on the safe management of children was being extended to include Reliance escort staff. There were close links between the local authority social services department and UKBA, G4S and Barnardo’s. Jointly agreed procedures and regular multi-agency meetings allowed for relevant safeguarding information to be exchanged. Arrangements were in place to ensure an appropriate level of independent scrutiny. Working relationships between agencies were consistently described as open and transparent. The circumstances surrounding each family’s case were discussed every week. Where incidents involving family members occurred, joint meetings were held in the centre to discuss lessons learned, but these were not always held promptly. The quality of the family welfare form varied depending on the local immigration team managing the case. In some cases we found incomplete information and weak conclusions. The family returns panel had asked for more information and the forms appeared to be improving.

HE.16 Force had been used in relation to six of the 39 families held since the centre opened, with handcuffs used on adults on five occasions. On two occasions minimal force that involved staff taking hold of elbows and escorting had been used to cajole children to the departures area. If the children had been more resistant, the situation might have escalated, raising the risk of injury. Children had become very distressed during forced removals and it was not possible to measure the psychological impact of removal on them. This was despite their needs being anticipated and actively managed by Barnardo’s staff.

HE.17 On two other occasions similar force had been used to take mothers to departures. Full control and restraint had been used with two men and once with a woman. In each case seen there had been significant attempts at de-escalation, and force was nearly always minimal and defensible given the instruction to effect removal. The paperwork was completed thoroughly with clear descriptions of what had happened. Recordings of planned use of force showed generally appropriate management of difficult situations, with some very good examples of care shown by staff. However, camerawork was poor in some cases, with the situation not shown clearly, and in two cases the recording did not start from the point that force was first applied, when the situation was at its most tense.

HE.18 Substantial force had been used in one case to take a pregnant woman resisting removal to departures. The woman was not moved using approved techniques. She was placed in a wheelchair to assist her to the departures area. When she resisted, it was tipped-up with staff holding her feet. At one point she slipped down from the chair and the risk of injury to the unborn child was significant. There is no safe way to use force against a pregnant woman, and to initiate it for the purpose of removal is to take an unacceptable risk.

HE.19 The ‘cool down’ separation room had only been used once and appropriately, but it was an unnecessarily stark room, which was unlikely to encourage calm. The governance arrangements were unclear.

HE.20 Records suggested that half those held at Cedars had asked for legal assistance and in nearly all cases appointments had been arranged for the same or the following day. Detainees could communicate with their lawyers easily by telephone, email and
fax. Solicitors reported positively on arrangements for legal visits. All tested legal websites were accessible.

HE.21 Detainees arrived at Cedars having exhausted their appeal rights. The fact that most families arrived at Cedars from the north of the country suggested differing practices by local immigration teams and inconsistent application of criteria to detain families. Families had been held for an average of less than three days and most were detained for less than 72 hours. Sixteen had been held for more than three days.

HE.22 Parents clearly did not want to be removed from the country, but if it was to happen, the parents we spoke to said they would rather be held at Cedars for a short period than be removed immediately, both to allow time for last-minute judicial review and to prepare themselves and their children for removal. On-site UKBA staff were accessible and the induction interview we observed was reasonably well conducted. The quality of a healthcare letter ('Rule 35') relating to a detainee who might have been subject to torture was better than we normally see.2

Respect

HE.23 Accommodation was high quality and designed around the needs of children. Relationships between staff and families were very good. Diverse needs were met appropriately through an individualised approach. Faith provision was good. Complaints were well investigated. The standard of food was high and parents could cook for their families. Families had easy access to health care. Provision for those with mental health problems was limited. Outcomes for detainees against this healthy establishment test were good.

HE.24 The accommodation was of a very high standard. The apartments were comfortable, most were spacious and all were suitable for families with children of all ages. The centre was very clean and well maintained. It was designed around the needs of children, and the décor reflected its international and multicultural population. Outside areas were attractive. Parents had swipe cards to their rooms and their need for private space was respected.

HE.25 We observed good relationships between staff and families. All parents we spoke to reported very positively on their treatment by detention and Barnardo’s staff, and showed confidence in them even at times of high stress, such as forced removals. Staff were responsive to the individual needs of parents and children of all ages from the start to the end of the process.

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2 Inspection methodology: There are five key sources of evidence for inspection: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections, we use a mixed-method approach to data gathering, applying both qualitative and quantitative methodologies. All findings and judgements are triangulated, which increases the validity of the data gathered. Survey results show the collective response (in percentages) from detainees in the establishment being inspected compared with the collective response (in percentages) from respondents in all establishments of that type (the comparator figure). Where references to comparisons between these two sets of figures are made in the report, these relate to statistically significant differences only. Statistical significance is a way of estimating the likelihood that a difference between two samples indicates a real difference between the populations from which the samples are taken, rather than being due to chance. If a result is very unlikely to have arisen by chance, we say it is ‘statistically significant’. The significance level is set at 0.05, which means that there is only a 5% chance that the difference in results is due to chance. (Adapted from Towl et al (eds), Dictionary of Forensic Psychology.)
HE.26 There was a straightforward and clear equality and diversity policy, and a committee to oversee the management of equality and diversity work. The diversity manager established if families had any particular needs and staff were responsive to requests. There was a well-equipped apartment for people with limited mobility or other disabilities. Staff had all received training in diversity. Cultural events and religious festivals were celebrated. Professional interpretation was used regularly.

HE.27 There were good facilities for detainees to worship in the multi-faith room and in the well-equipped chapel. A team of six chaplains covered major faiths and other chaplains could be brought in as needed. Chaplains were responsive and offered personalised input, such as special services and pastoral support. Positive attempts were made to link family members to churches in the country to which they were returning.

HE.28 Complaint forms in a range of languages were available in the library and in each room. Four complaints had been submitted by detainees while at the centre and all had been investigated thoroughly. Replies were polite and constructive. However, one that was submitted in a different language had still received a reply in English. Child friendly comment forms were available but none had yet been submitted.

HE.29 Detainees were offered good quality food prepared to meet their preferences. Families could eat together or were able to cook for themselves in well-equipped kitchens in their apartments. Healthy snacks and drinks were available in the play areas.

HE.30 There was 24-hour access to nursing services and daily access to a GP. There was no health needs analysis, but one was being developed. None of the health care staff covering Cedars had children-specific qualifications, although some had relevant experience and limited training. There was limited access to a visiting psychiatrist and some support by registered mental health nurses from nearby immigration removal centres. Mental health awareness training had not yet been delivered. The health information received prior to families coming to Cedars was generally good. The observed health care screening was adequate overall, but poor consideration was given to the needs of children and for confidentiality when a parent was asked questions about torture and self-harm in front of her children.

Activities

HE.31 Facilities and resources for activities were excellent. The library was well stocked, attractive and easy to use. Activity planning was age appropriate and tailored to individuals. We observed children engaged fully with a range of semi-structured activities, and purposefully occupied. Outcomes for detainees against this healthy establishment test were good.

HE.32 There was a very good range of facilities, equipment and resources, providing purposeful and stimulating activities for children. The areas for younger children, older children and the gym were all well equipped. Outdoor facilities were also good and included football, basketball and play areas for younger children. Activities rooms were bright and airy. They were well managed and contained stimulating displays, though there was scope to display more children’s artwork in corridors throughout the centre.
HE.33 The library was attractive, well stocked and well used, allowing reasonable access to the internet to research legal information in particular. A small number of Kindles enabled families to access a wide range of foreign newspapers and magazines other than those held in hard copy.

HE.34 Activities were suitable for the different ages and abilities of children. The outcomes of activities were matched to the national curriculum and the early years foundation stage. Where possible, initial planning was informed by the information contained in the family welfare form and discussions at multi-agency teleconferences. The level of detail in the family welfare form about children's educational history varied considerably.

HE.35 We observed children in the playroom engaging fully in a good balance of structured and semi-structured activities, and some free play using the impressive range of resources and toys in the playroom. We also observed children playing happily outside. The unobtrusive supervision by the project workers was appropriate.

**Preparation for removal and release**

HE.36 Families received good support to prepare for removal or release. Families could have daily visits, but the visits room lacked privacy. Access to telephones, email, fax and internet were all good. Removal plans were not always received or fully implemented. Useful country information packs were provided to all families. Efforts were also made to contact support organisations in destination countries. A good range of clothing was available for those who needed it. Grants were regularly provided to help detainees meet immediate needs on arrival and make their way to final destinations. Post-removal follow-up information was limited. Outcomes for detainees against this healthy establishment test were good.

HE.37 A high level of welfare support was given to detainees while they were in the centre by Barnardo's and G4S workers. Practical support for families being released rather than removed had also been very good.

HE.38 There had been few visitors. Social visiting times were good and property could be brought in for detainees. The visits area was bright and welcoming, but afforded little privacy. It could not comfortably accommodate more than one family. Detainees were able to keep mobile phones without cameras, or were provided with one by the centre. On observed removals, some were able to retain their phones during escort to the airport but others were not – the rationale for this was not clear. Access to internet, fax and email was good, but restrictions on social networking sites were excessive, given the importance that children place on such media.

HE.39 The removal plan required details of post-return support to enable the family to reach a final destination, which had to be approved by the independent panel. However, the views of the panel sometimes did not arrive at the centre until after removal. Escorts were routinely briefed on the details of the approved removal plan, but not all escort team leaders spoken to were aware of it. Some elements of removal plans had not been followed and the family returns panel had not been made aware of such discrepancies. Police were appropriately called to investigate an allegation of assault by escort staff during a removal attempt, but a second attempt at removal was not delayed to allow completion of the investigation.
Individualised and very helpful country information packs were provided to families setting out details of welfare organisations, schools, hotels and other useful information. If detainees consented, contact with appropriate organisations in other countries was helpfully made by Barnardo's in advance of departure. A personalised bag of age-appropriate toys and books was put together for each child on leaving the centre. A good range of clothing was available for detainees who needed it, and there was a fund to purchase more if needed. Grants were available for families to get safely to a final destination and to meet immediate needs. Very little information had so far been received from or about families post removal.

Main concern and recommendation

Concern: Force had been used against a pregnant woman for the purposes of removal rather than because of an imminent risk of harm. This posed an unacceptable risk to the unborn child.

Recommendation: Force should never be used to effect the removal of pregnant women or of children. It should only ever be used in relation to such vulnerable groups in order to prevent harm.
Section 1: Safety

Escort vehicles and transfers

Expected outcomes:
Families under escort are treated safely, decently and efficiently. Due regard is given to the specific needs of children.

1.1 Escort journeys were generally well managed. Staff were sensitive to the needs of children, and proactive and respectful in caring for families. Some families said they were given insufficient time to pack by UK Border Agency (UKBA) arrest teams. Not all escorts were aware of the approved removal plan and the detail in at least one was not followed. The number of night time moves was high. Inappropriate language was used by escorts within earshot of one family.

1.2 As well as speaking to families in the centre about their experience of escorts, we inspected four escort journeys. They were from Glasgow to the centre via a plane and coach journey; a coach journey from Rochdale to the centre; and two coach journeys from the centre to the point that families boarded aircraft at Heathrow airport. All were managed well overall. Spacious coaches, appropriate for the transport of children, were used on each of the observed escorts. However, we saw one family arrive at the centre after a lengthy journey in a smaller van, accompanied by several escort staff and a paramedic. The child on board the vehicle had been very restless and found the journey difficult to manage as he was unable to move around.

1.3 UKBA arrest teams arrived at family homes early in the morning at around 7am. Records indicated that families often had only one hour between arrest and handover to escorts, which was insufficient for them to receive a full explanation about what was happening, have breakfast, dress, pack their belongings and prepare their children. Most parents complained about the lack of time to pack, and one felt the UKBA team, in uniforms including stab vests, was intimidating. The children we spoke to in one family said they were upset by the team, and said they were very noisy, banging on doors and walls and shouting. Families were taken by the arrest team to a secure location, either a police station or a reporting centre, for handover to the Reliance escort team. We observed one handover carried out in a public place outside a police station, causing embarrassment. It drew attention as the 10 UKBA and seven Reliance staff were all in uniform. During another handover we observed at a reporting centre, the number of UKBA and Reliance staff crowded into a small area with the family was inappropriate and unnecessary given that the family was entirely compliant.

1.4 Families reported positively on their treatment by escort staff. Both in-country and overseas escorts were called upon to transport families to Cedars, and subsequently to the airport for removal. Vehicles used were generally large commercial coaches with toilet facilities. They were clean, fit for purpose and had the requisite child seats fitted. Escort records were initiated for all detainees, and record keeping was thorough and accurate in the cases examined.

1.5 Journeys were sometimes very long (we observed one that took a total of 11 hours from Scotland), but staff care for families was generally excellent. They were proactive in the way they looked after families, quickly building up good relationships and offering support and reassurance throughout. Security on board vehicles was not overbearing and family members...
were permitted to sit together. Food and drinks were offered regularly and also given on request, and those being transported to the airport for removal were each given an individual bag containing sandwiches, fruit and drinks by the centre. Escorts comfortably and regularly conversed with families, and informed them of what was happening at every stage. We observed a telephone interpretation service being used for one family during escort to facilitate this. Care was taken to interact with the children and efforts made to keep them entertained with age-appropriate toys and DVDs. Paramedics were routinely present during escorts, and we observed them responding quickly to specific health care concerns and administering medication when required (see health care section).

1.6 Escort teams should have been briefed on the details of the removal plan approved by the independent family returns panel to ensure that it was followed. However, one escort team leader we spoke to was unaware of the plan. A significant number of families (20 out of 39) had been subject to tiring night time moves to meet flight times. There was evidence in some cases that alternatives had been considered by caseworkers but were unworkable because of the scheduling of onward flights or strict time criteria set by receiving countries. However, on one observed night time removal the escort vehicle stopped at 4am for an hour and a half in a car park and then for a further 45 minutes in a lay-by to pass time, which was a long time for a family with three young children to be waiting by the roadside. The removal plan in this case had advised that the family should wait for their flight at Cayley House, an airside holding facility at Heathrow with reasonably comfortable family waiting areas. We were told by escorts that ticketing and security opening times meant this was often not possible. This had not been fed back to the independent family returns panel.

1.7 Although staff undertaking the family escorts that we observed were respectful, and largely adopted a calm and considerate approach, there were some shortcomings. During an unsuccessful removal attempt where a detainee became distressed and resisted boarding an aircraft, staff allowed themselves to be drawn too readily into the heat of the moment. Several were talking loudly to the detainee at the same time and some almost shouting at her that she was not going to be made to go. The children, including a two year old who became very distressed, witnessed the incident. A calm approach, with just one person speaking quietly to the detainee, would have de-escalated the situation more quickly. We also observed offensive language and gestures used by a member of escort staff (‘fuck off’ and a two finger gesture), on an unrelated escort with an adult detainee, while talking to a colleague on a family escort. This was within the hearing and sight of a family, including two young children. This was inappropriate and unprofessional.

Recommendations

1.8 At the point of initial arrest parents should have adequate time to prepare themselves and their children for their journey, and UKBA teams should conduct the arrest as sensitively, calmly and quietly as possible.

1.9 The handover from arrest teams to escorts should be conducted in a private location out of public view.

1.10 Escort staff should remain calm, polite and respectful at all times.

1.11 Families should only be transported in appropriate and spacious vehicles, and held on them for the minimum possible time.
1.12 Removal plans should be adhered to, and any deviations should be fed back promptly to the independent family returns panel.

## Arrival

**Expected outcomes:**
Families arriving at the centre are treated with respect, have the correct documentation, and are held in safe and decent conditions.

1.13 Preparation for arrival was very good. Detailed information was received in advance and shared with appropriate staff. The arrivals area was welcoming, and staff were sensitive to the needs of children. Reception paperwork took too long to complete. Apartments were individualised taking into account the preferences of children. Families were allocated a dedicated care officer and a key worker.

1.14 Thirty-nine families had been detained at Cedars from the centre opening to date, comprising 52 adults, 32 children under the age of five years, 27 children aged 5-10 years, 21 children aged 10-15 years, and four children aged 15-18 years. The length of detention ranged from 14 hours to 170.5 hours.

1.15 Preparation for the arrival of families was very good, and demonstrated well established working relationships between Barnardo’s, G4S and UKBA. The family welfare form was received at the centre in advance of arrival and shared with senior staff. A conference call was held with the UKBA Office of the Children’s Champion, the UKBA Family Returns Unit (FRU) and the local immigration team managing the case to discuss concerns such as potential safeguarding issues and specific requirements. We saw minutes of these calls which we were told were fed back to the Independent Family Returns Panel by the FRU for their consideration when assessing the removal plan. Barnardo’s produced a summary sheet of relevant information, which was well communicated to appropriate staff, including health care, via a series of planning meetings and daily briefings, some of which we observed. All key issues were discussed, including risk information such as self-harm. An arrival plan, a departure plan and a support plan for the duration of the family’s stay were also produced. Those we saw were individualised and effectively addressed the particular needs of each family.

1.16 The arrivals area was attractive and welcoming, and age-appropriate toys, books and games were selected and set out in advance of arrival. A dedicated Barnardo’s key worker and G4S family care officer were allocated to the family and present on arrival, plus extra staff from both if there were several children. At observed arrivals the handover between escorts and G4S was detailed, and highlighted risks. All detainees had a completed IS91 form (authority to detain). Staff were sensitive to the needs of the family, offered them food and drink and engaged the children extremely well while parents were with reception staff. A nurse was present and all new arrivals underwent a health care screening. Adults were searched out of sight of the children, and children were not searched. A free telephone call was offered, including to children if they wanted to call friends or family.

1.17 However, the reception process was lengthy, with documentation taking too long to complete and staff unfamiliar with the computer system, further exhausting families arriving after long journeys. One family with four children had taken 11 hours to reach the centre. The reception process then took a further two and a half hours, although staff took the children off for a tour around the centre to keep them occupied. During the tour the younger children were describing
the facilities as ‘wicked’ and ‘awesome’ and seemed to have little sense of the seriousness of their situation. All detainees were photographed. The children’s photographs were taken with due regard to their age and understanding. Staff taking the photos engaged with the children beforehand, explaining what they were doing, and showed them the photos afterwards.

Apartments were individually prepared for families, with particular attention paid to the needs and preferences of children. A range of toys was set out in the living room, and books suitable to the age of each child were left by their beds. Barnardo’s provided individualised bags with the child’s name on, containing, for example, a soft toy for younger children or gel pens and a notebook for older children, which were placed on the child’s bed. Barnardo’s staff also observed from a distance the management of children in the arrivals area to pick up learning points and ensure that apartments were further individualised, based on the toys children were taking an interest in during arrival. Cupboards were stocked with a range of food, and a basket of basic toiletries, nappies and other essentials was put together. A welcome pack containing key information about the centre and other helpful leaflets was also provided, although we were told some information was available in English only. The family care officer and Barnardo’s key worker accompanied families to their apartment to show them around, help them settle in and go through the welcome pack.

Recommendations

The reception process should be undertaken quickly and all relevant staff should be familiar with completing reception procedures.

Key information should be available in an appropriate range of languages and formats including notices, booklets and DVDs.

Bullying and personal safety

Families feel and are safe from bullying and victimisation.

There was no evidence of bullying. Safer community committee meetings were well attended and reports comprehensive. It was not clear if staff had the authority to separate detainees.

There was no evidence of bullying and it was rare for more than a single family to be held at the same time. The anti-bullying strategy, published in May 2011, formed part of the safer community strategy document for Cedars. The safer community committee met monthly, covered suicide and self-harm, and was chaired by the residential manager. Meetings were well minuted and attendance good. The safer community report, published for each meeting, was comprehensive and covered ACRTs (assessment, care in residence and teamwork), self-harm incidents, referrals for mental health assessments and dirty protests. As the numbers passing through the centre were low, it was not possible to identify trends.

If bullying was suspected, staff would interview the perpetrator. If no evidence of bullying was found, a written warning was issued and an anti-bullying document opened for monitoring purposes. In cases where bullying was proved, the centre could monitor the detainee, arrange a meeting with a religious leader or transfer the detainee to another establishment. Detainees could also be removed from association. As the centre was not run under the Detention Centre
rules, it was not clear under what authority staff separated detainees (see casework section). Victim support booklets could be opened to support victims.

1.24 The strategy mentioned children, but the intention was for Barnardo’s social workers to deal with bullying between children informally, which was appropriate. Children were very closely monitored while at the centre.

Suicide and self-harm

Expected outcomes:
The centre provides a safe and secure environment which reduces the risk of self-harm and suicide.

1.25 Detainees at risk of suicide or self-harm were well cared for. ACRTs were generally of good quality and case reviews were regular, but UKBA did not always attend. No children had been placed on an ACRT. The primary cause of stress to detainees was imminent removal. There had been few self-harm incidents.

1.26 Detainees at risk of suicide or self-harm were well cared for. Detainees in crisis were managed through the ACRT care planning system. G4S and Barnardo’s staff had completed ACRT foundation training and there were five ACRT assessors, though more were needed.

1.27 Fifteen ACRTs had been opened at the centre and one detainee had arrived on an open ACRT. The quality of ACRT documentation was generally good, although triggers were not always adequately recorded. There was confusion about the significance of triggers. Some ACRTs recorded the manifestations of the detainee’s crisis, for example, ‘statement of intent to kill herself’, rather than the cause. One case did not record triggers at all. In all cases it was evident that imminent removal was the primary cause of the crisis. Immediate action plans and assessment interviews were good. Care maps were generally good, though in one case a care map had not been completed. Case reviews were regular and multidisciplinary but UKBA did not always attend. We attended a review which was conducted sensitively. The recording of observations was timely and entries detailed, suggesting that staff took a caring approach to detainees and talked to them in depth. We noted cases where chaplains had provided support for detainees. A detainee on an open ACRT told us that the staff were ‘great’ and that if she needed anything it was provided. There were separate booklets and policies for children on ACRTs, although they were much the same as the adult versions. No children had been placed on an ACRT since the centre opened.

1.28 There had been two incidents of self-harm, each of which was thoroughly documented. A detainee on constant watch had put a handbag strap around her neck but did not harm herself. She was seen promptly by the centre nurse. Another detainee on an ACRT had punched her own face in frustration causing her tongue to bleed. An ambulance was called but the detainee refused hospital treatment.

1.29 The safer suite, Orchid, had been occupied three times since the beginning of 2012. A window between each room and the hallway enabled staff to monitor detainees on ACRTs without entering the room. Not all detainees on constant watch were placed in Orchid if they had settled into another apartment. In these cases, staff sat in the hallway with the detainee’s door ajar so they could be monitored. A blue night light was used so the main bedroom light did not
have to be turned on. Reviews of Barnardo’s case files showed that children of detainees in crisis received high levels of support.

1.30 A food and fluid refusal policy had been published in October 2011. Systematic monitoring of food consumption was impossible because detainees could cook and eat in their apartments. Despite this, staff were alert to food refusal and, as far as possible, kept an eye on what detainees were eating. If they knew that a detainee had missed a meal, the detainee was asked why. Extra fruit and snacks could be put in the apartment.

1.31 Staff had not strip-searched any detainees.

Housekeeping point

1.32 More staff should be trained as ACRT assessors.

Safeguarding adults

**Expected outcomes:**
The centre promotes the welfare of all detainees, particularly adults at risk, and protects them from all kinds of harm and neglect.³

1.33 No at-risk adults had been held at the centre. However, potentially at-risk adults received a high level of care and support. Detailed procedures and guidance had been developed and referral pathways to the local authority were in place.

1.34 No at-risk adults had been held at the centre but potentially at-risk adults received a high level of care and support. We reviewed the files of two mothers with mild mental health problems. Prior to attending the centre, a conference call had been held between Cedars’ UKBA staff, the local immigration team, Barnardo’s and the family returns unit to plan their care. Arrival, family support and departure plans were implemented. While at the centre, the family received support from Barnardo’s family project and social workers. Detailed observation and interactions recorded by Barnardo’s showed a high level of care and support.

1.35 Detailed procedures and guidance on adults at risk had been developed and arrangements made with West Sussex Adult Social Services to refer at-risk adults. To date, no referrals had been made. It was unlikely that at-risk adults would receive better levels of care and support than they would at Cedars.

³ We define an adult at risk as a vulnerable person aged 18 years or over, ‘who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation’. ‘No secrets’ definition (Department of Health 2000).
Safeguarding children

Expected outcomes:
The centre promotes the welfare of children, particularly those most at risk, and protects them from all kinds of harm and neglect.

1.36 Effective joint work had been carried out between the agencies involved to ensure that suitable policies and procedures were in place to safeguard children. The meeting structure enabled relevant information to be shared among the appropriate people and there was sufficient independent oversight. The balanced skill mix of staff working at the centre helped to ensure that children were cared for properly and were adequately protected.

1.37 Some children were very upset at the point of arrest and removal in particular (see arrival and use of force and separation sections), and they were clearly affected by their parents' distress. However, there was no evidence that the conditions in detention were themselves an issue, and procedural safeguards were good. The local authority and local safeguarding children board had worked closely with Barnardo's to produce safeguarding guidance and procedures for the centre. These had been jointly agreed with UKBA and G4S. A memorandum of understanding had also been produced which outlined the partner agencies' responsibilities for child protection.

1.38 The family welfare form was the most consistent basis of information, although the quality varied according to the local immigration team managing the case. In one case we found incomplete information and conclusions that did not appear to be supported. The form stated that the relevant social work department did not think the proposal would have a negative impact on the children; in fact, no judgement, positive or negative, had been made. The family returns panel had occasionally had to ask for more information and the forms showed signs of improvement.

1.39 Working relationships between the partner agencies in the centre were described to us as open and transparent by all those involved. Regular multi-agency meetings took place in the centre which enabled the exchange of safeguarding information about families. The local authority representatives who attended these meetings appropriately saw their role as scrutinising and challenging the joint arrangements between the three agencies, as well as examining the overall effectiveness of safeguarding. In consequence, child care arrangements at Cedars were subject to a high level of external scrutiny.

1.40 There had been no formal child protection referrals to the local authority since the centre opened. Staff had twice consulted the local authority for advice on how best to look after children.

1.41 A wide range of staff with relevant experience and training in child care worked at the centre. Some of the project workers, who undertook practical care work with children, had vocational qualifications. Two Barnardo's staff, who were qualified social workers, took lead operational responsibility for child protection matters in the centre. Other Barnardo's staff were also social workers. An on-call arrangement ensured that a qualified social worker was always available to attend the centre. All centre staff had received basic training in safeguarding and child protection and had been vetted to at least enhanced Criminal Records Bureau level.
1.42 Each family’s case was routinely discussed each week and additional meetings were arranged to discuss any incidents involving family members and lessons learned. These were not always held promptly. The removal of a pregnant woman and her family had not yet been discussed, although it had happened more than a month previously (see use of force and separation section).

1.43 The safeguarding procedures and guidance related only to how children and young people were protected while living at Cedars. Post-removal contact with families was very limited (see preparation for removal and release section).

**Recommendations**

1.44 ‘Lessons learned’ meetings should be held promptly.

1.45 UKBA should ensure consistent quality of family welfare forms.

**Use of force and single separation**

**Expected outcomes:**
Force (control and restraint) and single separation are only used legitimately and as a last resort and for the shortest period necessary.

1.46 Force had been used in relation to six families. It followed significant attempts at de-escalation. Documentation was sound, but recordings of the incidents were not always adequate. The use of force on a pregnant woman to effect removal was particularly concerning, given that it was impossible to do this safely. Two children had been escorted using ‘physical control in care’ techniques. In these cases force was used to effect removal rather than to prevent harm. The separation room was stark though it had only been used once.

1.47 Force had been used with six of the 39 families held since the centre opened and handcuffs had been used on five occasions. On two occasions, ‘physical control in care’ had been initiated on children by staff to effect removal, rather than to prevent harm. It involved staff taking hold of elbows and escorting the children to the departures area. The compulsion was minimal in these cases but if the children had resisted, there was a risk of escalation leading to the possibility of injury and psychological trauma to the children involved. Similar techniques had been used twice to take mothers to the departures area. Full control and restraint had been used with two men and once with a woman, who was eventually carried to the departures area.

1.48 Children had become very distressed during forced removals of their parents, despite anticipation of their needs and active management of the children by Barnardo’s staff. The latter usually removed them from the scene of conflict between parents and staff and reunited them when the situation had calmed down.

1.49 In each case there appeared to be significant attempts at de-escalation and persuasion. UKBA staff saw families who suggested they would not comply to explain that force, including handcuffs, could be used. Barnardo’s staff also encouraged families to leave compliantly and took the main responsibility for explaining to children that, if they resisted, G4S staff might compel them to leave. Force was usually minimal and defensible given the instruction to effect removal. Documentation was thorough with clear descriptions of the incidents.
1.50 Recordings of planned use of force showed generally appropriate management of difficult situations, with some very good examples of care shown by staff. However, camerawork was poor in some cases: incidents were not shown clearly, and in two cases the recording did not start when force was first applied, when the atmosphere was at its most tense with the greatest chance of excessive force being applied. During one removal, a paramedic had operated the hand-held video camera, which was inappropriate and a distraction from the primary duty to the safety of the detainee.

1.51 In one case, an escort had grabbed a disruptive detainee by the hair before reverting to conventional techniques. This had been the subject of a complaint which had been investigated and upheld. The member of staff was undergoing disciplinary procedures.

1.52 Force had been used in one case to take a pregnant woman resisting removal to departures. She had been placed in a wheelchair to assist her to the departures area. When she resisted, the wheelchair was tipped-up with staff holding her feet and pushing the chair a considerable distance. This was not an approved technique. At one point she slipped down from the chair and, although she appeared to be unhurt, the risk of injury was significant. This use of force on a pregnant woman presented an unacceptable risk to the health of an unborn child. It also placed a considerable burden on the staff tasked with removing her (see main recommendation HE.40). This is despite the fact that the woman was provided with good health care oversight and support throughout.

1.53 The pregnant woman’s husband had been disruptive the night before his family’s planned removal from Cedars. He had been shouting and kicking doors, causing some damage, and at one point it was judged that he had been trying to separate health care staff offering to examine his wife to take them hostage. Staff were sufficiently concerned by his behaviour to take him to the ‘cool down’ separation room in full personal protection equipment before his removal. The recording of this event showed that he was passive and disengaged throughout and the handcuffs were correctly removed en route after about five minutes.

1.54 A staff member who had been the family’s care officer on the previous day was called and went into the cool down room to speak to him, which appeared to calm the situation. The detainee remained in separation for about two hours on constant watch until the arrival of overseas escorts.

1.55 The cool down separation room was used if residents became violent or refractory (see photograph, Appendix II) until they became calm and compliant. We were told that it was only used for a maximum of two hours. The governance of this separation was unclear. Detention Centre Rule 40 documentation was completed, but this had no jurisdiction in Cedars. We did not see a separate log for use of the room, though a running contact log was written into a detailed incident report. The room was stark and not conducive to helping people calm down. Two apartments were also certified under Rule 40 of the Detention Centre rules (see self-harm and suicide, and accommodation sections).

Recommendations

1.56 Paramedics on escorts should focus on their primary duties and not operate hand-held cameras.

1.57 Separation should be governed by clear rules and staff should be aware of how to record its use. The unit should be less stark, with some furniture and decoration.
Legal rights

Expected outcomes:
Detainees are fully aware of and understand their detention. Detainees are supported by the centre staff to freely exercise their legal rights.

1.58 Legal advice was available through a Legal Service Commission rota and appointments were made promptly. Detainees could easily communicate with solicitors. Solicitors reported positively on arrangements for legal visits.

1.59 Detainees had exhausted their statutory appeal rights before arrival but many continued to fight their removal by submitting fresh claims and applying for judicial review. Two firms of solicitors provided advice through a Legal Service Commission rota and could instigate urgent high court action by way of judicial review to prevent removals.

1.60 During induction interviews, UKBA staff checked if detainees had legal representation. UKBA records showed that 21 of 43 detentions had had legal representation on arrival and 22 had asked for assistance. In all but one case, appointments had been arranged for the same or the following day. Two-thirds of detainees requesting assistance through the rota had face-to-face appointments and a third telephone appointments. Notices around the centre promoted the Office of the Immigration Services Commissioner but not the Legal Ombudsman.

1.61 Detainees and solicitors confirmed that they could easily communicate with each other. Solicitors reported positively on arrangements for legal visits and said that centre staff were helpful and accommodating. They were permitted to take laptops and mobile phones without cameras into the centre. The legal visits room was spacious and fit for purpose. Detainees could easily access legal websites.

Housekeeping point

1.62 Notices promoting the Legal Ombudsman should be prominently displayed.

Casework

Expected outcomes:
Detention is carried out on the basis of individual reasons that are clearly communicated. Detention is for the minimum period necessary.

1.63 Most families arrived from the north of the country. An on-site UKBA team liaised with case owners around the country. Detainees were interviewed on arrival and before removal. The average length of detention was just under three days. A high quality Detention Centre Rule 35 report had led to a review of detention.

1.64 Most families arrived at Cedars from the north of the country. The centre’s UKBA staff could see no reason for this other than the criteria for detaining families being applied inconsistently by local immigration teams.
The on-site UKBA team comprised five staff who liaised with case owners in UKBA offices around the country. UKBA staff interviewed detainees on arrival. An induction interview that we observed was reasonably well conducted, although the officer used some obscure language, for example a ‘91R’ rather than ‘reasons for detention’.

UKBA staff conducted exit interviews shortly before detainees were removed to determine whether detainees would depart voluntarily and to explain the possibility of force being used to effect removal (see use of force and separation section).

The average length of detention was two days, 21 hours, 47 minutes. Families could only be held for more than 72 hours with ministerial approval and only for a maximum of seven days. Fifteen of 39 families had been held for more than 72 hours and the longest time spent at the centre was seven days, two hours, 29 minutes. This detainee had received an injunction preventing her removal and was to be released at 11am but she chose to eat lunch at the centre, which took her over the seven day limit.

Families clearly found the process of detention traumatic and did not want to be detained or removed from the country. However, the parents we spoke to said they would rather be held in an environment like Cedars for a short time than be removed immediately, to allow time for last-minute judicial review and to prepare themselves and their children for removal. Many had arrived at the centre after long journeys and needed time to settle their children.

The centre did not operate under Detention Centre rules but under interim operating standards. During our inspection, health care staff submitted a Detention Centre Rule 35 report recording a detainee’s allegation of torture. The quality was better than we usually see: it was typed and described the detainee’s emotional state and how the injuries occurred. In light of the report, UKBA reviewed detention and treated it as a further representation. The replies were issued after our inspection.

**Recommendations**

1. **UKBA should ensure that local immigration teams are consistent in their approach to detention.**

1. **The legal basis for the operation of Cedars should be clear.**
Section 2: Respect

Accommodation

Expected outcomes:
Families are held in decent conditions in an environment that is safe, well maintained and child-friendly.

2.1 Accommodation was high quality, clean and appropriately decorated. Families could experience a semblance of family life in the self-contained apartments. It was easy for families to wash their clothes.

2.2 Families were located together in nine self-contained apartments with kitchens, baths or shower rooms, and living rooms. The smaller apartments accommodated two people and the largest up to six people. The furnishings were altered to suit the specific needs of families, assessed before and at the point of arrival by Barnardo’s staff, and depended largely on the ages of the children. All apartments were attractive, well equipped and designed to meet the needs of families of varying sizes (see photographs, Appendix II). Parents had swipe cards to get into their rooms and could move around the centre easily.

2.3 Lavender and Orchid suites were designed to accommodate families presenting particular welfare concerns and were located in the east wing, closer to the departures area. Orchid had been designed to house residents at risk of self-harm (see suicide and self-harm section) and had bedrooms, kitchen, living room and shower room. Lavender accommodated families who were disruptive. It did not have a kitchen. Lavender had not yet been used and Orchid had only been occupied three times. A well adapted ground floor apartment was available for detainees with mobility problems. Pregnant women were also located here.

2.4 The communal areas were attractive and clean, and professional cleaners were constantly visible in the centre. Detainees could wash their clothes easily in the laundry rooms.

Positive relationships

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

2.5 Relationships between families and staff from all agencies were good. The level of individual care and attention given to adults and children was excellent.

2.6 Staff were responsive to the individual needs of parents and children. We observed good relationships between staff and families throughout the inspection. All parents and children we spoke to talked very positively of their treatment by detention and Barnardo’s staff. It was notable that, even during forced removal when tensions were high, parents continued to show confidence in the care that Barnardo’s and G4S staff were providing to their children.
Equality and diversity

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

2.7 Staff dealt with family members as individuals and considerable effort was put into attempts to understand the distinctive needs of family members while they were at the centre. There was an adapted apartment for those with mobility problems. Telephone interpretation was used fairly regularly.

2.8 The equality and diversity manager received advance background information on all families being admitted to the centre and usually met them early on the day after they arrived. This initial contact took the form of a ‘guided conversation’ to establish if any members of the family had particular needs during their short stay. This often involved dietary or religious requests which were usually met.

2.9 The equality and diversity policy was clear and straightforward. It was based on relevant legislation and guidance and reflected the specific characteristics of Cedars. Given the small scale of the unit and the high staffing levels, there was a strong emphasis in the policy on treating detainees as individuals and on learning from experience.

2.10 Although he had not completed any training for this role, the manager of religious affairs had designated responsibility for equality and diversity. He chaired a quarterly committee set up to oversee equality and diversity work. The committee had met on three occasions and was well attended by staff from G4S, Barnardo’s and the UK Border Agency (UKBA), and representatives from the health care and catering departments. Much of the early discussions had focussed on promoting staff awareness of diversity and equality.

2.11 No family member had made a complaint about equality or diversity but records showed an appropriate level of self-criticism by staff who had made a mistake in their treatment of a detainee. While the conduct of staff whom we observed was good, we were told that earlier in the year two members of staff had been suspended as a result of inappropriate comments.

2.12 All staff had completed basic training in equality and diversity as part of their induction. There were regular awareness-raising activities for centre staff, such as quizzes and small group presentations. Religious festivals and cultural events were celebrated every month whether or not families were present.

2.13 We were told that the majority of family members arriving at the centre were able to communicate in English. Telephone interpretation was available and had been used reasonably frequently given the small population. There was no restriction on its use.

Housekeeping point

2.14 The manager designated with lead responsibility for equality and diversity should receive formal training for this role.
Faith and religious activity

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

| 2.15 | The religious and spiritual needs of detainees were well catered for. The facilities available for detainees to worship were good and they had ready access to chaplains, who responded sensitively to their circumstances. |
| 2.16 | The manager of religious affairs was always on site when families were present. He normally met members of the family at breakfast or lunch the day after they arrived and then showed them the facilities for worship. These consisted of a small multi-faith chapel for use by Christians, Jews and Buddhists, and a small multi-faith room, which was used by Muslims, Sikhs and Hindus. These areas were both well equipped and provided a suitable space for detainees to pray or to spend time in private. |
| 2.17 | The chaplains communicated with families on a personal basis and, for example, offered to organise a special service if family members requested this, something which we observed during the inspection. Given the stressful nature of placement at Cedars, chaplains tried to be as constructive as they could towards family members even if this consisted simply of listening to their problems. |
| 2.18 | The centre and two other centres nearby were covered by a team of chaplains representing all the major faiths. Approximately half the families at the centre were Muslim and about a quarter, Christian. The manager of religious affairs made sure that any family member who wanted to see a chaplain of their own faith was able to do so. The Christian chaplain and the visiting Muslim chaplain were both on call. Chaplains were often present at removals, when they tried to comfort detainees in distress through prayer. |
| 2.19 | Initial training for centre staff included religious awareness, which covered matters such as searching and handling of religious items. With families’ agreement, chaplains tried to link them with members of their own church in the country to which they were returning. |

Complaints

Expected outcomes:
Effective complaints procedures are in place for families.

| 2.20 | Complaints forms were available in a range of languages. Five complaints had been submitted and investigated thoroughly. Replies were constructive but always in English. |
| 2.21 | Detainees could use the UKBA detention services complaints system. Complaint forms in English and 14 other languages were available in the library which contained three complaints boxes for G4S, UKBA and the Independent Monitoring Board (IMB). While it was necessary to have a separate complaints box for the IMB, detainees may not have been able to distinguish between the different agencies in the centre. |
2.22 Four detainees had made complaints, not all of which related to centre staff, and a third sector organisation had made a complaint. Complaints were investigated thoroughly and reasonably quickly. Replies were polite and constructive but always in English, even if the complaint was in a different language. Some complaints were found to be partially substantiated. UKBA kept a record of complaints made but not of outcomes. As there were so few complaints, it was not possible to monitor trends, but complaints were discussed at safeguarding meetings.

**Recommendation**

2.23 Complaints should be replied to in the language of the complaint.

**Housekeeping point**

2.24 There should be one complaints box for G4S and UKBA.

**Health care**

**Expected outcomes:**
Health services are provided at least to the standard of the NHS, include the promotion of wellbeing as well as the prevention and treatment of illness, and recognise the specific needs of displaced families who may have experienced trauma.

2.25 Health care services were adequate and residents had good access to nursing and medical staff. There was limited access to adult mental health services and child and adolescent mental health services (CAMHS), which was about to be reviewed. In view of the short periods that residents spent at Cedars, no other health care services were provided on site. Clinical governance arrangements were being developed in line with the new organisational requirements.

2.26 Nursing services were provided by G4S Integrated Services and GP services by Saxonbrook Medical Centre. Staff were well supported by a clinical nurse manager and a deputy nurse manager. Nursing staff were available 24 hours a day when families were in residence. There was access to a GP each morning. There was little need for other health care services. Health care staff covered the nearby Brook House and Tinsley House immigration removal centres (IRCs) as well as Cedars, but regular staff were usually allocated to work at the centre.

2.27 We were told that a health needs assessment was being undertaken for all IRCs. A range of policies and procedures were being updated to conform to G4S organisational requirements. A training programme was being developed and staff were to be offered training in intermediate life support, mental health awareness, nurse triage and assessment, and care in residency. Neither the nurses nor the GPs had up-to-date children-specific qualifications, though some had relevant experience.

2.28 Medicine policies and procedures were in place and up to date. There was an up-to-date prescribing formulary, although we noted that not all medical literature, for example the British National Formulary, was up to date. There were no patient group directions, which were being developed. One nurse was a prescriber, but she did not use these skills at the centre. Medication was administered by nursing staff at times to suit family members, but it could not be held in possession by any residents, which was an excessive restriction. On discharge,
residents who needed it were given 12 days' supply of malarone (an anti-malarial medication) and a mosquito net.

2.29 There were two health care rooms, one large room and one room used by the GP with a couch in a small adjoining examination area. A larger room in the reception area was used for patient assessments and day-to-day work including storage of medicines. The rooms were modern and had a good range of equipment. The environment was compliant with infection control requirements.

2.30 A range of information was available in different languages, although we were told that it was difficult to get hold of translated medical information. Written questions in a range of languages were available for reception screening and staff had access to telephone interpretation services. Health care logs showed that interpretation services had been used by health services staff six times since the opening of the centre.

2.31 There was weekly access to a psychiatrist. This service was shared with Brook House and Tinsley House and only two people could be seen per session which could result in delays when Cedars residents needed an appointment. This was under review. A mental health nurse from Brook House or Tinsley House was available when required. There was limited contact with CAMHS and no mental health awareness training for any staff.

2.32 We observed a family arrive in reception and the nurse received a comprehensive handover from the paramedic escort in the health care room, which preserved confidentiality. We were aware that this did not always happen. The clinical nurse manager identified a resident who had not been adequately assessed or treated by a paramedic during an escort.

2.33 The reception screen, an electronic template, included questions about physical and mental health, substance use, and learning difficulties. This was used appropriately to assess the family, although we noted that the mother was not afforded sufficient confidentiality as the children accompanied her to the health care room and remained there for her assessment. This meant that they overheard inappropriate information on her physical injuries which related to potential torture and mental health. The whole family was assessed by the GP the next morning.

2.34 All medical records were kept electronically using Cross Care, an IT system. Additional information was kept in a locked cupboard and filing cabinet in compliance with data protection and Caldecott guidance. We observed appropriate information sharing, including medical concerns. However, insufficient medical information had been received about a family due to arrive at Cedars within the next few days, in particular a child who had been assessed for in-patient psychiatric treatment. This information would have been essential to his safe management. We were told that this case had been deferred pending medical assessments.

**Recommendations**

2.35 Parents should have medication in possession unless individual risk assessment indicates otherwise.

2.36 A health needs assessment should be undertaken, including a mental health needs assessment. Appropriate access to adult, child and adolescent mental health services should be available.

2.37 All clinical staff should receive training in child-specific care and treatment.
2.38 Parents should be able to discuss their medical needs with health care staff in confidence.

2.39 All relevant health care information should be received before families arrive on site.

Housekeeping points

2.40 Centre staff and staff undertaking health care duties on escorts should exchange full handover information.

2.41 All medical literature such as the British National Formulary should be up to date.

Catering

Expected outcomes:
The everyday catering needs of families are met and special diets are catered for.

<table>
<thead>
<tr>
<th>2.42</th>
<th>The quality of food provided was of a high standard and efforts were made to meet individual dietary requirements.</th>
</tr>
</thead>
</table>

2.43 The catering manager received information in advance of a family’s arrival and tried to anticipate the family’s diet from their nationality and age. Food options were discussed with family members and, if necessary, special items were bought. The menu was designed to meet the individual requirements and preferences of family members. A children’s menu was available, as well as special diets, including one for pregnant women.

2.44 Kitchen staff made sure that suitable food was available for families at all times of the day and night. Detainees could eat together in the communal dining area or cook for themselves in their apartments and eat together as a family. A wide range of food products was provided for this purpose and staff were responsive to special requests. Healthy snacks, including a variety of fruit, and drinks were available throughout the day in the play rooms and in the reception and departure areas. Detainees reported positively on the quality and quantity of food, though many adults in particular were too anxious to focus on the food.
Section 3: Activities

Expected outcomes:
The centre encourages activities to preserve and promote the mental and physical wellbeing of detainees.

3.1 A very good range of facilities provided purposeful, stimulating activities for children, particularly those of primary school age. The small library was stocked with appropriate texts. Activities were well planned and outcomes were matched to national curriculum and the early years foundation stage. The detail in family welfare forms about children’s previous educational history varied considerably.

3.2 A very good range of facilities and equipment provided purposeful, stimulating activities for children. Facilities for primary school age children were particularly varied, including a selection of computer games. Resources included a large, well-equipped play area for younger children, a multi-sensory room, a lounge for older children and a gymnasium. Outdoor facilities included a variety of play areas and equipment, some under-cover, landscaped gardens and a basketball court that could also be used for football and other sports. There was also a ‘pet’s corner’ where rabbits were kept.

3.3 A small library contained six computers and a printer for detainees’ use, a small range of newspapers and magazines, adult and children’s fiction, non-fiction and audio texts. Dictionaries, legal texts, the Register of Immigration Advisers and lists of other support organisations were also held. A small number of Kindles enabled families to access a wider range of foreign newspapers and magazines.

3.4 Accommodation for activities was very good. Rooms were bright and airy and well managed with stimulating wall displays, although most of these were focused on primary school age children. Children’s artwork was displayed in the play area and there was scope for further displays in corridors throughout the centre.

3.5 Initial planning of children’s activities was informed by the family welfare form and discussion during conference calls prior to arrival. Detail in the family welfare form about children’s previous educational history and attainment and their interests varied considerably. Some forms contained little more than the name of the school the child had attended. Where interests had been identified, every effort was made to accommodate these with innovative, enjoyable activities.

3.6 Activities were well planned with appropriate consideration of the age and ability of each child. Activities were matched to the national curriculum and the early years foundation stage outcomes of communication, language and literacy, creative development, knowledge and understanding of the world, personal, social and emotional development, physical development, problem solving, reasoning and numeracy. Underpinning these activities was a range of tasks focused on ‘cultural activities worldwide’ which was effective in the promotion of cultural diversity. However, wall displays explaining cultural diversity were too complex for younger children. Barnardo’s staff collated information about the education system in the destination country and included this in family information packs.

3.7 Children were encouraged successfully to experience a range of activities in the play area. During the morning session, we observed children engaging fully in a balance of structured and semi-structured activities, such as painting and catching games, and free play using the
impressive range of resources and toys. Children were able to explain what they had been doing and spoke with enthusiasm about what they had achieved.

3.8 We also observed children who had arrived the previous evening making full use of the play facilities outside in the early morning. The unobtrusive supervision by the project workers was appropriate. A range of activities had been planned for them during the day and an activity plan produced which acted as a prompt. Plans included making decorations, African sand art, ceramic painting, and designing and painting t-shirts. Children were able to choose from this list or choose something different.

Recommendation

3.9 All family welfare forms should contain detailed information on previous educational history and attainment.

Housekeeping point

3.10 All wall displays should use age-appropriate language.
Section 4: Preparation for removal and release

Expected outcomes:
Families are able to maintain contact with the outside world and be prepared for their release, transfer or removal. Families are able to retain or recover their property. Families with children and others with specific needs are not detained without items essential to their welfare.

4.1 Support to prepare families for removal or release was very good. Detainees could have daily visits, but the visits room was small and lacked privacy. Access to telephones, faxes and the internet was good. Helpful information packs were provided about the destination country. Minutes of the independent family returns panel were not always received prior to removal. A good range of clothing was available for detainees, and financial support was provided to ensure that families reached their final destination safely.

4.2 Of the 39 families who had been detained at Cedars by the end of the inspection, 17 removals had failed, often because a last-minute injunction had been received, or because a detainee was considered too disruptive or distressed. Nine of these families were subsequently released. Six families had been detained twice, and one three times, following failed removals. One detainee had made an allegation of assault against escort staff during a removal attempt and the police had been called. A second, unsuccessful attempt at removal was not delayed while the complaint was investigated.

4.3 The support given to families being released rather than removed was very good. We saw helpful assistance given to one family returning to South Yorkshire. A Barnardo’s worker offered to accompany the family on the journey but the mother declined. They were able to shower and eat before setting off. Sandwiches, water and snacks were provided for the journey, with bread and milk for breakfast the following day. G4S and Barnardo’s staff consistently treated the family with respect and demonstrated concern for their welfare.

4.4 Social visits took place daily from 9am to 9pm and booking was straightforward. Demand had been low with nine visits from the centre opening to date. The visits area was bright and welcoming with a good range of toys, although it was next to the main entrance of the centre, and the open plan design did not afford privacy. It was also small and could not comfortably accommodate more than one family. The centre was served by Gatwick detainee visitors group but only one request for a visit had been submitted. Transport links to the centre were very good, with a bus stop directly outside, and travel information was displayed in the centre.

4.5 Detainees were able to retain their mobile phone in the centre if it had no camera, or were provided with one. We saw one detainee who had arrived with no credit being given two £5 top-up cards. On observed removals, some detainees were able to keep their phone during escort to the airport, while others were not. This was not on the basis of a risk assessment and the rationale was unclear. Families had restricted but reasonable access to the internet and this facility was used well by detainees, particularly for researching legal information. Detainees could send emails and faxes freely without vetting by centre staff. However, UKBA restrictions allowed no access to social networking sites, a primary mechanism for young people maintaining contact with each other.

4.6 The centre did some very good work to help families prepare for removal. Individualised country information packs were provided to families on arrival, which gave details of welfare
organisations, schools, hotels and other pertinent information about the destination country. Barnardo’s staff addressed the issue of removal sensitively and soon after arrival engaged children in structured activities describing the destination country to help the family come to terms with it. If the detainee consented, Barnardo’s made contact with relevant non-governmental organisations in advance of departure. Staff went to some lengths to research organisations on the internet before making contact or providing details to detainees. All families were given the Barnardo’s email address and telephone number to provide feedback post return, but none had to date.

4.7 The removal plan included details of post-return support, such as financial support or short-term accommodation, to enable the family to reach their final destination, and this required approval by the independent panel. Some of this support was arranged by the centre. However, minutes of panel meetings signifying if support arrangements had been approved were not always received until after removal. Escorts were routinely briefed on the approved removal plan, but not all escort team leaders whom we spoke to were aware of it. Some elements of removal plans had not been followed, for example one family had waited for a long period on the coach in a lay-by instead of going to Cayley House. We were told that ticketing and security opening times at airports dictated this, but the family returns panel had not been made aware of such deviations from the plan.

4.8 A good range of clothing was available for detainees who needed it, and there was a fund to purchase more if required. Opaque bags were provided for property. Both escort and centre staff took a pragmatic approach to luggage limits and no unreasonable restrictions were applied: the families we observed were able to bring as much property as they had been able to pack following arrest. Visitors were also permitted to bring in property for detainees. Money was available for those who needed it to reach their final destination. Records showed that ‘destitute payments’ were regularly provided, commonly in the £200-250 range. A personalised bag with the child’s name painted on the front containing age-appropriate toys and books was put together for each child leaving the centre, together with toys they had become attached to during their stay.

Recommendations

4.9 The centre should be informed of the views of the independent family returns panel prior to removal of the family.

4.10 Escort staff should be fully briefed on removal plans and any deviations should be fed back to the family returns panel.

4.11 If allegations of assault made by detainees during removal attempts are supported by medical evidence, the removal should be delayed while the complaint is investigated.

4.12 The visits area should afford detainees and their visitors privacy and should accommodate several families simultaneously.

4.13 Detainees should retain their mobile phones during removal unless an individual risk assessment determines otherwise.

4.14 Children should be able to access social networking sites.
Housekeeping point

4.15 ‘Destitute payments’ should be appropriately renamed.
Section 5: Recommendations and housekeeping points

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

Main recommendation

To UKBA and the centre manager

5.1 Force should never be used to effect the removal of pregnant women or of children. It should only ever be used in relation to such vulnerable groups in order to prevent harm. (HE.40)

Recommendations

To the Chief Executive, UKBA

Escort vehicles and transfers

5.2 At the point of initial arrest parents should have adequate time to prepare themselves and their children for their journey, and UKBA teams should conduct the arrest as sensitively, calmly and quietly as possible. (1.8)

Safeguarding children

5.3 UKBA should ensure consistent quality of family welfare forms. (1.45)

Casework

5.4 UKBA should ensure that local immigration teams are consistent in their approach to detention. (1.70)

5.5 The legal basis for the operation of Cedars should be clear. (1.71)

Activities

5.6 All family welfare forms should contain detailed information on previous educational history and attainment. (3.10)

Preparation for removal and release

5.7 The centre should be informed of the views of the independent family returns panel prior to removal of the family. (4.9)

Recommendations

To UKBA and the centre manager

Safeguarding children

5.8 ‘Lessons learned’ meetings should be held promptly. (1.44)
Use of force and single separation

5.9 Separation should be governed by clear rules and staff should be aware of how to record its use. The unit should be less stark, with some furniture and decoration. (1.57)

Complaints

5.10 Complaints should be replied to in the language of the complaint. (2.23)

Health care

5.11 Parents should have medication in possession unless individual risk assessment indicates otherwise. (2.35)

5.12 A health needs assessment should be undertaken, including a mental health needs assessment. Appropriate access to adult, child and adolescent mental health services should be available. (2.36)

Recommendations

To UKBA and the escort contractor

Escort vehicles and transfers

5.13 The handover from arrest teams to escorts should be conducted in a private location out of public view. (1.9)

Preparation for removal and release

5.14 Escort staff should be fully briefed on removal plans and any deviations should be fed back to the family returns panel. (4.10)

Recommendation

To UKBA, escort contractor and centre manager

5.15 If allegations of assault made by detainees during removal attempts are supported by medical evidence, the removal should be delayed while the complaint is investigated. (4.11)

Recommendations

To the escort contractor

Escorts vehicles and transfers

5.16 Escort staff should remain calm, polite and respectful at all times. (1.10)

5.17 Families should only be transported in appropriate and spacious vehicles, and held on them for the minimum possible time. (1.11)

5.18 Removal plans should be adhered to, and any deviations should be fed back promptly to the independent family returns panel. (1.12)
Use of force and single separation

5.19 Paramedics on escorts should focus on their primary duties and not operate hand-held cameras. (1.56)

Preparation for removal and release

5.20 Detainees should retain their mobile phones during removal unless an individual risk assessment determines otherwise. (4.13)

Recommendations

To the centre manager

Arrival

5.21 The reception process should be undertaken quickly and all relevant staff should be familiar with completing reception procedures. (1.19)

5.22 Key information should be available in an appropriate range of languages and formats including notices, booklets and DVDs. (1.20)

Health care

5.23 All clinical staff should receive training in child-specific care and treatment. (2.37)

5.24 Parents should be able to discuss their medical needs with health care staff in confidence. (2.38)

5.25 All relevant health care information should be received before families arrive on site. (2.39)

Preparation for removal and release

5.26 The visits area should afford detainees and their visitors privacy and should accommodate several families simultaneously. (4.12)

5.27 Children should be able to access social networking sites. (4.14)

Housekeeping point

To the escort contractor and centre manager

Health care

5.28 Centre staff and staff undertaking health care duties on escorts should exchange full handover information. (2.40)
<table>
<thead>
<tr>
<th>Housekeeping points</th>
<th>To the centre manager</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suicide and self-harm</strong></td>
<td></td>
</tr>
<tr>
<td>5.29</td>
<td>More staff should be trained as ACRT assessors. (1.32)</td>
</tr>
<tr>
<td><strong>Legal rights</strong></td>
<td></td>
</tr>
<tr>
<td>5.30</td>
<td>Notices promoting the Legal Ombudsman should be prominently displayed. (1.62)</td>
</tr>
<tr>
<td><strong>Equality and diversity</strong></td>
<td></td>
</tr>
<tr>
<td>5.31</td>
<td>The manager designated with lead responsibility for equality and diversity should receive formal training for this role. (2.14)</td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td></td>
</tr>
<tr>
<td>5.32</td>
<td>There should be one complaints box for G4S and UKBA. (2.24)</td>
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</table>
The inspection team included four qualified social workers, three of whom usually work in the juvenile prisons team and have substantial experience of inspecting secure detention for children. All also have substantial previous experience of working with children. The team was accompanied by an experienced Ofsted inspector specialising in secure children’s homes and juvenile prisons.
Appendix II: Inspection photographs

Bedrooms within the family apartments
The playroom

The library
The cool down room