Report on an unannounced inspection of the short-term holding facilities at

Longport freight shed, Dover Seaport and Frontier House

by HM Chief Inspector of Prisons

7 September, 1–2 and 5–6 October 2015
Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our ‘Guide for writing inspection reports’ on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/
Fact page

Task of the establishments
To hold newly arrived clandestine migrants (male, female and families).

Location
The main facility is at Dover Seaport. Longport freight shed and Frontier House are located in Folkestone.

Name of contractor
Dover Seaport and Frontier House are contracted out by the Home Office to Tascor. The Home Office’s Immigration Enforcement arm runs Longport freight shed.

Number held during inspection
Longport on 5–6 October while inspectors were on site: 40
Dover on 5–6 October while inspectors were on site: 84
Frontier House on 6 October while inspectors were on site: 12

Last inspection
This is the first inspection of the current facilities. We last inspected Dover short-term facilities in 2009, when they were located elsewhere in the port and consisted of a non-residential holding room run in tandem with a separate residential holding facility holding 55 detainees. These facilities are no longer in use.

Escort provider
Tascor
Introduction

This report covers inspections of the short-term immigration detention facilities at Dover Seaport, Frontier House in Folkestone, and the Longport freight shed, also in Folkestone. We had previously inspected Dover Seaport in February 2015, but before publication of that report it became apparent that the situation had changed significantly as a result of higher numbers of migrants arriving from France. We therefore carried out a further scoping inspection visit on 7 September 2015 to establish the nature and extent of these changes. During this visit we learned that a new 'non-detained' area had been created at Dover, and an overflow detention facility, Frontier House, had opened in Folkestone. Inspectors returned to inspect Dover Seaport and Frontier House in early October 2015 to examine these detention facilities in more detail. During the course of the inspection, it became apparent that people were also being detained at a third site in Folkestone, Longport freight shed, where many of those going to Dover or Frontier House had first arrived. An inspection of this area was also conducted.

The purpose of all the facilities was to detain clandestine migrants attempting to gain entry into the UK without being detected; they were hidden in vehicles on the ferry to Dover or in the Channel Tunnel, or on freight trains arriving in Folkestone. In June 2015, there had been a sudden and substantial increase in the number of such migrants coming through the Channel Tunnel in particular. This was in line with the general increase in migration to Europe from countries experiencing upheaval, including Eritrea, Sudan and Syria. Migrants arriving through the Channel Tunnel and detected there were all first detained in Longport freight shed before being moved to the holding room in Dover or the Frontier House overflow facility. Some detainees were picked up by the police on nearby motorways as they disembarked from freight vehicles and a small number were detected on vehicles at the port of Dover itself. Many of the detainees who entered the UK in this way had previously been living in insanitary conditions in makeshift camps in Calais.

It was clear that the unprecedentedly high number of people arriving from France had led to a strain on the infrastructure and placed considerable pressure on Tascor and Home Office staff. While both had made efforts to manage the situation, this had not gone far enough and quickly enough to prevent the poor outcomes that we found for many detainees. There was no Independent Monitoring Board for any of the facilities.

The Longport freight shed was a wholly unacceptable environment in which to hold people. From 31 August to 3 October 2015, a total of 569 people were detained there, including 90 children1. While the vast majority of detainees were held for under 12 hours and most for much shorter periods, the longest single period of detention was for 21 hours 25 minutes and was of an unaccompanied child. We were concerned that on various occasions Home Office staff told us that they did not consider Longport to be a place of detention. This was despite detainees being in possession of legal authority to detain documentation and obviously being unable to leave. At this facility, the normal mechanisms of internal oversight and accountability that should apply to any form of detention were lacking. Tascor staff trained in detention were not contracted to work at Longport, which was managed by Immigration Enforcement staff with no such training.

Dover Seaport was the main facility holding the largest number of detainees. It was crowded and poorly ventilated, providing generally poor conditions. It was not designed to hold people for more than a few hours and had no sleeping facilities. It did not provide a safe environment for the detention of women and children. In the three months from July to September 2015, 2,781 detainees had been held in this facility for an average of over 18 hours, including 381 children. A quarter of the detainees had been held for more than 24 hours and the longest period of detention was for nearly three days. We were pleased to find that a refurbishment of the Dover holding room was due to

---

1 Immediately after the inspection, we alerted the Office of the Children’s Commissioner, the Director of Children’s Services and the Chair of the Local Safeguarding Children’s Board in Kent to our concerns.
take place shortly after the inspection, during which time Frontier House was to be used for most detainees, with a contingency plan in place to use some spaces at Dover Immigration Removal Centre if necessary\(^2\). A praiseworthy innovation at Dover was the ‘Atrium’, an area where detainees released from the adjacent holding room received support from third sector organisations. Migrant Help assisted adults and the Refugee Council was contracted to work with children. We were told that as well as providing much needed assistance, this area was intended to reduce the amount of time that people spent in the holding facility, although it was too early to see how successful it was in achieving this goal.

The overflow facility at Frontier House was only used to accommodate adult male detainees without any apparent complex needs. It had no showers and nowhere to rest. It was only suitable for stays of a few hours. It had been used on 30 days in the three months to the end of September, accommodating 822 detainees, 17% of whom had been held for more than 24 hours.

There is no doubt that the increases in migration initially overwhelmed the existing facilities and an emergency response was required. This inspection took place some months after that emergency response was initiated and it was unacceptable that arrangements were still not in place to process detainees quickly, efficiently and decently while ensuring the most vulnerable, such as children, were safe and that the basic physical needs of all detainees for food, rest and clothing were met. We were told that the Home Office was working urgently with Eurotunnel to build a new facility, similar in design to other short-term holding facilities, which would lead to the closure of the freight shed within weeks. In the meantime, we were told that transport and support for Longport had been improved and that detainees were being moved on more quickly.

The events of the summer and early autumn of 2015, in terms of the numbers of migrants arriving through the Channel Tunnel, were indeed unprecedented, but in light of the build up of activity over several months they were not unpredictable. That being so, rather than respond to unfolding events, it is difficult to understand why effective contingency plans were not put in place to cater for the rise in the number of migrants so that they could be treated in an appropriate manner.

We will conduct a follow-up investigation in due course.

Peter Clarke
Chief Inspector of Prisons
February 2016

\(^2\) The induction wing of Dover Immigration Removal Centre had been used some weeks previously as an overflow facility for 30 detainees from Dover Seaport.
About this inspection and report

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.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK’s response to its international obligations under the Optional Protocol to the UN 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.

Inspectorate of Prisons reports normally carry a summary of the conditions and treatment of detainees, based on the four tests of a healthy prison that were first introduced in this inspectorate’s thematic review *Suicide is everyone’s concern*, published in 1999. The tests have been modified to fit the inspection of short-term holding facilities, both residential and non-residential. The tests for short-term holding facilities 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 the centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees
- **Preparation for removal and release** – that detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their country of origin and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.

Given the unique conditions and structures that we found in Dover, we have adapted our normal approach to focus on key issues of concern, such as environment and basic conditions, health care and safeguarding. Dover Seaport was the busiest and most established site, and we have reported on it in more detail. Inspectors kept fully in mind that although these were custodial facilities, detainees were not held because they had been charged with a criminal offence and had not been detained through normal judicial processes.
Summary

Longport freight shed

S1 Longport freight shed was managed directly by the local Immigration Enforcement team. It had not been adapted for use as a holding facility and staff were not trained to manage detention. The facility was opened in June 2015 and had been operating for about three months at the time of our inspection.

S2 Conditions were wholly unacceptable. Detainees were held overnight and/or for several hours with no clean or dry clothes, no food or hot drinks, and nowhere to sleep other than on a concrete floor. Many had had long and arduous journeys before arrival at Longport. Some detainees had not eaten for very long periods and many were hungry. Detainees gestured to us that they were hungry by pointing to their open mouths.

S3 Detainees arrived with scabies, headaches and other conditions related to dehydration, such as diarrhoea. However, toilet and washing facilities were inadequate and blankets were not washed after each use, presenting obvious health risks. There appeared to be a lack of urgency to transfer detainees from the facility.

S4 From 31 August to 3 October 2015, a total of 569 detainees were held, including 90 children, most of them unaccompanied. The average length of detention was just under four hours and the vast majority of detainees were held for under 12 hours. However, the longest single period of detention was for 21 hours 25 minutes and was of a child. Records did not allow us to establish the cumulative length of detention for people held at Longport before being moved either to Dover or to Frontier House. The detention of women and minors in this environment created safeguarding concerns.

S5 Following our inspection, Home Office Immigration Enforcement managers informed us that a suitable short-term holding facility was to be built to replace Longport. We were also told that in the meantime detainees were being held at Longport for less time.

Dover Seaport

S6 The number of people detained at Dover Seaport had increased significantly. In the first nine months of 2014, there were 2,118 detentions; in 2015, the figure had more than doubled to 4,785. Many detainees were exhausted on arrival and had health problems. Induction interviews to establish risks and needs and searching took place in the sight and hearing of other detainees. Use of telephone interpretation by detainee custody officers (DCOs) for initial interviews was good but there was little meaningful interaction between staff and detainees thereafter. Health care provision had been increased to a degree but was insufficient to meet need. Permission was required from immigration staff before detainees could shower, which was an unnecessary restriction that impeded hygiene and decency. Access to telephones was poor.

S7 The accommodation was not fit for purpose. It was crowded, poorly ventilated and smelled badly. There were no sleeping facilities for the large numbers held for long periods. In the previous three months, nearly a quarter of detainees had been held for over 24 hours. The longest detained person had been held for nearly three days. Data on length of detention did not include the time detainees had spent in Longport freight shed. Detainees were issued
with written reasons for their detention (IS91R) only after their screening interview, which could take place many hours after they were first detained.

When more than a few detainees were held, supervision in the holding room was insufficient to ensure that more vulnerable detainees were safeguarded. DCOs showed little understanding of adult safeguarding issues. The holding room did not provide appropriate facilities for the detention of women and children; they were often held in the same room as unrelated adult men. The length of detention for children was routinely excessive, and in one case a child had been held for over 58 hours. A total of 370 unaccompanied children had arrived at the facility in the previous three months. Not all detainees claiming to be children underwent a Merton compliant age assessment.

A large and well equipped area known as the Atrium, or non-detained area, had been opened some weeks previously. Detainees went there once they had been granted temporary admission. A separate area in the Atrium specifically for minors provided welcoming facilities and recreational activities for children and young people. Migrant Help and the Refugee Council were based in the Atrium, which we considered to be an example of good practice. It was intended that the Atrium would reduce the amount of time that detainees spent in the holding room, but it was too early to tell if this had happened.

**Frontier House**

Transfers from the Longport freight shed to Frontier House took too long; we observed the transfer of 12 detainees in two vans which took a total of three hours. All detainees were handcuffed between the escort van and the facility without individual risk assessment. This was particularly inappropriate in light of the fact that all were asylum seekers who were normally released shortly afterwards.

The accommodation was only suitable for very short stays; there was nowhere suitable to rest, no shower facilities, no windows and the pay phone did not work. The facility had been used on 30 days in the three months to the end of September, accommodating 822 detainees. A little under a third of these detainees had been held there for more than 12 hours, and 17% for more than 24 hours. Women and minors were not held at Frontier House.

Unlike at the Dover holding room, detainees who were released were not able to see a worker from Migrant Help before being transported to their destination.
Section 1. Longport freight shed

Arrival

1.1 Detainees who entered the UK on freight trains coming through the Channel Tunnel were detained in Longport freight shed, which is located in a secure area next to the Eurotunnel terminal. It had previously been used by customs officials to search lorries. The area was managed by Immigration Enforcement staff and had not been adapted for use as a holding facility. Detainees were held there pending onward movement to the holding facility at Dover Seaport, or the overflow facility at Frontier House in Folkestone (see below). The freight shed had been in use since June 2015 but lacked even basic facilities.

1.2 In order to avoid detection in Calais, most detainees boarded trains at night which meant they often arrived between midnight and 2am. All detainees we spoke to during the inspection had been held over the previous night, some for more than 12 hours. Many detainees had spent some time living in insanitary conditions near Calais, and most had made arduous journeys, culminating in the Channel crossing, many under lorries and freight trains.

1.3 On arrival, detainees’ phones were taken from them and there were no facilities for them to make an outside call to contact families or lawyers. We were told that detainees were given a brief interview by immigration staff, sufficient to prepare the authority to detain (IS91) and to check if there were any immediate medical needs. They were interviewed again, more fully, some time after they were transferred to the holding facilities in Dover or Frontier House. These subsequent interviews often took place several hours after their transfer and it was only then that they were given written reasons for detention (IS91R).

1.4 There was a high need for health care attention. A number of detainees arrived with injuries sustained during the journey, in particular cuts from razor wire. We were told the most common health problems on arrival were scabies, headaches and other conditions related to dehydration, such as diarrhoea. There was no routine screening by health professionals to identify individual health needs, nor was there any identification of potential public health risks.

Safeguarding children and adults at risk

1.5 The very poor physical conditions (see below) and lack of procedures created considerable safeguarding risks for all those held. The detention of women and minors in this environment was especially concerning. Immigration staff had not been trained as custody officers and were unaware of, and therefore did not use, safeguarding procedures such as assessment, care in detention and teamwork (ACDT) case management for detainees at risk of suicide and self-harm. Women and children were prioritised for transfer to Dover Seaport holding facility, but nonetheless many were accommodated overnight at Longport.

1.6 During our inspection 10 minors were held in the facility. One entered the facility at 10.19pm but did not leave until 7.30am the next day, a stay of over nine hours. A girl under the age of 18 was also held during our inspection. She was brought to the facility at 2.19am and only released at 7.05am – almost five hours later. Women and children could not be held separately from men.

---

3 ACDT involves opening a care planning and monitoring booklet.
Section 1 – Longport freight shed

1.7 About 40 detainees were held when we arrived. We received data relating to Longport freight shed from 31 August to 3 October 2015. A total of 569 detainees were held during this period, including 90 children. The data did not allow us to disaggregate accompanied from unaccompanied children. The average length of detention was just under four hours. While the vast majority of detainees were held for under 12 hours, the longest single period of detention was for 21 hours 25 minutes and was of a child. Records did not allow us to establish the cumulative length of detention for people held at Longport before being moved either to Dover Seaport or Frontier House.

1.8 We later obtained data for 5–6 October. On these dates, a total of 122 people were held at Longport, including 30 children. The longest detained person was held for 17.5 hours and the longest detained child was held for just over nine hours.

Environment and relationships

1.9 Men, women and children were all held together. Although many detainees had been up all night and needed to sleep, there was no appropriate bedding. Detainees were given blankets and slept on a concrete floor. These blankets were not washed before being handed over to other detainees, increasing the risk of the spread of disease.

1.10 Many slept in the lorry bay bordered by plastic road traffic barriers (see photographs in Appendix II). The lorry bay was overlooked by a raised area that was about a metre higher. More adult detainees, some still bedded down from the night before, were located at the back of the raised area, again on a concrete floor. We were told this was where children and women were placed. When inspectors arrived, several immigration staff were standing in the raised area talking to each other. They wore police-style fatigues, stab-vests and carried batons. We saw little interaction between immigration staff and detainees, other than that connected with processing their departure.

1.11 It had rained heavily the night before our October inspection and many detainees had become soaked through during their journey. Other than black plimsolls the facility did not issue clothing. Some detainees had to sleep in wet clothes. Others with spare clothes hung wet ones (often filthy) on the traffic barriers to dry them. A number of detainees complained they were cold. There was heating in the freight shed but it was not switched on when we visited. There was one unisex toilet in the shed and two ‘portaloo’ facilities outside, but no showers, which were obviously badly needed. There were only two tables and 12 chairs for detainees to sit on.

1.12 As inspectors walked to the back of the shed, a number of detainees pointed to their open mouths to indicate they were hungry. No detainee we spoke to had been offered a hot drink or food, despite some not having eaten for many hours. They asked us when they were going to be given some hot food. There were no structured arrangements to provide food; immigration staff said that they were arranging a food contract and for a fridge to be delivered. This situation was ongoing four months after the opening of Longport.
Preparation for removal and release

1.13 There appeared to be a lack of urgency to transfer detainees from the facility. We observed two Tascor escort vans with four staff arrive to move 12 detainees. The team worked inefficiently and it took two hours to process detainees for the transfer.

Recommendation

1.14 The use of Longport freight shed to hold detainees should immediately cease.
Section 2. Dover Seaport

Arrival

2.1 Some detainees were brought to Dover Seaport by the police, but the majority detected at port were transported by Tascor detainee custody officers (DCOs). Female DCOs said that they would always accompany female detainees. DCOs told us that they rarely used handcuffs. Detainees arrested by the police often arrived handcuffed and DCOs said these would be promptly removed on arrival. DCOs had completed the new training in HOMES (Home Office manual for escorting safely).

2.2 The onward transfer of detainees often took place at night for reasons of administrative convenience and we saw records confirming this. In one example, a detainee was transferred to Dover Immigration Removal Centre (IRC) at 3.30am, having been held at Dover Seaport for almost 38 hours.

2.3 On arrival, detainees were taken, several at a time, to an induction room where induction interviews and ‘pat down’ searching took place in sight and hearing of other detainees. Although a privacy screen was available, it was not used. We did not observe any children being searched, but were told that this was done with a handheld wand, avoiding the need for physical contact. We observed a number of detainees being given a very brief induction interview. Apart from being asked about any medical needs, no other information was sought about their welfare. Use of telephone interpretation for initial interviews was good and better than we normally see, although interpreters were rarely used subsequently. A number of detainees told us they wanted to make a phone call but could not do so. They were not advised that they could request a call and the pay phone in the main holding room was out of order. Tascor staff held five mobile phones in the staff room, but detainees were not told of their availability.

2.4 The shower room in the holding room was locked. Staff told us permission to shower was required from Home Office staff, which was an unnecessary restriction that impeded decency and hygiene. There were stocks of spare clothing and underwear, towels and hygiene packs. However, spare clothing was only given for those with the most pressing need, for example if their clothes were wet through. This was, in any event, too late for detainees who had come from the Longport freight shed (see Section 1), and we saw detainees with torn and dirty clothes who were not given fresh clothing.

Recommendations

2.5 Detainees should not be transferred late at night unless there are urgent operational reasons.

2.6 Detainees should be searched and interviewed in private.

2.7 All new arrivals should have free access to showers and be given clean clothing if required. They should be offered an immediate free phone call and have access to a working telephone thereafter.
Safeguarding adults at risk and preventing bullying and self-harm

2.8 There was no safeguarding adults policy or procedure, although Tascor had drafted one that was awaiting Home Office approval. DCOs had not been trained in this area and showed little understanding of adult safeguarding issues. They could not recall having received any trafficking training and had not heard of the National Referral Mechanism. During the inspection, Tascor had been told by immigration staff that a young female detainee was a suspected victim of trafficking, but this information was not included in the childcare plan completed by Tascor.

2.9 There was some understanding of broader safeguarding needs. A woman DCO had noticed severe bruising on a woman detainee she was searching, and suspected that the detainee had been assaulted, possibly sexually, during her journey to the UK. This was reported to immigration staff who organised for the detainee to be removed to hospital. However, given the pressure on DCOs to undertake other tasks, the high number of particularly vulnerable detainees and prolonged periods of detention, we considered safeguarding arrangements to be inadequate (see recommendation 2.13).

2.10 Staff were aware of the potential for bullying and harassment, although none could recall recent training in this or in suicide and self-harm prevention. Staffing levels had been increased in the summer from four to six DCOs, but the range of responsibilities, including outside escorts, searching and interviewing new arrivals, meant that as few as two could be present in the main staff room overlooking the holding area. These staff were often fully engaged in administrative tasks and did not supervise the holding room, which was often very crowded. At one point during the inspection, 20 adult detainees and 19 unaccompanied children, including one girl, were detained over the same period. All the boys were held in the main holding room with adults.

2.11 Three lone females were held during the inspection. All claimed to be minors and one was a suspected victim of trafficking. Two, including the suspected victim of trafficking, were placed in the small family room. However, the only toilet was across the main holding room which was crowded with men and boys. We observed a third girl sitting in the main holding room with a group of adults. We asked staff why this was, but they had not noticed that she was in the main room. They said she must have left the family room where she had been placed. When we spoke to her with an interpreter she said that she did not know there was a separate family room and felt very uncomfortable in the main room with so many adult men (see recommendation 2.19).

2.12 There were few self-harm incidents and the most recent serious incident had been some years previously when a detainee attempted to hang himself in the toilets. Suicide and self-harm awareness forms were initiated in six cases in the six months before the inspection. Documentation suggested little understanding of the how the process was intended to protect detainees at risk: for example, in one case it specified that a detainee placed on ‘constant supervision’ should have hourly welfare checks.

Recommendation

2.13 Managers should ensure that detainee custody officers understand and implement best practices in relation to safeguarding adults, trafficking and suicide and self-harm prevention.
Safeguarding children at risk

2.14 The number of unaccompanied asylum-seeking children passing through the facility was high and had increased considerably over the previous three months. From November 2014 to January 2015 a total of 83 unaccompanied children had been held at the facility; from July to September 2015, this had increased to 370 unaccompanied children, 36% of whom were 15 years old or younger. Records indicated 252 of them had been referred to social services. Eleven accompanied children had been held in the same three month period.

2.15 Children were routinely detained for excessive periods of time, often overnight and with inadequate supervision. Accompanied children were held for an average of 16 hours, with the longest detention being 40 hours. Unaccompanied children were held for an average of 12 hours and 19 minutes, with the longest detention being 58 hours and 20 minutes. The facility could not safely accommodate children in these numbers and for this length of time. The family room was too small and children were often detained in the main holding room with adults (see paragraphs 2.10 and 2.11). The new Atrium facility was intended to alleviate some of these problems (see preparation for release and removal section).

2.16 All the DCOs we spoke to had undertaken Barnardo’s safeguarding children training and DCOs prepared care plans for all children. All relevant immigration staff had completed levels 1, 2 and 3 of the Home Office’s ‘Keeping Children Safe’ training. Immigration staff were not permitted to interview minors on arrival, beyond asking a few basic questions agreed by the Children’s Commissioner. The local social services department collected minors in and out of office hours, and this was confirmed by holding room records. However, many of these children may have been held for substantial periods of time in Longport freight shed before arrival at Dover Seaport (see Section 1). Given the excessive periods for which children were detained we were concerned that referrals to Kent Children’s Services, which should be made at the start of detention, were routinely subject to significant delay. We were told there was a log showing the timing of referrals, but we were unable to obtain this from the Home Office, despite repeated requests.

2.17 After a period of what was referred to as ‘reflection’ in the care of social services, minors were returned for an interview with immigration staff accompanied by a social worker. We saw some detainees who said they were children assessed by a chief immigration officer as being significantly over the age of 18 rather than undergoing a Merton compliant age assessment by social services, which was inappropriate.

Recommendations

2.18 Children should only be detained exceptionally and for the shortest possible time.

2.19 Suitable separate facilities should be provided for receiving women and children, including those with families. Unaccompanied children should never be held with unrelated adults.

2.20 All detainees claiming to be children should undergo a Merton compliant age assessment by social services.

Use of force

2.21 Force was rarely used. Most detainees had little incentive to be non-compliant as they had just arrived in the country and had claimed asylum. In November 2014, three Eritreans had been brought into a caged area outside the holding room but refused to enter the holding
room itself. One of the detainees produced a small blade and force was used to remove it from him and escort him into the facility. In April 2015, an illegal entrant was arrested in the docks’ freight lanes but refused to move. Officers used force to bring him to the holding room. In July 2015, in two separate incidents, two detainees had to be pulled apart by staff after an altercation. The records suggested that force had been used appropriately and proportionately in these instances. All staff had up-to-date training in HOMES. A waist restraint belt and a leg restraint belt were held in the holding room office. DCOs we spoke to had never used them.

Legal rights and casework

2.22 Detainees were only issued with written reasons for their detention (IS91R) after their screening interview, which could take place many hours after they were initially detained. IS91Rs were issued in English only, although immigration staff explained the contents of the notice using an interpreter where required.

2.23 The Civil Legal Advice helpline was advertised in a range of languages, but detainees had no effective access to telephone facilities (see paragraph 2.3). Detainees could not freely use a fax machine or access email. Immediately after release, detainees met a representative from Migrant Help who offered basic advice on asylum. Normally such detainees would wait until arrival in the area to which they were dispersed to, or at an IRC, before instructing solicitors. However, children in the care of Kent Social Services attended screening interviews with their legal representatives.

2.24 There had been a 126% increase in detentions during 2015. In the first nine months of 2014, there were 2,118 detentions; in 2015, the figure had increased to 4,785. Between July and September 2015 alone, there had been 2,781 detentions at Dover. The average length of detention was 18 hours 18 minutes. A quarter had been detained there for more than 24 hours and the longest period of detention was for nearly three days (66 hours 25 minutes). During the inspection we saw one detainee who had arrived at 10.45pm on 29 September, and was still there at 1.05pm on 1 October, nearly 40 hours later. We were told that he had refused to be interviewed the previous evening. Records did not allow us to establish the cumulative length of detention for people held at Longport freight shed before being moved to Dover.

2.25 The long detentions appeared to be due partly to a lack of resources. Senior managers said that it took about three hours to process each detainee after they entered the holding room. This included welfare checks, finger printing and screening interviews. These processes took place 24 hours a day. Tascor and the Home Office had both increased resources (seven extra immigration staff had been brought in, and 45 staff from other locations had volunteered and been trained to strengthen the permanent immigration team as a contingency response if necessary) but the staffing level was clearly still not commensurate with demand. A lack of Tascor and immigration officers meant there were prolonged periods of time with nothing happening, while detainees remained waiting in the holding room.

---

4 Some detainees were held more than once. For example, they were held at the Dover STHF, moved to the IRC and then returned to the STHF. This equates to one detainee but two detentions.
Recommendations

2.26 Detainees should promptly be given written reasons for detention (IS91R) in a language they can understand, and have free access to a telephone and fax machine to contact legal representatives.

2.27 The Home Office and Tascor teams should be sufficiently staffed to ensure that detainee welfare can be assured and detention is kept to a minimum.

Environment and relationships

2.28 The accommodation was not fit for purpose. It was too small for the numbers held. It could hold 58 detainees but felt very cramped during our inspection when, at one point, 46 detainees were held. Some detainees sat or lay on the floor to rest. There were insufficient tables for detainees to eat at and some detainees sat on the floor to eat.

2.29 The holding facility consisted of one large room with natural light through frosted glass windows and a small family room. The main room contained rows of fixed metal seating, and three tables with attached seating (see photographs in Appendix II). There were four recliners, which were not an adequate substitute for proper sleeping facilities. There was damage to the ceiling caused by an ongoing water leak. The holding room was cleaned daily.

2.30 There were separate toilets for men and women and one shared shower facility, which was rarely used despite considerable need (see paragraph 2.4). The facility was poorly ventilated and smelled badly. The toilets were fully screened but had no seats or lids. The payphone was out of order and lacked a privacy hood (see paragraph 2.3).

2.31 The family room was small, with fixed metal seats and two beanbags. There was no table to eat at and no highchairs. It had a range of children’s toys and books, some in poor condition. There was a baby changing area, and travel cots and a child’s car seat. The room had natural light and the heating could be controlled separately from the main room. The room did not have its own toilet, shower or telephone so family members had to share those with the detainees in the main holding room (see paragraph 2.11).

2.32 The short-term holding facility was due to be refurbished the week after our inspection. Stores of blankets and pillows were available but not freely provided. We were told that a complaints box was emptied daily by immigration staff, but no complaints had been submitted in the previous three months.

2.33 Staff had little time to meaningfully interact with detainees or check on their welfare. Contact was generally limited to functional tasks such as the delivery of meals. DCOs were often redeployed to other duties, for example transferring detainees or staffing Frontier House, which sometimes left only two officers to care for up to 57 detainees. DCOs used professional telephone interpretation well when booking detainees into the facility, but not always subsequently when required.

2.34 DCOs had received initial training in equality and diversity. Some staff had also completed a further short training package, but it was not tailored to working with asylum seekers and detainees. The holding room had religious books and a prayer mat but no compass to indicate the direction of Mecca. Staff used care plans to help support detainees identified as having a disability. We saw a plan for a detainee who had impaired vision and had lost a limb, which competently outlined additional support that may have been necessary.
2.35 There were sufficient activities to occupy detainees held for short periods only. These included books, magazines and newspapers, although these were mainly in English. There was a television and DVDs in both holding rooms, and the family room had some books and toys for children. Detainees could not go outside to exercise and the environment was not conducive to wellbeing.

2.36 Detainees were offered drinks, hot ready meals and sandwiches. Ambient ready meals were not suitable for those held for prolonged periods. Fruit and snacks were not available and hot drinks had to be requested from staff as the vending machine was in their office area. Baby food was available and staff said they would buy more as needed.

Recommendations

2.37 All detainees should be held in decent, well ventilated and properly maintained accommodation which is suitable for their specific needs. They should have access to blankets and pillows and to hot drinks.

2.38 DCOs should be able to regularly and proactively check on individual detainees’ welfare, using telephone interpretation where required.

2.39 DCOs should receive regular training that helps them to understand the needs of refugees and asylum-seekers.

2.40 The holding rooms should have appropriate foreign language reading material, and those held for longer periods should have access to fresh air.

Health services

2.41 There was a high need for health care attention. Common health problems experienced by detainees included scabies, injuries sustained during the journey (often cuts from razor wire), headaches and other conditions related to dehydration, such as diarrhoea. Immigration staff completed an initial assessment to identify any health concerns and Tascor asked if detainees had any medical conditions or were on medication during their induction interviews. However, detainees did not receive routine health screening.

2.42 Tascor had contracted a health care provider, IPRS Aeromed, to provide a 24 hour medical triage telephone line staffed by clinicians. All the DCOs we spoke to were fully aware of this service, details of which were clearly displayed, and those that had used it said it was very helpful. Following a risk assessment and Home Office agreement, DCOs could escort detainees to hospital or contact an ambulance service in urgent situations. During our September inspection visit, a man collapsed in the toilet and an ambulance was called as no health care staff were on site. The ambulance arrived within 20 minutes, and paramedics concluded that the man’s blood sugar was low and that he was simply exhausted as he had apparently not slept for 19 hours.

2.43 As a result of the rise in detainee numbers, a nurse from IC24, the provider for Dover IRC, had attended the facility to see detainees with non-urgent care needs for a period of two weeks. This arrangement had ended and support was now more ad hoc. DCOs had received first aid training and could dress a simple wound. However, detainees with dehydration and headaches did not have access to mild analgesia unless the nurse attended. Detainees who had scabies were only treated if the nurse was attending the facility.
2.44 There was a fully functioning automated external defibrillator (AED) on loan from IC24, but there was no clear process for checking that it was in working order. DCOs did not have defibrillator training. The first aid kit contained an anti-ligature knife and basic supplies which were in date and replenished following use with a documented checklist.

2.45 DCOs were mindful of the physical conditions endured by some detainees before their arrival and the impact this could have on their health. Health concerns and the actions taken were well recorded on the IS91 form, the daily occurrence/briefing log and the PER (person escort record). This had recently included the hospitalisation of a man with malaria.

2.46 Custody staff we spoke to understood safe drug administration. Medication was stored with the detainees’ property and we observed a man who had come from hospital following an injury to his leg receiving antibiotic medication in an appropriate, safe and considerate manner.

2.47 The small medical room was unlocked and did not have a desk or a telephone to access telephone interpretation. A small amount of medication, including soluble paracetamol and permethrin cream for the treatment of scabies, were stored in an unlocked cupboard and the stock balance was inaccurate. Heat sensitive medication was stored in the kitchen fridge, but there was no assurance that it was stored correctly as temperatures were not recorded.

Recommendations

2.48 A full review should be carried out to establish what type of service provision is required to meet the health needs of detainees. In the meantime, all detainees should receive a health screening to identify any appropriate treatment pathway and potential public health issues.

2.49 Custody staff should be trained to use the external automated defibrillator, which should have regular documented checks.

2.50 The medical room should be fit for purpose with a desk and telephone access for interpretation services, and medication should be stored appropriately.

Preparation for removal and release

2.51 A large and well equipped area known as the Atrium, or ‘non-detained’ area, was opened at the beginning of September 2015. Detainees were moved there to wait for transport to their accommodation once they had been granted temporary admission into the UK. This reduced the time spent in the holding room for some detainees. Food and drinks were available in the Atrium, and a Migrant Help worker was based there during weekday office hours to help detainees complete asylum support paperwork. There were plans to expand this provision to ensure that a worker was permanently on site.

2.52 A separate area in the Atrium specifically for minors provided welcoming facilities and recreational activities for children and young people. A Refugee Council worker with considerable experience of working with unaccompanied minors was based in this area, again during weekday office hours. As with Migrant Help there were advanced, funded plans to expand this provision to 24 hours a day, seven days a week. Other Refugee Council staff included some with useful language skills, for example one was an Arabic speaker.

2.53 Those detainees being transferred to an IRC were given information cards with the IRC address and telephone number.
Recommendation

2.54   **Detainees should have supervised access to the internet, email and Skype facilities.**

Good practice

2.55   **The Atrium non-detained area was a positive initiative to limit the amount of time that people spent in detention and provided useful specialist support for both adults and children in a decent facility. The collaborative work with third sector agencies to help meet the needs of detainees was particularly positive.**
Section 3. Frontier House

Arrival

3.1 Frontier House is located in Folkestone. It was used as an overflow facility when the Dover Seaport holding room was full. Detainees usually arrived there from the Longport freight shed, but some were transferred from Dover Seaport.

3.2 The facility was used on 30 days in the three months to the end of September, accommodating 822 detainees. It was not possible from the data provided by Tascor to calculate the average period of detention. However, it did show that 29% of these detainees had been held there for more than 12 hours, and 17% for more than 24 hours. This does not include the time many of these detainees would have previously been held in the Longport freight shed.

3.3 Detainees were escorted to the facility by Tascor staff, who also staffed the Dover Seaport holding room. We observed 12 detainees being transferred from Longport to Frontier House in two vans. The transfers took far too long. The first detainee boarded the van at Longport at 11.15am but the van did not depart until almost two hours later at 1.12pm. Each detainee was searched and given a welfare interview before boarding the van, but interviews were brief and detainees were not asked about their welfare beyond their medical needs. Nor were detainees advised they could make a telephone call. The last detainee did not disembark at the nearby Frontier House until 2.07pm.

3.4 The escort van parked in a non-secure car park to the rear of Frontier House, a few metres from the facility entrance. Rigid handcuffs were applied to all detainees between the escort van and the facility, regardless of their individual circumstances. The use of handcuffs without individual risk assessment was particularly disproportionate given that all the detainees were asylum seekers and likely to be released a few hours later.

3.5 As in the Dover holding room, the payphone was out of order and no mobile phones were available for detainees' use. A phone call was not offered and detainees could not therefore contact a lawyer or a family member. Detainees were not given written reasons explaining why they were detained (IS91R) until after they had a screening interview, and then only in English.

3.6 Health care needs were similar to those in the Longport freight shed and Dover Seaport, with detainees suffering from scabies and injuries sustained during the journey, and conditions related to dehydration. Detainees did not receive a routine health screening to identify individual or public health issues (see recommendation 2.48).

Safeguarding of children and adults at risk

3.7 We were told only compliant adult males with no complex needs were held at Frontier House. Women, children and families were not held at the facility.

---

5 We were unable to obtain detailed daily logs to analyse ourselves, only the Tascor summary sheet of detentions during these months.
Environment and relationships

3.8 The accommodation was only suitable for very short stays. The facility comprised a single large holding room with hard seats for 46 detainees, although we were told capacity was 30 detainees as there were only two DCOs present. There were no windows. There were separate toilets for men and women but only one was used. The toilets were fully screened but lacked seats and lids, and the doors could not be locked. The water fountain in the holding room did not work but DCOs distributed small bottles of water shortly after arrival. Many detainees had lived rough in camps in France before their journey to the UK and badly needed to bathe, but there was no shower in the holding room. Many were tired after long journeys and a night in the Longport freight shed, but there was nowhere suitable to rest. Some detainees slouched over tables to try and sleep.

3.9 Two DCOs staffed the facility. They were polite towards detainees but spent little time interacting with them. DCOs were occupied completing paperwork and preparing microwavable meals. Their focus appeared to be processing detainees rather than caring for their needs. Detainees could practice their religion. Holy books and prayer mats were available but not a compass.

3.10 All detainees held during the inspection had previously been detained in the Longport freight shed. Some had not eaten for over 24 hours and many were hungry. They had been arrested at around 1am and given water but not food at Longport. Despite being in the care of Home Office for over 12 hours, none were given food until 2pm when they received a microwave meal from Tascor staff. There was no complaints box in the facility.

Preparation for removal and release

3.11 Unlike at Dover, detainees did not see a worker from Migrant Help at the point of release.

Recommendations

3.12 Detainees should only be handcuffed if justified by an individualised risk assessment.

3.13 All detainees should be held in accommodation that is fit for purpose, with access to phones, email and internet, adequate sleeping facilities and hot and cold drinks, snacks and hot meals.

3.14 DCOs should be able to regularly and proactively check on individual detainees’ welfare, using telephone interpretation where required.
Section 4. Recommendations and housekeeping points

Recommendations

To the Home Office and Tascor

4.1 Detainees should not be transferred late at night unless there are urgent operational reasons. (2.5)

Recommendations

Longport freight shed

4.2 The use of Longport freight shed to hold detainees should immediately cease. (1.14)

Dover Seaport

Arrival

4.3 Detainees should be searched and interviewed in private. (2.6)

4.4 All new arrivals should have free access to showers and be given clean clothing if required. They should be offered an immediate free phone call and have access to a working telephone thereafter. (2.7)

Safeguarding adults at risk

4.5 Managers should ensure that detainee custody officers understand and implement best practices in relation to safeguarding adults, trafficking and suicide and self-harm prevention. (2.13)

Safeguarding children at risk

4.6 Children should only be detained exceptionally and for the shortest possible time. (2.18)

4.7 Suitable separate facilities should be provided for receiving women and children, including those with families. Unaccompanied children should never be held with unrelated adults. (2.19)

4.8 All detainees claiming to be children should undergo a Merton compliant age assessment by social services. (2.20)

Legal rights and casework

4.9 Detainees should promptly be given written reasons for detention (IS91R) in a language they can understand, and have free access to a telephone and fax machine to contact legal representatives. (2.26)
4.10 The Home Office and Tascor teams should be sufficiently staffed to ensure that detainee welfare can be assured and detention is kept to a minimum. (2.27)

Environment and relationships

4.11 All detainees should be held in decent, well ventilated and properly maintained accommodation which is suitable for their specific needs. They should have access to blankets and pillows and to hot drinks. (2.37)

4.12 DCOs should be able to regularly and proactively check on individual detainees’ welfare, using telephone interpretation where required. (2.38)

4.13 DCOs should receive regular training that helps them to understand the needs of refugees and asylum-seekers. (2.39)

4.14 The holding rooms should have appropriate foreign language reading material, and those held for longer periods should have access to fresh air. (2.40)

Health services

4.15 A full review should be carried out to establish what type of service provision is required to meet the health needs of detainees. In the meantime, all detainees should receive a health screening to identify any appropriate treatment pathway and potential public health issues. (2.48)

4.16 Custody staff should be trained to use the external automated defibrillator, which should have regular documented checks. (2.49)

4.17 The medical room should be fit for purpose with a desk and telephone access for interpretation services, and medication should be stored appropriately. (2.50)

Preparation for removal and release

4.18 Detainees should have supervised access to the internet, email and Skype facilities. (2.54)

Frontier House

4.19 Detainees should only be handcuffed if justified by an individualised risk assessment. (3.12)

4.20 All detainees should be held in accommodation that is fit for purpose, with access to phones, email and internet, adequate sleeping facilities and hot and cold drinks, snacks and hot meals. (3.13)

4.21 DCOs should be able to regularly and proactively check on individual detainees’ welfare, using telephone interpretation where required. (3.14)
Good practice

Dover Seaport

4.22 The Atrium non-detained area was a positive initiative to limit the amount of time that people spent in detention and provided useful specialist support for both adults and children in a decent facility. The collaborative work with third sector agencies to help meet the needs of detainees was particularly positive. (2.55)
Section 5. Appendices

Appendix I: Inspection team

Hindpal Singh Bhui  Team leader
Beverley Alden  Inspector
Colin Carroll  Inspector
Deri Hughes-Roberts  Inspector
Maureen Jamieson  Health care inspector
Martin Kettle  Inspector
Appendix II: Photographs

Longport freight shed holding area
Section 5 – Appendix II: Photographs

28 Longport freight shed, Dover Seaport and Frontier House short-term holding facilities
Section 5 – Appendix II: Photographs

Longport freight shed, Dover Seaport and Frontier House short-term holding facilities
Longport freight shed, Dover Seaport and Frontier House short-term holding facilities
Frontier House overflow holding room
Dover Seaport holding room

Ceiling of main holding room in Dover Seaport
Dover Seaport family room

Atrium (non-detained area) adjacent to Dover Seaport holding facility
Appendix III: Analysis of detainee logs

Dover Seaport logs analysis for 1 July to 28 September 2015

We used individual-level data provided by Tascor Services to assess the characteristics and experiences of detainees held at Dover Seaport short-term holding facility over a three-month period.

1. Overview

Total number of detainees held at the facility during this three-month period: 2,781

Proportion of detainees who were male: 96%

Average (mean) age of detainees: 24 years

Proportion of detainees who were travelling individually: 99%

Number of different countries detainees originated from: 32

Most common countries of origin: Sudan (31%), Eritrea (29%), Syria (9%) and Afghanistan (9%).

Average (mean) length of detention: 18 hours 19 minutes

Longest period of detention: 66 hours 25 minutes

Proportion held for over 12 hours: 75%

Proportion held for over 24 hours: 25%

Proportion of detainees held at the facility more than once: 4%

2. Unaccompanied children

Total number of unaccompanied children held: 370

Proportion of children under 16: 36.4%

Proportion of children under 15: 18.6%

---

6 We were unable to obtain detailed daily logs for Frontier House and had only the Tascor summary sheet of detentions during these months. No further analysis of Frontier House data, beyond what is reported in the text, was therefore possible, and only Dover and Longport analyses are included here.

7 This is likely to be an underestimate. Individual detainees within the dataset were identified using a port reference number (PRN). From the 3,067 detention events recorded, details of the PRN were missing in 182 (6%) cases.

8 With ages ranging from 0 to 61 years (median age 23). One case with an age of 115 was considered to be a data entry error and deleted (N=2,773).

9 N=2,781.

10 N=3,067.

11 N=2,781.

12 N=150. Ages ranged from 0 to 17 years, with a mean average of 15.4 and median of 16. There appeared to be at least one data entry error by Tascor, as a child under a year old had been recorded as being unaccompanied.
Average (mean) length of detention for unaccompanied children: 12 hours 19 minutes

Longest period of detention for unaccompanied children: 58 hours 20 minutes

Proportion held for over 12 hours: 37%

Proportion held for over 24 hours: 8%

Main outcome for unaccompanied children (e.g. referred to SS, etc): TA’d to Kent Social Services

3. Accompanied children

Total number of accompanied children held: 11

Age of the youngest accompanied child: 4 years

Average (mean) length of detention for accompanied children: 16 hours 2 minutes

Longest period of detention for accompanied children: 40 hours

Number held for over 12 hours: 5

Number held for over 24 hours: 2

Main outcome for accompanied children (e.g. referred to SS, etc): TA’d to Atrium

4. Who was most at risk of being held for over 12 hours?

Age, gender and country of origin were all found to be significant predictors of being detained at Dover for 12 hours or more between July and September 2015. Each year of increasing age was associated with a six per cent increase in the odds of being detained for this period. Men were significantly more likely to be detained than women (76% compared with 62%), with the odds of women being detained for this length of time being 49% lower than men. Finally, those detainees originating from outside Africa were significantly less likely to be detained for 12 hours or more (71% compared with 78%), with the odds of these detainees being held found to be 33% lower than African detainees. Whether the detainee was travelling individually or in a group had no bearing on detention length.

---

14 N=66
15 Based on 401 detention events involving an unaccompanied child, with a median detention length of 9 hours 40 minutes.
16 The shortest period of detention was 1 hour 50 minutes.
17 No outcomes were recorded for 136 (of 401) detention events involving an unaccompanied child.
18 PRN details were missing for two detention events logged as involving an under 18-year-old travelling as part of a family group. We have assumed these were two unique individuals for the purpose of our analysis.
19 Up to a maximum of 16 years, with an average (mean) of 9.5 years (N=11).
20 Median of 10 hours 35 minutes (N=11).
21 With the shortest period of detention logged as 5 hours 10 minutes.
22 Exp(B)=1.06; p=.000
23 p=.001
24 \( \exp(B)=5.1; p=.001 \)
25 Africa was chosen as the reference category as it was the most common region for detainees to have originated from.
26 p=.000
27 \( \exp(B)=.67; p=.000 \)
28 65% vs. 75%; p=.377
Longport freight shed logs analysis for 31 August to 3 October 2015

We used individual-level data provided by Home Office Immigration Enforcement (in paper form) in order to assess the characteristics and experiences of detainees held at Longport facility over a one-month period. Please note that records did not include whether the detainee was travelling individually or as part of a group. It was therefore not possible to determine whether a minor was accompanied or unaccompanied.

1. Overview

Total number of detainees held at the facility during this month period: 569

Proportion of detainees who were male: 97%

Average (mean) age of detainees: 24 years

Number of different countries detainees originated from: 15

Most common countries of origin: Sudan (41%), Eritrea (38%), Afghanistan (7%), Syria (4%).

Average (mean) length of detention: 3 hours 54 minutes

Longest period of detention: 21 hours 25 minutes

Proportion held for over 12 hours: 1%

Proportion held for over 24 hours: 0%

2. Children

Total number of detention events at the facility involving minors: 90 (16%)

Proportion of detained minors who were male: 94%

Average (mean) age of minors detained: 16 years

Number of different countries minors originated from: 10

Most common countries which minors originated from: Eritrea (52%), Afghanistan (17%), Sudan (13%) and Ethiopia (8%).

Average (mean) length of detention for minors: 2 hours 56 minutes

---

29 We did not receive data for every day within this time period. There were no logs included for 6 September 2015, 7 September 2015, 9 September 2015, 10 September 2015 and 20 September 2015.
30 With ages ranging from 11 to 60 years (median age 24). (N=563).
31 N=568.
32 The median time for the detention events logged was 3 hours and 6 minutes (N=528).
33 N=528.
34 N=563
35 With ages ranging from 11 to 17 years (median age 16).
36 The median length of detention for minors was recorded as 2 hours 40 minutes (N=84).
Longest period of detention for a minor: 21 hours 25 minutes

Proportion of minors held for over 12 hours: 0%\(^{37}\)

Proportion of minors held for over 24 hours: 1%

\(^{37}\) N=84.