

*Return to an Address of the Honourable the House of Commons
dated 25th July 2007
for the*

**Report of the Investigation into the
disturbances at Harmondsworth and
Campsfield House Immigration
Removal Centres**

by Robert Whalley CB

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Lin Homer
Chief Executive
Border and Immigration Agency

Disturbances at Harmondsworth and Campsfield House Immigration Removal Centres

Report of Investigation by Robert Whalley CB

Part 1: Introduction

Terms of Reference

1. On 1 February I was appointed by your Deputy Chief Executive
 - to investigate the circumstances of the disturbance at Harmondsworth Immigration Removal Centre on 28/29 November 2006;
 - to establish the lessons to be learnt from this event for the management of immigration detainees and for the immigration detention estate; and
 - to report to you accordingly.
2. I was asked to take account of separate police enquiries and to conduct the investigation in a way which did not impede any criminal investigation.
3. Following a disturbance at Campsfield House Immigration Removal Centre on 14 March 2007, I was asked to extend my investigation to that establishment also, with similar terms of reference, taking account likewise of any police enquiries.
4. I was also asked to identify any issues which might be relevant across the immigration estate generally.
5. No timetable was set for the investigation, but I was asked to report as swiftly as possible.

Key Message: Continuing Risk of Disturbances:

6. The Harmondsworth and Campsfield House disturbances were very different, both in causation and in how they unfolded. Both occurred at a time when recent population pressures, falling heavily on vulnerable fabric in a hard-pressed detention estate, were accompanied by dislocation in casework handling, especially in the case of Foreign National Prisoners, which caused a build up of latent tensions. (Foreign National Prisoners are defined for this purpose as ex-foreign national prisoner detainees.)

7. It did not take much to trigger these events. When they started, they soon escalated, despite best efforts to prevent this happening. The underlying causes are still there and, without any changes, the same thing could happen again at either establishment.

8. Action is proposed in respect of

- **procedures in both centres**
- **improvements to the fabric of immigration removal centres**
- **training for staff both in the centres and in caseworking units**
- **oversight by BIA of the conduct of operations in centres**
- **improved management of casework within BIA**
- **better information for detainees and their legal representatives**

Structure of this Report

9. In **Part 2, immediately following this introduction, I summarise my main conclusions under the headings of:**

- Harmondsworth
- Campsfield House
- Main lessons:
 - Foreign National Prisoners and Population Pressures
 - Casework Progression

10. In **Parts 3 to 5, I look in more detail at Harmondsworth, under the headings of:**

- Narrative of Events (Part 3)
- Tactical Issues (Part 4)
- Strategic Issues (Part 5)

11. In **Parts 6 to 8**, I look in similar terms at Campsfield House:

- Narrative of Events (Part 6)
- Tactical Issues (Part 7)
- Strategic Issues (Part 8)

12. In **Part 9** I examine an issue which in my judgment lies at the heart of current difficulties:

- Foreign National Prisoners and Population Pressures and the effect of recent events on the immigration removal estate and its staff.

13. In **Part 10** I look at another source of difficulty

- Casework progression such as information for detainees about the progress of their cases, together with contact with BIA and the legal system.

Parliamentary Context

14. The Home Secretary announced the Harmondsworth investigation by way of a Written Answer to Nick Clegg MP on 7 February 2007. The Home Secretary said that, subject to ensuring that any possible criminal prosecutions were not prejudiced, he would arrange for the outcome of the investigation to be available to the House.

15. The extension of the investigation to Campsfield House was announced by Liam Byrne MP, Minister of State at the Home Office, by way of Written Ministerial Statement on 15 March 2007.

Police Dimension

16. In accordance with my terms of reference, I have maintained contact throughout the investigation with the Metropolitan Police Service and Thames Valley Police, so as not to impede any criminal investigation into either disturbance. I have described this contact in more detail in the Annex setting out my Method of Investigation.

Scope of the Investigation

17. I have contacted a wide range of individuals and organizations in the course of the investigation, visited several immigration removal centres, and reviewed written material and CCTV footage. Full details of the methods followed and of those whom I have consulted are set out in the Annex.

18. I have made clear to all those with whom I have come into contact that:

- this is a Departmental investigation, reporting to you;
- it is not a judicial investigation and has no legal powers;
- neither is it a management inquiry, or one concerned with the conduct of any individuals;
- but it is independent in its approach, and decisions on what should be reported are for me to judge;
- my terms of reference specifically invite me to establish lessons to be learnt, so that the emphasis can be positive and forward-looking, working within the system so as to identify issues which will benefit immigration detainees and the staff charged with responsibility and care for them and their cases.

19. Inevitably, and understandably, I have been invited by a wide range of contacts and respondents to examine many issues concerned with the position of immigration detainees in a number of categories – asylum seekers, failed asylum seekers, illegal migrants and overstayers, Foreign National Prisoners, and other groups who may be detained in the course of consideration of their immigration or asylum status.

20. My attention has been drawn particularly to the position of those who may have suffered torture or persecution in their own country, those who may have been resident in the UK for some time, women, children and family groups, and those with healthcare issues, including those with mental health conditions or at risk of attempts at suicide.

21. With my terms of reference in mind, and bearing in mind the requested timescale for my report, I have not attempted a comprehensive assessment of all these issues. All of them are important and they all must remain under close and continuous public scrutiny.

22. My approach has been:

- to focus on the core issues arising from the circumstances of these events and the lessons to be learnt;
- to try to identify the main causative issues and to suggest possible remedies;
- to concern myself with policy and operational issues only to the extent that they seem relevant to the matters at hand;
- to link my investigation as closely as possible to the options available to you and your colleagues in BIA, so that action may follow swiftly if considered necessary;

- to acknowledge that other fora exist for the consideration of wider issues, both outside the Home Office (for example, the recent report by the Joint Committee on Human Rights on The Treatment of Asylum Seekers, *Tenth Report of Session 2006-7*), and inside (for example the Detention Users' Group).

Previous Inquiries

23. This is not the first inquiry about either establishment. In 1997, a disturbance at Campsfield House was investigated by Her Majesty's Chief Inspector of Prisons, and in 2004 a disturbance at Harmondsworth was investigated by Sue McAllister, then Head of the Prison Service Security Group.

24. In addition a major disturbance at Yarl's Wood Removal Centre in 2002 was investigated by Stephen Shaw CBE, the Prisons and Probation Service Ombudsman.

25. HM Chief Inspector of Prisons, Anne Owers CBE, carried out announced inspections of Harmondsworth from 17 – 21 July 2006 and of Campsfield House from 30 October – 3 November 2006.

Importance of Preventing Further Disturbances

26. In the light of previous investigations it is salutary to note the importance of learning lessons:

- the need to ensure the proper care for detainees, both within centres and in relation to resolution of their immigration status, and the disruptive effects of disturbances on these requirements;
- the need to give staff responsible for detainees the fullest possible confidence in their task;
- the damage to public confidence in the immigration removal system caused by serious disturbances;
- the disruption to the effective management of the immigration detention estate;
- the costs arising to public funds from the loss of detention facilities and the work needed to re-instate them.

Acknowledgments

27. I am very grateful for all the advice and assistance I have received in conducting this investigation. Those who have contributed are listed in the Annex. In particular, I must thank all those bodies and groups who submitted material in writing, supplemented in some cases by oral discussion.

28. Senior staff within the main Home Office and in BIA, and senior management of the private contractors, together with the Independent Monitoring Boards and management and staff at Harmondsworth and Campsfield House, and detainees, have given me valuable insights.

29. I also wish to thank the Metropolitan Police Service, Thames Valley Police, the London Fire Brigade and Oxfordshire and Fire and Rescue Service for their advice and assistance.

30. I was given valuable advice at the start of the investigation by HMCIP, Anne Owers CBE, by the Prisons and Probation Ombudsman, Stephen Shaw CBE, and by Sue McAllister from the National Offender Management Service.

31. Finally, I must record a personal debt of gratitude to the Home Office staff, Laura Jayawardane and Nadine Walsh, for their excellent support to me throughout this investigation. They have demonstrated high standards, energy, commitment and patience at all times.

ROBERT WHALLEY CB

19 July 2007

Part 2: Conclusions

Harmondsworth

Accuracy and Timing of Call-out procedures

C4.1. I conclude that there were avoidable delays in establishing contact between Harmondsworth and Prison Service Headquarters which resulted in delay in starting a call out procedure for support. I recognize that senior managers will want to assess the situation fully before triggering those calls. But in this case crucial time was lost. While that might not have been relevant in the early stages, it certainly became a factor as the night wore on.

Review of Call-out Procedures

C4.2. I endorse the need for the review of call out procedures which is in hand. It is crucial that these work as intended. All those potentially involved in operating them must be fully fluent to the extent that procedures become second nature. Staff should be trained to think ahead into the potentially developing incident and consider what further action might be needed in the immediate future. This is all the more regrettable since the same problem seems to have happened in 2004 (McAllister Report, paragraph 7.11).

Fire Service Call-out

C4.3. The confusion in the call-out of the fire service, which meant that the first appliance took 14 minutes to arrive (according to the centre management log) rather than the 5 minutes the fire brigade would have expected, points to the continuing failure, despite repeated references in reports over the years about Harmondsworth, to install in the A4 by-pass any road signs indicating the locations of either Colnbrook or Harmondsworth. On this occasion, the delay was of little consequence: another time, it might matter. I understand that directional signs to Harmondsworth and Colnbrook have been agreed with the local authority and will be installed shortly.

Keeping Procedures Up To Date

C4.4. Once the review of call-out procedures is complete I recommend that it is exercised fully to remove the risk that what happened on 28 November is repeated. Furthermore, such exercises should become both routine and frequent so as to capture staff new to the system. Senior managers should nominate staff to be responsible for ensuring that call out lists containing contact telephone and pager numbers are kept up to date. The lists of those to be contacted should include the Contract Monitor and the IMB as priority calls.

Key Responsibilities

C4.5. I conclude that the structure should look like this:

- **The core of the command and control arrangements should continue to be based on Silver at the centre;**
- **In the early stages, links will need to be developed with the local police;**
- **Thereafter the most important need is a strong link to Prison Service Gold. BIA Gold should be present alongside Prison Service Gold in the Prison Service Headquarters Gold command suite;**
- **At the same time BIA Gold should be liaising directly with senior BIA management to ensure the flow of information and take delivery of top level concerns and expectations;**
- **Prison Service Gold should then set the strategy, communicate it to Silver and leave it to Silver to implement it and to report regularly on the direction of events. Silver should have responsibility for negotiation tactics.**

Objectives

C4.6. The objectives of such a structure should be to:

- **Facilitate clarity over the respective responsibilities of the various Gold, Silver and Bronze commands;**
- **Recognize the importance of a clear information flow to senior levels, enabling key strategic messages to be received from the Gold level;**
- **Deliver a clear set of expectations from Gold to Silver level and provide every resource to enable that to be done;**
- **Settle strategies for deciding issues such as planning for interventions when the options of offering the opportunity for surrender may not have been exhausted;**
- **This will require the closest alignment of thinking on the part of both Gold and Silver: it was an issue on Wednesday morning and early afternoon.**

Further Work

C4.7. I endorse the value of further work to clarify the precise expectations which BIA and the Prison Service have of each other at Gold level. I am also told that not all Prison Service Gold Commanders have visited immigration removal centres so as to become familiar with them.

Areas for Development

C4.8. I also commend a review of the operation of the contingency plans in the contract to make sure that they cater for every contingency and do so robustly. This was an issue noted in the McAllister inquiry but not fully resolved since then.

C4.9. Such a review should cover the fire service interests, both on arrival and in drawing up an effective fire plan, to ensure that the fire service do not enter unsecured areas except to save life.

C4.10. It should focus on ensuring that Silver commanders are comfortable in their role and that they have support on crucial issues, identified below, at Bronze level, in sufficient strength. It needs to include arrangements for food and drink for detainees and staff, which are discussed below.

Why the disturbance proved so difficult to control

C4.11. A false impression had been created from the strengthening work done after the 2004 incident. It proved illusory. The residential areas could not be zoned off as planned, and the wall fabric was easily broken through. CCTV cameras were again vulnerable to physical attack, and their destruction removed the control room of information vital to an early attempt to regain control.

C4.12. The free-flow through the courtyards denied the opportunity for a phased recovery. An intervention scheduled for six o'clock on Wednesday morning, when the incident was already 9 hours old, was not complete until some 33 hours later. I understand that the centre manager is looking at this free-flow through the courtyards.

Capacity for intervention

C4.13. I conclude that the options for trying to regain control were going to be limited until early morning: there simply was not the capacity to match the escalation of the disorder with a commensurate response.

C4.14. This raises the question of what options might in future be available. Among them are:

- Ensuring that a capability greater than 28 C and R trained staff is available within one hour of call out;
- Involving the local police inside the centre, rather than just as containment outside;
- Intervening with a limited number of Tornado teams before all the requested units have arrived.

C4.15. Each of these options is difficult. The first would probably require a variation of the contract, the second could not just be agreed locally but would need full consideration within the wider Home Office and by ACPO, and the third would challenge long-standing assumptions about the need to match disorder with decisive capacity. I understand that the centre manager is exploring the possibilities under the first of these options.

Safety and proportionality of response

C4.16. All these options raise major questions of safety of staff and the proportionality of response, given the fabric of the building, the speed with which control can be lost, the risks to detainees if an incident is prolonged, and the risks to staff and detainees if intervention is made with inadequate resources.

C4.17. I have encountered differing views at senior levels in BIA as to the best way forward. But I identify this as a major issue in need of review. It should not just be taken forward locally since it raises issues of policy and cost.

Confining detainees in their rooms

C4.18. A strategy of confining detainees to their rooms which does not take account of the negative factors identified above is problematic, given the nature of the fabric at Harmondsworth. There is a strong case for appointing a senior manager, at Bronze level, to act as “champion” for detainees’ interests in such extreme situations, with their welfare as the prime consideration, so that such considerations can be taken fully into account in the tactical planning to recover control, which is never going to be easy in a place like Harmondsworth.

Sprinklers

C4.19. There is no alternative to fitting sprinklers. They played a significant role in this incident. I hope that the debriefing with the fire service will review how best the risks from fire and smoke can be balanced against the negative effects of prolonged activation of the sprinkler system on detainees and on the fabric. The fire service are aware that there is an issue here.

Food and drink

C4.20. The supply of food and drink needs careful review, which should include the following:

- Inclusion of food and drink supply in the centre’s contingency planning, on the assumption in a bad scenario like this that the kitchen may be lost;**
- Planning to include liaison with nearby custodial and detention establishments so that supplies of food and drink may be quickly mobilized (ideally on a reciprocal basis) building on current arrangements which worked to some extent;**

- **Planning to include the possibility of a protracted incident, which may require the designation at a senior level (Bronze) of someone to manage, with authority, the supply of food and drink to the centre and its allocation between staff and detainees;**
- **The Prison Service to consider what support it may need to give to its teams on the basis that provision at the centre may not be sufficient either on arrival or through a prolonged incident;**
- **Careful planning at Silver level for strategies for withholding food, balancing the inducement factor with the risk of distress to innocent victims caught up in the disturbance and of potential harm in some medical circumstances, for example in the case of diabetics.**

Transfer plans

C4.21. In looking at contingency planning for transferring detainees in emergency circumstances, renewed attention should be given to

- **Enabling detainees to be reconciled with as much of their property as possible before removal – obviously dependent on how safe the centre is at the time they leave and the timing of their departure;**
- **Maintaining these efforts rigorously after transfer to avoid detainees suffering lengthy frustration while they await reconciliation with their property, an issue which can affect their attitude in their new location;**
- **How best to maintain a comprehensive and accurate profile of the numbers of detainees who have been transferred, and to where, in the course of the disturbance;**
- **Appointing at senior level (again at Bronze level) liaison with the police and DEPMU to determine how long the police will take to process detainees before transfer, and what resources are likely to be needed, so that all concerned in the transfer process can plan accordingly.**

Indicators of Risk

C5.22. With hindsight the report of 8 November looks significant. But it was not considered out of the ordinary at the time. My conclusion from examining the Riot Risk Reports of the centre from April to December 2006 is that no specific indicators of potential unrest, beyond what is normally the case, were missed.

C5.23. That judgment is based on the way in which potential incidents of unrest were picked up by intelligence reports and followed up. The Reports show a constant flow of minor incidents involving individual detainees which are written up in considerable detail. The regime changes were reported and show no adverse effects on detainee mood.

Effect of Foreign National Prisoners

C5.24. The influx of FNPs comes through as a constant apprehension, arising from the lack of information about those with a prison background, their unknown security risk, uncertainty about population pressures and changes to the profile, concern about the suitability of FNPs for the Harmondsworth regime, and restlessness among detainees about what was going to happen to them.

Contract Monitoring

C5.25. I conclude that there would be value in reviewing the mechanisms for local oversight of the contract so as to strengthen the BIA presence, give greater clarity to the lines of accountability, and help enhance shared strategies for the centre positively.

C5.26. Much work has been done in this respect in recent months. The Operating Standards give clear guidance on what is expected. The imminent re-opening of part of the centre provides further opportunities in this respect.

Maintaining Regime Development

C5.27. When two of the residential wings of Harmondsworth re-open after re-instatement, some of the apprehension about the population and the fabric will inevitably return, together with personal feelings and worries on the part of those who were involved on 28/29 November. I assume that both BIA and Kalyx will acknowledge these feelings and respond sensitively to them.

C5.28. But a proper concern for the staff needs to be accompanied by an equally powerful determination to resume, without delay or diminution, the improvements in regime and culture which the disturbance so abruptly curtailed.

The Impact of Publicity About HMCIP's Report

C5.29. It cannot have been sheer coincidence that the disturbance happened on the day that Harmondsworth was receiving substantial and largely negative coverage on the media. But the mood in the centre around that time was largely benign and the recent regime improvements would have been clear to all.

C5.30. The underlying cause is not to be found in any build up of tension of the kind customarily detected by the usual indicators. I do not regard the fact of publication itself as a causative factor. Rather it should be seen as a trigger for events.

Other explanations

C5.31. Frustrations of a more subtle but less direct kind were probably in play:

- population pressures and the impact of Foreign National Prisoners, especially considered against the fabric of the building;
- concern about the progress of immigration cases, long and unexpected periods in detention, and uncertainty about outcomes.

C5.32. I consider both these issues in Parts 9 and 10.

Future plans for the site

C5.33. I understand that the current plan is to refurbish half the site. I have been briefed about this by the Kalyx senior management and by your senior colleagues. The rebuild plan seems to me to be the only option offering longer term security at the site for the full range of the population. It should be feasible to use two wings (giving a total of 259 places) provided that other measures are taken to minimize risk; in particular, this accommodation will be suitable only for lower risk detainees.

C5.34. A total rebuild is the only way to guarantee the continuity of places which is critical to the Government's strategies for removal. The capital costs are large. But the alternatives are potentially quite damaging to key policy objectives. I therefore strongly endorse the option of an entire rebuild of the site.

Campsfield House

Planning for Removals

C7.35. The strategies for extraction and removal at Campsfield House need a full appraisal, beginning with risk assessment, through to advance planning, and finally on to tactical implementation. They should cover the training for staff at the centre who carry out these removals, especially in the case of a detainee who plainly does not want to go. They need also to address the support available to the detainee at a high point of vulnerability and anxiety. The centre management have started this work off, but Detention Services should be closely involved in it.

C7.36. The circumstances of this removal were by no means unusual. But they led to a major incident, the loss of control of the centre for several hours, and injuries to detainees and staff.

Initial Response

C7.37. The staff on management duty at the centre correctly judged that they were facing a major incident. They realised, given the resources available to them, that it would require outside help as soon as possible. This gave a good basis for mounting the recovery from the incident.

C7.38. Apart from the failure to include the IMB in the initial round of calls, and doubts about the alerting of healthcare staff, the speed by which outside assistance was summoned was good and was correctly judged. But not all the initial calls conveyed enough information or the sense of the urgency of the situation.

Radios, Batteries and CCTV

C7.39. The centre management should brief the staff fully about the position in respect of radios, batteries and CCTV camera maintenance. Progress has been made since the disturbance, but any remaining issues should be put beyond doubt.

Command Structures

C7.40. I am concerned that it was considered necessary to change the Silver commander early on in the incident. That was a correct judgment in the circumstances, but it was a drastic response, and shows the need to review the planning.

C7.41. All those in the centre, and others outside, need to have confidence that those with the immediate command responsibility in a crisis are able to carry out their duties competently, at a time when accurate information about what is happening may be scarce. In the event, the confusion meant that control was lost for a while, turning this into a much longer incident for which the presence of the Tornado teams became necessary.

C7.42. The responsibility for ensuring the adequacy of the command arrangements in a crisis and the competence of the senior staff lies unequivocally with GEO corporately and with the centre management.

C7.43. I conclude that more work needs to be done to ensure that satisfactory procedures are in place should a disturbance like this happen again. The centre management say that this work is in hand.

Contingency

C7.44. It is of the utmost importance, for the safety of detainees and of staff, that all staff are fully briefed about every aspect of contingency plans, and not just those which involve them individually.

C7.45. I conclude that, for the avoidance of doubt, there would be value in the centre manager, together with the Contract Monitor, reviewing the contingency arrangements as a whole and validating them by reference to Detention Services.

C7.46. The centre management's efforts to ensure full outside participation in table top exercises should be given full support from outside agencies.

Fire Precautions

C7.47. I conclude, from the facts as I have found them, that the procedures for enabling the fire service to gain access to the site need to be reviewed to ensure that there is no delay and that all areas of the establishment can be reached quickly.

C7.48. The centre management should ensure that the tasking of an Emergency Services Liaison Officer (ESLO) is satisfactory, so that facilities which the emergency services assume will be available to them can be guaranteed. There should be a review with other services of the means of access and egress for emergency service vehicles.

C7.49. The example of a Memorandum of Understanding (MoU) which Oxfordshire Fire and Rescue Service have formed with Huntercombe Young Offenders Centre should be looked at to see if it provides a useful model for the provision of fire and rescue services. The centre management say that this is in place. It would benefit from further discussion with the Fire and Rescue Service.

C7.50. Since the visit of the senior fire service officer, a survey has been made of the smoke seals in the doors and doorframes in the sleeping areas. This work needs to be validated with professional fire precautions advice.

Fire Fighting

C7.51. All the fire extinguishers need to be checked, to establish beyond doubt that they work properly. Staff who may have to use fire extinguishers and any other fire equipment should be trained and confident in doing so.

C7.52. Consideration should be given, in discussion with the Fire and Rescue Service, to the provision in the centre of Self Contained Breathing Apparatus (SCBA) for staff making the first response to fire and smoke, together with initial and refresher training for staff.

C7.53. The expectations of staff who make a first response to fire and smoke should be firmly agreed between the centre management and the fire and rescue service. Staff must be clearly advised of the limitations of what they are expected to do and must then follow instructions.

Fire Evacuation Strategies

C7.54. In the light of the fact that two detainees and seven staff suffered smoke inhalation in this incident, to the extent that they required examination in hospital, I conclude that the fire evacuation strategy should be reviewed. It should consider in particular the position of the healthcare centre, but should not be confined to that. The review should include scoping of the work necessary to zone off the operation of the fire alarm.

Follow-up work

C7.55. The centre management should take the lead, with the assistance of the Oxfordshire Fire and Rescue Service, to ensure that all the lessons from this incident are absorbed and applied. BIA Detention Services must also be closely involved, as the Authority for the fabric, and because of the seriousness of the matters at issue.

C7.56. The follow up work on fire issues should be included in the multi-agency debrief, work on which should now proceed as a matter of priority.

Staff Courage

C7.57. Revised instructions will clarify what staff should do when they realise detainees may be in danger from fire and smoke. Meanwhile I commend those staff who went back into the centre to rescue detainees for their bravery in doing so.

Security of Healthcare Centre and Staff

C7.58. There is still work to be done to ensure the security of the healthcare centre and the staff who work in it. The centre management believes there would be value in a review of the stocks of pharmaceuticals to see if they could be reduced, and this should be included. This should be considered by the new healthcare centre manager.

Medical Dimension to a Major Disturbance

C7.59. The medical aspects of a potential emergency must be fully covered in contingency plans from the start of handling a major disturbance – from the alert stage, through to various contacts with detainees when they come under control, to the point when they leave the establishment. These plans should cover possible requirements for first aid assistance for detainees and staff.

C7.60. They should also cover the need to establish whether the facts of the incident suggest that detainees may have ingested large amounts of pharmaceutical drugs and, if so, what should be done to treat them.

Conduct of Review

C7.61. The centre management staff and the healthcare centre staff should initiate this work. I understand that a new healthcare centre manager will shortly be appointed: this provides the opportunity to take this work forward. But it should be subject to external scrutiny and validation, which Detention Services should arrange.

Managing Foreign National Prisoners at Campsfield House

C8.62. There is no easy solution to the question whether Campsfield House should continue to take FNPs. Campsfield House provides 10% of the capacity of the immigration removal estate and has an important role to play. The numbers of FNPs which BIA need to accommodate, in an immigration estate lacking in flexibility and bursting at the seams, mean that there is probably no other option at present but to send large numbers of them to Campsfield House.

C8.63. That being so, more needs to be done to deal with that reality. The future direction of the centre needs to have the FNP issue at its heart, at least for the foreseeable future, and to focus on responding to the challenges which they present.

Anticipation of the incident

C8.64. I conclude that there were sufficient grounds for concern about the possibility of an incident, taking all the indicators together. There are differences of view about whether this incident could have been better anticipated. But I do not think it can be argued that this incident came out of the blue. The immediate trigger was the escorted removal of an Algerian FNP.

Risk assessments

C8.65. The incident should stimulate a review of the risk assessments in operation at the centre, to include the profile of the population, the information known about them, and strategies for handling the diverse groups in the population and their individual needs.

C8.66. It should be linked to the review of the planning for removals and the training of those carrying out removals proposed in the discussion of tactical issues.

Awareness of Risk

C8.67. I conclude that the centre management should review the intelligence systems in operation at Campsfield House so as to establish whether any further indication could have been gathered in advance about this incident. That work should be linked up with efforts to risk assess every detainee arriving newly at the centre, so as to provide room-sharing risk assessments, for example, as HMCIP recommends.

Security Reporting

C8.68. The centre management should clarify to staff what information should be reported in an Incident Report and what in a Security Information Report. I believe that the Contract Monitor has requested to see the criteria for form filling and completion, which gives a good basis for this work.

C8.69. Revised instructions should be carefully explained to staff, preferably without any further expressions of disappointment, and the position regularly reviewed to make sure that staff understand what is required of them and are complying with instructions.

Smoking: Need for Policy Decisions and Ground Rules.

C8.70. I hope that an energetic effort will be made to resolve the smoking issue. It is absorbing a lot of people's time and energy at present, disproportionately so, and is a manifestation of wider feelings of mistrust and confusion.

C8.71. Subject to wider BIA policy decisions, there is a need for consistency of rules in the centre. These should then be enforced, on detainees and on staff. The change in the law from 1 July provides an opportunity to change the culture on smoking.

C8.72. I conclude that

- the centre should move to a complete non-smoking position from 1 July;
- detainees should not have personal lighters: there will be no legitimate use for them after 1 July inside the building, and to let them have lighters will only be taken as a sign of hesitancy or tacit licence to smoke on the part of the authorities;
- automatic lighters should be available outside the building, and if the present ones are inadequate, they should be replaced;
- the position should be carefully explained to existing and new detainees in the context of changes coming into force across the country from 1 July;
- the centre should make preparations now to offer support to detainees and staff who have come to rely heavily on smoking.

Management Strategies

C8.73. The centre management needs to be advised by Detention Services that there is a significant amount of staff discontent in the centre which requires urgent attention. I understand that action is in hand on this.

Discussion with Staff

C8.74. There should then follow an urgent process of discussion in which staff express their anxieties and management express their expectations. This should lead to shared outcomes, focusing on specific issues, with timetables attached. These need then to be taken forward.

Training

C8.75. This process should include training programmes covering key issues such as the needs and expectations of the varied ethnic groups in the centre. It should also include training in the issues which FNPs present, such as difficult behaviour, if possible with support from Prison Service staff seconded to the centre for short periods. I believe that this can be done without stimulating regression, in the minds of FNPs, to their custodial environment.

Staff Confidence

C8.76. The aim of this work should be to restore confidence to the staff, many of whom were clearly finding it difficult to come to terms with this disturbance, to lessen feelings of isolation and stress, and to enable staff to respond better to a complex and changing detainee clientele, not only in terms of safety and control but also in helping detainees with individual problems.

C8.77. It is also clear that the number and speed of recent senior staff changes have been unsettling for staff. That is the prerogative of the centre management, but they could with advantage reflect on the impact of such a policy on staff who are under pressure and need reassurance about the competence and continuity of their senior management.

How This Should Be Done

C8.78. This is a big task for a small centre. HMCIP's report is also on the agenda. I doubt whether it is feasible or wise to leave all this to be done within the centre alone, although the centre management must lead it, with the close involvement of the Contract Monitor.

C8.79. Detention Services should therefore consider what kind of external support can be provided, combining the resources of BIA and the Prison Service, perhaps in conjunction with a well-respected and sympathetic change management agency. The IMB should be closely involved.

Anonymous Letter

C8.80. I can find no conclusion in the results of the enquiries made into the anonymous letter. I make no comment on whether the allegations have any substance or not: I have no basis for making such a judgment. I note the clear position established from the enquiries by the senior auditor for GEO and do not doubt his conclusions. My difficulty is that such enquiries, however thorough and high-level, have not been carried out by anyone whose appointment was independent of the management.

C8.81. The only way to make progress with this would be for a third party, whether me or someone else, to take matters further with some form of legal process, where allegations could be more fully tested. The letter was anonymous, which creates a difficulty at the outset in this respect.

C8.82. I do not think that such a course would serve much purpose. I recommend that no further action is taken on the anonymous letter, although it is unsatisfactory in some respects to leave the matter like that. The way forward is to follow up the conclusions in this report quickly and thoroughly.

Main Lessons

Continuing Risk of Disturbances

C9.83. The Harmondsworth and Campsfield disturbances were very different, both in causation and in how they unfolded. Both occurred at a time when recent population pressures, falling heavily on vulnerable fabric in a hard-pressed detention estate, were accompanied by dislocation in casework handling, especially in the case of FNPs, which caused a build up of latent tensions.

C9.84. It did not take much to trigger these events. When they started, they soon escalated despite best efforts to prevent this happening. The underlying causes are still there and, without any changes, the same thing could happen again at either establishment.

Accommodating population pressures and individuals presenting risk

C9.85. The Prison Service and BIA are now in different Ministries. It will be important that, with the increased formality in the relationship (inherent in different Ministerial accountabilities, different financial and budgeting systems and different targets and objectives) new protocols reflect in robust terms the reality of the population pressures to which BIA will be subject. These should continue to cover ceilings on numbers as in the past.

C9.86. It must also remain a priority to retain in the prison system, albeit under BIA authority, those sentenced prisoners scheduled for deportation whose location in immigration removal centres would present risks, either of control or other personal circumstances, but with a corresponding flexibility to transfer cases not qualifying under the criteria but assessed as safe to do so. The current protocol provides this and will need to be maintained.

Management of the Estate

C9.87. The active management of the numbers by DEPMU, within Detention Services, is probably the best way at present of trying to match supply to demand. The Centre and Escorting Managers' Meetings, of which I have seen the minutes, show that BIA staff are alert to the pressures and quick and responsive in dealing with them. But the position is very fragile and will remain so.

Movement of Detainees

C9.88. Frequent movement around the estate is bad both for the detainee and for the system. A transfer is usually necessary, but every effort should be made

to keep transfers to a minimum. There should be a planned effort to explain to centre staff – both contracted and BIA – how the system works, their part in it, and the criteria and reasons for transferring detainees. The phrase “operational reasons” should be used as a last resort.

Helping the detainee and his legal representative

C9.89. I judge that there would be big gains if greater efforts were made to give more information to centre staff about transfers in individual cases, so that they can pass this on to the detainee and his legal representative. Lack of information is a major source of complaint.

Assessment of Security Risk

C9.90. This is one of the top issues if progress is to be made in deciding the best location for FNPs and in reassuring staff that those thought unsuitable for their centre will not be transferred there.

C9.91. When accompanied by more preparation for staff about how to handle FNPs and progress with case handling, it will help to lessen the impact which FNPs are having on the immigration detention estate.

C9.92. The reality is that there will be no choice for the foreseeable future but to accommodate substantial numbers of FNPs and the expectations of centre managers and staff should be guided by that.

Assessment of Mental Health Risk

C9.93. I do not think there is a direct link between incidents of suicide, self-harm and mental health risk and disturbances in IRCs. But in so far as they contribute to anxiety and frustration, especially among FNPs, they are a closely relevant factor. And they must continue as a focus for attention, whether or not they contribute to unrest, because of the duty of care to the individual detainee.

BIA staff in prisons

C9.94. Expensive though this is in staffing terms, it is a very good investment, so as to get ahead with risk assessment, planning for transfers, and early consideration for deportation. The benefits will accrue not only in bringing more certainty to individual FNPs but also in a reduction in needlessly blocking detention spaces.

Impact of FNPs

C9.95. The increased number of FNPs has had a major impact on immigration removal centres:

- There has been a heavy and unexpected influx of FNPs: on 28 November there were 177 in Harmondsworth out of 501 detainees;

- **On 5 June 2007, there were 1165 FNPs in removal centres and 349 (all time served) in prisons;**
- **Many FNPs arrive in IRCs with little known about them, making staff anxious about the issues they may present;**
- **Many of them have been behaviourally conditioned by their time in prison and find the IRC regime disorientating;**
- **Some of them will present manipulative and bullying behaviour which will have an impact on vulnerable detainees;**
- **Some FNPs will take advantage of the poor fabric of centres such as Harmondsworth and Campsfield House;**
- **Some will find the dual pressures of further time in custody and uncertain date of release frustrating, to the extent that, “with nothing to lose”, the temptation to join in gratuitous disorder may prove too much;**
- **A concentration of discontented detainees may prove so volatile that an otherwise innocuous event may prove a trigger point for concerted disturbance;**
- **Staff were unprepared for the influx of FNPs and not all have coped confidently with the changes.**

C9.96. The strategies to deal with this need to include:

- **Maintaining a clear protocol with the prison service about the suitability of certain categories of FNPs;**
- **A strong presence of BIA staff in prisons who can assess risk and start early work on forthcoming deportations;**
- **Better information to accompany transferred FNPs arriving in IRCs;**
- **More training for IRC staff about how to cope with FNPs, drawing on Prison Service experience;**
- **More information for detainees and better contact with BIA staff (discussed in Part 10).**

FNPs presenting risks

C9.97. There are several groups of FNPs presenting high risk in terms of potential for disorder. There is little to inhibit them if an opportunity to engage in wanton disorder presents itself. The greater their frustration at their position, the greater the risk of disorder.

Casework practice

C10.98. Much benefit would be gained, and much frustration relieved, by giving more attention to basic office disciplines and courtesies such as answering faxes, returning phone calls, checking information is accurate, and giving regular updates.

C10.99. This does not entail sophisticated new practices; rather it is a matter of simple time and desk management and awareness of how much a helpful response matters to another member of staff.

Getting the best out of the Casework Information Database

C10.100. The Casework Information Database (CID) is a vital shared tool for processing FNP cases. It has much potential, but is being held back by incomplete or inaccurate information. Developing it, and helping staff to make best use of it, is a priority task.

Locally Engaged Administration Staff

C10.101. The decision has been taken to replace BIA staff in removal centres with locally recruited administration grades. I see no merit in seeking to re-open that issue. But in the light of the pressures on staff as a consequence of the FNP problem, more should be done to help new locally recruited staff develop their skills and confidence. It requires input not only from Detention Services but also from senior managers responsible for casework.

Mobile phones, telephone links and internet access.

C10.102. There is much to gain, and little to lose, by giving detainees as much access as possible to mobile phones, telephone lines and internet access. Subject to devising the necessary protocols on use, I conclude that the provision of these facilities in all IRCs would be a major benefit.

Improving links between centre staff and caseworkers.

C10.103. This is a high priority issue. There are lots of ways of doing it: I have suggested a few, but those who have to manage these links will no doubt think of others. The key to progress is to fix the importance of these links firmly in the minds of caseworkers and to embed it as a personal objective for new staff.

Part 3: Harmondsworth: Narrative of Events

32. This section is intended to give an outline of the chronology of events on the days of the disturbance at Harmondsworth. Timings and information have been drawn from police records, Prison Service records and notes made by the centre management. This material is presented here to give a picture of how the disturbance developed, and timings should not be treated as exact.

Tuesday 28 November 2006

33. During the day shift (1200 hrs – 2000 hrs), centre management observed nothing out of the ordinary, and received no adverse intelligence. On-site and senior IND staff had spent time in the centre on the day and considered the centre to be calm. There was a normal handover at 2000 hrs.

34. At around 2115 hrs, tension began to develop on B Wing – cameras were being smashed and some detainees were expressing discontentment regarding the HMCIP report and general discontentment at being detained. The command suite at Harmondsworth was opened and senior Kalyx managers were called into the centre. A “Gate Freeze” (where no-one can pass in or out of the centre) was imposed, and gates on stairwells in B Wing were locked.

35. At approximately 2230 hrs, a fire alarm was activated in a laundry room in B Wing and detainees were evacuated onto the courtyards from B, C and D Wing. The London Fire Brigade attended, confirmed the fire was out and posed no further safety issues and then left the centre. However, they were required to attend once more very shortly afterwards after another fire had been started. The fire was extinguished, but the local police were called as a precautionary measure.

36. Cameras continued to be lost and disorder soon began to spread to D Wing. Centre management made several attempts to contact the Prison Service National Operations Unit by leaving messages and making pager calls, but were unable to obtain a response. A total of four attempts to contact the National Operations Unit (NOU) were made, but contact was not successfully made for an hour.

37. The police response unit arrived at 2315 hrs and was asked by centre management for a CAD (Computer Aided Dispatch) to be created. The possibility was discussed with police that they may be required for external perimeter support, should the incident escalate.

38. Over the course of the next hour and a half, three more alarms were triggered in C Wing and two in D Wing. Staff were unable to control the fire on C Wing and the London Fire Brigade attended the scene once again. As it became apparent the incident was escalating, staff recovered knives from the kitchen and shut off the medical gas and natural gas supply.

39. At 2345 hrs the IND Contract Monitor was informed of the disturbance. The Independent Monitoring Board (IMB) had also been called and informed.

Wednesday 29 November 2006

40. At around 0045 hrs, centre management spoke to the police again and opened a CAD, as it appeared there was not one already open. The local police attended the scene and were securing the perimeter. By 0115 hrs the Prison Service was aware of the disturbance and the Prison Service Gold Command Suite had been opened up.

41. Disorder continued to grow in the centre and cameras continued to be lost on all wings. By 0200 hrs all cameras had been lost on B Wing. Staff were being threatened and bottles being thrown at them on the wings.

42. Centre managers visited B Wing, where they were told by detainees that they were rioting. Attempts to engage in conversation or negotiation with detainees were unsuccessful, and having heard objects being smashed and doors being kicked, centre managers returned to the Command Suite. Further attempts had been made by managers to re-enter the centre and negotiate, but this had limited success.

43. Detainees were, by this time, freely mixing between wings as a result of automatic doors being opened, which happens when sprinklers operate for longer than four minutes in the centre. A roll-count was called and staff attempted to get detainees back in bedrooms and top lock the doors and secure stairwells. Staff were overwhelmed as some detainees kicked through doors to release other detainees from their rooms.

44. Staff were then given the instruction to withdraw from the centre. All staff were accounted for and withdrew from the centre. Gates were chained and padlocked and staff awaited support from the Prison Service Tornado Units.

45. 13 Tornado units were deployed to Harmondsworth to provide assistance. The teams came from: Feltham, Coldingley, Wandsworth (x2), Highdown (x2), Wormwood Scrubs (x2), Brighton, Mount, Huntercombe (x2) and Reading.

46. While awaiting the arrival of Tornado teams, the Detainee Escorting and Population Management Unit (DEPMU) began to look for bedspaces to accommodate transfers across the estate, having anticipated the loss of some parts of the centre.

47. Centre management spent the time waiting for Tornado teams to arrive to telephone rooms and speak to detainees in order to gain any intelligence available. This was before 0400 hrs, at which time all phones were disconnected in the centre by centre management, including payphones.

48. By 0300 hrs, all power had been lost on D Wing and sprinklers were operating throughout the centre. Some detainees were inside the centre and others on the courtyards. Substantial damage was caused within the centre to association rooms, vending machines and courtyard windows. Several small fires were set. Damage was also caused in the central spine in the education area.

49. Tornado units began to arrive at the centre at 0300 hrs, and continued to arrive until 0600 hrs. Intervention plans drawn up at the centre were approved by the Prison Service Gold Commander, and at around 0715 hrs, the intervention commenced. At

this stage, most detainees were still out on the courtyards, having evacuated the building the previous night during fire alarms. They had been using blankets and bedding to keep warm. There were, however, some detainees still inside the building.

50. Tornado teams did not meet any resistance from detainees, and it took approximately 45 minutes per landing to secure the centre. By 1050 hrs, Tornado leaders reported all units as secure, and that there appeared to have been no serious injuries during the disturbance. The courtyards remained to be cleared.

51. Around 1100 hrs, lunch was arranged for detainees and staff inside the building. A large group of detainees remained in courtyards and had constructed an “SOS” sign from bedsheets, which was being broadcast on television by a media helicopter flying over the centre. Police were making efforts to move the media away from the airspace above the centre.

52. Detainees began to be processed back into the centre as they were surrendering. Upon being processed, food was made available and detainees were given access to toilet facilities.

53. Police also processed every detainee before they were transferred to other establishments. They took photos, finger prints and DNA from detainees. Detainees were given an opportunity to give a statement to the police on whether they were harmed during the incident. The World Faith Team and IMB were on hand to talk to detainees at this point.

54. The decision was made that all detainees identified as potentially difficult would be transferred to other establishments, and some of those who were passive would be kept at the centre, provided there was still suitable accommodation available.

55. In the afternoon, 10 fresh Tornado units were deployed to relieve the other units. It became apparent that all detainees were not under control as first thought, as doors and walls were being kicked through in B wing – the centre was not therefore secure as had been previously thought. Tornado units re-swept some areas of the centre again to ensure it had been secured.

56. At 1340 hrs there were still 110 – 120 detainees on courtyard three who were either refusing or reluctant to re-enter the centre, saying it was unsafe. These detainees were given food and water on the courtyard. Two detainees were being treated for medical problems. One was taken to hospital with hand injuries, and another was being treated on site for a suspected heart attack.

57. Processing detainees out of the centre was going slowly and the decision was taken to speed up the processing of detainees by dealing with property within a few days of their transfer as opposed to prior to transfer. By 2100 hrs approximately 60 detainees were still left on the yard. This number had decreased to about six by 2240 hrs when A, B and C Wings were reported to be “quiet.”

Thursday 30 November 2006

58. At approximately 0215 hrs all sprinklers in the building were turned off. The decision was made to keep 60 detainees in the establishment, and that when there were 60 remaining, C&R assistance would no longer be required. This number was achieved by 0640 hrs on 30 November. Prison Service resources then withdrew from the incident and their Gold Command Suite was closed.

Part 4: Harmondsworth: Tactical Issues

Introduction: Debriefs and Follow Up.

Work in Progress

59. Part 3 of this report sets out the narrative of events, constructed from the available records and discussion with key players. Much of the essential learning and follow through was done by those with the main operational and professional responsibility and there is probably little I can add to those views and comments.

60. The debrief carried out by Kalyx on 1 December and the “10,000 Volt Discussion Amongst Friends” held at Hendon Police Centre on 5 December under Professor Jonathan Crego addressed the issues while they were still fresh in people’s minds.

Handling of the Incident

61. What is striking from these debrief sessions is the feeling among many of those involved in the incident in 2004 and the one in November 2006 that this one had been much better handled, and that lessons had been learned in so far as immediate incident management was concerned. This is welcome and reflects credit on those involved.

Next Steps

62. At this distance from events my most useful contribution is to examine issues which stand out for further attention, either as aspects of contingency planning or because they are relevant to preventing or handling further disturbances.

63. I do not intend to comment in any detail on the operational decision-making about the tactics for staff deployment, withdrawal, negotiation, surrender planning or tactical intervention by the Tornado teams. I was not present at the scene and it would be unwise of me to second-guess those who were.

64. I shall therefore deal with issues which emerge from the information available to me. Many of them will be obvious to those who took part or have responsibilities for follow up.

Initial Call Outs

Contacting Prison Service Headquarters

65. This did not happen as it was meant to. I have studied a report from the Central Authorities and Intelligence Bureau of HM Prison Service setting out the sequence of contacts from Harmondsworth to Prison Service Headquarters (PSHQ). I have also studied the Protocol for the Provision of Prison Service Assistance to Immigration Service Removal Centres (Version 2, January 2007, Annex F).

Sequence of Events

66. A telephone message from Harmondsworth (which, in accordance with out of hours procedures, was diverted to a pager) should have reached the Prison Service National Operations Unit (NOU) soon after 2331 hrs but did not do so until 2357 hrs, and gave a number to ring back which proved to be unobtainable.

67. It was not until 0028 hrs that a pager message was received with viable phone numbers for reply, including the text words “in desperate need for support urgently”.

68. Furthermore, this error was compounded by the failure to follow due process. Annex F says that if the person requesting assistance does not receive a reply from the Duty Officer within 10 minutes, a back-up procedure, involving a call to a specified pager number, should be made. This did not happen.

69. In the heat of the moment there may have been explanations why the correct procedures were not followed. But if those concerned had been properly familiar with them, contact with NOU could have been established some 10 minutes or so after the 2331 hrs call. Nearly fifty minutes were lost.

Prison Service Procedures

70. However, the problems were not just at the Harmondsworth end:

- Some time after 2357 hrs, the NOU Duty Officer contacted the staff officer to the PS Gold Command Suite who had received the 2357 hrs pager message to say that after entering the NOU messaging system she had extracted two messages, the first being at 2330 hrs.
- I am not clear why those messages were not picked up at 2330 hrs or what systems were in place to ensure that this should happen. I understand that the Prison Service are reviewing their pager system and replacing it with a human system. This seems sensible.

Timing of Initial Call-out

71. Finally, there is the question why the call to NOU was not made till 2330 hrs:

- According to the Kalyx debrief of 1 December, senior managers at Harmondsworth were advised at 2155 hrs that Beech House was in a state of disorder, after some 40 minutes of tension in the House. Events were considered serious enough to open the command suite at Harmondsworth.
- An alerting call to the NOU at that point would have been a prudent precaution. It would not necessarily have led to a call out of Tornado teams but it would have been better than leaving the calls for mutual aid to 0110 hrs, the time noted in the Central Authorities and Intelligence Bureau log.

Fire Service Call-out

72. The incident note from the London Fire Brigade (prepared as a short briefing note, not as a full report) begins with the account of their brief attendance at Harmondsworth earlier in the day (at 1540 hrs) to deal with a fire in a bin:

- They received a call from centre staff at 2226 hrs and attended at 2240 hrs, confirmed that a fire started in a laundry room in B Wing had been extinguished, and left.
- They received a further call from centre staff at 2336 hrs and dispatched a fire appliance to Colnbrook IRC next door, because the name Colnbrook was mentioned, not Harmondsworth.
- It is possible that the call-out referred to the Colnbrook by-pass, to help identify the location of the site, since there are no road signs on the by-pass indicating the location of either Colnbrook or Harmondsworth.
- When the fire service arrived at the centre, the centre staff could not find the special hydrant key.
- The fire service also encountered “initial confusion and chaos” and felt that liaison between the fire brigade and the centre management was “hit and miss”. They felt the need for more frequent meetings at Silver level.

Contract Monitor and IMB

73. The debrief also records disagreement about the timing of an alerting call from the centre to the Contract Monitor: it is claimed no contact was made until after 2345 hrs. I can find no record that the IMB were notified until 0130 hrs.

Conclusions

Accuracy and Timing of Call-out procedures

C4.1. I conclude that there were avoidable delays in establishing contact between Harmondsworth and Prison Service Headquarters which resulted in delay in starting a call out procedure for support. I recognize that senior managers will want to assess the situation fully before triggering those calls. But in this case crucial time was lost. While that might not have been relevant in the early stages, it certainly became a factor as the night wore on.

Review of Call-out Procedures

C4.2. I endorse the need for the review of call-out procedures which is in hand. It is crucial that these work as intended. All those potentially involved in operating them must be fully fluent to the extent that procedures become second

nature. Staff should be trained to think ahead into the potentially developing incident and consider what further action might be needed in the immediate future. This is all the more regrettable since the same problem seems to have happened in 2004 (McAllister Report, paragraph 7.11).

Fire Service Call-out

C4.3. The confusion in the call-out of the fire service, which meant that the first appliance took 14 minutes to arrive (according to the centre management log) rather than the 5 minutes the fire brigade would have expected, points to the continuing failure, despite repeated references in reports over the years about Harmondsworth, to install in the A4 by-pass any road signs indicating the locations of either Colnbrook or Harmondsworth. On this occasion, the delay was of little consequence: another time, it might matter. I understand that directional signs to Harmondsworth and Colnbrook have been agreed with the local authority and will be installed shortly.

Keeping Procedures Up To Date

C4.4. Once the review of call-out procedures is complete I recommend that it is exercised fully to remove the risk that what happened on 28 November is not repeated. Furthermore, such exercises should become both routine and frequent so as to capture staff new to the system. Senior managers should nominate staff to be responsible for ensuring that call-out lists containing contact telephone and pager numbers are kept up to date. The lists of those to be contacted should include the Contract Monitor and the IMB as priority calls.

Gold and Silver arrangements.

Background: how it should work.

74. The system of Gold, Silver and Bronze levels, which originated in the police service as a means of handling major incidents, has been adopted by many agencies. It is intended to clarify the different responsibilities which go with each level.

Broadly,

- Gold represents the strategic level
- Silver the tactical level
- Bronze the implementation or delivery level.

75. The success of such a system under the intense pressure of an incident depends on how well this concept of differing responsibilities is understood by those involved, whether they are comfortable with it, and whether they are prepared to let others play their part as well as discharge their own.

Numbers of Commanders

76. Each of the agencies likely to be involved in handling a major incident will want to allocate responsibilities corresponding to these levels:

- With the centre manager, BIA, the Prison Service, the fire service and the police, there may well be five each of Gold, Silver and Bronze;
- Some will be on site, and others in different locations, either headquarters or main operational buildings.

77. Even with the best prepared contingency plan, this is a lot of people. Ensuring that it works as intended requires familiarity, skill, practice and patience.

Need for clarity

78. The complexity of the command structure was noted by several of those who took part in the debriefs. In general, the structure worked well – “the best he’d seen” – from one participant. A consistent theme coming through was the need for more commanders at Bronze level to pick up specific responsibilities. I have identified some of them later on.

Who needs to be involved

79. There are several elements:

- The core of this structure in immigration removal centres is the link between the Silver command level of the centre manager, based in the command centre or control room, and the Gold command level in Prison Service HQ;
- That may not be fully effective until an incident has been running for some time, and there will therefore usually be a need for a prior link between Silver in the centre and the police (which might require further briefing for Territorial Police Commanders about the work of IRCs);
- At some point, possibly for only a limited time but crucial while it lasts, a link with the fire service will be needed;
- Finally, BIA will have a presence in the centre, a Gold presence at headquarters level, and also an active concern to ensure that top management in the BIA and the Home Office, and Home Office Ministers, are kept fully informed.

Blurring of functions

80. In this incident, I detect that the distinction between Gold and Silver became blurred at times, especially in the area of negotiation with the self-appointed leaders of the disturbance:

- The three-tier structure works on the principle that those who do the negotiation should not be the same people as those who are taking the executive decisions. Otherwise, negotiators have no room for manoeuvre when confronted with demands which are usually not acceptable. There is always the risk of making concessions at variance with the Gold strategy or the tactical plan at Silver level.
- The records show that the Silver command in the centre, some time before 0130 hrs, correctly identified the need for sufficient negotiators to deal with the various groups now moving around the centre. But this may not have seemed sufficient to some of those involved, and direct negotiations at a senior level took place later on with self-appointed spokesmen.
- This led to the handing in of letters of protest making varying demands. I have read these letters and the link with the actual circumstances of the disturbance is tenuous (which is not unexpected, in the views of centre staff).

81. While direct negotiations may have seemed necessary and logical at the time, they carried the risk of cutting across the Silver level tactics and undermining Silver's authority.

Timing strategies

82. Resorting to direct top level negotiations may also reflect strong concern at the very centre to bring an incident to a swift conclusion. That is a clear imperative and one which needs to be communicated to and understood by those setting the strategy.

83. By this stage, however, with the centre effectively lost, the question of how quickly this could have been done was bound to raise all sorts of issues about the safety of detainees and staff which were not likely to be readily resolved.

84. Certainly, the need for a clear flow of accurate and comprehensive information out of the centre is a requirement right from the start, to ensure that those with the ultimate public accountability are kept fully informed. Plans should recognize this important need and make provision for it.

Contingency Planning and the Contract

85. Finally, I have examined the requirements in the contract between the Home Office and the centre manager for contingency planning:

- Paragraph 7.8 iii is of relevance. The requirements are rigorous and designed to cover events such as those of 28 November: six exercises per year, some testing more than one plan, all plans to be tested at least annually either by live use or by means of tabletop exercises.
- In the time available I have not been able to check that all the requirements for exercises, debriefs and amendment of plans have been carried out, but I have no reason to suppose that they have not been.

- It was clear to me that the centre managers were aware of them and indeed are receptive to further work being done at senior level to make sure they are fully effective.

86. I hope that the opportunity will be taken to review the command arrangements within the context of the clear expectations for incident management laid down in the contract.

Conclusions

Key Responsibilities

C4.5. I conclude that the structure should look like this:

- **The core of the command and control arrangements should continue to be based on Silver at the centre;**
- **In the early stages, links will need to be developed with the local police and the fire service;**
- **Thereafter the most important need is a strong link to Prison Service Gold. BIA Gold should be present alongside Prison Service Gold in the Prison Service Headquarters Gold command suite;**
- **At the same time BIA Gold should be liaising directly with senior BIA management to ensure the flow of information and take delivery of top level concerns and expectations;**
- **Prison Service Gold should then set the strategy, communicate it to Silver and leave it to Silver to implement it and to report regularly on the direction of events. Silver should have responsibility for negotiation tactics.**

Objectives

C4.6. The objectives of such a structure should be to:

- **Facilitate clarity over the respective responsibilities of the various Gold, Silver and Bronze commands;**
- **Recognize the importance of a clear information flow to senior levels, enabling key strategic messages to be received from the Gold level;**
- **Deliver a clear set of expectations from Gold to Silver level and provide every resource to enable that to be done;**
- **Settle strategies for deciding issues such as planning for interventions when the options of offering the opportunity for surrender may not have been exhausted;**

- **This will require the closest alignment of thinking on the part of both Gold and Silver: it was an issue on Wednesday morning and early afternoon.**

Further Work

C4.7. I endorse the value of further work to clarify the precise expectations which BIA and the Prison Service have of each other at Gold level. I am also told that not all Prison Service Gold Commanders have visited immigration removal centres so as to become familiar with them.

Areas for Development

C4.8. I also commend a review of the operation of the contingency plans in the contract to make sure that they cater for every contingency and do so robustly. This was an issue noted in the McAllister inquiry but not fully resolved since then.

C4.9. Such a review should cover the fire service interests, both on arrival and in drawing up an effective fire plan, to ensure that the fire service do not enter unsecured areas except to save life.

C4.10. It should focus on ensuring that Silver commanders are comfortable in their role and that they have support on crucial issues, identified below, at Bronze level, in sufficient strength. It needs to include arrangements for food and drink for detainees and staff, which are discussed below.

The quality of the response: the legacy of the 2004 Inquiry

Overall review

87. As in 2004, the response varied in its effectiveness in different aspects:
- Lost ground had to be made up after the initial delayed callouts and confusion;
 - But those who had been involved in both incidents felt that this one was handled significantly better than the last and that lessons had been learnt;
 - Contact between the centre management and the staff and between the centre and the police was noted to be significantly better;
 - Despite its long-drawn out nature, it was resolved without any serious injury to detainees (one detainee punched through a window and was taken to Hillingdon hospital A and E department where he received stitches to his arm and another was treated for a suspected heart attack) or to staff;
 - There were no escapes from the secure perimeter.

Effect of earlier problems on control strategies:

88. A number of points recurred, however, and would benefit from renewed attention:

- After the 2004 disturbance efforts were made to separate floors by installing iron – mesh gates on the staircases leading between the landings, in effect to create zones which could be isolated from one another in the event of a widespread disturbance:
 - These gates proved to be inadequate in strength when attacked by detainees. This frustrated the main tactic of the Prison Service Tornado teams, which was to gain access to the top floor and sweep downwards;
 - The resulting delay required revision of the intervention planning, clearly visible on the CCTV coverage from the cameras which remained undamaged in the area of the staircases;
 - The Prison Service teams believed that they could operate Control and Restraint techniques on the staircases, but this was not the case;
 - Furthermore, there is doubt whether the doors were in fact been locked when the order to do so had been given.
- To prepare fully for incidents of this kind, the Prison Service need to have full plans of immigration removal centres:
 - I was told that hitherto they have not had full plans, but that this is now in hand and they are obtaining them. This task needs to be completed urgently.
 - It should not just be a paper exercise but should be accompanied by familiarization visits to enable the Prison Service to be as well prepared as possible.
 - If paper plans have not already been supplemented by short videos following prospective routes through the building, they might add a further dimension to planning.
- The main difficulty faced by the intervention units was the impossibility of keeping detainees in their rooms because the flimsy nature of the fabric meant that they could easily break through them and also into the riser cabinets:
 - When the fabric was wet from the effect of the sprinklers it was even easier to break down. Thus one of the main tactics in the 2004 incident – top-locking rooms – proved impossible.

- Not only did it frustrate the Tornado teams, it meant that the disturbance became much more protracted.
 - Some detainees broke out of their rooms because it was easy for them to do so. Others did so because of fright at being kept in their rooms, especially when they feared for the air supply into their rooms, and in the knowledge that fires had been started.
 - I shall consider the fabric issues in more detail in Part 5 but note here the major impact they played in the difficult resolution of the incident.
 - The expectation may have been gained from the McAllister Inquiry (paragraph 8.5) that locked doors would provide not only some physical barrier but also “an indicator of control on the part of staff”. This proved to be an illusion.
- Furthermore, it created conflicting impressions of whether the incident was “under control”:
 - this caused difficulty, particularly over how long the Prison Service Gold arrangements should stay open;
 - For BIA, the incident is not resolved until the immediate future of all the detainees is secured.
- A pattern of staff withdrawal similar to 2004, and for similar reasons, became necessary:
 - The zoning plans after the 2004 incident proved inadequate;
 - The flimsy fittings of CCTV cameras, fixed onto easily accessible low ceilings, presented easy targets, as shown in the final moments of footage on some of those cameras;
 - The ready access to all the courtyards, following the automatic opening of all the courtyard doors following the fire alarm activation, generated by the smoke from the laundry fire, made impossible a staged response to enable areas, and the detainees in them, to be brought under control;
 - It also made it impossible to isolate the main perpetrators from other detainees, with the added risk that weaker detainees might have been coerced into continuing to take part.
- Ad hoc negotiations with groups of detainees were likely to have only limited success because of the free flow and the detainees’ obvious sense that they had quickly gained the upper hand:

- The frequent use by detainees of the wall-mounted telephones, shown on the CCTV footage before the cameras were destroyed, shows the extent of this movement;
 - It was thus inevitable that the residential areas of the centre would become unsafe for staff, requiring their withdrawal and the securing of the perimeter;
 - Staff who were trying to maintain contact with detainees were being verbally abused and threatened as they did so. As Harmondsworth is currently configured, once that has happened a protracted incident is inevitable.
- The planned intervention to regain the centre inevitably became a long process:
 - The plan was activated at 0602 hrs on Wednesday, but at 1450 hrs, nearly 9 hours later, detainees were still breaking through walls on Beech and Cedar units;
 - At 2000 hrs on Wednesday the wings were “reasonably quiet” but the log shows that it was not until 0552 hrs on Thursday morning that “the 3s” and Ash wing had been cleared;
 - And still further till 1526 hrs on Thursday afternoon before the Prison Service Control and Restraint teams reported that all the wings had been cleared.

Conclusions

Why the disturbance proved so difficult to control

C4.11. A false impression had been created from the strengthening work done after the 2004 incident. It proved illusory. The residential areas could not be zoned off as planned, and the wall fabric was easily broken through. CCTV cameras were again vulnerable to physical attack, and their destruction removed the control room of information vital to an early attempt to regain control.

C4.12. The free-flow through the courtyards denied the opportunity for a phased recovery. An intervention scheduled for six o'clock on Wednesday morning, when the incident was already 9 hours old, was not complete until some 33 hours later. I understand that the centre manager is looking at this free-flow through the courtyards.

Timing of Interventions

Who provided support and how quickly

89. It is clear from the tactical issues described so far that the nature of the response was inevitably going to be shaped by the initial confusion over call-outs and the difficulty in restoring order because of the layout of the residential areas.

90. With future planning in mind, I have therefore examined three issues which are relevant if the key objective of the strategy is to try to bring the situation under control as far as possible:

- The first question is whether the local response from centre staff is likely to be sufficient.
 - Under the contract, the centre is required “*to train sufficient staff to ensure that it can provide 28 staff trained to advanced level in control and restraint techniques when activated. The Contractor will be able to deploy these staff at the Detention Centre within one hour of activating contingency plans*”.
 - The issue of local response was discussed at the weekly Operational Meeting on 11 November, a couple of weeks before the disturbance. The Contractual position was checked, and the centre management said that “sufficient staff will be trained to provide 2x14 staff units and commanders...5 people have been booked on a course, but...obtaining training is difficult”. The training availability issue was to be investigated further across the immigration removal estate.
- A clear view in the debrief process was that the collective response was not fast enough or effective enough to deal with the escalation of the situation.
 - The debrief reports show that by 2155 Beech House was in a state of disorder and cameras were being lost;
 - Another member of staff commented that there was “a distinct lack of dedicated bronze commanders eg siege area bronze controlling movements in and out”;
 - Other reports show that staff tried to engage detainees in conversation until it was no longer safe to remain, at around 0130 hrs. Both these points are well demonstrated on the CCTV footage.
- This raises the question whether more outside support is needed early on, so as to deal with disorder as soon as possible and to demonstrate clear determination and capacity to detainees in the early stages of an incident.
- Local outside help did arrive quite quickly, and the debrief reports comment on this. Compared with 2004 the plans seem to have worked well. The Fire Brigade attended at 2226 hrs, after the short delay noted above, and

confirmed that the fire in the laundry room had been extinguished. They left, only to return about an hour later.

- The Police Response Unit arrived at 2315 hrs, and were effectively placed on hold:
 - It was not immediately clear that they were fully aware of the potential need to activate a Computer Aided Despatch (CAD) to ensure that sufficient police resources were dispatched quickly. This point comes through repeatedly in some of the logs.
 - The police's main function was to contain the perimeter and prevent any escapes, and the reports show (though not in any detail) police deployment with dogs, at various times from 0210 hrs onwards in the fire road, in the knowledge that at least one window had been broken, with the perimeter secure at 0247 hrs.
- The main support for those trying to control the scene came, in accordance with plans, from the Prison Service Tornado teams:
 - This process was delayed by the confusion in the call-out procedures described above, but the logs show that by 0225 hrs 13 Control and Restraint (C and R) Units had been activated, with various estimated times of arrival from 0400 hrs onwards. Twelve Units were due to arrive by 0530 hrs and the last one by 0700 hrs.
 - An intervention plan was under discussion in the Gold suite from 0402 hrs.

Conclusions

Capacity for intervention

C4.13. I conclude that the options for trying to regain control were going to be limited until early morning: there simply was not the capacity to match the escalation of the disorder with a commensurate response.

C4.14. This raises the question of what options might in future be available. Among them are:

- **Ensuring that a capability greater than 28 C and R trained staff is available within one hour of call out;**
- **Involving the local police inside the centre, rather than just as containment outside;**
- **Intervening with a limited number of Tornado teams before all the requested units have arrived.**

C4.15. Each of these options is difficult. The first would probably require a variation of the contract, the second could not just be agreed locally but would need full consideration within the wider Home Office and by ACPO, and the third would challenge long-standing assumptions about the need to match disorder with decisive capacity. I understand that the centre manager is exploring the possibilities under the first of these options.

Safety and proportionality of response

C4.16. All these options raise major questions of safety of staff and the proportionality of response, given the fabric of the building, the speed with which control can be lost, the risks to detainees if an incident is prolonged, and the risks to staff and detainees if intervention is made with inadequate resources.

C4.17. I have encountered differing views at senior levels in BIA as to the best way forward. But I identify this as a major issue in need of review. It should not just be taken forward locally since it raises issues of policy and cost.

Welfare of Detainees

The most important consideration

91. So far I have considered factors affecting how the incident was brought under control. This is important in the interests of all those concerned, both staff and detainees.

92. But the welfare of the detainees is the paramount consideration and it is put at risk by disturbance – risk of being caught up in physical disorder; risk from fire and smoke; risk of intimidation and coercion from ringleaders; risk of being kept out of their rooms, possibly in the open air, for long periods; risk of disruption to supplies of food and drink; risk of damage to their property or becoming separated from it; risk of abrupt removal to another immigration removal centre and risk of disruption to the processing of their immigration cases.

93. Many of these issues have been raised within a letter you received from civil liberties group, Liberty, of which I have been sighted. This was accompanied by a number of witness statements detailing detainee experiences at Harmondsworth both during and prior to the disturbance.

Specific Issues Affecting Detainees' Welfare

94. Among the issues emerging from this disturbance from the perspective of the welfare of detainees are these:

Locking detainees in rooms

- The contract assumes that facilities will be available to lock detainees in their rooms from the outside “so as to preserve evidence in the event of an incident, secure a room to protect property or secure detainees for control purposes

where necessary". On this occasion that plan failed because some detainees managed to unlock doors, and others simply broke through walls.

- This may have been done by some detainees to escalate the disorder. But allowance needs also to be made for detainees' alarm and distress, in the knowledge that fire alarms were sounding, that staff were no longer in control, or even that the air supply to their rooms would be blocked by water from the sprinklers coming under the doors, of which I have received some anecdotal evidence, at a time when supplies of drinking water in rooms were likely to be limited.
- An outside support group which contacted detainees in their rooms reported that some found the event highly traumatic, with detainees locked in their rooms for long hours without access to food, water or toilet facilities; another detainee inhaled smoke in his room causing him to vomit; another endured the sound of the fire alarm in his room for about 5 hours.
- The Silver strategy of ringing telephones in rooms to check to gain intelligence shows a proper concern to try to establish what conditions were like for those cut off in their rooms.

Sprinklers

- The sprinklers were installed in all areas of the centre after the Yarl's Wood incident in 2002, and were activated in the 2004 incident. As in 2004, their activation prevented fires from spreading further.
- I have studied closely the discussion of sprinklers in Stephen Shaw's report on Yarl's Wood. There is in my view no alternative to installing sprinklers in a centre like Harmondsworth, given the risk which fire and smoke would otherwise present:
 - The activation of sprinklers is not without cost, in terms of discomfort and distress to detainees in their rooms, which is increased if they are moved into the open air. This is demonstrated by the CCTV footage showing detainees huddling in the courtyards in blankets.
 - Furthermore, water damage to flimsy partitions destroyed any remaining strength in them and aided escape. Water caused longer term damage to the building, demonstrated to me when walking around the damaged units – undrained water just below floor level and mould and fungi growing on walls.
 - In this case, the sprinklers were kept running for 24 hours, which may have been judged necessary while fires kept on being started, but which came at a considerable cost both to detainees and to the fabric. The fire service report said that "*the intricacy of the separate sprinkler systems and the fact that fires were still raging/being lit rendered this request (to turn off the sprinklers) inoperable*".

Food and drink

- Food and drink are issues of supreme importance in immigration removal centres. I have found conflicting evidence, some believing that the arrangements worked well, others that they did not, either for detainees or for staff. It was noted as an issue by the Harmondsworth Independent Monitoring Board while the disturbance was in process.
- The Independent Monitoring Board next door at Colnbrook, to which some detainees were moved, told me that:

“the arrivals in the evening were hungry (ravenous, I’d say) and cold and very grateful for the reception at Colnbrook...there was no food (not even cold) available for them at Harmondsworth, so I understand...catering in circumstances like this might be an issue that needs looking at.”

- The kitchens at Harmondsworth were lost at an early stage. Food and drink were provided from a number of sources. When the centre shop was broken into, food and drink were taken. Colnbrook provided 2800 additional meals that week. The debriefs acknowledge that “Colnbrook effectively fed everyone for 3 days as did HMP Bronzefield”. Feltham sent a van of crisps and drinks. In the early stages food came from McDonalds. Detainees potentially missed out on 5 consecutive meals.
- At other times food was withheld from detainees at loose in the yard to increase the inducements to them to surrender. The logs show some conflict between this strategy, formulated at Silver level, and concerns mainly at Gold level to ensure that minimum needs of food and drink were being met.
- Food for the staff, especially the Prison Service Tornado teams, was also an issue:
 - I was told that when the Tornado teams arrived, no provision had been made for feeding them. I have also seen anecdotal claims that food intended for detainees was diverted to feed the Tornado teams;
 - One report said that adequate food was made available but “was diverted and stored by some elements causing others to go without” – it is not clear who the “elements” were;
 - Another report cast doubt on whether priority was given to feeding the detainees, though I cannot say whether that report was fully informed by the tactical decisions about making food available to them.
- The police service had their own feeding arrangements but these were available only for the police service.

- This was a protracted incident. Quite apart from the tactical issues about when to give detainees access to food, providing food for large numbers of people over a period of nearly 40 hours went beyond logistics and came to be something of a morale issue.

Conclusions

Confining detainees in their rooms

C4.18. A strategy of confining detainees to their rooms which does not take account of the negative factors identified above is problematic, given the nature of the fabric at Harmondsworth. There is a strong case for appointing a senior manager, at Bronze level, to act as “champion” for detainees’ interests in such extreme situations, with their welfare as the prime consideration, so that such considerations can be taken fully into account in the tactical planning to recover control, which is never going to be easy in a place like Harmondsworth.

Sprinklers

C4.19. There is no alternative to fitting sprinklers. They played a significant role in this incident. I hope that the debriefing with the fire service will review how best the risks from fire and smoke can be balanced against the negative effects of prolonged activation of the sprinkler system on detainees and on the fabric. The fire service are aware that there is an issue here.

Food and drink

C4.20. The supply of food and drink needs careful review, which should include the following:

- **Inclusion of food and drink supply in the centre’s contingency planning, on the assumption in a bad scenario like this that the kitchen may be lost;**
- **Planning to include liaison with nearby custodial and detention establishments so that supplies of food and drink may be quickly mobilized (ideally on a reciprocal basis) building on current arrangements which worked to some extent;**
- **Planning to include the possibility of a protracted incident, which may require the designation at a senior level (Bronze) of someone to manage, with authority, the supply of food and drink to the centre and its allocation between staff and detainees;**
- **The Prison Service to consider what support it may need to give to its teams on the basis that provision at the centre may not be sufficient either on arrival or through a prolonged incident;**

- **Careful planning at Silver level for strategies for withholding food, balancing the inducement factor with the risk of distress to innocent victims caught up in the disturbance and of potential harm in some medical circumstances, for example in the case of diabetics.**

Transfer of detainees

How this was done

95. The records show that early consideration was given to the need to transfer detainees away from the centre. From the early stages, the tactics comprehensively included the involvement of BIA's own Detention Escorting and Population Movement Unit (DEPMU), the escorting company, other immigration removal centres, prisons and police stations. The police on site set up in the Sports Hall and in courtyard 4. The main issues were these:

- All this had to be done out of office hours as well as within:
 - Although those concerned in this system are aware of the need that at any moment they will have to switch to 24/7 mode, this was an impressive achievement, not least because in the early hours of Thursday reports were received of a possible "copycat" incident at the IRC at Lindholme;
 - The whole immigration removal system was under sudden stress and responded extremely well. Displacement across a detention estate with limited flexibility inevitably involved a ripple effect extending as far as Dungavel in Scotland.
- There were some problems, especially in separation of detainees from their possessions:
 - This was likely to be the source of immediate frustration and distress. Linkage of detainees with their property (which in the case of detainees transferred to Colnbrook led to complaints which did not tail off till February) was still an issue at Campsfield as well;
 - At an early stage in the disturbance it was decided that detainees should leave with their property but, due to the time taken, this was abandoned part way through the process.
- A recurrent theme in the logs is concern over how many detainees were accounted for, and how many were being transferred:
 - Inevitably the fluid circulation of detainees around the courtyards, the problems of where to hold those brought under control, and the renewed loss of areas thought to be under control, compounded this problem, as did the varying arrangements for transfer as places and transport became available;

- The question of how many were accounted for surfaced twice when the incident was almost resolved on the Thursday afternoon.
- Control of records of movements under conditions of stress may again benefit from senior level designation:
 - This is another task to fix on a Bronze commander;
 - It should include ensuring that detainees leave with their property and their records and files, giving support to those working, in some confusion and under severe pressure, to ensure that this is done accurately.
- There was also an issue over the time taken to “process” detainees for transfer:
 - The lead was with the police, who were concerned to ensure that nothing was lost of potential evidential value in terms of criminal proceedings;
 - As the detainees were fed they were given access to toilet facilities: the police then took photographs, fingerprints and DNA, after which the detainees were given the opportunity to give a statement and say whether they were harmed.
 - These were necessary measures, but inevitably they added to the frustration for some detainees whose normal lives had been disrupted for the best part of two days, many of whom were wet, cold, tired and hungry;
 - There is one report that at one stage the police ran out of DNA kits which hindered the removal process.
- The timetable for the transfer of detainees proved rather erratic:
 - Some of the transport which had been arranged waited so long that drivers were “out of hours”;
 - Later on the speed of discharges increased but the processing arrangements were hard pressed to keep up;
 - These necessarily, and correctly, entailed assessing the suitability of detainees for their new location, according to their risk factors.

Conclusions

Transfer plans

C4.21. In looking at contingency planning for transferring detainees in emergency circumstances, renewed attention should be given to:

- **Enabling detainees to be reconciled with as much of their property as possible before removal – obviously dependent on how safe the centre is at the time they leave and the timing of their departure;**
- **Maintaining these efforts rigorously after transfer to avoid detainees suffering lengthy frustration while they await reconciliation with their property, an issue which can affect their attitude in their new location;**
- **How best to maintain a comprehensive and accurate profile of the numbers of detainees who have been transferred, and to where, in the course of the disturbance;**
- **Appointing at senior level (again at Bronze level) liaison with the police and DEPMU to determine how long the police will take to process detainees before transfer, and what resources are likely to be needed, so that all concerned in the transfer process can plan accordingly.**

Part 5: Harmondsworth: Strategic Issues

Police Enquiries

Harmondsworth before the disturbance

96. Assessment of the conditions in Harmondsworth in the period leading up to the disturbance on 28 November is a key issue. I shall deal with it first among the strategic issues which might have relevance to the disturbance.

Progress of police enquiries

97. I refer to my terms of reference, and in particular to the requirement to take account of police enquiries and to conduct the investigation in a way which does not impede any criminal investigation.

98. I established contact with the Metropolitan Police Service at the outset. I explained to them the nature of my task and invited them to tell me as much as they could about their enquiries so that I could avoid any action which might impede their work.

99. I have kept in touch with them at intervals since the initial meeting and am grateful for the assistance they have given me. In particular, I have asked them to indicate whether any particular lines of investigation on my part were likely to concern material which was going to be part of their investigations.

Basis of police action

100. At an early stage, the police told me that they would give consideration to whether any of the material they had gathered at the site and subsequently was likely to give rise to criminal proceedings. That was inherent in the enquiries they made before detainees were transferred, as set out in Part 4. It has been my close concern to have regard to that possibility. I understand that five people have now been charged with criminal offences, which are likely to come to trial after I have completed my report.

Timing of investigation in relation to police enquiries

101. I took advice on whether I should defer completion of my report until after any trials. On the basis of advice, I decided to complete that part of my report which considers the background to the disturbance. I believe there is a public interest in doing so. To defer any comment until after any trials would risk leaving at large issues which, if addressed, might help to prevent further disturbances. That would perpetuate risks potentially harmful to both detainees and staff, which to my mind would be unacceptable. You had a similar consideration in mind in asking me to report as swiftly as possible.

102. Furthermore, issues about the mood within the establishment can be considered generically and quite separately from issues about the actions of any

particular individuals. Such issues have already been considered in the debriefs which have already taken place.

No comment on individual detainees

103. Against that background, I offer no comment in this report on the conduct of any individual detainee and make no reference to individuals who might have been caught up in the disturbance or offered statements about it. It is perfectly possible that preparatory actions on the part of individuals could have been carried out without coming to the attention of the authorities.

104. To the extent that the report lacks specific detail in this respect, therefore, it reflects the need not to impede the police investigation. I have however judged it right to consider a wide range of possible causative factors.

Assessment of the Mood Prior to the Disturbance.

An atmosphere of calm

105. There is a clear view among all those whom I consulted that the mood in the period prior to the disturbance was in general good, both in the days beforehand and on 28 November itself. I base this statement on these conclusions:

- No-one involved in the senior management of the centre, either in the Kalyx leadership or in the management team at the centre, expected the disturbance. Nor had the BIA Contract Monitor or Deputy Monitor, who toured the centre for an hour in the course of the afternoon, detected any variation in mood.
- None of the indicators which would normally act as a guide to the mood of the establishment showed anything unusual. If anything, they suggested that the mood was relatively benign.
- This view was substantiated by those from outside the centre who had visited in the day or so before. The IMB had detected no obvious signs. The Refugee Council had visited the centre on 27 November. They regarded the atmosphere in the centre as poor generally, but did not think it out of the ordinary on the day of their visit. They did not interact with any detainees.
- On the day of the disturbance itself, a group from the Prison and Probation Ombudsman's Staff and a senior member of staff from the Detention Services Directorate had visited Harmondsworth. Neither had identified any signs suggesting that any disruption was imminent.

Indicators and Intelligence

The measures available

106. If a disturbance breaks out when none of those who might have detected something did so, the indicators should be reviewed to see if they are adequate, if they are measuring the right things, and if they are being interpreted correctly. They will

not necessarily reveal anything if a disturbance has been planned covertly, and they may turn out to be inadequate, but they provide a starting point for assessment of the mood.

Security Information Reports and Incident Reports

107. I have therefore, with the assistance of the staff at the centre with responsibility for security, looked through material on Security Information Reports (SIRs) and Incident Reports to see if they indicate anything relevant to this disturbance:

- The weekly risk assessment had indicated that Harmondsworth had been calm and stable for a number of weeks without any notable incidents or increase in tension in the centre;
- The Riot Risk Reports from April to November 2006 do not show trends of significance:

○ April:	129 incidents	low risk assessment
○ May	157 incidents	low risk assessment
○ June	163 incidents	medium risk assessment
○ July	166 incidents	medium risk assessment
○ August	136 incidents	medium risk assessment
○ September	201 incidents	medium risk assessment
○ October	148 incidents	medium risk assessment
○ November	213 incidents	medium risk assessment
○ December	87 incidents	high risk assessment
- The assessment was raised from medium to high on 28 November in line with the incident. The report for November, in describing the disturbance, says that
 - “There was no prior intelligence received by the Security Department to indicate the possibility an incident of such scale would occur”
 - “No prior reports were received from staff therefore the trigger point remains unidentified”
 - “Prior to the incident, and to date, intelligence indicates no specific threat group held in custody within the establishment”
- The risk assessment was raised from low to medium in June. The report for June says:
 - “During the month of June the Centre was quiet, but the management internal assessment remained at medium, due to the amount of detainees arriving from HMP”
- This brief reference in the June report was amplified in these terms:

- “UKDS continue to receive a large amount of Detainees from the IS initiative “Operation Scully” which is a Home Office operation to locate foreign national prisoners released from custody without due consideration being given to their deportation...The minutes received from the last security meeting, convened and led by UKIS, record the following statement from a senior UKIS representative, *“the temperature in the estate is expected to rise due to this increase which estimates 7400 ex offenders expected to be transferred to the IS estate over the next two years; therefore requiring the need for extra vigilance by all”*
- The Riot Risk Assessment reports indicate the potential for some disorder:
 - The August report refers to *“intelligence relating to potential unrest within the Centre, due to the introduction of stairwell gates in A Wing and the associated change of regime”*
 - In September there was intelligence on a planned protest on *“the closing off of association rooms during the night to introduce a quiet time”*
 - But neither of these incidents materialized and in the second case the situation was resolved by discussion with detainee representatives.
- The reports for October and November, which would have anticipated any disorder if this had come to light, are mixed:
 - There is the continuing concern over the influx of Foreign National Prisoners (FNPs), which I examine in more detail in Part 9, expressed in apprehensive terms;
 - There is one report for 8 November referring to *“a plot underway to cause a disturbance at Harmondsworth”*. Security staff note that such reports occur frequently;
- On the other hand, the impact of recent regime changes, discussed below, is beginning to come through. October’s report says:

“In September’s report the Security Department reported feedback on the completion of the new internal regime. We can now confirm that, during the month of October, there have been no reports to state that there were any concerns of unrest within the Centre regarding the new regime”.

Conclusions

Indicators of Risk

C5.22. With hindsight the report of 8 November looks significant. But it was not considered out of the ordinary at the time. My conclusion from examining the

Riot Risk Reports of the centre from April to December 2006 is that no specific indicators of potential unrest, beyond what is normally the case, were missed.

C5.23. That judgment is based on the way in which potential incidents of unrest were picked up by intelligence reports and followed up. The Reports show a constant flow of minor incidents involving individual detainees which are written up in considerable detail. The regime changes were reported and show no adverse effects on detainee mood.

Effect of Foreign National Prisoners

C5.24. The influx of FNPs comes through as a constant apprehension, arising from the lack of information about those with a prison background, their unknown security risk, uncertainty about population pressures and changes to the profile, concern about the suitability of FNPs for the Harmondsworth regime, and restlessness among detainees about what was going to happen to them.

Oversight by BIA Contract Monitor of BIA Performance Standards

Importance of Contract Monitor Role

108. In looking at possible indicators bearing on the mood of the centre, I include the oversight exercised by the BIA Contract Monitor. I do so because under a contracted-out arrangement the day to day operation of the centre is necessarily at arm's length from BIA.

109. It is of course in the contractor's interest to remain alert to any possible indicators of trouble while maintaining an open and active engagement with detainees.

How the Contract is monitored at Harmondsworth

110. I have therefore briefly reviewed the indicators available to the Contract Monitor:

- Physical presence in the centre, which on 28 November revealed nothing unusual when the Contract Monitor visited the centre for about an hour;
- Reviewing on a 24 hour basis the use of Rule 40 (Removal from Association), Rule 42 (Temporary Confinement) and Rule 43 (Special Control and Restraint) under the Detention Centre Rules 2001:
 - These important provisions exist to ensure that the Secretary of State has effective oversight and authority over the control of difficult detainees. They are a valuable indicator to the Contract Monitor of any untoward issues;

- The Contract Monitor did not report any particular concerns from the use of these powers, nor were any issues bearing on security apparent;
- Formal communication at Harmondsworth between the Contract Monitor and the centre manager, done by means of Weekly and Monthly meetings held in the Contract Monitor's Office under the Contract Monitor's Chairmanship:
 - The monthly meetings include BIA representation on the contract management side also. I have seen a number of these minutes, but they do not comprise a full record;
 - It is not always clear that an action tasked at one meeting had been followed through or reported back at a subsequent one. Various people were tasked to follow up a range of issues;
- The minutes of the weekly meeting on 11 November show concerns about the increase in self harm attempts over the previous few months. There was some discussion about whether this represented:
 - an increase in those received in Harmondsworth who had been previously assessed as at risk from self-harm;
 - or whether it meant an increase in actual attempts at self-harm.
- The minutes of the monthly meeting on 16 November show:
 - Under the "operational trends and riot risk" report, lack of information was still a concern and there had been an upward trend in assaults which the centre management were researching;
 - Concerns were expressed about the number of self harm cases in the centre, on which more statistics were to be gathered.

What these reports showed

- It is clear that these meetings, especially the monthly meetings, enable the Contract Monitor to raise issues of concern, and it is also clear that they have been used for that purpose.
 - The minutes I have seen reflect the issues I would have expected to see discussed, both security issues and the incidence of self-harm;
 - The references to assaults on staff and self-harm are clearly of concern. But they do not amount to activity suggestive of the possibility of disturbances to the extent of this incident.
- The initiative with resolving some of these issues rests with the centre manager. The relationship is supposed to be an equal one, backed up by contractual sanctions. I am not convinced that it works quite like that. Without wanting to re-open the old wounds of the previous contractual

dispute, and taking due account of the significant improvements under the recent centre management leadership, I think that the BIA stance could do with being strengthened.

- I was told of a tendency for the centre management to leapfrog the Contract Monitor and take issues to Detention Services central management.
- It will be for BIA to respond to this point, but I wonder if more use should be made of the Detention Services Operating Standards manual, of which I have seen a consolidated version.
 - This has to be set alongside the Detention Centre Rules and the centre-specific contract;
 - The relationship between the three documents may need to be clarified.
- But the Operating Standards provide:
 - an audit trail, especially in the area of record keeping, but also a means by which the BIA staff on site can hold the centre management to account;
 - Examples of such record keeping include case progress, healthcare, personnel, race relations, safer removal centres, security, escorts, searching, self-audit, suicide and self-harm, and use of force.
- This must of course be kept in proportion. The last thing one wants to see would be centre staff retreating from the wings into offices so as to fill in forms all day long. And the Contract Monitor may need to be selective and focus on areas of real concern, as was clearly the case here.
- But the Standards seem to be very clear in their high expectations of performance. Where they lay down requirements for record keeping and reporting, they should be followed. If this enhanced the authority of the Contract Monitor directly within the centre, it would re-balance things somewhat. It would certainly enable the Contract Monitor to probe issues which were not directly related to the contract.
- The contractor might object to that. But public accountability rests with BIA and with Home Office Ministers and, against the background of the problems of the past year, anything which enhances that is, in my judgment, desirable.

Conclusions

Contract Monitoring

C5.25. I conclude that there would be value in reviewing the mechanisms for local oversight of the contract so as to strengthen the BIA presence, give greater clarity to the lines of accountability, and help enhance shared strategies for the centre positively.

C5.26. Much work has been done in this respect in recent months. The Operating Standards give clear guidance on what is expected. The imminent re-opening of part of the centre provides further opportunities in this respect.

Regime Improvements.

Past Criticisms

111. The regime at Harmondsworth has been a focal point for comment for some time:

- It had attracted much criticism for excessive concentration on security (for example, in not allowing detainees to have bars of soap in case imprints of keys were taken);
- It was characterized as having a prison-like atmosphere, where detainees were not treated with respect (for example, being referred to by their room number or given name only);
- It was claimed that insufficient attention was paid to the provision of a varied regime, or equally to the needs of immigration detainees, which are very different from those of sentenced prisoners.

112. This was the picture broadly painted by Her Majesty's Chief Inspector of Prisons, in her report of an announced visit in July 2006, when she produced what she described as "undoubtedly the poorest report we have issued on an IRC".

Recent Developments

113. Several of my interlocutors painted an equally bleak picture. The more discerning of them however had noticed the significant, some would say dramatic, improvements in the regime since the summer of 2006. A change in leadership at the centre was accompanied by a determination to improve the staff/detainee relationship and the overall culture of the centre.

114. This had been favourably commented on both by BIA staff and by visiting groups. It is a tribute to the centre's leadership that outside groups whose natural inclination is not to find much to praise in the management of detention cases have acknowledged to me the significant progress which has been made.

Effect of Regime Improvements

115. In all the evidence I have received, I have detected nothing which indicated that regime issues lay behind this disturbance:

- Whatever concerns detainees may raise about their cases, few concerns about the regime were mentioned;

- Nor were the staff showing undue concern about the changes which were being introduced under a vigorous change management programme;
- I have no doubt that there were elements among the staff who found the changes challenging, as inevitably happens in such situations, but the mood of the staff meeting which I conducted, and more particularly the responses to my questionnaire to staff, do not reveal a staff lacking in confidence or unwilling to get stuck into the challenge of taking the regime forward positively;
- The concerns raised with me by staff were about the profile of the detainees and the risks of accommodating them in the questionable fabric of the centre, not about the regime which they were required to operate;
- It is a good thing that the centre has been kept going since the disturbance with a reduced staff to cater for a population of 60, so providing continuity between past and future.

Conclusions

Maintaining Regime Development

C5.27. When two of the residential wings of Harmondsworth re-open after re-instatement, some of the apprehensions about the population and the fabric will inevitably return, together with personal feelings and worries on the part of those who were involved on 28/29 November. I assume that both BIA and Kalyx will acknowledge these feelings and respond sensitively to them.

C5.28. But a proper concern for the staff needs to be accompanied by an equally powerful determination to resume, without delay or diminution, the improvements in regime and culture which the disturbance so abruptly curtailed.

The publication of HMCIP's report

How significant was it?

116. HMCIP's report of her visit in July was published on the morning of 28 November and it is a natural assumption to make a causal link between that event and the disturbance which started later in the day. Few commentators, however, have made such a direct link.

117. The report of the July visit, which included strong criticisms of what the Inspectors had found, was running on news bulletins from around 0630 hrs in the morning. The media reporting included archive footage of the 2004 disturbance as background: this is the first time this had happened in relation to the publication of HMCIP reports either for Harmondsworth or for any other centre. It would have been available to anyone in the centre with access to a television set, including those watching television in their rooms.

118. Some of those watching the images of the 2004 disturbance may have found them unsettling, or may even have allowed them to re-assess their own situation, with all its frustrations and uncertainties, in a new light.

119. But it does not seem to have led to an increase in tension during the day, since none of those who visited the centre during the day, or the centre managers, noted anything out of the ordinary. I have seen a notice to staff issued on Monday 27 November alerting staff to the publication of the report the next day, so there would have been a general awareness on the part of staff.

Effect on individuals?

120. It would be difficult to be certain, in the case of individual detainees, whether the images on the television screens would have had a cumulative effect on the aggrieved or the vulnerable, inducing in them either a lower capacity for self-restraint or making them more prey to the inducements of others.

Examination of this point properly belongs to the Crown Prosecution Service and the police in the context of the criminal proceedings and I will not comment on it further.

Blocking the TV screen?

121. One report suggested that when the news bulletin about HMCIP's report came on the news, a detention custody officer stood in front of it to block it from view, sparking off anger among detainees:

- I have been unable to secure any confirmation for this story. It lacks credibility. The news broadcasts were running all day long, and were accessible to detainees across the centre and in their rooms;
- I cannot prove or disprove this report, nor assess whether it has any basis in fact or was merely an exaggeration or an invention;
- But I do not think we should look to it for the explanation of what happened.

Staff reaction to the news coverage

122. The television coverage of the HMCIP report features significantly in the staff comments in the questionnaires and debrief material:

- Part of this is undoubtedly an expression of frustration on the part of staff who resented what they saw as criticism when they thought they were trying to do a good job;
- Some staff draw a more direct link between publication of HMCIP's report and the disturbance;
- Others in the centre cast doubt on such a direct link.

Conclusions

The Impact of Publicity About HMCIP's Report

C5.29. It cannot have been sheer coincidence that the disturbance happened on the day that Harmondsworth was receiving substantial and largely negative coverage on the media. But the mood in the centre around that time was largely benign and the recent regime improvements would have been clear to all.

C5.30. The underlying cause is not to be found in any build up of tension of the kind customarily detected by the usual indicators. I do not regard the fact of publication itself as a causative factor. Rather it should be seen as a trigger for events.

Other explanations

C5.31. Frustrations of a more subtle but less direct kind were probably in play:

- **population pressures and the impact of Foreign National Prisoners, especially considered against the fabric of the building;**
- **concern about the progress of immigration cases, long and unexpected periods in detention, and uncertainty about outcomes.**

C5.32. I consider both these issues in Parts 9 and 10.

Fabric issues and refurbishment options.

Current position

123. The fabric of the building is an overwhelming point of criticism in comment from those with direct knowledge of Harmondsworth.

124. To someone who remembers the old Harmondsworth before its redevelopment in 2000/1, the new centre presents itself as an impressive and powerful building. But inside the centre it soon becomes clear, even in the damaged state in which I saw it, that it is a badly designed and poorly constructed structure, betraying the impression of solidity and resilience conveyed from outside.

125. This investigation has progressed at the same time as the refurbishment of the damaged fabric. I have not enquired into the contractual and insurance issues involved in the refurbishment, which are beyond my brief. I have assumed that the fabric will be restored, at least for half the building.

126. The conclusions from this review will be available to those responsible for the centre when it re-opens. That is one of the drivers, though not the only one, for a swift review.

Legacy from the past

127. The structure of Harmondsworth was described to me as “1960s student-type accommodation”. With some allowance for linguistic latitude that description broadly conveys the sense of the problem. The design and structure were intended for detainees very different from the current detainee population – largely compliant, accepting of house rules, presenting very few problems of control, destined to stay in the centre for only a few days, and largely uniform in their characteristics and expectations.

Current Expectations

128. That is far from the picture today. The population at Harmondsworth is very complex, drawn from the 9 BIA commands who have been given ring-fenced allocations within the detention estate, and at full capacity offering 501 bed-spaces out of the capacity for male detainees of 2138.

129. It has the added advantage of proximity to Heathrow airport for removals, and is shown in the DEPMU December and February detention space lists as under an obligation under the contract to take all detainees and having the regime and facilities to cope with a limited number of difficult cases and having a hospital (in reality, a healthcare centre with inpatient facilities).

Recent Changes

130. Since it was opened in 2001 it has seen several changes. The first was the installation of sprinklers and some physical security changes in the aftermath of the Yarl’s Wood fire in 2002, whose structure Harmondsworth resembles.

131. Some three months after the centre re-opened fully on completion of that work in summer 2004, it suffered the disturbance on 19 July, the subject of the McAllister investigation:

- That gave rise to the enhancements to the security of the gates between the landings which proved so illusory on 28 November, together with some changes to the fire evacuation strategy, which again were insufficient to prevent free circulation among the courtyards.
- Even so, the fabric gave little room for confidence, especially when compared with Colnbrook IRC, which was built next door to Prison Service Category B standards in 2004.

Population pressures.

132. A fabric as weak as this might have been just about adequate for a detainee population matching past expectations. But the pressures of the detainee population have recently afforded no such luxury. For these reasons:

- The centre was running largely at full capacity of 501 from November 2004 to 2006

- The length of time detainees spent at Harmondsworth began to vary considerably:
 - The majority of people were spending less than one month at the centre. But some came for only a day or so, allowing them hardly anytime to settle down;
 - This limited the opportunity for the BIA staff to become familiar with their cases and the centre staff to match them up with the regime facilities on offer;
 - Others came for much longer periods, into a regime not designed for lengthy periods of detention, and with the increased frustrations and uncertainties associated with longer periods of detention.
- Into this population came the 150 fast track cases which were handled under arrangements quite different from the rest of the population:
 - I shall look at the fast track population in more detail in Part 10, but the imperative of speed in their cases contrasts with the slow pace of others;
 - This produced a variety of reactions in the remainder of the population: anxiety on the part of those who did not wish to leave and frustration on the part of those who did.
- From March 2006 Harmondsworth held an increasing number of ex-Foreign National Prisoners (FNPs) who were commonly held for 3 months or more:
 - Their characteristics were quite different from other detainees and I will discuss this more fully in Part 9;
 - Because of their custodial experience, some of this group presented a potential threat for disruption which furthermore had to be set against the weak fabric and the poor staff/detainee relationships identified in the HMCIP report of July 2006;
 - This was compounded by a long-running contractual dispute between BIA and the centre management which was concluded by mediation only in the summer of 2006.
- Against that background it is something of a miracle that the centre leadership were able to make significant progress with the regime in the second half of 2006:
 - But that was not as strong as the pressures coming the other way – the churn of detainees, the sometime lengthy periods in detention with

uncertain outcomes, the FNP population, which comprised 177 of the 501 in Harmondsworth in November 2006, and the fast-track cases;

- That came on top of the legacy of the past over-controlling strategy, driven in large part by nervousness about the strength of the fabric, together with the continued realization that the fabric was vulnerable to stress.

Options for the Harmondsworth site

133. All these pressures have been cited by my interlocutors as potentially causative of the disturbance. In this section I simply comment on the fabric issues, which seem to me to underlie much of the problem.

134. Most of the other pressures, in particular the heavy pressure of the FNP population, are unlikely to diminish in the near foreseeable future, even when BIA takes delivery of a secure detention facility in Gatwick in 2008:

In the short term, the fabric is being restored. But the basic limitations of the building will remain:

- weak interior partitions and walls which are vulnerable to simple physical attack and water damage;
- poor sight lines with abundant spaces to hide; inability to close off floors because of weak anchorages for secure gates; low ceilings and narrow, claustrophobic corridors;
- flimsy and easily accessible fittings for CCTV cameras;
- a fire evacuation system which immediately generates a free flow of the entire detainee population when activated.

The immigration removal estate is under severe strain which is unlikely to diminish in the near future:

- Improvements in case handling, especially with the new regional structure and the New Asylum Model, can be expected to come through, but they will take time;
- In the meantime, the pressure of the Foreign National Prisoner population as well as the other removal programmes will continue and possibly intensify, especially if BIA take more FNPs because of pressures on the prison estate.

Harmondsworth will have to continue to take its share of all the categories of detainees.

135. Under the contract it is obliged to do, and there is no short-term prospect of relief in the population pressures.

There is therefore an ongoing risk, unless something else changes, that another disturbance could arise at any moment, with similar results.

136. It may be that changes in handling disturbances if they occur, and in the processing of casework, can be made in the light of this recent experience, but these are by no means guaranteed and are likely to take time:

One positive aspect is the prospective continuation throughout this interim period of the regime developments already in train:

- This is essential if Harmondsworth is to continue to meet the general requirement in Rule 3 (1) of the Detention Centre Rules 2001;
- But it was not regime deficiencies which lay behind this disturbance.

Conclusions

Future plans for the site

C5.33. I understand that the current plan is to refurbish half the site. I have been briefed about this by the Kalyx senior management and by your senior colleagues. The rebuild plan seems to me to be the only option offering longer term security at the site for the full range of the population. It should be feasible to use two wings (giving a total of 259 places) provided that other measures are taken to minimize risk; in particular, this accommodation will be suitable only for lower risk detainees.

C5.34. A total rebuild is the only way to guarantee the continuity of places which is critical to the Government's strategies for removal. The capital costs are large. But the alternatives are potentially quite damaging to key policy objectives. I therefore strongly endorse the option of an entire rebuild of the site.

Part 6: Campsfield House: Narrative of Events

137. This section is intended to give an outline of the chronology of events on the day of the disturbance at Campsfield House. Timings and information have been drawn from incident reports from staff and other key witnesses and participants. This material is presented here to give a picture of how the disturbance developed, and timings should not be treated as exact.

Wednesday 14 March 2007

138. An Algerian detainee in the centre was due for removal, and had a flight booked for 1030 hrs. Staff had been aware that his removal was likely to be difficult, due to his previous behaviour, the fact he had had three previous failed removal attempts, and the behaviour of detainees around him who were forming a group around him in one of the rooms.

139. In anticipation of the difficult removal, the centre management instructed two Control and Restraint (C&R) teams to change into their C&R uniform and attend the Manager's office for a briefing at 0620 hrs.

140. Following this briefing, the C&R teams proceeded to Blue Block, where the detainee concerned was residing. There was also one officer accompanying the team who was tasked with videoing the removal of the detainee. One of the centre managers was accompanying the teams.

141. The detainee was approached and told that it was time to leave the centre for his flight. The detainee in question refused to leave, claiming he had an outstanding Judicial Review, and that his removal would be illegal.

142. Centre staff contacted the Detainee Escorting and Population Management Unit (DEPMU) in order to enquire about the detainee's status. DEPMU faxed back evidence that he had been unsuccessful in his Judicial Review.

143. Despite having seen evidence of his case status, the detainee continued to refuse to leave the centre. As a result of this, a C&R team escorted the detainee to hand over to the escorts using C&R techniques to control him.

144. While the C&R teams were walking the detainee down to the escorts, some other detainees were attempting to get involved in the situation, to frustrate the removal. However, the C&R team managed to move the detainee away from the situation. As the escorts had requested he be handed over in handcuffs, the C&R team applied handcuffs to the detainee. He was successfully escorted from the centre.

145. At around 0640 hrs, immediately following the removal of this detainee, there was some disorder in Blue Block, and a fire alarm was activated, caused by two fires at either end of the corridor from which the detainee had just been removed (the upper level of Blue Block).

146. Evacuation procedures were immediately executed by staff – detainees were evacuated into the dining room compound, and Yellow Block was also evacuated. A

roll check was done of all detainees, and the atmosphere in the dining room was initially orderly, and detainees were compliant with the roll-call procedure.

147. The atmosphere seemingly changed with the arrival in the dining room of some of the detainees who had been surrounding the individual who was earlier removed from the centre. There was some unrest, and some abuse of officers and threats made to the C&R team that was earlier involved in the removal from the centre that morning.

148. Detainees overpowered staff and some re-entered the centre, some saying that they wanted to retrieve their property from rooms in anticipation of a disturbance. An instruction was given to staff to return to the office, as they were reported to be in fear of their safety.

149. While all staff had been instructed to withdraw from the centre, some re-entered Blue Block, having heard reports from detainees that some detainees were trapped on the corridor where the fires had been set. They used a fire hose when attempting to extinguish the fire, after having difficulty using a fire extinguisher initially.

150. The staff smashed a window with the fire extinguisher at the end of the corridor in order to allow some air to circulate into the area. Staff re-entered the building several times forming a chain to assist detainees to exit the building.

151. Once the fire brigade were on scene, staff were instructed to withdraw from the centre entirely. Some staff did continue to enter the building to attempt to remove any remaining detainees to safety. The staff who were involved in the rescue attempts were affected by smoke inhalation, due to the extremely thick smoke in the building, and some were treated either by the ambulance on scene or were taken to the local hospital (The John Radcliffe Hospital). Two detainees were also taken to hospital with smoke inhalation.

152. The fire brigade did experience some initial difficulty accessing the scene. The key for the gate could not be found immediately, and this resulted in the fire brigade cutting a hole in the gate in order to gain access to the centre. The key was located after a short delay, and the gate opened. Police also arrived on the scene and secured the perimeter.

153. While the rescue of trapped detainees was ongoing, cameras were smashed in the centre, severely limiting the amount of information centre management had of the development of the incident.

154. The shop was broken into and food and drink removed and consumed by detainees, and the healthcare centre was also breached, where all drugs were removed from cabinets. Within the healthcare centre, it is claimed that there was urination in staff areas. Classroom windows were broken. Computers were broken in the education area, but some facilities, such as driving simulators, were left intact.

155. The Prison Service National Operations Unit was informed of the incident and deployed Tornado teams to the scene by early afternoon, when a full intervention was

staged. Tornado teams swept through and secured the building, and escorted detainees one by one to the visitors' centre around 1600 hrs, where they were all searched by centre staff. This process was also videoed by centre staff.

156. Detainees were given food when being processed. Detainees identified as having been perpetrators of disorder were escorted to the detainee waiting area and searched prior to removal from Campsfield House for transfer to other centres.

157. Large areas of the centre were left undamaged by the disturbance, meaning most of the accommodation, apart from the areas damaged by smoke and fire, could remain in use. 60 detainees were transferred to other centres because of the damage to some areas of the accommodation unit affected by the fire. This damage was repaired quickly and the centre soon returned to full operational capacity.

Part 7: Campsfield House: Tactical Issues

Introduction

158. The narrative in Part 6 sets out the events at Campsfield House on 14 March arising from the enforced removal of a detainee. I turn now to the tactical issues arising from the handling of this incident.

Police Enquiries

Link with police enquiries

159. As with the Harmondsworth investigation, I shall set out here the position so far as the police enquiries are concerned, so as to comply with the requirement in my terms of reference that my investigation should be conducted in such a way as not to impede any criminal investigation.

Current position on police investigations

160. Thames Valley Police investigated the incident with a view to deciding whether any criminal charges should be brought. I have seen the report of their conclusion on this. I am informed that they do not intend to bring charges and that BIA have been notified to that effect.

161. That removes any inhibition on comments in this report which might impede any criminal proceedings. But, as with the Harmondsworth report, I do not intend to comment on the actions of individuals. Instead I will concentrate on issues, procedures and outcomes.

Background to the Incident

Difficult Removals

162. From the narrative in Part 6 it is clear that the context for this incident was a difficult removal, which was resisted by the detainee involved. The ensuing incident drew in other detainees and matters escalated. Within a short time, officers were forced to withdraw and control was lost.

163. It is important to reaffirm at the outset that removals must continue to take place, when – but only when – all legal proceedings have been completed and the decision to remove has been confirmed. These are removal centres – no longer detention centres – and the expectation must continue to be that people who have no further rights to remain in the UK will be removed. That is a central part of the Government's immigration strategy, and establishments such as Campsfield House exist to facilitate it.

Planning for removals

164. That makes it all the more important that:

- removals should continue to take place as planned;

- individuals or groups should not be allowed to frustrate them, once the legal processes have been completed and confirmation of the removal is the outcome;
- everything possible should be done to confirm the expectation among detainees, when that stage is reached, that the legal process has been completed, that the removal is valid, and that it will go ahead;
- removals should be done with the minimum risk both to detainees and to staff, based on comprehensive risk assessments and planning;
- everything possible should be done to keep to a minimum, and to mitigate, the distress and upset which the individual detainee may experience at the time of removal;
- the risks of incidents not proceeding as planned should be anticipated and planned for;
- planning should be directed towards achieving these objectives.

165. Many of these objectives were clearly in view on 14 March. Equally it is clear that the removal did not go according to plan. It is reasonable to assume therefore that there are some lessons to be learnt, both in the tactical handling of the incident and in the longer term. The comments which I have read from the centre management and staff at Campsfield House show that they are thinking hard about these matters.

Detailed Aspects of Planning for Difficult Removals

Preparation of detainees

166. Cases will have reached the point where legal proceedings have been concluded and removal has been confirmed. The expectation is that detainees will be given three days notice of their removal. This is a humane and decent expectation, to enable them to prepare to live in another country, to raise any last minute personal issues, and to make any arrangements with their family or friends or for the disposal of property.

167. I understand that the provision of three days' notice has been an issue at Campsfield House in the past. But the message that removal is now about to take place should be conveyed clearly and firmly.

Detainees' concerns and expectations

168. The period of notice can also mean that if the detainee is unhappy about the prospect of removal he will have the opportunity to come to terms with it. It also means that he may react against it, to the extent of deciding to resist or frustrate it. That is a natural human reaction and may well require extra support for the detainee at that stage. This point is referred to by the Joint Committee on Human Rights at paragraphs 293 and 294 of their report of 22 March 2007, in commenting on evidence from HMIP. It requires strategies for resolution.

The day before

169. On this occasion, the movement order in relation to an Algerian detainee was received from DEPMU at 1630 hrs on Tuesday 13 March, with removal directions set for the following day, 14 March. Accordingly, the night shift manager made preparations to speak to the detainee and inform him of the impending move.

170. The detainee refused to meet the night shift manager to discuss the matter or to come out of the centre. There was reason to believe that he thought that his legal remedies were not exhausted. Even a fax from DEPMU, arranged by the centre, did not satisfy him despite the fax showing evidence that he had been unsuccessful in his judicial review of his case. He was supported by other Algerian detainees in his opposition to the process.

171. Some staff felt that some minor incidents such as small fires were instigated to test out their reactions and discover how many staff were on duty in the centre. Some staff also felt that tension was high because a number of detainees were angry about a previous enforced removal. In this case there had been two previous attempts at a removal. The IMB did not record any increase in tension in their assessment two days before the incident.

Preparation of staff

172. The decision was taken at 2300 hrs to defer the removal until 0630 hrs the next day, Wednesday 14 March. The Incident Reports (numbered from 07/45 to 07/83) which I have seen give a good account of the preparation which staff received by means of early calls at home from 0430 to 0445 hrs asking them to attend the centre.

173. Most staff arrived around 0615 hrs for a briefing. Staff left the briefing at about 0630 hrs and made their way to the accommodation block. Control and Restraint teams were dispatched to Room 80 in Blue Block where the Algerian detainee was sleeping. Other staff were dispatched throughout Blue Block, with others in the control room. One officer's report shows that he was detailed to video the removal, which he did alongside the Control and Restraint teams.

Staff Expectations

174. The reports are mixed in terms of concern on the part of staff at what they were required to do:

- For some of them the call out came very early in the morning, giving them little time to prepare. The briefing was very short – about 10 minutes long. One officer thought that staff were being sent into the centre unbriefed.
- The duty manager had used the opportunity during the night to plan the removal. Several staff however felt that the removal had been poorly prepared and was ill-advised in the light of the indications of likely resistance.

- One officer challenged early morning lifts on the basis that detainees would awaken to shouting and confusion. Others thought that more could have been done to call in staff from home when the scale of events became clear.
- On the whole, the conclusion I draw is that a professionally trained staff would expect to be called upon to carry out difficult removals, possibly at short notice, and would recognize that force might be needed to carry it out. But there is a clear apprehension among some of the staff about how well prepared the centre is to carry out removals such as this, and a feeling that improved planning, co-ordination and communication are needed.
- Staff also expressed concerns that not enough staff were present in the knowledge that this was going to be a difficult removal with potential repercussions for control beyond the detainee himself. The centre management takes the view that 26 day staff coming on shift plus 13 night staff going off shift, together with 9 staff engaged in training for that day present at the time, was adequate for the potential seriousness of the situation.

Risk assessments and planning

175. This incident reveals some difficult tactical issues. The removal was timed to coincide with the availability of the escort, both because of “hours” considerations for the escort and because an overseas removal was planned. The planning had to anticipate not only that the detainee might resist removal, but also that other detainees, not linked with him but sympathetic to his position, might seek to become involved, as happened with other Algerians in this case. There is evidence that the detainee concerned had indicated earlier in the day that he would resist removal.

Tactical Judgments

176. I hesitate to offer much by way of comment on these difficult tactical judgments, which are best done by those on the spot informed by professional advice from the Prison Service and BIA. But perhaps I could offer one or two observations:

- At the heart of the process must be the fullest possible risk assessment – about the detainee to be removed, other detainees and the general mood in the centre – set alongside the resources likely to be available, and the need to ensure that the removal goes ahead. In the case of an escorted removal, the centre management favours a multi-agency risk assessment approach, with the centre staff present when the immigration removal directions are served.
- One suggestion was that the detainee to be removed should be kept separate from others in the period leading to the removal, not only to accustom him to the fact of removal but to lessen the opportunity for others to join in. That has the merit of pre-planning and retaining the initiative, and allows more space for helping the detainee to adjust to the impending change in his circumstances. The chair of the IMB is sympathetic to this view.
- It needs to be balanced of course against the possibility that, at whatever point the detainee is separated, other detainees will seek to join in to frustrate removal.

Nor would it be right to isolate the detainee at a time when he may need the support of other detainees, other than to meet the security and safety criteria in Rule 40 (1) of the Detention Centre Rules, which may be quite strong in such cases.

- I received comments, from the centre management and some staff, that when a removal is imminent, other detainees should be locked in their rooms to prevent their joining in. I was told that this was normal practice, but not followed on this occasion.
 - I do not want to second-guess those who have to make these tactical judgments, but I have difficulties with this as a tactic, since it carries the risk of arousing alarm or worse among the wider detainee population in the centre at a time when effort should be directed towards keeping the pressure down;
 - I am not an expert on the issue. It needs to be reviewed with advice from Detention Services.
- The options at a centre like Campsfield House are limited, not least by the small-scale and cramped fabric and the small numbers of staff on duty. Deciding on the best tactics will have to be a priority task in the light of this disturbance. I understand that thought is being given to reconfiguring the fabric to provide more flexible options for this purpose.

Conclusions

Planning for Removals

C7.35. The strategies for extraction and removal at Campsfield House need a full appraisal, beginning with risk assessment, through to advance planning, and finally on to tactical implementation. They should cover the training for staff at the centre who carry out these removals, especially in the case of a detainee who plainly does not want to go. They need also to address the support available to the detainee at a high point of vulnerability and anxiety. The centre management has started this work off, but Detention Services should be closely involved in it.

C7.36. The circumstances of this removal were by no means unusual. But they led to a major incident, the loss of control of the centre for several hours, and injuries to detainees and staff.

Contingency Planning

Initial Response

177. I encountered conflicting views about the extent to which the centre was prepared for a major disturbance:

- A consistent theme from the replies to questionnaires from staff was that there was much confusion among the centre management about how to handle the

incident, that no-one seemed to be in charge, that clear instructions were not given, and that as a result the detainees quickly gained the upper hand. These claims are verified by the decision made to change the leadership at Silver command level soon after the incident began;

- The Silver control log does however show that those in direct charge soon realized that they were in difficulties and responded accordingly:
 - at 0640 hrs the Duty Manager opened the Silver suite “due to concerted indiscipline”;
 - at 0645 hrs the Gold command in the Prison Service National Operations Unit (NOU) was informed;
 - at 0650 hrs Thames Valley Police were informed;
 - at 0655 hrs DEPMU were informed;
 - at 0656 hrs the Centre Manager was informed;
 - at 0658 hrs a message was left on the telephone of the duty director for GEO.

- There is no record of a call to the IMB but their own records show that at 0720 the duty rota member on the Board received a telephone call from the duty manager to say that a fire had been started by detainees and that a “situation” had developed. Nor is there any log record of the contract monitor being contacted, but she received a call at approximately 0700 hrs and was on site by 0800 hrs.

- The healthcare manager says that she was not informed at home, when she would have expected to be on past practice. This view reflects the possibility that medical resources, for example immediate first aid, might be required. The centre management say that the healthcare centre was informed.

- Apart from not alerting the IMB at the same time as everyone else, and insufficient recognition of the healthcare dimension (at least as far as the records show), the records show a satisfactory initial response to the incident.

Assessing the scale of the incident

178. The scale of the disturbance was appreciated by all those directly involved in the centre. Major incident procedures had been initiated by 0700 hrs, according to the Silver log quoted above. Between 0700 hrs and 0705 hrs the log shows that:

- detainees were damaging cameras and taking lights out in Blue Block;
- smoke was seen coming out of Blue Block and the Fire Panel had been activated;
- total evacuation of the centre was in process.

179. The emergency services responded likewise. At 0715 hrs, according to the Silver log, one tender from the fire service arrived at the main gate. At 0720 hrs, Thames Valley Police set up a Silver command at Abingdon police station.

180. However, the urgency of the situation was not conveyed in the calls which were made to the IMB duty rota member at 0720 hrs or to the centre manager whether at 0656 hrs or at 0730 hrs.

The role of the IMB

181. The call to the duty rota member said that a fire had been started by detainees and a “situation” had developed. The duty rota member responded that he would come into the centre. When he reached the centre at 1000 hrs, with police and emergency services vehicles outside the gate in Langford Lane, the scale of what was going on was immediately clear to him. I am told that steps have now been taken to ensure that the IMB are telephoned concurrently with others.

182. He at once telephoned the Chair of the IMB, whose own contacts to the centre were not very productive of information. This probably reflects the pressure on staff in the centre at a difficult time.

183. But it is possible that it also reflects a lack of appreciation of the vital importance of ensuring that the IMB are fully involved and kept up to date at times of emergency such as this. The IMB report says that “the duty member did not know of the severity of the situation until he saw the emergency services and after his briefing in the Silver suite”. The staff probably assumed that the duty rota member would keep the Chair informed, which was indeed the case.

Briefing for the IMB Duty Rota Member

184. The IMB duty rota member gained access to the centre within five minutes of arriving outside the gate, was directed to the Silver suite, and was briefed by the Duty Manager.

185. The briefing, which the duty rota member noted in full, and which I have seen, was factually accurate and comprehensive, covered the most important point – the extent of known casualties among detainees and staff – and showed what assistance had been requested from outside the centre. The duty rota member described the atmosphere in the Silver suite as “calm and efficient and very busy”.

Radios and CCTV.

186. Several staff told me that there was a problem with radios not working and batteries failing at critical times, requiring the member of staff concerned to leave the scene of the incident temporarily to fix the problem. Others said that faulty CCTV cameras had been taking a long time to repair. They also said that, subsequently, the centre was brought back into operation before the CCTV cameras were repaired. The centre management said that the accommodation where the cameras had been damaged was not brought back into use until the cameras were replaced. The IMB had discussed the problem of the radios at their monthly meetings from August to November.

187. The Contract Monitor commented that there was a problem about batteries, that a new radio system was on order, and also that “DCOs can contact first response therefore no danger”. The centre management informed me that they had inherited a radio system so old that replacement parts were unobtainable; and, at the end of April, they told me that a new base station and radios had been received and installed, that software problems had prevented the immediate activation of the radios, but that the software problem would be rectified in the near future.

188. I make no judgment on whether the lack of replacement CCTVs compromised safety when the centre was re-opened: that would have depended on the risk assessment made at the time. CCTVs are important, as shown by the sudden loss of information in the Silver suite when cameras started to be taken out.

189. The efforts to get the centre back up and running, especially the replacement of the damaged computers in the education room, were a positive response in all the circumstances, given the pressures on the detention estate.

Emergency Exercises

190. In discussions with staff, it was clear that the risks of fire were very apparent to them, and that they were comfortable with procedures for response and evacuation, if not for firefighting. But none of those to whom I spoke said that they had exercised for major incidents other than fire. I understand that there had been a contingency exercise in the autumn of 2006 using the scenario of concerted indiscipline.

191. Under the contract, there is a requirement to exercise emergency plans and the centre management explained to me the process for doing this on a monthly basis by table top exercises, to which all the emergency services are invited, but which all do not attend every time. The comments from staff are perhaps explained by lack of familiarity with the extent of the contingency plans which might need to be activated in an emergency.

Conclusions

Initial Response

C7.37. The staff on management duty at the centre correctly judged that they were facing a major incident. They realised, given the resources available to them, that it would require outside help as soon as possible. This gave a good basis for mounting the recovery from the incident.

C7.38. Apart from the failure to include the IMB in the initial round of calls, and doubts about the alerting of healthcare staff, the speed by which outside assistance was summoned was good and was correctly judged. But not all the initial calls conveyed enough information or the sense of the urgency of the situation.

Radios, Batteries and CCTV

C7.39. The centre management should brief the staff fully about the position in respect of radios, batteries and CCTV camera maintenance. Progress has been made since the disturbance, but any remaining issues should be put beyond doubt.

Command Structures

C7.40. I am concerned that it was considered necessary to change the Silver commander early on in the incident. That was a correct judgment in the circumstances, but it was a drastic response, and shows the need to review the planning.

C7.41. All those in the centre, and others outside, need to have confidence that those with the immediate command responsibility in a crisis are able to carry out their duties competently, at a time when accurate information about what is happening may be scarce. In the event, the confusion meant that control was lost for a while, turning this into a much longer incident for which the presence of the Tornado teams became necessary.

C7.42. The responsibility for ensuring the adequacy of the command arrangements in a crisis and the competence of the senior staff lies unequivocally with GEO corporately and with the centre management.

C7.43. I conclude that more work needs to be done to ensure that satisfactory procedures are in place should a disturbance like this happen again. The centre management say that this work is in hand.

Contingency

C7.44. It is of the utmost importance, for the safety of detainees and of staff, that all staff are fully briefed about every aspect of contingency plans, and not just those which involve them individually.

C7.45. I conclude that, for the avoidance of doubt, there would be value in the centre manager, together with the Contract Monitor, reviewing the contingency arrangements as a whole and validating them by reference to Detention Services.

C7.46. The centre management's efforts to ensure full outside participation in table top exercises should be given full support from outside agencies.

Reaction to Fire

192. It can be assumed that any incident of major disorder will involve the deliberate starting of fires. There are several issues about this incident.

Access for the Fire Service

193. The Silver log records the arrival of a fire service tender in these terms: "0715 Fire Brigade arrived at Main Gate (1 tender). Taken round to prison service compound."

194. But it is clear that the fire and rescue service were not able to gain access as required. One report suggested that it took two attempts to obtain a key so that the fire service could gain access to Blue Block. When the fire service tender arrived, fire service personnel had to cut through the fence to gain access for their personnel.

195. I was briefed about this by a senior member of Oxfordshire Fire and Rescue Service who accompanied me on a visit to Blue Block. I was also told that when the fire and rescue service arrived there was no Emergency Services Liaison Officer (ESLO) available: if there had been, the fire crews would have immediately been provided with keys to the site and with detailed plans to supplement the "72D" card carried on the fire tender which gave them basic information about Campsfield House.

196. The fire and rescue service also told me that liaison with senior staff at the centre, both on arrival and during the incident, as well as the overall command and control arrangements, were not as good as they should have been.

197. I was also told that there were problems over managing access to the site from the narrow driveways which lead off Langford Lane. The arrival of vehicles for the police service and ambulance services, and the prison service Tornado teams, caused congestion. The fire tenders were blocked in, which would have hindered a rapid response to an emergency call if it had been needed somewhere else.

198. I note from HMCIP's recent Inspection report that "Fire prevention plans had been updated in 2006. Although the local fire and rescue service was familiar with the site, the fire brigade had not visited in 2006 and had not participated in the centre's contingency plans".

Extent of fire

199. There are logged reports that there were up to three fires in the initial episode, further fires in the classrooms, and later on a fire alarm sounding in the shop corridor.

200. There are other reports that centre detention custody staff extinguished the fire, and I met one non-uniformed member of staff who claimed to have done so. Other members of staff said that they attempted to tackle the fire with fire extinguishers but that the fire extinguishers did not work, and that they had to use fire hoses for which they had not been trained. I was told that the fire extinguishers are tested each month, but that it was possible that detainees might have tampered with them.

201. The Duty Manager's report sets out the sequence of events in these terms: "The DCO staff managed to fight the fire and remove 3 detainees from within the affected area, they then handed over to the fire brigade who confirmed that the fire had been extinguished and they had also rescued 2 detainees from the block. At this stage 7 DCO staff and 2 detainees were taken to hospital with smoke inhalation".

Effects of fire in Blue Block

202. On my first visit to Campsfield House, five days after the disturbance, I saw the evidence of fire on the first floor of Blue Block – burnt and blackened floors, doors, walls and ceilings, damage to electrical wiring and melted glass in the partitions at the end of the corridor leading to the floor below. The damage was mostly superficial.

203. I made a subsequent visit with a senior officer from Oxfordshire Fire and Rescue service. He was aware of the density of smoke at the end of the top floor of Blue Block, into which centre staff had ventured to rescue detainees, and the effects this smoke might have had if it had penetrated sleeping rooms.

204. On a brief inspection by the senior fire service officer it was clear that not all the doors and doorframes to the sleeping rooms had the necessary smoke seals fitted, so that smoke could have got into the rooms. Some detainees had stayed in their rooms because they did not want either to be removed or to be caught up in the incident.

205. The windows to these rooms can be opened from the inside, so that some fresh air would have been available from outside, but the effect of smoke could still have been harmful, especially if it contained toxic fumes from the burning floor coverings, which are quite old.

Staff Reaction

206. Staff went back into Blue Block, after they had been ordered to withdraw on safety grounds, to deal with the fires and to rescue detainees. Amidst the smoke and confusion they did not know whether detainees had barricaded themselves in their rooms or were unable to escape. Their accounts of having to find their way in the darkness and in smoke which had descended almost to floor level make graphic reading.

207. The fire and rescue service were concerned that in doing so the centre staff had put themselves at risk: in their view the extent of staff involvement should have been limited to dealing with small fires and the immediate rescue of detainees before the fire and rescue service arrived to carry out rescue, in accordance with proper procedures, and to fight the fire.

208. This issue will need to be worked out clearly in the debriefs. For the present, I note that those staff who went back into the centre, in a scene which was doubly unsafe – from smoke and from potentially hostile detainees – showed considerable bravery. Seven of them required hospital treatment.

Evacuation strategies

209. The activation of the fire alarm caused all the fire doors to be unlocked, enabling free circulation of detainees. This was a problem not only in terms of controlling detainees but also for the safety of the emergency services. The centre management and the fire and rescue service believe it should be possible to zone the operation of fire doors, so that detainees could be more easily contained in discrete areas of the centre.

210. There is a specific issue in relation to the night duty nurse locked in the healthcare centre. For the healthcare staff, “the lack of an emergency exit for nurses not carrying keys remains a grave concern”. The centre management believe that the problem can be solved with adequate provision of keys for staff in the healthcare centre and that there has always been a fire exit from the healthcare centre. The contract monitor confirms that there is a fire exit in the healthcare centre, which leads into the induction block compound.

Conclusions

Fire Precautions

C7.47. I conclude, from the facts as I have found them, that the procedures for enabling the fire service to gain access to the site need to be reviewed to ensure that there is no delay and that all areas of the establishment can be reached quickly.

C7.48. The centre management should ensure that the tasking of an Emergency Services Liaison Officer (ESLO) is satisfactory, so that facilities which the

emergency services assume will be available to them can be guaranteed. There should be a review with other services of the means of access and egress for emergency service vehicles.

C7.49. The example of a Memorandum of Understanding (MoU) which Oxfordshire Fire and Rescue Service have formed with Huntercombe Young Offenders Centre should be looked at to see if it provides a useful model for the provision of fire and rescue services. The centre management say that this is in place. It would benefit from further discussion with the Fire and Rescue Service.

C7.50. Since the visit of the senior fire service officer, a survey has been made of the smoke seals in the doors and doorframes in the sleeping areas. This work needs to be validated with professional fire precautions advice.

Fire Fighting

C7.51. All the fire extinguishers need to be checked, to establish beyond doubt that they work properly. Staff who may have to use fire extinguishers and any other fire equipment should be trained and confident in doing so.

C7.52. Consideration should be given, in discussion with the Fire and Rescue Service, to the provision in the centre of Self Contained Breathing Apparatus (SCBA) for staff making the first response to fire and smoke, together with initial and refresher training for staff.

C7.53. The expectations of staff who make a first response to fire and smoke should be firmly agreed between the centre management and the fire and rescue service. Staff must be clearly advised of the limitations of what they are expected to do and must then follow instructions.

Fire Evacuation Strategies

C7.54. In the light of the fact that two detainees and seven staff suffered smoke inhalation in this incident, to the extent that they required examination in hospital, I conclude that the fire evacuation strategy should be reviewed. It should consider in particular the position of the healthcare centre, but should not be confined to that. The review should include scoping of the work necessary to zone off the operation of the fire alarm.

Follow-up work

C7.55. The centre management should take the lead, with the assistance of the Oxfordshire Fire and Rescue Service, to ensure that all the lessons from this incident are absorbed and applied. BIA Detention Services must also be closely involved, as the Authority for the fabric, and because of the seriousness of the matters at issue.

C7.56. The follow up work on fire issues should be included in the multi-agency debrief, work on which should now proceed as a matter of priority.

Staff Courage

C7.57. Revised instructions will clarify what staff should do when they realise detainees may be in danger from fire and smoke. Meanwhile I commend those staff who went back into the centre to rescue detainees for their bravery in doing so.

Detainee Welfare Issues

211. This incident was not nearly as prolonged as that at Harmondsworth, and reading the record and log books it is clear that plans were being made from an early stage to restore the centre to normal working as soon as possible.

Food

212. Food presented much less of an issue than at Harmondsworth, largely because it did not form part of the surrender strategy and the kitchen was not lost, although the food store was broken into.

213. The report from the IMB says that when detainees were brought under control they were offered light food and refreshments; that there was a plentiful supply of refreshments during the whole of the afternoon and early evening; and that the kitchen was brought into operation early evening and a hot meal served to all detainees.

Detainees' Property

214. Similarly, the arrangements to reconnect detainees with their property were generally effective. This was desirable bearing in mind that some detainees had been concerned about their property and had tried to re-enter their rooms to retrieve it during the evacuation: this was a concern to those who had been in Harmondsworth at the time of the November disturbance. Belongings taken by detainees from their rooms, contained in plastic bags, were tagged and placed in the gymnasium. This was done before refreshments were offered.

215. That was a sensible move in the light of potential anxiety on the part of detainees about the location and safety of their property, in anticipation of their likely removal from the centre later on in the day.

Healthcare and Detainees' Medical Needs.

216. By comparison, the position in relation to healthcare and detainees' medical needs was not satisfactory. Despite some dispute over what happened there are some issues that need to be pursued.

The Healthcare Centre

217. The Healthcare centre sustained considerable physical damage in the course of the incident. Furniture and cabinets were broken, it is claimed that there was urination over the carpets, and the pharmacy cabinet was broken into and pharmaceutical drugs were removed. Many healthcare records were destroyed or defaced.

218. Of all the areas which I visited, five days after the incident, the healthcare centre was the least restored. Staff still seemed to be in considerable distress in coming to terms with what had happened.

Recovery of stolen medication

219. The IMB report that, in the process of checking surrendered detainees, a certain amount of goods recovered from the looted shop were recovered. During these searches, a different report says, “illicit medication was removed from them without reference to nursing staff. It may have been that some of them needed nurse consultation for their own safety”.

Patient Records

220. I am told that, for whatever reason, the lists of those being transferred were not checked to see if they needed to take medication with them. Even though the medical records had been lost, I was told that it would have been possible to identify the diabetics or hypertensives from the list and send them off with short term supplies.

221. The staff at the receiving centres questioned why no medical records had accompanied the transferees. Presumably the reason is that they had been lost, but that is a separate question from lack of short-term medical supplies.

Detainees being transferred under influence of pharmaceutical drugs

222. The pharmaceutical cupboards had been stripped out of sedatives, codeine and other drugs with mood-changing effects. I saw reports that detainees who had absorbed large quantities of these drugs were transferred from the centre without medical supervision.

223. Another report said “On arrival at their destination it was obvious that they were under the influence of potentially fatal medication.” The Contract Monitor has also noted this point. The centre management told me however of the close supervision of the loading of detainees onto transport when they left the centre.

Conclusions

Security of Healthcare Centre and Staff

C7.58. There is still work to be done to ensure the security of the healthcare centre and the staff who work in it. The centre management believes there would be value in a review of the stocks of pharmaceuticals to see if they could be reduced, and this should be included. This should be considered by the new healthcare centre manager.

Medical Dimension to a Major Disturbance

C7.59. The medical aspects of a potential emergency must be fully covered in contingency plans from the start of handling a major disturbance – from the alert stage, through to various contacts with detainees when they come under control, to

the point when they leave the establishment. These plans should cover possible requirements for first aid assistance for detainees and staff.

C7.60. They should also cover the need to establish whether the facts of the incident suggest that detainees may have ingested large amounts of pharmaceutical drugs and, if so, what should be done to treat them.

Conduct of Review

C7.61. The centre management staff and the healthcare centre staff should initiate this work. I understand that a new healthcare centre manager will shortly be appointed: this provides the opportunity to take this work forward. But it should be subject to external scrutiny and validation, which Detention Services should arrange.

Part 8: Campsfield House: Strategic Issues

Foreign National Prisoners

Impact on Campsfield House

224. The impact of Foreign National Prisoners (FNPs) is the biggest external issue affecting Campsfield House at present. It is putting the centre under great strain. The main points are:

- The centre is receiving large numbers of FNPs: the centre management assessed this as 52% of the population at the end of May 2007. Their behaviour can be very challenging, partly because many of them resent a further period in detention when they have served their sentence, and partly because the constraints to which they had been accustomed in prison, and which may to some extent have controlled their behaviour, are not apparent to them at Campsfield House. Some of them want to go home, others do not. This is quite a volatile mixture.
- It is important not to demonise FNPs: some of them present no control problems, while others are familiar with custodial routines and adapt easily. But overall the effect has been to change the dynamics of the centre quite significantly.
- The staff are struggling to come to terms with detainees markedly different from those that they were used to in the past, either in terms of their authority to challenge unacceptable behaviour or because FNPs do not always value the kind of personal friendship and advice which the staff would like to offer. The group of selected detainees, some FNPs and some not, with whom I spent a couple of hours in discussion, were full of praise for the kindness which they were receiving from staff.
- The fabric is not suitable for FNPs. It has none of the strength of a prison, nor does it offer any flexibility for dealing with difficult incidents or detainees. While the centre management and staff are making excellent efforts to offer a good regime, there is limited scope to do so, especially in the case of detainees who are staying there far longer than in the past. The centre management told me that the average length of stay had increased from 10 to 35 days.
- This incident arose from the attempted removal of an FNP: this needs to be the focus for revised removal strategies.

Conclusions

Managing Foreign National Prisoners at Campsfield House

C8.62. There is no easy solution to the question whether Campsfield House should continue to take FNPs. Campsfield House provides 10% of the capacity of the immigration removal estate and has an important role to play. The numbers of FNPs which BIA needs to accommodate, in an immigration estate lacking in

flexibility and bursting at the seams, mean that there is probably no other option at present but to send large numbers of them to Campsfield House.

C8.63. That being so, more needs to be done to deal with that reality. The future direction of the centre needs to have the FNP issue at its heart, at least for the foreseeable future, and to focus on responding to the challenges which they present.

The management of the centre

Recent change of management

225. The contract for the management of Campsfield House was transferred from Global Solutions Limited (GSL) to GEO at the end of May 2006. Health care services are sub-contracted. Veritas, the Health Care sub-contractor, went into administration in December 2006 and healthcare is now run by Drummond's Medical Ltd.

226. The change of management has clearly been a significant event at Campsfield House and it has inevitably altered the way in which the centre is being run. A major programme of refurbishment is under way to improve what was obviously a tired environment, and changes to the regime are under way.

227. The new centre management place great emphasis on developing interpersonal relationships between staff and detainees, moving away from what they describe as the more controlling strategies of the past. This is an excellent approach, but not all the staff are finding it easy, especially as it has coincided with a big change in the composition of the population.

Assessment of the centre

228. HMCIP, in her report of an announced inspection from 30 October to 3 November 2006, found that after five months under the new management Campsfield House was "a reasonably safe and respectful establishment, making an effort to assist detainees to prepare for release or removal. However, it was not providing sufficient purposeful activity". HMCIP also "applauded the innovative provision of mobile phones to detainees".

229. The IMB, in their general overview of the year in their Annual Report for 2006, published in January 2007, comment that "New procedures and working practices were introduced with the change of management and, with the natural resistance to change, the first seven months of the contract have not been easy". But they also say that "there has been no reduction in the duty of care during this period".

230. Dr Evan Harris MP told me that concerns had been raised with him about the management since September 2006.

Atmosphere in the centre

Staff Comments

231. Against that background I received a number of comments from staff expressing concern about recent developments in the centre. These comments came in the returned questionnaires and in meetings with staff, both in groups and individually, on two separate days. My analysis and conclusions are based upon what I was told by staff or read in reports. Where I assess a staff comment to be of potential significance to the running of the centre, I have thought it right to mention it.

232. Among the major themes in the comments from staff were:

- Poor quality of management since GEO took over (commented on in writing by 26 staff from various parts of the centre, both recent recruits and more experienced staff) leading to a collapse in morale, feelings of insecurity and increased tension throughout the centre.
- Increased difficulties with detainees, many of whom now showed much less respect than in the past, and the lack of effective sanctions in the face of inappropriate behaviour and threats of violence from detainees, both to male and to female staff.
- The large influx of Foreign National Prisoners (FNPs), many with serious criminal backgrounds and “streetwise” in their custodial experience, the inability of the small and insecure fabric of the centre to cope with FNPs presenting such characteristics, the sudden relaxation of constraints on FNPs by comparison with prison and the lack of things for them to do.
- The lack of information accompanying detainees on their arrival, especially risk assessments, and the difficulties in finding out about them from caseholders and staff records, despite the efforts of immigration staff in the centre.

Analysis of comments received

Scope of comments

233. The large volume of comment from the centre management, the Contract Monitor, staff at the centre, and the other sources, including HMCIP’s report, the IMB’s recent annual reports, and discussions with the Chairman of the IMB and with Dr Evan Harris MP, has entailed careful analysis.

234. It is not my task to run a mini-inspection of Campsfield or to replicate the work done by HMCIP or the IMB. My brief is to investigate the lessons to be learnt from this incident, and to focus on potentially causative issues and issues with a sufficiently strong link to the circumstances of the incident to merit investigation.

Immediate Trigger

235. I have no doubt that there is a direct link between the enforced removal of an Algerian FNP and the disorder which ensued. The rapid timetable of events shown in the logs and Incident Reports, the immediate involvement of other Algerian detainees, the starting of fires and the threats made to staff, which required them to leave the area and thus lose control, form a direct sequence of events.

Underlying issues

236. The issues which I consider next are not necessarily causative. But they form a close backdrop to what happened.

Anticipation of the incident

Differences of view about whether an incident was expected

237. The centre management had no particular reason to expect an incident of this kind. Many of the staff took the opposite view and said that they expected a disturbance sooner or later. Some of these feelings may reveal the benefit of hindsight, or they may represent validation of post-incident feelings and reflections. The centre management said that no reports had been filed to the effect that there were threats of rioting and that the security department did not hold information exhibiting concerns.

Staff concerns about safety – and about authority

238. Some of the concerns which staff have expressed about their safety merge with concerns about recent challenges to their authority. In the short term some staff may fear that a more informal relationship with detainees is likely to undermine their ability to exert authority when needed. Over time the new strategy will bring results, but it is not working yet and new tactics are urgently needed to move the issue forward.

Conclusions

Anticipation of the incident

C8.64. I conclude that there were sufficient grounds for concern about the possibility of an incident, taking all the indicators together. There are differences of view about whether this incident could have been better anticipated. But I do not think it can be argued that this incident came out of the blue. The immediate trigger was the escorted removal of an Algerian FNP.

Risk assessments

C8.65. The incident should stimulate a review of the risk assessments in operation at the centre, to include the profile of the population, the information known about them, and strategies for handling the diverse groups in the population and their individual needs.

C8.66. It should be linked to the review of the planning for removals and the training of those carrying out removals proposed in the discussion of tactical issues.

Intelligence and Reporting of Security Information

Intelligence strategies

239. I did not investigate in detail the intelligence strategies in use at Campsfield House. None of the staff mentioned them to me, and I did not get the impression that they featured to any significant extent in the assessment of risk.

Awareness of risk

240. Comments from staff showed confusion about whether to report security issues by means of Incident Reports or Security Information Reports (SIRs). They believe that they are under pressure to use the latter method because, they further believe, SIRs are not reported to GEO headquarters in Texas, so that the extent of any problems will be disguised from the top management.

241. There is more assertion than hard fact in these allegations, but it does trouble me for what they reveal about lack of communication and confidence. Whatever the merits of reporting by Incident Reports or SIRs, the intention and outcome should be the same – to alert the centre management to any developments or trends in risk. A recent notice to staff from the centre management expressing disappointment at the failure to use the correct form adds further confusion.

242. This issue needs to be worked through frankly and conclusively. The important point is that staff should report concerns freely, that these should be quickly picked up and assessed, and that staff should be briefed accordingly. Otherwise, a pattern of confusion and insecurity will simply go on repeating itself.

Calibration of risk

243. Whether greater awareness would have helped staff to prepare for this removal, in the light of the detainee's clear reluctance to leave, and the "testing out" of staff which some of them reported earlier in the day, is difficult to say. By that stage, the issue had moved from one of intelligence to tactical management. But the security reporting systems should have picked up the growing concerns of staff, as related to me after the event, assessed them and calibrated their significance.

Conclusions

Awareness of Risk

C8.67. I conclude that the centre management should review the intelligence systems in operation at Campsfield House so as to establish whether any further indication could have been gathered in advance about this incident. That work should be linked up with efforts to risk assess every detainee arriving newly at the centre, so as to provide room-sharing risk assessments, for example, as HMCIP recommends.

Security Reporting

C8.68. The centre management should clarify to staff what information should be reported in an Incident Report and what in a Security Information Report. I believe that the Contract Monitor has requested to see the criteria for form filling and completion, which gives a good basis for this work.

C8.69. Revised instructions should be carefully explained to staff, preferably without any further expressions of disappointment, and the position regularly reviewed to make sure that staff understand what is required of them and are complying with instructions.

Smoking

Need for clarity

244. This issue is in some confusion at Campsfield House. It arouses passions as strong there as anywhere else in the community, but some staff have come to see it as symbolic of their wider concerns, especially about the sanctions available to them if they ask a detainee to stop smoking and he refuses.

Factors to take into account

245. I set out what I understand to be positions adopted on this issue:

- The Centre Manager commented on 26 April: “IRC is non smoking”.
- Detention Services commented on 26 April, in respect of an allegation that there was smoking in rooms, “Some Detainees disobey the rules and smoke in rooms. IRC is non-smoking”.
- Evidence of smoking was apparent on my visits to the centre. In particular, when I visited on 30 April, the atmosphere in the “big screen room” was heavy and thick with cigarette smoke.
- I am told that it used to be the practice to require detainees to go outside to smoke, using automatic lighters to light up, but that the machines “only work a limited number of times” and “overheat with misuse”.
- Staff are not allowed to smoke in the centre.
- The risks from passive smoking, both for detainees and for staff, are an important concern both for health reasons and because of the duty of care.

Detainees’ views and expectations

246. This issue is very complex. From the detainees’ perspective also, it is a difficult issue. Some detainees will dislike the effects of passive smoking. Some may find that smoking helps relieve stress and tedium and will have formed quite a dependency.

Detainees who were allowed to smoke in prison may find the change of rule unsettling, especially if they have a strongly formed smoking habit. It is understandable therefore that some detainees dislike being asked to stop smoking. The centre management assess that 85% of the detainees in the centre are smokers.

Staff Concerns

247. Staff are concerned that detainees refuse to stop smoking in the centre when asked to do so, and have no sanctions when they do refuse. They are also concerned about the risk that, if detainees have lighters, they will use them to start fires randomly, for example by igniting toilet rolls in the toilets. With the experience of the fires on 14 March still a live issue in the minds of staff, lighters arouse strong emotions.

The IMB

248. Smoking has been discussed recently by the IMB, and I have seen notes of their meetings in January (paragraph 4.1), February (paragraph 3.7) and April (paragraph 4.1). On the point of lighters in rooms, comments were offered by the centre management that if detainees do not have lighters, they may use “hairdryers”, which are “far more dangerous”; and that although lighters were not allowed in 1997, detainees still managed to set fire to the centre during the major disturbance.

249. In preparation for the change in the law about smoking in public places from 1 July, the Contract Monitor, at the April IMB meeting, “agreed to clarify the position with senior managers as consistency is required across the detention estate”.

Management Strategy

250. The centre management believe that the best way to enforce a no smoking rule is by warnings, followed up by withdrawal of incentives and privileges. In the absence of a more formal disciplinary procedure, which they would not favour (and on which I agree) they believe that would be the best way forward. The question is whether all detainees, particularly heavy smokers, would find that sufficient disincentive to disregard requests to stop smoking.

Conclusions

Smoking: Need for Policy Decisions and Ground Rules.

C8.70. I hope that an energetic effort will be made to resolve the smoking issue. It is absorbing a lot of people’s time and energy at present, disproportionately so, and is a manifestation of wider feelings of mistrust and confusion.

C8.71. Subject to wider BIA policy decisions, there is a need for consistency of rules in the centre. These should then be enforced, on detainees and on staff. The change in the law from 1 July provides an opportunity to change the culture on smoking.

C8.72. I conclude that

- **the centre should move to a complete non-smoking position from 1 July.**

- **detainees should not have personal lighters: there will be no legitimate use for them after 1 July inside the building, and to let them have lighters will only be taken as a sign of hesitancy or tacit licence to smoke on the part of the authorities.**
- **automatic lighters should be available outside the building, and if the present ones are inadequate, they should be replaced.**
- **the position should be carefully explained to existing and new detainees in the context of changes coming into force across the country from 1 July.**
- **the centre should make preparations now to offer support to detainees and staff who have come to rely heavily on smoking.**

Staff Confidence

General Comment

251. This is a serious issue, and one which is closely linked with the events on 14 March. It is therefore desirable that I examine it. The comments from those staff who have contributed to this investigation convey, in terms which are sometimes stark and disturbing, their apprehensions about safety and control in the centre, both for detainees and for themselves. The centre management comment that management of the centre has not been easy. They say “strenuous efforts have been made and are being made to ensure that staff are fully briefed regarding the contract and the expectations within it. Many staff do not want to see change.”

Impact of recent changes

252. It is inevitable that when a new management takes over a centre like Campsfield House, changes will follow. Some staff will welcome them, some will not. An element will always find change difficult. The IMB had picked this up, HMCIP less so.

253. Some staff greatly regret the change in the detainee profile, to the extent that they almost wish they could choose the detainees who should come to Campsfield House, particularly if they felt that they can help them – and there is a strong yearning to do so on the part of most of the staff whom I met.

254. Given the population pressures which BIA is having to deal with, in particular the FNP population, BIA must make the best use it can of the estate, and Campsfield House will have to take its share of the extant casework, subject to the twin risk assessments on the limitations of the fabric and individual detainees’ profiles.

Regime improvements

255. For some staff, particular changes will cause individual difficulty, especially if they cannot see the rationale for them. An example is the introduction of mobile phones for detainees, which immediately give detainees a new element of independence and

strength. Allowing detainees to have mobile phones seems to me to be sensible and desirable.

256. Anything which lessens detainees' feelings of isolation and anxiety is not only good in its own terms; it will help lessen frustrations which might be directed towards others around them, whether staff or other detainees. The same is true of internet access, which I consider further in Part 10.

257. It is important not to regard detainees, even ex FNPs, as if they were sentenced prisoners. Schemes of incentives and privileges are desirable in themselves, particularly to help manage detainees who find themselves in the centre for a considerable time. But immigration detainees are quite different from sentenced prisoners in their legal status and in the reason for their detention.

258. Similarly, regime developments are an important means of lessening the tedium of detention, making constructive use of time, and enabling detainees to take their minds off their worries. This becomes even more important when detainees spend much longer in the centre than was the case in the past, requiring the provision of more activities, not fewer. Staff should be encouraged to see the positive aspects of providing opportunities for paid work, such as gardening outside and painting and decorating inside.

Extent of Staff Concern

259. My conclusions are these:

- I believe that some of the worries expressed to me reflect undue anxiety or personal discontent. Furthermore, most of the comments from the staff were critical, so it is not possible to assess how many of the remainder of the staff were satisfied with the centre or felt no need to comment.
- But even allowing for these factors, there is an amount of staff concern at Campsfield House which I find very worrying. It goes beyond the quite normal tendency in any organization to criticize the management or to wish to see things done differently.
- An institution which shows staff disaffection to the degree which I have encountered is facing more challenge than is desirable. It is not enough to move ahead rapidly with a change of culture and style, however well merited, without ensuring the success of efforts to take the staff along and deal with their worries, in detail and depth. That may be the intention, but it has yet to come good.
- The staff reports show a significant lack of confidence, especially after the incident, not only in their management but also in their own abilities to deal with detainees. That lack of confidence will soon communicate itself to detainees, encouraging the powerful and frightening the weak, who will fear even more for their own safety.
- The rapidly changing nature of the centre population is a big factor here, and comes at a time of adjustment to the change of management. Staff need to be given much more help to adjust to this, for example in terms of the challenges

presented by FNPs, and the mix of experience and ethnic composition of the detainees. Forty five nationalities were represented in the centre on 22 February when a survey was done.

Conclusions

Management Strategies

C8.73. The centre management needs to be advised by Detention Services that there is a significant amount of staff discontent in the centre which requires urgent attention. I understand that action is in hand on this.

Discussion with Staff

C8.74. There should then follow an urgent process of discussion in which staff express their anxieties and management express their expectations. This should lead to shared outcomes, focusing on specific issues, with timetables attached. These need then to be taken forward.

Training

C8.75. This process should include training programmes covering key issues such as the needs and expectations of the varied ethnic groups in the centre. It should also include training in the issues which FNPs present, such as difficult behaviour, if possible with support from Prison Service staff seconded to the centre for short periods. I believe that this can be done without stimulating regression, in the minds of FNPs, to their custodial environment.

Staff Confidence

C8.76. The aim of this work should be to restore confidence to the staff, many of whom were clearly finding it difficult to come to terms with this disturbance, to lessen feelings of isolation and stress, and to enable staff to respond better to a complex and changing detainee clientele, not only in terms of safety and control but also in helping detainees with individual problems.

C8.77. It is also clear that the number and speed of recent senior staff changes have been unsettling for staff. That is the prerogative of the centre management, but they could with advantage reflect on the impact of such a policy on staff who are under pressure and need reassurance about the competence and continuity of their senior management.

How This Should Be Done

C8.78. This is a big task for a small centre. HMCIP's report is also on the agenda. I doubt whether it is feasible or wise to leave all this to be done within the centre alone, although the centre management must lead it, with the close involvement of the Contract Monitor.

C8.79. Detention Services should therefore consider what kind of external support can be provided, combining the resources of BIA and the Prison Service, perhaps in conjunction with a well-respected and sympathetic change management agency. The IMB should be closely involved.

The anonymous letter

260. An anonymous letter dated 3 April, some three weeks after the incident, was received by a Senior Director at BIA Headquarters in Croydon, with a wide copy list. The letter made a number of allegations about:

- security issues at Campsfield, both the incident on 14 March and more generally
- the response of the centre management and the BIA staff to these issues
- the profile of some of the detainees being received at the centre.

Action taken

261. BIA arranged for the letter to be forwarded to GEO, whose Managing Director wrote to Detention Services Commercial Unit on 13 April, saying that following receipt of the letter on 6 April, the contents of the letter had been taken very seriously, that he had already initiated an enquiry and discussed further action with GEO Group in the USA, that initial investigations had substantiated none of the allegations, and that an experienced auditor from the USA would examine the enquiries to ensure they were as complete and robust as possible. I have seen the draft of this report.

262. BIA also arranged for the salient points in the letter to be audited by the Contract Monitor at Campsfield House and by the Detention Services Commercial Team.

263. BIA also sent the letter to me, with a request that I consider it as part of my investigation. (I raised the letter with the managing director of GEO when I interviewed him on 29 May and also with the Centre Manager and Contract Monitor when I saw them at Campsfield on 25 May.)

264. I have also seen notes of a meeting of Detention Services Staff on 16 April and notes of a telephone conversation on 26 April between the Centre Manager and Detention Service Staff.

Contents of the letter

Allegations made

265. The letter makes 48 allegations in total, after grouping together related points. Some are specific, some general, some capable of factual confirmation or denial, and some much more subjective.

Nature of the Allegations

266. Some of the allegations were wrong or ill-informed. Others reflect personal feelings rather than issues of fact or shared concern.

Response to these allegations

267. The responses to them which I have seen are not sufficiently detailed to establish the position with any certainty.

268. The investigation by the senior auditor at the request of GEO management reports that “although he did not address each individual allegation depicted in the letter, he determined that the few allegations which had merit had been previously identified and measures taken to rectify the deficiencies.”

Conclusions

Anonymous Letter

C8.80. I can find no conclusion in the results of the enquiries made into the anonymous letter. I make no comment on whether the allegations have any substance or not: I have no basis for making such a judgment. I note the clear position established from the enquiries by the senior auditor for GEO and do not doubt his conclusions. My difficulty is that such enquiries, however thorough and high-level, have not been carried out by anyone whose appointment was independent of the management.

C8.81. The only way to make progress with this would be for a third party, whether me or someone else, to take matters further with some form of legal process, where allegations could be more fully tested. The letter was anonymous, which creates a difficulty at the outset in this respect.

C8.82. I do not think that such a course would serve much purpose. I recommend that no further action is taken on the anonymous letter, although it is unsatisfactory in some respects to leave the matter like that. The way forward is to follow up the conclusions in this report quickly and thoroughly.

Part 9: Foreign National Prisoners and Population Pressures

Introduction to Parts 9 and 10.

General Lessons

269. I move on now to the general lessons to be learnt from the Harmondsworth and Campsfield House disturbances. I was asked to establish any points going beyond the circumstances of these incidents which might be relevant to the management of immigration detainees and the immigration detention estate.

270. I have drawn two broad sets of conclusions:

- The first concerns the population pressures and the impact of Foreign National Prisoners (FNPs) on them, which I will consider in Part 9. This is the “detention estate” end of the problem
- The second relates to the position of individual detainees and the circumstances in which they find themselves. This is the “detainees” dimension, in Part 10.

How to break into the current problems

271. Some would argue that the two issues cannot be divided in this way and that population pressures lead inexorably to increased frustrations for detainees. I have some sympathy with that point of view and especially as it affects the individual detainee, caught up in a system which he may find very hard to understand or to negotiate his way around.

272. But it is a very limited view and implies that nothing can be done to improve things. There are lessons to be learnt for both ends of the problem, and BIA’s current strategy is configured accordingly: giving effect to Government policy on removals, but doing so in a way which recognizes the unique concerns of each detainee in the process.

Policy Questions

273. I have received much comment from groups and individuals with long experience of dealing with immigration detention issues, especially with asylum seekers. They argue that these problems will continue to fester away so long as detention is used as an instrument for removal, that the restraints on executive powers of detention are ineffective, and that the weak and vulnerable are the first to suffer.

274. It is not part of my brief to challenge fundamental aspects of policy and this report will disappoint those who were hoping that it would. But the situation of the vulnerable and disadvantaged is a key concern and high on the list must be recognition of the risks in the current position and the need for steps to mitigate them.

Conclusion

Continuing Risk of Disturbances

C9.83. The Harmondsworth and Campsfield disturbances were very different, both in causation and in how they unfolded. Both occurred at a time when recent population pressures, falling heavily on vulnerable fabric in a hard-pressed detention estate, were accompanied by dislocation in casework handling, especially in the case of FNPs, which caused a build up of latent tensions.

C9.84. It did not take much to trigger these events. When they started, they soon escalated despite best efforts to prevent this happening. The underlying causes are still there and, without any changes, the same thing could happen again at either establishment.

Population Pressures

Intense pressure on prison and immigration detention estate.

275. The recent pressures on the immigration detention estate are well-documented, as are related pressures in the prison service, with numbers reaching all time seasonal highs several times in recent months. The relationship between the immigration detention and prison populations is close and sensitive.

Limitations of immigration detention estate.

276. The smaller immigration detention system is always likely to feel the pressure from its larger neighbour, both in terms of getting people out of the prison system, and in making difficult judgments about whether to take individuals at the margins of risk, assessed in terms of whether the places available for them are likely to be suitably secure or appropriate.

277. These problems have been a major feature of tactical planning in recent months as BIA has sought to grapple, under an inflexible system, with influxes of ex-prisoners for whom the accommodation was never designed.

278. The IRCs are smaller than prisons, more scattered across the country, less secure, not suitable for longer term detention, not able to offer as much by way of regime as prisons (despite the best efforts of centre managers and staff such as those at Harmondsworth and Campsfield House) and understandably lacking experience in handling the challenge presented by former sentenced prisoners.

New Whitehall architecture

279. The transfer of the National Offender Management System (NOMS) from the Home Office to the new Ministry of Justice from 9 May will require a new system of protocols to govern relationships between the two Ministries. I understand that the protocols between NOMS and BIA have recently been updated accordingly.

280. These protocols exist at present, for example:

- the Protocol for the Provision of Prison Service Assistance to Immigration Removal Centres;
- the Protocol Governing the Management of Foreign National Detainees Held in Prison Custody.

281. These have been necessary because of the Prison Service's agency status, at a time when IND has still been part of the core Home Office (now in transition as a shadow agency to full agency status from 1 April 2008).

Conclusion

Accommodating population pressures and individuals presenting risk

C9.85. The Prison Service and BIA are now in different Ministries. It will be important that, with the increased formality in the relationship (inherent in different Ministerial accountabilities, different financial and budgeting systems and different targets and objectives) new protocols reflect in robust terms the reality of the population pressures to which BIA will be subject. These should continue to cover ceilings on numbers as in the past.

C9.86. It must also remain a priority to retain in the prison system, albeit under BIA authority, those sentenced prisoners scheduled for deportation whose location in immigration removal centres would present risks, either of control or other personal circumstances, but with a corresponding flexibility to transfer cases not qualifying under the criteria but assessed as safe to do so. The current protocol provides this and will need to be maintained.

How the immigration detention estate is managed

Allocation of spaces

282. Elaborate arrangements are needed to match immigration detainees to available spaces. This is the responsibility of Detention Estate and Population Management Unit (DEPMU). The arrangements are elaborate because of the small room for manoeuvre in balancing supply and demand.

283. On the supply side, the main factors are:

- The small number of centres (10) throughout the UK, the majority in the South East, but geographically spread out, so that travelling times for transferred detainees and visiting family members can be quite extensive, and “knock on” effects of population turbulence can be quite far-reaching.
- Their differing capacities (501 at Harmondsworth until 28 November, 112 at Lindholme).
- Differing hours for admissions and discharges.

- Their inflexibility: the only centre taking females and families is Yarl's Wood (284) and the only other centres taking females and families are Dungavel (14) and Tinsley House (12), plus a capacity to hold females in the Short Term Holding Facility (STHF) at Colnbrook.
- Only one centre – Colnbrook – has any physical security comparable to a Category B prison – a much more significant issue given the growth in the FNP population.
- Some have only limited segregation facilities.
- The smallness of the estate overall – 2127, comprising 1817 males and 310 females in February 2007 with some family bedspaces. The loss of 441 places at Harmondsworth (501 less the 60 retained in the central spine) took out over 20% of the male estate capacity (2138 at the time) at a stroke.
- Little relief can be expected until at least mid-2008 when a new secure removal centre will open at Gatwick. The opening of this new centre will be offset by the closure of Oakington at about the same time.

284. On the demand side:

- The system operates on the basis of ring-fenced allocations between 9 distinct BIA commands.
- These consist of a mixture of functional commands, such as Border Control, geographical (Regions), and casework of various kinds.
- The biggest allocation is the 1100 male and 100 female bedspaces, with 1165 occupancy on 5 June, for Criminal Casework Directorate (CCD) who have responsibility for FNPs. On 28 November there were 825 FNPs in the immigration detention estate.

Scope for flexibility

285. I set this out in some detail because I wanted to explore whether any more flexibility in matching places to people could be created. I have not found any. The allocation system reflects the various priority objectives which BIA has acquired in recent years, against little increase in capacity.

National or Regional Allocations?

286. A ring-fenced allocation system has the merit of restraining demand, though it is always subject to internal and informal negotiation. I considered whether there was scope for regionalization, in the light of BIA's move to a regional structure. But there is too little flexibility of location and the only real flexibility comes from operating a national system. At least the current system provides places where the majority of cases arise, in South East England.

Conclusion

Management of the Estate

C9.87. The active management of the numbers by DEPMU, within Detention Services, is probably the best way at present of trying to match supply to demand. The Centre and Escorting Managers' Meetings, of which I have seen the minutes, show that BIA staff are alert to the pressures and quick and responsive in dealing with them. But the position is very fragile and will remain so.

Managing the limitations of the estate

Options

287. Since I can see little alternative to the current awkward system, I turned next to whether any of its disadvantages can be mitigated. I have looked at two areas – movement of detainees around the estate, and assessing suitability and risk.

Movement around the system

288. What struck me was the amount of “ghosting”, with some detainees moving frequently around the estate. If a transfer meets the criteria of assisting removal or assisting the detainee, whether with personal issues or with progression of his case, it is helpful.

289. But on balance frequent movement is a bad thing:

- it unsettles the individual detainee, particularly if he moves from one regime to a very different one, or if he has had bad experiences in the past about his property accompanying him;
- unless he can understand the reason for it, he comes to feel even more helpless about his personal circumstances;
- it can disrupt medical treatment, either because medical notes failed to accompany the detainee, or because medical appointments may be lost;
- it can disrupt contacts with his caseworker or the legal process, probably the most unsettling factor of all;
- both HMCIP and the Joint Committee on Human Rights believe that frequent moves, without a comprehensive custodial record, serve to disguise the total period in custody;
- frequent moves are very expensive in their use of escort and reception resources.

Unsettling effects of frequent transfers

290. Many outside commentators have drawn my attention to the unsettling effects of frequent transfers on individual detainees. When the reason for a transfer is not known or poorly explained, the frustration is likely to affect the detainee's behaviour, and in these cases it does not take much for a collective sense of grievance to gather pace.

291. Sometimes, a detainee will know that a transfer in effect means that removal is imminent, as at Campsfield House on 14 March, and he will resist it. But that is not going to be so in every case.

292. One case put to me was of an FNP released, it was said, from Bedford prison, transferred to Harmondsworth, and moved next day to Doncaster prison – three beds in three nights:

- His legal representative was not told where he was or why he was being moved. There was probably a good reason – on arrival it obviously became apparent that he was suitable only for prison accommodation. But that should have been sorted out before he left Bedford.
- A scenario like this is bad for the detainee and bad for the detention system. The Joint Committee on Human Rights point in paragraph 310 of their report to the need to minimize movements around the detention estate.

Helping staff to understand the reasons for transfers

293. There seems to be a general lack of awareness in centres as to why transfers are necessary. When a particular transfer is questioned, the cause given is usually “operational reasons”, a phrase I encountered a good deal in the course of this investigation:

- I do not doubt the validity of these reasons: DEPMU are under tremendous pressure 24 hours a day and it is wrong to suggest that transfers are sanctioned randomly or without good cause.
- But more should be done to develop a better understanding within centres of how the system works, not least how fragile it is.
- That should complement the excellent work which Detention Services do at headquarters level to brief centre and escort managers.

Conclusion

Movement of Detainees

C9.88. Frequent movement around the estate is bad both for the detainee and for the system. A transfer is usually necessary, but every effort should be made to keep transfers to a minimum. There should be a planned effort to explain to

centre staff – both contracted and BIA – how the system works, their part in it, and the criteria and reasons for transferring detainees. The phrase “operational reasons” should be used as a last resort.

Helping the detainee and his legal representative

C9.89. I judge that there would be big gains if greater efforts were made to give more information to centre staff about transfers in individual cases, so that they can pass this on to the detainee and his legal representative. Lack of information is a major source of complaint.

Assessing suitability and risk

294. I encountered inconsistent practice in assessment of the risk which an individual might present, both in security and in personal terms. Both are important. The security risk is a much bigger issue with FNPs than with other detainees, but both groups present risks in terms of mental health and self-harm issues. The Joint Committee on Human Rights has raised concerns about Campsfield House in this respect (paragraph 299 of their report).

Security risks

295. Partly because of the upheaval in the system in recent months, I encountered much criticism from staff about how little they knew about each detainee when they received him. It was said that often transfer records failed to arrive with him, and in the case of FNPs prison files often arrived late or not at all.

Prison Service Information

296. There is risk that staff will take an unduly cautious attitude, to the detriment of the detainee, because of fear of the unknown. Equally, they need to know more than they often do at present about the FNP arrivals, particularly the facts of the conviction, the sentence, and any adjudications in prison. On the other hand, those staff who have good access to Prison Service information systems speak highly of the quality and value of the information they obtain.

Police National Computer Checks

297. At Harmondsworth, on the initiative of a senior member of staff, the system is short-circuited by means of checks of the Police National Computer (PNC), arranged locally with the police. I could not discover whether that arrangement was replicated elsewhere or whether it was sanctioned by BIA. I can see both advantages and disadvantages in this – speed on the one hand, dangers of an over-cautious judgment on the other, affecting staff attitudes to individuals. Greater consistency of practice would be helpful here.

The Protocol between the Prison Service and BIA

298. A key document governing the handling of FNPs is the Protocol Governing the Management of Foreign National Detainees held in Prison Custody:

- It restricts the use of prison service accommodation for immigration detainees to categories involving criteria of national security, criminality, security or control;
- It provides for the Prison Service to advise the immigration service of potential detainees 14 days in advance of the expected release date;
- DEPMU should aim to transfer the FNP to immigration detention within 14 days following the date of release, subject to the notification process above;
- The only exception to this process is where removal is due to take place within 14 days.

Recent Changes

299. Changes to the protocol were agreed in May this year. The new text:

- Includes the requirement that *“Prior to transfer to an IRC all time served prisoners detained will be risk assessed by BIA staff to establish their suitability for such locations. Those not deemed suitable will be referred to the Prison Service with a request they remain in Prison Custody”*.
- Allows for these criteria to be set aside if behaviour in custody justifies it.

How to make the revised protocol more effective

300. This agreement gives BIA better control over which FNPs might not be suitable for detention accommodation although the revised protocol includes an increase in the length of sentences and offences that would be accepted into the removal estate. If used effectively it should meet many of the anxieties which were evident at both Harmondsworth and Campsfield House. It sets criteria, but allows suitable flexibility; and the traffic is not all one way.

301. The crucial test is whether:

- The notifications which start the process off will happen in time;
- BIA will respond to them quickly;
- BIA will be able to ensure retention in prison service accommodation of FNPs risk assessed as unsuitable for IRCs;
- There will be agreement about well-behaved detainees;
- BIA will be able to ensure removal to an IRC.

302. These are important conditions, and BIA will need to be able to demonstrate that they can manage the process effectively and can maintain the understanding with NOMS about the need to retain in prison service accommodation detainees unsuitable for immigration accommodation. Subject to that, and subject to records being kept up

to date and accessible (of which more later) it should now be possible to make progress with the staff apprehension in IRCs that they will be asked to take inappropriate cases.

Suicide, Self-Harm and Mental Health Problems

Extent of concern

303. I received much comment from outside groups that the current pressures were contributing significantly to an increased incidence and risk of suicide, self-harm and mental health problems.

304. This is presented as:

- A reported increase in numbers of people with mental health problems;
- Lack of time to assess and treat people moving quickly through the system, as under the fast-track arrangements;
- A fall-off in support in the case of FNPs whose mental health problems are well documented;

Statistics

305. I have looked at statistics for incidents of self-harm requiring medical treatment and numbers of individuals on formal self-harm at risk from April 2006 to January 2007. These do not show significant information:

- So far as Harmondsworth and Campsfield House are concerned, the numbers of cases are lower in proportion to their share of the detained population;
- The exception is the numbers of individuals at formal self-harm at risk at Harmondsworth, where there is a slightly higher figure (21% of the total number of cases where Harmondsworth holds 20% of the estate). But this is not a significant variation. Furthermore, the numbers had been declining in the second half of 2006.

An indirect link to disturbances

306. These statistics do not suggest a direct causal relationship between the incidence of these cases and the disturbances at Harmondsworth and Campsfield House. But the need for care of these cases remains a priority, both FNPs and other detained cases. In particular, they reinforce the need to improve information for detainees as the crucial issue in relieving uncertainty and distress.

HMCIP's March 2007 Report

307. I have seen the report of HMCIP, published on 22 March this year, noting an increase in self-harm among FNPs (held both in prisons and IRCs) in the second half of 2006. She makes an indirect link between the pressures caused by the influx of

FNPs into the system, the uncertainty of their position, and increased incidence of self-harm. HMCIP also says that these trends have been noted by IMBs also.

Consideration for deportation

Importance of early consideration

308. In addition to consideration for transfer of those still in prison, there is also the question of consideration for deportation during the sentence. This is crucially important to ensuring early decisions on the proposed action in the case of each sentenced foreign national, in two respects:

- It reduces the risk that the FNP may spend a further period in detention: the frustration of those spending more time in detention when they had prepared themselves to leave prison and return home is a big factor in building up individual and collective tension;
- It cuts down the period spent waiting in the IRC and hence blocking space for other cases.

Recent Developments

309. You wrote to the Chairman of the Home Affairs Select Committee on 19 February advising him that deportation was now being considered 4 months before release in the majority of cases. By 15 March consideration of cases was starting 5½ months before the Earliest Date of Release, thus achieving steady progress towards the target you have set of considering cases 6 months before release, which it was hoped to reach by 1 April.

Need to start the deportation process early

310. This is an important objective in streamlining the process and is worth a good deal of investment by BIA in terms of putting staff into prisons who can then start working on cases well before the date of release. That is what has been crucially lost in the past few years and tackling it is the only way to cut into the issue before it becomes a problem.

Conclusions

Assessment of Security Risk

C9.90. This is one of the top issues if progress is to be made in deciding the best location for FNPs and in reassuring staff that those thought unsuitable for their centre will not be transferred there.

C9.91. When accompanied by more preparation for staff about how to handle FNPs and progress with case handling, it will help to lessen the impact which FNPs are having on the immigration detention estate.

C9.92. The reality is that there will be no choice for the foreseeable future but to accommodate substantial numbers of FNPs and the expectations of centre managers and staff should be guided by that.

Assessment of Mental Health Risk

C9.93. I do not think there is a direct link between incidents of suicide, self-harm and mental health risk and disturbances in IRCs. But insofar as they contribute to anxiety and frustration, especially among FNPs, they are a closely relevant factor. And they must continue as a focus for attention, whether or not they contribute to unrest, because of the duty of care to the individual detainee.

BIA staff in prisons

C9.94. Expensive though this is in staffing terms, it is a very good investment, so as to get ahead with risk assessment, planning for transfers, and early consideration for deportation. The benefits will accrue not only in bringing more certainty to individual FNPs but also in a reduction in needlessly blocking detention spaces.

Impact of FNPs

C9.95. The increased number of FNPs has had a major impact on immigration removal centres:

- **There has been a heavy and unexpected influx of FNPs: on 28 November there were 177 in Harmondsworth out of 501 detainees;**
- **On 5 June 2007, there were 1165 FNPs in removal centres and 349 (all time served) in prisons;**
- **Many FNPs arrive in IRCs with little known about them, making staff anxious about the issues they may present;**
- **Many of them have been behaviourally conditioned by their time in prison and find the IRC regime disorientating;**
- **Some of them will present manipulative and bullying behaviour which will have an impact on vulnerable detainees;**
- **Some FNPs will take advantage of the poor fabric of centres such as Harmondsworth and Campsfield House;**
- **Some will find the dual pressures of further time in custody and uncertain date of release frustrating, to the extent that, “with nothing to lose”, the temptation to join in gratuitous disorder may prove too much;**
- **A concentration of discontented detainees may prove so volatile that an otherwise innocuous event may prove a trigger point for concerted disturbance.**

- **Staff were unprepared for the influx of FNPs and not all have coped confidently with the changes;**

C9.96. The strategies to deal with this need to include:

- **Maintaining a clear protocol with the Prison Service about the suitability of certain categories of FNPs;**
- **A strong presence of BIA staff in prisons who can assess risk and start early work on forthcoming deportations;**
- **Better information to accompany transferred FNPs arriving in IRCs;**
- **More training for IRC staff about how to cope with FNPs, drawing on Prison Service experience;**
- **More information for detainees and better contact with BIA staff (discussed in Part 10).**

Part 10: Casework Progression

Background

Introduction

311. I believe that progress with their cases is the single biggest issue of concern to detainees and lies at the heart of much of the personal frustrations and anxiety which I found. The main worries are:

- Uncertainty about their future;
- Delay in resolving problems;
- Lack of information;
- Spending much longer in detention than they had expected.

Reasons for this judgment

312. I base this judgment on:

- Views expressed to me by detainees;
- Comments from centre management and Contract Monitor staff;
- Comments from staff meetings and when walking around Harmondsworth, Colnbrook, Campsfield House and Yarl's Wood;
- Written representations from several groups.

313. The weight of opinion is, overwhelmingly, that progress with this issue would bring the greatest benefit of any of the suggested ways of improving the current system. The issues are particularly acute in the case of FNPs but are not confined to them.

Gap between individual detainees and caseworkers

314. There is a huge gap in perception on the core problem of lack of information. It is a daily reality of life for those in the centre, both staff and detainees. But to hard-pressed caseworkers, the reality may not be so vivid:

- Their concerns are to make progress on individual cases where they can, often in the face of incomplete information, limited case records, lack of assistance from detainees or their legal representatives, and obstruction from foreign embassies and missions;
- Many of them, especially those involved with FNPs, have been caught up in an issue of great complexity, under a fierce media spotlight;

- They have been pitched in to deal with cases, with limited training or preparation, in a difficult atmosphere;
- Faced with these pressures, it is not easy for them to put themselves in the place of the individual detainee and understand what it looks like from that perspective.

Assessment of the Problem

315. Since the FNP issue has been such a major concern for you and your senior colleagues in the past year, there is little point in my rehearsing all that has happened or the measures taken to deal with it.

316. In any event, Ministers and you yourself have made regular public comments on the progress you have been making. HMCIP has devoted much attention to it, in her reports of July 2006 and March 2007.

317. In these circumstances, the most useful contribution I can make is to try to break down the general anxiety into some specific issues and then assess whether any of the suggested solutions might help.

Main problems needing resolution

318. Casework problems are not new: IND has been grappling with them for years. The legacy of past backlogs, the growth in asylum cases in the 1990s, the failed Casework Programme, the pressure for removals, the introduction of managed migration programmes, the growth in visa regimes, increasing legal complexities – all add up to a formidable challenge for caseworking operations.

319. The problems over FNPs last year added fresh burdens to a hard-pressed system. This has led me to try to identify what is new about the FNP casework issue. I say that because there is little value in my commenting on strategies which BIA has already put in place. That would not be particularly relevant to the issues thrown up by these disturbances.

320. The issues therefore are:

- whether the FNP casework has created new problems;
- whether there are implications for any other casework.

FNP Casework Problems

Inherent Difficulties

321. For the FNP who now finds himself in an IRC, it can look like this:

- for some (a small number) there is the question whether they should be subject to deportation at all:

- If they claim to be British citizens, Irish or EU nationals, or if they have been resident in the UK for a very long time and want to mount a legal challenge on those grounds;
- This is a tiny number where it should be increasingly possible to clarify matters before they leave prison;
- It seems unlikely that this group featured significantly in the disturbances, since they were few and had a lot to lose by getting caught up in the trouble. But nevertheless the sense of personal injustice will have hit many of them very hard.
- Others may well question whether they need to be detained rather than in the community:
 - They may have formed no intention of absconding before removal, and might have been told before release that they no longer presented a threat to the public;
 - In terms of declared policy, bail applications may have offered little prospect of release;
 - By nature this group are unlikely to be in the forefront of a violent protest, but their attitude to an incipient disturbance may be at best neutral.
- For some, a further period in detention may seem unjustified and hard to bear:
 - As far as they are concerned, they have paid their debt to society and would have expected deportation proceedings to have been started in prison;
 - Some were not expecting to be deported at all; others will find themselves spending longer awaiting deportation than they spent in custody;
 - This group are likely to feel very aggrieved. In terms of propensity to cause disturbance they are a high risk and should be a priority for casework action.
- Another group will have been reconciled to the fact of deportation and are frustrated at the length of time the process is taking:
 - They want to go home, and the longer they wait the more anxious they will feel, especially if they are keenly wanting to rejoin family members (in some cases, however, they may be contributing to the delay by providing incorrect information);
 - The frequent departure of others, while they continue to remain in detention, will reinforce their sense of grievance on a daily basis;

- Many of them will look enviously on the fast-track process, with its strict timetables and resident caseworkers, demonstrating to them that if BIA wants to remove someone, it can so do;
 - The presence of 115 fast-track cases alongside 177 FNPs in Harmondsworth on 28 November may well have contributed to the frustration of those whose desire to go home was not being met;
 - On the other hand, the detained fast-track programme, designed to process up to 30% of new asylum cases, is a key part of BIA's Five Year Strategy and there is little point in challenging it;
- Those who want to go will find particularly difficult the fact that they are staying far longer than the regime and facilities were designed to cater for and may soon exhaust what is available, especially if they lack any motivation to engage with them;
- They too have nothing more to lose and must be considered high risk: the opportunity to join in inflicting random violence on the fabric surrounding them may prove too much to bear.
- Others will not want to go, and will do what they can to frustrate removal:
 - This was clearly the case with the Algerian detainee at Campsfield House
 - In the knowledge that nothing much that they do will affect the fact that sooner or later they will have to go, they must also be considered a group at risk of causing disturbance;
 - The solution for these cases, once it is clear beyond doubt that removal is the decided course, is to focus on strategies for removal, as set out in the analysis of the Campsfield House incident;
 - It was put to me that one solution to this group was to devise a set of penalties similar to the offences and adjudications system in prisons. I know that this has been considered and rejected by BIA. I agree with that decision. Whatever their past record, detainees are not the same as prisoners;
 - While it is desirable that IRC staff should become more familiar with prison procedures and culture, and I mention this in respect of Campsfield House in particular, I think it would be a bad move to make IRCs any more like prisons than they need to be. Their functions are quite different.

- Lack of information is a problem for many detainees in the casework process:
 - the failure to secure replies to faxes or queries; lack of continuity with caseworkers; being told that the caseworker has gone on leave without an accompanying offer to try to help; self-evident lack of progress in the monthly reviews, with repetitious answers – all this will add to a sense of despair;
 - The Joint Committee on Human Rights underline these points at paragraphs 273 and 310 of their report;
 - The problems over lack of information may or may not tip an individual over the top, depending on the circumstances, but they do lend themselves to specific improvements to the casework process.

Conclusions

FNPs presenting risks

C10.97. There are several groups of FNPs presenting high risk in terms of potential for disorder. There is little to inhibit them if an opportunity to engage in wanton disorder presents itself. The greater their frustration at their position, the greater the risk of disorder.

Solutions: the casework chain

322. I have looked at this from three points:

- The casework function;
- Casework in IRCs;
- Improving links between caseworkers and IRCs.

The Casework function

323. I have not examined the casework function in its totality. That would not be possible in a brief investigation such as this, and would not directly bear on the matters under investigation. So I have concentrated on the FNP casework.

324. Some of what follows may however be relevant to other caseworking areas, bearing in mind that there are nine contributors to the detainee population, with differing working practices, not all of which will be clear to the staff or the detainees in the centres.

Criminal Casework Directorate (CCD).

325. This Directorate has had the responsibility for handling FNPs. I spent an afternoon talking to CCD managers and staff, to understand the issues from their end and to find out what they were doing about them.

326. I have also seen the minutes of the Criminal Casework Tasking and Co-ordination Group from July 2006 to March 2007:

- The starting point has been the need to deal with the batch of 1013 FNPs identified when the problem came to light; but the casework has grown since then and has not yet reached the point of a “steady state” when the numbers being deported match the numbers requiring deportation;
- You reported to the Home Affairs Select Committee that by 12 February around 2240 FNPs had been deported or removed since April 2006; and that of the original 1013, you were seeking to deport 675, and had done so in the case of 163;
- I was told that since the early days of the FNP crisis, staff numbers had grown considerably: there were now about 600 staff in CCD, with a budget for 2007/8 of £16.3m;
- Efforts had been made to catch up on the shortfall of staff training;
- Cases were allocated to individuals and were carefully stored at night with clear identification of the case owner;
- A pairing system had been introduced so that when a member of staff was away someone else could step in;
- The basic working tool was the Case Information Database (CID) which provides a basic case record plus record of action taken.

327. I was very impressed with the determination I found in CCD, the realization on the part of caseworkers that a great deal was expected of them, and their care to ensure continuity and follow up of cases. I also got the impression that they would benefit from more senior management support.

Is this working?

328. When I asked staff in centres whether the efforts which CCD were making were bearing fruit, I was told that there had been some progress but that there was some way to go. The areas to concentrate on, it was suggested, were:

- Returning telephone calls and answering faxes;
- Ensuring cover for staff when they were away;
- Giving more information about the case;
- Explaining, when the monthly reports showed no change, why this was the case and, more important, what was being done to challenge it:

- This last point was a huge concern to detainees. Staff should give as much information as possible about why there is no change in the circumstances;
- Where, for example, an Embassy is simply refusing to issue a travel document because it does not want to take its own national back, the position should be explained to the detainee, and his active assistance sought in unblocking the problem;
- This may seem common sense, but does not seem to be done in every case.

Conclusion

Casework practice

C10.98. Much benefit would be gained, and much frustration relieved, by giving more attention to basic office disciplines and courtesies such as answering faxes, returning phone calls, checking information is accurate, and giving regular updates.

C10.99. This does not entail sophisticated new practices; rather it is a matter of simple time and desk management and awareness of how much a helpful response matters to another member of staff.

CID

329. As a database, CID seems to me to be crucial. While the staff who demonstrated it to me clearly felt comfortable using it, they were hampered by gaps in the records, caused by incomplete or inadequate inputting. Some of the records which I saw contained basic errors of fact (for example, about someone's nationality, numbers of applications for bail, or dates of hearings before an immigration tribunal).

330. Not everyone putting data into CID seemed clear why they were doing so, what use was being made of the data, and – crucially – why it mattered to someone else. This is not an easy attitude to improve, given the scattered locations of caseworkers, the legacy of past silo working and the rapid recruitment of staff, many from agencies with little background in immigration work or aptitude for it.

331. This dysfunction in processing immigration casework is not new. But the fragility of the system is magnified when a problem like FNPs blows up. It must be a priority for staff training to:

- Explain to staff how CID works and how everyone's input is important;
- Reinforce to staff the crucial importance of checking basic facts and avoiding simple clerical errors when inputting. One tiny slip, such as getting the wrong nationality when writing off to an Embassy, might take weeks to put right.

Access to CID

332. BIA staff in centres have access to CID. They should therefore have access to basic data. But if CID contained more information, and staff felt more confident about its accuracy, there would be less need for staff in centres to have to double-check with caseworkers. The same is true of other casework data bases.

333. I assume that BIA staff working in prisons have access to CID and can start inputting as soon as they know about a case: that way, work on risk assessments can start early on.

334. It may be that some fields, containing either security data or sensitive personal information such as health records, need to be blocked off from some groups of staff: but that should be quite possible technically, and if it is not possible now it should be a priority for action.

Conclusions

Getting the best out of the Casework Information Database

C10.100. The Casework Information Database (CID) is a vital shared tool for processing FNP cases. It has much potential, but is being held back by incomplete or inaccurate information. Developing it, and helping staff to make best use of it, is a priority task.

New ways of handling casework

335. BIA is moving to a new way of handling casework with a caseowner concept. I endorse this as a way of stimulating case ownership, promoting consistency, and giving focus on desired outcomes. It is long overdue.

336. Together with the regional structure and the New Asylum Model (NAM), there is a real possibility of changing the culture with which caseworkers have had to struggle for so long. The trick will be to make sure that these moves are accompanied by excellent databases, available to those who need them, accurate and up to date. The aim should be to:

- generate fast replies to queries for detainees;
- help caseworkers to keep the individual detainee in their sights at all times and to develop better understanding of the reality of life as a detainee.

Casework in IRCs

Recent Changes

337. Many people raised with me concerns about the removal last year of Immigration Service (“badged”) staff and their replacement by locally recruited main grade administrative staff.

338. The purpose of the change was to streamline the caseworking procedures with casework responsibility clearly based with port staff. BIA decided that Immigration Service staff were better used elsewhere and that locally recruited staff could assume the functions of casework liaison, especially if they “got out and about” more in the centres.

339. I am aware that HMCIP has criticized this change and IMBs have certainly noticed a fall off in BIA presence. The Joint Committee on Human Rights mention it also at paragraph 310. This was expressed partly in terms of the loss of authority of “badged” staff, and partly as a problem during the transitional phase, when the Immigration Service staff found jobs elsewhere, but before main grade administrative staff could be recruited to fill the gap and provide continuity of service.

340. I make no judgment on the original decision: it was for BIA to decide where best to use its staff in the light of all resource demands. There is no reason why the new system should not work, especially once the transitional phase is over. But it has coincided with the FNP problem and casework liaison has thus suffered from lack of traction just when it came under strain.

Support for locally engaged staff

341. In these circumstances it is all the more important that BIA staff in centres should have good and speedy access to casework advice and information:

- Many staff joining from outside may find it takes time to feel at home with BIA’s operating systems and language;
- The Contract Monitors, with their focus on managing the contract, keeping in touch with centre staff, and fulfilling their duties in respect of Rules 40 to 43, may not be able to meet the full needs of locally engaged staff in this respect, despite their best efforts;
- This is an issue which would benefit from further attention not only from Detention Services but also by senior managers responsible for casework.

Conclusions

Locally Engaged Administration Staff

C10.101. The decision has been taken to replace BIA staff in removal centres with locally recruited administration grades. I see no merit in seeking to re-open that issue. But in the light of the pressures on staff as a consequence of the FNP problem, more should be done to help new locally recruited staff develop their skills and confidence. It requires input not only from Detention Services but also from senior managers responsible for casework.

A role for centre staff in handling casework?

342. It was suggested to me that the problem might be eased if contracted centre staff were to take over more responsibility for liaison with casework units and groups:

- I can see the attraction of this idea, in terms of speeding up answers to detainees' questions, for which centre staff are in the front line;
- I can also see its merits in terms of nourishing contacts between staff and detainees.

343. But it has limitations:

- Under statute, immigration functions are exercised in the name of the Secretary of State by staff accountable to him or her;
- Centre staff are accountable, for the equally important task of caring for the detainees for whom they are responsible, to the centre management;
- Once the separation of functions has been recognized and set out clearly in contracts, it would blur the line for centre staff to become involved in casework.

344. I conclude that:

- Despite its best intentions, it would sooner or later run into difficulties over accountability and decision taking;
- The position is unlikely to change when BIA becomes an agency, unless decisions were to cease to be taken in the name of the Secretary of State, which I assume is not the intention.

345. There is every advantage in centre staff becoming more familiar with immigration procedures. But I do not think that should extend to involvement in managing casework. That is quite different from passing on information, where more could be done.

Mobile phones and telephone links

346. I see every advantage in allowing detainees to have access to mobile phones, as an obvious way of keeping in contact with the outside world, whether with families and friends or with legal advisers. Anything which allows them to take more responsibility for themselves will help to lessen their feelings of frustration and disempowerment. My understanding is that mobile phones can now be used by detainees in all centres.

347. I encountered criticism over the costs of phone cards for fixed phone lines in some cases. This seems an unnecessary irritation.

348. I can see arguments on grounds of cost and risk of abuse against these initiatives:

- But compared with the costs of running the detention estate, staffing up casework units and tribunals, or putting right damaged IRCs, the money seems small and the investment worthwhile. Even a simple risk analysis would show that;
- The perfectly plausible argument that detainees will misuse mobile phones with cameras or recording devices is easily met by providing mobile phones without these facilities.

349. Constant use of mobile phones may be an irritation for some detainees. Some will say that the issue will soon become as difficult as smoking. But I do not think it should be impossible to devise house rules and encourage detainees to follow them for the sake of others.

Internet access

350. I take a similar view about providing internet access for detainees. During my visit to Colnbrook, where an experiment with internet access has been run, I was struck by the positive atmosphere in the internet room:

- It was not just that the detainees have something to do. The internet offers them the opportunity to keep in contact with family, friends and legal advisers;
- It also enables them to keep in touch with events in the countries to which BIA intends to remove them, and to take up opportunities to entertain or educate themselves.

351. I am fully aware of the risk of access to inappropriate sites, however defined. But many institutions – schools and colleges for example – face the same problem, and overcome it, whether by barring access to certain sites or by manual over-ride, as is the case at Colnbrook. I see no reason why solutions cannot be found.

352. I have followed recent policy discussions within BIA about developing internet access more widely beyond the Colnbrook experiment. I endorse the direction of travel on this issue and hope it will be done as quickly as possible. BIA should be prepared to ride out criticism that undue risks are being taken or that it is pampering people who do not deserve these facilities.

Conclusions

Mobile phones, telephone links and internet access.

C10.102. There is much to gain, and little to lose, by giving detainees as much access as possible to mobile phones, telephone lines and internet access. Subject to devising the necessary protocols on use, I conclude that the provision of these facilities in all IRCs would be a major benefit.

Improving links between caseworkers and IRCs.

Existing links not strong enough.

353. The existing links between caseworkers and centres are not strong enough and require improvement. There is too much mutual incomprehension. The result is delay which hinders removals and causes frustration for individual detainees.

Possible ways of improving links:

- Enhancing direct communications links between centre staff and caseworkers:
 - At present there is email, fax and telephone. The addition of video conferencing links would add a further dimension, bringing home to each end of the chain the reality which the other was facing;
 - Video links will be installed during the summer of 2007 between all IRCs and immigration hearing centres. This provides an opportunity to widen usage of video, provided that video links are available at each end.
 - I would not rule out enabling detainees to take part in such video conferences themselves in some circumstances.
- Arranging reciprocal visits to the other workplace:
 - Taking staff away from their desks is never an easy call, but the value to be gained, with so many new staff and a training deficit because of the rapid pace of recent events, would seem to me to be a good investment at the present time;
 - This could be done either as one-to-one exchanges or as structured workshops;
 - It would need to be done with the full authority of BIA's top leadership and be managed vigorously;
 - I would make one such visit a compulsory personal objective for every new member of staff in their first three months in the job.
- Tasking middle managers to look for every opportunity to develop links by following up slow cases, drawing lessons learned and correcting errors in inputting and using data on CID and other databases;
- Above all else, striving to bring home to everyone involved in casework the importance of valuing the individual detainee and the need to do everything possible to fulfil the obligations so eloquently summarised in Rule 3 of the Detention Centre Rules.

Conclusions

Improving links between centre staff and caseworkers.

C10.103. This is a high priority issue. There are lots of ways of doing it: I have suggested a few, but those who have to manage these links will no doubt think of others. The key to progress is to fix the importance of these links firmly in the minds of caseworkers and to embed it as a personal objective for new staff.

Annex: Method of Investigation

Harmondsworth

- Visits to the centre on 2 March, 30 March, 27 April and 30 May
- Meetings with centre management
- Meetings with Contract Monitor
- Distribution of questionnaire to all staff and analysis of replies
- Group and individual meetings with staff
- Meeting with Independent Monitoring Board
- Meeting with Kalyx
- Meeting with Professor Jonathan Crego
- Discussions with Metropolitan Police Service
- Discussions with London Fire Brigade

Campsfield House

- Visits to the centre on 19 March, 30 April and 25 May
- Meetings with centre management
- Meetings with Contract Monitor
- Distribution of questionnaire to all staff and analysis of replies
- Group and individual meetings with staff
- Meeting with detainees
- Meetings with Chair of Independent Monitoring Board
- Meeting with GEO Group UK Ltd
- Discussions with Thames Valley Police
- Discussions with Oxfordshire Fire and Rescue Service
- Meeting with Dr Evan Harris MP

Other Immigration Removal Centres

- Visit to Colnbrook 2 March
- Visit to Yarl's Wood 4 April

Home Office Discussions

- BIA Criminal Casework Directorate
- BIA Detention Services Directorate
- BIA Detainee Escorting and Population Management Unit (DEPMU)
- BIA New Asylum Model Detained Fast Track
- BIA senior staff
- Prison Service senior staff
- Prison Service National Operations Unit staff
- Legal Adviser's Branch
- Human Resources Group
- Trades Union Side

Consultations with Previous Enquiries

- Anne Owers CBE, Her Majesty's Chief Inspector of Prisons
- Stephen Shaw CBE, Prisons and Probation Ombudsman
- Sue McAllister, National Offender Management Service

Meetings with Outside Groups

- Association of Visitors to Immigration Detainees (AVID)
- Bail for Immigration Detainees (BID)
- Immigration Law Practitioners' Association (ILPA)
- London Detainee Support Group
- The Refugee Council

Written Comments and Material

- Colnbrook IRC Independent Monitoring Board
- Legal Services Commission
- Royal College of Nursing



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