



# **An inspection of contingency asylum accommodation:**

**HMIP report on Penally Camp and Napier Barracks**

**(November 2020 - March 2021)**

**David Neal**

Independent Chief Inspector of  
Borders and Immigration

# **An inspection of contingency asylum accommodation:**

**HMIP report on Penally Camp and Napier Barracks**

**(November 2020 - March 2021)**



© Crown copyright 2021

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at [www.gov.uk/official-documents](https://www.gov.uk/official-documents)

This publication is available at [www.gov.uk/ICIBI](https://www.gov.uk/ICIBI)

Any enquiries regarding this publication should be sent to us at

Independent Chief Inspector of  
Borders and Immigration,  
5th Floor, Globe House,  
89 Eccleston Square,  
London SW1V 1PN  
United Kingdom

ISBN 978-1-5286-2651-4

CCS0521649620 07/21

Printed on paper containing 75% recycled fibre content minimum.

Printed in the UK by the APS Group on behalf of the Controller of Her Majesty's Stationery Office.

## **Our purpose**

To help improve the efficiency, effectiveness and consistency of the Home Office's border and immigration functions through unfettered, impartial and evidence-based inspection.

All Independent Chief Inspector of Borders and Immigration inspection reports can be found at [www.gov.uk/ICIBI](http://www.gov.uk/ICIBI)

**Email us:** [chiefinspector@icibi.gov.uk](mailto:chiefinspector@icibi.gov.uk)

**Write to us:** Independent Chief Inspector  
of Borders and Immigration  
5th Floor, Globe House  
89 Eccleston Square  
London, SW1V 1PN  
United Kingdom



# Contents

Foreword from the Independent Chief Inspector of Borders and Immigration, David Neal	2
Annex A – Letter from David Bolt to the Home Office, 21 March 2021	4
Annex B – HMIP report	7

# Foreword from the Independent Chief Inspector of Borders and Immigration, David Neal

As part of the package of measures available to those seeking asylum, the Home Office provides accommodation and financial support to those who would otherwise be destitute while their claim is being processed, under Section 95 of the Immigration and Asylum Act 1999. Reliant on private contractors and supportive local authorities, the provision of this accommodation has to balance the needs of asylum seekers with the limited availability of housing stock within the UK.

During the normal operation of the Home Office asylum accommodation and support contracts, its accommodation providers have plans in place to procure additional accommodation in the event of a surge in asylum intake. This includes exploring options across the seven contract areas (Midlands and East of England; North East, Yorkshire and Humberside; North West; Northern Ireland; Scotland; South; and Wales), looking at available Dispersed Accommodation (DA) procurement as well as available hotel contingency.

If an applicant no longer has an undetermined asylum claim, an undetermined Article 3 claim under the European Convention of Human Rights or a pending appeal, they cease to be eligible for Section 95 support under the provisions of the Immigration and Asylum Act 1999, and support must be discontinued unless their household includes a dependent child under the age of 18. Following the initiation of national lockdown measures at the end of March 2020 as a result of the COVID-19 pandemic, the Home Office took the decision to pause the cessation of asylum support. This meant that service users would remain in their existing accommodation to comply with Public Health England guidance, but that while the UK continued to receive asylum seekers, no service users were leaving support. The Home Office therefore needed to quickly identify additional contingency accommodation.

As restrictions on the public reduced during the pandemic, the Home Office started to resume support cessations. However, the 'outflow' of people from the system was less than the 'inflow' of new asylum seekers, particularly those arriving by small boat. This presented a risk of the Home Office failing to meet its statutory obligations through a lack of available accommodation. The Home Office looked to identify available accommodation, including on the Crown Estate, that could be stood up at short notice using emergency planning powers. This exercise resulted in the identification of two former Ministry of Defence properties at Napier Barracks in Folkestone and Penally Training Camp in Wales. The sites were handed over to the Home Office on 12 and 13 September 2020 and were operational (being operated by one of its accommodation providers) from 21 September.

From October 2020, a number of stakeholders contacted my predecessor, drawing attention to concerns about the quality of the properties being used as contingency asylum accommodation. My predecessor also met with a number of representatives from the Welsh Government, the local policing commander, and the local health board seeking an urgent investigation into the Home Office's use of Penally Camp.

My predecessor invoked Section 52 of the UK Borders Act 2007 to enable HM Inspectorate of Prisons (HMIP) to provide support for the inspection of the barracks accommodation, given their experience of inspecting large institutional settings. The inspection was led by the ICIBI and my staff accompanied

HMIP on their visits to both sites. Visits to Napier Barracks and Penally Camp were conducted in the week of 15 February 2021.

The key findings from the visits were shared with the Home Office and published on the ICIBI and HMIP websites on 8 March 2021. HMIP's inspection report was shared with the Home Office on 21 March 2021. My predecessor's accompanying letter (at Annex A) drew the Home Office's attention to a number of concerns: the failure by the Home Office to consult local stakeholders, on whose services and support the camps would be reliant, before taking the decision to proceed with their use; inadequate assessments of the physical and mental health of those selected to be moved to the camps; poor communication with the camp residents; poor employment practices by the camp contractors at Napier Barracks; and use of insecure means to share the personal information of the Napier Barracks residents by sub-contractors.

The Home Office closed Penally Camp on 21 March but continued to use Napier Barracks. In response to the HMIP report, it stated on 7 May that it had: undertaken a "lessons learned" exercise with internal and external stakeholders to learn from the first six months of the operation of Napier Barracks to apply to the future operation of the site; guidance had been reviewed and tightened to ensure residents' health and safety is safeguarded, and if it becomes apparent that a resident at Napier no longer meets the suitability criteria, arrangements are made to transfer them to more suitable accommodation; weekly virtual meetings are held with residents, supported by interpreters, to listen to residents' concerns; and it had significantly increased its oversight of the management of Napier Barracks. On 18 May, the Home Office stated that an audit of all contingency subcontractor employment practices at Napier Barracks had been undertaken with a list of actions identified and completed. It also said that a data incident had been raised with the Data Protection Officer in the Home Office on the basis that data owned by the department involving camp residents may have been at risk due to the contractors' use of an insecure email account, which was no longer in use.

My predecessor's letter of 21 March also explained his intention to append the HMIP report to ICIBI's inspection report of contingency asylum accommodation when that inspection is completed. That inspection, which will focus on the use of hotels as contingency accommodation, has only recently commenced and will report in due course. I have decided to publish the report on Napier Barracks and Penally Camp now to enable the Home Office to make use of the learning points it raises, which are relevant to the continued use of Napier Barracks and to any consideration of alternative forms of asylum accommodation going forward.

I also visited Napier Barracks on 12 April 2021 and my experiences echoed those of my inspectors and HMIP.

This report was sent to the Home Secretary on 7 June 2021.

**David Neal**  
**Independent Chief Inspector of Borders and Immigration**



# Annex A – Letter from David Bolt to the Home Office, 21 March 2021

Emma Haddad  
Director General  
Asylum and Protection  
Home Office  
2 Marsham Street  
London



21 March 2021

Dear Emma,

## **An inspection of contingency asylum accommodation: HMIP report on Penally Camp and Napier Barracks**

Please find attached HMIP's report on Penally Camp and Napier Barracks. HMIP has provided this to me on the understanding that it will be appended to ICIBI's inspection report when the contingency asylum accommodation inspection is completed. HMIP is mindful that it was acting in support of ICIBI and will not publish it separately ahead of this.

The report is self-explanatory. From my visits to both camps, I believe that it is both accurate and fair. I am forwarding it to you now as it raises a number of important learning points that are relevant not only to the Home Office's immediate plans for Napier Barracks but also to any considerations that are being given to alternative forms of asylum accommodation going forward.

Over the past few months, I have been in dialogue with residents and former residents of both camps and with some of the third sector organisations that have been supporting them. More recently, I have spoken with stakeholders in Wales and Kent, as well as some from other areas. This has raised many issues, but there are four that I would like to draw out here.

Firstly, the failure to consult local stakeholders on whose services and support the camps would be reliant before taking the decision to proceed was a serious mistake and the need to move at speed is not a satisfactory excuse. The fact that in both cases local stakeholders learned of the decision via rumours rather than from the Home Office made matters worse. Professional courtesies aside, it is hard to see how the Home Office and Clearsprings Ready Homes were able to make an accurate assessment of the risks and suitability of either site without input from these stakeholders. Was it known, for example, that two of the four GP practices in Folkestone had recently closed?

There are clear lessons here about early engagement if any new locations are being considered, particularly if these are remote, or are not existing dispersal areas, or where large concentrations of asylum seekers are involved.

Secondly, from my discussions with medical professionals and those providing health services, as well as with residents and former residents of both camps, it was evident that whatever assessments had been made of the physical and mental health of the men selected as suitable to be moved to Penally and Napier, they were wholly inadequate. In fact, only a tiny percentage arrived at Penally with a health assessment. At both camps, a number of men were identified as suffering from serious underlying physical and mental health conditions, including one case of active TB at Napier.

This is really a question about whether more needs to be done when the Home Office first encounters an asylum seeker to establish their health and welfare needs, both to ensure appropriate professional care and to safeguard against any public health risks (not merely COVID-19 but other communicable or blood-borne diseases, particularly where the person may have been living rough for a prolonged period). This would require a medical examination and tests rather than the current self-declaration through the screening interview.

I mentioned this briefly in my valedictory meeting on 18 March with the Minister for Future Borders and Minister for Immigration Compliance and Justice. We agreed that there would be significant legal and handling issues regarding consent. Nonetheless, I believe that the Home Office should explore this further, particularly given the government's intention to overhaul the asylum system.

Continuity of health care was raised with me by several stakeholders. This is obviously made more difficult if service users are being moved around the asylum accommodation estate. From this perspective, it may therefore have benefited some Penally and Napier residents that they were obliged to stay there for longer than the "few weeks" that was originally envisaged. To be clear, this is not an argument in favour of Penally or Napier over other forms of asylum accommodation, but is about providing asylum seekers with some stability.

Thirdly, communication with the men in both camps has been extremely poorly managed and has been at the heart of many problems, including the fire at Napier, but more generally the levels of stress and anxiety felt by everyone. I accept that COVID-19 made it much more difficult to say how long anyone would be required to stay in either camp, but the lack of notice and information when men were being moved into and out of Penally and Napier suggested that they were very much seen as "cases" not "faces".

This raises questions about the management of asylum accommodation provision, and also about the role played by Migrant Help, which go wider than Penally and Napier. While I am not arguing against these functions having been outsourced, I believe that the Home Office has been too 'hands-off' in the case of the camps and should have had a regular presence at both, as I mentioned to the Permanent Secretary back in January.

But it also raises questions about the asylum process itself. You will already know that what asylum seekers want to know more than anything is what is happening with their claim. Few understand that they should not expect to hear anything from the Home Office for months, until called forward for their substantive interview. Penally and Napier residents were/are no different, except for a feeling that their claims had been marked out as in some way inferior.

I am aware that one of the aims of the planned overhaul of the asylum system is to speed up the process. Regardless, the volumes and the current backlog mean that some claimants will be waiting many months for a substantive interview and decision. It would therefore be sensible to consider whether to build periodic updates on the progress of individual claims into any new system.

Finally, there are two matters regarding actions by the sub-contractor at Napier about which I wanted to be sure that you were aware.

The first concerns poor employment practices. When the ICIBI/HMIP team visited Napier on 17-18 February they found that some employees were living onsite in squalid and unsafe accommodation and were seemingly working in breach of their student visa conditions. When I visited on 4 March, I was told that these individuals were no longer working for the sub-contractor as they were not willing to reduce their hours. I was also told that the accommodation they had been using was no longer in use and locked.

The second concerns the use by the sub-contractors of Gmail to share personal information, including service users' dates of birth, CID references and details of safeguarding concerns. Inspectors were concerned that this constituted a data breach and, as such, should be reported by the department to the Information Commissioner.

You will obviously want to satisfy yourself regarding the facts. ICIBI will be interested in the outcome of your investigations, and in knowing what actions have been taken.

As you know, my term as Independent Chief Inspector ends on 21 March 2021. I would like to take this opportunity to thank you and your staff for the help you have provided with this inspection and to wish you luck with one of the most challenging areas of the department's borders and immigration business.

I am sure that David Neal may wish to pick up some of these points with you in due course. Meanwhile [\[redacted\]@icibi.gov.uk](mailto:[redacted]@icibi.gov.uk) is now leading the contingency asylum accommodation inspection, which is beginning to look beyond Penally and Napier to the use of hotels.

I am copying this letter to the Home Secretary, Minister for Future Borders, Minister for Immigration Compliance and Justice, the Permanent Secretary, and to HMIP.

Yours sincerely,



**David Bolt**  
**Independent Chief Inspector of Borders and Immigration**

## **Annex B – HMIP report**

Report on an inspection of

# **Contingency Asylum Accommodation**

by HM Chief Inspector of Prisons  
for the Independent Chief Inspector of  
Borders and Immigration

**16-19 February 2021**

# Contents

About this inspection and report	9
About Napier Barracks and Penally Camp	10
Summary of findings for Napier Barracks and Penally Camp	11
Leadership and management at Napier Barracks and Penally Camp	14
Section 1. Napier Barracks	16
Safety	17
Respect	21
Preparation for leaving the accommodation	27
Section 2. Penally Camp	28
Safety	29
Respect	33
Preparation for leaving the accommodation	39
Section 3. Appendices	40
Appendix I: Inspection teams	40
Appendix II: Photographs	41

# About this inspection and report

The Independent Chief Inspector of Borders and Immigration (ICIBI) carried out an inspection of the use of barracks as contingency asylum accommodation between November 2020 and March 2021. The ICIBI sought the assistance of Her Majesty's Inspectorate of Prisons (HMI Prisons) to carry out visits to Penally Camp and Napier Barracks. HMI Prisons is an independent, statutory organisation which normally reports on the treatment and conditions of those detained in prisons, young offender institutions, immigration detention facilities and police custody. The ICIBI sought our assistance in light of HMI Prisons' experience of inspecting large institutional settings, particularly during the pandemic.

The inspection visits were carried out in the week starting 15 February 2021. HMI Prisons inspectors were joined by colleagues from ICIBI (see Appendix 1) and spent two days at Penally Camp (16-17 February) and two days at Napier Barracks (17-18 February). The ICIBI also visited Napier Barracks on 4 March.

# About Napier Barracks and Penally Camp

## Task of the facilities

To provide accommodation for adult men seeking asylum in the UK.

## Location

Napier Barracks is in Folkestone. Penally Camp is near Tenby in Wales.

## Last inspection

There have been no previous inspections. This inspection was carried out to assist the Independent Inspector of Borders and Immigration who is undertaking a broader inspection of contingency asylum accommodation.

# Summary of findings for Napier Barracks and Penally Camp

## Leadership and management

- S1** Penally Camp and Napier Barracks were opened as contingency asylum accommodation in September 2020. The Home Office contracted Clearsprings Ready Homes (CRH) to manage the accommodation. CRH sub-contracted to other companies to provide services, and they in turn sub-contracted to other providers. Managers at both sites lacked the experience and skills to run large-scale communal accommodation.
- S2** The Home Office gave CRH less than two weeks to make each site operational and did not adequately consult with local stakeholders, including health services, who needed to set up essential services for residents.
- S3** In September 2020, Public Health England (PHE) had advised the Home Office that opening multi-occupancy dormitory-style accommodation at Napier was not supported by current guidance. Both PHE and, in relation to Penally Camp, Public Health Wales (PHW), expressed concerns to the Home Office about the COVID-19 safety of the accommodation. However, the sites were opened before PHW and PHE recommendations had been implemented. Given the cramped communal conditions and unworkable cohorting at Napier, once one person was infected a large-scale outbreak was virtually inevitable.
- S4** The Crown Premises Fire Safety Inspectorate (CPFSI) informed us of serious concerns about fire safety at Napier that had not been fully addressed at the time of the inspection. The work recommended by CPFSI at Penally had been largely completed.
- S5** The Home Office had been slow to recognise the impact on residents of prolonged stays in accommodation that was not designed or intended for long-term residence. The resources, skills and assurance systems required to support long-term communal accommodation were inadequate at both sites. On-site management structures were unclear, partly because of the multiple sub-contractors, and partly because of inadequate oversight by the Home Office, whose staff were rarely present at either site. There were fundamental failures of leadership and planning by the Home Office.

## Safety

- S6** We met many men who described feeling depressed and hopeless at their circumstances. In our resident survey, all those who responded at Napier and the vast majority at Penally said they had felt depressed at some point (56 resident surveys and 68 staff surveys were returned across both sites between 16 and 18 February 2021). At both sites, about a third of respondents said they had mental health problems; about a third of respondents at Napier said they had felt suicidal.



- S7** We had serious safeguarding concerns in relation to Napier. Some residents who were identified as unsuitable to be located there remained on site for considerable periods; for example, in one case a resident identified by the Home Office as a potential victim of trafficking remained at the Barracks for a further 10 weeks before being transferred out. There was inadequate support for people who had self-harmed. People at high risk of self-harm were located in a decrepit building that was described as the ‘isolation block’; we considered it unfit for habitation. Residents who may have been children were also housed in the same block pending an age assessment; in one case we were told that this had been for up to two weeks.
- S8** Residents at both sites were usually able to come and go. The exception was during the major COVID-19 outbreak at Napier, when over a hundred people were confined to their billets for approximately four weeks and unable to go outside except to use the mobile toilets or showers. They were warned that they might be arrested if they left the camp. In at least one case, a resident was forcibly returned to the camp by the police.
- S9** At both sites, residents described feeling trapped in poor conditions because of the negative consequences of leaving; some told us they were afraid of jeopardising their only source of financial support; others were concerned that their asylum cases might be negatively affected.
- S10** Residents at both camps told us that one reason they had not wanted to leave the camp was because they had been shouted at and intimidated by protesters and members of the public who objected to their presence. While Napier was close to a town (Folkestone), Penally Camp was isolated and the nearest town (Tenby) was a long walk.

## Respect

- S11** The environment at both sites was impoverished, run down and unsuitable for long-term accommodation. Cleanliness at both sites was variable at best and cleaning was made difficult by the age of the buildings. The accommodation contractor had made efforts to improve the facilities, for example by installing mobile shower and toilet units. At the beginning of March 2021, work was in hand at Napier to reconfigure the interior of some blocks into smaller living units. However, the age and general condition of the buildings made the costs of more substantial refurbishment prohibitive given the uncertainty over how long they would be required as asylum accommodation.
- S12** At Napier, the number of residents had reduced from almost 400 in mid-January 2021 to 62 in mid-February. Since December 2020, the number at Penally had reduced to about 80, having been double this at its peak. The multi-occupancy billets at both sites were cramped, which made effective social distancing difficult. Before the numbers were reduced, residents told us that distancing was impossible. This was confirmed by our own observations of the available space and number of people who had been accommodated.
- S13** Most current residents had been in Penally or Napier for several months. They did not know how much longer they would be there and this was a major cause of distress. They had been told initially that they would be there for only a few weeks. All the residents we spoke to who still remained in the camp said they did not understand why they were still there while others had been moved out. Some believed, mistakenly, that it was in some way connected to the Home Office view of the strength of their asylum claim and the fact that they had been in Penally or Napier would count against them. Many residents told us they had heard so many different things about their stay and moving on that they now did not trust anything they were told.

- S14** Most residents were awaiting a substantive asylum interview for which they did not yet have a date. Home Office communication with them was poor and its staff had only recently started video meetings with residents. These did not provide information about individual asylum claims, which was what concerned residents most. The dearth of official information gave rise to misunderstandings and rumours, which had a negative effect on individuals and the collective mood. Managers did not systematically survey or consult residents to seek to understand their concerns or to keep them better informed.
- S15** Most residents we spoke to said that on-site security and services staff were friendly and treated them with respect. All residents had a mobile phone throughout their stay and could access the internet, although wireless internet reception at Penally had been poor until recently. Residents had little to do to fill their time, a lack of privacy and a lack of control over their day-to-day lives. They had limited information about what would happen to them. These factors had had a corrosive effect on residents' morale and mental health.
- S16** While there were some, usually COVID-19-related, restrictions regarding access to the sites, local voluntary groups were supporting residents at both camps, including with clothing and other necessities. They were organising some activities. They were also signposting residents to services and facilitating access to legal representatives. The Migrant Help charity supplemented its contracted telephone helpline service with workers at both sites.

## Preparation for leaving the accommodation

- S17** Most residents had been in hotel accommodation before being moved to either Penally or Napier. Typically, they received little notice, often a matter of hours, of the plan to move them to one of the sites. They were not told why they were being moved and the same was true when they moved out of Penally or Napier to other accommodation, usually back to a hotel.
- S18** Following our inspection, at the beginning of March 2021, Napier residents were informed that they would all be relocated by 2 April, but they were not told the location. Most did not believe it would happen and feared that, if there were new arrivals before they left, they could again become trapped by a new COVID-19 outbreak.
- S19** There was little focus on helping residents to prepare for the next steps, but the visiting agencies and charities provided useful practical support for those who were moving on.

# Leadership and management at Napier Barracks and Penally Camp

- S20** Penally Camp and Napier Barracks were opened as contingency asylum accommodation in September 2020. Preparing accommodation designed for other purposes for use by asylum seekers would have presented substantial logistical challenges at any time. During a pandemic, these challenges were even greater. The barracks at both Napier and Penally had previously been used to house military personnel for short periods of one to two weeks and they required considerable renovation to make them suitable for relatively long-term asylum housing.
- S21** It was therefore surprising that the Home Office gave contractors only about two weeks to make each site operational. Local stakeholders who needed to set up essential services for residents, including health care provision, were not consulted in advance of the Home Office taking the decision to proceed. They were not given enough time to prepare before the first asylum seekers arrived and there seems to have been little understanding or regard on the Home Office's part of what impact this would have at the local level.
- S22** Both sites were opened before Public Health Wales and Public Health England recommendations had been implemented. Public Health England had advised the Home Office that opening multi-occupancy dormitory-style accommodation at Napier was not supported by current guidance, and both they and Public Health Wales expressed concerns about the COVID-19 safety of the two sites. Public Health England further advised that if the accommodation was still to be used, the ability to isolate positive cases and/or establish small cohorting arrangements was essential to contain a COVID-19 outbreak.
- S23** In our resident survey at Napier, none of those who responded felt they had been kept safe from COVID-19. At Penally, the vast majority also did not feel they were being kept safe from the risk of infection. Given the cramped communal conditions and ineffective cohorting at Napier, it was clear to us that once one person was infected a large-scale outbreak was virtually inevitable.
- S24** Despite a large fire at Napier, inadequate action had been taken to address ongoing serious fire safety concerns at Napier. The Crown Premises Fire Safety Inspectorate (CPFSI) had regular oversight of the site and informed us of continuing and, in some cases, serious fire safety shortcomings. At Penally, the work recommended by CPFSI had been largely completed and the remaining concerns related to unoccupied accommodation.
- S25** COVID-19 restrictions meant that some asylum seekers were accommodated at Penally Camp and Napier Barracks for much longer than had been originally envisaged. However, the Home Office had been slow to recognise the impact on residents of prolonged isolation in accommodation that was not designed or intended for long-term stays. Senior leaders had not responded adequately to the unique challenges of accommodating asylum seekers for several months in accommodation designed for short stays. The resources, skills and assurance systems required to provide long-term communal accommodation were inadequate at both sites and had resulted in, for example, poor oversight of the isolation block at Napier, little

accountability for the use of force and a lack of evidence on how managers were dealing with reports of intimidation and bullying between residents.

- S26** The Home Office contracted Clearsprings Ready Homes (CRH) to manage the accommodation. CRH sub-contracted to other companies to provide services, and they in turn sub-contracted to other providers. On-site management structures were unclear, partly because of the multiple sub-contractors and partly because of inadequate oversight by the Home Office and the contracting companies. Managers at both sites lacked the experience and skills to run large-scale communal accommodation, although outcomes were better at Penally.
- S27** Home Office staff were rarely present at either site. There were fundamental failures of leadership and planning by the Home Office, which had led to dangerous shortcomings in the nature of the accommodation and poor experiences for the residents.
- S28** Home Office communication with residents was poor. The Home Office had only recently started video meetings with residents at both sites, but they did not provide information about individual asylum claims. The dearth of official information gave rise to misunderstandings and rumours, which had a negative effect on individuals and on the collective mood.

# Section 1. Napier Barracks

# Safety

## Arrival at the accommodation

- 1.1** UK Visas and Immigration had appropriately suspended transfers into Napier Barracks on 14 January 2021, shortly after the first residents tested positive for COVID-19. Transfers had not resumed by the time of the inspection and we were therefore unable to observe the reception and induction process for new arrivals.
- 1.2** The transfer of migrants already at Napier had taken place during the day and journeys were short, although some residents told us they received as little as 30 minutes' notice of their transfer. Temperatures were taken on arrival, but there was no COVID-19 testing.
- 1.3** Induction took place on arrival, but residents were given no private interview for staff to identify vulnerability. Useful written induction information was given to residents which included NHS information on COVID-19 safety translated into five commonly spoken languages. The advice was useful, but not specific to the Barracks environment. Apart from the occupancy agreement, all other information was also translated into the five most common languages.
- 1.4** Most interpreting was carried out by staff and other residents, rather than professional interpreters. The Home Office told us that £18,500 had been spent on interpretation services from 1 September 2020 to 23 February 2021, an average monthly spend of about £3,100.

## Safeguarding

- 1.5** The eligibility criteria for the camp excluded those with serious health problems and vulnerability. Migrants with poor mental health or a history of self-harm, victims of torture, potential victims of trafficking and those with a history of disruptive behaviour, should not have been located at Napier Barracks. However, 31 residents had been transferred from the Barracks to more suitable accommodation after health and safeguarding concerns were identified. More had been transferred following legal intervention, although managers were unable to tell us how many.
- 1.6** All residents had been given an asylum screening interview by immigration officials before their transfer to the Barracks. Many had crossed the English Channel in small boats and we had previously found weaknesses in the identification of vulnerability in asylum screening interviews for these migrants (see HMI Prisons, Report on an Unannounced Inspection of the Detention of Migrants Arriving in Dover in Small Boats). Residents were not given a health screening on their arrival in Napier Barracks and it was unclear how many had previously been given a health screening (see paragraph 1.62).
- 1.7** A third of the residents responding to our survey said they had experienced mental health problems. All residents who responded said they had felt depressed during their stay at the Barracks. Systems intended to safeguard residents did not ensure that vulnerability was always identified and acted on promptly. Safeguarding expertise was provided by the national

safeguarding team of Clearsprings Ready Homes, who were based off site. We saw evidence that they engaged actively with residents' safeguarding needs when identified. However, they relied on information provided by on-site staff, who had little awareness of trafficking and other safeguarding needs. Onsite Clearsprings Ready Homes staff had raised no concerns about trafficking with first responders under the National Referral Mechanism (NRM). With the exception of the one Migrant Help worker, none of the staff we spoke to had any knowledge of the eligibility requirements for Napier Barracks and could not reliably identify residents who were not suitable.

- 1.8** Safeguarding and other reports made to the national safeguarding team, including in cases where the safeguarding team had asked on-site staff to explore and report on specific concerns, often did not demonstrate enough investigation or action. For example, the national Clearsprings Ready Homes safeguarding team asked staff at Napier to look into the following concerning report from Migrant Help: 'We have received a complaint from the above applicant's legal rep advising that he has back, neck and throat pain due to the effects of the fire in Napier. He also suffers from PTSD, poor mental health, poor sleep and is a victim of torture.' The response was: 'I have spoken to [X] about the below, he feels good in himself and is happy at the camp at the moment. He said he did have a bad few days but since the troublemakers have left and his health has picked up, he has no problems being in the camp.'
- 1.9** In one case, the Home Office decided that a resident was a potential victim of trafficking, but he remained at the Barracks for a further 10 weeks before being transferred out in February 2021. The Home Office did not inform the resident's legal representative or Migrant Help of the decision despite their repeated subsequent requests for an NRM referral. In another case, on 6 February, a medical charity informed the Home Office that a resident, who had been at Napier since 29 September, was a victim of torture who suffered from PTSD and poor mental health. The resident was moved out five days later.
- 1.10** The lack of regular multidisciplinary safeguarding meetings, at which information on risk could be shared, assessed and acted on, was a major weakness. This was compounded by the lack of structured support and care planning for residents considered to be the most vulnerable. These included residents who said they were children, or who were on constant watch as a result of self-harm or other risks.
- 1.11** Data suggested that seven residents had self-harmed and seven others had threatened suicide since the barracks had opened. Some self-harm incidents had been serious. A third of the residents who responded to our survey said they had felt suicidal at the Barracks.
- 1.12** More vulnerable residents were moved to a single room in the decrepit and wholly unsuitable conditions of the 'isolation block' (see paragraph 1.35). This included residents who said they were children and one at imminent risk of harm who was subject to constant watch by staff. Residents on the block did not have a radio or television and had little means of distracting themselves. They were watched by security guards with no training in managing safeguarding and self-harm risk. A nail protruding from the door frame afforded an obvious ligature point and staff did not carry anti-ligature knives.
- 1.13** An actively suicidal resident had remained on the site for more than a month. Communication between agencies and centre staff was poor and there had been a 20-minute delay in attending the resident after he first threatened suicide. He was placed under constant supervision following this incident, but there were no multidisciplinary case reviews to ensure the appropriate assessment and management of risk. Records suggested there were periods at

night when he was left alone. He was taken off constant supervision following a conversation between the site manager and a security guard who had been watching him. The following day he was found hanging and required overnight hospital treatment. He was transferred out of the Barracks three weeks later, following a further incident in which staff intervened to prevent him self-harming. There had been no review of this case to learn lessons. Documentation indicated little meaningful engagement with the resident before he tried to hang himself, and no engagement with him after that incident. Home Office electronic records showed little meaningful attention to the resident's vulnerability and it was unclear why he had not been transferred to more suitable accommodation much sooner.

- 1.14** Two residents were taken into the care of social services for an age assessment. In the first of these cases, the resident was accommodated in the Barracks for 16 days before being transferred, following legal intervention. He had been previously assessed as an adult by a local authority, a decision they later accepted as erroneous.
- 1.15** In the second case, the resident remained at the Barracks for more than two months, before being taken into the care of social services. Immigration officials assessed him to be adult on arrival in the UK. However, a referral for third country removal was refused by the proposed destination country because its records indicated the resident was a child. Despite this, the Home Office did not review its decision to treat him as an adult. He remained at the Barracks for a further three weeks before being taken into the care of social services following legal intervention.
- 1.16** In the absence of any formal care planning, managers at the Barracks could supply little documentary evidence of the support provided to these residents. It was unclear how long they were located in multi-occupancy dormitory accommodation or how long they may have been held in the completely unsuitable 'isolation block' (see paragraph 1.35).
- 1.17** Managers did not maintain a record of the treatment of residents who said they were children. We were told that potential children had been located for up to two weeks in the isolation block while their age was considered, under the supervision of security guards.
- 1.18** We were told that before the COVID-19 outbreak, welfare checks had been conducted each week by administration staff. Records of welfare checks were often superficial and in some cases, there was no record that checks had taken place, even for residents identified as vulnerable. In our survey, only one out of 18 residents who had felt depressed or suicidal said they had received any help from staff.
- 1.19** Until December 2020, managers had used a non-secure email network to communicate information about vulnerable residents. There was no evidence that confidential information went astray as a result.

## Personal safety

- 1.20** Most on-site staff were security guards. Those whom we spoke to had a background in personal protection, and retail, hotel and nightclub security. We observed pleasant, respectful interactions with residents, but staff were ill-equipped to deal with the complex issues they faced.
- 1.21** There had been several protests about conditions in the Barracks and the slow pace of decision-making by the Home Office. A major disturbance involving a small number of residents



had taken place at the end of January 2021, when they were told their COVID-19 isolation was to be extended for a further 10 days beyond the initial 14 days that they were told would be required. A billet was set on fire and the kitchens were put out of use (see paragraph 1.39).

- 1.22** In our survey, only two of the 22 residents who responded said they felt safe in Napier Barracks and none said they had been kept safe from COVID-19. Half the respondents said they had received verbal abuse from other residents, about a third said they had experienced threats and intimidation, and about a quarter said they had been physically assaulted. In relation to staff, about a third of those who responded said they had experienced verbal abuse, a quarter threats or intimidation and one person said he had been physically assaulted by staff.
- 1.23** We observed prompt action to safeguard and move one resident out who was under threat from others. Managers could not provide evidence that some reported incidents had been investigated and there was little evidence of the management of perpetrators of bullying. Some repeatedly disruptive residents were not transferred from the Barracks promptly.
- 1.24** We were told that security staff had restrained residents on a number of occasions, but systems of oversight and accountability were poor. There was little governance of use of force. Body-worn camera footage held by the security contractor was not routinely viewed by site managers and was deleted after 30 days. We were shown reports of four incidents where force had been used. In one case, its use was not mentioned and the other three reports were inadequate, with very little explanation of how force was used.
- 1.25** Residents had been allowed to come and go from the Barracks until the COVID-19 outbreak in January 2021, when more than a hundred people had been confined to their billets for about four weeks, unable to go outside except to use the mobile toilets or showers (see paragraph 1.34). They were warned that they might be arrested by the police if they left the camp. One resident who appeared to staff to have mental health problems tried to leave the Barracks on about eight occasions over a two-day period. Once, at least, he was forcibly returned by the police. Shortly after, he was transferred to alternative accommodation.
- 1.26** A number of residents described feeling trapped in poor conditions and feared that if they moved out, they would jeopardise their only source of support, and potentially their asylum cases. Some told us they had been shouted at and intimidated by members of the public who did not want them there and that this made them reluctant to leave the camp before the COVID-19 outbreak.

## Legal rights

- 1.27** Most residents had been in the Barracks for several months awaiting decisions on their asylum claims. Communication about their asylum cases was poor and many spoke of frustration at the lack of information. There was no Home Office representative on site, which could have helped decision makers to identify, understand and act on residents' concerns and vulnerability. The Home Office had undertaken a single video meeting with residents at Napier Barracks, which did not include discussion of their cases.
- 1.28** There were no legal aid immigration surgeries in the Barracks, although residents we spoke to said they had an immigration solicitor.

# Respect

## Accommodation and facilities

- 1.29** Before the COVID-19 outbreak at Napier Barracks, residents could move freely around the site and had access to limited social activities (see paragraph 1.37), a multi-faith room and a communal dining area. All these facilities had been closed at the start of the outbreak in January and, apart from the multi-faith room, were still out of use at the time of the inspection.
- 1.30** Residents had previously been allowed to leave the site unaccompanied and could stay away for 24 hours, though they were required to sign in and out. If they remained out after 10pm, site staff contacted them to check on their welfare. Staff and residents told us that there was a degree of flexibility in the agreed return time as long as they had contacted the site. Many residents told us they did not go out. Logs were not always legible, but some showed that residents regularly left the site.
- 1.31** At the time of our inspection, the number of residents at the Barracks had reduced sharply from almost 400 in mid-January to just 62 a month later. Residents told us that living conditions were extremely cramped when the camp was at its most full and there was little privacy in the billets. Before the reduction in numbers, residents could not have socially distanced in the cramped multi-occupancy billets, which accommodated 28 men when full.
- 1.32** Most accommodation was in a poor and dilapidated condition. The billets were dark and dreary and in need of renovation and redecoration. Plywood dividers and bed sheets had been installed around each bed but afforded little privacy. Residents said that it was difficult to relax and rest, or even to speak on the phone because of the noise when the billets were full. One billet had basic single and double rooms, which provided a better standard of accommodation, although we observed three residents sharing some of these rooms, sometimes sleeping on mattresses on the floor. We were told that this was by their own choice.
- 1.33** Beds and mattresses across the Barracks were in poor condition. Most residents had a wardrobe, a table and a lockable cabinet. All billets were double glazed and the heating system kept them at a comfortable temperature. There were no electronic systems to raise the alarm or alert staff. Residents told us that they had called ambulances for other residents themselves on some occasions.
- 1.34** There were two toilets and two showers in each billet, which was adequate at the time of the inspection, but not when the billets held 28 residents. The showers afforded limited privacy. Additional portable shower units brought the ratio up to one per five residents, but required residents to go outside, sometimes in very cold weather. Toilets, washing and shower areas were dirty and run down and we observed a poor standard of cleaning (see paragraph 1.54). In our survey, only a small minority of residents said they had enough soap and sanitiser to keep their hands clean. Clean bedding was offered to residents each week.

- 1.35** A six-room isolation block was located in the middle of the camp. It was run down and derelict and unsuitable for habitation (see key concern S7). The interior of the building was filthy, and there were no showers, toilets or washing facilities inside. At the time of our inspection, a resident who was isolating as a result of illness was living in these appalling conditions. Outside areas were reasonably clean and tidy, but austere and bleak. There was a tarmac exercise area, but few green spaces.
- 1.36** Some residents raised with us concerns about fire safety at the Barracks and many had been upset by the recent incident when a billet had been set on fire. Residents cited the old bedding sheets used as room dividers in billets as a potential fire risk; they were used by some in addition to fire resistant curtains to provide extra privacy. The Crown Premises Fire Safety Inspectorate (CPFSI) had seen the site before it opened and had visited several times subsequently, including just before and after our inspection. The CPFSI had identified continuing failings in fire safety, for example shortcomings in staff training, an out-of-date fire safety risk assessment and fire doors which did not close fully. Some of these failings had been notified to managers in 2020. We observed sleeping accommodation being used by staff, which the CPFSI had identified as unsafe on at least two occasions. They had been told by managers that it would not be used. Following our visit, the CPFSI inspected the site again and received written assurance from managers that the accommodation would not be used until fire safety work had been completed. The building had now been emptied of beds and locked.

## Activities

- 1.37** There were two social rooms on site, each of which had a television. One room had two pool tables and another contained a small amount of games equipment, which was not enough even for the reduced population. These rooms had been closed during the recent COVID-19 outbreak and managers told us they had no plans to reopen them.
- 1.38** Most residents told us they found it hard to fill their time on site, and we observed very little to occupy or stimulate people who had often been at the Barracks for several months. There was no access to televisions or a library. A few residents had radios, playing cards and domino sets. Some spent long periods in bed and many told us that they were depressed (see paragraph 1.18). It was clear that the lack of meaningful activity, together with long stays and lack of progress on asylum claims, was affecting the mental health and well-being of residents.

## Catering

- 1.39** Following the recent disturbance (see paragraph 1.21), the kitchen and dining area were out of use. Managers had put a sensible contingency plan in place for residents to receive hot lunches and dinners, including for special diets, prepared and delivered by local restaurants. A cold breakfast was still served on site in the form of a cold grab bag.
- 1.40** Most residents said that the food delivered was reasonably good and that the quality of food cooked on site was not as good. They missed eating together in the central dining hall.
- 1.41** There was no shop for residents on site. Free snack packs containing bottled water, fruit and crisps were available from a storeroom on site between the hours of 3 and 5.30pm every day. Some kettles were available to residents and tea, coffee and milk were delivered to the billets each day.

## Respectful treatment

- 1.42** In our survey, about half the residents said that staff treated them with respect always or most of the time and the remainder some of the time. Less than half those who responded said they could turn to a member of staff if they had a problem.
- 1.43** Some staff had received basic fire awareness training, but otherwise most told us that they received very little relevant training before taking up post. They did not have the experience to care effectively for potentially vulnerable asylum seekers (see paragraph 1.12).
- 1.44** Staff were generally enthusiastic about their role and we observed them being polite and friendly towards residents. Most residents said that staff spoke to them every day. There had been an increase in security staff at the Barracks following the recent incident and they were located around the site, mainly in front of the billets. They had limited interaction with residents.
- 1.45** There was no organised consultation with residents to help understand their views and identify potential concerns. There were no procedures for identifying unfair treatment of ethnic, national, cultural or other groups.
- 1.46** Most residents did not speak fluent English and some used friends who had left the camp as interpreters. Others struggled to find ways to communicate effectively. Professional interpreting services were available, but managers could not give us evidence of how often they were used at Napier.
- 1.47** Faith support had been provided voluntarily by members of the local community before the COVID-19 outbreak. It had not restarted at the time of our inspection and there were no plans for resumption. The multi-faith room had been closed for several weeks but it re-opened during our inspection.

## Feedback and complaints

- 1.48** In our survey, very few residents said that they could easily make a complaint. No information was displayed on how to make a complaint and no written forms were available in any language. Residents told us they generally complained verbally and informally to staff, but these conversations were not recorded and site managers could not identify any resulting changes.
- 1.49** Residents had access to an online portal managed by Migrant Help (see paragraph 2.51). Migrant Help staff on site helped residents to raise concerns through the portal system although they were not confident that complaints were always responded to or resolved. The Home Office was unable to provide us with data on the number of complaints or the response times. Residents could also use the 24-hour Migrant Help complaints phone line, but we had no means of establishing the effectiveness of this service in the absence of data. An interpreter was available if anyone calling the phone line needed one.

# Health care

## COVID-19 safety measures

- 1.50** About two weeks' notice was provided to the local authority, Public Health England and health commissioners of the planned opening of Napier as asylum accommodation. Public Health England expressed concerns about COVID-19 safety on the site and indicated to the Home Office that the use of multi-occupancy accommodation was not supported by the prevailing guidance. They said that if the accommodation was to be used, it was essential for positive cases to self-isolate and effective cohorting arrangements to be established in managing any COVID-19 outbreak.
- 1.51** An outbreak of COVID-19 was declared on 14 January 2021 when there were 381 residents. Minutes of the subsequent outbreak control team meetings appropriately indicated all the key actions that stakeholders were required to take. An initial on-site review on 20 January by Kent and Medway Clinical Commissioning Group identified deficiencies in essential infection prevention standards and poor contingency arrangements for managing the outbreak. The housing provider, Clearsprings Ready Homes, agreed to generate an action plan to address these concerns but our request for a copy of the plan was not met. Some actions were taken, including all potentially vulnerable residents who had tested negative being moved off the site. Other steps taken included weekly COVID-19 testing on the site and enhanced communication with residents.
- 1.52** We had significant concerns about the conditions at the camp and the response to the outbreak. There was no evidence of a risk assessment to determine the maximum COVID-19 safe occupancy at Napier. An assessment had been undertaken by Human Applications (an independent risk management agency) on 2 November 2020, but only once the site was operational. The audit provided few substantive judgements on COVID-19 risks within this environment.
- 1.53** There was no reasonable prospect of effective isolation bubbles being established in the event of a COVID-19 outbreak. Given the cramped communal conditions and ineffective cohorting, once one person became infected a large-scale outbreak was virtually inevitable. No residents who responded to our survey felt they had been kept safe from COVID-19. Additional external showers and toilet facilities had been provided, but it was difficult to see how these could be used effectively in winter, nor how they could be made available to identified cohorts on a controlled basis (see paragraph 1.56).
- 1.54** We visited all accommodation areas. The poor-quality and cramped dormitory accommodation limited the ability to socially distance, particularly at the occupancy levels reached before the outbreak. There was no mechanical ventilation and air flow was restricted to windows and fire doors. Cleaning regimes had been increased since the outbreak to twice a day but despite this cleaning practices were inadequate. Many areas were filthy. Most internal showers and toilet facilities were in a poor condition with build-up of detritus, particularly in the showers. Shower pipes were leaking in some areas and had been 'lagged' by residents to prevent excessive spray.
- 1.55** This extremely poor-quality, dormitory-style accommodation with its inadequate shared toilet and showering facilities, coupled with a deficient cleaning regime meant the environment was not in our view COVID-19-safe.

- 1.56** The management of the outbreak had appropriately involved all key partners. The assessment undertaken by the Clinical Commissioning Group (CCG) six days after the outbreak had started provided very clear advice on how to reduce risk and manage the outbreak. The CCG found that in the Barracks accommodation plywood partitions were being used to differentiate bed spaces, but not to floor level. No single accommodation was available and discrete cohorting of residents on this site was not practical. There was no evidence of residents applying social distancing effectively and some of the communal facilities were still in use. The assessment indicated that limited guidance was given to residents, there was limited signage and all materials were only available in English. Cleaning routines were not being carried out twice a day and there were no cleaning materials for residents. Some alcohol hand gel was available in parts of the site, but this was not consistent.
- 1.57** There had been some improvements over the CCG's findings when we inspected. Over a short period, the number of residents had reduced dramatically in response to the outbreak and this enabled better distancing. Residents had been given face masks and hand gel for personal use. Hand gel was available at the entrance to all accommodation blocks and cleaning materials were now available for residents to clean their own personal living space. Information about COVID-19 safety was displayed on notice boards, but it was unclear how these key safety messages were being reinforced and sustained.
- 1.58** No residents had been hospitalised as a result of COVID-19. Polymerase chain reaction (PCR) testing was accessible to residents and testing arrangements had become more systematic after the outbreak. Residents with symptoms had initially attended the local testing centre but on-site testing soon became the norm. Many inconclusive test results suggested that some residents had not understood the instructions on how to take the tests.

## Physical and mental health

- 1.59** The Home Office had not planned to place anyone with significant health risks at Napier, but there was no evidence that residents were screened for health conditions before arriving on site. These only came to light when residents arriving at Napier declared underlying health conditions. There was no systematic health check for residents on arrival, but the nurse practitioner told us these would have been introduced but for the outbreak.
- 1.60** A nurse was available on site throughout the week, Monday to Friday, from 9am to 5pm. He was experienced, skilled and capable of undertaking triage, clinical assessments and minor treatments. He was also able to prescribe. Cover was provided in his absence. The service was promoted effectively and residents simply had to approach a health administrator to make an appointment. Residents were usually seen on the same day which ensured that general health needs were met in a timely fashion.
- 1.61** Appointments with the nurse generally lasted for 30 minutes to allow time to use interpreting services. Facilities in the designated clinic area were basic but all the necessary equipment was available. An automated external defibrillator was located in the health facility and was in working order when tested. It could be used by site staff out of hours if required.
- 1.62** The nurse practitioner had established a range of services and had plans to offer common vaccinations and full health screening. This had been prevented by the outbreak. All residents had been registered with a local surgery and the care provided by the nurse practitioner was reviewed each day with the GP. This supervision was good and enabled acute health concerns to be addressed and risks to be escalated if further support was needed. The service

had helped to identify residents with underlying conditions, some of whom had moved to alternative accommodation.

- 1.63** Before the outbreak, residents had been able to collect their own medicines and attend the GP surgery if required. During the outbreak there was only virtual access to the GP and medicines were delivered to the site. No delays had been reported with this procedure and most new prescriptions were delivered on the same day. Dental and eye care had been commissioned. A mobile dentist unit 'Dentaid' had been due to visit Napier and would be rescheduled when appropriate. In the meantime, residents were able to access community services.
- 1.64** Residents were not screened on arrival to assess their mental health and emotional needs despite possible exposure to previous trauma. It was unclear how many residents had been screened before arrival (see paragraph 1.59). The CCG was responsible for commissioning mental health services and had established a clinical framework for asylum seekers with commissioners in Slough. This was intended to facilitate access to trauma-informed psychological interventions, but the service was not yet in place.
- 1.65** There was no specialist mental health presence on site, but access to the standard mental health pathways was available. In cases of acute mental illness, support from the crisis team could be accessed through the nurse practitioner. Nine referrals to community services had been received over at least the previous five months, but few had been accepted on to the conventional case load. Some residents had described distress caused by their situation that was not necessarily amenable to clinical treatment. In these cases, guidance was given to the Home Office on how these residents could be supported.
- 1.66** All respondents to our survey said they had been depressed at some point. The lack of occupation, the poverty of the environment and lack of information on progress with their cases had a potentially deleterious impact on residents' mental health and well-being.

# Preparation for leaving the accommodation

## Communications

- 1.67** Wi-fi internet access was available in all billets which residents could access on their mobile phones. Most residents told us this worked well. Residents who did not have their own phones were loaned a handset.
- 1.68** Social visitors were not permitted into the camp. With the exception of the COVID-19 isolation period, residents were allowed to leave the site to see other people.

## Leaving the accommodation

- 1.69** Nearly all residents leaving Napier had gone to hotels or dispersed accommodation. A few who had been removed from the site following the recent incident (see paragraph 1.21) were located at Tinsley House Immigration Removal Centre, which had been converted into bail accommodation.
- 1.70** Residents were given very little notice or information on where they were being moved to, sometimes as little as an hour. No advice or assistance on immediate needs was provided for residents leaving the site.
- 1.71** Two charities visited the barracks regularly and worked with Migrant Help to support residents. Clothing and books had been donated and one charity had recently raised £3,000 to buy good quality rucksacks for residents. No fitness training could be arranged for residents because of COVID-19 risks. The single on-site Migrant Help worker provided good support.



## Section 2. Penally Camp

# Safety

## Arrival at the accommodation

- 2.1** There had been no new arrivals at Penally since the Welsh Government had imposed COVID-19 national lockdown restrictions in December 2020. We were, therefore, unable to observe the arrival and reception process.
- 2.2** The majority of residents had arrived during the night. Managers had decided to facilitate arrivals at night on the advice of local police, to shield residents from potential violence and intimidation as a result of protests which had been taking place at the periphery of the camp in late 2020. However, protests were not taking place every day and routine night-time moves could not be justified on this basis alone. Most residents said they had been brought to Penally from the South-east of England and had experienced lengthy overnight coach journeys.
- 2.3** A considerable number of residents said they had been given very little notice of their transfer to Penally, some as little as 10 to 15 minutes to pack their belongings and prepare to move. Many had not been told where they were going or why they were being moved. Residents described this uncertainty and the night transfers as a stressful and bewildering experience.
- 2.4** A group induction was delivered on arrival in a large, open room with adequate space for social distancing. There was no private interview during induction to enable staff to identify immediate concerns or vulnerability. The induction packs given to residents were comprehensive, but not specific to the camp environment and only available in English. Residents were asked to sign an occupancy agreement, which was also only available in English.
- 2.5** A telephone interpreting service was used with residents who could not speak English to explain the induction pack and the lengthy and complex occupancy agreement. Most residents confirmed that interpreting had been used during their induction, but many had not fully understood what they were being asked to sign.
- 2.6** On arrival at Penally, residents were given a booklet outlining COVID-19 safety, including social distancing rules and advice on handwashing and wearing face coverings. The booklet was translated into five commonly-spoken languages. Residents were not tested for COVID-19 on arrival, but their temperatures were taken.
- 2.7** After induction, residents were offered hot food and drinks, showers, and access to a telephone if they did not have their own.

## Safeguarding

- 2.8** The eligibility criteria for the camp excluded those with serious health problems and vulnerability. Migrants with poor mental health or a history of self-harm, victims of torture, potential victims of trafficking and those with a history of disruptive behaviour, should not have been located at Penally Camp. Despite this, Home Office information suggested that men with both physical and mental health conditions that should have excluded them had been located in the camp.
- 2.9** One-third of residents who responded to our survey said they had a mental health problem, and 90% said they had felt depressed while living at Penally. Only one resident said they had received help with these problems.
- 2.10** There were procedures to refer potential victims of trafficking to the National Referral Mechanism (NRM). The Home Office and local police were alerted to concerns about trafficking and the individual was referred to the Multi-Agency Risk Assessment Conference for Wales, which develops safeguarding and support plans for potential victims of trafficking. One man who had previously been resident at Penally had been referred to the NRM. He had been moved off site and it was found that there were reasonable grounds to believe that he had been trafficked.
- 2.11** When vulnerability or safeguarding concerns were identified, individuals were assessed and transferred to more suitable accommodation when necessary. Since September 2020, 24 referrals had been made to the Clearsprings Ready Homes safeguarding team, and 10 residents had been moved off the site once safeguarding concerns had been recognised by the Home Office. It was unclear from the records how long these residents were on site before being moved. Safeguarding records showed that, once agreed, transfers generally took place within 24 hours.
- 2.12** Three residents had said that they were children since the camp had opened. Two of these residents were soon found to have existing age assessments on file which determined that they were adults. Staff told us that residents who claimed to be a minor were accommodated separately and supervised by staff while awaiting an age assessment or referral off site. They were unable to show us documentary evidence of the care of minors.
- 2.13** Effective safeguarding relied on on-site staff identifying and referring individuals with suspected vulnerability. All staff at Penally had completed basic online safeguarding training, and almost all the staff members who responded to our survey said they felt that vulnerable residents were being supported as well as possible and could talk to staff about their concerns. However, not all vulnerable individuals were being identified, nor was prompt action always taken when vulnerability was identified. Incident reports showed that some safeguarding concerns were followed up appropriately by staff, for example by conducting welfare checks or referring to the safeguarding team. In other instances, appropriate actions were not taken or recorded. In one case, a man who had said that he had suicidal thoughts and wanted to return to his home country was directed to call Migrant Help. We were told they made a safeguarding referral, but there were no records of any further support provided on site following his disclosure of suicidal ideation.
- 2.14** Safeguarding referrals were sent to the national safeguarding team of Clearsprings Ready Homes who had the appropriate expertise. Until the implementation of national lockdown measures in Wales in December 2020, a member of the safeguarding team had visited the site

occasionally, but this work had taken place remotely since then. We saw evidence of prompt and effective support when safeguarding concerns were escalated to the team, but neither the Home Office nor Clearsprings Ready Homes could provide us with comprehensive records of these cases and we were unable to assess fully the effectiveness of safeguarding procedures.

- 2.15** A multi-agency safeguarding meeting took place each week involving staff from the Home Office, Clearsprings Ready Homes, and third sector organisations associated with Penally. Staff told us that these meetings afforded a valuable opportunity to share information about safeguarding processes and to discuss cases of concern. There was a lack of structured support and care planning for individual residents considered to be the most vulnerable.
- 2.16** Each resident received a welfare check at least once a week comprising set questions on physical and mental health, COVID-19, and wellbeing. Welfare checks were reasonably comprehensive and provided prompts for staff to ask about problems that residents were experiencing and to disclose any concerns if they wished. The outcomes of welfare checks were recorded electronically, generating a record for each resident. Staff also recorded attendance at mealtimes and conducted an additional check if a resident did not attend several consecutive meals.
- 2.17** It was unclear how many instances of self-harm had occurred at Penally. On-site staff and safeguarding records indicated that there were no recorded incidents. However, incident logs identified an incident of self-harm, where an ambulance had been called after a resident under the influence of drugs and alcohol set fire to bed linen in his room. According to the record, he ‘tried to hurt himself by hitting the metal cabinets available in the room’.

## Personal safety

- 2.18** In our survey, 70% of residents said they did not feel safe at Penally and 43% that they had experienced threats or intimidation from other residents.
- 2.19** Rules and information were widely displayed around the site, and some had been translated into other languages. Residents whom we spoke to said they were aware of the rules which they were willing to follow.
- 2.20** Staff told us that serious incidents, such as fights and violence, were logged and recorded and were relatively rare. Incident reports indicated that there had been nine incidents since September 2020. In two cases, residents had been found with or under the influence of drugs. One resident had reported concerns about trafficking which were recorded appropriately, including actions and follow-up. Incidents such as protests were also fully recorded.
- 2.21** There had been several instances of challenging behaviour, mostly during the weeks after the site first opened. Both staff and residents confirmed that these had soon stopped. Incident records corroborated this, indicating that almost all incidents were low-level infractions such as smoking in rooms, alcohol consumption, or residents becoming angry. Residents were generally spoken to by staff or issued with an informal warning as a result of challenging behaviour. At the time of our inspection the site was calm.
- 2.22** Incident logs showed that, since September 2020, police had attended the site in relation to 28 incidents, in some cases to warn the camp about protests outside. They had only attended on five occasions as a result of serious behaviour. The Home Office was unable to tell us how many residents had been arrested or charged.

- 2.23** Security staff were trained in de-escalation techniques and had a ‘hands off’ policy of avoiding physical contact with residents, although they would use a guiding or firm hold on residents who became violent. Home Office incident logs showed that, since September 2020, six incidents of use of force had been recorded. Three of these had involved security guards separating fights between residents, and the other three restraining residents who became aggressive towards security staff. Although the records were detailed, they did not specify the form of force that had been used but simply that residents had been ‘separated’ or ‘restrained’, or that ‘reasonable force’ had been used.
- 2.24** Serious incidents and challenging behaviour were logged and recorded, but we did not see evidence of learning or best practice being identified as a result of incidents. Staff told us that they discussed incidents and how best to respond, but the demands of running the site only allowed them to respond to incidents reactively. They had been unable to develop a more strategic approach to reducing violence or managing behaviour, or to identifying and embedding good practice in promoting safety.

## Legal rights

- 2.25** The residents we spoke to had been at the camp for several months and were awaiting decisions on asylum. Home Office officials had not attended Penally since the Welsh national lockdown measures were introduced, and, even before this, their presence had been inconsistent. The Home Office had recently started a weekly telephone surgery to answer residents’ questions about their accommodation at the site and the asylum system in general, but residents could not use these sessions to ask about individual cases. Only four of these had taken place at the time of our inspection, and Home Office staff had visited Penally once in late January. The lack of engagement and communication from the Home Office left many residents feeling poorly informed and frustrated.
- 2.26** Access to legal representation was adequate. Migrant Help were able to signpost residents towards legal representatives, and the Welsh Refugee Council were helping residents to access legal representation and to contact their solicitors, using interpreting when necessary. We observed several residents on video calls with their solicitors, which were facilitated by the third sector organisations working at Penally. Residents whom we spoke to said that a legal representative was dealing with their asylum claim.

# Respect

## Accommodation and facilities

**2.27** Residents could move freely around the site and leave if they wished. They had to sign out and in and logs showed that a number of residents had left for exercise or to visit local shops and the town. All but four respondents to our survey said that they were able to leave the accommodation. Many residents did not leave because of the remote location of the site and poor weather and in our survey about half said that they were allowed to leave only 'some of the time'. Staff and residents explained that many residents did not leave the site in the early stages when there were protesters outside (see paragraph 2.2). A protester had injured one resident who had to be hospitalised.

**2.28** Residents also explained that they did not leave the site because of a lack of motivation, the distance to the town, their inability to speak English, the winter weather or a lack of funds. We received a number of written comments in response to our survey from residents at Penally. One told us:

*'I have been here five months. I finished my final interview in December. I should have been in dispersal accommodation in August. I am not sleeping, my head is aching, my body is spinning, I have back problems with the small iron bed, I have been to hospital for it, I am tired, tired, tired.'*

**2.29** Another resident described his experience as follows:

*'Personally, I fled from indefinite military service and illegal imprisonment. but I end up here in Penally similar institution I escaped from. I don't know how long I will stay here I am developing stress I can't sleep. I was locked here for long time that I forgot I am in UK. Can you please get me out of this prison please help please help.'*

**2.30** Another said, *'I have been developing stress since I came to this camp. I feel like in prison.'*

**2.31** Community groups had facilitated trips during the early weeks, but these had stopped during the Wales lockdown. Clearsprings provided two minibuses and drivers which were used to take residents to health or immigration appointments or to their destination when they moved from Penally.

**2.32** There had been as many as 198 residents at Penally. At the time of the inspection, there were 80. Managers informed us that the full capacity while remaining COVID-19-secure was 234 residents. The numbers were decreasing slowly, as individuals were moved on.

**2.33** The accommodation was in ageing, wooden billets, most of which were in a poor and dilapidated condition. They were furnished with iron double bunk beds, metal cupboards and furniture. At the time of our inspection, there were up to three people in each hut with enough space to satisfy COVID-19 restrictions, but still cramped and uncomfortable because of the large quantity of furniture. A resident wrote to us:

*'I'm tall and big and the bed is very small and I cannot sleep and I have pain in my neck. This bed caused me additional problems and the bed on the second floor is very short that I always hit my head, and I cannot read or sit up and this causes me pain in my back.'*

- 2.34** The huts were dispiriting and unsuitable for occupation day and night for many months. One resident said, *'I escaped from Military and now I am in military camp this makes stressing.'* Another took a nuanced view of the accommodation, but still described the negative overall effect on his well-being:
- 'The accommodation here at least kept me safe from some troubles that I would suffer if I am home; and provide me sufficient food though it doesn't keep its consistency in regard to quality. So, I thank you! The big problem is the depression is increasing. The longer I staying here the more developing depression.'*
- 2.35** Showers and toilets were in separate blocks, not always close to the living billets. This had presented particular difficulties during very cold weather, especially when residents needed to use the toilet at night.
- 2.36** Portable shower units had been installed to improve access, but these were not suitable for use over several months. In our survey, more than half the respondents said they were not able to shower every day. The toilet, washing and shower areas were cleaned regularly, but many were far too dilapidated to be kept acceptably clean. Some residents said that the standard of cleaning had improved only very recently.
- 2.37** In our survey, about two-thirds of residents said they did not have enough soap and water to keep their hands clean. There was no privacy in many of the shower blocks, with multiple shower heads along an open row. Shower curtains had been installed in two blocks just before our inspection.
- 2.38** Residents had good access to toiletries and were able to wash their clothes, although less than half said in our survey that they had enough clean, suitable clothes for the week. Clean bed linen was provided each week. A full-time maintenance officer repaired minor faults quickly. A cleaning team kept the outside areas tidy and free of litter.
- 2.39** Improvements had been made to fire safety following two minor incidents and a fire safety officer visited regularly. There was no outstanding work in any occupied blocks.

## Activities

- 2.40** Most residents we spoke to said they were bored and had felt themselves losing morale and motivation over the months. One said:
- 'My brain is already damaged because I am not working. Eat and sleep, eat and sleep, like an animal. No information about anything.'*
- 2.41** Common rooms were equipped with table tennis and pool but were otherwise bare and unwelcoming. A small library was stocked with about 350 donated books, all of which were in English. Four computers were available in a classroom, and a church group had donated a number of tablets for residents' use.
- 2.42** The Oasis charity, a well-established local group, provided appropriate activities and useful coordination, training and advice to other community groups and charities wishing to offer voluntary, practical support. Volunteers were suitably supervised. About 30 bicycles had been supplied and were maintained and other sporting activities and training had been organised, as well as music and art activities. The County of Sanctuary Pembrokeshire provided chess sets, books and DVDs. Most of the activities had been paused during the prevailing lockdown.

- 2.43** English classes were re-starting online and one or two teachers among the residents were supporting their peers. Not all residents knew about or had access to the classes: one resident wrote: *'Hello if it is just possible to provide a place to exercise and English language classes for us so that while we are based here, we can learn English better'*.

## Catering

- 2.44** Three cooked meals were served each day from a four-week menu cycle. Few residents were unhappy with the food, although some found it too plain and lacking variety. Managers and staff said that the standard of catering had been inadequate until the new manager arrived. The food that we tasted was of acceptable quality. Snacks and drinks were available for sale, and tea, coffee and bottled water were freely available.
- 2.45** Hygiene and safe storage arrangements were adequate considering the age of the huts in which the kitchen and food stores were located. An environmental health inspection had taken place and we were told that the small number of recommendations had been implemented.

## Respectful treatment

- 2.46** Staff were civil and often friendly towards residents. The security staff tended not to engage unless approached, but many individual members of staff took the initiative to be encouraging and supportive. In our survey, a third of residents said that staff treated them with respect some of the time and just over a quarter said they were never treated with respect. One wrote:

*'The employees don't smile to me and don't take into account our mental health problems, and this increases these mental health problems because we feel that they are here against us and not for us. They always record what we say using cameras, and when we talk to them, they turn on the cameras to threaten us and to make us nervous. They do not take into account that we don't speak English.'*

- 2.47** There was no organised consultation for residents to help understand their views or identify potential concerns. Two thirds of residents who responded to our survey said that there were no members of staff they could turn to for help if they had a problem.
- 2.48** Staff had access to telephone interpreting. Many of the residents did not speak English fluently. Managers could not provide data on where the service had been used in the camp. There was little evidence of unequal or discriminatory treatment of particular groups within the population. Residents felt that all groups got on well with each other.
- 2.49** Faith support was provided voluntarily by ministers and faith community members. Worship spaces were provided in two huts.

## Feedback and complaints

- 2.50** There were no complaint forms or notices about how to make a complaint. In our survey, only a third of residents said it was easy to make a complaint.
- 2.51** Residents would often take a complaint informally to staff, particularly in the administration office whose staff were helpful and responsive. Migrant Help had a 24-hour complaints phone line for residents to raise issues about Migrant Help's work or concerns to be passed to the accommodation provider. A web portal enabled residents to make such complaints online,



but in English only. The telephone line offered an interpreting service, but some residents had waited a long time to access the service and some had given up altogether. We were later told that the average waiting time for calls that were answered in February 2021 was 10:48 minutes.

## Health care

### COVID-19 safety measures

- 2.52** The decision to use Penally Camp for asylum seekers was poorly communicated to key stakeholders, who had very limited time to establish services. The Health Board was informed three days before the camp opened. The Health Board and Public Health Wales (PHW) had expressed concern about the appropriateness of the accommodation and did not consider it to be COVID-19-safe.
- 2.53** A multi-agency approach had been adopted across west Wales to respond to the Home Office decision to place up to 200 asylum seekers at Penally Camp. The initial focus had been to provide access to suitable health services for asylum seekers while maintaining services for the local community. Priority was also given to providing advice and support on the management of communicable diseases with particular reference to COVID-19.
- 2.54** A multi-agency team including the Health Board and PHW visited the camp just before it opened to make recommendations on improving COVID-19 security. These recommendations were not implemented before residents had started to arrive. Clearsprings Ready Homes had subsequently endeavoured to implement them, but the state of the accommodation prevented them from doing this fully.
- 2.55** Residents were notionally organised into ‘bubbles’ on the advice of PHW, but this was not working in practice. The layout of the site did not lend itself to keeping groups separate. We observed staff following social distancing reasonably well.
- 2.56** On arrival residents were given a booklet of information about COVID-19, which was translated into commonly spoken languages. COVID-19 information and advice were laminated and displayed in different languages around the camp, including pictorial posters demonstrating effective hand hygiene.
- 2.57** A plentiful supply of masks and hand sanitisers was available across the site and residents were given their own supplies. Not all residents were wearing masks, but we observed staff encouraging their use.
- 2.58** Residents had their temperatures checked three times a day at mealtimes and whenever they left or returned to the site. Staff and visitors also had their temperatures checked on arrival.
- 2.59** Two adequate isolation areas with nine beds had been established. There had been very little use of isolation, but it had been used appropriately for three residents. Only one resident had displayed COVID-19 symptoms at the camp since its opening. Clearsprings Ready Homes followed the procedures and guidance from PHW for dealing with COVID-19 issues. The symptomatic resident had been isolated and a COVID-19 PCR test completed promptly with a negative result. The isolation unit was deep cleaned after each use.
- 2.60** Advice from the Health Board and PHW had largely been followed to make the isolation units as compliant as possible with infection prevention and control guidance. An action plan had been drawn up of measures needing to be implemented and this had been reviewed. Furniture

and mattresses had been replaced to ensure they could be cleaned easily. In other respects, the units were not fully compliant with infection prevention guidance, including the flooring and the toilet and shower areas. Paint was flaking from some skirting boards and some flooring was old and worn.

- 2.61** The Home Office contingency plan was to transfer symptomatic and positive COVID-19 residents to accommodation in London. This did not reflect COVID-19 guidance on travel restrictions and preventing the spread of the virus nor would it have been conducive to residents' health to be moved if they were unwell. The Health Board and PHW had requested information on how this would be facilitated but had not received any. They also expressed concern about the low number of isolation beds on site and the impact of a potential outbreak for residents and staff and for the local infrastructure.

## Physical and mental health

- 2.62** Partnership working was effective and there were regular multi-agency meetings between Clearsprings Ready Homes, the Hywel Dda University Health Board, PHW and other partners. Some concerns remained about the overall responsibility taken by the Home Office for implementing advice and guidance, the location and use of the site and pressures on the local infrastructure and COVID-19 safety.
- 2.63** All residents at Penally Camp had been registered with the local GP surgery at Tenby to access comprehensive primary health care services.
- 2.64** Health services were delivered via triage and two clinics were held each week. These were run by an experienced advanced paramedic practitioner who was a non-medical prescriber, and a nurse also attended. They had access to the GPs at the practice for complex cases. Following a disturbance at the camp, the Health Board carried out a risk assessment and decided that it was unsafe for health care staff to continue to attend. Two clinics a week were set up at a local hospital and run by the advanced paramedic practitioner. While this was being organised, remote triage and consultations continued via telephone and use of video consultation software. Interpreting services were used when needed.
- 2.65** Two drivers provided transport to and from health appointments on eight-seat minibuses taking no more than four residents at a time. Several journeys could be made if required. They also collected prescriptions and we observed positive and friendly interactions between the drivers and residents.
- 2.66** Since the site opened, health staff had seen 177 patients with various needs, including acute physical health conditions and the diagnosis and monitoring of long-term conditions. Referrals to specialist services had been made and appropriate care given. Medication and repeat prescriptions were facilitated and information about the medication was provided in the resident's language.
- 2.67** The Health Board was assured that an initial health assessment (IHA) would be undertaken before the transfer of any individual to the camp. Despite this, only five out of 179 residents had received an IHA before coming to Penally, some of whom arrived with complex health needs. This had led to the Health Board recommending to the Home Office that 10 residents be transferred to alternative accommodation in view of their health needs and the unsuitable environment at Penally. They were subsequently moved.

- 2.68** The practice nurses from Tenby surgery had completed 48 IHAs, including blood-borne virus testing, before these were suspended to focus on the COVID-19 vaccination programme.
- 2.69** The health appointment system was clinically triaged. Basic information for this and the initial registration forms to join the GP practice were handled by Clearsprings Ready Homes administrative staff rather than health staff, which compromised patient confidentiality. There was no direct access to the GP service and some residents said they did not feel comfortable sharing confidential medical information with non-medical personnel.
- 2.70** An emergency dental pathway had started at the end of October 2020. Antibiotics and pain relief were available and the service had received 26 referrals. Links with a local optician had been established by Clearsprings Ready Homes staff.
- 2.71** In our survey, about a third of residents said they had mental health problems. Referrals to primary and secondary mental health services were made promptly, including access to a psychiatrist who had seen two residents. A weekly primary mental health clinic had started in January 2021 to meet an increased rate of referrals in December and January. The clinic had received about 40 referrals, most of whom had been seen but some had been moved before their appointment took place.
- 2.72** The team manager for the Pembrokeshire Local Primary Mental Health Support Service ran the clinic. Most referrals were for mild to moderate mental health conditions, including sleep problems, anxiety and depression. Some referrals had experienced trauma, but it was difficult to start long-term treatment with the uncertainty of how long the resident would be at the camp. A range of support and self-help guidance was offered in appropriate languages and translation services could be used on an electronic tablet.
- 2.73** Several residents we spoke to said they were feeling anxious and depressed, compounded by being at the camp and not knowing what was happening to them. A few said they had experienced verbal abuse and unfriendly reactions from local residents when they had gone into the town which had affected their morale and feelings of self-worth (see paragraph 2.27). Many expressed a loss of motivation and a sense of hopelessness.
- 2.74** Health staff were not always informed when residents were moved from the site, but they made concerted efforts to forward information on outstanding health needs or test results to provide continuity of care.

# Preparation for leaving the accommodation

## Communications

- 2.75** Residents could keep their mobile phones on arrival, with internet-enabled SIM cards. Phones were provided to any resident without one.
- 2.76** There was internet access through phones and Wi-Fi was available in the common rooms, although residents did not always find this effective. Internet access was being installed in the billets. A community group had donated 20 tablets for residents' use.

## Leaving the accommodation

- 2.77** All residents leaving the centre had gone to hotels or similar initial or dispersed accommodation.
- 2.78** No help was provided by staff for residents to prepare for their future in the UK or another country. Community groups provided this support on their own initiative on a voluntary basis.
- 2.79** The visiting agencies and charities offered a wide range of assistance in practical matters and to meet immediate needs. Oasis delivered an English for speakers of other languages service focused on practical issues for integration, such as visiting the doctor in the UK. There were plans to start a 30-session programme in March 2021 on practical integration, run by the PeaceJam charity, with funding from a local Rotary group.

# Appendices

## Appendix I: Inspection teams

### Inspectorate of Prisons

Charlie Taylor	HM Chief Inspector of Prisons
Hindpal Singh Bhui	Team Leader
Rebecca Mavin	Inspector
Martin Kettle	Inspector
Deri Hughes-Roberts	Inspector
Darren Wilkinson	Inspector
Steve Eley	Health inspector
Maureen Jamieson	Health inspector
Rahul Jalil	Researcher
Joe Simmonds	Researcher
Annie Bunce	Researcher

### Inspectorate of Borders and Immigration

David Bolt	Independent Chief Inspector of Borders and Immigration
Tessa Wilson	Inspector
Caroline Parkes	Inspector

## Appendix II: Photographs



Outside of billets, Penally Camp



Washroom, Penally Camp



Resident sleeping area, Penally Camp



Outside of billets, Napier Barracks



Resident billet, Napier Barracks



Resident sleeping area, Napier Barracks





Resident sleeping area, Napier Barracks



Currently occupied isolation unit room, Napier Barracks



Currently occupied isolation unit room, Napier Barracks

Crown copyright 2021

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Any enquiries regarding this publication should be sent to us at the address below or: [hmiprisons.enquiries@hmiprisons.gsi.gov.uk](mailto:hmiprisons.enquiries@hmiprisons.gsi.gov.uk)

This publication is available for download at: <http://www.justiceinspectorates.gov.uk/hmiprisons/>

Printed and published by:

Her Majesty's Inspectorate of Prisons  
3rd floor  
10 South Colonnade  
Canary Wharf  
London  
E14 4PU  
England

