

# Annual Report 2015

## Yarl's Wood Independent Monitoring Board (IMB)



**Independent Monitoring Board  
YARL'S WOOD  
IMMIGRATION REMOVAL CENTRE  
Chair: Mary Coussey  
Vice-Chair: Bali Chand**

## **1. Statutory Role of the IMB**

The Prisons Act 1952 and the Immigration and Asylum Act 1999 require every prison and immigration removal centre to be monitored by an independent Board. Members of IMBs in Immigration Removal Centres are appointed by the Home Secretary from members of the community in which the centre is located.

The Board is required to:

- Satisfy itself as to the humane and just treatment of those held in the immigration removal centre
- Promptly inform the Secretary of State or any official to whom she has delegated authority as it judges appropriate, any concern it has
- Report annually to the Secretary of State on how far the immigration removal centre has met the standards and requirements placed on it and what impact these have on those held in the centre.

To enable the Board to carry out these duties effectively its members have right of access to every resident and every part of the centre and also the centre's records.

### **IMB Equality statement**

We adopted the following equality statement in 2011:

The IMB will not discriminate directly or indirectly against anyone because of age, disability, gender reassignment, marital and civil partnership status, pregnancy and maternity, race including colour, nationality, ethnic or national origins, religion or belief, sex and sexual orientation, in recruitment, in the treatment of members, and in the way they monitor the treatment of people in custody.

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### **3. Description of Centre**

**3.1.** Yarl's Wood IRC ("the Centre") is a purpose-built Immigration Removal Centre operated under the Detention Centre Rules 2001. It is located outside the village of Clapham in Bedfordshire and was opened in 2001.

**3.2.** Yarl's Wood is the principal UK centre for the detention of single women and families under immigration legislation. For the purposes of this report, the term "families" means couples or families detained with children over the age of 18. There is also a Short Term Holding Facility ("STHF") at the premises, with accommodation for up to 38 male residents. The Centre and the STHF are operated on behalf of Home Office Immigration and Enforcement ("HOIE") by Serco Limited ("Serco" or "the Contractor").

**3.3.** The accommodation at Yarl's Wood IRC consists of five residential units housed in a large, two-storey building. Occupancy is an average 349, with the great majority being single women. There is a family unit, (Hummingbird) a female induction unit (Crane), two female residential units (Avocet and Dove), and the STHF, known as Bunting. The four main residential units are connected by a central corridor, from which all ancillary areas, including the Healthcare centre, can be accessed. Residents in temporary confinement under rule 42 ("TC") are held in the separation unit, which also contains removal from association ("RFA") rooms.

**3.4.** There is a Healthcare Centre on site, which currently is operated by G4S. This provides primary healthcare for residents, with secondary care being the responsibility of NHS England.

**3.5.** In 2015, Yarl's Wood again operated in the spotlight of intense interest from the media, pressure groups, governmental and non-governmental organisations.

## 4. Executive Summary

4.1. Yarl's Wood is a unique establishment within the IRC estate, catering for a wide variety of residents from all over the world, sometimes with quite complex needs. This has been a challenging year for a number of reasons. We commend the efforts made by Serco staff in trying to operate the Centre under difficult circumstances but have had cause for concern on a number of issues.

4.2. We commend the important work of the Religious Affairs team at Yarl's Wood.

4.3. Food and meals are a very important part of the day for the residents, and the IMB feels that residents' needs have not been adequately met this year. In particular, the changes to the lunchtime menu have resulted in a limited choice with very little variation from day to day.

**We recommend that the lunchtime menu should be revised to introduce variety and take into account the cultural and nutritional requirements of the population. [Serco]**

4.4. In September 2014, NHS England took over the running of Healthcare within Yarl's Wood. The difficulties caused by this change were highlighted in our last report and have continued through 2015. Problems with healthcare again dominated the IMB's concerns during 2015, although significant improvement could be detected in the latter part of the year.

4.5. Healthcare lacked permanent staff throughout the year, a factor which has undermined the service to residents.

**We recommend that urgent priority continues to be given to the recruitment of permanent members of staff to allow Healthcare provision to be effectively delivered. [G4S]**

4.6. The IMB identifies three principal areas of concern in the Healthcare provision: access to GPs; the attitude and demeanour of staff; and problems with prescription medication. We record improvements made in all these areas over the course of the year.

4.7. We again report concerns about the detention of women with serious mental health issues, many of whom are held in the separation unit. We do not feel that the Centre has adequate facilities or trained staff to look after them.

**We recommend that women with serious mental health issues should not be detained. We also recommend that the Centre improves the staffing, training and facilities to cater for residents who are found to have mental health issues after they are detained. [HIOE, Serco, G4S]**

4.8. We again highlight the apparent failure of HOIE to follow its own policy on the detention of pregnant women and repeat our concerns. We also highlight difficulties in obtaining verified statistics about the detention of pregnant women at Yarl's Wood.

**We again strongly recommend that pregnant women should not be detained. We also recommend that the collation and reporting of statistics about pregnant women be improved.**

**4.9.** There has been a reduction in the total number of residents removed from the UK from Yarl's Wood, down to 19% in 2015. The number of female residents leaving the Centre who have been detained for more than 12 months has increased from 4 in 2014, to 10 in 2015.

**We repeat our recommendations that:**

- **There should be a maximum time-limit for detention**
- **The decision-to-detain process should be reviewed as it appears to be becoming less effective**
- **Detention should only be used in cases where removal is inevitable and imminent.**
- **Greater use be made of community-based monitoring**

**4.10.** Use of RFA has increased in 2015, which is a matter of concern. We highlight examples where we consider its use to have been incorrect or inappropriate. In some cases, we feel that it has been used as a way of controlling or punishing challenging detainees.

**We recommend that the use of RFA should be investigated to ensure compliance with DC rules. [Serco]**

**4.11.** There has been a small increase in use of force at Yarl's Wood against a backdrop of a downward trend in recent years. We highlight two occasions where we consider that the force used by custody staff was excessive.

**4.12.** We raise concern about the increased use of handcuffs for women being escorted to hospital visits. We note that some residents have missed appointments as they found the practice of handcuffing humiliating and refused to go to their hospital visit.

**We recommend that the use of handcuffs for hospital visits should be investigated to ensure that efforts are made to limit its use, whilst addressing any security concerns. [Serco]**

**4.13.** This year has seen a reduction in staffing levels, largely due to the new contract that was entered into in April 2015. This has had a negative impact on the running of the Centre and we highlight the areas that have been affected.

**4.14.** In March 2015, the Centre was the focus of a Channel 4 News report, in which serious allegations were made. This had an impact on staff and residents and led

directly to the appointment, by Serco, of Kate Lampard to conduct an in-depth investigation into culture and practices at Yarl's Wood.

## **5. Specific areas of monitoring**

### **5.1. Equality and Diversity**

**5.1.1.** This area covers the monitoring of the ethnicity, social and demographic characteristics of the residents and the efforts made within the unit to address their social, cultural, and particularly, religious needs. The Centre has a Religious Affairs Team led by a retained Christian Pastor and supported by a Muslim Cleric, a Buddhist Leader, a Hindu/Sikh Leader and a Chinese Christian Leader. They collectively provide spiritual and emotional support to the residents and meet regularly to discuss multi-faith provision within the Centre.

**5.1.2.** Serco have a Regimes and Equality Officer responsible for this area who reports monthly to the Equality Action Tem (“EAT”) with an updated analysis of relevant demographic and religious statistics.

**5.1.3.** Particular areas which have been of note since the last IMB report are:

**5.1.4.** The induction of new residents to the Unit: Serco have designated certain existing residents as “Meeters and Greeters” who are responsible for showing around new arrivals and introducing them to relevant individuals. These meeters and greeters are expected to attend the last part of the regular EAT meetings. This procedure appears to be working satisfactorily and is well received by the new residents.

**5.1.5.** HOIE has issued detailed guidance on the care of transgender residents, of which there have been a number in the last year. At Yarl’s Wood each of these residents has their own room, unless they request to share a room. They each have a care plan and are seen by Healthcare, when necessary.

**5.1.6.** Christianity continues to be the largest faith group within the Centre followed by Islam and Hinduism. In addition to the Christian services in the prayer room, Hindus and Muslims each have their own faith room for their religious activities. The various faith groups also organise appropriate religious festivals for their devotees.

**5.1.7.** The festival of Ramadan is particularly important for the Muslim community, during which time devotees fast between sunrise and sunset each day. The Centre recognises the needs of Muslims during this period and special dispensations are given to enable residents to participate. The Imam officiates at services daily and because people are fasting at normal mealtimes, Serco offer a selection of food packs which are distributed each day at sunset and provide a varied evening meal, drinks and breakfast. This extra provision was well-received by the residents who gave generally positive feedback and Serco should be commended for their efforts.

**5.1.8.** An Activities Group, run by Serco, organised social events throughout the year. These included: charity days, “Children in Need”, a Caribbean Festival and World Refugee day, which are generally well- supported and enjoyed by most of the residents.

## **5.2. Activities, Education and Employment**

**5.2.1.** The residents at Yarl's Wood are of many different nationalities and from many different cultures. This diversity is reflected in their needs and interests, so the activities, education and employment opportunities offered are important in helping to ensure their well-being. Moreover, as there is no enforced structure to the day, it is important that residents have a varied range of available activities to keep them occupied.

**5.2.2.** When staffing permitted, a varied range of activities and events was planned. It was pleasing to see the efforts made to organise a varied programme of activities celebrating dates and events which are important across the cultural and religious range within the Centre.

**5.2.3.** The Café Central continues to be a very popular facility, particularly with residents from the Indian sub-continent, and provides opportunities to prepare food to their taste and also to engage in a meaningful and social activity. Unfortunately, during 2015 there were times when it could not be staffed and so residents were unable to use it.

**5.2.4.** The Salon remains very popular. It has continued to provide two jobs for residents, who appear to enjoy the work. There are also salon slots available for male residents.

**5.2.5.** The Welfare team provides valuable support for residents in a number of areas and their services were used in 2015 by many of the nationalities in the centre. With slight monthly variations, the main users were from India, Nigeria and Jamaica, in line with the higher proportion of residents from these countries than from others. There has been a small, but regular, number of ex-Foreign National Offenders ("ex-FNOs") who have used the welfare services.

**5.2.6.** The library is an essential source of information and entertainment for residents. Some of the materials on offer are in relevant foreign languages. Important information about access to legal advice and other services is displayed, along with the dates of focus group meetings and details of employment opportunities within the Centre.

**5.2.7.** There are 65 opportunities for paid employment for residents. However, the ever-changing population of the Centre means that it has not always been possible to fill them all and it is predominantly the longer-stayers who take up the posts. Most of the employed residents are aged between 19 and 50, although there has been a very small but consistent number of older employees. Some nationalities are under-represented and there are few opportunities for male residents.

**5.2.8.** In 2015 the post room was created as an additional facility. It is also a distribution centre for items of personal hygiene and hair-styling appliances. The post room provides three employment opportunities which are currently filled. There is plenty of useful information on display in the room and it is often very busy with residents collecting post or sending faxes.

**5.2.9.** The sports hall offers a good timetable of activities. Some are more popular than others, but this must reflect the interests of the current residents. The gym is well-used and it is good to see that there are men-only sessions, as well as sessions exclusively for older residents. We welcome the addition of the new outdoor sports area that offers cricket, football and volleyball activities.

**5.2.10.** The arts and crafts room is a valuable resource, providing worthwhile and enjoyable activities. It is popular and residents have to book a slot if they wish to use the facilities. The room is well-organised and the sewing machines are in good condition. The range of items made continues to grow and some of the items are sold - 50 pence of each sale goes to charity and the rest is used to replace materials. When the tutor is absent, cover is provided, but no major new projects can be scheduled during periods of planned absence.

**5.2.11.** Tuition is offered in English, maths and IT. The IT facilities continue to be popular. Five more computers have been added to the main IT suite, but the IT room in Bunting is under-used. A number of residents have completed basic computer training and some have successfully completed certificated programmes of study at different levels. The IMB are aware of a few occasions where classes have had to be cancelled due to a shortage of staff.

**5.2.12.** Social events are important in brightening up the time spent in the Centre and a good range of activities has been organised. Attendance varies according to the origins of the residents at the time of the event. Some of the more light-hearted, non-religious events (e.g. Red Nose Day, Chinese Ribbon Dancing) are very well-attended.

**5.2.13.** The weekly bingo session in the sports hall is very popular and when staffing permits, there is a fortnightly disco, which is very much enjoyed by the participants.

### **5.3. Food**

**5.3.1.** The Board member on rota duty normally eats a meal with residents. On the whole we can report favourably on the quality of food and the lengths that the catering staff go to cater for a vast variety of nationalities, cultures and religions, particularly for the evening meal.

**5.3.2.** The lunchtime menu, however, has not been adequate. Our concern for most of the year was that the mid-day meal was too carbohydrate-laden, with pizza, large white baguettes, and chips being frequently on offer. This was not sufficiently culturally diverse or nutritionally balanced. The IMB had received complaints via informal discussion with residents and expressed our concerns to management.

**5.3.3.** In November the lunchtime menu was revised: residents are now given soup and sandwiches or wraps every day. While the soups are freshly-made and of good quality, the sandwiches are of more variable quality and the lunchtime menu is not culturally diverse.

**5.3.4.** There is a food comments book in each dining room and we are pleased to note that it is used and staff respond to comments.

**5.3.5.** Dining also gives an opportunity for us to talk informally to residents.

## **5.4. Healthcare and Mental Health**

**5.4.1.** The demand for medical services at Yarl's Wood, in relation to both physical and mental health, is high. In 2015, we felt that that demand was not being adequately met. Problems with Healthcare continued to dominate IMB concerns, although by the end of the year considerable progress had been made in improving the service to residents. There is still some way to go, particularly to increase resident confidence.

**5.4.2.** Under arrangements which came into force on 1<sup>st</sup> September 2014, healthcare at Yarl's Wood is commissioned by NHS England from G4S. In our 2014 report we identified serious deficiencies in the provision, which were exacerbated by the change in contractor and the new commissioning arrangements. During 2015 many of the same problems continued, although the Board acknowledges the efforts being made, particularly by the new local management, to improve the service to residents and to increase confidence. The department started 2015 seriously under-staffed and over-dependent on agency nurses (although some of these are former Serco Health employees who have transferred to agencies). In June, the department was 80% staffed by agency personnel, with only one nursing post filled by a permanent member of staff. This had an enormous impact on the department's budget and on management's ability to introduce improvements in practice. Strenuous efforts have been made to recruit, and vacancies are being filled, but by the end of 2015, only 12 out of 24 posts in the department were held by permanent staff, with another two in the vetting stage. Recruitment is a slow process because of the need for all staff to be security-cleared.

**5.4.3.** We commented in our 2014 Report on the difficulties caused by the new contractual arrangements. These continued into 2015. Neither the main contractor, Serco, nor the Home Office manager at Yarl's Wood, had sight of the Healthcare contract and the Home Office manager had no role in monitoring the contract. Serco and Home Office staff were dealing day-to-day with residents' frustration at the department's performance but had no contractual role to influence it. These divisions in the contractual arrangements could be seen filtering down to custodial staff. IMB members received many comments from officers about Healthcare's lack of responsiveness. On one occasion of which the Board was made aware in March, a custody officer, rightly or wrongly, called an ambulance for a resident experiencing an epileptic fit as he was not satisfied with Healthcare's response.

**5.4.4.** During the second half of 2015, however, we have observed a concerted effort on the part of all parties to co-operate and work constructively in order to improve the service. This happens formally through the bi-monthly Partnership Board meetings and the recently-instituted monthly Integrated Governance Meetings, to both of which the IMB is invited. The Healthcare Manager is also helpful in answering queries from the IMB about individual residents.

**5.4.5.** The IMB received 40 applications, written and oral, from residents about Healthcare during 2015. This is a similar number to those received during 2014 but does not include passing comments or concerns raised during conversations where no

follow-up was asked for. It is the area about which residents complained most to the IMB during 2015. A total of 122 formal complaints were also made to HOIE via the DCF 9 complaints procedure, of which 17 were upheld either partially or in full. We do not have access to these complaints so we are unable to comment on their substance or on the quality or timeliness of the responses, although we were made aware of substantial delays in dealing with healthcare complaints in the early part of the year. It is interesting to note that 84 of the 122 complaints were made in the first six months of 2015, which tends to bear out our assessment that the service has improved over the course of the year.

**5.4.6.** Applications to the IMB consistently raised the following three problems: first, delays in obtaining GP appointments. In 2015, the GP provision was for 42 hours a week over seven days. There were, however, difficulties over the GP contract during the year which on occasion led to reduced availability. The Board is aware of three days in the year on which there was no GP available for residents although, where possible, the service was doubled on subsequent days to make up for the absence. This combination of factors led to delays in routine appointments and also in the consideration of rule 35 applications, for which numbers have increased steadily throughout the year. However, figures reported to the Partnership Board in November 2015 indicated that the situation has improved considerably with the wait for a GP appointment having reduced to only two days. An extra 10 hours per week has also been allocated for rule 35 appointments, as well as improved training, supervision and appraisal for the practitioners carrying out this important work.

**5.4.7.** We also identify communication difficulties, as Board members are often told, on enquiry, that a resident has not attended an appointment. G4S figures for “DNAs”, where a resident did not attend an appointment made for them, are high: in May the rate was 20%. In September this had reduced slightly to 16%. It is not clear where the difficulties lie but there is some work to do to ensure that residents fully understand the system for booking appointments and, when an appointment has been made, that they are told in a communication that they can understand, when that appointment is.

**5.4.8.** One aspect of GP provision that the Board is particularly concerned about is the dramatic reduction in the initial GP appointments which are required under rule 34. Rule 34 provides that a resident “shall be examined by a medical practitioner within 24 hours of arrival”. Previously, an appointment was automatically made by Healthcare for new arrivals but there was a high number of DNAs. In January 2015, for example, there were 454 new admissions to Yarl’s Wood, but only 193 residents attended such an appointment within 24 hours. DNAs on these appointments continued at this rate until the practice was changed: residents are now simply offered an appointment, but the majority decline and no appointment is made. In August, for example, under the new system, there were more than 500 new arrivals but only 31 initial appointments were held<sup>1</sup>.

**5.4.9.** The Board is concerned that the new practice of simply offering an appointment is not compliant with rule 34 and that an appointment should be made for each resident, with residents being positively encouraged to attend. There is a risk that residents’ serious physical or mental health problems might not be picked up by the initial nurse assessments, especially since these are often carried out by a male nurse,

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<sup>1</sup> *Serco management figures*

and very often happen at night when the resident has arrived at the end of a long journey. These are not ideal conditions for disclosure of sensitive medical information. 49% of respondents to the survey conducted by HMIP during their April 2015 inspection reported that they had health problems on arrival<sup>2</sup>.

**5.4.10.** A second theme of resident applications to the IMB, and of many passing comments, was that Healthcare staff are rude and dismissive. The Board has persistently reported this over the years and is concerned that it is not apparently being addressed. We should make it clear that we have not observed any such conduct during our routine visits to Healthcare, (of course we only witness exchanges in the reception area) but it is such a recurring theme of applications to us and of responses to HMIP's surveys and interviews, that it continues to cause us concern.

**5.4.11.** Efforts have been made during 2015 to address the negative perceptions that residents have of Healthcare. One of these initiatives was the introduction of "Healthcare Champions". These were residents employed to explain to new arrivals how the system worked, and to report problems back before they escalated. Unfortunately, there was not enough take-up of these posts for the initiative to continue. A second initiative was the Healthcare Focus Group, which was designed as an open forum for residents to voice their concerns about the service. Attendance at these meetings was poor. These, together with the Health and Fitness awareness days organised throughout the year, are laudable efforts to try to improve confidence in the system but clearly there is some way to go.

**5.4.12.** The third area of concern, also noted in our 2014 report, was around the prescribing and issuing of medication. Residents reported delays of a week or more in obtaining medication and complained of mistakes. The Board therefore welcomed the appointment of a Pharmacy Technician in October to oversee the storage and distribution of all medication. In addition, a room, separate from Healthcare reception, is under construction to store and distribute medicine. This should contribute to better storage of routine medication and management of prescriptions, as well as relieving pressure in reception, where medication is currently dispensed.

**5.4.13.** Another welcome development is that paracetamol is once more stocked on the residential unit offices. At one stage, residents were required to go to Healthcare to be given paracetamol. A member of the IMB carrying out a monitoring visit one night observed 17 residents queuing to leave one of the units to go to Healthcare for medication. Of these, 10 wanted only paracetamol. Putting this back in the unit office is a sensible decision.

**5.4.14.** Mental health is also a matter of huge concern at Yarl's Wood. As is well-documented and described, both in IMB reports and in those of many other bodies, immigration detainees suffer from a wide range of mental health problems. In the course of his recent review<sup>3</sup>, Stephen Shaw commissioned a review of mental health literature by Professor Mary Bosworth, which concluded that detention is of itself

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<sup>2</sup> HMCIP: *Report into an unannounced inspection of Yarl's Wood IRC, 13 April – 1 May 2015, para 2.72.*

<sup>3</sup> *Review into the Welfare in Detention of Vulnerable Persons; a report to the Home Office by Stephen Shaw, published January 2016,*

damaging to mental health and contributes to vulnerability. Our experience, gleaned from the women we meet over many visits, would tend to bear this out.

**5.4.15.** The mental health problems experienced by the residents at Yarl's Wood range from feelings of anxiety or depression to acute episodes of psychosis. The incidence of self-harm is high and has increased from 58 cases in 2014 to 96 in 2015. [see 5.7.4]. In their most recent report HMIP found<sup>4</sup> that 49% of residents reported feeling depressed or suicidal on arrival. Added to this may be extreme anxiety about their immigration cases and their future, as well as, in many cases, anxiety about children being cared-for outside the detention setting. None of these problems will improve in detention.

**5.4.16.** There is therefore an enormous need for a wide range of mental health therapies and interventions. Some women simply need someone to talk to and coping strategies; others need treatment or crisis intervention. Unfortunately, these needs have not been adequately met during 2015. For women with needs at the lower end of the scale, we reported in 2014 that the counselling service had been scrapped. This also coincided with the reduction in custody staff numbers with the consequence as we report in section 5.10.2, that officers had much less time to get to know and interact with residents.

**5.4.17.** The situation has improved through the year with the introduction of the Justice Health 4 Steps pathway to mental health. Step 1 includes guided self-help and computerized Cognitive Behaviour Therapy. Further steps, which are prescribed by the GP, include Talking Therapies, now available two days a week. There is also a Wellbeing Room offering a number of different complementary therapies for those with lesser needs. The Board has seen feedback forms from residents attending a colour therapy session in November, for example, and they were universally extremely positive.

**5.4.18.** The women who arrive at Yarl's Wood with acute mental health problems continue to cause serious concern, and the numbers appear to be increasing. Many are detained at the airport and our impression is that there is nowhere else for them to go. In 2015, 13 residents were sectioned and transferred to a secure facility. However, they endured difficult and disturbing stays, some of several weeks, at Yarl's Wood while that process was underway.

**5.4.19.** Home Office Enforcement Instructions and Guidelines state (para 55.10) that those suffering from serious mental illness "which cannot be satisfactorily managed in detention" are amongst those people who "are normally considered suitable for detention only in very exceptional circumstances. [However] In exceptional circumstances it may be necessary for detention at a removal centre to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act." For the acutely ill women detained in 2015 the delay in transferring them to a more suitable location did not usually lie in obtaining diagnoses but in obtaining a bed in a secure treatment facility. Their detention may therefore have fallen within the guidelines in that they were kept "safe" from themselves and the public was kept safe from them. However, we would like to stress the unsuitability of the detention

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<sup>4</sup> HMCIP: Report into an unannounced inspection of Yarl's Wood IRC, 13 April – 1 May 2015, para1.34

setting for these patients. We have already referred to well-documented concerns that mental health problems are made worse by detention [5.4.15 above].

**5.4.20.** Our main concern is the lack of proper facilities for caring for these women. There is a limited number of beds in Healthcare but this is not a functioning inpatient facility. We welcomed the opening of a Care Suite in 2015 which provided a softer environment for a number of vulnerable women. It was used extensively in the case of a New Zealand resident with complex issues who was able to be cared for in an environment where her needs could be catered for. However, we feel it has its limitations as it is not considered suitable, for example, for women who are violent or destructive of property. The result is that women with mental health problems, who very often do present as challenging and violent, or destructive of property, are often placed in the Kingfisher separation unit, supervised by custody officers not medical staff, to keep them from harming themselves or other residents. One woman was placed in Kingfisher on at least four different occasions before she was sectioned. Many hours of staff time are involved in keeping them “safe” in this way; staff complain to us that they are not equipped or trained to look after people who should be viewed and treated as patients. We are pleased to note that mental health awareness training is now being given to custody staff but that can do little more than raise their awareness of problems and symptoms, not equip them to manage women with serious problems.

## **5.5. Pregnant Women**

**5.5.1.** For yet another year the Board continues to be concerned about the detention of pregnant women. Many of them in the early stages of pregnancy find that attending the dining room is a nauseous ordeal, and consequentially often miss meals. Each pregnant resident is allowed to take extra fruit, a sandwich, and a small bottle of milk to their room each day, but this is no substitute for a missed meal. Many are very concerned about the health of their unborn child and believe that the fact they are in detention has a deleterious effect on their own mental and physical health.

**5.5.2.** As part of Healthcare’s Action Plan in response to the HMIP report, a clear pathway between the Community Midwifery service, NHS England and G4S has been in place since October. This includes guidelines for ante-natal care and a specific operating protocol relating to out-patient care for residents at Yarl’s Wood.

**5.5.3.** Last year the Board pointed out that the Home Office does not follow its own policy on the detention of pregnant women. This still appears to be the case. Chapter 55.9.1 of the Home Office Enforcement Instructions and Guidance states that ‘Pregnant women should not normally be detained. The exceptions to this general rule are where removal is imminent and medical advice does not suggest confinement before the due removal date, or, for pregnant women of less than 24 weeks gestation, at Yarl’s Wood as part of a fast-track asylum process’. The evidence suggests that the practice of detaining pregnant women does not appear to further the aims of the Returns Directorate, as most detained pregnant women gain Temporary Admission to the UK.

**5.5.4.** The IMB has had great difficulties in obtaining official audited figures on the number of pregnant women being detained at Yarl’s Wood. This is of great concern and we are having to report on management figures supplied by HOIE. However, HOIE

have been unable to supply us with figures on the length of detention of pregnant women.

**5.5.5.** According to data supplied by HOIE, the number of pregnant women held at Yarl's Wood has dropped this year to 89<sup>5</sup>. Only 17 of the 89 pregnant residents were returned to their country of origin, with 81% gaining temporary admission to the UK. These figures suggest that removal was not "imminent" in the great majority of cases.

**5.5.6.** Other independent reports, such as the Shaw report and HMIP in 2015, have criticised the detention of pregnant women, and indeed the Shaw Report recommended that it should cease. The Board would like to express disappointment at the Government's response<sup>6</sup> which does not adopt this recommendation.

**5.5.7.** The Board, again, strongly recommend that the detention of pregnant women should end, but if it is to continue, the Home Office should, at the very least, adhere strictly to its own guidelines.

**5.5.8.** In October 2015 the Home Office offered a formal apology and was ordered to pay compensation to a pregnant Congolese asylum seeker who was unlawfully arrested and detained at Yarl's Wood. The government admitted that the woman, who was five months pregnant when she was arrested, should not have been detained, and that the Home office had breached its own policy.

## **5.6. Removal from Association, Temporary Confinement and Use of Force**

**5.6.1.** The Security Committee meets on a monthly basis to review the monthly intelligence reports and security threats. The IMB is represented at these meetings whenever possible and in 2015 attended 8 out of 12. On occasions, meeting dates and times have to be changed at relatively short notice and this can make it difficult for the IMB member to attend.

**5.6.2.** Room searches were conducted each month, according to a pre-determined schedule for each Unit. Inevitably, these searches are quite intrusive, especially when male officers are involved, and residents can feel intimidated by these activities. The room-searching policy was changed in April 2015, so that searches are intelligence-led, rather than a matter of routine, a development which the IMB welcomes.

**5.6.3.** Contingency plans are also reviewed and updated on a regular basis.

**5.6.4.** Use of Force video recordings are also reviewed. The observations made are taken on board and may be fed back to the officers involved and/or incorporated into future training for staff. Use of Force recordings are also viewed by individual IMB

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<sup>5</sup> All figures quoted have been derived from management information and are therefore provisional and subject to change. This information has not been quality assured under National Statistics protocols

<sup>6</sup> *Immigration Detention: Response to Stephen Shaw's report into the Welfare in Detention of Vulnerable Persons: Written statement - HCWS470*

members on occasions during the year where concerns have been raised in connection with particular incidents.

**5.6.5.** The Board has expressed concerns about what we regard as excessive use of force on two occasions this year. Force was used on 78 occasions compared with 75 in 2014. This represents a small increase against a backdrop in recent years of a downward trend.

**5.6.6.** The most serious incident was on 9th April 2015 when officers were deployed in Personal Protective Equipment in order to effect a resident's removal. An officer struck and injured a resident with a riot shield. This incident is covered in section 5.11.4 to 5.11.7 below.

**5.6.7.** On another occasion, a resident who had taken off all her clothing and was being removed from association, was surrounded by an excessive number of officers, the majority of whom were male, and, we believe, not enough effort was made by officers to cover the resident with a blanket to maintain some decency.

**5.6.8.** There were 93 occasions on which Removal from Association (RFA) was used. In such cases the IMB is informed and the member on duty will visit the resident concerned. The numbers of RFA have increased from the 66 in 2014 and 72 in 2013. Increasingly, also, residents with mental health issues are removed from association, sometimes for extended periods, because the Centre is unable to cater for their needs in normal association conditions. We do not feel that this is appropriate and again recommend that people with mental health issues should not be detained.

**5.6.9.** The Board is concerned about the increase in the exercise of rule 40 and has drawn management's attention to occasions where it considered the use of RFA to have been unnecessary and/or detrimental.

**5.6.10.** For example, there was an incident in June in the Post Room, during a freeze on movements. A few minutes after the freeze was imposed, a resident urinated in the bin in the Post Room. She was taken to Kingfisher under rule 40, even though she appeared to be calm, and other residents did not seem to be troubled by her actions. Once in Kingfisher she refused to go into the cell, then was unfortunately allowed to get hold of the plastic bag containing her urine, which she started swinging around at officers. Force was used to remove the bag from her and to get her into the cell; she dropped to the floor where she appeared to have some kind of medical fit or episode. Healthcare was called immediately and she was stabilised. The IMB member who witnessed her removal to Kingfisher and her subsequent collapse visited her again after she had returned to her unit the next day and she appeared fairly well, but the IMB member felt that the whole episode could have been avoided.

**5.6.11.** The Board is also concerned that RFA is sometimes used as a form of control or punishment when dealing with challenging residents. On one occasion there was an altercation between three residents at an evening party, and later on it had continued under a stairwell, where one resident was waiting for the other two. It ceased when officers arrived on the scene. Later, several officers came to the room of two of the residents and said they were going to Kingfisher. The residents protested their innocence, and the officers spent about twenty minutes trying to persuade them to go voluntarily, but the ladies became increasingly agitated. Eventually force was used,

with disastrous results. One of the residents smashed a mug on the head of an officer, which resulted in him going to hospital and receiving 12 stitches. He was off work for five days. The police were called and the resident was removed to prison. The Board wonders if it would have been better to have left the resolution of this matter until the morning (the removal was about 9.30pm), when all three residents could have met with an officer, and perhaps a VRI opened. The RFA was clearly not required for the safety of the residents, as they were, by then on separate units.

**5.6.12.** Temporary Confinement (TC) was used on 18 occasions which is a slight decrease on the 19 instances in 2014.

**5.6.13.** The Board is concerned about the significant increase in the use of handcuffs when escorting residents to hospital appointments.

**5.6.14.** For example, in the period May to August, 130 external, escorted hospital visits were made by residents. Handcuffs were not deployed on any occasion for these visits. However, in the period September to December, 118 external, escorted hospital visits were made by residents. Handcuffs were deployed on 17 occasions during this period.

**5.6.15.** This has led to a number of residents refusing to attend hospital appointments. The Board is concerned that the health and safety of residents may be put at risk as a result.

## **5.7. Safer Detention**

**5.7.1.** Safer Detention is the process for identifying, monitoring and supporting the most vulnerable residents. The process involves HOIE, Healthcare, Religious Affairs, senior managers, DCOs and the IMB.

**5.7.2.** A Safer Detention report is produced and a monthly meeting is held to review the number of ACDTs (Assessment, Care in Detention and Teamwork) opened every month, why they were opened and by whom. These figures are compared month by month and year by year. Other variables are considered, such as nationality and religious faith, to assess whether there are any trends. The IMB monitors these documents on rota visits and also attends the monthly meetings wherever possible.

**5.7.3.** 355 ACDTs were opened in 2015, which include 100 ACDTs opened when a resident has missed six consecutive meals in the Centre. There was a spike in food refusals after the new menu was introduced in November but the next month the number dropped down again. There is a book for comments in each dining room, and staff regularly consult it.

**5.7.4.** In last year's report we commented on a steady rise in the numbers of ACDTs. This year has shown a decrease from 427, but instances of actual self-harm have increased from 58 to 88. The majority of this increase was due to a few challenging residents self-harming on multiple occasions and the increased number of residents with mental health issues.

**5.7.5.** Constant Supervision is the highest level of ACDT, used when a resident is a high risk of self-harm. In 2015 there were 86, a significant drop from 186 in 2014. These totals are highly affected by the actions of one or two individuals.

**5.7.6.** Additionally, there is a weekly Complex Case Review process and Individual Needs meeting at which a multi-disciplinary team, including the IMB, discuss any resident's needs and assess whether there has been any change.

**5.7.7.** There was one death in custody in April 2015 which is outlined in section 5.12 below.

**5.7.8.** The ACDT and Constant Supervision processes are intrusive, and we welcomed the decision taken during the year that only women staff should monitor female residents on constant supervision.

## **5.8. Length of Detention**

**5.8.1.** In 2015, a total of 3011 females left the Centre compared with 2972 in 2014<sup>7</sup>. Figures published by the Home Office shows the following figures for females leaving the Centre based on the length of stay.

	<b>2015</b>	2014
A: 3 days or less	<b>217</b>	217
B: 4 to 7 days	<b>206</b>	365
C: 8 to 14 days	<b>525</b>	598
D: 15 to 28 days	<b>769</b>	617
E: 29 days to less than 2 months	<b>718</b>	610
F: 2 months to less than 3 months	<b>250</b>	266
G: 3 months to less than 4 months	<b>135</b>	141
H: 4 months to less than 6 months	<b>130</b>	90
I: 6 months to less than 12 months	<b>51</b>	64
J: 12 months to less than 18 months	<b>8</b>	3
K: 18 months to less than 24 months	<b>2</b>	0
L: 24 months to less than 36 months	<b>0</b>	1
M: 36 months to less than 48 months	<b>0</b>	0
<b>Grand Total</b>	<b>3,011</b>	2,972

**5.8.2.** We would like to note our concern that the number of residents leaving the Centre having been detained for 12 months or more has increased from 4 to 10.

**5.8.3.** In our reports every year, we highlight the high proportion of residents who are detained but subsequently released. We note that during 2015, only 19% of residents were removed from the country.

<sup>7</sup> All figures in this section are derived from Home Office Immigration Enforcement figures.

**5.8.4.** Based on the data, we would question the quality of the initial decision to detain, especially as HOIE's own guidelines state that people should only be brought into detention for the shortest possible time and where there is a realistic expectation that removal can be effected within a reasonable time. The figures would suggest that these guidelines are not being followed and show a sharp deterioration when compared to 2014.

**5.8.5.** We have highlighted, in paragraphs 5.4.14 to 5.4.18 above, the mental health problems which we and others have observed amongst immigration detainees. We and others have recorded, in this and previous reports, the many other difficulties encountered by those in detention. It should be borne in mind, in particular, that many of the women held in detention have children being looked after under formal or informal fostering arrangements. Some are carers for other family members. For these reasons, and because of the apparent failure of detention as a means of enforcing removal, we repeat our recommendation that there should be a maximum period for detention, such as the six-month period prescribed by the 2008 European Returns Directive.

**5.8.6.** We also recommend a review of the decision to detain process and that detention should be used only in cases where removal is imminent. We would like to see a greater emphasis on community-based monitoring and we therefore welcome the Government's commitment, in its response to the Shaw review, "to implement a new approach to the case management of those detained...[to] ensure that the minimum possible time is spent in detention". The Government does not, however, accept the desirability of a maximum time limit.<sup>8</sup>

## **5.9. Access to Legal Advice**

**5.9.1.** Legal advice surgeries are held in the Legal Aid Corridor and are manned by three different firms of solicitors. Appointments for this provision are made in the library. The waiting list for these is short: a day or two, or sometimes an appointment can be made for the following day. This is just for initial advice and there is no guarantee that the solicitors will thereafter take on the resident's case. That said, the majority of residents seen by the IMB report that they have solicitors acting for them.

## **5.10. Staffing**

**5.10.1.** In November 2014 Serco was awarded a new, seven-year contract to run Yarl's Wood. The contract started on 27<sup>th</sup> April 2015. The IMB was briefed about the philosophy behind the new contract – a "secure hotel" concept – based on the principle that residents should be allowed to manage more of their day-to-day business themselves. The Board was, to say the least, sceptical.

**5.10.2.** The total staffing complement was reduced by over 25% under the new contract. New shift patterns were introduced and, as mentioned in section 5.11.5 and 5.13.5, seven staff members were removed as a result of disciplinary processes.

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<sup>8</sup> *Immigration Detention: Response to Stephen Shaw's report into the Welfare in Detention of Vulnerable Persons: Written statement - HCWS470*

Added to that there were the normal expected absences through sickness and attrition. It soon became clear that the numbers were far too low and that this was impacting on residents and staff. In addition, officers were no longer assigned to individual units so did not get the opportunity to get to know the residents.

**5.10.3.** There were some positive changes introduced by the new contract, such as the post room, where residents could receive and send faxes and mail. This freed up officers on the units, who had previously been required to do all the faxing in the unit office. There are also paid positions for residents here. The biometric kiosks for ordering food are also a good development, but occasionally residents need help in sorting out how these work.

**5.10.4.** The Board monitored staffing levels, and how they impacted on residents, carefully throughout the year. We observed:

- Several occasions where there was no officer on Bunting unit when we visited;
- The member of staff assigned to Bunting unit being required to do several tasks at once, such as inducting new residents, looking after the other residents, or serving meals.
- No member of staff in evidence in dining rooms on occasion, while a query arose over a resident's meal choices.
- No member of staff present on Hummingbird unit as officers are required to escort a male resident to other parts of the Centre – residents left locked on the unit with no member of staff present.
- Wheelchair-bound residents having to wait to be taken to lunch as there was only one member of staff to escort them in the lift.
- Residents complaining that the unit office was often locked and they could not find an officer to sort out a problem.
- A man waiting to be let out of Hummingbird and becoming very agitated as he was late for his Healthcare appointment
- Only one officer being assigned to each residential unit at night: we observed an occasion when a medical emergency arose on Avocet unit, which meant that a resident had to be taken to Healthcare. The night-café was opened for residents only because a member of the Activities team, who was going off duty, agreed to stay late.
- Education classes being cancelled as the teacher had to be deployed elsewhere.
- Café Central closed as there was no other officer who was trained to supervise it.

**5.10.5.** Incidents such as those recorded above, which we observed during our visits, were matters of immediate concern. What is less tangible, but none the less important, is the effect of having an undoubtedly stretched workforce looking after a population consisting, in the main, of vulnerable women. Many women we see tell us horrific stories of their past and of their journeys into the UK. Their immigration cases are complicated and they often have children on the outside about whom they are anxious. They need sympathetic contact, often just someone to talk to. To their credit, most of the staff recognise this and were frustrated that they did not have time to get to know the residents in their care.

**5.10.6.** The Board has made representations to Serco and to HOIE about the inadequacy of the staffing levels during the course of 2015. We are pleased to record that new officers have been recruited and trained, and that the staffing model has been revised to take account of concerns raised not only by us but also by HMIP in its most recent report<sup>9</sup> and by Kate Lampard in her review of the Centre<sup>10</sup>.

**5.10.7.** The IMB also has concerns about the ratio of male to female staff in this predominantly female centre. There are some tasks which can only be undertaken by female staff, such as searching and looking after women on constant supervision. There are many women who are frightened of men as a result of incidents in their past and who may react badly to men. The privacy of the women at Yarl's Wood has also been a subject of complaint and controversy. Again, we acknowledge management's efforts to recruit more women staff, but are not convinced that the target of 60% women officers is adequate.

## **5.11. Resident Protests**

**5.11.1.** In 2015 the IMB was called out to observe four protests staged by residents. There were also several demonstrations held by protestors outside the Centre. The IMB was present inside during one of these external protests and the Centre remained calm.

### **3rd and 4th March 2015**

**5.11.2.** These two protests, held on successive nights, took the form of residents gathering in the garden of one of the residential units and refusing to come in at evening roll-count. They were a direct reaction to the Channel 4 News broadcasts [see section 5.13]. Tensions had been raised during both these days with many residents refusing the lunchtime meal. They wished to express their understandable distress and disappointment at the recording of officers apparently referring to them in offensive terms.

**5.11.3.** The protests in the garden both passed off peacefully and without incident and were appropriately managed. On the first night the majority of women came inside before too long as it was a very cold night, leaving only three outside until about 1am.

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<sup>9</sup> HMIP report into an unannounced inspection of Yarl's Wood IRC, para 2.11

<sup>10</sup> Independent investigation into concerns about Yarl's Wood immigration removal centre, Kate Lampard & Ed Marsden January 2016

These three women eventually came inside of their own volition, where the duty director spent a long time talking to them and trying to answer their concerns. On the second night the weather was equally cold and all the residents were inside, again of their own volition, by about 9pm. IMB members held discussions with residents on the night of 4<sup>th</sup> March after they had come back inside. They took the opportunity to complain about their detention, their immigration cases and, quite vociferously, about problems with Healthcare. Despite the strength of feeling, the atmosphere remained good-natured.

## **9th April 2015**

**5.11.4.** This incident started when a small number of residents gathered in the bedroom of another resident in order to thwart her removal from the Centre to the airport. They refused to leave the room when asked to do so or to let the resident, who was being removed, leave. After a warning, officers in protective kit (including helmets and riot shields) entered the room and started removing the women. One of the residents, who was sitting on the bed, was injured when an officer struck her with a riot shield.

**5.11.5.** This incident and in particular the striking of the resident with a riot shield was investigated by the Home Office's Professional Standards Unit. The force used by the officer was found to have been excessive; his licence to serve as a custody officer was revoked and he no longer works at Yarl's Wood.

**5.11.6.** The duty IMB member that week was informed of the protest and the planned intervention but by the time he arrived at the scene the incident was over. The Board subsequently reviewed the video footage and the surrounding paperwork. We were concerned not just about the individual use of force that led to a resident being injured, but about the decision – unprecedented at Yarl's Wood – to send officers kitted up in protective gear into a resident's bedroom to effect a removal.

**5.11.7.** The decision to intervene in this way was based on intelligence that the women would be armed with makeshift weapons, including cutlery from the dining room and lids from tinned food cans. The IMB reviewed this intelligence and found it to be thin. There was also the consideration that one of the women was an ex FNO with a history of violence including against an officer. Notwithstanding this, we were not satisfied that the intervention was justified or appropriate. No weapons were found. Nor did it appear from the footage we reviewed of the incident that the warning issued to the residents about the consequences of their non-compliance was sufficiently clear.

## **7<sup>th</sup> September 2015**

**5.11.8.** On 7<sup>th</sup> September an IMB member was at the Centre from 9:15am on her rota visit. She was informed that a peaceful protest was taking place in Avocet garden whereby residents were congregating in the garden and refusing to come back inside. At various points there were between 25 and 40 residents in the garden. The protest was perfectly peaceful and officers let it take its course. Residents eventually came back inside on their own and the IMB member left the Centre at 11:15pm. The IMB member who monitored the incident was concerned that, although the decision not to intervene seemed correct, officers on the ground expressed the view that there were

not enough managers in evidence and they felt unsupported in case the situation changed.

## **5.12. Death in Custody**

**5.12.1.** On 20<sup>th</sup> April 2015 a male resident, Mr Patel, who was housed on the Hummingbird family unit, died suddenly. An inquest found that his death was due to natural causes. He had been detained at the airport with his wife nine weeks earlier. An IMB member was on-site soon afterwards, and observed all the appropriate inquiries and investigations taking place. It also appeared that his widow, the staff immediately affected, and other residents on the family unit, were being given good support. The Board was concerned that his widow was not released until a few days after her husband's death, but HOIE needed to be satisfied that the accommodation to which she was to be released was safe and suitable for her.

**5.12.2.** The circumstances surrounding Mr Patel's death have been fully investigated by the Prisons and Probation Ombudsman<sup>11</sup>. The Ombudsman found that Mr Patel's death was sudden and unforeseeable. However, recommendations were made in two areas. It can be seen that two of these recommendations, in particular about access to GPs, and about staffing, echo concerns raised in this report. One of the recommendations was:

**5.12.3.** That residents should have appropriate access to GPs for both routine and urgent appointments, except in exceptional circumstances. Mr Patel had been referred for a GP appointment on 15<sup>th</sup> April, but none had been booked by the time of his death on 20<sup>th</sup> April.

**5.12.4.** We note above [section 5.4.6] that waiting times for GP appointments are monitored and that they have reduced during 2015.

**5.12.5.** The emergency response at Yarl's Wood was found to be inadequate, because:

- there were two confusing and contradictory local policies about calling an ambulance;
- there was a problem with the operation of the vehicle gates;
- there was only one officer on duty in the control room and no contingency for increasing staffing there during emergencies.

We are assured by management that these recommendations have been completed and in particular that daily and weekly checks are carried out on the operation of the gates.

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<sup>11</sup> *Independent investigation into the death of Mr Pinakinbhai Patel, a detainee at Yarl's Wood Immigration Removal Centre on 20 April 2015 published on the PPO website*

## **5.13. The Channel 4 News Reports**

**5.13.1.** On 2<sup>nd</sup> and 3<sup>rd</sup> March, Channel 4 News broadcast two reports, part of a series on immigration detention, in which officers at Yarl's Wood were recorded apparently making extremely derogatory, offensive, and in some cases, cruel remarks about residents in their care. The broadcast also made allegations about the quality of the Healthcare provision, the detention of pregnant women, and high levels of self-harm among residents. Serco acted appropriately and quickly to identify and suspend the officers concerned and instituted disciplinary proceedings. The company also appointed Kate Lampard to carry out an independent review of the culture and practices at Yarl's Wood.

**5.13.2.** The IMB was shocked to view this footage. The Board has never witnessed any conduct of this kind by officers, the majority of whom treat residents with courtesy and kindness. Our view, which is reinforced by the findings of Ms Lampard<sup>12</sup> and of HMCIP<sup>13</sup>, is that there is no culture of abuse at Yarl's Wood. There have been incidents of impropriety in the past but we do not consider there is any degree of tolerance of this on the part of management.

**5.13.3.** That is not to say that there is room for complacency or that systems to prevent abuse are perfect. We have made recommendations to HOIE for improved monitoring of the Centre and again feel that more female staff will better safeguard residents. We welcome the decision for officers to wear body cameras to monitor their actions more effectively.

**5.13.4.** The other issues covered in the broadcasts are matters about which we also have had serious concerns, which we have raised with management and with HOIE during the course of our monitoring duties throughout the year, and now in this report.

**5.13.5.** In the immediate aftermath, residents were understandably upset by the language and attitudes apparently displayed towards them by officers, leading to the protests on 3<sup>rd</sup> and 4<sup>th</sup> March. Officers and managers worked hard, however, to restore confidence and we continued to observe very positive interaction during this difficult period. The impact on staff morale was considerable. Officers felt let down by their colleagues and, moreover, that there was now a stigma around working at Yarl's Wood. A number of experienced officers left during this period. Healthcare also experienced difficulties in recruiting. The broadcast also had an immediate impact on staff numbers in that one of the officers featured was dismissed straight away, and five others were suspended. They were all experienced staff and two were managers. While the disciplinary actions were completely appropriate, they exacerbated the staffing problems which we identify in section 5.10 above.

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<sup>12</sup> *Independent investigation into concerns about Yarl's Wood Immigration Removal Centre, Kate Lampard & Ed Marsden January 2016*

<sup>13</sup> *HMIP report into an unannounced inspection of Yarl's Wood IRC,*

## 6. The Work of the Independent Monitoring Board

BOARD STATISTICS	2015	Change versus 2014
Recommended Complement of Board Members	12	-
Number of Board members at the start of the reporting period	9	0
Number of Board members at the end of the reporting period	7	-2
Number of new members joining within the reporting period	3	+3
Number of members leaving within the reporting period	4	+2
Total number of Board meetings within the reporting period	12	+1
Average number of attendees at Board meetings during reporting period	7	-2
Number of attendances at meetings other than Board meetings	54	-16
Total number of visits to the IRC (including meetings)	263	+26
Total number of applications/complaints received (written and oral)	84	+10
Total number of segregation reviews held	N/A	N/A
Total number of segregation reviews attended	N/A	N/A

## Subject-matter of Applications to the Board

Code	Subject	2015	Change versus 2014
A	Accommodation	2	+2
B	Access to/quality of legal advice	0	-2
C	Diversity related	0	0
D	Education/employment/training/activities	0	0
E	Family/visits	2	0
F	Food/kitchen related	4	0
G	Health related	40	+2
H	Property	0	-3
I	Related to detainee's immigration case	19	-4
J	Staff/prisoner/detainee related	9	-7
K	Transfers/escorts	2	0
L	Miscellaneous	6	+5